

**THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA
MINISTRY OF WATER IRRIGATION AND ENERGY**



WATER SUPPLY & SANITATION SECTOR

NATIONAL ODF CAMPAIGN 2024

April, 2019



NATIONAL ODF CAMPAIGN 2024
Campaign Framework Document (Draft)

(2019/20 – 2023/24)

DRAFT

EXECUTIVE SUMMARY

In the last 80 years, since the first report of the League of Nations Health Organization on Water Supply and Sewage Treatment in 1936, various steps were taken to transform the global water supply and sanitation status. The most recent ones are the effort to achieve MDGs and most recently the formation of SDGs. By 2015, 181 countries achieved 75% at least basic water supply coverage while only 154 countries achieved the same percentage in sanitation coverage. In absolute figures, the population without basic water supply and basic sanitation services was 0.84 billion and more than 2 billion (70% in rural areas) respectively by 2015 showing that the sanitation gap is nearly 2.5 times more than that of water supply. One of the indicators that show the absence of basic sanitation services is open defecation.

By 2015, nearly 0.9 billion practice open defecation. This is one of the targets of the recent SDG targets SDG6.2 which states *“By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations”*. Such target is set to curb the impact of lack of basic sanitation on the health of the population and economic development of communities. Poor drinking water, sanitation and hygiene access directly accounts for 882,000 diarrheal deaths every year. Cholera still affects more than 40 countries. About 2.9 million cases and 95,000 deaths per year due to cholera were estimated globally. In Africa it is estimated that 40 – 80 million people live in Cholera “hotspots”. The Cholera hotspots considering data from 2010 – 2016 shows most of cholera hotspot areas are in Sub-Saharan Africa. . With regard to economic impact, a 2012 World Bank survey of eighteen countries to understand economic burden of poor sanitation revealed that the annual loss in each country was 1–2.5 per cent of the GDP.

The Government of the Federal Democratic of Ethiopia has carried out a number of initiatives to improve WaSH sector particularly the sanitation component both in the MDG and SDG period. Through these efforts, a substantial improvement was achieved in access to basic sanitation as reported in JMP 2015, access to basic sanitation increase from 8% in 1990 to 71% 2015 and open defecation (OD) practicing population decreased from about 90% in 1990 to about 30% in 2015. This is a tremendous achievement and this was also confirmed by the 2015/16 CLTSH program survey by UNICEF which states the OD population to be 32%. The performance in reducing open defecation from 2000 to 2016 from 82% to 32% has contributed significantly for improvement of the health status of under-five children. In the same period, under-five mortality reduced from 166 per 1,000 live births to 67.

The problems encountered while implementing the various sanitation programs are mainly related to inconsistency of performance, substandard infrastructure, lack of progress in institutional WaSH, data inconsistency and lack of institutional coordination and integration. Though population wise, the average ODF status of Ethiopia is 32%, regional level percentages show significant disparity. The regional percentages of OD population, considering rural population which is over 80% of the total population, ranges from less than 1% in Benishangul-Gumuz to 88% in Afar region. These shows the performance is inconsistent and requires extensive action, especially in Afar and Gambela regions. Ethiopia is praised to bring percentage of population practicing OD from 90% to 32%. However, since the sanitation facilities

constructed are of very poor quality, the status of Ethiopia in the sanitation ladder is globally the lowest. What this means is, Ethiopia has made significant strides in reducing the number of people at the bottom of the sanitation ladder through access to rudimentary community latrines. However, only 7.1% of the population has access to basic sanitation.

The other critical problem of the sanitation sector which hinders the success in creating ODF nation is the lack of institutional coordination and mandate overlap. Efforts to improve sanitation are being carried out by different Ministries and Regional Bureaus (MoH & MoWIE / Regional Health and Water Bureaus), agencies, utilities, NGOs, CBOs. Though there is ONEWASH program which is unique its success is mainly in water supply not sanitation. Such scattered effort creates a vacuum of responsibility which is endangering the achievements to date and sustainability of the sanitation services.

Ethiopia's past effort to promote sanitation is based on the constitution and policies designed to realize the constitutional rights through strategies, programs and projects. One of the critical issue here is both the Health Sector and Water Sector have produced policies, strategies, programs and projects to implement sanitation. However giving priorities to their main sector MoH for health and MoWIE for water supply, **sanitation has become almost an orphan that does not have committed owner.** Unless this situation is changed there is a risk whatever has been gained could be lost.

The effort that is being carried out under the umbrella of GTP2 through One WaSH National Program (OWNP) and specially the Community Led Sanitation and Hygiene initiative are not successful in bringing proper basic sanitation and increase the number of ODF kebeles. An independent evaluation of CLTSH program supported by UNICEF and WSSCC from 2012 to 2015 showed **only about 25% of triggered kebeles have become ODF some of them with a risk of returning to OD status.**

Thus, considering the above facts it is clear that the basic sanitation intervention which is expected to be the cornerstone of creating healthy and productive citizens both in rural and urban areas is in clear problem unless immediate action is taken to rectify it through an ODF campaign. Otherwise, the whole progress can be reversed in a short period and the benefits of having basic sanitation will be a dream as most of our prior interventions are traditional that could not be sustained.

The overall campaign objective is to eradicate open defecation and declare all Woredas and Ethiopia ODF by end of 2024. The specific objectives of the campaign are to:

- Create ODF baseline database by Woreda
- mobilize stakeholders to one national campaign to eradicate open defecation
- mobilize fund and other resources
- Train necessary manpower that would lead the national target or goal of ODF
- Bring behavioral change that would sustain utilization of improved and safely managed latrines
- Prepare alternative model latrine designs
- Monitor and evaluate performance of Kebeles towards ODF and certify and declare if the Kebele is ODF through study

- Design steps towards ODF+

Availability of alternative latrine options that suit various socio-economic and physical settings is a key to the creation of ODF community. The low level of improved and decent latrine usage in Ethiopia should therefore be changed to meet the vision of ODF campaign. There are several latrine options that can be broadly categorized into dry and wet latrine groups. Available improved dry latrines include simple pit latrines, ventilated improved pit latrines and Ecosan toilets. The wet latrine systems in use include pour-flush and full flush toilets that are connected to leach pits, septic tanks or sewers. **There is a need for preparing an illustrated catalogue that contains adequate information on different improved latrine options and contribute to informed choices by customers.** Efforts shall be exerted to promote widespread use of improved latrines following the sanitation ladder of sustainable development goals.

In order to convince customers to having improved latrines, **design and construction of demonstration toilets** in accessible areas like public institutions, model households, market places, etc is recommended. **The single pit compost latrine, Arborloo, is the technology that is proposed for rural areas** because of its simplicity, availability of land, and possibility of using the compost for growing trees. There have been success stories in promoting and using a large number of arborloos in Ethiopia. **Simple pit latrine is the proposed model latrine for small towns** because of difficulty of getting pit emptying services and relative ease of space availability for digging and using pits. **Ventilated double vault improved pit latrine is recommended for medium towns** to allow continuous usage and save space. **A pour flush toilet connected to off-set leach-pit is proposed for large towns** where the use of flush toilets that are discharging into open drains is a problem. The provision of sanitation facilities through community and public toilet complexes is proposed in situations where land availability is a problem like in high density urban quarters or there are areas with high percentage of floating population like market areas, transport stations, etc. **Two-seat pour flush toilets connected to septic tank or sewer are recommended for large towns and two-seat double vault VIP latrines are proposed for medium and small towns.** Community and public toilets shall meet minimum requirements with regard to location, number, cubicle size, etc. **Two-seat VIP latrines and pour flush toilets that meet minimum requirements are proposed for healthcare establishments.** Different types of two-door latrines that meet minimum requirements are recommended for schools. A sanitation marketing strategy that is developed based on empirical studies and meets the needs of entrepreneurs, customers and other stakeholders shall be developed and implemented. It shall be backed by relevant policy and legal instruments, implementation capacities and financial arrangements at different levels. **Establishment of functional rural sanitary market and production centers is proposed.** An effective awareness raising and behavior change communication campaign using different means such as interpersonal communication and IEC materials shall be conducted. Tailored trainings on different topics such as production of latrine inputs, construction and use of latrines, sanitation marketing, etc shall be developed and delivered to relevant groups.

Improved sanitation provides several socio-economic and environmental benefits to citizens and a nation through the protection of public and environmental health. Committed financial and technical supports are therefore expected from different stakeholders. **Federal and regional governments shall allocate adequate budget** for the success of the campaign and create relevant enabling environment. Major financial and technical supports are also expected from development partners and NGOs. The success of the campaign also counts on the active involvement of different such as households, schools and healthcare establishments, financial institutions, business enterprises, community based organizations, the media and influential figures. A five-steps monitoring and evaluation system will be implemented to evaluate the success of the ODF campaign. Declaration and verification of ODF Areas shall be done following the protocol developed by the Ministry of Health. Results and key lessons associated with the campaign shall be properly documented and disseminated. Activities that ensure the sustainability of the initiative and its alignment with sustainable development goals will also be carried out. Relevant units equipped with the necessary resources shall be established at different levels to implement the ODF campaign. **The campaign will be coordinated through the national one WaSH program** and will have a high-level steering committee consisting of members from MoWIE, MoH, MoE and MoFED. The total estimated cost of the campaign from initiation to completion is USD 1.67 billion.

ABBREVIATIONS

CBO	Community Based Organizations
CLTS	Community Led Total Sanitation
CLTSH	Community Led Total Sanitation and Hygiene
CSA	Central Statistical Authority
EDHS	Ethiopian Demographic and Health Survey
EPHI	Ethiopian Public Health Institute
EWRMP	Ethiopian Water Resources Management Policy
GDP	Gross Domestic Product
GTP	Growth and Transformation Plan
IEC	Information, Education and Communication
IUSHS	Integrated Urban Sanitation and Hygiene Strategy
JMP	Joint Monitoring Program
LDC	Least Developed Countries
MDG	Millennium Development Goals
ME	Monitoring and Evaluation
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
MoUDH	Ministry of Urban Development and Housing
MoWIE	Ministry of Water, Irrigation and Energy
NGO	Non-Governmental Organizations
OCHA	Office for the Coordination of Humanitarian Affairs
OD	Open Defecation
ODF	Open Defecation Free
RSM/PC	Rural Sanitary Markets and production Centers
SDG	Sustainable Development Goals
UAP	Universal Access Plan
UWWM	Urban Water and Wastewater Management
VIP	Ventilated Improved Pit Latrine
WaSH	Water, Sanitation and Hygiene
WHO	World Health Organization
WSP	Water and Sanitation Program
WSS	Water and Sanitation Strategy

VISION AND MISSION

VISION

The Vision of the National ODF Campaign Ethiopia 2024 is to see Clean Ethiopia where its citizens enjoy healthy life with dignity.

MISSION

The Mission of the National ODF Campaign Ethiopia 2024 is to mobilize all stakeholders and required resources from grassroots community to the highest level of the Government of FDRE, Regional Governments, public and private institutions, civil societies and NGOs, bilateral and international partners; to achieve the Clean Ethiopia vision through bringing behavioral change and introduction of at least basic sanitation infrastructure at household, communal and institutional levels and thereby creating ODF kebeles throughout the nation ensuring healthy life with dignity for all Ethiopians by 2024.

CONTENTS

EXECUTIVE SUMMARY	i
ABBREVIATIONS	v
VISION AND MISSION	vi
1 GLOBAL PERSPECTIVE OF SANITATION	1
1.1 Historical Background.....	1
1.2 Global Water and Sanitation Status	1
1.3 Sustainable Development Goals.....	2
1.4 Adverse Impact of Poor Water, Sanitation and Hygiene (WaSH).....	3
1.4.1 Health.....	3
1.4.2 Education	4
1.4.3 Economy.....	5
2 SANITATION SITUATION IN ETHIOPIA	6
2.1 Achievements.....	6
2.2 Problems Encountered.....	9
2.2.1 Inconsistent Performance.....	9
2.2.2 Sub-standard infrastructure.....	10
2.2.3 Data Inconsistency	11
2.2.4 Lack of Coordination	11
2.2.5 Limited Institutional WaSH.....	12
2.3 Adverse Impact of Lack of Sanitation.....	13
2.3.1 Health Impact.....	13
2.3.2 Economic Impact	13
3 PAST EFFORTS TO PROMOTE SANITATION	14
3.1 The Constitution.....	14
3.2 Policies	14
3.2.1 Water Resource Management Policy.....	14
3.2.2 Health Policy.....	15
3.2.3 Urban Development Policy.....	15
3.3 Strategies	15
3.3.1 National Water Sector Strategy of Ethiopia.....	15
3.3.2 Urban Wastewater Management Strategy (May 2017)	16
3.3.3 National Hygiene and Environmental Health Strategy (December 2016).....	17
3.3.4 Integrated Urban Sanitation and Hygiene Strategy (April 2017)	18
3.4 Plans, Programs and Projects	19
3.4.1 Growth and Transformation Plan.....	19
3.4.2 One WASH National Program.....	20
3.4.3 Community Led Total Sanitation Hygiene Program	22
4 RATIONALES AND OBJECTIVE OF ODF ETHIOPIA 2024	26
4.1 Rationale.....	26
4.2 Objective	27
4.3 Scope of the Campaign	27
5 LESSONS FROM INTERNATIONAL EXPERIENCE	30
5.1 Building Clean India by 2019	30
5.2 The National ODF Kenya 2020 Campaign Framework Kenya	32

5.3	Making Nigeria Open Defecation Free by 2025 – A National Road Map.....	32
6	METHODS AND STRATEGIES	34
6.1	General Framework and Components of the Campaign	34
6.1.1	Mobilization Phase of the campaign.....	34
6.1.2	Implementation Phase Components of the Campaign	34
6.2	Component-I: The Sanitation Infrastructure for ODF Campaign 2024	35
6.2.1	Latrine Technologies in Ethiopia.....	35
6.2.2	Latrine options	35
6.2.3	Catalogue of latrine options.....	38
6.2.4	Model toilet design and construction.....	38
6.2.4.1	Rural areas	39
6.2.4.2	Households in Small towns	40
6.2.4.3	Households in Medium towns.....	42
6.2.4.4	Households in Large towns	44
6.2.4.5	Community and Public toilets	45
6.2.4.6	Toilets for Healthcare institutions	46
6.2.4.7	Toilets for schools	47
6.2.5	Sanitation market Centers	47
6.2.6	Annual targets for construction of latrines.....	48
6.3	Component-II: Capacity Building	49
6.3.1	Design and delivery of tailored trainings.....	49
6.3.2	Experience sharing.....	50
6.4	Component-III: Advocacy, Behavior Change and Communication	50
6.4.1	Awareness raising	50
6.4.2	Advocacy	51
6.4.3	Social and behavior change communication.....	51
6.5	Component-IV: Resource Mobilization to ODF campaign	52
7	MONITORING AND EVALUATION	55
7.1	Enabling environment	55
7.2	Documentation and Reporting	56
7.3	Declaration of ODF Areas.....	56
8	BEYOND 2024: ODF +	58
9	IMPLEMENTATION ARRANGEMENT AND ACTION PLAN	59
9.1	The Campaign Framework.....	59
9.2	Institutional Setup	60
10	BUDGET	63
10.1	The Campaign Budget Estimates	63
10.2	Financing Mechanisms of ODF 2024 Campaign	64
11	REFERENCES	68

LIST OF FIGURES

Figure 2-1: Access by Woreda to rural water supply (above) and sanitation (below) by July, 2013 (OCHA and UNICEF, 2013) (provide clear pictures from OWNP).....	7
Figure 2-2: Performance of Countries on Open Defecation from 2000 – 2015 (JMP, 2017)	9
Figure 2-3: Regional disparities in access to sanitation in percent of rural population (UNICEF, 2016)...	10

Figure 2-4: Progress in reduction of rural open defecation in Ethiopia – National Average (UNICEF, 2016)	11
Figure 6-1: Types of latrine facilities in Ethiopia (MoH, 2017).....	35
Figure 6-2: The sanitation ladder	38
Figure 6-3: Single pit Arborloo latrine	39
Figure 6-4: Model simple pit latrine (a)section (b) plan view	41
Figure 6-5: Model double vault VIP	43
Figure 6-6: Pour flush toilet discharging into leach-pit	44
Figure 7-1: ODF Monitoring, Verification and Declaration Process	57
Figure 8-1: Stages to ODF+	58
Figure 10-1: The overall financial estimate by different components of tasks	63
Figure 10-2: The budget distribution over the five years of the campaign	64

LIST OF TABLES

Table 1-1: Updated service ladder for global monitoring of drinking water supply and status 2015.....	2
Table 1-2: Updated service ladder for global monitoring of sanitation and status 2015.....	3
Table 2-1: Top ten countries that reduced open defecation by percentage (Water Aid, 2017)	8
Table 2-2: Top 10 countries with most people without decent toilets by percentage (Water Aid, 2018)	10
Table 2-3: Availability (%) of WaSH Facilities in Health (EPHI, 2018).....	12
Table 3-1: Categories of Cities in Ethiopia.....	16
Table 3-2: Summarized Indicators of Evaluated Regions	23
Table 4-1: Tasks for ODF campaign	28
Table 6-1: Some possible Latrine Technologies.....	36
Table 6-2: Annual targets for latrines	48
Table 9-1: Institutional arrangement framework for the campaign	59
Table 9-2: The ODF 2024 Campaign Implementation Schedule (Yearly).....	61
Table 10-1: Implementation Phase Cost breakdown	64
Table 10-2: Expected financing options of the Campaign.....	65
Table 10-3: Estimated budget of the Campaign	66

1 GLOBAL PERSPECTIVE OF SANITATION

1.1 Historical Background

In most recent history, since the foundation of the League of Nation the World has been carrying out various efforts to improve the health status of communities and ensure sustained economic growth by creating healthy and productive community. For more than 80 years, since the first report of the League of Nations Health Organization on Water Supply and Sewage Treatment in 1936, various steps were taken to transform the global water supply and sanitation status. Some of the key activities carried out until the 1990s are:

In 1948 the World Health Organization (WHO) established and formed a committee on Environmental Sanitation to promote the improvement of environmental hygiene, including sanitation and minimize the burden of water associated ill-health

In the 1950s, WHO and UNICEF conduct pilot projects focusing on rural sanitation in order to reduce disease through the introduction of safe water technologies and demonstration of excreta disposal methods.

The next two decades – the 1960s and 1970s- the focus was mainly on water supply. Community Water Supply Program was established in 1960s to provide water adequate in quantity and with acceptable quality for human, agriculture and industries. The 1977 United Nations Conference on Water adopted a program with realistic standards in quantity and quality, if possible, to provide water for urban and rural areas by 1990. The 1980s was declared as International Drinking Water Supply and Sanitation Decade which gave priority to the poor, less privileged and water scarce areas.

The various efforts that were carried out to improve the global water supply and sanitation status since the 1930s were focused improving mainly the water supply status and was only taken as sectoral agenda being handled by various sectors in a scattered manner. However, in 2000, it was understood that Water Supply Sanitation and Hygiene (WaSH) is a development agenda and the United Nations Adopted the Millennium Development Goals (MDG) taking 1990 as a base year spanning for 25 years until 2015.

1.2 Global Water and Sanitation Status

The MDG 7 targeted to halve the population without water supply and sanitation by 2015 taking 1990 as a base year. The performance in water supply is better than that of sanitation. In the final report it was considered the water supply target was achieved while that of sanitation requires substantial effort. By 2015, 181 countries achieved 75% at least basic water supply coverage while only 154 countries achieved the same percentage in sanitation coverage. In absolute figures, the population without basic water supply and basic sanitation services was 0.84 billion and more than 2 billion (70% in rural areas) respectively by 2015 showing that the sanitation gap is nearly 2.5 times more than that of water supply.

The coverage of basic water supply and sanitation shows disparity between regions. The least proportion of population with access to both water supply and sanitation service is registered in Sub-Saharan Africa, in both cases being less than 50% (WHO and UNICEF, 2017a).

One of the indicators that show the absence of basic sanitation services is open defecation. By 2015, nearly 0.9 billion practice open defecation. This is one of the targets of the recent Sustainable Development Goals (SDGs).

1.3 Sustainable Development Goals

The Sustainable Development Goals (SDG) 6 focuses on Water and Sanitation sector. The Goal of SDG 6 is to “Ensure availability and sustainable management of water and sanitation for all”. It has two targets: the first target (6.1) to “achieve access to safe and affordable drinking water” and the second target (6.2) to “achieve access to sanitation and hygiene and end open defecation”

To achieve these targets, the SDG 6 sets global ladders for both water supply and sanitation as shown in table 1.1 and 1.2. including remarks on their status by end of 2015 when the SDGs began.

Table 1-1: Updated service ladder for global monitoring of drinking water supply and status 2015

Service Level	Definition	Baseline Status (2015)
Safely managed	Drinking water from an improved water source that is located on premises, available when needed and free from fecal and priority chemical contamination	5 billion people
Basic	Drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing	1 billion people
Limited	Drinking water from an improved source for which collection time exceeds 30 minutes for a round trip, including queuing	0.263 billion
Unimproved	Drinking water from an unprotected dug well or unprotected spring	0.84 billion
Surface water	Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal	0.159 billion people collect directly from surface water sources

Table 1-2: Updated service ladder for global monitoring of sanitation and status 2015

Service Level	Definition	Baseline Status (2015)
Safely managed	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite	3 billion people (60% in urban/ 40% in rural areas)
Basic	Use of improved facilities that are not shared with other households	2 billion people
Limited	Use of improved facilities shared between two or more households	0.6 billion people
Unimproved	Use of pit latrines without a slab or platform, hanging latrines or bucket latrines	0.876 billion
Open Defecation	Disposal of human faeces in fields, forests, bushes, open bodies of water, beaches or other open spaces or with solid waste	0.92 billion

The two tables clearly show there is a difference in the achievement obtained by the end of the MDG period in the water supply and sanitation targets and hence sanitation will be one of the biggest challenges to achieve by 2030 as stipulated in SDG6 as:

“By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations”

SDG6.2 targets to eradicate open defecation with a baseline population of nearly 1 billion practicing open defecation in 2015. Based on the recent report of WHO and UNICEF (2017), the regional and global status of sanitation as per updated sanitation ladder presented in table 2, 12% of global population practice open defecation and among regions of the world Central and Southern Asia and Sub-Saharan Africa have the highest number of open defecation with about 30% and 25% respectively.

1.4 Adverse Impact of Poor Water, Sanitation and Hygiene (WaSH)

The major global challenges encountered by communities due to poor WaSH are direct effect on health, indirectly influence education of mainly girls and strategic impact on the economy due to inactive work force.

1.4.1 Health

The impact of poor WaSH is tremendous on the health of communities and as a result on the day to day economic activities of individuals and the national economy at large. Safe drinking water and adequate sanitation are essential to end preventable deaths from diarrhea and other water-related diseases which affects mainly vulnerable communities that do not have basic WaSH

services. Poor drinking water, sanitation and hygiene access directly accounts for 882,000 diarrheal deaths every year (Pruss-Ustun and others, 2014). Cholera still affects more than 40 countries. About 2.9 million cases and 95,000 deaths per year due to cholera were estimated globally (Ali and others, 2015). In Africa it is estimated that 40 – 80 million people live in Cholera “hotspots”. The Cholera hotspots considering data from 2010 – 2016 shows most of cholera hotspot areas are in Sub-Saharan Africa (Lesslers and others, 2018).

The Cholera incidences prevail in areas where basic water and sanitation services are lacking like crowded and unhygienic slums and refugee camps, rural areas, along rivers and lake shores. The incidence of Cholera is affected by the degree of access to water and sanitation. But the data from both Cholera and non-cholera endemic countries shows that very low percentage of basic sanitation coverage causes more Cholera incidences though the degree of use of basic drinking water supply services has a role too (GTFCC, 2017).

Poor access to WaSH causes the expansion of neglected tropical diseases (NTDs) which affect over 1 billion people in 149 countries. The diseases are:

- trachoma which is causing blindness or visual impairment of 1.9 million people in 41 countries (WHO, 2018b) which resulted from bacterial infection transmitted through eye-seeking flies breeding in feces
- Soil transmitted helminthiases and schistosomiasis which are linked to open defecation or practices such as reuse of untreated wastewater and fecal sludge for food production. One quarter of the world’s population is estimated to be infected by soil-transmitted helminth infection and 218 million people are estimated to require preventive treatment for schistosomiasis (WHO, 2018c).

1.4.2 Education

It is well known that access to water increases attendance to education through increased girls enrolment to schools. But studies also show providing water at village level for communities is not sufficient to ensure girls education. Absence of WaSH services specially sanitation services at schools is a deterrent to girls education.

In 2013, only 52 per cent of primary schools in LDCs had adequate access to water supplies, and only 51 per cent had adequate sanitation. Such percentage of coverage is low compared to global figures for primary schools of 71 per cent and 69 per cent, respectively (UNICEF, 2015b). Girls enrolment increased more than that of boys following the construction of school latrines in India (Adukia, 2017). Clean and well-maintained primary school toilets were more important than the number of toilets for improving attendance in Kenya (Dreibelbis and others, 2013).

Gender inequalities and the lack of water and sanitation have important implications for girls’ education. In Zambia, improved water and sanitation in schools reduced repetition and dropout rates for girls. Adequate sanitation provision has an even stronger impact than water supply (Agol and others, 2017).

1.4.3 Economy

A 2012 World Bank survey of eighteen countries to understand economic burden of poor sanitation revealed that the annual loss in each country was 1–2.5 per cent of the GDP (Water Sanitation Programme Report, 2012 and JMP report, 2017). The study showed that the major cost could be attributed to premature deaths, including of children under the age of five, by diseases like diarrhea. Other significant costs were loss of productivity and time due to the practice of open defecation. The study estimates that the countries lost around US \$2 billion annually due to only open defecation. The study explains that each person without access to a toilet can spend up to 2.5 days a year in search of privacy to defecate, resulting in losses totaling almost US \$500 million. Women shoulder a huge proportion of this cost as they spend additional time accompanying young children or sick or elderly relatives to relieve themselves, as well as finding a safe place for urination.

As discussed above, considering the global perspective of sanitation, Ethiopia is required to implement the SDG6 which aspires to eradicate open defecation by 2030 as it is committed to mainstream the various SDGs in its development endeavor. In the following sections baseline sanitation situation, previous efforts carried out to improve the sanitation situation at various levels, the rationale and objective of the envisaged ODF Campaign, lessons from previous ODF campaigns in various countries and strategies designed to achieve Ethiopia's ODF initiative including implementation arrangement and budget is presented.

2 SANITATION SITUATION IN ETHIOPIA

The Government of the Federal Democratic of Ethiopia has carried out a number of initiatives to improve WaSH sector particularly the sanitation component both in the MDG and SDG period. The achievements to date, problems encountered and impact of limited or no sanitation services are briefly elaborated in the following sub-chapters.

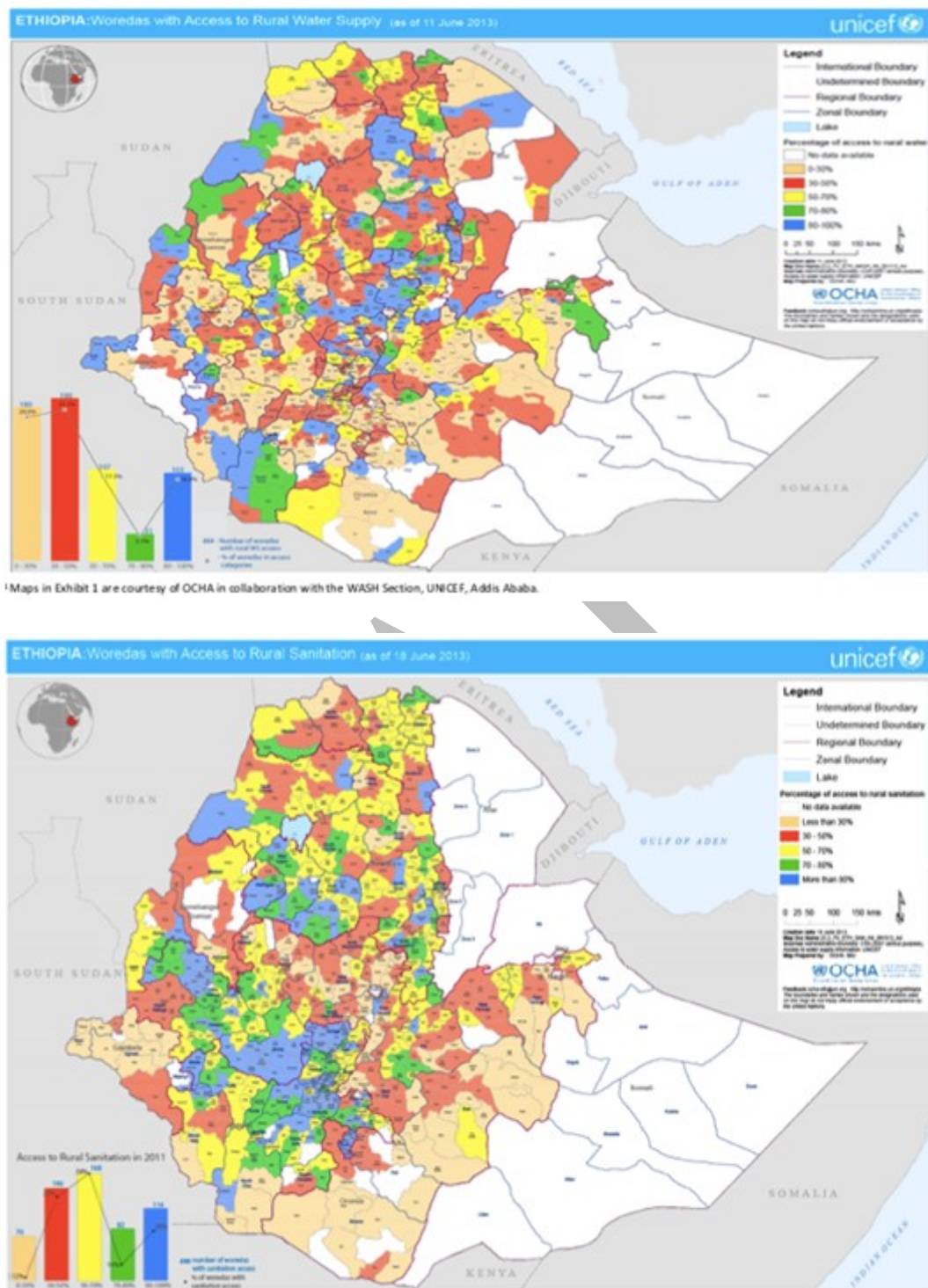
2.1 Achievements

Ethiopia, through the core guidance of the constitution, sector policies, strategies and various programs and projects has implemented a number of national initiatives to improve the water supply and sanitation status both rural and urban population.

A map produced after the National WaSH inventory of 2011 for the water supply and sanitation coverage by Woreda (fig. 2.1) prepared by OCHA in collaboration with WaSH Section UNICEF Addis Ababa (2013) gives some clue in the status before five years by the end of GTP I.

Through these efforts, a substantial improvement were achieved in access to basic sanitation as reported in JMP 2015, access to basic sanitation increase from 8% in 1990 to 71% 2015 and open defecation (OD) practicing population decreased from about 90% in 1990 to about 30% in 2015. This is a tremendous achievement and this was also confirmed by the 2015/16 CLTSH program survey by UNICEF (UNICEF,2017) which states the OD population to be 32%.

The Growth and Transformation Plan II (GTPII) under the targets of health has planned to increase the per cent of households having improved sanitation facility from 28% (2015) to 82% (2020). As per the data obtained from the MoH, the performance towards achieving GTP II targets by 2017 for improved and traditional was 28 % and 40% respectively. With regards to ODF Kebeles in 2017 it was 27% and reached 32% in 2018 and is planned to reach 50% by the end of the 2018/19 budget year.



Maps in Exhibit 1 are courtesy of OCHA in collaboration with the WASH Section, UNICEF, Addis Ababa.

Figure 2-1: Access by Woreda to rural water supply (above) and sanitation (below) by July, 2013 (OCHA and UNICEF, 2013) (provide clear pictures from OWNPN)

The Water Aid publication under the title “Out of Order – The State of the World’s Toilets 2017” puts Ethiopia in the first rank of top 10 countries that reduced open defecation by percentage as shown in table 2.1. In the African context the Open Defecation Reduction performance is presented in a map shown in fig. 2.2

Table 2-1: Top ten countries that reduced open defecation by percentage (Water Aid, 2017)

Rank	Country	% point decrease	%of people practicing open defecation in 2000	% of people practicing open defecation in 2015	No. of people practicing open defecation in 2015
1	Ethiopia	52.7	79.8	27.2	26,997,570
2	Cambodia	42.2	82.7	40.6	6,319,829
3	Laos	39.9	62.0	22.1	1,501,104
4	Nepal	34.8	64.6	29.8	8,504,753
5	Pakistan	29.9	41.5	11.5	21,813,413
6	India	26.1	66.0	39.8	522,261,058
7	Sudan	24.3	50.9	26.7	10,728,934
8	Burkina Faso	23.4	71.4	48.0	8,686,380
9	Solomon Islands	22.0	63.0	41.1	239,588
10	Sao Tome and Principe	20.8	70.6	49.8	94,775

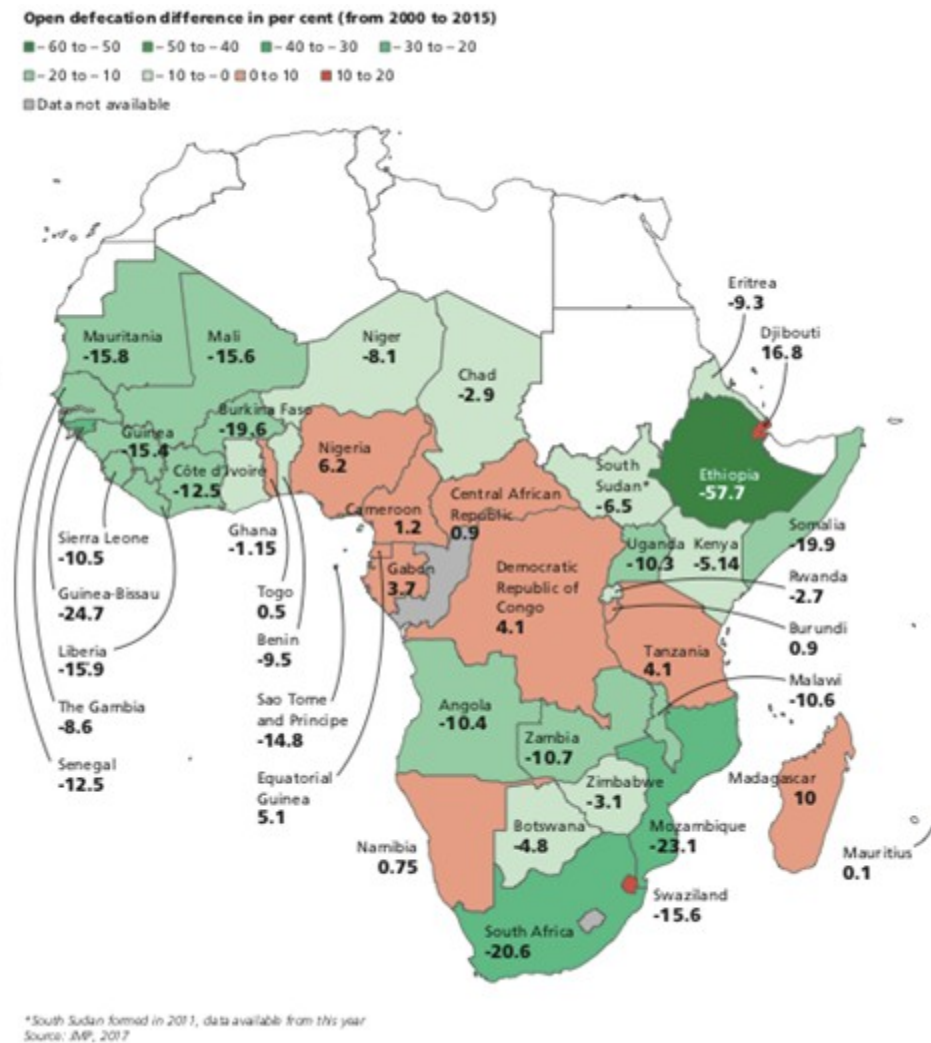


Figure 2-2: Performance of Countries on Open Defecation from 2000 – 2015 (JMP, 2017)

The performance in reducing open defecation from 2000 to 2016 from 82% to 32% has contributed significantly for improvement of the health status of under-five children. In the same period, under-five mortality reduced from 166 per 1,000 live births to 67 (MoH, 2017).

2.2 Problems Encountered

The problems encountered while implementing the various sanitation programs are mainly related to inconsistency of performance, substandard infrastructure, lack of progress in institutional WaSH, data inconsistency and lack of institutional coordination and integration.

2.2.1 Inconsistent Performance

Though population wise, the average ODF status of Ethiopia is 32%, regional level percentages show significant disparity as shown on fig. 2.2. The regional percentages of OD population,

considering rural population which is over 80% of the total population, ranges from less than 1% in Benishangul-Gumuz to 88% in Afar region. These shows the performance is inconsistent and requires extensive action, especially in Afar and Gambela regions.

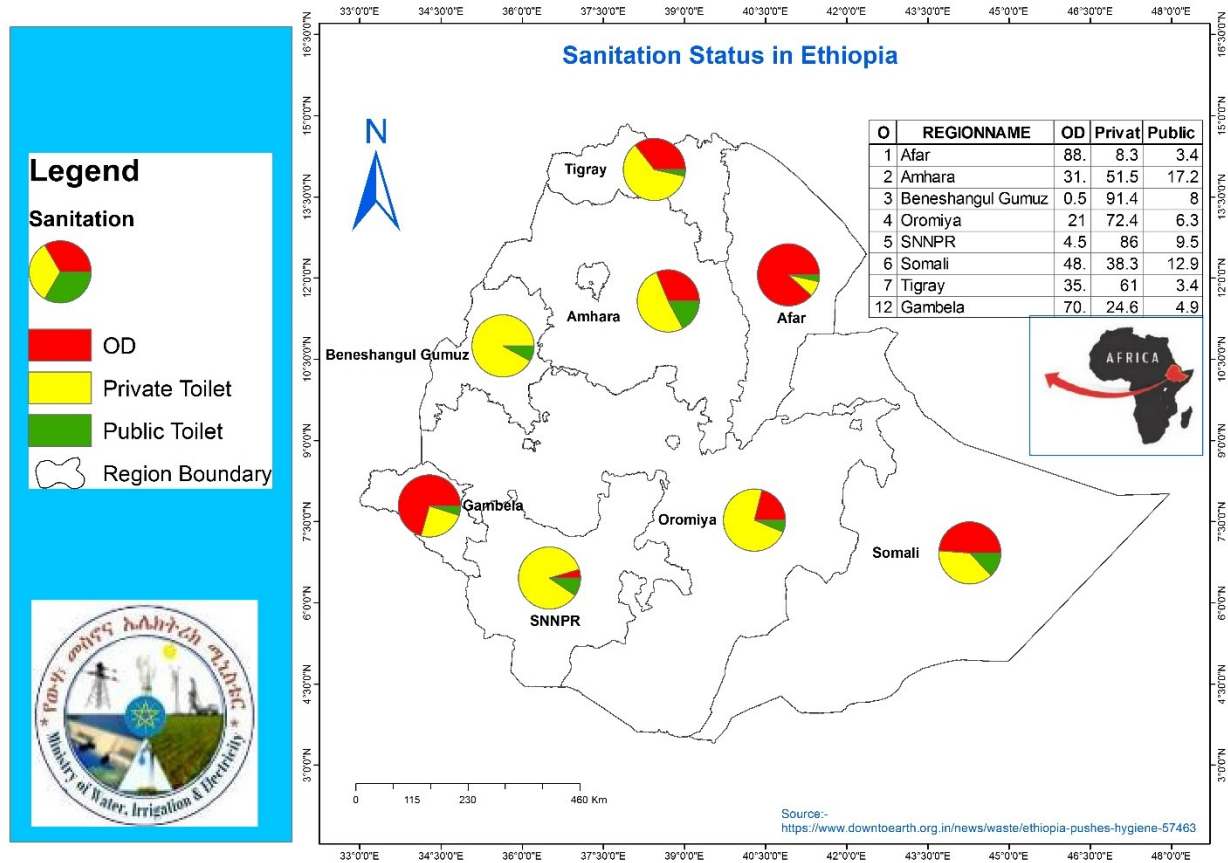


Figure 2-3: Regional disparities in access to sanitation in percent of rural population (UNICEF, 2016)

2.2.2 Sub-standard infrastructure

Ethiopia is praised to bring percentage of population practicing OD from 90% to 32%. However, since the sanitation facilities constructed are of very poor quality, the status of Ethiopia in the sanitation ladder is globally the lowest. Recently, Water Aid publication, “Out of Order – The State of the World’s Toilets 2017” puts Ethiopia as a country where over 90% of the population has no decent toilet as presented in table 2.2.

Table 2-2: Top 10 countries with most people without decent toilets by percentage (Water Aid, 2018)

Rank	Country	%population without access to at least basic sanitation	No. people without access to at least basic sanitation
1	Ethiopia	92.9	92,354,960
2	Chad	90.5	12,697,120
3	Madagascar	90.3	21,886,092
4	South Sudan	89.6	11,062,628

5	Eritrea	88.7	4,639,271
6	Niger	87.1	17,324,706
7	Benin	86.1	9,364,257
8	Togo	86.1	6,285,700
9	Ghana	85.7	23,495,896
10	Sierra Leone	85.5	5,515,157

Water Aid continues its opinion on Ethiopia’s unprecedented effort to expand sanitation coverage “Ethiopia is both top of the list of countries with the greatest percentage of people living without decent toilets, and best improved in reducing the number of people practicing open defecation. What this means is, Ethiopia has made significant strides in reducing the number of people at the bottom of the sanitation ladder through access to rudimentary community latrines. However, only 7.1% of the population has access to basic sanitation.”

2.2.3 Data Inconsistency

The data with regards to coverage of sanitation facilities in JMP report, individual UN agencies and CSA are not matching mainly due to not using different standards for key indicators the graph in fig. 2.3 is a very good example. The data of UNICEF and Demographic Health Survey (DHS) are almost identical showing approximately 32% OD, over 60% unimproved including shared and less than 10% improved sanitation.

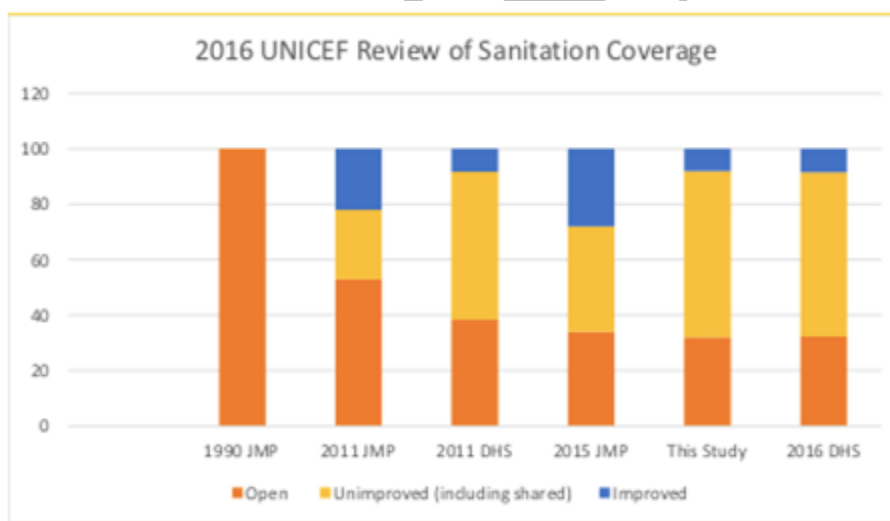


Figure 2-4: Progress in reduction of rural open defecation in Ethiopia – National Average (UNICEF, 2016)

2.2.4 Lack of Coordination

Efforts to improve sanitation are being carried out by different Ministries and Regional Bureaus (MoH & MoWIE / Regional Health and Water Bureaus), agencies, utilities, NGOs, CBOs. Though there is ONEWASH program which is unique its success is mainly in water supply not sanitation. Such scattered effort creates a vacuum of responsibility which is endangering the achievements to date and sustainability of the sanitation services.

2.2.5 Limited Institutional WaSH

Health Facilities

The Services Availability and Readiness Assessment (SARA) carried out by the Ethiopian Public Health Institute (EPHI), 2018 shows that on average only 61% and 34% have sanitation and improved water supply services as shown in table 2.3.

Further detail assessment of each type of facility, shows that the level of service highly varies between urban and rural facilities and higher health institutions and basic health service like hospitals and health posts. For example, among health posts only 51% and 15% have sanitation facilities and improved water supply source respectively. The power access is dismal – only 5% of health posts have power supply and the average value considering the various types of health facilities.

The available WaSH facilities show that the percentage of sanitation facilities is relatively better than that of access to improved water supply. The evaluation data indicates that health facilities managed by public institutions has less access to both water supply and sanitation services than others which are managed by private, NGO, etc.

Table 2-3: Availability (%) of WaSH Facilities in Health (EPHI, 2018)

	Improved Water Source (%)	Sanitation Facilities (%)
Facility Type		
Referral Hospital	100	97
General Hospital	99	98
Primary Hospital	96	96
Health Centre	69	86
Health Post	15	51
Higher Clinic	99	99
Medium Clinic	98	98
Lower Clinic	67	69
Managing Authority		
Public	26	58
Others	77	78
Urban / Rural		
Urban	67	75
Rural	23	56

Education

As per the UNICEF report of 2014 the water supply and sanitation coverage in primary schools across Ethiopia in 2014 is 31% and 33 % respectively. Such limited access of sanitation facilities has substantial effect in girls enrolment. (if there is data for 2017 or 2018 from ONEWASH)

2.3 Adverse Impact of Lack of Sanitation

2.3.1 Health Impact

According to WHO (1997), 30% of the disease burden in Ethiopia is attributable to poor sanitation and 15% of total deaths are due to diarrhea. The MDG report (2010) clearly states that 23% of the causes of under-five mortality in Ethiopia are due to diarrhea resulting from poor sanitation and hygiene. The recent Health Sector Transformation Plan (HSTP) and the 2008/9 and 2009/10 Health and Health related Indicator also indicated that diarrhea is the second biggest killer for under five children next to acute respiratory infection. According to EDHS 2011, the wealth index, under five mortality rate and education are correlated with wealth quintiles. The data indicate that the poorer societies are less educated and mortality of under five children also increases with poverty. The costs of poor sanitation are inequitably distributed with the highest economic burden falling disproportionately on the poorest. The richest 20 per cent in sub-Saharan Africa are five times more likely to use improved facilities than the poorest 20 per cent. (Achieving the MDGs with Equity, UNICEF 2015)

The study by World Bank 2013, established that malnutrition is not only due to lack of food but also the result of environment risk factors such as poor sanitation and hygiene. However, the nutrition status in Ethiopia is improving as indicated by three years result of the EDHS 2011. But still total removal or control of the risk factors is the most important guarantee for a sustained child development.

2.3.2 Economic Impact

The effect of poor sanitation or its absence in society is not only limited to health but also to an economic and welfare dimension. Economics of Sanitation Initiative (ESI) desk review conducted by WSP/World Bank 2013, indicates that poor sanitation costs Ethiopia Birr 13.5 billion each year, equivalent to about Birr 170 per person per year or 2.1% of the national GDP.

Better sanitation can not only save lives (human resource), and money otherwise spend on healthcare, but it is also an important marker of improved infrastructure, attracting tourists and investments from outside.

3 PAST EFFORTS TO PROMOTE SANITATION

Ethiopia has been trying to improve the sanitation situation for more than 20 years. The framework of the WaSH sector in Ethiopia is enshrined in the constitution of the Federal Democratic Republic of Ethiopia and is supported by sector policies, strategies; and programs and projects that brings down WaSH services to the grassroots communities - both in the rural and urban context.

3.1 The Constitution

The constitution of the Federal Democratic Republic of Ethiopia has set the corner stone with regard to development and environmental issues which includes water supply and sanitation.

Development and environmental issues are addressed under Article 43, 44, 90 and 92 of the Constitution. In Article 43 under the Right to Development sub-article 1 states “The People of Ethiopia... the right to improved living standards and sustainable development”. Environmental Rights are mentioned under article 44 in sub-article 1 which reads “All persons have the right to a clean and healthy environment”. Article 90 deals with Social Objectives. Sub-article-1 reads “To the extent the country’s resource limit, policies shall aim to provide all Ethiopians access to public health and education, clean water, housing, food and social security”.

In article 92, environmental objectives of the constitution are enumerated in four sub-articles. It is stated that the government shall ensure that all Ethiopians live in a clean and healthy environment.

The above constitutional frameworks emphasizes that clean water and improved sanitation, environmental safety and protection, and being beneficiaries of sustainable development are the rights of the citizen as much as the capacity of the country allows.

3.2 Policies

There are a number of policies that address various aspects of WaSH. The major ones are the water resources management, health and urban development policies.

3.2.1 Water Resource Management Policy

The water resources management policy in its section dealing on sanitation has given a number of policy direction. Among the directions the following key points can be the policy basis for this ODF campaign document.

The policy document among others expects MoWIE :

- to develop a collaborative and cooperative framework for the development of sanitation systems through definition of the responsibilities of the different governmental and other major stakeholders in sanitation at all levels.
- to define and implement acceptable minimum sanitation facilities differentiated in urban and rural scenarios.

- to foster culturally and socially acceptable methods and facilities for sanitation
- to develop standards for different types and levels of sanitation systems including both on - site and off-site, non-water dependent and water- dependent systems; and
- to promote that sanitation services are based on participation-driven and -responsive principles without compromising social equity.

These policy directions are the basis for the preparation of this National ODF Ethiopia 2024 Campaign Framework Document.

3.2.2 Health Policy

The 1993 health policy gives emphasis to the development of environmental health. It also calls for the realization of environmental health through giving emphasis to inter sectoral integration in:

- Accelerating the provision of safe and adequate water for urban and rural population, and
- Developing safe disposal of human, household, agricultural and industrial waste.

The health policy with regards to environmental health for which sanitation is one of the pillars clearly demands inter-sectoral integration for its achievement. Thus, this National ODF Ethiopia 2024 Campaign Framework Document requires inter-sectoral integration for its achievement.

3.2.3 Urban Development Policy

The urban development policy which was published in 2012 under its section of Environmental Protection in Cities focuses on:

- controlling household and institutional pollution through administration measures
- the need for participatory involvement and integration of city administration, community and investors in the pollution prevention and disposal of solid and liquid waste.

The urban development policy document mainly emphasize on regulatory measures and the need for participatory and integrated approach for environmental protection which includes sanitation.

3.3 Strategies

The various sector policies had designed pertinent strategies in order to guide the implementation programs and projects to achieve sector specific goals. The MoWIE and MoH has distinct subsector specific strategies addressing sanitation issues.

3.3.1 National Water Sector Strategy of Ethiopia

The national water sector strategy of Ethiopia, which was prepared by the then Ministry of Water Resources, directs the implementation water sector programs and projects in accordance with

water resources management policy. It has specific strategies to the various subsectors of water. One of these subsector specific strategies is the Water Supply and Sanitation (WSS) Strategy.

The main objective of the WSS strategy is to secure basis for the provision of sustainable, efficient, reliable, affordable and acceptable WSS services to the Ethiopian people. The strategy addresses; the technical and engineering, financial and economic, institutional, capacity building, social and environmental aspects of WSS. Some of the key strategies which address the sanitation component of WSS are:

- Develop standards for different types and levels of sanitation systems – including both on-site and off-site, non-water dependent and water dependent systems. Ensure application of these standards in the design of future sanitation projects to sustain the functioning of these systems in relation to availability of water resources.
- Launch public awareness campaigns to educate people about important WSS issues and related environmental risks.
- Promote improvement of environmental sanitation in urban centers and rural areas and protect water bodies from being polluted and contaminated.

The WSS strategies highlight that MoWIE has the role of developing standards for sanitation systems at various levels including non-water dependent sanitation facilities which are the ones to create ODF environment.

3.3.2 Urban Wastewater Management Strategy (May 2017)

This strategy focuses on urban wastewater management which mainly deals with water-based systems. It also recognizes that wastewater management options should be based on the master plan of the concerned town and its level of development.

The MoWIE initiated the UWWM system strategy document preparation late 2014 within the framework of the EWRMP, 2003 and GTP II. In addition to this SDG program Goal 6(6.3) set to improve water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally by 2030.

Focusing on urban wastewater management, the strategy follows different approaches depending the CSA / MoUDH categorization of cities into five categories based on population size.

Table 3-1: Categories of Cities in Ethiopia

Category #	Population
I	>1,000,000
II	100,000 – 1,000,000
III	50,000 – 100,000
IV	20,000 – 50,000
V	< 20,0000

This Strategy taking into account the national categorization has sorted out the cities and towns into small, medium & large and Mega groups. It recommends appropriate measures to handle sanitation issues as per the development level of the towns. Particularly, the strategy stating the fact that the small towns (Category V) basically use pit latrines suggests the need to manage wastewater with low cost technology and disposal system and recommends the following steps.

- a. Assess their demand according to the town development status to develop appropriate sanitation chain.
- b. Introduce basic wastewater management systems to dispose safely
- c. Introduce low cost business models for waste management
- d. Disposal regulation manuals and guide lines should be in place
- e. Connect to neighboring large towns for vacuum truck service or introduce a separate small size vacuum truck

The strategy recommends various approaches of handling wastewater for higher category towns (Category III and IV) and mega cities and towns (Category I and II) focusing on wastewater management.

The strategy assumes that towns of any category has a minimum of pit latrine as the lowest level of sanitation infrastructure and also gives emphasis for assessing the existing sanitation demand. Though, the strategy focuses on wastewater management, the issue of presence of minimum sanitation infrastructure goes with the need to make towns and cities ODF. Thus, towns should be part of the ODF campaign.

3.3.3 National Hygiene and Environmental Health Strategy (December 2016)

The MoH prepared the National Hygiene and Environmental Health Strategy to comprehensively implement key domains of the Hygiene and Environmental Health (HEH) through community empowerment and institutional enhancement.

There are ten strategic objectives designed to be addressed a number of strategic initiatives. The key strategic objectives highly related to basic sanitation services that could lead to ODF are the strategic objectives 1 to 3 which are directly referred from the document.

Objective 1

By 2020 achieve access to adequate and equitable sanitation for all.

Strategic initiatives:

1. Increase access to improved latrines and hand washing facilities
2. Increase latrine utilization
3. Increase Open Defecation Free (ODF) verified Kebeles
4. Increase integrated solid waste management service
5. Increase integrated liquid waste management service
6. Increase latrines emptied and properly disposal services

Objective 2

By 2020 promote basic hygiene behavior in order to control related communicable diseases. Strategic initiatives:

1. Increase hand washing practice with soap/substitute at all critical moments
2. Increase face, oral and body hygiene practice
3. Increase menstrual hygiene management practices

Objective 3

By 2020 ensure safe water from the point of source to consumption. Strategic initiatives:

1. Increase using drinking water from protected source
2. Increase effective correct and consistence use of household water treatment
3. Increase household water treatment products regulation
4. Increase implementation in improved water scheme
5. Increase water supply system quality surveillance and regulation

The above strategies specially strategic objective 1 and the initiatives listed are directly related to the campaign objective of creating ODF Ethiopia by 2024. It aims to ensure adequate sanitation for all by 2020 but the initiative mentions to increase ODF verified Kebeles. If sanitation for all is achieved which is doubtful ODF is assumed to be achieved if not for the purpose of verification.

Considering, the existing situation, National ODF 2024 Ethiopia document is necessary and could utilize the steps taken in the implementation of this strategy as input.

3.3.4 Integrated Urban Sanitation and Hygiene Strategy (April 2017)

The Integrated Urban Sanitation and Hygiene Strategy (IUSHS) document was prepared under the leadership the Ministry of Health but other Ministries and institutions have actively participated and specifically the Ministries had signed a memorandum of understanding to partner in its effective implementation. The key ministries are the then Ministry of Urban Development, Ministry of Water Irrigation and Electricity, Ministry of Environment, Forestry and Climate Change, Ministry of Finance and Economy Cooperation.

The vision is to see all cities/towns enjoying safer and cleaner man-made and natural environments that contributes to the achievement of a healthy, productive and prosperous nation.

The overall goal of the strategy is to mitigate the negative impacts of poor urban sanitation on health, environment, society, education and the economy by implementing full sanitation systems (from containment through to disposal) for liquid and solid waste through the introduction of sustainable service delivery systems, ensuring uptake of services, intensifying behavioral change communication, strengthening sector integration, and institutional capacities and enforcing regulations.

Among the strategic objectives set in the strategic document the following are highly relevant to the National ODF 2024 Ethiopia Framework Document.

- To bring sustained behavioral change for better hygienic practices, installation of facilities and delivery and uptake of sanitation services by 2020.
- To ensure open defecation free cities and towns by 2020 from current average of 6% to zero percent open defecation.
- To ensure that 100% of urban households in any given town or city have access to improved latrines or toilets by 2020.
- To increase the faecal sludge management systems capable of safely removing, treating and recycling faecal matter to 70% coverage by 2025 (interim targets of 30% by 2020).

The discussed for strategy documents two each from the MoWIE and MoH show that sanitation issues could only be handled in strong partnership between the two Ministries with clear demarcation of the key mandates for each Ministry. With regards to ODF, as this will be a National Campaign working in strong partnership even with other Ministries and stakeholders is crucial for its success.

3.4 Plans, Programs and Projects

3.4.1 Growth and Transformation Plan

The Growth and Transformation Plan (GTP) is the leading document to achieve both national and international goals such as SDGs. The sanitation components of WaSH targets are addressed mainly by the MoWIE and MoH.

MoWIE GTP2

The MoWIE GTP2 targets with regards to WaSH sub-sector focuses on provision of rural and urban water supply and urban sanitation of bigger cities. Among the core strategic direction sets in the document :

- Upgrade the water supply service infrastructure to the level of middle income countries by 2020
- Increase the water supply access coverage upgrading the service level
- Establish urban wastewater management system

Objectives and targets were set for these core strategic directions. An objective (1) was formulated “Increase safe water supply upgrading the service level and improve urban water management system”. In order to achieve this objective the following three goals were set.

- Provide rural water supply access with GTP-2 minimum service level of 25 l/c/day within a distance of 1 km from the water delivery point for 85% of the rural population of which 20% are provided with RPS.
- Provide urban water supply access with GTP-2 minimum service level of 100 l/c/day for category-1 towns/cities, 80 l/c/day for category 2 towns/cities, 60 l/c/d for category-3 towns/cities, 50 l/c/day for category-4 towns/cities, up to the premises and 40 l/c/day for

category-5 towns/cities within a distance of 250 m with piped system for 75% of the population.

- Carryout study and design of urban wastewater management system of 36 category 1,2,3 towns/cities and build wastewater management infrastructure for 6 towns/cities with a population of 200,000 and more.

The GTP2 plan of MoWIE focuses on provision of urban and rural water supply without which sanitation intervention could not be successful and urban wastewater management which was practically a neglected issue except few efforts in the capital. But rural sanitation was not included in the GTP2 plan of MoWIE.

MoH GTP2

The MoH has set targets towards increasing access to improved sanitation “Male and female headed households with access to improved percent toilet facility coverage”. The plan is to increase improved sanitation coverage from 28% to 82%. A general objective of increasing ODF was also mentioned in the document. Besides, the key health related targets mentioned in GTPII are directly or indirectly affected by the presence or absence of improved sanitation. For example, diarrhea which is the result of the absence of safe water supply and improved sanitation is critically affect the targets such as.

- Reduce under 5 child mortality rate (U5CMR) from 64/1000 live births in 2014/15 to 30/1000 live births by 2019/20.
- Reduce infant mortality rate from 44 in 2014/15 to 20 per 1000 live births by 2019/20.

The Fourth Health Sector Development Plan (HSDP IV, 2011 – 2015), Universal Access Plan (UAP), and the country’s Growth and Transformation Plan (GTP, 2011 – 2015) target to achieve 100% access to basic sanitation and, as outlined in the Millennium Development Goals, 82% access to improved sanitation by 2015. Furthermore, HSDP IV set out to increase the proportion of Open Defecation Free (ODF) Kebeles from 15 to 80%.

3.4.2 One WASH National Program

The One WASH National Program (OWNP) is a program that is spearheaded by the MoWIE but led by a steering committee in which key partners are involved in the program management and implementation monitoring and evaluation.

The targets for sanitation and hygiene set out in the Universal Access Plan (UAP) are that all Ethiopians will have access to basic sanitation, while 77% of the population practice handwashing at critical times, safe water handling and water treatment at home, and that 80% of communities in the country achieve open defecation free (ODF) status.

The Program's Development objective is to contribute to improving the health and well-being in rural and urban areas by increasing water supply and sanitation access and the adoption of good hygiene practices in an equitable and sustainable manner.

The WASH Implementation Framework (WIF) sets out four guiding principles that will govern the implementation of the Program:

- Integration of the water, health, education and finance sectors
- Alignment of partners' activities with those of the Government of Ethiopia
- Harmonization of partners' approaches and activities
- Partnership between implementing parties at all levels

Component 1: Rural and Pastoral WASH

Estimated cost: USD 1.03 billion (water supply) and USD 0.4 billion (sanitation and hygiene). Activities by the water bureaus will include construction of 55,865 new conventional water points and water supply schemes and rehabilitating 20,010 existing schemes. Furthermore, 42,529 household dug wells and community dug wells are expected to be constructed by households and communities through self-supply.

Component 2: Urban WASH

Estimated cost: approximately USD 786 million for water supply and USD 95.7 million for sanitation improvements in urban areas. Main activities include study and design, capacity building and management support, environmental and resettlement safeguards, immediate service improvements and expansion and augmentation of water supplies. Sanitation and urban environmental improvements will include desludging equipment and facilities, management of wastewater and public toilets in selected locations.

Component 3: Institutional WASH

Estimated cost: USD 545.7 million. Activities include support to improving water supply and sanitation facilities and hygiene practices at health institutions, which will be the responsibility of the Ministry of Health (MoH) and regional and city health bureaus and woreda health office. The Ministry of Education (MoE) and regional and city education bureaus and woreda education offices will be responsible for planning and implementing WASH activities in schools. Regional/city water bureaus may provide technical assistance in the design, construction and supervision of water supplies in institutions. The indicated amount includes 11,415,542 USD to be used for water quality monitoring. Doing so is expected to increase economy of scale and ease out administration arrangements.

There is also a fourth component – Program Management and Capacity Building which targets to build capacity at all level.

The OOWNP is a unique approach which also has an ultimate target reaching 100% ODF and could be a basis for the National ODF 2024 Ethiopia campaign. A number of projects including CLTSH are under implementation within the OOWNP framework.

3.4.3 Community Led Total Sanitation Hygiene Program

The MoH put in place a National Hygiene and Sanitation Strategy in 2005 and a National Hygiene and 'On-Site' Sanitation Protocol' in 2006. In addition to these policy measures, the Federal Ministry of Health adopted Community Led Total Sanitation and Hygiene (CLTSH) approach in addressing hygiene and sanitation concerns (2011). The Ministry also developed and endorsed the National CLTSH Implementation Guideline, the National CLTS Training Manual and the National CLTSH Verification Protocol (2011).

The Hygiene and Sanitation Strategic Plan of Ethiopia, developed in 2011, clearly stated that public health system has been radically changed during the past several years in Ethiopia with the advent of the Health Extension Program and its over 34,000 Health Extension Workers (HEWs) who greatly expanded the scope and reach of Ethiopia's health system, especially in rural areas. According to the Health and Health related indicators, Ethiopia (2013 – 2014), out of a total of 14923 kebeles planned for triggering, 3655 (24.5%) kebeles had declared the ODF status and would be assumed to adopt key health practices for improved hygiene and sanitation.

An Outcome Evaluation of a CLTSH program sponsored by UNICEF in 86 Woredas (2012 – 2015) and Water Supply and Sanitation Collaborative Council (WSSCC) with a support of Global Sanitation Fund (2013 – 2015) in 40 Woredas of eight regional was carried out in 2016 by BDS – Centre for Research and Development. The evaluation gives a summary of indicators by evaluated regions as summarized in table 3.1 slight modification in calculating percentages of triggered kebeles which become ODF and decrease or increase of prevalence of Diarrhea as reported in DHS 2005 and 2011.

Table 3-2: Summarized Indicators of Evaluated Regions

Indicators	Region								Total
	Afar	Amhara	Benishangul Gumuz	Gambella	Oromia	SNNPR	Somali	Tigray	
Access to Latrine	51.17 %	63.11%	57.0%	29.2%	48.5%	74.25%	40.1%	54.7%	
Triggered Kebeles	65	1,329	127	54	1,490	3,022	8,678	111	14,876
ODF Kebeles	4	1,076	34	20	223	2,168	4	118	3641
% of Triggered (ODF)	6.15%	80.96%	26.77%	37.03%	14.97%	71.74%	0.05%	106.3%	24.47%
Access to Clean Safe Water Source	34.8 %	46.04%	59.7%	64.73%	49.8%	42.02%	40%	52.74%	
Diarrhea Prevalence (DHS 2005)	13.7 %	14.6%	21.3%	15.1%	17.7%	25.1%	12.2%	12.8%	
Diarrhea Prevalence (DHS 2011)	12.7 %	13.0%	22.7%	22.6%	11.3%	16.4%	19.5%	13.4%	
%Decrease (between 2005 and 2011)	7.3%	10.96%	-6.60	-49.67	36.16%	34.66%	-59.83%	-4.69%	
Note : -ve % decrease means prevalence of diarrhea has increased									

The summarized indicators clearly show that less than 25% of triggered kebeles became ODF and diarrhea prevalence increased substantially in two regions Gambella and Somali by about 50% and 60% respectively. These regions have the lowest access to latrine – Gambella (29%) and Somali (40%).

The outcome evaluation has concluded the following points based on detail evaluation of both interventions in the 8 regions of Ethiopia.

- There is low coverage of hygiene and sanitation service; the vast majority of households do not treat water before they use it; the vast majority of respondents reported that they are not washing their hands at critical times and most of households do not have hand-washing facilities.
- Despite having a highly supportive and conducive policy, strategic documents and CLTSH Implementation Guideline in the country, process assessment in this outcome evaluation clearly showed that the implementation of pre- triggering, triggering and post triggering of CLTSH phases in almost all program areas is found to be not strictly following guides listed in National CLTSH Implementation Guideline.
- In addition to this, the National CLTSH Implementation Guideline was not available in almost all health posts in the study area.
- Moreover, the National CLTSH Implementation Guideline does not include the step by step guiding components considering post ODF phase of CLTSH. Implementation and Community Conversation/ Family Dialogue Training Manual adopted for Hygiene and Sanitation was not prepared as it is required by the National CLTSH Implementation Guideline.
- The health system of Ethiopia has a well-designed health structure extending from federal to kebele levels where the necessary manpower is assigned at all level. Despite of all these, instruments for effective follow up and efficient data bases for CLTSH program was found to be critical shortage in this evaluation. Above all, lack of people specifically assigned and committed to ensure the quality of CLTSH implementation at all levels of health system is critical and decisive finding in this evaluation.

Based on these conclusions the outcome evaluation has forwarded the following general and specific (at various levels) recommendations that could help to improve future CLTSH programs that aspire to increase the number of ODF kebeles.

General

- Organizing introductory workshops and trainings on CLTSH in a cascading manner to all relevant health professional and stakeholders at all administrative levels; and organizing and establishing functional, effective and efficient coordinating body within the health system which will coordinate and ensure quality implementation of CLTSH at all administrative levels.

Federal Level:

- Improving the processes of implementation of CLTSH according to the outlines given in the National Implementation Guideline and continuing to respect its subsidy free principle; updating the National CLTSH Implementation Guideline mainly to strengthen the post triggering follow up and guide implementers in line with improving sanitation facilities to climb up the sanitation ladder; preparing user friendly training manual on CC/FD which is adapted to sanitation and hygiene; organizing introductory workshops and trainings on CLTSH in a cascading manner to all relevant health professional and stakeholders at all administrative levels; and organizing and establishing functional, effective and efficient coordinating body within the health system which will coordinate and ensure quality implementation of CLTSH at all administrative levels.

Regional Level:

- Provide directions to all health desks, offices and health posts about the introductory workshop and the RHBs and stakeholders at regional level should also take the initiative to conduct the workshop at zone and woreda levels; develop data collection and storage tools and reporting formats with indicators measuring the process, outputs and outcomes of CLTSH implementation; establish CLTSH data base which supports the front line CLTSH implementers and researchers for further study and program improvement; regulate consensus building workshops, CLTSH training sessions and community triggering related activities and ensure their quality at regional level and delegate with authority and accountability to the woreda offices for activities at woreda and kebele level; take the responsibility of distributing all CLTSH related documents to all health desks, offices, health posts and other relevant stakeholders; based on the guidance given in the National CLTSH Implementation Guideline, ensure the establishment of regional, zonal (if required), woreda and kebele level CLTSH verification team; and support small-scale enterprise groups so that it is possible for them to produce, promote and distribute improved sanitation facilities.

Woreda and Kebele Level:

- Regulate the quality of CLTSH related activities (consensus building workshops, CLTSH training, community triggering, etc.) and ensure their implementations at woreda and kebele levels; to design and ensure continuing training programs for CLTS implementers at woreda and kebele levels. Ensure regular review meetings for HEWs and CLTSH team members with the purpose of follow up on the implementation of community action plan at development unit and ensuring continuing training program for HEWs and CLTSH team members; ensure the organization of kebele level CLTSH verification team; and support small-scale enterprise groups so that it is possible for them to promote improved sanitation, ensure demand based production of sanitation and hygiene facilities, and arrange space for product distribution center at affordable price.

4 RATIONALES AND OBJECTIVE OF ODF ETHIOPIA 2024

4.1 Rationale

The above sections shows mixed realities with regards to sanitation situation in Ethiopia urging some transformative actions should be taken to bring the sanitation sector to improve the health status in a sustainable manner for rural and urban population. Some of the salient features that reflect the paradoxes in the sanitation sector are:

- Ethiopia has reduced open defecation as percentage of population 90% in 1990 to 30% in 2015 which is the highest registered increase rate globally and has contributed a lot to decrease of under-five child mortality in combination with other health related actions
- However, still ODF kebeles are less than 30% even for that there is no reliable baseline data both from MoH and MoWIE.
- The other important point is though there is an increase in latrine coverage as most are traditional latrines that even does not fulfill basic sanitation they could not address the basic requirement of containment of fecal matter hence disease can spread by flies.
- The fact that recent report of Water Aid labeling Ethiopia as number one of the top ten countries where most of its people that does not have decent toilet – almost 93% without basic sanitation is an alarm that triggers question on the way sanitation improvement is handled in Ethiopia.
- Moreover the findings of the outcome evaluation of the CLTSH program implemented in eight regions of Ethiopia with support of UNICEF and WSSCC has indicated that despite the presence of a strong Health Extension Program where environmental sanitation is one of the packages, presence of CLTSH manuals and guidelines the campaign is more or less a failure. About only 25% of triggered kebeles have become ODF without any guarantee for sustainability as there are indications that some ODF kebeles are going backward in becoming OD kebeles.
- The baseline survey shows that though two Ministries are trying to address sanitation sector with seemingly some mandate overlap, practically there exists institutional vacuum on the ground except for availability of policies and strategies. Currently, MoH is more focused on other health sector agendas though it has some activities in hygiene and sanitation. It is sufficient to see the 2018 performance report which has some pages on urban sanitation that mentions some training not that much about real sanitation issues. Similarly MoWIE is mostly focused on rural/ urban water supply and urban wastewater management and sanitation.
- There is clear lack of coordination even in the presence of OWP program as reported in annual reports and various stakeholders forums.

- Not that much behavioral change is achieved and hence returning to the tradition of not using latrines... is a highly likely scenario.
- There is severe lack of data even to know the actual ODF status of Ethiopia except some estimates of the CLTSH program

Thus, considering the above facts it is clear that the basic sanitation intervention which is expected to be the cornerstone of creating healthy and productive citizens both in rural and urban areas is in clear problem unless immediate action is taken to rectify it through an ODF campaign. Otherwise, the whole progress can be reversed in a short period and the benefits of having basic sanitation will be a dream as most of our prior interventions are traditional that could not be sustained.

4.2 Objective

The overall campaign objective is to eradicate open defecation and declare all Woredas and Ethiopia ODF by end of 2024. The specific objectives of the campaign are to:

- Create ODF baseline database by Woreda
- mobilize stakeholders to one national campaign to eradicate open defecation
- mobilize fund and other resources
- Train necessary manpower that would lead the national target or goal of ODF
- Bring behavioral change that would sustain utilization of improved and safely managed latrines
- Prepare alternative model latrine designs
- Monitor and evaluate performance of Kebeles towards ODF and certify and declare if the Kebele is ODF through study
- Design steps towards ODF+

4.3 Scope of the Campaign

The major scope of the campaign is to map the baseline situation of ODF, mobilize resources, create awareness and bring behavioral change, implement capacity building and physical projects towards ODF after 5 years by the mid of 2024. The various tasks that are going to be accomplished in this campaign are presented in table 2.4.

Table 4-1: Tasks for ODF campaign

Task #	Major Task	Sub-Task	Expected Deliverable
Task 1	Mobilization of Resources	<ul style="list-style-type: none"> - Stakeholders mobilization - Human resources mobilization - Fund mobilization 	<ul style="list-style-type: none"> - Stakeholder forum - Key human resources selected - Fund secured
Task 2	Capacity Building	<p><i>Training</i></p> <ul style="list-style-type: none"> - Training need assessment - Training Material Preparation (Existing manuals/ Refresher course...) - Training provision (Training at various levels // Woreda/ Kebele/ Volunteers / Supervisors) <p><i>Experience Sharing (Exchange Visits)</i></p> <ul style="list-style-type: none"> - Local knowledge exchange (among stakeholders / NGOs/ Local administration/ Model Woredas / Households...) - International exchange 	<ul style="list-style-type: none"> - Training need assessment report - Training Material - Trainees ready to lead campaign activities - Synthesis report of local knowledge relevant to speed up the campaign - Summary of international experience relevant to the campaign
Task 3	Implementation	<ul style="list-style-type: none"> - Intensive Public Awareness (Branding ODF/2024 Campaign) - Identification of public institutions for ODF creation - Model toilet design - Model toilet demonstration - Production of toilet fixtures (MSEs/Training component) - Selection of low 	<ul style="list-style-type: none"> - Logo and brochure for ODF/ 2024 - List of public institutions - Alternative toilet design standards - Pilot assessment

Task #	Major Task	Sub-Task	Expected Deliverable
		income households for financial support	report - Scaling up guideline - Organized and trained SMEs producing toilet
Task 4	Documentation and Dissemination	<ul style="list-style-type: none"> - Report format preparation - Digital data collection (video / photo / GPS) - Central digital archive establishment (dynamic or WWW) - Publishing Progressive bulletin / documentaries / publications 	<ul style="list-style-type: none"> - Report formats - Dynamic digital archive - Periodic reports, documentaries and publications
Task 5	Monitoring and Evaluation	<ul style="list-style-type: none"> - ME format preparation - Periodic ME report preparation - Establishment of independent body for ODF Certification and Declaration - Organizing Award Ceremonies 	

5 LESSONS FROM INTERNATIONAL EXPERIENCE

The ODF campaign is being carried out in different countries. For example, Kenya has a National campaign to reach 100% ODF country by 2020 led by Ministry of Health; while India has a target date of October 02/2019 for ODF an initiative by the current Prime Minister to mark 150th birth day of Mahatma Gandhi led by the Ministry of Drinking Water and Sanitation. Hereunder the Indian experience is presented in brief.

5.1 Building Clean India by 2019

The Clean India Mission (Swachh Bharat Mission) began in 2014 under the leadership of the Prime Minister promising to have Clean India by October 02/2019, a date which is the birthday of Mahatma Gandhi. In 2014, only 39% of India was ODF by Sept. 2018 the ODF villages has reached 93% considering the rural India population. The six pillars of Clean India are:

- Leadership at the highest level
- Behavior change at the heart of the mission
- Time-bound goal: ODF by 2nd October 2019
- Focus on quality and sustaining sanitation gains
- Monitoring outcomes and not just output
- Sanitation as everyone's business

These pillars are the cornerstones for the success of the Indian Campaign and could be adapted to the context of Ethiopia.

Among these pillars, the first one – leadership of the highest level - is the key. The story of the Swachh Bharat Mission (SBM) in India is one of high-level political leadership, with the Prime Minister Modi making it one of his top priorities and progress chasing to make sure the government machinery delivers. In one of his first speeches to the nation, he set the vision of an ODF India by 2019. He put in key positions in the Ministry people he knew were able to deliver, and created strong team at federal level with a dynamic officer with vast sanitation experience at the help.

Moreover, the Indian government ensured that political prioritization trickled down to states and districts, pushing the agenda and aligning the incentives of those in charge of sanitation: performance in the SBM became part of indicators that shaped career advancement of civil servants; district officers and village leaders championing SBM were visited by relevant authorities and publicly recognized; rankings according to SBM progress were developed, and the PM awarded top-performers in national ceremonies. This in turn gave a sense of empowerment at the local level, especially to district level officials, allowing them to innovate in order to find solutions to the practical challenges that emerged, be it resources, technology or institutional blockages. Districts also were provided additional human resources for two years.

Furthermore, the Indian government made a substantial effort to promote sanitation, putting it at the centre of the nation's concerns and using a narrative that presented it as a matter of pride,

cleanliness and dignity, linking it to national historical references. SBM makes multiple references to Gandhi, and his glasses are the campaigns' logo, which can be found everywhere in the country, including its banknotes. This narrative, along with wider behaviour change messages, were disseminated via a massive awareness raising campaign, with a two-pronged approach: national and local. At the national level, top-level personalities were part of media stunts, including the PM himself sweeping the streets to launch the campaign, and the SBM director emptying a composted latrine pit with his own hands. National media also featured SBM 'success stories', from a woman selling her goats to build a toilet, to a girl suing her parents for not building a toilet. The most popular living Bollywood actor starred in various TV ads promoting toilet use, and there was been a blockbuster 'Toilet: a love story'. At the local level, an army of local level motivators was recruited to trigger communities and persuade households door to door. School children participated in competitions (eg poems about sanitation) and were even part of sanitation rallies and awareness raising efforts.

To begin, the Government of India proved that they were taking SBM seriously and would 'walk the talk'. Early on in the campaign, they covered 100% of schools with sanitation facilities, and focused on the top 100 touristic spots in the country. By modelling sanitation facilities in visible places they displayed the importance of sanitation. Equally, schools were seen as a key driver, in the sense that they could instill hygienic habits in the young generations. Some challenges emerged regarding continued use (due to the increased water demand), cleanliness and sustainability of the facilities. The education ministry was in charge of school sanitation, with its own budget and monitoring system. Similarly different ministries were in charge of different areas of sanitation (road and transport for commuting hubs and trains, health for health centres, etc). To ensure multi-sectoral coordination, the Prime Minister Office took the leadership and ensured different sectors/ministries contributed as per their responsibilities.

With regards to implementation follow up and monitoring, to support and enable course correction, SBM had a robust monitoring and information systems. An online portal tracked budget expenditure and progress towards toilet construction targets. Sub-district officers would upload the data (including geo-tagged pictures) after their field visits. Being an open database, anyone can check the numbers, down to the household level. This helped create a sense of transparency and reduce corruption. There were also systems for information sharing and adaption. This included both formal ones -such as monthly video conferences between the ministry and key state officers- and informal groups -such as field visits or WhatsApp groups at multiple levels that enabled information sharing across hierarchy lines. To respond to stances of over-reporting, coverage and ODF verification protocols were put in place, albeit with limited success. Over reporting was one flipside of the unparalleled ambition of the Swachh Bharat Mission.

With regards to financing, For the rural Swachh Bharat Mission (2014-2019), the total investment planned was 22 billion USD, 90% of it coming from the Indian government budget and the rest from development partners. 8% of the total investment was allocated for capacity building and behaviour change; that represents 18 USD per unserved household. Poor unserved households received 180 USD as a post-construction subsidy.

5.2 The National ODF Kenya 2020 Campaign Framework Kenya

The National ODF Kenya 2020 Campaign Framework was developed to achieve ODF by 2020 considering lessons from previous efforts to eradicate open defecation. In economic terms, Kenya loses KES 27 billion annually due to poor sanitation. Open defecation costs Kenya US\$ 88 million per year. The Government of Kenya initiated a nationwide Community Led Total Sanitation campaign to end open defecation. A clear ODF rural Kenya Roadmap 2011-2013 was developed with an aim to achieve this goal - 100% ODF Kenya by 2013. This was partly also to accelerate the achievement of MDG 7 (b) which the country has largely missed. However by the end of the period, out of total of 59,915 villages in the country, a dismal 1,273 (2%) had been ODF certified. Apart from the burden of sickness and death, inadequate sanitation threatens to contaminate Kenya's water sources and undermine human dignity.

A clear ODF rural Kenya Roadmap was guided by the National Environmental Sanitation and Hygiene Strategy 2010-2014 and the National Environmental Sanitation and Hygiene policy 2007. The environment within which the campaign was designed however, fundamentally changed in the context of devolved government context. As a result, even though the campaign had overall aim to eradicate open defecation in rural Kenya by the end of 2013, there has been no significant progress in the implementation of the activities as had been envisaged.

It is believed that the National ODF Kenya 2020 Campaign Framework has taken the lessons to achieve the ODF Kenya 2020 target by devolving the implementation modality to the county level and utilizing the basic principles CLTSH.

5.3 Making Nigeria Open Defecation Free by 2025 – A National Road Map

Recognizing the public health risks, the National Council on Water Resources at the 2014 council meeting recommended the development of an Open Defecation Free (ODF) Roadmap for Nigeria. The ODF Roadmap clearly articulated the strategies, plans and investments needed to eliminate open defecation by 2025. Achieving an ODF environment implies having access to toilets not only in the communities but also within schools, health centres, markets and other public places.

The development of the road map considered the following lessons learnt from past efforts and problems associated with slow progress in sanitation coverage based on several studies have been carried out by the Government, UNICEF, Water Aid and others to understand the various aspects of the problem.

- Inappropriate technology options to meet the needs of various geo-physical conditions like loose and collapsible soils, high ground water level, flooded area, rocky terrain etc.
- Lack of appropriate technology option to suit the preference of the people and their paying capacity
- Slow pace in moving up the Sanitation Ladder
- Lack of appropriate tools and methodologies for social mobilization, advocacy, demand generation and behaviour change

- Inadequate skilled facilitators for effective scaling up of CLTS
- Weak institutional arrangements and limited technical knowhow
- Non-availability of effective alternate delivery mechanism
- Low private sector participation in service delivery
- Low involvement of NGOs and CBOs
- Lack of understanding at all levels of the importance of sanitation and hygiene to public health, economy and protection of the environment
- Lack of harmonization across many policies, implementation guidelines and tools for sanitation management
- Low political and financial commitments
- Absence of a suitable credit mechanism at community level to support sanitation
- Inadequate follow up and monitoring by the LGA WASH Departments/ units due to irregular and inadequate financial supports from the LGA authorities and States
- Poor documentation and record keeping of CLTS outputs at the LGA and State levels
- Heterogeneous population groups in peri-urban and urban areas
- Lack of adequate space, particularly in peri-urban and urban areas and the land tenure ship for constructing household latrines
- Slow progress in promoting sanitation in schools, health centres market places etc.
- Lack of uniformity in the provision for subsidy at household level

The lessons from the implementation of ODF campaigns India, Kenya, and Nigeria indicate that the following are key aspects that should be seriously considered

- Leadership from highest level
- Focus on behavioral change
- ODF as an assignment for all
- Institutional coordination
- Introduction of appropriate, affordable and hence sustainable technologies
- Consistent application of CLTSH
- Monitoring and evaluation that focuses on outcome
- Strict post ODF monitoring and supervision

Thus, considering the lessons both from local and international practice of ODF initiatives, this National ODF Ethiopia Campaign 2024 - Campaign Framework Document is developed. The methods and strategies are suggested in the sections ahead.

6 METHODS AND STRATEGIES

6.1 General Framework and Components of the Campaign

The proposed National Campaign to achieve universal ODF is a national sanitation agenda aimed at creating Clean Ethiopia by end of 2024. Thus, active participations of all citizens, federal and regional institutions, public and private stakeholders, NGOs, Community Based Organizations (CBOs), media, celebrities and others are required.

Moreover, it should be spearheaded top political leadership and need to be a national priority agenda. The lessons from India and other countries noted in section 5 are examples that dictate the need for leadership commitment at all levels, bringing behavioral change and active participation of grassroots communities from the beginning.

6.1.1 Mobilization Phase of the campaign

In this phase of the campaign, the main purpose is to create an enabling environment for the upcoming implementation phase of the campaign. The following major activities will be carried out utilizing specified methodologies

- Review of existing efforts and **identification main gaps**
- Identifying leading, partner and collaborating stakeholders based on their primary mandates and responsibilities; which will lead to **establishment of steering committee**.
- Preparing awareness creation workshops to determine duties and responsibilities of each stakeholder at national, regional, zonal, woreda and kebele level and also at key influential institutions
- Organizing fund raising events through various means from different sources
- Organizing key human resource that will supervise and monitor the day to day activities and carry out periodic evaluations

Moreover, during the mobilization phase, standard documents for project implementation, budget plan and detailed strategies will be prepared. The key activities are shown in section 7 and overall campaign schedule in section 9.

6.1.2 Implementation Phase Components of the Campaign

For the proposed campaign, four main components are expected to be undertaken. These components mainly include:

- Component-1: The Sanitation Infrastructure
- Component-2: Capacity Building
- Component-3: Advocacy and
- Component-4: Resource Mobilization

6.2 Component-I: The Sanitation Infrastructure for ODF Campaign 2024

Proper supply, construction and use of sanitation hardwares is an important component of the open defecation campaign. This section briefly presents latrines technologies that are in use in Ethiopia and the world. The proposed model latrines and annual targets for latrine construction are also presented.

6.2.1 Latrine Technologies in Ethiopia

A recent survey at household level by the Ministry of Health indicated that more than 70% the population depends on traditional pit latrines with or without slabs (Fig. 6.1). Use of improved latrines such as VIPs and flush toilets is very low. A lot has to be done to eradicate open defecation through the use of hygienic and decent latrines.

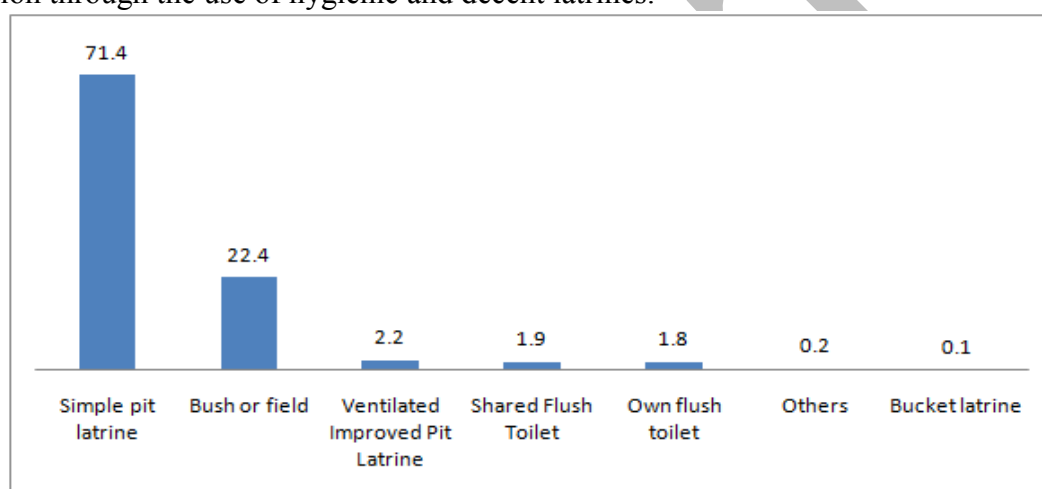


Figure 6-1: Types of latrine facilities in Ethiopia (MoH, 2017)

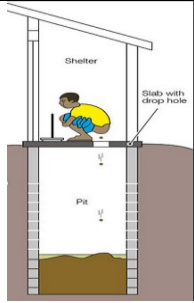
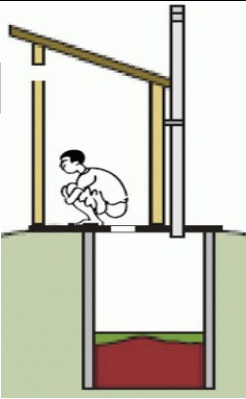
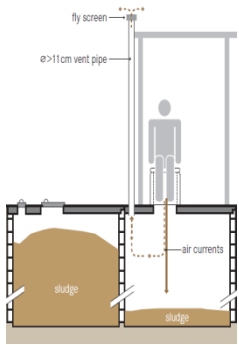
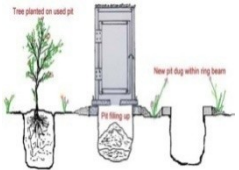
6.2.2 Latrine options

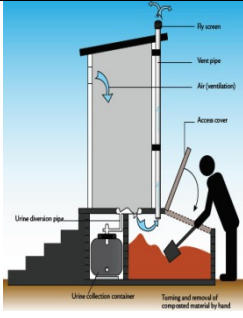
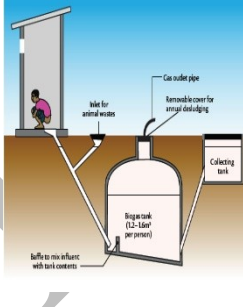
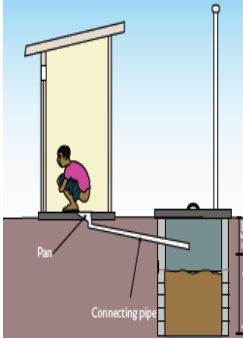
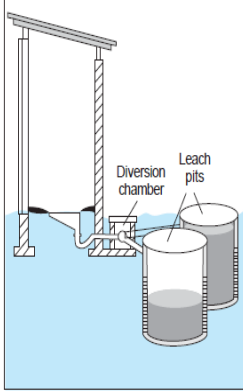

Availability of alternative latrine options that suit various socio-economic and physical settings is key to the creation of ODF community. Latrine technologies are classified into different groups as indicated below:

- Dry systems (e.g. simple pit latrine, ventilated improved pit latrine, EcoSan toilet, etc)
- Wet systems (e.g. pour-flush toilets, water closet toilet, biogas digester, simplified sewerage)
- Prefabricated toilets
- Portable toilets

The spatial application level and advantages and disadvantages of some the possible latrine options are shown in Table 6.1

Table 6-1: Some possible Latrine Technologies

Category	Type of latrine	Applicability	Advantage and Disadvantages	Sketch
Dry sanitary systems	Simple pit latrine	Rural, Peri-urban	<ul style="list-style-type: none"> + Can be built and repaired with locally available materials + Does not require a constant source of water + Can be used immediately after construction + Low (but variable) capital costs depending on materials - Flies and odours are normally noticeable - Sludge requires secondary treatment and/or appropriate discharge - Costs to empty may be significant compared to capital costs - Low reduction in BOD and pathogens - Possible groundwater pollution - Not suitable for areas where land is scarce 	
	Single pit ventilated improved latrine	Rural, Peri-urban	<ul style="list-style-type: none"> + Flies and odours are significantly reduced (compared to non-ventilated pits) + Does not require a constant source of water + Suitable for all types of user (sitters, squatters, washers and wipers) + Can be built and repaired with locally available materials + Can be used immediately after construction + Low (but variable) capital costs depending on materials and pit depth + Small land area required - Sludge requires secondary treatment and/or appropriate discharge - Costs to empty may be significant compared to capital costs - Low reduction in BOD and pathogens 	
	Double pit ventilated improved pit latrine	Rural, Peri-urban, Urban	<ul style="list-style-type: none"> + Longer life than Single VIP (indefinite if maintained) + Potential for use of stored faecal material as soil conditioner + Flies and odours are significantly reduced (compared to non-ventilated pits) + Does not require a constant source of water + Suitable for all types of user (sitters, squatters, washers and wipers) + Can be built and repaired with locally available materials + Can be used immediately after construction + Small land area required - Low/moderate reduction in pathogens - Higher capital cost than Single VIP; reduced operating costs if self-emptied 	
	Arborloo	Rural	<ul style="list-style-type: none"> + Simple technique for all users + Low cost + Low risk of pathogen transmission + May encourage income generation + (tree planting and fruit production) - Labour intensive 	

	Urine diverting toilet	Rural, Peri-urban, Urban	<ul style="list-style-type: none"> + Does not require a constant source of water + No real problems with odours and vectors (flies) if used and maintained correctly (i.e. kept dry) + Can be built and repaired with locally available materials + Low capital and operation costs + Small land area required - Requires education and acceptance to be used correctly - Is prone to clogging with faeces and misuse - Requires constant source of ash, sand or lime - Requires a use/discharge point for urine and faeces - Urine and faeces require manual removal 	
	Biogas latrine	Rural, Peri-urban, Urban	<ul style="list-style-type: none"> + Generation of a renewable, valuable energy source + Low capital costs; low operating costs + Underground construction minimizes land use + Long life span + Can be built and repaired with locally available materials + No electrical energy required + Small land area required (most of the structure can be built underground) - Requires expert design and skilled construction - Gas production below 15°C is not economically feasible - Digested sludge and effluent still requires treatment 	
Wet sanitary systems	Single pit pour flush toilet	Peri-urban, Urban	<ul style="list-style-type: none"> + The water seal effectively prevents odours + The excreta of one user are flushed away before the next user arrives + Suitable for all types of users (sitters, squatters, wipers and washers) + Low capital costs; operating costs depend on the price of water - Requires a constant source of water (can be recycled water and/or collected rain water) - Cannot be built and/or repaired locally with available materials - Requires some education to be used correctly 	
	Twin pits pour flush toilet	Peri-urban, Urban	<ul style="list-style-type: none"> + Can be built and repaired with locally available materials + Because double pits are used alternately, their life is virtually unlimited + Excavation of humus is easier than faecal sludge + Potential for use of stored faecal material as soil conditioner + Flies and odours are significantly reduced (compared to pits without a waterseal) + Low (but variable) capital costs depending on materials; no or low operating costs if self-emptied + Moderate reduction in pathogens - Excreta require manual removal - Clogging is frequent when bulky cleansing materials are used 	
	Cistern flush toilet	Urban	<ul style="list-style-type: none"> + The excreta of one user are flushed away before the next user arrives + No real problems with odours if used correctly + Suitable for all types of users (sitters, squatters, wipers and washers) - High capital costs; operating costs depend on the price of water - Requires a constant source of water - Cannot be built and/or repaired locally with available materials 	

6.2.3 Catalogue of latrine options

An illustrated catalogue that contains adequate information on different latrine options and contribute to informed choices by customers shall be prepared. The required information items include: graphical representation, advantages and disadvantages, cost, applicability, construction materials and requirements, and toilet location, proper use and hygiene. The catalogue will introduce people with the various available options of toilet so that they select the one which is financially viable yet technologically sound as per their needs. Efforts shall be exerted to promote widespread use of improved sanitation facilities (Fig. 6.2) as this is in line with SDG 6.

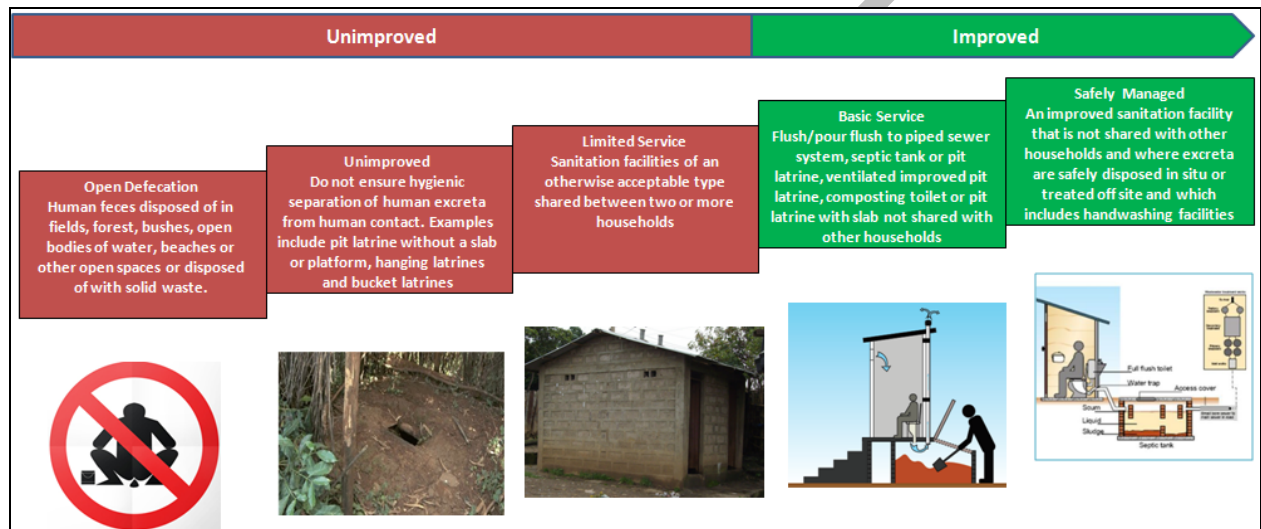


Figure 6-2: The sanitation ladder

6.2.4 Model toilet design and construction

Model latrines shall be designed and constructed in selected areas for demonstration purposes. Model toilets shall be constructed in areas where accessibility is high and protection is guaranteed. The following are preferred locations

- Schools
- Healthcare institutions
- Farmer training center
- Kebele administration offices
- Homes of ODF promoters
- Public gathering areas such as open markets, event quarters, etc.

The model toilet design shall contain engineering drawings with dimensions and material estimates. Different model toilets that suit rural, peri-urban and urban settlements, soil and groundwater conditions and land use types shall be provided. Latrines that are suitable for individual households, densely populated and low-income areas, schools, health institutions, and transport corridors and stations need to be demonstrated.

The following sanitation options have been proposed as model latrines with relevant information on their applicability, material requirements, dimensions and design considerations.

6.2.4.1 Rural areas

A large number Ethiopia's population resides in rural areas and agriculture is the mainstay of livelihood. In rural areas space availability for digging latrine is not a problem and use of compost is appreciated. The single pit compost latrine, Arborloo, is the technology that is proposed for these areas. There have been success stories in promoting and using a large number of these toilets in Ethiopia. More than eighty thousand households have constructed arborloos in rural Ethiopia with the support of Catholic Relief Services since 2004.

The technology is recommended in areas where there is problem of water supply, space requirement is not an issue and use of human excreta as fertilizer is accepted. The Arborloo is made up from four parts (Fig. 6.3)

1. The pit which is 1 to 1.2 m deep and 0.8 m in diameter
2. The ring beam
3. The concrete slab which sits on the ring beam and has dome shape with 1 m diameter and 5 cm thickness
4. The latrine house or superstructure

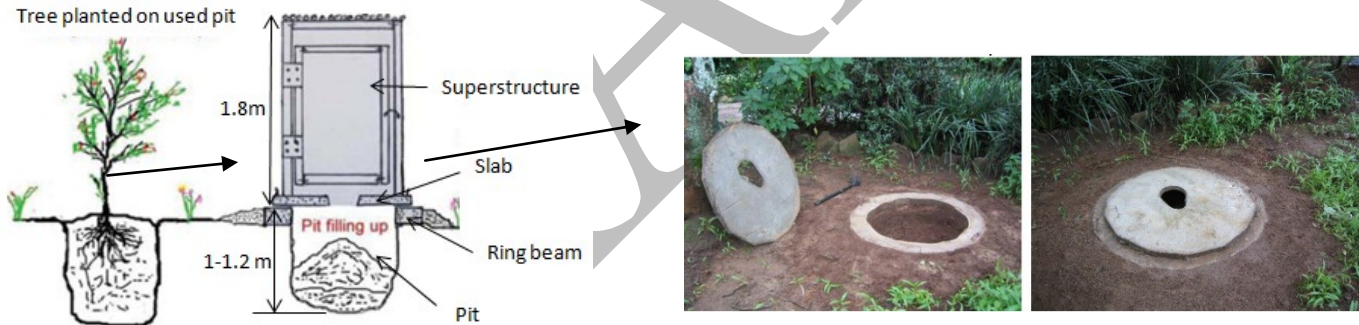


Figure 6-3: Single pit Arborloo latrine

Construction material

- Footing/Pit protection: cement ring, brick ring, sheet metal, half a barrel
- Latrine Slab: wood and mortar/earth, concrete (reinforced)
- Drop Hole Cover: wood, plastic, concrete
- The latrine house: thatch, bamboo or other locally available cheap material

Use of Arborloo

- Three cups of soil and one cup of ash are added after every use.

- When the Arborloo pit is full, the parts of the toilet are moved to another place, rebuilt and used in the same way again
- A thick layer of soil, at least 150mm thick, is placed over the filled pit
- Allow a composting process to take place for 6-12 months
- A young tree is planted in this soil and is watered and cared for

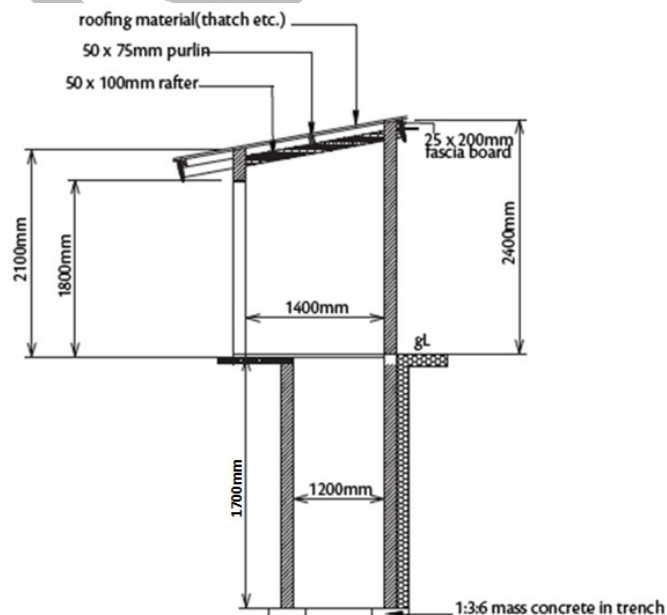
6.2.4.2 Households in Small towns

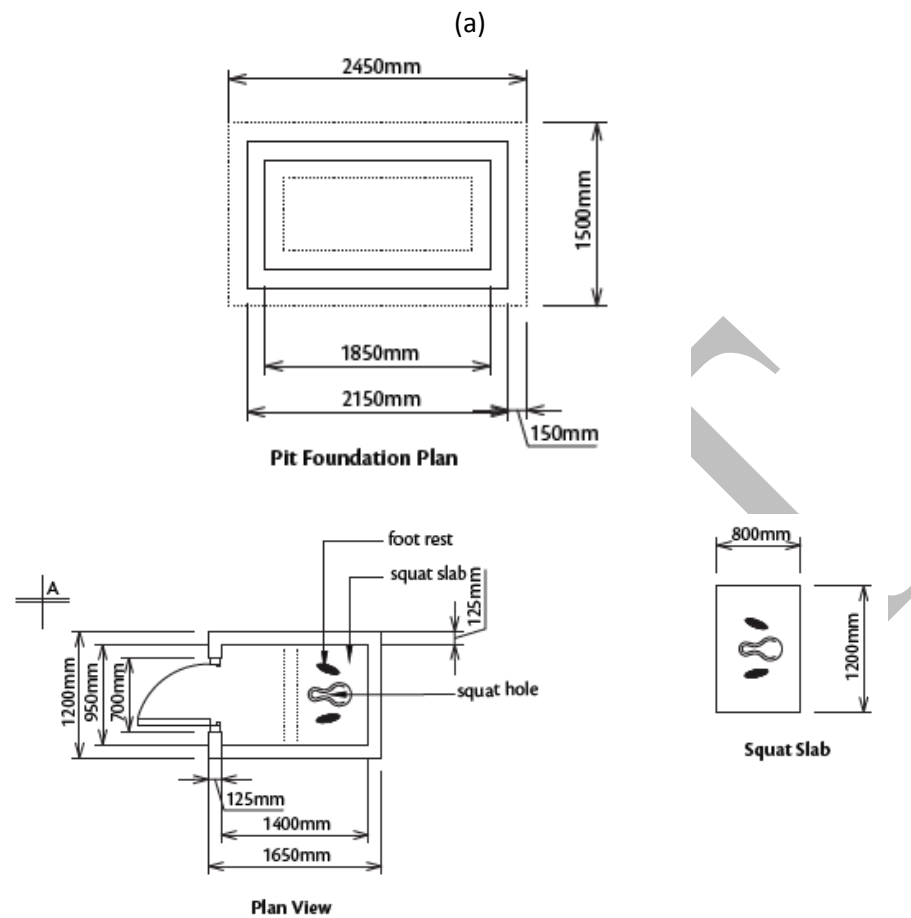
Small towns refer to Category-V urban centers as classified in GTP-II. Small towns have a population in the range of 2000 and 20,000 and a large number of Ethiopian urban centers fall under this category. But, only about 30% of the urban population resides in small towns. In these towns vacuum trucks are not available for pit emptying services and relatively there is space for digging and using simple pit-latrines. The proposed model latrine for these settlements is simple pit latrine which is suitable in situations where:

- People use solid/ hard materials for anal cleansing.
- There is scarcity of water or where the water supply is not regular.
- The ground is easy to dig, where the water table is low, places where there are no issues with water-logging and flooding.
- There is space to dig a new pit and move the superstructure when the old pit becomes full
- Transportation of imported materials is difficult and costly.
- The inhabitants cannot afford to build a costly latrine system, easy to build with local materials only.

Dimensions of the model latrine

The model pit latrine with the dimensions in shown in Fig. 6.4 can serve a household with five family members for ten years.





(b)
Figure 6-4: Model simple pit latrine (a)section (b) plan view

Construction materials

- Pit cover-slab/ floor: This can be made out of round timber logs or concrete
- Walls: Walls can be of wood and mud, bamboo, bricks, iron sheet; if wood is used it is advisable to treat with ‘dirty engine oil’ to avoid rotting
- Roof: This can be made from bamboo matting, corrugated galvanized iron sheets, or thatch over wood rafters and purlins. The roof should be firmly secured to prevent wind damage
- The pit can be lined with stones 400mm to 450mm thick to prevent collapse of the earth

Toilet location, proper use and hygiene

- This toilet should be built at least 30meters away from the house
- The location should be chosen considering wind direction
- The toilet should be located at a minimum distance of 30 meters from any type of water source
- Once a week, sweep, wash and clean the toilet floor (preferably using disinfectant), and clean the toilet surrounding area
- Once a month, clean the walls, door and ceiling
- Repairs should be carried out immediately problems are identified.
- The pit must not be used for garbage disposal

6.2.4.3 Households in Medium towns

Towns that have a population in the range of 20,000 - 100,000 (Category 2 and Category 3 towns in GTP-II) are classified as medium towns. About 20% of the urban centers fall in this category with 26% of the urban population. Availability of land and adequate water are issues of concern in these settlements.

The double vault ventilated improved pit latrine (Fig. 6.5) is the proposed model latrine for these urban areas. It allows continuous usage and permits safer and easier emptying. By using two pits, one pit can be used, while the content of the second rests, drains, reduces in volume, and degrades. When the second pit is almost full it is covered, and the content of the first pit is removed. Due to the extended resting time, the material within the pit is partially sanitized and humus-like.

Double vault VIP is suitable where

- People use solid/ hard materials for anal cleansing. These can be directly deposited into the toilet pit
- There is scarcity of water or where the water supply is not always dependable
- The ground is easy to dig, where the water table is low; places where there are no issues with water-logging and flooding There is not much space available to dig a new pit and move the superstructure when the old pit becomes full, hence suitable for urban areas
- Building with local materials is feasible

Dimensions

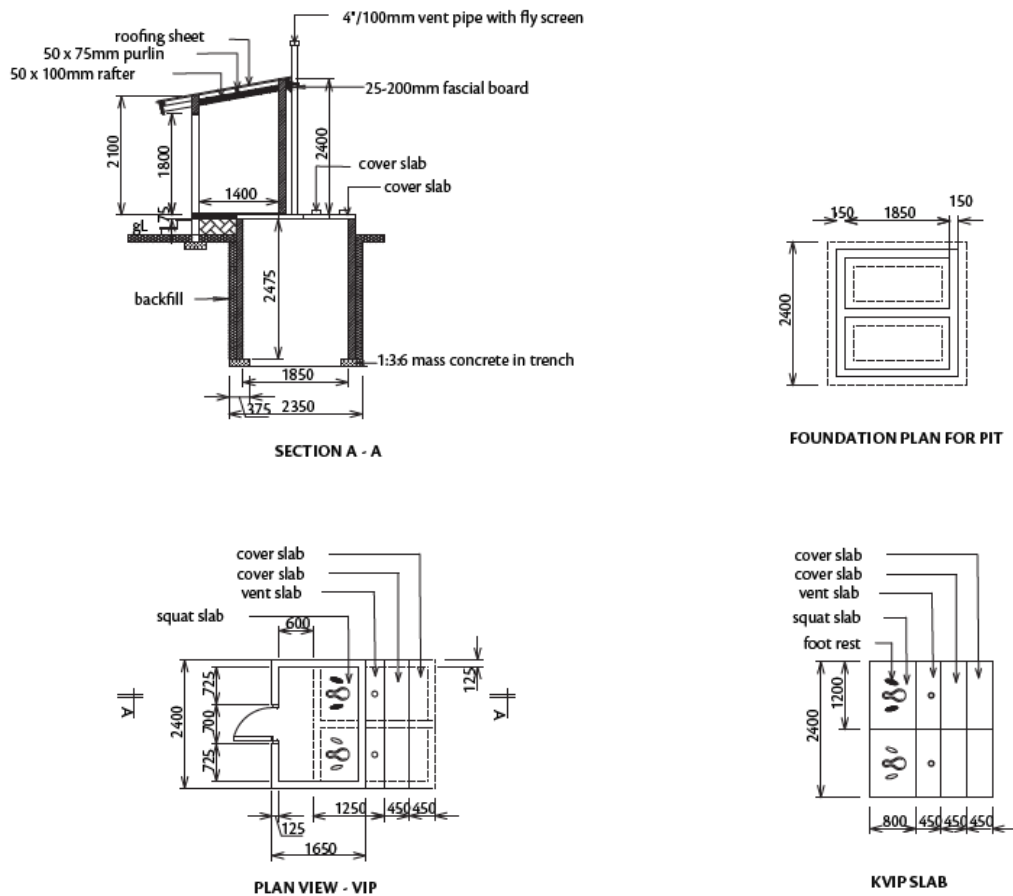


Figure 6-5: Model double vault VIP

Construction

- Pit cover-slab/ floor: This can be made of reinforced concrete slab. The floor should be smoothly finished and made impervious to water and urine penetration. The cover slab should be reinforced with 12mm diameter mild steel bars spaced at 200mm centre to centre
- Walls: Walls can be made of wood and mud, blockwork. Mud walling built up to 300mm above the ground level will help keep wood superstructures from rotting.
- Roof: This can be made from bamboo matting, corrugated galvanized iron sheets, or thatch over wood rafters and purlins. The roof should be firmly secured to prevent wind damage.
- Vent-pipe: The vent-pipe can be PVC pipe 100mm/150mm diameter. The top of the vent-pipe must be fitted with a fly-screen that allows sunlight to enter the Pipe. The pipe should extend a minimum of 300mm above the highest point of the roof.
- The pit can be lined with dry hammer-dressed stones or blockwork to prevent the collapse of the soil.

Toilet location, proper use and hygiene

- This toilet can be built closer to the house than the traditional pit latrine.
- The location should be chosen considering wind and sunlight direction
- The toilet should be located at a minimum distance of 15 meters from any type of water source.
- For the air to be able to flow, use of a drop-hole cover is not recommended during day time.
- Once a week, sweep, wash and clean the toilet floor (preferably using disinfectant but not a detergent), and clean the toilet surrounding area.
- Once a month, clean the walls, door and ceiling.
- Once every six months check the fly-screen on top of the vent-pipe and check that the pipe is not obstructed.
- Repairs should be carried out immediately when problems are identified.
- The pits must not be used for garbage disposal

6.2.4.4 Households in Large towns

Urban centers having more than 100,000 population are classified as large towns and they correspond to Category 1 and 2 urban levels of GTP-II. Availability of land is a serious problem in these areas. The use of flush toilets that are discharging into open drains is a problem. A pour flush toilet connected to off-set leach-pit (Fig. 6.6) is proposed for these settlements. It is suitable in areas where

- the ground is easy to excavate and the water table is not high
- there is regular water supply, at least 3 or 4 liters per use
- users are accustomed to using water for anal cleansing; if hard materials are used, they must not be put into the toilet.

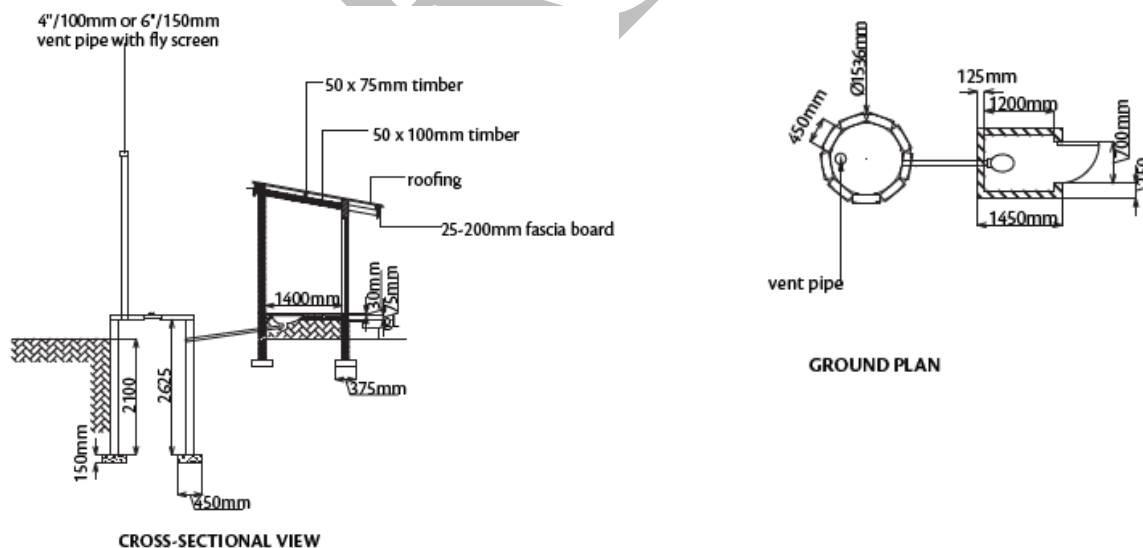


Figure 6-6: Pour flush toilet discharging into leach-pit

Construction

- Floor: Compacted earth covered by concrete, smoothly finished and made waterproof
- Walls: Wood and mud, blockwork. Stone walling built up to 30 cm above ground level will help avoid rotting of timber
- Roof: This can be made from bamboo matting, corrugated galvanized iron sheets, or thatch over wood rafters and purlins. The roof should be firmly secured to prevent wind damage.
- Vent-pipe: The vent-pipe can be PVC pipe 100mm to 150mm diameter. The top of the vent-pipe must also allow sunlight to enter the pipe and it should extend 100mm to 150mm above the roof.
- A container filled with water for flushing purpose
- The leach-pit can be lined with dry hammer-dressed stones 400mm thick. The cover can be made with concrete with either bamboo or steel reinforcement. A vent pipe should be fitted in the leach-pit cover.

Toilet location, proper use and hygiene

- This toilet can be built inside, attached to, or close to the house.
- The location of the leach-pit should be chosen considering wind direction
- Clean the toilet floor, squatting pan and surrounding area one a week
- Clean the walls, door and ceiling once a month
- Check the whether the vent pipe is not obstructed every six month
- Carried out repairs in case of problems

6.2.4.5 Community and Public toilets

Individual household toilets may not be feasible in situations where land availability is a problem or there are areas with high percentage of floating population (e.g. markets, religious places, transport stations, seasonal event quarters). The provision of sanitation facilities through community and public toilet complexes is the most suitable option for such situations.

The type of Community toilet will be selected on the basis of land availability as well as willingness and ability of the recipient body. Two to four seat pour flush toilets connected to septic tank or sewer are recommended for large towns and two to four seat VIP is proposed for medium towns. For small towns, simple pit latrines are suitable. Community and public toilets shall meet a minimum of the following design requirements:

- Size of the toilet block shall be as per the user population
- Should be accessible to the users throughout the year
- Selection of the site should be in consultation with the community
- Separate toilets for men and women with separate entries
- Special seats for children and disabled

- Urinal facilities for men
- Norms for community toilets in residential areas: One seat for 35 men; One seat for 25 women
- Norms for public toilets in non-residential areas: one seat for 100 men; one seat for 50 women
- Toilet cubicle size: 900 x 1200 mm

6.2.4.6 Toilets for Healthcare institutions

Healthcare establishments must have improved toilet facilities that are accessible, functional and clean at all times. Toilets should be cleaned and maintained in a way that they remain hygienic and do not become a centre for disease transmission. Improved toilets in health care facilities include VIP, flush or pour flush toilets. Two-door VIP is proposed as a demonstration latrine for healthcare facilities.

Healthcare facilities should comply with the following requirements:

- Improved toilets should be of sufficient number to meet the needs of all patients, staff and visitors, as follows:
 - For outpatient settings (e.g. health centers), there should be at least four toilets (one for staff, one for women/girls, one for men and one for people with limited mobility)
 - For in-patient settings and larger facilities (e.g. hospitals), more than four improved toilets should be built to meet the needs of the facility. The actual number of toilets/latrines required will depend on the average number of persons at the facility per day. There should be a minimum of one toilet for every 20 users (staff, patients, visitors and caregivers).
 - Toilets for women must be equipped for menstrual hygiene management (i.e. a bin with a lid on it within the cubicle for disposal of sanitary pads/cloths, and water and soap available for washing).
- All toilet facilities should have a functioning handwashing station inside the toilet room or outside within five meters.
- Water should be available at all times in the toilet room for flush/pour flush toilets.
- All improved toilet facilities should have clear signposts indicating men, women or people with limited mobility.
- All toilets should have a door that can be locked from the inside during use to ensure privacy.
- All toilets should have enough light to ensure safety and accessibility for nighttime use.

6.2.4.7 Toilets for schools

Failure to provide adequate and decent latrines in schools may lead to massive open defecation in nearby areas. According to a recent study by WaterAid 60% of Ethiopia's schools do not have toilets. All schools shall have improved toilets and meet the following minimum requirements:

- i. Have sufficient toilets with the following norms: at least one toilet for 50 girls and one for female staff; one toilet plus one urinal for 50 boys, and one for male staff
- ii. Toilets are easily accessible to all, including staff and children with disabilities; on more than 30 m from all users. Male and female toilets are completely separated
- iii. Toilets provide privacy and security- a minimum of 15m distance between toilets of boys and girls;
- iv. A minimum space of 0.80 to 0.90m (width) and 1.0m (length) should be provided for every squatting space.
- v. A minimum distance of 30m away from drinking water sources
- vi. Toilets are hygienic to use and easy to clean
- vii. Toilets have convenient handwashing facilities
- viii. Toilets are clean and functional at all times

Three types of two-door latrines are recommended for schools: simple pit latrines in small towns, double pit ventilated improved pit latrines in medium towns and twin pit pour-flush latrines in large towns.

6.2.4.8 Latrine construction in challenging environments

It is recommended to use latrine type and construction methods indicated in the On-site Household Latrine Technology Manual of the Federal Ministry of Health in areas where the risk of flooding is high, groundwater table is shallow, and the soil is loose or difficult to dig.

6.2.5 Sanitation market Centers

Sanitation market centers are locations where locally manufactured and imported sanitary hardwares are sold. They can be opened and operated by unemployed youth groups, MSEs, women organizations, etc. These establishments create job opportunities for several local individuals. The sanitation market centers should have a formal agreement with the local implementing agency that has a responsibility of ensuring the quality of products. Cheaper and good quality materials suitable for the local preference can be produced by the Production Centers. In case production centers are not established, the sanitation market centers have to make sure that a variety of quality and affordable hardwares are available. The government is expected to provide some financial support to centers for construction of sheds and trainings as revolving fund. The revolving fund shall be refunded to the government when the sanitation market center becomes profitable and attains sustainable position. The profitability of a sanitation market center depends on demand for its material and services in the area, the sale

price fixed by the government and the cost involved. Effective and continuous sanitation marketing shall be done to keep the demands for latrine hardware high.

Effective sanitation marketing can be conducted following the five steps proposed by Unicef (2015) based on field data from four regions of Ethiopia.

- Identify the existing latrine problems. Dedicated visits to OD hotspot areas and discussions among relevant actors shall be made. Technical and socio-economic problems associated with the selection, design, construction, and use of latrines shall be identified.
- Product design and prototype testing: latrine hardware that are affordable, durable and functional shall be designed to respond to the problems identified in the first step.
- Business model development which is responsive to the requirements of customers and profitable to the seller/producers. The model should address different business aspects that include supply of raw materials, manpower requirements for production, product promotions, delivery and installation of hardware. The model shall ensure sustainability of the business and clearly show the key actors and their roles.
- Sales volumes of products shall be assessed and factors responsible for success and failure shall be identified. Necessary improvements shall be made based on the assessment.
- Development of implementation plan to scale up and sustain production of latrine hardware

6.2.6 Annual targets for construction of latrines

The annual targets for latrines and related activities are presented in Table 6.2. A total of 15,000 Kebeles (10,000 Rural and 5,000 Urban) have been considered for the estimation. Open defecation is assumed to be practiced in 40% of the Rural Kebeles. One sanitation market center and one model latrine have been proposed for five Kebeles. It is also assumed that 10% of urban households will be served by community latrines, one for 4 households. Moreover, 15,000 standard latrines have been proposed for schools and health posts in rural areas. Each urban kebele will also be provided with one standard institutional latrine and one public toilet.

Table 6-2: Annual targets for latrines

No.	Component	2020	2021	2022	2023	2024	Total
1	Rural						
1.1	Sanitation Market Centers	1,000	1,000				2,000
1.2	Model latrines	1,000	1,000				2,000
1.3	Household latrines (Arborloo)		800,000	1,400,000	1,400,000	400,000	4,000,000
1.4	Upgrading of HH latrines		400,000	700,000	700,000	200,000	2,000,000
1.5	Institutional latrines		2,000	6,000	6,000	1,000	15,000

No.	Component	2020	2021	2022	2023	2024	Total
2	Urban						
2.1	Sanitation Market Centers	500	500				1,000
2.2	Model latrines	500	500				1,000
2.3	Institutional toilets		2,000	2,000	1,000		5,000
2.4	Community Toilets		12,500	50,000	50,000	12,500	125,000
2.5	Public Toilets		500	2,000	2,000	500	5,000

6.3 Component-II: Capacity Building

Achievement of ODF targets requires active involvements of different actors such as local government officials, communities, natural leaders, teachers, health extension workers, artisans, sanitary hardware manufacturers and sellers, etc. Each actor has distinct and important roles in the process. Availability of relevant knowledge, skills and attitude in different areas is a prerequisite for these actors to properly and effectively play their roles. Awareness creation and tailored trainings need to be conducted on different topics that include:

- Policies, programs, strategies and manuals related to sanitation
- Planning and design of Sanitation technologies
- Construction of latrines
- Operation and maintenance of latrines
- Sanitation marketing
- Advocacy and communication skills
- etc

6.3.1 Design and delivery of tailored trainings

Relevant training modules shall be developed and delivered to each group. To this end the following tasks are required.

- Training need assessment: The objective of this task is to identify the real knowledge, skill and attitude gaps of each group in implementing ODF activities. It requires identification the key groups and their roles, design of data collection instruments, collection of data, data analysis and identification of gaps. Questionnaires that solicit specific training requirements need to be used. The outcome of the need assessment is ranked training topics for each group of trainees.
- Curriculum design: This task comprises two major activities- content development and methodologies and tools of trainings. Based on the identified knowledge, skill and attitude gaps, draft training modules shall be prepared for the identified priority training areas. Each module shall indicate learning outcomes, topics to be covered, duration of the training, training methods and tools, and minimum qualifications of trainers. Training methods and tools should be such that trainees are able to acquire the required knowledge, skills and attitude effectively.

- **Testing and piloting:** The draft training curriculum shall be tested and piloted in selected areas in order to verify its efficacy and efficiency in imparting the intended content using the methodologies and tools within the given timeframe. Feedbacks and suggestions shall be collected at the end of each training module.
- **Preparation of the final training materials:** The final training document shall be developed by improving the draft curriculum based on the outcomes of the testing and piloting stages. The training materials may consist of handouts, powerpoint slides, case studies, pictures and videos.
- **Delivery of trainings:** The trainings shall be conducted after having prepared a detailed schedule and arranged the necessary logistics. The number of trainees in a group shall be optimum for effective interaction. The use of ToTs is recommended for cheaper, rapid and wider effects.
- **Evaluation:** Feedbacks and suggestions shall be collected for each training session. They will further be evaluated and the finding shall be used to refine the training materials. The refinement may comprise contents, methodologies and tools.

6.3.2 Experience sharing

There are success and failure stories in achieving ODF status in different parts of the world. Compendium of best practices in rural sanitation shall be prepared by drawing relevant lessons from local and international experiences. This will enhance the success of the campaign and attainment of ODF in short period of time. Lessons should be drawn on different areas such as latrine options, institutional arrangement, capacity building, sanitation marketing, etc. Thousands of villages in Ethiopia had declared ODF status. Case studies shall be developed based on selected ODF villages as part of the training document. Moreover, field visits to selected ODF villages shall be made. Relevant lessons shall be synthesized and shared to ODF actors.

6.4 Component-III: Advocacy, Behavior Change and Communication

Effective advocacy and communication strategies are important component of a successful open defecation free campaign. It is an interactive, evidence-based, consultative process that uses communication to promote and facilitate behavior change a. It comprises three overlapping phases that aim at bringing the desired behavior changes at different levels through relevant communication activities. They include awareness raising, advocacy and social and behavior change communication.

6.4.1 Awareness raising

The purpose of this phase is to get support from the general public at national scale and create an enabling environment. Awareness on the adverse health effects of open defecation and the need

for having and using improved latrines shall be imparted through mass media, outdoor media, social media, etc.

6.4.2 Advocacy

Advocacy is used to raise resources as well as political and social leadership commitment to development actions and goals. It addresses different audiences at national and regional scales and may include policy makers, program managers, media, opinion leaders, youth, academia, and the private sector.

Evidence-based advocacy communication shall be used to influence key actors and secure supports to translate commitments into concrete actions. This can be achieved through different advocacy activities such as one to one meeting, sensitization workshops, field visits, conferences and public-private partnerships.

6.4.3 Social and behavior change communication

Social and behavior change communication (SBCC) is used to move the people from awareness to action. It is the process of working with individuals, families and communities through different communication channels to promote positive health behaviors and support an environment that enables the community to maintain positive behaviors taken on. It uses mass and social media, community-based media, and interpersonal communication channel to increase individual knowledge, encourage changes in attitudes, and practices among target audiences. The target audiences may include individuals, families, school children, CBOs, teachers, community leaders, religious leaders, frontline workers like health extension workers, etc.

The success of ODF campaign rests on the active and committed involvement of community members. It is therefore crucial to raise the awareness of the target population through systematic and convincing campaigns. To this end a campaign communication strategy that aims at educating the community about the dangers of open defecation on public and environmental healths as well as create demands for improved sanitation infrastructure and services need to be developed and implemented. Different communication media that include intercommunity communication, interpersonal communication, radio, TV and printed items in local languages can be used. The preferred channel for behavior change is the intercommunity and interpersonal communications as they help identification of barriers to positive behavior change. Strengthening and broadening the CLTSH initiative can be used as strategy.

The campaign should make communities react strongly against open defecation and mobilize them towards adoption and hygienic use of improved latrines. Information, Education and Communication (IEC) materials like banners, posters, wall paintings and brochures shall also be prepared and circulated amongst school children and community members to raise awareness. Banners and paintings shall be eye-catching and they should be placed at major locations and open defecation spots. Use of pictures of artists and famous people may help. Use of award winning films and media programs on sanitation are also recommended to effectively

communicate the message of sanitation across the community. Use of illustrations (e.g. glass of water exercise) that clearly indicate the relationship between open defecation, water pollution and potential adverse health effects will also contribute to the acceptance of the ODF campaign.

6.5 Component-IV: Resource Mobilization to ODF campaign

Financing the water supply and sanitation endeavors of a country significantly drops the health risks of infants and ultimately minimizes the costs of healthcare. One in three of us practices open defecation and as a result are dominantly affected by fecal contamination. Financing Sanitation sector means financing individual's healthcare and safety, maintaining personal dignity and ensuring national pride. Poor sanitation pollutes the environment and is the main source of contamination of water supply that ultimately leads to waterborne diseases. The health and subsequent economic loss is high and despite all this little attention is given to sanitation.

In a nation of over 100 million, addressing sanitation requires engagement of multiple stakeholders and the community. Sanitation is not only government's concern but also an individual's threat. The government, private sectors, donor groups, NGOs, political activists, the media group, an individual household, religious leaders, prominent figures, artists, business people, private and public schools, health centers, the youth organization and local 'Idir' are all required to advocate with the leadership of the central and local government. Therefore, resources are expected to be mobilized from various directions and jointly put into one account to finance the same.

The Federal Government: The Federal government is expected to allocate known threshold magnitude for the next five years (2020-2024). This package is uniquely designed by the government of Ethiopia to support the rural sanitation for ODF-campaign 2024. The Federal Government budget will further be redistributed to regions based on the Open Defecation coverage of each region and their respective ease of accomplishment to meet the preset targets within stipulated timeframe. The budget will be released based on real accomplishment after verification. The initial startup budget will be distributed to each region based on regional ODF coverage with a close performance follow up of the Ministry of Water, Irrigation and Energy.

The Regional Government: Regional governments are expected to allocate a counterpart financing distributed over three years based on the regional coverage of improved sanitation facility. Each household is expected to own an improved latrine within its premises as much as possible.

The Development partners: The national water supply and sanitation coverage over the past few years has been significantly financed by development partners. The contribution so far is commendable. Such contribution will be enhanced and continued to address the ODF campaign. Among other, the World Bank Group, Department for International Development (DFID), African Development Bank, French Development Agency (AFD), Italian Development

Cooperation (IDC), European Investment Bank (EIB), European Union (EU), The Government of Finland, UNICEF, will be extending their generous and heartfelt support to this endeavor.

The NGOs: There are plethora of local as well as international organizations operating in the areas of water supply, sanitation, mother and child care, and nutrition. As the present ODF campaign boldly presents the government of Ethiopia is committed to prioritize rural sanitation so that the scattered efforts will come together to bring proven outcomes. Thus, all NGOs, in one or the other, will be major stakeholders in this national campaign. The contribution in terms of advocacy, social mobilization, capacity development, technology and innovation, building improved toilets for the poor will be focus areas.

Religious institutions: As most Ethiopians are committed to their religious norms and being submissive to the religious leaders, religious institutions (churches, mosques and others) will be popular hubs to generate sufficient finance and teach the followers to engage in sanitation endeavors. Religious followers are expected to contribute a lot to the success of pro-poor sanitation. All men and women will engage for 3-6 hours labor work each week to build latrine to the poor in the vicinity.

Government Institutions: All government institutions will allocate nearly 0.5% (the actual amount to be decided later in agreement) of their annual budget consecutively for five years to support the present campaign. Significant financial and technical supports can also be drawn from nearby universities/colleges of a particular region.

Health centers and Schools: Health institutions are the leading sectors to advocate and finance the campaign. School children will devote half-day per week to build toilets around their school premises and support the nearby village pro-poor while constructing toilets

Private Sectors and Business People (Contractors, Consultants and Businessmen): Private sectors engaged in consultancy, construction, business activities, suppliers, traders etc will actively participate and pledge the required resources for the success of this national mission.

Artists and Prominent Figures and Political and Human right Activists: Artists (musician movie actors/actress, Comedians) and prominent figures are active segments of the society to advocate this endeavor passionately. An example from India where various artists, prominent figures, local elders, religious leaders and politicians who played a pivotal role in freeing a large number of persons from open defecation can be taken as an extraordinary intervention of our time.

Local Elders, local structures (IDir, Ikub) and The Youth: These are local groups that will have great contributions to the success of the campaign.

The Media: The Media has by far the largest role while advocating the ODF campaign. Be it in radio or TV show, the media can consistently transmit an influential messages, lessons, best

practices, and satirical statements to favor the ODF campaign. The media can communicate every season's interventions locally and nationally to the wider community.

Other Financial means- Out of Box Financial Approach: Substantial amount of finance can be mobilized to this ambitious ODF campaign easily, if all rounded commitment is exerted. Some of such approaches seem to be uncommon in the beginning. However, if the government and the institutions are committed to ensure the dignity of citizens and the nation's pride, this is a simple approach.

Ethiopian Airlines: Ethiopian Airlines is known for its international reputation in various world class fleet parameters and has currently been drawing the attention of many world travelers. This iconic institution has national responsibility to serve the poor as it has been doing. We are not advocating the Ethiopian Airlines to allocate a huge sum of money for this purpose. However, we encourage it to show its solidarity to support the current efforts. Ethiopian Airlines is expected to just raise \$1 per each foreign traveler and 5 birr per local traveler for the period of the campaign (2020-2024)! A great deal of financial support can be drawn from this initiative.

Household Contribution: Each household is expected to cover at least 30-100 % cost of the respective toilet construction cost. The contribution could be in terms of labor or cash. The bottom 25 % low income group or the poorest of the poor will be fully subsidized by the ODF campaign program.

Sanitation loan: Long-term concessional loan to finance construction of rural improved toilets may gain substantial financial resources from microfinance institutions (MFI) credit facility. The MFI has been providing credit facility for rural water supply scheme construction and expansion. It has also been supporting the low income family with credit facility to engage in local merchandising activities.

7 MONITORING AND EVALUATION

A systematic and objective assessment at the completion of the campaign is vital and essential to draw lessons from the process of the implementation. It measures the outcome and impact due to the program and it gives guide to redesign the campaign and revisit the sanitation guidelines, strategic documents and policies as well.

In Ethiopian context, there are tremendous efforts taken by different stakeholders, however, most of them overlook the role of improved access to water supply in the sanitation process. Therefore, the evaluation and monitoring of current campaign shall be considered as the integral part of national water supply and sanitation program.

However, in any approach for community led total sanitation (CLTS), the concept of monitoring and evaluation is the process through which the success of ODF is to be evaluated. For the monitoring and evaluation purpose, a step by step procedure depicted in Figure-7.1, will be adopted throughout the campaign.

Step-1: -Preparation of Standard Monitoring Document (Format)

In the course of the ODF campaign, there has to be standard report prepared in a coherent manner at different stages. Therefore, the monitoring format is prepared right from the community level to the final ODF declaration stage.

Step-2: - Establishment of independent ODF monitoring and verification body

For every stage of the ODF monitoring process, there has to be an independent body that can verify the and propose for further certification. The independent body shall comprise individuals from key stakeholders, fund providers, decision makers (presumably politicians) and religious leaders.

Step-3: - Setting up Verification Criteria

The independent body established in step-2 above sets verification criteria, following CLTS guidelines and manuals. This can be seen from two levels of achievements that spans between two end points of Figure 2 (i.e. from OD to ODF⁺):

Level 1- ODF: *Every household uses a latrine with privacy, there is no shit in the bush (100% latrine coverage, sharing is acceptable)*

Level 1- ODF⁺: *Every household has a latrine with cover and hand washing facilities (100% coverage, sharing is acceptable); all religious institutions, market centers and health centers in the catchment area have latrines with covers and hand washing facilities (100% coverage).*

Step-4: - Periodic Report Preparation

Using the standard monitoring format, a coherent report shall be prepared at different stages. The report shall clearly show the infrastructure development, functionality (status), coverage area and communities behavioral change as a community traverses along the path of OD to ODF⁺(Figure 8.1).

7.1 Enabling environment

The key elements of enabling environment include policy and legal frameworks, institutional arrangements and financing mechanisms. Sanitation marketing shall be backed by relevant

policy and legal instruments, implementation capacities and financial arrangements at different levels of government.

7.2 Documentation and Reporting

Documentation of all the processes in the ODF activities and the final dissemination of results are the key to the success of the planned national campaign. Moreover, it will pave a way for the ODF PLUS (ODF⁺) after the 2024 planned threshold time in the present campaign document.

The following are key activities to be considered under this task.

7.3 Declaration of ODF Areas

For declaration and verification of ODF Areas, the protocol developed by the MoH shall be adopted with some modifications for inclusion of water supply component and the new GTP-II.

DRAFT

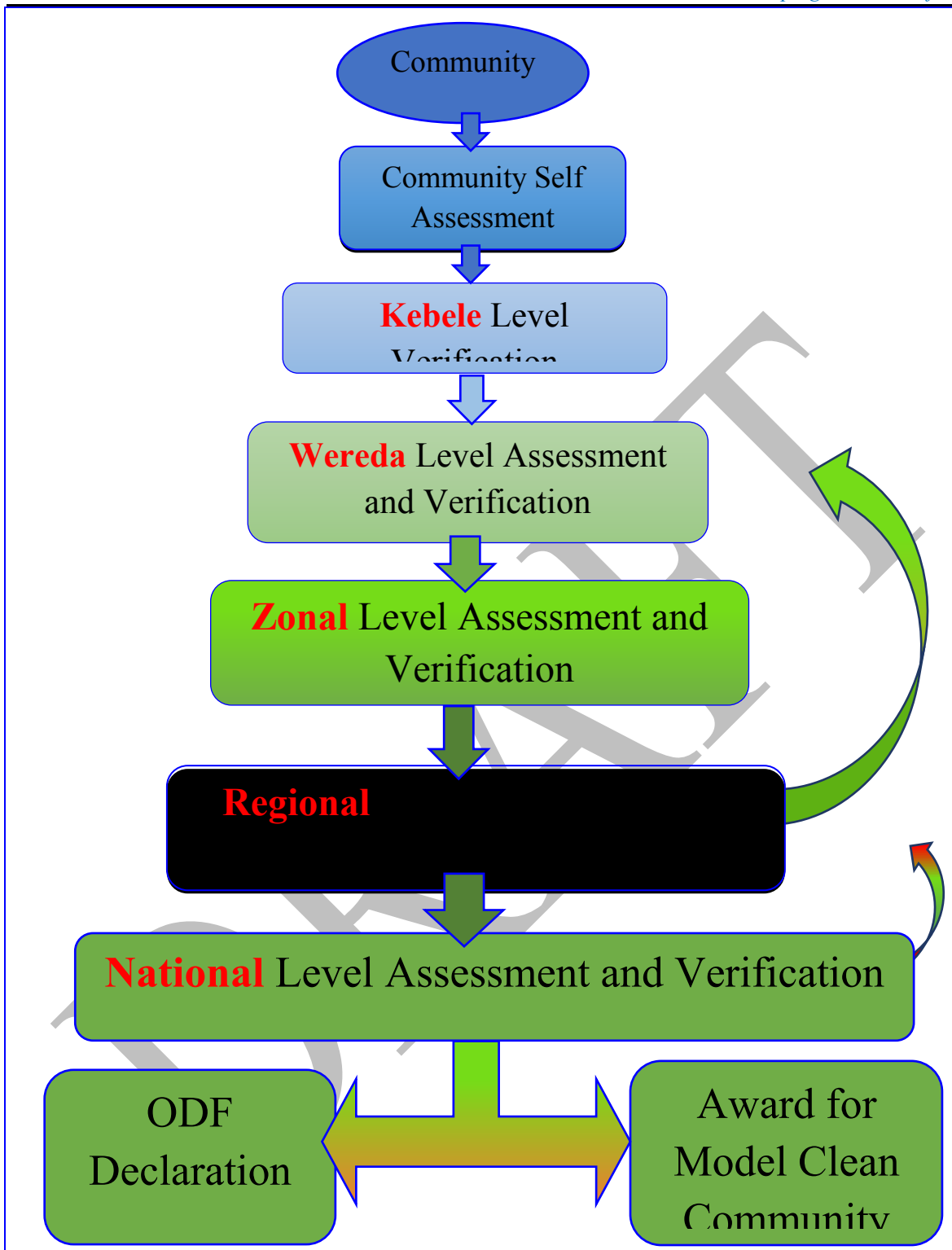


Figure 7-1: ODF Monitoring, Verification and Declaration Process

8 BEYOND 2024: ODF +

Many programs in CLTS are considered to be a low-cost, bottom-up approach ending at the certification of ODF status. It is believed that once mobilized and empowered, communities would sustain their behavior and take care of monitoring and follow-up themselves. However, ODF should not be seen as the destination, but a stage on the road to sustainable sanitation (Figure 8.1).

It is obvious that a poorly maintained toilets with poor sanitation infrastructure leads to the reversion to open defecation. Such reverse action can be controlled by keeping the sustainability of ODF campaign with all its goal achieved. In the process, both the infrastructure and behavioral change shall be long lasting and it passes through staged process. The following behavioral change shall be considered as stages that lead to ODF+.

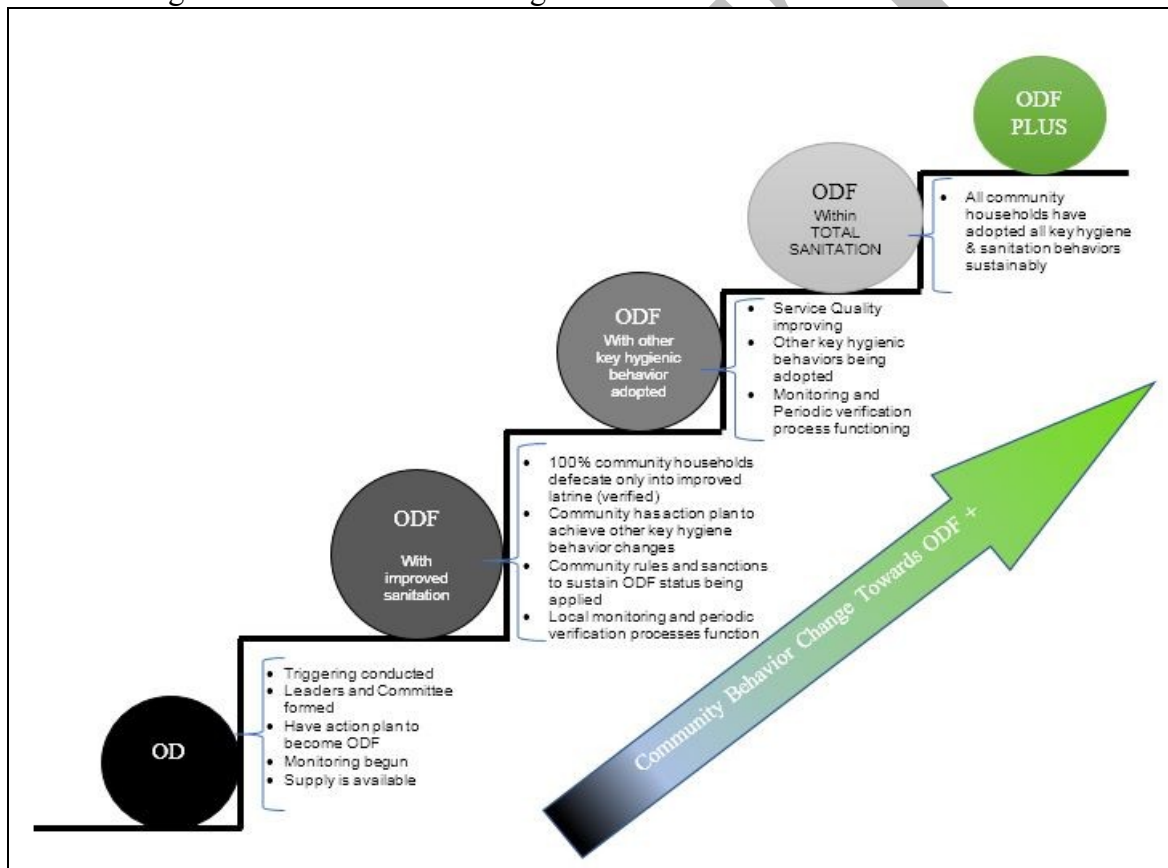


Figure 8-1: Stages to ODF+

9 IMPLEMENTATION ARRANGEMENT AND ACTION PLAN

9.1 The Campaign Framework

The proposed campaign shall be commenced in the forthcoming fiscal year as an integral part of the MoWIE’s and other key stakeholders’ annual plan. The institutional arrangement and proposed action plans for the campaign will concurrently progress with the national WaSH implementation program. This program is found to be a good model as it is a multi-stakeholder program and the base for the ODF as well.

The ODF campaign’s institutional arrangement is also aligned with the monitoring, verification and declaration process depicted in figure 6.7. above. Accordingly, six staged institutional setups will be envisaged in this campaign.

Table 9-1: Institutional arrangement framework for the campaign

Stages	Team Composition	Functions/ Tasks
Stage-1	<p><u>Village ODF Campaigners (10)</u></p> <ul style="list-style-type: none"> • Village Leader (1) • Women Representative (1) • Two Students from Intermediate school (1F+1M) • Village representatives (2F+2M) • Religious Representatives (2) • Health Extension Worker 	<ul style="list-style-type: none"> • The village campaigners directly interact with communities in their vicinity to mobilize the campaign.
Stage-2	<p><u>Kebele ODF Coordinators</u></p> <ul style="list-style-type: none"> • Leaders of Village Campaigners • Health Extension Team Leader • WaSH Coordinator • School Director/ Representative 	<ul style="list-style-type: none"> • Continuously regulate the ODF campaign • Propose ODF village for Award
Stage-3	<p><u>Wereda ODF Office</u></p> <ul style="list-style-type: none"> • Kebele Coordinators • Health Center Leader • Wereda WaSH Team Leader • Wereda Education Bureau (Sanitation Expert) • Highschool Director/Representative 	<ul style="list-style-type: none"> • Regularly evaluate the activities of Kebele ODF • Provides technical Support for the Kebele ODF • Closely work with Wereda Water Bureaus and Town Water Utilities
Stage-4	<p><u>Zone ODF Campaign Coordinator</u></p> <ul style="list-style-type: none"> • Zonal Water Bureau (WaSH team leader) • Zonal Health Center Leader • Zonal Education Bureau • TEVT 	<ul style="list-style-type: none"> • Organize Quarterly workshops for ODF Campaign in the Zone • Organize and Support the activities of Wereda ODF

Stages	Team Composition	Functions/ Tasks
	<ul style="list-style-type: none"> • Technical Assistants 	
Stage-5	<p style="text-align: center;">Regional ODF Office</p> <ul style="list-style-type: none"> • Regional WaSH Coordination • Zonal Water Bureau (WaSH team leader) • Zonal Health Center Leader • Zonal Education Bureau • Celebrities 	<ul style="list-style-type: none"> • Deliver training at Zonal lever for the Campaigners • Duplicate and Transfer Documents to Wereda Team • Organize declaration of ODF • Propose strategies for ODF+
Stage-6	<p style="text-align: center;">National ODF Coordination Office</p> <ul style="list-style-type: none"> • MoWIE +MoH +MoE + MoFED • One WaSH Coordination Office • Technical Experts 	<ul style="list-style-type: none"> • Formulate the national Campaign strategies; • Establish Database Management System for the Campaign; • Prepare Training Manuals and Deliver TOT; • Prepares ODF declaration formats • Plan for ODF + beyond 2024

9.2 Institutional Setup

The implementation of the national ODF campaign will be coordinated through the one WaSH national program. The institutional setup is expected to be governed from top-to-bottom with direction from the top national governance. Based on the higher official direction, a steering committee will be established consisting of key ministerial offices. The steering committee will further make quick assessment on the existing efforts and similar campaigns (i.e like one WaSH national programs) to establish national coordination office. The national coordination office will consist of three sub-team: (i) Technical team (engineering); (ii) Public Advocacy Team; and (iii) Stakeholder coordination team.

The **technical team** is responsible for all the engineering designs of model toilets, document preparation and database establishment for the entire campaign process. The team will have also the mandate to prepare standard documents for capacity building, declaration procedures of ODF, and monitoring and evaluation methods.

The **public advocacy team** shall take care of all the coordination activities from top leadership down to the community level during the campaign. All the stages of ODF shall be monitored and governed by this team. Activities on behavioral change and awareness creation will be the other concern of the public advocacy. Potential sanitation marketing and possible funding sources will be identified by the team.

The **stakeholder coordination team** will have the mandate to bridge the efforts of different governmental and non-governmental offices. Wherever needed, the team will organize a multi-stakeholder forum at all levels of the campaign.

The overall organization framework and detailed project implementation plan will be prepared during the preparation phase as part of the project implementation manual (PIM).

Table 9-2: The ODF 2024 Campaign Implementation Schedule (Yearly)

S.No.	Activities/Tasks	Unit	2019/20	2020/21	2021/22	2022/23	2023/24
			2012 E.C.	2013 E.C.	2014 E.C.	2015 E.C.	2016 E.C.
1	PREPARATION AND MOBILIZATION PHASE	--					
	1.1. Establishment of Steering Committee	--					
	1.1. Review of Existing Practices and Gaps	--					
	1.2. Identification of Public Institutions for ODF creation	--					
	1.3. Reporting (M&E) Format Preparation	--					
	1.4. Overall Project Management & Logistics	--					
2	IMPLEMENTATION PHASE	--					
	2.1. Component-I: The Sanitation Infrastructure for ODF Campaign 2024	--					
	2.1.1. Preparation of Standard Latrine Designs	--					
	2.1.2. Establishment of Sanitation Market Centers (3000)	--					
	2.1.2.1. Urban (1000)	No of Centers		500	500		
	2.1.2.2. Rural (2000)	No of Centers		1000	1000		
	2.1.4. Construction of Standard Rural Latrines	--					
	2.1.4.1. Construction of model Latrines (2000 for demonstration)	No of Latrines		600	1400		
	2.1.4.1. New household basic latrines (4 Million Arborloo)	No of Latrines		500,000	2,000,000	1,300,000	200,000
	2.1.4.2. Upgrading to Double Ventlated Improved Pit (DVIP)- 2 Million	No of Latrines		400,000	700,000	700,000	200,000
	2.1.4.3. Construction of Institutional latrines (School & Health) - 15,000	No of Latrines		2,000	6,000	6,000	1,000
	2.1.5. Construction of Standard Urban Latrines	--					
	2.1.5.1. Model Latrines (1000 for demonstration)	No of Latrines		500	500		
	2.1.5.1. Institutional latrines (health & School) - 5,000	No of Latrines		2,000	2,000	1,000	
	2.1.5.2. Community latrines - 125,000	No of Latrines		12,500	50,000	50,000	
	2.1.5.3. Public latrines - 5,000	No of Latrines		500	2,000	2,000	500
	2.2. Component-II: Capacity Building	--					
	2.2.1. Training Need Assessment	--					
	2.2.2. Training Material Preparation	--					
	2.2.3. Training Provisions at various level	--					
	2.2.4. Knowledge sharing (International Practices)	--					
	2.2.5. Knowledge sharing (Local Practices)	--					
	2.3. Component-III: Advocacy, Behavior Change and Communication	--					
	2.3.1. Preparation of Standard Guidelines, Manuals, and IEC materials	--					
	2.3.2. Intensive Public Awereness (Branding ODF/2024 Campaign)	--					
	2.3.3. Conducting Advocacy Campaign	--					
	2.3.4. Conducting Social and Behaviour Change Campaign	--					
	2.4. Component-IV: Resource Mobilization to ODF campaign	--					
	2.4.1. Preparation of fund rasing proposals for the identified potential institutions	--					
	2.4.2. Preparation of the disbursement mechanism	--					
	2.4.3. Undertake the Campaign (Involving public institutiona and the community)	--					
3	Documentation and Dissemination	--					
	3.1. Digital data collection (video / photo / GPS)	--					

S.No.	Activities/Tasks	Unit	2019/20	2020/21	2021/22	2022/23	2023/24
			2012 E.C.	2013 E.C.	2014 E.C.	2015 E.C.	2016 E.C.
	3.2. Central digital archive establishment (MIS or Dynamic WWW)	--					
	3.3. Publishing Progressive bulletin / documentaries / publications	--					
4	Declaration of ODF	--					
	4.1. Periodic M&E Report Preparation	--					
	4.2. Establishment of Independent body for ODF Certification and Declaration	--					
	4.3. Organizing Award Ceremonies (ODF Declaration 15000 Kebeles)	No of Kebeles		2000	3000	5000	5000
5	Monitoring and Evaluation (for sustainability - Road map to ODF +)	--					

Note: The numbers in each year corresponding to the activities indicate the expected implementation plan. It **shall not** be considered as the budget which is already given in table 10.3.

DRAFT

10 BUDGET

10.1 The Campaign Budget Estimates

The budget for the campaign is estimated based on the fact that most Woredas of Ethiopia have not declared the Open Defecation Free environment. However, the existing report of One WaSH national program assumed that by the end of the fiscal year nearly 32 percent will be achieved. Hence, out of the total Woredas in the country, nearly 60% are not ODF which need to be considered in the planned campaign.

The overall estimated budget is USD 1.67 Billion which will be distributed over the five-year period of the campaign, 2019/20 to 2023/24. Cost estimates have been made for the various tasks of the campaign whose share is presented in the pi-chart below.

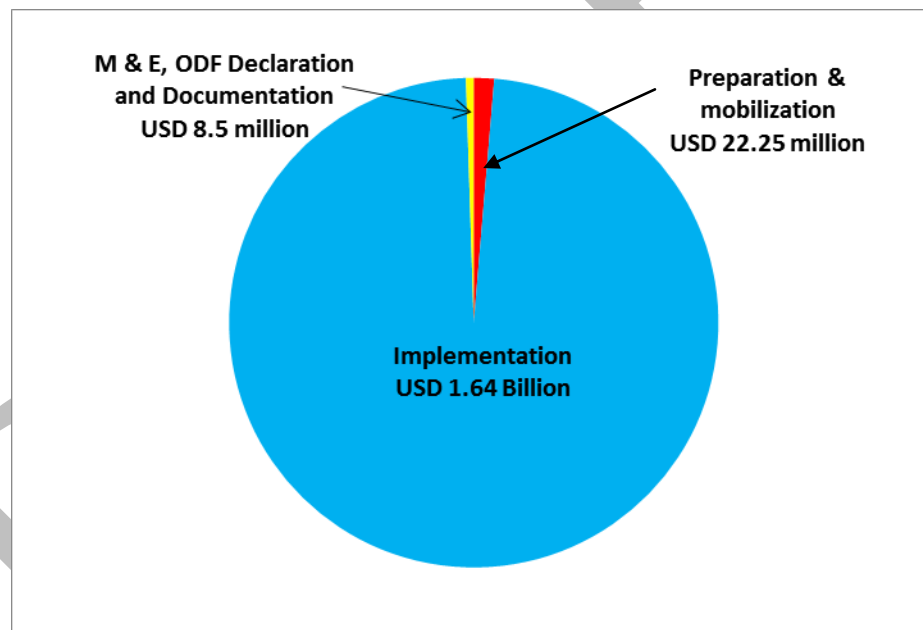


Figure 10-1: The overall financial estimate by different components of tasks

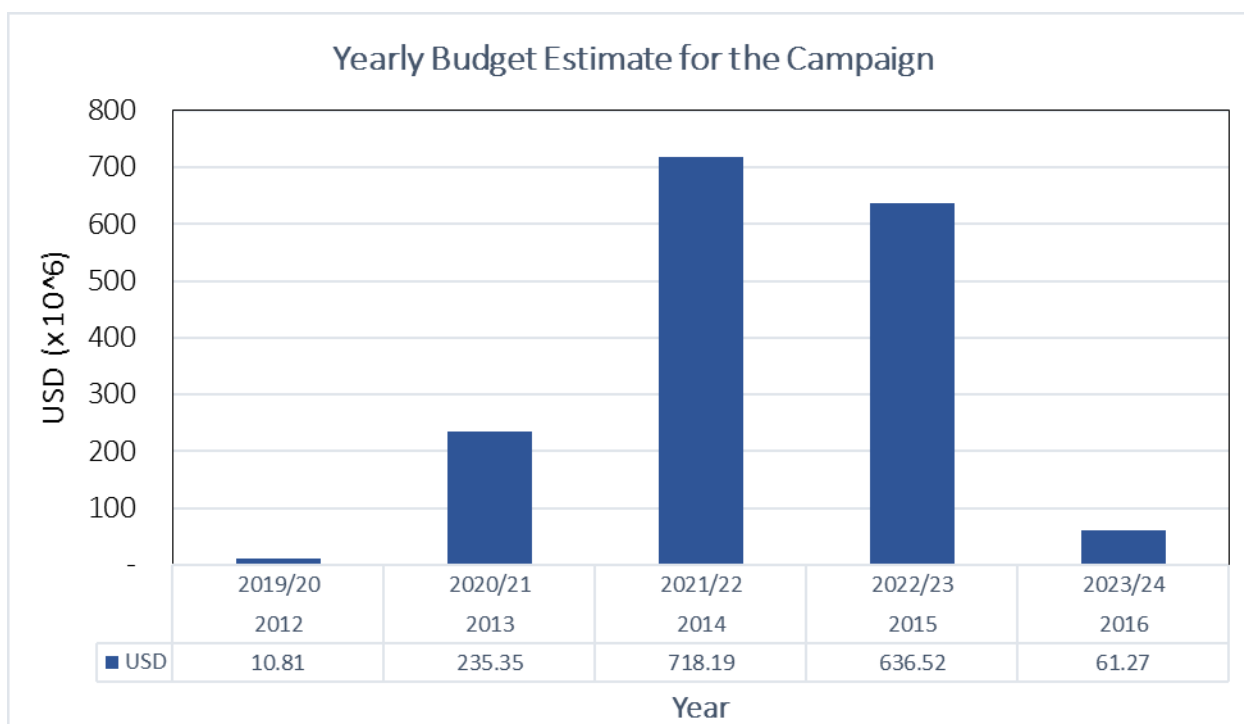


Figure 10-2: The budget distribution over the five years of the campaign

As depicted in figure 10.1, the largest share corresponds to the implementation task of the campaign which consists of different components: Infrastructure (USD 1.63 Billion), Capacity development (USD 0.8 million), Advocacy and communication, (USD 1.5 million) and Resource mobilization (USD 2.1 million).

Table 10-1: Implementation Phase Cost breakdown

S.No.	Tasks	Budget (USD)	Percentage
1	Component-I: Infrastructure for ODF Campaign 2024	1,626,933,333	0.9973
2	Component-II: Capacity Building	800,000	0.0005
3	Component-III: Advocacy, Behavior Change and Communication	1,500,000	0.0009
4	Component-IV: Resource Mobilization to ODF campaign	2,166,667	0.0013

10.2 Financing Mechanisms of ODF 2024 Campaign

Successful implementation of the ODF campaign will require the committed involvement of different stakeholders that include the community, government, and local and international development partners. The government will cover 40% of the estimated budget and play the leading role in forging strong alliances and mobilizing resources. Another 40% of the overall budget is expected to come from different partners such as the World Bank Group, African

Development Bank Group, EU, UNICEF, NGOs and the private sector that are committed to support the development endeavors of the country. The community has indispensable roles in ensuring successful implementation and sustainability of the national ODF initiative and is expected to make the remaining 20% budgetary contribution.

Table 10-2: Expected financing options of the Campaign

S.No.	Funding Sources	% Share	Total (USD)
1	Government	40	666,194,600.00
2	Development Partners and NGOs	40	666,194,600.00
3	Public Contribution	20	333,097,300.00
Total		100	1,665,486,500.00

Table 10-3: Estimated budget of the Campaign

S.No.	Activities/Tasks	Unit	Budget (ETB)	Budget (USD) = ETB x 30	2019/20	2020/21	2021/22	2022/23	2023/24
					2012 E.C.	2013 E.C.	2014 E.C.	2015 E.C.	2016 E.C.
1	PREPARATION AND MOBILIZATION PHASE								
	1.1. Establishment of Steering Committee	LS	5000000	166667	166667				
	1.1. Review of Existing Practices and Gaps	LS	8000000	2666667	2666667				
	1.2. Identification of Public Institutions for ODF creation	LS	5000000	166667	166667				
	1.3. Reporting (M&E) Format Preparation	LS	10000000	333333	333333				
	1.4. Overall Project Management & Logistics	LS	567595000	18919833	3783967	3783967	3783967	3783967	3783967
2	IMPLEMENTATION PHASE	--							
	2.1. Component-I: The Sanitation Infrastructure for ODF Campaign 2024	--							
	2.1.1. Preparation of Standard Latrine Designs	LS	8,000,000.00	266667	266667				
	2.1.2. Establishment of Sanitation Market Centers (3000)	--							
	2.1.2.1. Urban	Birr/1000	30000000	1000000		500000	500000		
	2.1.2.2. Rural	Birr/2000	60000000	2000000		1000000	1000000		
	2.1.4. Construction of Standard Rural Latrines	--							
	2.1.4.1. Construction of model Latrines (for demonstration)	Birr/2000	10000000	333333		100000	233333		
	2.1.4.1. New household basic latrines	Birr/4M	12500000000	416666667		52083333	20833333	135416667	20833333
	2.1.4.2. Upgrading to Double Ventlated Improved Pit (DVIP)	Birr/2M	8000000000	266666667		53333333	93333333	93333333	26666667
	2.1.4.3. Construction of Institutional latrines (School & Health)	Birr/15000	150000000	5000000		665000	2000000	2000000	335000
	2.1.5. Construction of Standard Urban Latrines	--		0					
	2.1.5.1. Model Latrines (1000 for demonstration)	Birr/1000	50000000	1666667		833333	833333		
	2.1.5.1. Institutional latrines (health & School)	Birr/5000	1000000000	33333333		13333333	13333333	6666667	
	2.1.5.2. Community latrines	Birr/12500	25000000000	833333333		100000000	366666667	366666667	
	2.1.5.3. Public latrines	Birr/5000	2000000000	66666667		6666667	26666667	26666667	6666667
	2.2. Component-II: Capacity Building	--		0					
	2.2.1. Training Need Assessment	LS	240000	8000	8000				
	2.2.2. Training Material Preparation	LS	2400000	80000	80000				
	2.2.3. Training Provisions at various level	LS	17040000	568000	568000				
	2.2.4. Knowledge sharing (International Practices)	LS	3600000	120000	120000				
	2.2.5. Knowledge sharing (Local Practices)	LS	720000	24000	6000	18000			
	2.3. Component-III: Advocacy, Behavior Change and Communication	--		0					
	2.3.1. Preparation of Standard Guidelines, Manuals, and IEC materials	LS	10000000	333333	333333				
	2.3.2. Intensive Public Awereness (Branding ODF/2024 Campaign)	LS	15000000	500000	250000	250000			
	2.3.3. Conducting Advocacy Campaign	LS	10000000	333333		333333			
	2.3.4. Conducting Social and Behaviour Change Campaign	LS	10000000	333333		333333			
	2.4. Component-IV: Resource Mobilization to ODF campaign	--		0					
	2.4.1. Preparation of fund rasing proposals for the identified potential institutions	LS	25000000	833333	833333				

S.No.	Activities/Tasks	Unit	Budget (ETB)	Budget (USD) = ETB x 30	2019/20	2020/21	2021/22	2022/23	2023/24
					2012 E.C.	2013 E.C.	2014 E.C.	2015 E.C.	2016 E.C.
	2.4.2. Preparation of the disbursement mechanism	LS	20000000	666667	666667				
	2.4.3. Undertake the Campaign (Involving public institutional and the community)	LS	20000000	666667		666667			
3	Documentation and Dissemination	--		0					
	3.1. Digital data collection (video / photo / GPS)	LS	5000000	166667		41667	41667	41667	41667
	3.2. Central digital archive establishment (dynamic or WWW)	LS	20000000	666667	333333	333333			
	3.3. Publishing Progressive bulletin / documentaries / publications	LS	10000000	333333	166667	166667			
4	Declaration of ODF	--		0					
	4.1. Periodic M&E Report Preparation	LS	3600000	120000	24000	24000	24000	24000	24000
	4.2. Establishment of Independent body for ODF Certification and Declaration	LS	6000000	200000	40000	40000	40000	40000	40000
	4.3. Organizing Award Ceremonies (ODF Declaration 15000 Kebeles)	LS	110400000	3680000		515200	736000	1214400	1214400
5	Monitoring and Evaluation (for sustainability - Road map to ODF +)	LS	100000000	3333333		333333	666667	666667	1666667
	<i>Sub Total</i>		49864595000	1662153167					
	<i>Contingency</i>		100000000	3333333	10813300	235354500	718192300	636520700	61272367
	<i>Grand Total</i>		49,964,595,000	1,665,486,500					

11 REFERENCES

1. BDS – Centre for Development Research, 2018, Outcome Evaluation of Community Led Total Sanitation Hygiene Program in Ethiopia, UNICEF and WSSCC supported, (2012-2015)
2. Dionna Fry, DejeneMideksa, ArgawAmbelu, YesheWaharegFeyisa, Bekele Abaire, Katherine Cunliffe and Matthew C. Freeman (2015). Adoption and sustained use of the arborloo in rural Ethiopia: a cross-sectional study, *Journal of Water, Sanitation and Hygiene for Development*.
3. Ethiopian Public Health Institute (EPHI)(2018). Services Availability and Readiness Assessment (SARA), Addis Ababa
4. FDRE (1995). The Constitution of the Federal Democratic Republic of Ethiopia, Addis Ababa
5. FDRE (2013), One WASH National Program (OWNP), Addis Ababa
6. FDRE (2015). Growth and Transformation Plan II (GTP II), (2015/16 – 2019/20)
7. Federal Ministry of Water Resources, The Government of Nigeria (2015). Making Nigeria Open Defecation Free by 2025 – A National Road Map
8. GNWP, UNICEF (2017). Latrine Technology Manual. Ghana Netherlands WASH Programme (GNWP), Accra, Ghana
9. Jacqueline Devine and Craig Kullmann (2011). Introductory Guide to Sanitation Marketing, Water and Sanitation Program Toolkit.
10. Josephine L. R. Exley, Bernard Liseka, Oliver Cumming, and Jeroen H. J Ensink (2015). The Sanitation Ladder, What Constitutes an Improved Form of Sanitation? *Environ. Sci. Technol.* 2015, 49, 1086–1094, DOI: 10.1021/es503945x
11. Ministry of Drinking Water and Sanitation, The Government of India, (2014). Building Clean India by 2019
12. Ministry of Health, The Republic of Kenya, (2016). The National ODF Kenya 2020 Campaign Framework Kenya
13. MoH (2013), FDRE Ministry of Health, Sanitation Marketing Guideline, Addis Ababa

14. MoH (2017), FDRE Ministry of Health. Ethiopian health accounts Household health service utilization and Expenditure survey, 2015/16, Addis Ababa
15. MoH, FDRE (2016). National Hygiene and Environmental Health Strategy, Addis Ababa
16. MoH, FDRE (2012) Implementation Guideline for CLTSH Programming, Addis Ababa
17. MoH, FDRE (2017). Integrated Urban Sanitation and Hygiene Strategy (IUSHS), Addis Ababa
18. MoH, FDRE (2018). Annual Health Sector Performance (2017/18), Addis Ababa
19. MoH, MoE, MWE, UNICEF (2010). Design and Construction Manual for Water Supply and Sanitary Facilities in Primary Schools.
20. MoH, MoUDH, MoWIE, MoEFCC (2016). Integrated urban sanitation and hygiene strategy, Addis Ababa
21. MoH, Transitional Government of Ethiopia (1993). The Ethiopian Health Policy, Addis Ababa
22. MoH, UNICEF Ethiopia and WSSCC-GSF (2016). Outcome evaluation of CLTSH Program in Ethiopia from 2012-2015
23. MoH, Federal Democratic Republic of Ethiopia Ministry of Health (2012). CLTSH Verification and Certification Protocol, Addis Ababa
24. MoUDC, FDRE (2012). Urban Development Policy, Addis Ababa
25. MoWE (2011). Ministry of Water and Energy. Urban Sanitation Universal Access Plan, Addis Ababa
26. MoWIE, FDRE (2015). Second Growth and Transformation National Plan for the Water Supply and Sanitation Sub- Sector (2015/16 – 2019/20)
27. MoWIE, FDRE (2017). Urban Wastewater Management Strategy, Addis Ababa
28. MoWR, FDRE (1999). Ethiopian Water Resources Management Policy, Addis Ababa
29. MoWR, FDRE (2002). The National Water Strategy of Ethiopia, Addis Ababa
30. NPC (2016), FDRE National Planning Commission, Growth and Transformation Plan II (GTP II): 2015/16-2019/20, Addis Ababa
31. Susmita Sengupta, Rashmi Verma and Samya Kazmi 2018, Bottom to the Fore: Rural sanitation in Sub-Saharan Africa, Centre for Science and Environment, New Delhi

32. UNICEF (2015). WASH Field Note, First Steps Towards Sanitation Marketing in Ethiopia Using a Human Centred Design Approach
33. UNICEF (2017). WASH Field Note, Progress on CLTSH in Ethiopia: Findings from a National Review.
34. UNICEF, 2017. WASH Field Note, Progress on CLTSH in Ethiopia: Findings from a National Review, http://www.wssinfo.org/fileadmin/user_upload/resources/JMP-Update-report-2015_English.pdf
35. United Nations (2018). Sustainable Development Goal 6, Synthesis Report on Water and Sanitation, New York, USA
36. Water Aid, 2017. Out of Order, The State of the World's Toilets 2017, WaterAid/ H&M Foundation/ GMB Akash/ Pano
37. WaterAid (2018). The Crisis in the Classroom: The State of the World's Toilets 2018