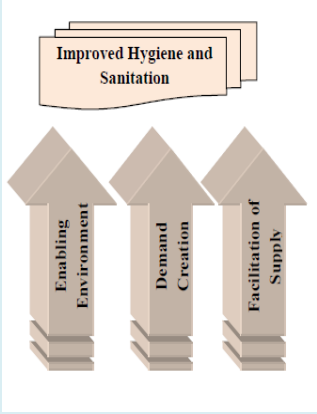
FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA MINISTRY OF HEALTH

PART II

FINAL

National Hygiene & Sanitation Strategic Action Plan for Rural, Per-Urban & Informal Settlements in Ethiopia



2011 – 2015
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Main Document

Foreword

Ethiopia has set itself upon a challenging course with its adoption of the Universal Access Plan for water and sanitation. First set forward in 2005, the "UAP" seeks to establish basic water and sanitation services for virtually all Ethiopians by 2015. In Ethiopia, as in many other developing countries around the world, provision of water supply services typically receives more attention (and more resources) than do hygiene and sanitation-related initiatives. As a result, hygiene and sanitation programmes have routinely made slower progress on the ground than have water supply improvements. However, the price we pay for lack of sanitation facilities and poor hygiene practices can be measured in the lives of children who succumb to diarrhoeal and other hygiene-related diseases, as well as the indignities suffered by those without such services, especially women and children who bear the greatest burden.

Health professionals as well as economists have increasingly come to recognise both the positive social and economic benefits that improved hygiene and sanitation services yield for individuals and communities, and for the nation as a whole. The financial return on investments in hygiene and sanitation services has been estimated at over nine units of benefit for each unit spent. Conversely, a failure to invest in these services results in tremendous financial losses to the nation in terms of increased family medical costs, lost income due to absences from work, lower school attendance and student performance, and security threats especially to women and girls who, out of shame, must wait till after dark to relieve themselves as well as environmental degradation.

Ethiopia has made great strides increasing both its water supply and sanitation coverage since 1990, when these indicators stood at 19% and 5% per cent, respectively. Much of the progress in access to sanitation has actually taken place since 2000 when the Health Extension Programme was introduced and its cadre of over 30,000 Health Extension Workers undertook household sanitation promotion as part of the Model Household programme. Innovative, large scale sanitation campaigns were then organised in SNNPR and later, in Amhara Region. More recently, introduction of the Community Led Total Sanitation and Hygiene (CLTSH) approach to community and household hygiene and sanitation has re-invigorated the sector and helped reach more communities with the goal of ending 'open defecation' through self-built toilets, and by encouraging appropriate hand washing and water handling practices.

In spite of this progress, about 30 million Ethiopians still lack basic sanitation facilities and less than 20 per cent of our population are regularly washing their hands with soap and water at critical times. Unsafe water handling and storage means that nearly 40 per cent of the water consumed in homes is contaminated with faecal matter. Sanitation and hygiene are not only important in terms of controlling communicable water-and hygiene-related diseases, but also because of the important link between these diseases and childhood malnutrition. Indeed, Ethiopia will not meet its goals for improving child health and nutrition if we do not tackle the hygiene and sanitation situation.

Here in Ethiopia, our eyes are on our GTP targets, but globally we are also committed to achieving the Millennium Development Goals (MDGs) and the hygiene and sanitation targets established through the AfricaSan process, including the 'eThekwini' commitments made in 2008. In addition, Ethiopia has recently joined the *Sanitation and Water for All* alliance, comprised of 77 organisations, including 35 developing countries, who share a mutual concern for the need to improve hygiene, sanitation and drinking water for the most vulnerable populations throughout the world. Ethiopia and other members of this alliance are seeking to redouble our efforts to reach MDG 7 targets for water and sanitation. We are proud that Ethiopia is looked to as one of the leaders in hygiene and sanitation progress in this process, but we are also keenly aware that we have a great deal of work ahead of us.

The document in your hand is the first National Hygiene and Sanitation Strategic Action Plan. We have developed this document to carry forward the work done on the *National Hygiene and Sanitation Strategy* (2005) and the *Needs Assessment to Achieve Universal Access to Improved Hygiene and Sanitation by 2012* (2007). The preparation of this Strategic Action Plan (SAP) does several things which will help Ethiopia realise its ambitious hygiene and sanitation targets. First, it clearly states that this effort will require the involvement of not only FMoH, but also our colleagues in the Ministry of Water and Energy and the Ministry of Education; as well as our colleagues in Regional, Zonal and Woreda level offices. Second, the SAP highlights the fact that progress on hygiene and sanitation will increasingly be driven by community initiatives and will require an active and well-supported private sector. Third, the SAP articulates a clear set of approaches to hygiene and sanitation work in Ethiopia which is intended to harmonise work in the sector around CLTSH and other relevant approaches. Finally, the SAP provides a detailed analysis of the tasks and associated costs for achieving our targets – demonstrating that Ethiopia will require 415 million US dollars to achieve these targets by 2015. The share of FMoH, FMoE and custody administration will be 238million USD,131million USD and 6million USD respectively. USD 39million is expected to be contributed by beneficiaries in the form of labour and local materials.

The Government of Ethiopia is committed to financing hygiene and sanitation over the next four years at approximately 0.5 per cent of total public expenditure – a level commensurate with the financial needs of the sector, and consistent with our country's commitment to the eThekwini Declaration we signed at AfricaSan. Considering that FMoH would generate the HSDP IV indicated financial needs of 165 million USD in collaboration with communities, NGOs and donors; there is still a gap of 73 million USD for implementing the FMoH portion of SAP.
School and custody centres sanitation and hygiene facilities are expected to be executed by FMoE and custody administration through the technical support of FMoH. Other institutions are also expected to benefit from the large scale creation of enabling environment and demand creation and construct sanitation and hygiene facilities in order to achieve the SAP target by 2015.
FMoH will actively work to fill in financial gaps in the coming months and years through consultation with FMoE and other concerned institutions.

It is at the local level where gains in hygiene and sanitation have truly benefitted from the efforts of the Health Extension Workers. Since 2001, several millions of families in rural communities have built toilets, often as one of the first manifestations of the Model Household Programme. This has radically changed the practices of communities throughout the country, creating a culture wherein toilets are an accepted part of the Ethiopian household. However, much more needs to be done in terms of ensuring that these toilets are properly and hygienically constructed, used by all community members, and that they are accompanied by a hand-washing facility that is equipped with soap (or substitute) and water.

This SAP highlights the importance of achieving the GTP and HSDP IV goals – which include ensuring that all Ethiopians have access to basic sanitation by 2015, as well as ensuring that 77 per cent of the population are practicing hand washing at critical times, safe water handling, and water treatment in the home, and that 80 per cent of communities in the country have achieved 'open defecation free' status. Meeting these targets will not be easy, but the task is achievable. Data from the ongoing National WASH Inventory (which will become available in early 2012), combined with the detailed strategies contained in this SAP document - should provide the basis for establishing Regional, Woreda, and Keble level plans that will effectively put the nation on the path to sustainably reaching all of these targets.

I would like to congratulate the National Hygiene and Sanitation Task Force (whose members are drawn from academic institutions, civil society, international organisations, as well as Government)

for successfully undertaking preparation of the Strategic Action Plan, and to thank the countless Regional, Woreda and local experts, stakeholders, development partners, and community members who contributed their time and expertise to help make this document both comprehensive and realistic. The strong partnerships which have developed in the lead-up to the work on this Strategic Action Plan, and which have been further strengthened during its preparation, give me great confidence that plans and goals outlined in the following pages will be achieved.

From this point forward, our tasks at the Ministry, and in the environmental health sector as a whole, are clear. We are on the final leg of our journey towards achieving the 2015 MDGs and the goals laid out in the GTP. The Government of Ethiopia's resolve to meet these targets is unwavering, and we ask that our partners continue with us on this journey, to realise our dream whereby every Ethiopian lives in a healthy, clean environment.

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ACKNOWLEDGEMENTS

The Federal Ministry of Health wishes to acknowledge the many contributions made to this first National Hygiene and Sanitation Strategic Action Plan. The overall effort was guided by the Federal the members of the National Hygiene and Sanitation Task Force (N-HSTF) , whose members come from a range of academic, civil society, governmental and international organizations. The Ministry also wishes to thank those organizations and individuals who devoted freely of their time and energy to this important process.

Thanks also should be extended to the Federal Ministry of Water and Energy; the Federal Ministry of Education; and the many Regional, Zonal and Woreda government officials, NGO representatives, academic and other experts who attended the consultation workshops in Dire-Dawa, Adama, Jimma, Dessie , Addis Ababa and whose valuable inputs greatly improved the Action Plan.

Finally, the Ministry wishes to thank UNICEF Ethiopia for providing both financial and technical support for the development of the Action Plan.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ACSRHP	A Country Status Report on Health and Poverty
AfDB	African Development Bank
AMCOW	African Ministers Council on Water
AWD	Acute Watery Diarrhoea
CATS	Community Assisted Total Sanitation
CD	Compact Disk
CHV	Community Health Volunteer
CRDA	Christian Relief and Development Association
CSA	Central Statistics Authority
EOC	Ethiopian Orthodox Church
EU	European Union
FINNIDA	Finnish International Development Agency
GC	Gregorian (western) Calendar
GDP	Gross Domestic Product
GTP	Growth and Transformation Plan
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
HEW	Health Extension Worker
HEP	Health Extension program
HH	Household
HSDP	Health Sector Development Plan
IEC	Information, education, and communication
IHS	Improved Hygiene and Sanitation
JICA	Japan International Cooperation Agency
JMP	Joint Monitoring Programme
MDG	Millennium Development Goal
MoE	Ministry of Education
M&E	Monitoring and Evaluation
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MoWE	Ministry of Water and Energy
NGO	Non-governmental organization
NHSTF	National Hygiene and Sanitation Task Force
ODF	Open Defecation Free
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
RWSEP	Rural Water Supply and Environment Programme
SAP	(Hygiene and Sanitation) Strategic Action Plan
SLTS	School-Led Total Sanitation
SM	Sanitation Marketing
SLTSM	School Led Total Sanitation Marketing
SNNPR	Southern nations and Nationality
SWOT	Strengths, weaknesses, opportunities and threats
TOT	Training of Trainers
TPL	Traditional Pit Toilet
TSSM	Total Sanitation and Sanitation Marketing
TVETC	Technical and Vocational Education Training Centre
UAP	Universal Access Programme
UHEP	Urban Health Extension Programme
UNICEF	United Nations Children's Fund
USD	United States Dollar
WASH	Water, sanitation and hygiene

WES	Water and Environmental Sanitation
SNNPR	Southern nations and Nationalities peoples Region
WHO	World Health Organization
WRHO	Woreda Health Office
WSP	Water and Sanitation Program

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[1] Interested offices could get the CD pack upon official request

Terms and Definitions

CLTS
Community-Led Total Sanitation is an approach to household and community sanitation carried out by facilitators who guide communities and individuals through a process of self-realisation, an objective of which is to end the practice of "open defecation" and to bring about improved hygiene behaviours. This typically includes construction of basic sanitation facilities at the household level without the use of external subsidies or prescribed designs.

CLTSH
Community-Led Total Sanitation and Hygiene is Ethiopia's expansion on CLTS whereby basic hygiene behaviours, including hand-washing with soap (or ash) and water at critical times, and safe water handling and treatment at the household level, are also addressed along with the drive to achieve 'open defecation free' status.

DITTO Similar as above

Hygiene
Hygiene refers to practices associated with ensuring good health and cleanliness. This includes Hand washing with soap and water at critical times most notably after defecation or before contact with food and strict observation of the safe drinking water chain.

Sanitation

Improved hygiene and sanitation: As defined by the 2005 National Hygiene and Sanitation Strategy, improved hygiene and sanitation is the process where people demand, develop and sustain a hygienic and healthy environment for themselves by erecting barriers to prevent the transmission of diseases, primarily from faecal contamination, whereas according to the Joint Monitoring Programme (JMP) for Water Supply and Sanitation (World Health Organization and UNICEF), "improved sanitation" methods include the following:

- Connection to a public sewer
- Connection to a septic tank system
- Pour-flush toilet
- Hygienic pit toilet (a toilet which does not contaminate water bodies; prevents contact between human beings and excreta; confines excreta in ways that make it inaccessible to flies or other insect vectors, and domestic or wild animals; and prevents emission of foul gases and odours).
- Ventilated improved pit (VIP) toilet.

- ***Basic sanitation As*** defined by the United Nations Millennium Project Task Force on Water and Sanitation, basic sanitation is the "lowest-cost option for securing sustainable access to safe, hygienic and convenient facilities and services for excreta and sullage disposal that provide privacy and dignity while at the same time ensuring a clean and healthful living environment both at home and in the neighbourhood of users."
- ***Sanitation within the scope of SAP:*** *As the extent of sanitation is broad this National Hygiene and Sanitation Strategic Action Plan does not address all sanitation issues. It only focuses on rural and urban domestic institutional on site sanitation, hand washing and safe drinking water handling in the home. It should be noted also that the urban aspects of the SAP address only peri-urban areas, small towns, and informal settlements whereby on site solutions can be applied.*

Model Household

- A "model household" has adopted at least 11 out of a total of 16 health and hygiene practices or packages. Seven of the 16 involve environmental health and hygiene aspects, such as access to and use of a household toilet, hand washing with soap (or ash) and water at critical times, and safe

drinking water handling and treatment in the home. In the context of SAP a Model *house hold is defined as a house having latrine, hand-washing, water storage, and treatment facilities.*

- ***Onsite Sanitation.*** A sanitation system whereby excreta are contained at the same location as the toilet – either in a pit, chamber, vault or septic tank.

- ***Offsite Sanitation.*** A water-borne sanitation system linked to a sewer whereby excreta are pumped or otherwise transferred to a treatment system at a different location.

- ***Improved Sanitation***
  Sanitation options which are not considered "improved" include:
  – Public or shared toilet
  – Open pit toilet
  – Bucket toilet

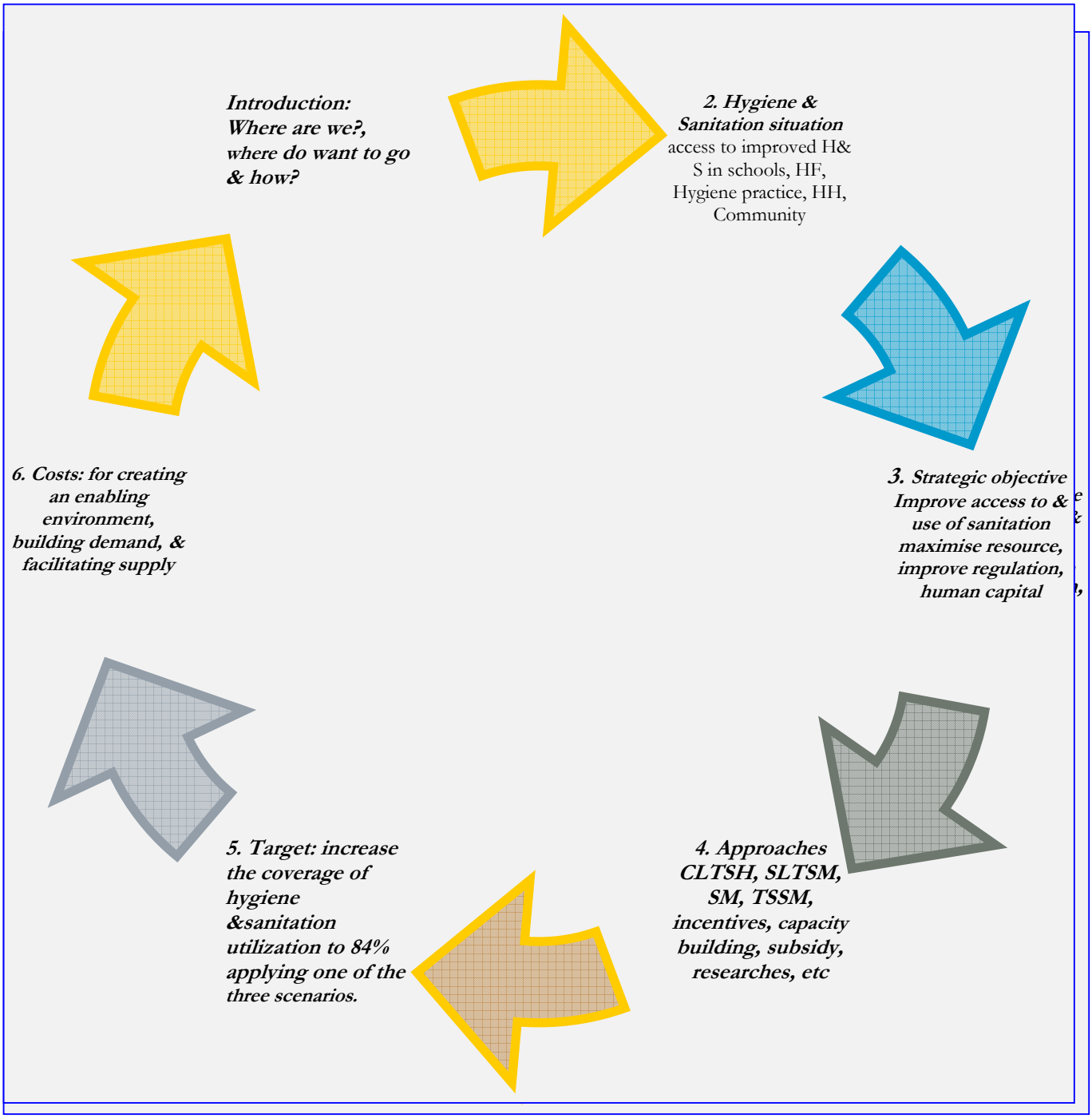
Sanitation Marketing
Satisfying sanitation requirements (both demand and supply) through a commercial exchange process as opposed to a welfare package.

NOTE on Calendar Dates

Dates provided in this document are Gregorian (Western) calendar dates, unless indicated otherwise. The current year in the Ethiopian Calendar (EC) is 2003; the Ethiopian New Year begins on 11 September of the Gregorian Calendar (GC), or 12 September in leap years.

***Vision**: To see all Ethiopians enjoying a safer and a cleaner environment by the year 2015.*
***Main objective**: to improve the health and the living conditions of the entire population of Ethiopia by ensuring the accessibility of improved and sustainable water supply, hygiene and sanitation facilities.*

The Strategic Arrangement of the NH &SSAP Process



SECTION 1. INTRODUCTION

This section covers:	
1.1	**Document Scope and Structure** – Where are we, where do we want to get to and how?
1.2	**Background** – demand creation for improved hygiene and sanitation centres on HEWs
1.3	**Supporting documents** – strategy, protocol and finance needs assessment

1.1 DOCUMENT SCOPE AND STRUCTURE

1.1.1 Scope

This document is a Five-Year Hygiene and Sanitation Strategic Action Plan (SAP) for Ethiopia which focuses on rural and urban, domestic and institutional "on site sanitation", hand washing and safe drinking water handling in the home. Note that the urban aspects of the SAP address only peri-urban, small town, and informal settlement sanitation whereby 'on site' solutions can be applied. A separate national strategy is under development to address large-scale and communal (off site) sanitation needs in urban areas in Ethiopia. As the construction and development of water supply falls under the responsibility of the Federal Ministry of Water and Energy (FMoW&E) a separate Strategic Action Plan on water will be developed and implemented together with the National Hygiene and Sanitation Strategic Action Plan.

1.1.2 Structure

The SAP main document has 6 sections as indicated in table below: Annexes that show regional detailed plans ,costs and assumptions are enclosed in a CD for further reference.

Table 1. The NH&SSAP is divided into 6 Sections:

Ser. No	***Sections***	***Issues Addressed in each section***
1	***Section 1***	Provides an introduction and background on hygiene and sanitation, with details of Ethiopia's key policy documents, public health proclamations, and other enabling environment information.
2	***Section 2***	Outlines the benefits accruing from improved hygiene and sanitation, including health, social, and economic benefits. The section also outlines the recommended approaches for achieving the Government of Ethiopia's sanitation and hygiene goals.
3	***Section 3***	Provides a brief situation analysis of the current hygiene and sanitation situation in Ethiopia, as well as looking at stakeholder roles and functions.
4	***Section 4***	Provides details of the national hygiene and sanitation vision, objectives, indicators and outcomes
5	***Section 5***	Explores best practices and lessons by detailing possible programming approaches, options and challenges.
6	***Section 6***	Provides details of the Strategic Action Plan including lines of responsibility, timing, and estimated costs. This section is supported with a series of spread sheets.
7	***Section 7***	Provides supporting information on targets, parameters and assumptions used in the cost calculation.

1.2 BACKGROUND –POLICY, LEGISLATION, AND PROGRAMMES

The public health system has been radically changed during the past several years in Ethiopia with the advent of the Health Extension Programme and its over 34,000 Health Extension Workers (HEWs) who have greatly expanded the scope and reach of Ethiopia's health system, especially in rural areas. Ethiopia now has a great number of "model households" who have adopted key health practices including toilet ownership and

better hygiene. There is a gathering momentum and determination to become the first country in Africa to declare itself open defecation free (ODF) by 2015.

There is some discussion on the figures related to access and usage of different types of toilets, as well as key hygiene practices in Ethiopia. International figures based on national surveys (e.g., the Joint Monitoring Programme and the Country Status Overview) suggest national toilet access is about 39 to 40 per cent[2]. The latest government figures from 2010 indicate access is approximately 60 per cent[3]. Accurate data are considered a high priority by Government to support its evidence-based planning – therefore Ethiopia is in the process of undertaking a "National WASH Inventory" which will be used to further inform this crucial aspect of the SAP.

The Ministry of Health, in its Health Sector Development Plan (HSDP) IV, has targeted 100 per cent coverage by basic sanitation, and 84 per cent access to "improved sanitation" by 2015 as its goal. These goals have been adopted for this Strategic Action Plan.

1.2.1 Supporting Constitution, Policy, Legislation, and Regulation

The Federal Democratic Republic of Ethiopia took the initiative of including protection of public health in the 1995 National Constitution. Both the Constitution and the Health Policy provide strong legislative and policy underpinning to the promotion of household and community level hygiene and sanitation. Further support for improved hygiene and sanitation was provided by Food Medicine and Health Care Administration and Control Proclamation No.661/2009[4]

Table 2. Environmental Health Issues Addressed in the Constitution, Policy & Food Medicine and Health Care Administration and Control Proclamation No.661/2009

Ser.No	Supporting Legislations	Public Health Issues Addressed
1	Constitution	The constitution in Article 90.1 states that "to the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health and education, clean water, housing, food and social security"[5]. Article 92.1 states also that the "Government shall endeavor to ensure that all Ethiopians live in a clean and healthy environment"[6].
2	Policy	The policy in Article 2, sub-Article 2.1 gives emphasis to the control of communicable diseases, epidemics and diseases related to malnutrition and poor living conditions", Sub-Article 2.2 also stress "the promotion of occupational health and safety", in Sub-Article 2.3 "Development of environmental health". The Health Policy's "general strategies" in Article 3 states the promotion of "intersect oral collaboration" including "accelerating the provision of safe and adequate water for urban and rural populations", "developing safe disposal of human, household, agricultural and industrial wastes and encouragement of recycling", and "developing measures to improve the quality of housing and work premises for health."

[2] Country Status Overview – Ethiopia. AMCOW (2010).
[3] HSDP IV (2010).
[4] Food Medicine and Health Care Administration and Control Proclamation No.661/2009[4]

[5] Health and health related indicator, Federal Ministry of Health, 2008/2009.
[6] The Constitution of the Federal Democratic Republic of Ethiopia, August 1995.

3	Food Medicine and Health Care Administration and Control Proclamation No.661/2009	Food Medicine and Health Care Administration and Control Proclamation No.661/2009 in Article 12, 31 and 30 have addressed the issue of Waste Handling and Disposal, Availability of Toilet Facilities, and Water Quality Control respectively. The inclusion of these Articles in the proclamation will support to accelerate the expansion of hygiene and sanitation services. The three Articles included are: Article 12: Waste Handling and Disposal in Article 12 states that: 1.No person shall collect or dispose solid, liquid or other wastes in a manner contaminating the environment and harmful to health 2.Any wastes generated from health or research institutions shall be handled with special care and their disposal procedures shall met the standards set by the excusive organ 3. It is prohibited to discharge untreated waste generated from septic tanks, seepage pits and industries into the environment, water, bodies or water convergences. Article 31: Availability of Toilet Facilities in Article 31 goes on to state: 1) Any institution or organization providing public service shall have the obligation to organize clean and adequate toilet facilities and keep open to its customers. 2) Any city or rural administration shall be responsible to provide public toilet and ensure its cleanliness. Article 30: Water quality control in Article 30 further states that: 1) It is prohibited to supply water for public consumption from spring well or through pipes unless its quality is verified by the appropriate organ. 2) It is prohibited to import or produce and distribute bottled mineral or plain water for public consumption unless its quality is verified by the existing organ,

Strategies: the Federal Ministry of Health has developed and issued two strategies to facilitate the expansion of hygiene and sanitation services in the country so that the MDGs target can be met by the year 2015. The focus and the purpose of the strategies are indicated in table below.

Table 3. Developed Strategies by Federal Ministry of Health (FMoH)

Ser. No	Strategies	The Focus & Purpose of the Strategies
	National Hygiene and Sanitation Strategy of 2005	➢ Provided further details on how household and community hygiene and sanitation were to be carried out. The Strategy's vision anticipates 100% adoption of improved hygiene and sanitation facilities by each community, which will contribute to better health, a safer, cleaner environment, and the socio-economic Development of the country. ➢ The Strategy defines improved hygiene & sanitation as the process whereby people demand, develop and sustain a hygienic and healthy environment for themselves by erecting barriers to prevent the transmission of diseases, primarily from faecal contamination. ➢ The Strategy's objectives were to ensure universal access to hygiene and sanitation as follows: o *Households:* All households have access to the use of a sanitary toilet. The resulting behaviour aimed at is: ▪ Reduced incidence of diseases derived from faecal contamination ▪ Reduced incidence of waterborne, water-washed, water related, and water based diseases o *Institutions:* Appropriate toilets with urinals and hand washing facilities are installed at schools, health posts, markets and public places.
		➢ The Strategy provided a 3-pillar approach to achieving its objectives: 1) Enabling Environment; 2) Sanitation and Hygiene Promotion; and 3) Access to Hardware. The Strategy envisioned the process to be led by communities (with the support of the Health Extension Programme and local health authorities): "The focus was on creating a sense of responsibility for sanitation at the household & the community level so that 100% sanitized households create 100% sanitized villages." ➢ The strategy clarified the role of private (e.g., household) investment vs. public investment: "Householders in rural and urban areas should contribute their own resources for domestic sanitation facilities with public finance dedicated to leveraging private resources." On the matter of subsidies, the Strategy stated that "Subsidy should only be applied if it is sustainable to the point where all needs are met." ➢ The 2005 Strategy was finalized but never formally adopted by FMOH. It is, however, referred to by sector practitioners as the main working document for hygiene and sanitation in Ethiopia.
2	National Hygiene and "On-Site" Sanitation Protocol" (2006).	The objective of the Protocol was to: ➢ Give a clear set of guidelines for all stakeholders promoting Improved Hygiene and Sanitation leading to better co-ordination and clearer lines of responsibility at the national, regional, zonal and woreda levels. ➢ Strengthen the integration of all programmes with an improved hygiene and sanitation component within woreda development plans and the health extension services programme ➢ Provide the basis for a comprehensive budgeting and investment framework ➢ Improve sector co-ordination with all stakeholders working from one set of guidelines ➢ Define minimum standards and a framework for information management and monitoring to ensure adequate sub-sector performance evaluation ➢ The Protocol called for a series of eight steps which are outlined in more detail in Section 1.3 below. The Protocol also provided further

Ser. No	Strategies	The Focus & Purpose of the Strategies
		reinforcement and clarification on the roles of public financing in Section 5.1.8. (i.e. "Strategic subsidy") ➢ Public funds are best used to lever investment by individual households, small scale providers, organisations and large scale private sector organisations. Public financing should be used for public health worker costs and all software activities such as advocacy, social marketing, capacity building, demonstration and regulation. Public finance should be available to fund and lever funding for the construction of institutional toilets; schools, health centres, market places, prisons, and other community sites.

1.2.2 The Health Extension Programme

The Health Extension Programme (HEP) was introduced in 2002-03 GC with the central philosophy that if the right knowledge and skills are transferred, households can take responsibility for improving and maintaining their own health. To implement the HEP, a total of 34,382 rural Health Extension Workers (HEWs) were trained and deployed up to the end of EFY 2002[7]. The rural health extension training comprised 16 preventative health packages of which seven are dedicated to environmental health, including hygiene and sanitation. Similarly the urban health extension program started in EFY 2001 and a total number of 3401 health extension workers were trained and deployed in agrarian regions(SNNPR, Amhara, Tigrai & Oromia) and in 3 urban areas(Harari, Addis Ababa & Dire Dawa)[8]. The urban health extension training comprised a total number of 15 preventive health packages of which 4 are dedicated to environmental health. The hygiene and sanitation mandate of the HEP has been reinforced by policies and strategies cited in the previous section.

1.2.3 Growth and Transformation Plan

The Ethiopian Plan for Accelerated and Sustained Development to End Poverty (PASDEP), which ran from (GC) 2005-6 to 2009-10, has been succeeded by the "Growth and Transformation Plan" (GTP) of 2010-11 to 2014-15. The GTP's health objectives are to improve the health of the population through provision of promotional, preventive, curative and rehabilitative health services. It is clearly stated in the GTP that Hygiene and Environmental health will be improved through the rigorous application of the Health Extension Programme packages designed to decrease the incidence of communicable diseases caused by poor hygiene and sanitation practices[9].

1.2.4 Significant progress reported

Introduction of the HEP and leveraged support from development partners has resulted in significant increases in sanitation "access" in many parts of the country. Programmatic changes also played a role, especially the expansion of the use of the "Community Led Total Sanitation" (CLTS) approach[10] to household sanitation, first introduced in 2006. CLTS (recently revised in Ethiopia to include an "H" for hygiene promotion) is an approach which focuses on community self-analysis of sanitation and hygiene conditions, followed by a drive to end "open defecation" throughout the community. However, in spite of the success of the HEP, CLTSH, and other sanitation programmes in Ethiopia, many challenges remain. These include:

- Hand washing with soap (or ash) and water at critical times is still practiced by a minority of the population (perhaps around 20 per cent)
- High *access* rates to household toilets are often not matched by high *usage* rates

[7] Health Sector Development Program, lll Annual Performance Report, EFY, 2002(2009/10)
[8] Health Sector Development Program, lll Annual Performance Report, EFY,2002(2009/10)
[9] Growth and Transformation Plan(GTP) MoFED), 2010/11-2014/15
[10] More information on CLTS can be found at http://www.communityledtotalsanitation.org/

- Many, if not most household toilets are simple, traditional pit toilets which fail to compartmentalize excreta from the environment - calling into question their sustainability and impact upon health.
- Household water handling (and lack of effective treatment) calls into question the bacteriological quality of drinking water at the point of consumption.

FMOH recognizes these challenges and the considerable remaining work to be done in order to realise national hygiene and sanitation goals. This Strategic Action Plan is intended to identify the tasks ahead, as well as to clarify roles, responsibilities, timing, and resource requirements to meet the HSDP hygiene and sanitation targets by 2015.

1.3 ACHIEVING IMPROVED HYGIENE & SANITATION

FMOH has previously published various guidelines and protocols which outlined the approaches (and associated costs) for achieving universal hygiene and sanitation in Ethiopia. These include the *National Hygiene and Sanitation Strategy* (2005), the *National Hygiene and "On-Site" Sanitation Protocol* (2006), and the *Needs Assessment to Achieve Universal Access to Improved Hygiene and Sanitation by 2012* (2007). Programmatic hygiene and sanitation approaches are further elucidated in the following documents:

- Woreda Resource Book - Community-Led Total Behaviour Change in Hygiene and Sanitation[11]
- Facilitator's Guide, Community-led Total Behaviour Change in Hygiene and Sanitation[12]
- Health Extension Worker Handbook, Community-led Total Behaviour Change in Hygiene and Sanitation[13]
- Community Led Total Sanitation and Hygiene (CLTSH) Implementation Guideline (November 2009 draft, currently under finalisation by FMOH)
- Community Led Total Sanitation and Hygiene (CLTSH) Training Manual (January 2010 draft, currently under finalisation by FMOH)
- Village Verification Guide for Open Defecation Free Status, Hand Washing, and Safe Handling of Water in the Home (March 2010 draft, currently under finalisation by FMOH)

1.3.1 The Improved Hygiene and Sanitation Strategy

The 2005 Strategy provides the planning framework under the three key pillars:

Pillar 1: Creating an enabling environment
Pillar 2: Building demand
Pillar 3: Facilitating the supply of desirable, appropriate and affordable hardware

The pillars detail the prevailing key principles underpinning the successful delivery of improved hygiene and sanitation.

1.3.2 The 8 Step Protocol to achieve improved hygiene and sanitation

The 2006 Protocol was developed out of a desire by the Government to standardise and harmonise hygiene and sanitation approaches in Ethiopia. The Protocol outlines an 8-step sequence, including allocation of stakeholder responsibilities.

Step 1: Participatory Situation Analysis
Step 2: Advocacy and Consensus building
Step 3: Inter-sectoral, broad-based planning (reflecting mandates)
Step 4: Human resource development, supervision, reporting
Step 5: Financing improved hygiene and sanitation
Step 6: Promotion, empowerment and enforcement
Step 7: Access to hardware for toilets, hand washing, safe water
Step 8: Monitoring and evaluation

[11] Amhara National Regional State Health Bureau, October 2008.
[12] Amhara National Regional State Health Bureau, January 2009.
[13] Ibid.

This 8-step protocol informs the design of this Strategic Action Plan.

1.3.3 The Needs Assessment

The *Needs Assessment to Achieve Universal Access to Improved Hygiene and Sanitation by 2012* (also referred to as the "Financing Needs Assessment") of 2007 estimated the total investment cost of achieving universal hygiene and sanitation access in Ethiopia excluding private household investment. It was calculated based on a 5-year planning and budgeting process and was based on a number of assumptions in the absence of robust data. about unit costs, existing sanitation coverage, and achievable implementation rates.

The total cost for achieving universal hygiene and sanitation access was estimated to be $645 million in this 2007 Needs Assessment. This latest Strategic Action Plan has been reformatted in line with new sector developments using actual delivery costs where possible and more considered assumptions where they are not currently available. A detailed summary of these estimates are presented in Section 6.

Of this estimated total cost, only about 10 per cent appeared to be available through development partner assistance at the time, based on estimates of donor contributions to the sanitation and hygiene sector.

Table 4. Estimated Financial Needs for Hygiene and Sanitation, USD Millions (2007-2012)14

All Regions	Software	Hardware	Water Quality Assurance	Capacity Building	Monitoring & Evaluation	Totals (USD Millions)
Urban	10	214	7	16	1	**250**
Rural	30	298	9	56	4	**395**
Total	**40**	**512**	**16**	**72**	**5**	**645**

Table 5. Estimated donor and NGO financial support 2007 to 2012 Funds allocated for Sanitation and Hygiene per year by development partners & NGOs

Development Partner	Total Aid Allocation	Estimated allocation to Hygiene and Sanitation	Estimated Hygiene and Sanitation Funding (USD millions)
DfID	28.5	10%	**2.85**
World Bank	54	10%	**5.4**
Government of Finland	10.5	10%	**1.05**
African Development Bank	17.7	10%	**1.77**
European Union	14	10%	**1.4**
Government of Italy	4.6	10%	**0.46**
UNICEF (not inc emergency funds)	18	30%	**5.4**
NGOs	14	6%	**0.84**
Total	**161.3**		**19.17**

It is important to emphasise that Table 2 does not include the GoE contribution to improved hygiene and sanitation delivered through the Health Extension Programme and progressive Health Sector Development Programmes which is assessed at 2% of the total health budget in the HSDP IV plan.

[14] *Needs Assessment to Achieve Universal Access to Improved Hygiene and Sanitation by 2012. Ministries of Health, Water Resources, Education, and Urban Development, and the European Union Water Initiative. Final Draft, May 2007.*

SECTION 2. WHY INVEST IN IMPROVED HYGIENE & SANITATION?

This section covers:	
2.1	**Health Benefits:** Reduced diarrhoeal disease, Trachoma, ARIs and Helminths
2.2	**Economic Benefits:** Every $1 invested can provide returns of $3 to $34
2.3	**Social Benefits:** Convenience, safety, privacy, prestige

2.1 HEALTH BENEFITS

2.1.1 Diarrhoea, Trachoma and ARIs

The Health Impact of sanitation is based on plausible inference deriving from wide sectoral acceptance of Esry's analysis[15] of 144 studies in 1991 and 1996, corroborated by Fewtrell's expanded study in 2004. Their analysis demonstrated that when improvements in sanitation and hygiene are widely practiced then the following health impacts can be achieved: safe excreta disposal resulted in an average 36 per cent reduction in diarrhoea, while sanitation combined with hygiene promotion led to as much as a 48 per cent reduction in diarrhoea[16] (x).

2.1.2 Diarrhoea and Trachoma

Randomised control trials of Emerson[17] and Luby[18] demonstrated the importance of toilet construction and hygiene promotion in controlling fly breeding, reducing diarrhoea by 23 per cent and trachoma by 75 per cent while Luby in a series of randomised control trials showed that hand washing with soap and water could reduce acute respiratory infections by up to 50 per cent. Furthermore, improvements in drinking water quality through household water treatment, such as chlorination and hygienic storage at the point of use, led to a reduction of diarrhoea episodes by 35 to 39 per cent[19].

2.2 ECONOMIC AND SOCIAL BENEFITS

2.2.1 The cost of poor sanitation

In their economic analysis, Hutton[20] and Haller (2004) based their global impact assessment for WHO on the widely accepted[21] figures that the lack of adequate sanitation and hygiene results in 5.4 billion cases of diarrhoea leading to 1.6 million deaths mainly among young children, each year. They estimate that the global cost of not meeting the MDG targets on water and sanitation at US$38 billion per year, with sanitation accounting for 92 per cent of this value (Hutton *et al.* 2006). A World Bank study[22] suggests that this assessment understates the costs by as much as 40 per cent or more by not including the malnutrition-mediated health effects, the long term costs of lower school performance, and the reduced cognitive development of WASH-related infections. Through expanded economic analysis in

> According to a desk study carried out by the Water and Sanitation Program (WSP), Ethiopia loses ETB 9.7 Billion each year, equivalent to US$ 650 million, annually which is higher than the SAP five years financial needs of US $**414 million** due to poor sanitation. This sum is the equivalent of US$9per person in Ethiopia per year or 2.3% of the national GDP.

[15] Esrey, S. A. et al. (1991*). "Effects of improved water supply and sanitation on ascariasis, diarrhoea, dracunculiasis, hookworm infection, schistosomiasis and trachoma*". Bulletin of the Royal Society of Tropical medicine and Hygiene Vol 77, No 4 pp 515-521
[16] Ibid
[17] Emerson (2000) '*Review of the evidence base for the 'F' and 'E' components of the SAFE strategy for trachoma control'*. Tropical Medicine & International Health (8): 515-27.
[18] Luby S.P. (2005) *Clean Hands Reduce the Burden of Disease* cited Pitet D. (2005) The Lancet, Volume 366, Issue 9481, Pages 185 - 187, 16 July
[19] Stockholm International Water Institute (SIWI) and World Health Organization (WHO), (2005), *Driving Development by Investing in Water and Sanitation. (*Stockholm: Stockholm International Water Institute, 2005).
[20] Hutton G. & Haller L.(2004) *Evaluation of the Costs and Benefits of water and sanitation at the Global Level.* WHO
[21] Pruss, A., Kay D., Fewtrell L. & Bartram J. (2002) *Estimating the burden of disease from water, sanitation and hygiene at global level.* Environ Health Perspec 2002;110:537-42. Murray and Lopez (1997) Global Burden of Disease Study
[22] The World Bank (2008) *Environmental Health and Child Survival.* Environment and Development

Pakistan and Ghana, the study showed that environmental health risks consume up to 9 per cent of these countries' Gross Domestic Product (GDP).
Furthermore, according to a desk study carried out by the Water and Sanitation Program (WSP), Ethiopia loses ETB 9.7 Billion each year, equivalent to US$ 650 million, annually due to poor sanitation. This sum is the equivalent of US$9per person in Ethiopia per year or 2.3% of the national GDP[23]. On the other hand the overall national SAP five years financial needs of USD 414,184,737.53 is relatively lower than the annual loss incurred due to not addressing hygiene and sanitation highly justifying the need for its immediate implementation.

2.2.2 The Potential Value of By-Products

There are other potential economic benefits which include the re-use of treated effluents for irrigation, re-use of bio-solids (composted sludge) as fertiliser for agriculture, and the production of biogas as a source of energy. There are other potential economic benefits as well, including for job creation (e.g., manufacturing and sales of sanitation commodities, construction, and servicing).

2.2.3 Enhanced Well-being

There is a considerable range of perceived social advantages in having an improved toilet which have been learned from both national and international knowledge, attitude, belief and practice studies[24]. The list includes: dignity, convenience, privacy, social prestige, security for women, increased school enrolment for girls and a general sense of well-being. As one woman reported from Arsi Woreda in Oromia region, "The toilet makes my house complete". As Jenkins and Scott concluded from one such study[25] in Ghana, health is often low on the list of factors considered when discussing motivation to build or improve toilets. In general it should be noted that, the list of benefits of improved hygiene and sanitation largely reflect studies outside Ethiopia highlighting the need to better understand impact and outcomes in the Ethiopian context. Ongoing verbal autopsy work by regional universities presents an important insight into causes of mortality which could be expanded to better understand impact and outcomes of different inputs from health extension through community promotion to sanitation marketing.

[23] World Bank, Water and Sanitation July, 2011Program(WSP),

[24] Hunde T. et al (2002/3) : *A KABP study of defecation practice, latrine preference & possible options – Oromia and Gondar*, WaterAid

[25] Jenkins M., and Scott B. (2008/9) *Behavioral Indicators of Household Decision-Making and Demand for Sanitation and Potential Gains from Sanitation Marketing in Ghana*. Social Science & Medicine 2007; 64(12):2427-42

SECTION 3. CURRENT SANITATION AND HYGIENE SITUATION IN ETHIOPIA

This section covers:	
3.1	Current Sanitation and Hygiene Situation in Ethiopia – moving above 60% as per MoH[26]
3.2	Hygiene Practices – hand washing, safe water chain – lagging behind the MDGs Target
3.3	School Access to improved hygiene and sanitation – the scale of the WASH challenge
3.4	Health institutions – considerable unmet demand
3.5	Stakeholders – roles, functions, coordination and planning – filling the supply vacuum

3.1 CURRENT SANITATION AND HYGIENE SITUATION IN ETHIOPIA

Ethiopia has made considerable progress to encourage increased access to and use of improved hygiene and sanitation through HEWs using house to house methods, as well as newer community empowerment tools such as CLTSH. Anecdotal reports suggest that this has resulted in reductions in diarrhoeal diseases but there are still worrying seasonal outbreaks of Acute Watery Diarrhoea (AWD) resulting in high reported levels of morbidity and mortality. Ethiopia has been relatively successful at creating demand and there is now an evolving "toilet culture" which places a high value on ownership and use of household toilets, and which shuns open defecation. However, there is a sanitation commodity and service "supply vacuum" which must be filled with an enabled private sector.

3.1.1 Morbidity & Mortality

According to the 2005 Country Status Report on Health and Poverty, child mortality in Ethiopia is among the highest in the world, nearly one in every ten babies born in Ethiopia (97 per 1000) did not survive to celebrate her/his first birthday and one in every six children dies before her/his fifth birthday[27] . At present the situation has greatly improved as a result the infant mortality rate has reduced to 77/1000, child mortality rate 50/1000 and under five mortality rates 123/1000[28]. Furthermore, the government has set a target to reduce under five mortality rate from 123 to 85/1000 live birth, and infant mortality rate from 77/to 45/1000 live birth[29].

3.1.2 Coverage: access and utilization

Agreeing actual access and usage levels in Ethiopia remains a major priority and a key issue for this strategic planning exercise. According to the AMCOW report, 12 per cent of the population use improved toilets, 7 per cent shared toilets, 21 per cent traditional toilets and 60 per cent practice open defecation (8 per cent urban and 71 per cent rural) (AMCOW, 2010) Government figures present a more positive picture.

Table 6. Access to Excreta Disposal by Region

Region	Access to Excreta Disposal		
	No. of HHs	No. of HHs with Toilet	Per cent coverage
Tigrai	1,030,199	726,946	71.0
Afar	258,572	16,795	6.5
Amhara	4,209,129	2,644,417	63.0
Oromia	6,011,967	3,377,365	56.0
Somali	708,028	18,660	3.0
BG	158,156	32,473	21.0
SNNPR	3,272,573	2,444,862	75.0

[26] Projected JMP's improved sanitation coverage figure for 2011 is 13.33% which is close to AMCOW's, 2010 figure
[27] A Country Status Report on Health and Poverty, (In Two volumes) Volume 1: Executive Summary, Africa Region Human Development, The World Bank, Ministry of Health, Ethiopia, July, 2005.
[28] Health Sector Development Programme lll Annual Performance Report, EFY 2002(2009/10)
[29] Ibid

Region	Access to Excreta Disposal		
	No. of HHs	No. of HHs with Toilet	Per cent coverage
Gambella	72,304	7,446	10.0
Harari	49,488	20,114	41.0
Addis Ababa	696,210	530,934	76.0
Dire Dawa	80,041	38,188	48.0
National	16,546,667	9,878,199	60.0

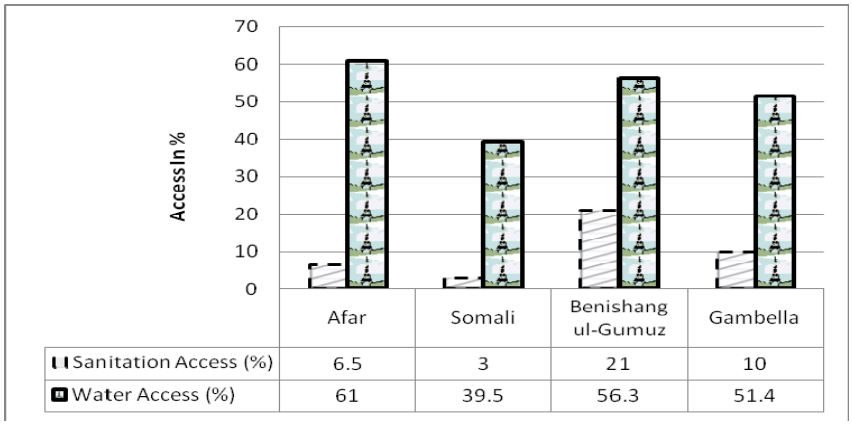
Source: FMoH, Health and Health Related Indicators, 2001E.C (2008/09G.C)

There is general agreement that Ethiopia is making progress. According to government figures[30], in the year 2000 less than 15 per cent of the Ethiopian population had access to basic sanitation but now after the introduction of the HEP and widespread hygiene and sanitation promotion the Federal Ministry of Health 2008/9 report[31] the national coverage of sanitation has reached 60 per cent. This more optimistic figure is further supported by the rapidly expanding number of (graduated) model households which must have and use a toilet while practicing a range of safe hygiene practices to comply.
According to the 2009/10 HSDP status report, current model household status is reported to be 61 per cent. However, the regional variation is very wide and ranges from 10 per cent in Gambella, 3 per cent in Somali and 75 per cent in SNNPR. The collection of accurate data on types of toilet and usage remains a national challenge but it is anticipated that the use of the national WASH inventory will provide reliable and useful data sets at all levels

3.1.3 Access in Pastoralist Regions

The emerging regions of Afar, Somali, Benshangul Gumuz, Gambella and pastoralist areas found in Oromia present a unique challenge in terms of health service delivery in general and hygiene and sanitation in particular. Figures on toilet access and hygiene practice are low, implying high risk to health. However, open defecation in desolate, scorched landscapes may present lower risk as dehydration of the waste is rapid (though waste can be transported to settlements by feet). Mobility is the key to human and livestock survival in these harsh environments; survival can be compromised if mobility is inhibited. Further, when large numbers of people and livestock are competing for limited water supplies, and open defecation is practiced, such conditions can lead to rapid faecal-oral disease transmission including outbreaks of AWD. Local government officials are aware of and are concerned about these risks, but acknowledge that water supply provision is their first priority, after which improved hygiene and sanitation can be considered[32].

Figure 1: Access to Water and Sanitation in Pastoralist Regions



Source: FMoH, Health and Health Related Indicators, 2001(2008/09)

[30] Central Statistics Authority, Addis Ababa, Ethiopia, 2000
[31] Health Sector Development Program, IV Annual Performance Report, EFY, 2002(2009/10
[32] Interviews with regional water and health bureaus in Afar and Somali regions

As shown in Figure 1 accessibility to safe water supply and adequate sanitation facilities in the four pastoralist regions is lower than the agrarian regions of the country. For example, the water and the sanitation coverage in the pastoralist regions ranges from 39.5 per cent to 61 per cent and 6.5 per cent to 21 per cent respectively, while in the other regions the water and sanitation coverage ranges from 62 per cent to 95 per cent and 41 per cent to76 per cent respectively[33].

Access to water and sanitation in Afar, Beleshangul Gumuz, Part of Oromia, Somalia and Gambella at both household and institutional level is well below national level. This is well illustrated by the situation in Afar region where only 3.35 per cent of the households in the region have access to sanitation facilities (4 per cent for rural households and 44.6 per cent for urban households). The proportion of households using open defecation in 1996, 2000, & 2004(EC) was reported to be 84.4 per cent, 83.3 per cent, 81.5 per cent respectively. As observed during field visits the very few available toilets constructed by the community are not well maintained and not used properly.

Access to potable water within 1.5 km (15 litres/capita/day) is reported to be 54 per cent. The sources of water include: rivers; lakes; unprotected wells; springs; public taps and privately owned taps (2007-2008). Due to the shortage of water, poor sanitation and limited hygiene, the region has been repeatedly attacked by AWD, in 2006, 2007, 2008 and 2009. According to a report on the epidemic made by the regional state health bureau in 2009, there were 6583 suspected cases and 183 deaths.

The major problems cited by Health Extension Workers, School Directors, Woreda health personnel and communities during the field visit centred round the shortage of resources, commitment and awareness as well as poor inter-sectoral collaboration, ineffective sanitation promotional programs and the limited availability of construction materials for latrines.

3.2 HYGIENE PRACTICES

3.2.1 Hand washing

Information on hand washing in Ethiopia is limited to a number of qualitative studies but compliance with the four critical times[34] (as a basic minimum) is thought to be as low as 7%[35]. The emerging picture suggests that there is a culture of hand washing before eating but with water only. The frequency of washing hands after defecation and after cleaning a child (after defecation) is also primarily with water only and generally not so widely practiced. Personal hygiene is key to model household status but the availability of soap and water to enable hand washing at critical times remains a considerable challenge. The importance of hand washing was recognised through the national WASH movement and activities formalised with the establishment of a National WASH Movement steering committee in 2004. Members, drawn from among different stakeholders including sector ministries, civil society and the private sector notably national journalists have been actively promoting hand washing with active campaigns around national hand washing day.

Table 7. Summary of Hand Washing Behavior

Behaviour	Caregivers	Children aged between 7 to 14 years	Children under 3 years
Hand Washing Behaviour after using the toilet/after defecation	• 10% hands not washed • 70% washed with water only • 19% washed their hands with soap • 1% used an alternative cleansing agent.	• 46% washed with water only • 34% hands not washed • 18% washed hands with soap	• 21% of the child's attendant/mother did not wash their hands • 56% rinsed hands with water only • 22% carried on as usual without washing.

[33] Ibid

[34] Before preparing food, before eating and after defaecation, after cleaning a child (after defaecation)

[35] HSDP III Report and HSDP IV targets

Behaviour	Caregivers	Children aged between 7 to 14 years	Children under 3 years
Hand washing behaviour before eating	• Majority rinsed hands with water only.	• 78% washed with water only • 12% washed hands with soap • 10% hands not washed.	• 54% rinsed hands with water only before feeding a child • 25% did not wash their hands at all before feeding the child
NB/ In most of these cases: ▪ **Food was eaten using hands** ▪ **Soap/cleansing agent situated far from water source in 56% of the cases with only 15% having soap/cleansing agent near water source (within arm's reach)**			

Source: Formative Research, September, 2010, FMoH, Ethiopia (unpublished)

3.2.2 National WASH Movement

Since the establishment of the National WASH movement a number of successful activities were accomplished to improve hand washing knowledge and practices, these include: the development of promotional and didactic materials in the five major Ethiopian languages (Amharic, Oromiffa, Afar, Somali and Tigrigna), complementary radio and television promotional spots and special events at national and regional level.

3.2.3 Hand washing practice at School

The hand washing situation is worse in schools where it was rare finding children who washed their hands after using the toilet and even more difficult to find evidence of hand washing before eating a snack while at school.. The following table provides detailed information about hand washing practice before eating at school.

Table 8. Hand Washing Before Eating – School

Hand washing behaviour before eating-School Structured Observation							
Soap use		**Time taken washing hands**		**How hands are washed**		**How hands are dried**	
Yes	8%	Less than a min	69%	Fingertips only	23%	Hands shaken in the air	85%
		1 min	15%	One hand at a time	46%	With a clean towel/cloth	15%
		2 min	15%	Both hands thoroughly with soap covering hands	8%		
				Both hands but not properly washed	23%		

Source: Formative Research, September, 2010, FMoH, Ethiopia (unpublished)

According to the above table students using soap, the time they take to wash their hands and how efficiently they wash their hands are the key points addressed. According to the formative research findings most children are not using soap; take less than a minute to clean their hands and some are only washing their fingers or one hand.

3.2.4 Safe drinking water chain

The number of people in Ethiopia following the safe drinking water chain from source to mouth is thought to be as low as 8%. Water is life and having enough clean water to live a healthy life is a basic human right. Protecting and fulfilling people's right to water is best achieved by publicly managed or community

controlled water systems. However, a protected 'safe' source of water is no guarantee of health. There are various ways where water can be contaminated and become unsafe for human consumption from source through mode of collection, transport, house storage and most significantly final extraction for consumption. Contamination derives from a range of sources: occurring naturally such as fluoride and arsenic in the ground water; man-made such as chemicals from agriculture, industry, and mining; but, by far the greatest level of contamination occurs in the home and is largely related to poor hygiene practices. There is some work on point of use treatment particularly in areas susceptible to outbreaks of AWD but for the majority of Ethiopians securing safe drinking water at home and school remains a major challenge.

Regarding water quality the FMoH is responsible for the national water quality control while the MoW & Energy is responsible for the development of safe and adequate water supply both for rural and urban populations. Increasing access has been remarkable and there is a strong focus on assessing and preserving quality which includes:

- Establishing and strengthening regional water testing Laboratories
- Developing a sustainable and ubiquitous water quality monitoring and surveillance system
- Improving sanitation and hygiene practices including water safety and the safe water chain management through the HEP supported by advocacy employing mass media campaigns and IEC.

3.3 SCHOOL ACCESS TO IMPROVED HYGIENE & SANITATION

3.3.1 The Case for Improved School Hygiene and Sanitation

The promotion of improved sanitation facilities and safe hygiene practices is essential in schools and ideally should go hand-in-hand with community/household activities. Use of schools, parent-teacher associations and children themselves are powerful tools in promoting behaviour change and greater awareness of hygiene issues. Schools without adequate water, sanitation and hygiene services will create high-risk environments for children and staff, and exacerbate children's particular susceptibility to environmental health hazards. Children's ability to learn may be affected by inadequate sanitation and hygiene services in several ways, these include helminth infections, and diarrhoeal diseases, all of which force many school children to be absent from school. Girls and boys are likely to be affected in different ways by inadequate sanitation and hygiene conditions in schools, and this may contribute to unequal learning opportunities, sometimes, girls and female teachers are more affected than boys because the lack of sanitary facilities means that they cannot attend school during menstruation.

3.3.2 The Scale of the School Challenge

To overcome the above critical problems schools need to have sufficient, accessible, and private, secure, clean as well as culturally appropriate toilets**. T**he number of students enrolled both in the primary schools and secondary schools are 22,581,707 (9, 829,850 urban and 12, 751, 857 rural – 53 per cent girls). The recommended toilet to student ratio is 25/1 for girls and 50/1 for boys (with urinals). There should be a separate toilet for male and female staff. Current studies indicate that there is a considerable range of ratios throughout the country with 1:365 in some regions. In such situations the school surroundings are likely to be infested with parasitic helminth. For secondary schools the MoE annual report 2008/9 put the ration at 1:163, a study conducted in 2013 schools by the Federal Ministry of Health in partnership with UNICEF revealed that out of the 1642 toilets observed about 77 per cent of the toilets were traditional pits. At least 76 per cent of the schools had some kind of toilet with 93 per cent functional and 35.5 per cent considered clean at the time of the data collection. In the same study, it was reported that only 4.4 per cent had access to hand washing facilities. The same study revealed that only 14 per cent of the schools had an adequate water source but with 83.7 per cent functionality[36].

Therefore although most schools have some form of toilet in Ethiopia to meet the recommended standard a considerable number of additional units are required to meet the drop hole ratio with necessary levels of , privacy, safety and cleanliness. Effective management to ensure toilets are clean without queues, bad smells

[36] School water Supply, Sanitation and hygiene education situation in Ethiopia

or buzzing flies which are reported to be key deterrents to use.[37] Conditions in pastoral schools are reported to be even worse and very few Alternative Basic Education schools (often the only source of education for girls and boys in pastoral communities) have access to toilets or clean water.

Table 9. Primary School Facilities (1-8)

Region	***Number of schools***	***Student population***		***Facilities***					
				Water			***Toilet***		
	Primary	***Boys***	***Girls***	***Water***	***Tap***	***well***	***Boys pit***	***Girls pit***	***Boys & girls***
Afar	*347*	*61589*	*38840*	*39*	*22*	*9*	*275*	*256*	*25*
Somali	*713*	*220576*	*137648*	*0*	*0*	*0*	*0*	*0*	*0*
B.Gumuz	*345*	*97916*	*73254*	*90*	*34*	*49*	*155*	*148*	*55*
Gambella	*180*	*44078*	*32997*	*85*	*24*	*28*	*55*	*56*	*19*
Total	***1585***	***424,159***	***282739***	***214***	***80***	***86***	***485***	***460***	***99***

Source*: Federal Ministry of Education, 2008/09*

Note: According to the above table water and sanitation report is not available for Somali region due to the absence of systematic reporting mechanism. As shown in the remaining 3 emerging regions the ratio of toilet to students is 1:247.

3.3.3 Water quantity and quality in Institutions

As indicated by the study quoted above, water availability is inadequate in both primary and secondary schools. In the absence of protected sources, students are obtaining their water from unsafe sources.

3.4HEALTH INSTITUTIONS

3.4.1 Health Institution Sanitation Access

In Ethiopia there are 14,416 health posts, 2,689 health centres and 195 hospitals (HSDP lV, 2010.) Health and health related indicator report and information obtained from regional health bureaus reveal that over 80 per cent of the health facilities are without adequate sanitation facilities. Data in some regions also indicate that hand washing facilities are only available in 3 per cent of the health facilities.

3.4.2 Institutional Toilet/HW demand

The number of sanitation facilities required by 2015 is not known and estimates will be made for planning including facilities which are not functional and which do not meet the recommended standard. Costing estimates will include:

- new toilet construction
- rehabilitating existing facilities
- compliance with national standards i.e. patient/staff per toilet ratio
- ensuring males and females (boys and girls) have access to separate toilets
- the provision of hand washing facilities with water and soap
- effective facility management - focus cleaning and emptying

[37] As observed during the field visits in several schools most of the toilets that are in use are very filthy without adequate separate toilets for boys and girls. Establishing/agreeing the exact number of toilets required country-wide represents a major challenge.

3.5STAKEHOLDERS – ROLES, FUNCTIONS & COORDINATION

3.5.1 Stakeholders – roles and functions

The government Health Extension Programme has provided the central thrust for the level of improved hygiene and sanitation status in the country ably supported by the national WASH programme. Government emphasis the important contribution of NGOs and the relatively untapped potential of the Private Sector emphasising the critical role being played by women at all levels. This is well illustrated and emphasized by government deployment of 34,382 women health extension workers (HEWs) and a new initiative to form (exclusively women) health teams to support the HEWs. A considerable effort has also been made to recruit women HEWs in the Developing Regional States where a new cadre of Grade 10 girls are currently undergoing training.

Currently there are over 15 government agencies (National and Local), Development Partners, international NGOs, local NGOs and members of the private sector dealing with water and sanitation activities. While creating demand is well-addressed through HEWs and Community Led Processes such as CLTSH and PHAST there is a supply vacuum. There is a pressing need to fill this vacuum through an enabled private sector or NGOs with consideration required of potential working models from proven best practice.

3.5.2 Coordination

Coordination and cooperation parameters are outlined in the Memorandum of Understanding (MoU) signed between the Ministries of Water, Health and Education. Opportunities for sector coordination include the National Sanitation and Hygiene Task Force, the various WASH coordinating structures and the annual multi-stakeholder forum. With so many different actors involved in hygiene and sanitation activities, their work has to be organized and coordinated so as to avoid duplication, unnecessary expenses and the application of conflicting approaches that confuse communities.

3.5.3 Planning

There is an overarching commitment to the principle of one plan, one common set of indicators, one budget with the central focus on the Woreda and the importance of true ownership and genuine capacity to manage the process at Woreda level. There are clear guidelines for the development of Woreda health plans and Woreda WASH plans and the Woreda administration is encouraged to identify priorities which will include hard choices between: hardware and software; urban and rural; pastoral and settled (semi) pastoral. In the national WASH programme there is provision for Woredas to access support from consulting groups contracted by the region to support planning and some level of implementation. These groups also identify and train community facilitation teams who have responsibility for the community mobilization which includes hygiene and sanitation promotion. The national WASH programme implementation manual is under revision and will incorporate key elements of this strategic plan.

Greater emphasis needs to be placed on the sanitation and hygiene elements of WASH so that CLTSH is mainstreamed in Woreda activities with appropriate quality control, supervision and follow-up (ODF verification) leading into a sanitation marketing approach to ensure the adoption of a sustainable toilet culture with durable, safe, affordable designs and enduring safe hygiene practice.

3.5.4 Risk and Assumption: some of the risks and assumption are the following:

- Unavailability of dedicated finance,
- High cost of sani-inputs,
- High turnover of staff,
- Incompatibility of fund with the growth of population,
- Poor coordination alignment with NGOs, &
- Unavailability of appropriate and affordable technology packages for agro-pastoralist & pastoralist communities.

SECTION 4. STRATEGIC OBJECTIVES

This section covers:	
4.1	**Strategic Objectives, Indicators, Targets and Initiatives**

4.1 STRATEGIC OBJECTIVES, INDICATORS AND INITIATIVES

STRATEGIC OBJECTIVES	STRATEGIC INDICATORS	TARGETS	INITIATIVE
4.1.1 COMMUNITY PERSPECTIVE – IMPROVED ACCESS			
SO1: Improve access to & use of sanitation & hygiene facilities at community levels.	• Increased proportion of HHs with access to both unimproved and improved sanitation facilities • Increased Proportion of HHs using improved sanitation facility (toilet utilization) • Increased Proportion of households practice hand washing with soap (a substitute) at critical times • Increased proportion of Kebeles free of open defecation • Increase Proportion of household water treatment and safe storage	60% to 100% 20 %[38] to 82% 7% to 77% 15% to 80% 8% to 77%	• Community Lead Total Sanitation and Hygiene (CLTSH) • Sanitation Marketing (SM) • Use Urban Sanitation Strategy with the alignment of CLTSH • Urbanization is rapidly increasing in Ethiopia as agricultural Study and design pastoralist and agro-pastoralist hygiene and sanitation approaches • Provision for the poor and vulnerable • Incentives and sanctions • Complete and roll out the CLTSH Approach
SO2: Expand community empowerment actions for improved sanitation and hygiene	• Increased model households • Increased awareness and safer behaviour[39] • Increased full participation (particularly women) in: policy formulation; planning; implementation; M&E; regulation; and resource mobilization.	61% to 100%[40] Expanded role of women in improving their own sanitation and hygiene	Community Empowerment

[38] As per the JMP the figure is 13.33%
[39] Awareness increase will be measured through conducting surveys.
[40] It will not apply to the whole Health Extension program package but applies only to latrine, water treatment and proper storage facilities.

SO3: Improve institutional sanitation and hygiene access and use	• Increased student latrine stance ration for girls and boys • Increased proportion of health centres and health posts with adequate water, latrine & hand washing facilities • Increased institutional Sanitation facilities to meet the full range of special needs including people living with HIV/AIDS & People with disabilities	• 1:40 (one latrine stance for 40 girls) • 1:75 (one latrine stance for 75 boys) • 78% to 100% sanitation facilities for health centres and health posts	School Led Total Sanitation and Hygiene (SLTSH) Hygiene promotion activities in schools (curriculum-based learning, student clubs, outreach from local health system, and outreach from schools to communities) Renovation and upgrading of existing school and health facility toilets to meet national performance standards; Installation of hand washing facilities for schools and Health Facilities School Community Synergy
4.1.2 FINANCE PERSPECTIVE			
SO4: Maximizing resource allocation, mobilization & utilisation	• Increased (more effective) mobilization of household, NGOs, and development partners (local and national private sector) resources • Equitable, effective and efficient use of resources	• Mobilized 100% required budget for the full implementation of SAP • Improve the efficient and effective utilization of the budget	Develop different project Proposals to solicit funds Develop coordinated action planning mechanisms at all level for effective and efficient use of resources, Arrange Project Management Cycle Trainings
4.1.3 INTEGRATION AND RESPONSIVENESS			
SO5: Improve quality of sanitation and hygiene services	• Improved promotional and innovative technologies options for Sanitation and Hygiene • Improve sanitation standards to the level of acceptable, affordable and sustainable • Strengthened the functionality of H&S coordination mechanisms at all levels	• Better demand created in the community through use of a variety of channels (electronic and print media) at all levels.	Operational researches Dissemination of Hygiene and Sanitation up to date technologies Application of different Types of latrine Technologies
SO6: Improve **emergency preparedness** and response	• Increased proactive response to Hygiene and Sanitation related emergencies • Initiate and strengthen multisectoral coordination mechanisms • Improved identification of WASH emergency health risks	100% preventive responses to WASH emergencies with a speed of rapid response and epidemic containment	Avail and implement WASH Emergency Response Guideline

SO7: Improve **supplies and services**	• Increased availability of sanitation materials, supplies and equipment • Improved the supply chain of the Sanitation supplies	100% woredas had sanitation market centres Certification of Community-Led Approach facilitators and artisans	Develop Sanitation Marketing Guideline Opening tested SaniMark centres Develop new sanitation technologies to give more options to the users
SO8: Improve **regulation**	• Ensured compliance with a proclamation number 661/2009 • Improved compliance with available guidelines and protocols to minimum acceptable sanitation and hygiene standards	Enforce 100% implementation of proclamation number 661/2009 at all levels	Implement proclamation number 661/2009 Put different guidelines in place at all levels
SO9: Improve **evidence based decision-making, alignment &** harmonization	• Planned robust data informing for budget priorities • Increased timeliness & completeness of hygiene and Sanitation reports • Enhanced coordination and partnership • Increased harmonization and alignment of WASH sector activities in planning and reporting	Improved inclusion of Hygiene and Sanitation indicators into HMIS Increase timeliness & completeness of hygiene and Sanitation reports from 57% to 90% Addressed one plan, one budget and one report at all levels Implemented Hygiene and Sanitation plans as per MoU signed by MOH Implemented WaSH plans as per WaSH Implementation Framework(WIF	Advocacy on harmonisation and alignment to decision makers

STRATEGIC OBJECTIVES	STRATEGIC INDICATORS	TARGETS	INITIATIVE
4.1.4 CAPACITY BUILDING (LEARNING AND GROWTH) PERSPECTIVE			
SO10: Improve **human capacities**	• Capacitated human resources at all levels(Federal, Regional/Zonal, Woreda Health Professionals including Health Extension Workers and Community Health Development Armies(CHDA) on Hygiene and Sanitation Planning and Implementation capacities • Prepared and distributed different implementation guidelines (CLTSH, Water Quality, Sanitation, etc) • Incorporated Sanitation and Hygiene implementation tools and approaches into the training curricula of higher teaching institutes • Improved and supported sanitation and hygiene operational researches • Trained skilled facilitators at all levels that compensate for staff turnover	Skilled and motivated professional staffs Improved implementation of Community-Led Approaches to total Sanitation (CATS) Increased skilled facilitators at all level to compensate for staff turnover	Cascading Integrated Refresher Training (IRT) Implement appropriate ,simple and easy to follow manuals and other job aides using local languages for technicians at local level (CLTSH, Sanitation Marketing, etc). Training relevant institutions (TVET schools), youth groups and artisans interested in making sanitation marketing as a business.

SECTION 5. HOW TO ACHIEVE THESE OBJECTIVES & OUTCOMES

5.1	**Community-Led Approaches**
5.2	**Strategic follow up**
5.3	**Sanitation and Hygiene in pastoralist areas**

In order to prioritise some of the best options likely to contribute to the attainment of the wide range of strategic objectives outline in section 4, this section outlines some of the best replicable practice and approaches both from within Ethiopia and from other countries.

5.1 COMMUNITY-LED APPROACHES

5.1.1 Community Empowerment – designing to meet demand

To improve Hygiene and Sanitation in a lasting way Hygiene and Sanitation promoters must listen to and work with people in the community to develop solutions based on their needs, abilities, and desires for change. Genuine community participation, demand and ownership are recognized as key factors determining the success of any sanitation programme[41]. Demand must be created and supply systems must be responsive and provide affordable technical options and viable service levels.

5.1.2 Community Lead Total Sanitation and Hygiene (CLTSH)

Community-Led Total Sanitation and Hygiene (CLTSH) have been adopted by the FMoH as a national approach to hygiene and sanitation promotion in Ethiopia. It has been adapted from CLTS work developed by Dr. Kamal Kar[42] and focuses on facilitating a collective approach to communal sanitation behaviour change rather than simply constructing toilets. The collective effort to achieve open defecation (ODF) encourages a more cooperative approach enabling people to decide together how they will create a clean and hygienic environment that benefits everyone.

The underlying principle is that there should be no individual household hardware subsidy and no prescribed toilet models in line with Ethiopian policy. Social solidarity, help and cooperation among the households in the community are common and vital elements[43] which fit well in the Ethiopian context. Weaknesses observed in the international experience with CLTS centre round the quality of facilitation, limited commitment to follow up and the limited availability of a sustainable system of supply of important hardware components[44].

National CLTSH guidelines are currently under production which draws on best practice both from within and outside Ethiopia including international CLTS and SanMark guidelines. There is a strong focus on good quality facilitation, strong follow-up and ensuring the necessary supply streams. At the time of the UNICEF joint review in 2010, CLTSH has been facilitated in 102 Woredas with a total of 4643 villages triggered of which 1913 have declared themselves open defecation free. The results from Amhara region will be detailed in the forthcoming evaluation report and figures updated accordingly. It is widely agreed that a training inventory needs to be kept up to date and that ODF needs to be independently verified.

[41] Deverill P., Wedgewood A., Bibby S. and Smout I. (2002) *Designing for demand – the engineer's perspective* WEDC/DFID
[42] Kar K. (2002) *The 100% sanitised village approach* IDS Bulletin 184
[43] WSP Field Note (2007) *CLTS in rural areas - an approach that works*
[44] IDS (2009) *Looking beyond CLTS,* IDS and Sijbesma C. (2008*) CLTS Plus - Some suggestions for improving CLTS* IRC

5.1.3 Use Urban Sanitation Strategy with the alignment of CLTSH

Urbanization is rapidly increasing in Ethiopia as agricultural opportunities diminish and employment opportunities increase in emerging towns. Such rapid increase puts considerable pressure on municipal, town and Woreda authorities to plan and implement sustainable urban sanitation. Although urban sanitation coverage is reported to be 88 per cent, JMP data (with its stricter definition of 'improved sanitation') suggests the figure is only 29 per cent[45] The Country Status Overview reports that investment in urban sanitation remains low, directed primarily at promotion work via urban-based HEWs and donor programs. On the infrastructure side, little investment is being made outside of large scale donor programs, primarily in the capital of Addis Ababa. Limited security of land tenure inhibits individual household investment in toilet construction, particularly in informal settlements.

CLTSH with its current agrarian focus will need to be adapted for the urban context in alignment with the new urban sanitation strategy being developed by the Ministry of Urban Development as well the Urban Health Extension Worker programme. While the UHEW programme has dedicated packages to improved hygiene and sanitation, the strategy considers important issues of space to build toilets, landlord responsibility and the complex challenge of faecal sludge management in unplanned areas. Special technology options will be required for different urban settings with the central challenges of access to desludging and emptying. It is recognised that an expanded range of technology, finance and labour supplies should be readily available or more easily mobilised than in rural areas. To improve and promote the health of the urban community the urban Sanitation Strategy is therefore expected to deal with both onsite and offsite sanitation:

5.1.4 School Led Total Sanitation and Hygiene (SLTSM)

There is evidence from some countries in West Africa and Asia that School Led Total Sanitation has showed good results including by Plan Ethiopia's pilot in SNNPR. Triggering schools can be conducted through observing and discussing the school toilets and children's practice of defecation to provoke action. It acts as a trigger for both teachers and students. In triggering tools such as Transect walk, mapping, calculation, shit and food, and pathways are used. In approaches developed in Sierra Leone and Nepal older school children actually facilitate CLTSH in their own community. A comprehensive guide has been developed by UNICEF in Sierra Leone and Nepal[46].

5.1.5 Sanitation Marketing (SM)

Sanitation marketing is about market development for sanitation: Promoting the availability of sanitary materials and allowing private suppliers to create bat also respond to the demand. [47] The products and their promotion are based on consumer motivation and preferences which are not just about hardware or health. Sanitation marketing requires a comprehensive assessment of the current market for sanitation products and services and the use of the results of this assessment to design a multi-pronged strategy to:

- Build the capacity of the private sector to engage on a business footing to develop and promote appropriate and affordable sanitation products.
- Create and strengthen incentives such as lines of credit and tax breaks for these actors to participate in the sanitation market and improve collaboration;
- Develop products and services that respond to consumer preferences; and
- Create marketing messages and communication plans to promote these products and services to consumers.[48]

[45] AMCOW(2010)Ethiopia Country status Overview WSP/EA
[46] UNICEF Nepal (2006*) Guidelines on School Led Total Sanitation* (SLTS)
[47] Cairncross S., (2004) The Case for Marketing Sanitation WSP Field Note
[48] Jenkins M. (2010) *SanMark for Managers*

5.1.6 Operational Research

Improving access to and use of sanitation and hygiene require different skills at different stages including qualitative research to reflect regional variations in status: whether the focus is on building demand (as in the case of Afar) or facilitating supply (as in the case of SNNPR). Where demand is low, the research will be used to assess the relative value of different demand creation techniques for different circumstances informing the development (customising) of different guidelines and manuals. This will combine both qualitative and quantitative approaches and might include a longitudinal study. There are a number of existing approaches[49] which will be customised for the Ethiopian context[50].

To create an enabling environment for supply, research will be used to assess the key elements of a sanitation and hygiene communications campaign. This will include household surveys informed by focus group work reflecting audience segmentation helping to develop creative ideas and appropriate messaging which will address how best to utilise mass media outlets and where best to market sanitation materials (product placement) . In addition this will be complemented by more classical sanitation marketing tools which will include Supply Chain Analysis and Market Assessment. The results of the latter will be used for business model and product development. This will also require a review of technical and service level options to consider existing products according to their acceptability in terms of distribution. This process will need to be effectively managed but again emerging lessons emphasise the value of 'social franchising' using a 'one stop sanitation shop'.

It will be necessary to consider implementation of the communication campaign strategy whether this needs to be outsourced to a specialist communication team or can be handled by the Task Force with inputs from partners. This might include the development of an integrated approach which includes schools, health centres, religious locations as well as radio and road shows which have proved successful in current sanitation marketing programmes. The Task Force will need to work with selected partners on monitoring and evaluating quality of products and overall performance of different components against both process and output indicators. Lessons learned will be made available at country level to inform national planning processes for sanitation and hygiene.

5.1.6 Subsidies

On the supply side, a zero hardware subsidy approach is advocated in the national strategy under the assumption that sanitation promotion and marketing will be sufficient to create demand for sanitation and households will construct their own simple toilets. Government support is required to create and maintain an enabling environment and facilitate demand creation. Government is also responsible for certain supply elements such as the construction of public and institutional (school and health) sanitation facilities and invoking the engagement of small and large scale private sector inputs.

However, in some situations, particularly where communal or family shared toilets are the only option, subsidies could be considered. In peri –urban settlements for example where space is an issue and many houses are occupied by tenants, subsidizing the construction of sanitary facilities might be feasible. Here the residents contribute labour and establish a maintenance schedule for the facilities while government pay for the materials for the structure.

[49] Jenkins M. (2010) *Sanitation Marketing for Managers* - HIP/USAID
[50] Mukherjee N. (2009) *Total Sanitation and Sanitation Marketing – Learning at scale* - WSP Field Note

5.1.7 Provision for the Poor and Vulnerable

Special consideration is made in the protocol for the poor and vulnerable in line with the fact that many households still rely on public safety nets and 'food for work' programmes. In line with CLTSH principles, the emphasis is on collective responsibility. In Ethiopia, communities have their own system for providing support which in some cases includes exempting the poor and vulnerable from certain payments and responsibilities.

5.1.8 Incentives and sanctions

With the exception of viable institutions cash incentives are generally discouraged in the CLTSH context but non-monetary awards(Banners, signboards and certificates) and ceremonies to recognize successful communities, natural leaders and facilitators, indicating that a community has achieved ODF status are considered to be appropriate motivation and largely anecdotal reports suggest that such 'awards' help to sustain behavioural change. The central lesson is that awards must ultimately be available for all villages as the ultimate goal is universal access and use. Following the creation of enabling environment and demand,
Sanctions should be introduced on defaulters in order to motivate the well performing households and institutions.

5.2 STRATEGIC FOLLOW UP

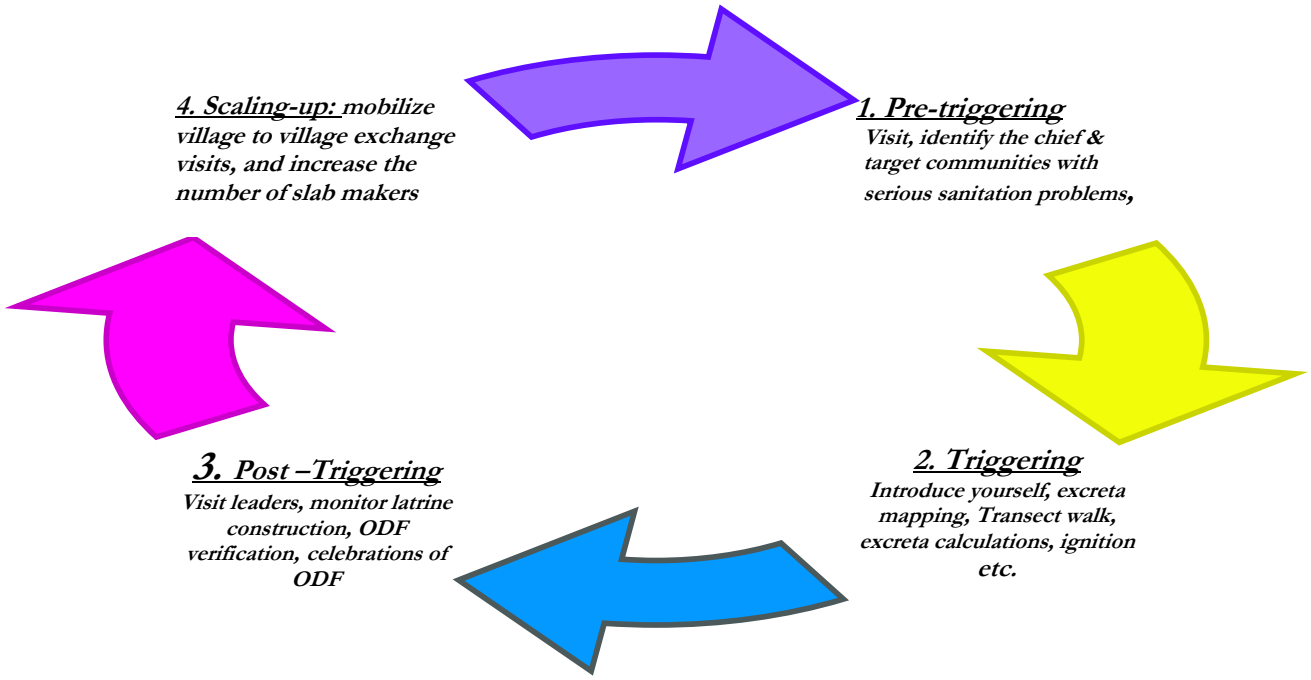
5.2.1 Complete and roll out the CLTSH Approach

The 13 step CLTSH approach adopted as a national approach provides the foundation for demand creation in this strategic action plan. It will be important that the guidelines are completed and a programme of training and supportive supervision rolled out in all regions. Other participatory approaches which can be applied at community level must be consistent with the principles of zero subsidy and collective action.

At present as CLTS approach is the only one so far that has demonstrated the potential to end open defecation and increase uptake and use of toilets at scale in rural areas. Hence, Ethiopia has adapted CLTS as a primary approach. CLTS uses participatory methodologies to raise awareness of the problem of open defecation and trigger collective community effort to end open defecation. It is adopted in over 30 countries. It was in 2006 CLTS has been introduced in Ethiopia & revised to include "H" for hygiene promotion.

Some of the benefits of CLTS include the absence of direct household subsidy, focus on stopping open defecation, and adoption of bottom-up approach where communities take the lead as an entity rather than as individual household. Following the introduction of CLTSH, people have begun to live in open defecation free villages and other are struggling to make their village ODF. Experience has shown that avoidance of holidays in implementing the steps shown below leads to desired success.

Figure 2: Critical Steps considered in the SAP to implement CLTSH



5.2.2 Adopt a National Standard

There is consensus that all 'on-site' toilets must be designed to maximise convenience, privacy, safety and hygiene. Key design features include the importance of a stable pit and a sustainable platform which can be cleaned and where possible moved when the pit is full. The drop-hole should not be a danger to small children and there should be a cover to inhibit flies and bad smells. There should be some system for hand washing and where acceptable ash should be available to reduce bad smells and improve the process of decomposition. The superstructure should be strong enough to resist extreme weather and animal incursion but not over-designed for the available foundations.

5.2.3 Expand the Range of Acceptable Affordable Options Available

One size does not fit all so it will be important to better understand regional (ethnic) attitudes to defecation linked to preferred toilet options and people's ability and willingness to pay. This might necessitate market research following the core tenets of Sanitation Marketing: the 4 Ps – Product, Place, Promotion and Price. Such research will investigate optimal promotion times, key messages for key audiences and the most appropriate channels of communication. It will also consider how best to put sanitation on a commercial footing at Woreda and Kebele level with a strong focus on improving the supply of acceptable and affordable toilet options. Within this process of commercialisation of sanitation it will be important not to lose sight of the special needs of people living with aids as well as those whose physical condition requires technical modification such as a pedestal to obviate squatting. Improved sanitation and hygiene are important parts of the holistic treatment and palliative care for people living with AIDS[51]in mitigating the risk of debilitating and potentially fatal opportunistic infections.

[51] Evelien K., and Wegelin-Schuringa M., (2003). HIV/AIDS and water, sanitation and hygiene.

5.2.4 Strengthen Capacity Building

It is recommended that there should be a comprehensive process of Training of Trainers (ToT) which flows to the most appropriate level but which is practical and well supervised. Such a system is already underway for CLTSH. This is outlined in the table below and similar system will be necessary for artisans and those who will be engaged in sanitation marketing.

Table 10. Training on CLTSH program

Administrative Levels	***Trainees***	***The Focus of the training***	***Trainer***
Federal	Staff from the national coordination unit, Staff from the FMoH Supporting agency central team Trainers	The Importance of CLTSH approach Training skills Planning and coordination , exchange visits in country or in the regions	UNICEF WES specialist International CLTS consultant, program planning and coordination specialist, NGOs, and others who are trained and have acquired practical knowledge on CLTSH
Regional	Staff of the Regional WASH coordination unit Regional supporting agency staff / consultant NGOs working on hygiene and sanitation promotion Community mobilization staff Regional trainers	The Importance of CLTSH and approach Training skills Planning and coordination, exchange visit in country or in the regions	UNICEF WES specialist International CLTSH consultant, program planning and coordination specialist, NGOs, and others are trained and have acquired practical knowledge on CLTSH
Zonal	Staff of the local government, Zonal cabinet members, HEW supervisions/facilitator/	Supervisory skills CLTS methodology, triggering monitoring and reporting skills	CLTS Specialist, National trainers trained at the regional level, NGOs, and others are trained and has acquired practical knowledge on CLTSH.
Woreda	CLTSH facilitators, Woreda health workers, Woreda cabinet members, (Woreda education, and water offices) school teachers, NGOs	Supervisory skills CLTSH methodology, triggering skill, monitoring and reporting skills, follow-up visits, reporting and monitoring skills	CLTSH Specialist National and Regional trainers NGOs, and others who are trained and have acquired practical knowledge on CLTSH
Kebele	HEW, school teachers, natural leaders, communities, students, women (Development	Triggering skills, reporting skills,	Woreda trainers and possibly Zonal WASH team, NGOs, and others are trained and

Administrative Levels	*Trainees*	*The Focus of the training*	*Trainer*
	team), Kebele Leaders, Volunteers.		have acquired practical knowledge on CLTSH

5.2.5 School Community Synergy

The school with its catchment in several villages and its "*messengers*" reaching into all homes provides a central focus for improved hygiene and sanitation through a healthy and hygienic learning environment which is mirrored at home. Carrying out CLTSH in catchment communities at the same time as SLTSH in the catchment school is an opportunity for reinforcement and synergy. The school management committee plus the parent-teachers association as well as school club can play an important role not only in managing infrastructure improvements but also in projecting those improvements into the homes making the school a 'sanitation marketing' centre for improved toilet designs.

5.2.6 Enforce and monitor institutional mandate

Although the urban strategy will be driven by the appropriate Woreda or town health office, ultimate responsibility for ensuring all the stakeholders fulfil their roles lies with the town mayor or Woreda administrator. There are a considerable number of stakeholders with overlapping roles but core principles are consistent with the national strategy. The emphasis is on:

- *Individual households* taking responsibility for constructing an improved toilet and adopting safe hygiene behaviours. Where housing is rented the responsibility lies with the landlord (often the Kebele administration) to provide toilets.
- Where individual toilets are not possible, *improved communal toilets* should be constructed for example through a community sanitation fund[52], managed by the regional micro-credit organisation administered by the Kebele development committee.
- The urban HEW working with community health promoters will provide the all-important interface with the household (providing advice on technology options and promoting safe behaviour). Artisans and small scale providers will be trained at technical colleges.
- The Woreda/town health office with support from the region/zone, consultants (such as the Town Support Group) and NGOs will develop a behaviour change communication approach to include mass media, schools, religious leaders, the private sector and the robust enforcement of minimum standards.

As shown in the table below there are 282 urban towns which will require considerable investment in public toilets, sludge management (including pit and septic tank emptying, as well as treatment or disposal) as well as waste water management which is beyond the scope of this Strategic Action Plan.

Table 11. Distribution of Rural and Urban Woredas and Towns by Region

Region	**No. of Zones**	**No. of Woredas**		**Total no. of Woredas**	**No. of towns with population >10,000**
		Rural	Urban		
Afar	5	28	2	30	4

[52] Community sanitation fund – following the successful RWSEP model applied to community water supply

Region	No. of Zones	No. of Woredas		Total no. of Woredas	No. of towns with population >10,000
		Rural	Urban		
Amhara	12	153	13	166	45
Benishangul-Gumuz	3	20	1	21	1
Dire Dawa	1	----	1	1	1
Gambella	3	12	1	13	1
Harari	1				1
Oromia	19	249	30	279	73
SNNPRS	14 Zones 8 Special Zones	125	15	140	29
Somali	9	42	11	53	13
Tigrai	6	36	11	47	18
Addis Ababa	1	----	10	10	1
Total	**82**	**665**	**95**	**760**	**187**

Source: Central Statistics Authority, Ethiopia, 2007

5.3 SANITATION AND HYGIENE IN PASTORALIST AND RESETTLEMENT AREAS

5.3.1 Improve hygiene and sanitation for agro-pastoralist and pastoralists

Special approaches are required to support pastoralists and agro-pastoralists requiring a higher level of understanding and appreciation than is currently available. There is recognition that toilets are suitable for agro-pastoralists (recognising their expressed technical priorities for a pour-flush style off-set squatting slab). 'Go and bury' defecation practice is more compatible with pastoral practice but close proximity to animals mean the living environment is highly contaminated and there are a number of pastoral practices including burning cow dung to ward off flies as well as more extreme methods to stimulate milk production which enforce high levels of human/animal intimacy. Hygiene practice namely hand washing with soap before food preparation and consumption is recognised as the essential barrier. Pastoralists have time honoured practices which need to be better understood, built-on and adapted to changing circumstances.

5.3.2 Study application of CATS in pastoralist areas

Access to hygiene and sanitation in the pastoralist areas where mobility is the key to survival is very low and the limited impact is felt only by those agro-pastoralists or pastoralists who have self-selected for villagisation. Conventional hygiene and sanitation approaches are not well suited for their extensive mobility and they are understandably ill-equipped for the considerable risks that they must face when forced to settle close to an already over-crowded water source.
As a result both adult and child populations are suffering from repeated outbreaks of AWD. For example, a study conducted in Afar regional state revealed that diarrhoea is endemic with some people suffering as many as 12 episodes every year. Special approaches are being considered for pastoral areas requiring additional understanding of regional, ethnic and different clans. This can be facilitated by qualitative research to better understand Knowledge Attitudes Beliefs and Practices among pastoral and semi-pastoral communities.

5.3.3 Support Application of Cats in Resettlement Areas

As resettlement areas are outside the systems of formal service provision settlers can be exposed to various types of infectious diseases. In order to stop such infectious diseases the accessibility of improved hygiene and sanitation facilities are required. The Hygiene and sanitation situation of the resettlement areas can be improved by the application of CLTSH approach.

SECTION 6. STRATEGIC ACTION PLAN, TASKS & ESTIMATED COSTS

Introduction:
The proceeding sections have demonstrated that although Ethiopia has made great strides to improve sanitation coverage and hygiene practice, there are still considerable gaps. These gaps centre round the quality of toilet constructed, level of toilet usage by all the family (and school children) and perhaps most critical, the level of hand washing with soap and water. The extent of these gaps remains a key unknown along with understanding of what might trigger the necessary changes in behaviour. The current systems have been successful up to a point but now there is a pressing need for new approaches to better understand the supply side, how to engage the private sector and how to mobilise additional private finance. It is anticipated that the National WASH Inventory will improve the quality of data as well as the accessibility of data for evidenced-based planning. It is also anticipated that through this SAP Woredas will have dedicated and possibly additional resources which ensure that hygiene and sanitation promotion are mainstreamed within the wider Woreda plan. The SAP provides for a selection of priced activities which can be adapted according to Woreda priorities and ability to find the necessary resources. The SAP is based upon the 3 pillars of the National Hygiene and Sanitation Strategy, which were outlined in Section 7:

PILLAR 1 – Creating an enabling environment: strengthening capacity to facilitate and supervise hygiene and sanitation promotion through community led processes. The emphasis will be on building consensus through strong convincing advocacy, evidence-based planning, dedicated (and expanded) finance, improved stakeholder coordination (maximising synergies such as facilitating school and community processes simultaneously), effective monitoring, and verification of ODF status linked to appropriate rewards and enforcement tools

PILLAR 2 – Building demand: will build on the successful work of the HEWs in helping a considerable number of households achieve model household status and expand community based, participatory processes which have been successful in creating demand for basic sanitation. This demand needs further development and strengthening with a formalised system of training backed up by supportive supervision. This will become the rule rather than the exception at Woreda level.

PILLAR 3 – Facilitating supply: This pillar involves establishing affordable means for providing sanitation commodities and upgrading toilets to a hygienic standard. This will build on the capacity of locally based entrepreneurs to provide affordable toilet improvement services where there is a level of demand to be met. This process will be strengthened by the formative research which will help guide the development of an appropriate but improved range of hardware options suitable for the widely varying conditions in Ethiopia. Appropriate technologies will be identified which can be produced at a convenient location, at an affordable price with consistent attractive promotional messaging. This will require an appropriate mix of research, innovation, flexible finance and an empowered private sector.

The action plan therefore makes provision for a degree of Woreda and regional flexibility to expand software and hardware capacity with assistance from national and regional sector experts, private consultants e.g. Woreda and town support groups as well as experienced NGOs. The inventory system will be a key tool for more evidence based planning and the Community Development Fund provides a stream of finance which could give communities greater control of their overall WASH development. This could span the development of school facilities plus an expanded outreach to improve domestic facilities.

A. PILLAR 1 - CREATE AN ENABLING ENVIRONMENT

This section will cover:	
A.1	**Situation Analysis Using WASH Inventory**
A.2	**Conduct Advocacy and Build Consensus**
A.3	**Ensure Coordination (Alignment and harmonisation)**
A.4	**Planning and Budgeting**
A.5	**Capacity Building**
A.6	**Monitoring and Evaluation**
A.7	**Procurement – Capital/recurrent**

A.1. SITUATION ANALYSIS USING WASH INVENTORY

TASK A.1.1 Maximise use of WASH Inventory

The National Hygiene and Sanitation Task Force will finalise guidelines for baseline data collection on improved hygiene and sanitation which will be harmonised with the National WASH Inventory and Health Management Information System. Cost of consultant's fee and travel expenses is considered. ***Similarly a guideline for quick survey that helps to measure the overall result of the five years intervention will be done at the end of the planning period.***

TASK A.1.2 Collect baseline data (based on National WASH Inventory)

Each Woreda will need to establish its baseline status with respect to the minimum standard for improved hygiene and sanitation. Costs for orientation meetings at Woreda level for the supervisors of HEWs, daily allowances and transport expenses for the supervisors of HEWs plus survey materials (stationery) are considered as baseline costs per Kebele if not covered by the national WASH inventory. ***In a similar manner, data on the accomplishment of the five years intervention will be collected and utilised for the reporting of final status at the end of the fifth planning year.***

TASK A.1.3 Baseline Data Analysis

Conduct baseline survey, data analysis and compilation for the Woreda WASH profile is to be done at Woreda level. The Woreda environmental health workers would be primarily responsible to verify, collect, analyse and compile Kebele level baseline data. Where there are statisticians in any sector at Woreda level, the analysis can be done in association with them. Woreda WASH profiles will be collected by the Zonal or regional environmental health workers and this is further compiled to determine the regional WASH profile. Similarly the regional WASH profiles are compiled at national level. Costs involved for collection and compilation of data are daily allowances for environmental health experts, transport and stationeries.

A.1	**SITUATION ANALYSIS**							
OUTPUT	**Improved, robust, evidence based baseline status for Hygiene and Sanitation**							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
A.1.1	Develop guidelines for baseline data collection, and analysis in harmony with WASH Inventory / A final survey at the end of the planning period	A total of 2 months In the 4th quarter of the 1st Ethiopian fiscal year of implementation/ Ditto but at the end of the planning year	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	7600/ 7600

A.1	SITUATION ANALYSIS							
OUTPUT	Improved, robust, evidence based baseline status for Hygiene and Sanitation							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
A.1.2	Orientation and carrying out baseline survey at community level./ A final survey at the end of the planning period	One month per Kebele, in the1st quarter of the second Ethiopian fiscal year of implementation/ Ditto but in the 4th quarter of the final year of the planning period	Rural Kebele Level	Health Extension workers and their supervisors	Woreda environmental health experts	Baseline survey formats, travel expenses	Lump sum per Keble	62.00/ 62.00
			Urban Kebele level		Town environmental health experts			44/44
A.1.3	Baseline data analysis and compilation for Kebele WASH profile/ A final survey at the end of the planning period	The 2nd quarter of the second Ethiopian fiscal year of implementation /Ditto but in the 4th quarter of the final year of the planning period	Rural Kebele Level	Health or other sector statisticians	Woreda environmental health experts	Travel expenses	Lump sum per Keble	30.00/ 30.00
			Urban Kebele Level	Health or other sector statisticians	Health centre environmental health experts	Travel expenses	Lump sum per Keble	9.00/ 9.00
	Baseline data analysis and **compilation for Woreda/town WASH/** A final survey analysis and compilation at the end of the planning period		Woreda /Town	Health or other sector statisticians	Woreda/town environmental health experts	Travel expenses	Lump sum per Woreda /town	220.00/ 220.00
	Baseline data analysis and **compilation for regional WASH/** A final survey analysis and compilation at the end of the planning period		Regional Level	Health or other sector statisticians	Regional environmental health experts	Travel expenses	Lump sum per Region	350.00/ 350.00

A.2. CONDUCT ADVOCACY AND BUILD CONSENSUS

TASK A.2.1 Coordination meeting amongst all sanitation and hygiene stakeholders

Presenting SAP at multi-stakeholder forum with sector partners provides a good opportunity to present the SMART national strategic action plan and ensure its implementation is a national undertaking. In addition conducting joint review quarterly review meetings amongst all sanitation and hygiene stakeholders at Woreda and regional levels and annual joint review and coordination meeting at National level is crucial for successful implementation. Cost of refreshment for a one day meeting at each level is considered.

TASK A.2.2 Review existing advocacy approaches, prepare guidelines to inform advocacy approaches at different levels

The NGO community have considerable experience in developing advocacy guidelines specifically for the Ethiopia context. They have also pioneered a range of advocacy approaches including the WASH movement initiative with national journalists which has spawned FM radio sessions and journalists visiting key WASH sites. The National Hygiene and Sanitation Task Force will hire consultants to review existing advocacy approaches and develop guidelines and the process for dissemination while the regional taskforce engages consultants to contextualize and translate into local language instructional guidelines and a handbook of advocacy approaches. Costs include the consultancy fee, travel expenses of the national and regional consultant for 30 and 50 days input respectively.

TASK A.2.3 Distribute policies, laws, regulations, manuals, handbooks and guidelines to regions with facilitation to ensure their proper implementation

Ethiopia has a raft of sound policies, proclamations, strategies, guidelines and manuals which need to be shared in a strategic manner with key stakeholders. Options include: WASH website; WASH meetings; workshops. Cost includes printing at national and regional level and distribution at regional and Woreda level.

TASK A.2.4 Conduct meeting (Whole System in the Room) for all stake holders (NGOs, Training Institutes, Health Institutions, WASH team) Woreda cabinet members, religious leaders, Woreda

The Whole-System-in-the-Room approach was successfully applied in the Amhara 'Learning by Doing' project in Amhara region. The WSR approach needs to be reviewed from the position of cost effectiveness – *is it an affordable and effective medium for advocating change and building consensus*? The Amhara regional picture as with SNNPR is very promising with an established toilet culture which needs a 'leg-up' to the next rung of the sanitation ladder. Cost for conducting workshop for 3 days for 20 Woreda cabinet members, 18 experts from sector offices, private sector and NGOs, and 2 representatives from every Keble in the Woreda.

A.2	**CONDUCT ADVOCACY AND BUILD CONSENSUS**							
OUTPUT	**Advocacy mainstreamed leading to National Strategic Action Plan to achieve 84% Hygiene and Sanitation endorsed at all levels**							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
A.2.1	Coordination meeting amongst all sanitation and hygiene stakeholders	Annually(1st to 5th year)	Federal Level	FMOH	H&S task force	Refreshment expenses	Rate /meeting	225.00
		Quarterly(1st,3rd year) (4meetings/annum)	Regional Level	RHB	H&S task force			480.00
		Quarterly(1st to 5th year) (4meetings/annum)	Woreda Level	WRHO	H&S task force			180.00
		Quarterly(1st to 5th year) (4meetings/annum)	Town Level	Health offices or centres	H&S task force			180.00
		Quarterly (1st t0 4th year) 4meetings/annum)	Rural Keble Level (	HEW	WASH team			120.00
		Quarterly(1st to 5th year) (4meetings/annum)	Urban Keble Level	HEW	WASH team			48.00
A.2.2	Review existing advocacy approaches, prepare instructional/participant guidelines to inform advocacy approaches at different levels	30 days in the 4th quarter of the first Ethiopian fiscal year of implementation	Federal Level	H&S task force	WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	6,000.00
		50 days in the 1st quarter of the second Ethiopian fiscal year of implementation	Regional Level	H&S task force	WASH coordination office			5,000.00
A.2.3	Distribute policies, laws, regulations,	The first month in the2nd quarter	Federal	Ministry of Health	Concerned Departmnet	Prinitng and travel	lumpsum per region	820.00

A.2	CONDUCT ADVOCACY AND BUILD CONSENSUS							
OUTPUT	Advocacy mainstreamed leading to National Strategic Action Plan to achieve 84% Hygiene and Sanitation endorsed at all levels							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
	manuals, handbooks and guide lines to regions with facilitation to ensure their proper implementation	of the second Ethiopian fiscal year of implementation				expenses		
		The first month in the4th quarter of the first Ethiopian fiscal year of implementation	Regional Level	Ministry of health concerned department	Regional environmental health experts	Printing and transportation expenses	Lump sum per region	480.00
		The first month in the 3rd quarter of the second Ethiopian fiscal year of implementation	Urban Keble	Woreda health office	Woreda environmental health experts	Travel expenses	lumpsum per Keble	38.00
		The first month in the 3rd quarter of the second Ethiopian fiscal year of implementation	Rural kebele	Woreda health office	Woreda environmental health experts	Travel expenses	lumpsum per Keble	80.00
A.2.4	Conduct meeting (Whole System in the Room or similar one) for Woreda cabinet members, religious leaders, NGOs, training institutions, Woreda sector experts/ supervisors, & Woreda WASH team	The first month in the 2nd quarter of the 1st and 3rd Ethiopian fiscal year of implementation	Woreda Level	Regional/Zonal health bureau	Regional/Zonal trained facilitators	Workshop expense	rate/ Woreda	855.00
		The second month in the 2nd quarter of the second Ethiopian fiscal year of implementation	Kebele	Woreda health office	HEWs	Workshop expense	rate/Workshop	150

Note:Zonal level is considered as part of the region. Core implementation levels are the kebeles, towns and woredas

A.3. ENSURE COORDINATION (ALIGNMENT AND HARMONISATION)

A.3.1 Reactivation of MOU to improve Sectoral coordination

The MoU reactivation process is ongoing and it is important that the actively engage to agree and define coordination mechanisms avoiding unnecessary duplication and overlap to maximise inter-sectoral synergies to include both community and school led total sanitation and hygiene operating in tandem.

A.3.2 Ensure CLTSH, SLTSH and Sanitation marketing is mainstreamed in WASH manual

It should be emphasised that community, school and health WASH facility installation must have community and school led total sanitation and hygiene and sanitation marketing appropriately scheduled into the process with ODF status a performance marker for contract completion.

A.3.3 Cascade the Hygiene and Sanitation Task Force or upgrade WASH Coordination Committee at all levels - maximising stakeholder participation and collaboration

The formation of the NSHTF is an important step to enhance stakeholder collaboration and partnership to improve sanitation and hygiene in the country but with existing WASH coordination structures and mechanisms at different levels, there is a need to define and agree NSHTF boundaries.

A.3	**Ensure Coordination, alignment and harmonization**							
OUTPUT	Improved levels of stakeholder coordination and inter-sectoral collaboration to limit duplication formalize cooperation and maximize synergies.							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
A.3.1	Reactivation/modification of MoU to improve sectoral coordination	In the 4th quarter of the first Ethiopian fiscal year of implementation	National Level	National WASH Team	H&S task force	Transport, perdiems and refreshment expenses	Lump sum	600.00
			Regional Level	National WASH Team	H&S task force			360.00
			Woreda Level	Regional WASH Team	H&S task force			255.00
			Town Level	Regional WASH Team	H&S task force			330.00
			Rural Kebele	Woreda WASH Team	H&S task force			90.00
			Urban Kebele	Regional WASH Team	H&S task force			28.00
A.3.2	Mainstream CLTSH/SLTSH and SanMark in the national WASH Programme Implementation Manual	In the 4th quarter of the first Ethiopian fiscal year of implementation	National Level	MOH	H&S task force	Consultancy fee	Lump sum	5,000.00
A.3.3	Cascading the Hygiene and Sanitation Task Force or upgrading WASH Coordination Committee at all levels - maximizing stakeholder participation and collaboration	In the 4th quarter of the first Ethiopian fiscal year of implementation	Regional Level	National H&S task force	National WASH Team	Transport, perdiems and refreshment expenses	Lump sum	380.00
			Woreda Level	Regional H&S task force	Regional WASH Team			255.00
			Town Level	Regional H&S task force	Regional WASH Team			330.00

A.4. PLANNING & BUDGETING

A.4.1 Facilitate and prepare annual WASH/Health plan and budget for improved hygiene and sanitation

Core components of the SAP need to be mainstreamed in Woreda and town WASH plans with budget allocated accordingly. This will require a level of prioritisation from a minimum to a comprehensive level of investment.

- The **minimum package** would rely on CLTSH, supported by HEWs and/or community volunteers, and backed up by a media (radio) campaign. The package would drive towards ODF status in communities, with appropriate validation and acknowledgement. This would then be complemented by the selection, training and equipping of artisans (possibly unemployed youth) either directly from communities or through Technical Colleges. This would only work with a strict system of follow up and quality control.
- The **intermediate package** would add SLTSH and the application of a Community Development Fund (adapted from the successful WASH model) for improved sanitation and hygiene facilities at schools and health posts using the school or the health post as a focal point for improved toilet promotion and slab production (material stock-piling and skill diffusion). The focal point could also be a Kebele market centre or hardware outlet.
- The **comprehensive package** includes aspects of the minimum and the comprehensive packages plus a comprehensive formative research process to prepare a full sanitation marketing approach.

A.4.2 Facilitate regular progress review at planning and budgeting meetings

It is important that there is a systematic review process to consider progress against a series of key milestones possibly using the national WASH inventory but including the following: # of CLTSH ToTs; # of communities triggered; of ODF communities; # of communities with trained artisans; # of Improved Hygiene and Sanitation marts established at schools, health posts and markets; # of households achieving improved hygiene and sanitation status.

A.4.3 *Review and compile annual WASH/Health plan and budget for improved hygiene and sanitation*

The annual plan produced at each level will need to be reviewed and compiled by the higher level with clear lines of accountability.

A.4.4 Appoint hygiene and sanitation coordinators at all levels

To ensure close follow-up and routine day-to-day management of the process, sanitation focal persons or coordinators need to be selected from existing institutions at all levels, with performance indicators reflecting agreed milestones.

A.4	**CARRY OUT IMPROVED PLANNING AND BUDGETING FOR HIS**							
OUTPUT	SMART evidence-based Woreda hygiene and sanitation plans with budget in place, informing priority implementation							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
A.4.1	Preparation of annual plan and budget	In the 4th quarter of the first Ethiopian fiscal year of implementation	Woreda Level	H&S task force	Woreda WASH Team	Transport, DSA and refreshment expenses	Lump sum /Woreda	100.00
			Rural Kebele Level				Lump sum /Keble	120.00
			Town Level	H&S task force	Town WASH Team		Lump sum / Town	200.00
			Urban Kebele Level				Lump sum / Keble	76.00
A.4.2	Review of plan and budget on a quarterly basis	Quarterly(2nd to 5th year) (4times/annum)	Woreda Level	H&S task force	Woreda WASH Team	Transport, DSA and refreshment expenses	Lump sum /Woreda	200.00
		Quarterly(2nd to 5th year) (4times/annum)	Rural Kebele Level				Lump sum /Keble	360.00
		Quarterly(2nd to 5th year) (4times/annum)	Town Level	H&S task force	Town WASH Team		Lump sum / Town	400.00
		Quarterly(2nd to 5th year) (4times/annum)	Urban Kebele Level				Lump sum / Keble	184.00
A.4.3	Facilitating, Reviewing, Compilation of annual WASH/Health plan and budget for improved hygiene and sanitation	Starting the 1st year annually in the 4th quarter of the Ethiopian fiscal year	Federal Level	NH&S task force	NWASH team	Transport, perdiems and refreshment expenses	Lump sum	600.00
			Regional level	RH&S task force	RWASH team			360.00
			Woreda Level	WH&S task force	WWASH team			340.00
			Town Level	TH&S task force	TWASH team			340.00
A.4.4	Transport and miscellaneous expenses for H&S coordination	Starting the 1st year annually in the 4th quarter of the Ethiopian	Federal Level	FMOH	NH&S task force	Staff fee	Lump sum/year	12,000.00
			Regional level	RHB	RH&S task force			9,600.00
			Woreda Level	WRHO	WH&S task			1,800.00

A.4	CARRY OUT IMPROVED PLANNING AND BUDGETING FOR HIS							
OUTPUT	SMART evidence-based Woreda hygiene and sanitation plans with budget in place, informing priority implementation							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
		fiscal year at regional level/For town and federal Level 2nd to 4th year			force			
			Town Level	THO	TH&S task force			2,400.00

A.5. CAPACITY BUILDING

A.5.1 Facilitate refreshment TOT CLTSH and related trainings for health professionals and other implementers

Refresher training will be given to those health professional staffs that already have taken CLTSH training and implemented in the past through UNICEF funded programs. The training will focus on the four major steps (pre-triggering, triggering, post – triggering and scaling-up).

A.5.2 Facilitate TOT CLTSH and related trainings for health professionals and other implementers

It is generally accepted that CLTSH/SLTSH training of trainers is best carried out in a practical setting (practicum training) to maximise skills learning and to 'weed out' those who are unsuitable facilitators. Agreement will be reached on the training flow with clearer definition of the roles of facilitators at different levels. This ToT training will be carried out for 8 days,

A.5.3 Carry out a National CLTSH Evaluation

It is important that there is an ongoing review process to monitor the CLTSH/SLTSH performance and process – rewarding good practice and correcting bad. External assessment has proved to be a useful 'audit' and reality check providing the opportunity for international comparison and learning between countries.

A.5.4 CLTSH training to natural community leaders, women's group and H&S volunteers focusing on the four major steps (pre-triggering, triggering, post-triggering and scaling-up)

This training is given for 2 days while the one in 5.1 is TOT training for health extension workers and others for 8 days. Recognising the difficulty in guaranteeing follow-up and ongoing supportive supervision, there is a strong body evidence emphasising the central role which is required of natural leaders to not only sustain the ignition process (ensuring fulfilment of the community action plan) but to also lead the post-triggering phase: the transition to sustainable behaviour change; the adoption of durable technologies; and most important, influencing neighbouring communities – engineering the process known as lateral diffusion.

A.5.5 Institute robust affordable system for supportive supervision & post-triggering follow-up

The focus is on creating supervision and support networks at the community level taking full advantage of the new government initiative to identify women's groups to provide support for HEWs. However, it will also be important to ensure that Woreda supervisors are able to provide HEWs with the necessary follow-up and support but this will have to be well planned and systematic to make best use of limited Woreda resources.

A.5.6 Development of sanitation marketing strategy

The Sanitation marketing strategy will be developed at national level in order to assist private sector implementers in basic sanitation business marketing and sales promotion.

A.5.7 Train artisans focusing on hygiene & sanitation promotion, Slab production, basic business (marketing and sales promotion) and sales management

Trainee artisans will be selected from Technical and Vocational Education and Training Centres (TVETCs) graduates and enthusiastic jobless (school leavers) who recognise the job (trade learning) opportunity and

will be trained in simple techniques for upgrading traditional toilets including the manufacture of basic slabs (varying options) with a rudimentary level of promotion, marketing and book keeping.

A.5.8 Arrange exchange visit to places with best practice

In CLTSH, the power of exchange visits (lateral diffusion) and cross-community learning/influence are well-known. This happens as a natural phenomenon but can also be engineered particularly through practicum training, radio broadcasts and a broad-based citizen review process.

A.5.9 Train Woreda environmental health experts and on water sampling and water quality test kit operation and maintenance

In line with the National Water Quality Monitoring Strategy, there will be a strong focus on water quality at all points of the 'safe drinking water chain' with a strong focus on the household (where a considerable level of contamination occurs)

A.5	**CAPACITY BUILDING**							
OUTPUT	**Improved Woreda and Kebele capacity/skills to deliver quality and required quantity of C & S LSTH training/facilitation/follow up plus rudimentary san mark**							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
A.5.1	Facilitate refreshment CLTSH & SLTSH ToT practical training to health professionals and others concerned	In the 2nd quarter of the 2nd year of implementation	Woreda Level	Regional H&S task force	RWASH team	Trainer's expense, refreshment for Woreda level trainee	lump sum per Woreda	250.00
			Rural Kebele Level	Woreda H&S task force	WWASH team	Transport, DSA and refreshment expenses	lump sum per Keble	120.00
			Town Level	Regional H&S task force	RWASH team	Trainer's expense, refreshment for to town level trainee	lump sum per Town	300.00
			Urban Kebele Level	Town H&S task force	TWASH team	Transport, DSA and refreshment expenses	lump sum per Keble	68.00
A.5.2	CLTSH & SLTSH ToT practical training to health professionals and others concerned	In the 4th quarter of years ranging from 1st to 4th year of implementation	Regional/ (Woreda Level)	Regional H&S task force	RWASH team	Trainer's expense, refreshment for Woreda level trainee	lump sum per Woreda	625.00
			Urban Kebele Level	Town H&S task force	TWASH team	Transport, DSA and refreshment expenses	lump sum per Keble	68.00
			Rural Kebele Level	Woreda H&S task force	WWASH team	Transport, DSA and refreshment expenses	lump sum per Keble	150.00
			Town Level	Town H&S task force	TWASH team	Trainer's expense, refreshment for Woreda level trainee	lump sum per Town	750.00
A.5.3	Carry out a national CLTSH/SLTSH review & regular audit	Annual national level review starting from the 2nd year of implementation	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	11,600.00
A.5.4	Extend practical	In the 3nd quarter of the	Rural Kebele Level	Trained HEW and their	WASH team	Transport, DSA and	Lump sum	120.00

A.5	CAPACITY BUILDING							
OUTPUT	Improved Woreda and Kebele capacity/skills to deliver quality and required quantity of C & S LSTH training/facilitation/follow up plus rudimentary san mark							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
	training to natural leaders & women's groups	2nd and 4th year of implementation	Urban Kebele Level	supervisors		refreshment expenses		68.00
A.5.5	Supportive supervision and Post-Triggering follow-up	Annually starting from the3rd year of implementation	Rural Kebele Level	Trained HEW and their supervisors	WASH team	Transport and DSA expenses	Lump sum	50.00
			Urban Kebele Level	H&S task force	TWASH team			50.00
A.5.6	Development of sanitation marketing strategy	In the 4th quarter of the 2nd Ethiopian fiscal year of implementation	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	10,900.00
A.5.7	Artisan training focusing on hygiene &sanitation promotion, Slab production, basic business (marketing and sales promotion) and sales management	In the 4th quarter of the 2nd an4th year of implementation	Woreda Level	Woreda health office	WASH team WASH team	Trainer's fee, per diem, transport Trainer's fee, per diem, transport	Lump sum	100.00
			Rural Kebele Level	Woreda health office				120.00
A.5.8	Exposure visit to places with good experiences	Annually end of the 4th quarter(2nd to 5th year)	National Level	NH&S task force	NWASH team	Transport and DSA expenses	Lump sum	700.00
		Annually beginning of the 4th quarter(ranging from 2nd to 5th year)	Regional level	RH&S task force	RWASH team			600.00
		Annually end of the 3rd quarter(2nd to 5th year)	Woreda Level	WH&S task force	WWASH team			280.00
		Annually beginning of the 3rd quarter(2nd & 4th year)	Rural Kebele Level	KH&S task force	KWASH team			280.00
		Annually end of the 3rd quarter(2nd to 5th year)	Town Level	TH&S task force	TWASH team			100.00
		Annually beginning of the 3rd quarter(2nd to 5th year)	Urban Kebele Level	KH&S task force	KWASH team			28.00
A.5.9	Training on water sampling and water quality test kit operation and maintenance	In the 4th quarter of the 2nd year of implementation	Regional Level	Trained Environmental health professionals		Transport and perdiems expenses	Lumpsum	220.00

A.5	CAPACITY BUILDING							
OUTPUT	Improved Woreda and Kebele capacity/skills to deliver quality and required quantity of C & S LSTH training/facilitation/follow up plus rudimentary san mark							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
			Woreda Level	Trainees				280.00

A.6. MONITORING AND EVALUATION

A.6.1 Ensure Inventory catches key sanitation and hygiene data

It is important that the NSHTF engages in final discussions on the roll out of the national WASH inventory to ensure key hygiene and sanitation priority indicators are captured and can inform the development of robust baseline data to inform the advocacy and planning process.

A.6.2 Develop and revise reporting formats for each level of health services (health post, Woreda, regional, national)

Linked to the national WASH inventory is the report card which provides a simple reporting format to track progress towards key milestones. Some modification might be required

A.6.3 Annual review meeting to track effective implementation of hygiene & sanitation program

Currently the annual multi-stakeholder forum provides the best opportunity for an annual tracking of and reporting on progress. In line with most Sector Wide review processes such high-level meetings are generally informed by sub-sector reviews reporting on annual progress against the SAP milestones.

A.6.4 Facilitate continuous supportive supervision and monitoring at all levels

Cascading supportive supervision at all levels is essential to monitor individual staff performance as well as progress against delivery of outputs and achievement of undertakings and key indicators

A.6	MONITORING AND EVALUATION							
OUTPUT	Accurate hygiene and sanitation data collected tracking progress on increasing access, ODF status, key hygiene behaviours, SAP milestones and financial tracking							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
A.6.1	Ensure Inventory catches key Sanitation/hygiene data	Annually in the 4th quarter of the first year	Federal Level	NH&S task force	NWASH team	Refreshment expense	Lump sum	600.00
A.6.2	Develop and revise reporting formats for each level of health services (health post, Woreda, regional, national)	In the 4th quarter of the 2nd Ethiopian fiscal year of implementation	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	11,600.00
A.6.3	Annual review meeting to track effective implementation of hygiene & sanitation program	Annually in the 4th quarter ranging from 1st to 5th year	Federal Level	NH&S task force	NWASH team	Refreshment expense	Lump sum	450.00
			Regional level	RH&S task force	RWASH team			200.00
			Woreda Level	WH&S task force	WWASH team			150.00
			Town Level	KH&S task force	KWASH team			300.00
			Rural Kebele Level	TH&S task	TWASH			90.00

A.6	MONITORING AND EVALUATION							
OUTPUT	Accurate hygiene and sanitation data collected tracking progress on increasing access, ODF status, key hygiene behaviours, SAP milestones and financial tracking							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
				force	team			
			Urban Kebele Level	KH&S task force	KWASH team			38.00
A.6.4	Continuous supportive supervision	Annually in the 4th quarter starting from the 1st year of implementation	Woreda Level	WRHO	WWASH team	Transport and per diems expenses	Lump sum	720.00
			Woreda Level	WRHO	WWASH team	Transport and perdiem expenses	Lump sum	480.00
			Town Level	THO	TWASH team			480.00
			Rural Kebele Level	HEW's supervisors	KWASH team			100.00
			Urban Kebele Level		KWASH team			28.00

A.7. PROCUREMENT – CAPITAL AND RECURRENT COSTS

A.7.1 Provision of means of transport

Reliable transportation is required for Woreda and Regional staff to facilitate trainings and to conduct supportive supervision and follow-up is essential for the entire work flow process. Regions will require 4 x 4 vehicles and motorcycles for the transport of facilitators, supervisors, artisan equipment and materials. Provision of vehicles and motorcycles will be linked to maintenance contracts to help ensure longevity and safety of the vehicles. Provision of station wagon, pickups and mobile unit has also been considered at FMOH level.

A.7.2 Provision for Office equipment and stationery

Woreda offices in particular will require essential office equipment and supplies according to government guidelines. Items identified include: Lap Top computer, Digital Camera and LCD projector

A.7.3 Purchase and distribution of water quality testing kits

To complement regional laboratories it is generally recommended that Woreda offices have basic portable testing kits particularly in areas with high risk of AWD

A.7.4 Purchase and distribution of water quality testing chemicals

Woredas will ensure the up to date availability of water quality testing chemicals.

A.7	PROCUREMENT							
OUTPUT	Improved more sustainable and safe mobility, more functional offices and officers better equipped to monitor water quality.							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
A.7.1	Procurement of transportation means	In the 4th quarter of the 1st year of implementation	Federal Level	MOH		Station wagons, pickups, & mobile unit	Lump sum	300000
			Regional Level	RHB		Pick ups	Number	50000
		In the 2nd quarter of the 2nd year of implementation	Woreda Level	WRHO		Motor cycle	Number	3000

A.7	PROCUREMENT							
OUTPUT	Improved more sustainable and safe mobility, more functional offices and officers better equipped to monitor water quality.							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
		In the 4th quarter of the 1st year of implementation	Town Level	THO		Motor cycle	Number	3000
A.7.2	Procurement of office equipment	In the 4th quarter of the 2nd year of implementation	National Level	MOH		Lap Top computer, Digital Computer, LCD projector	Lump sum	-
			Regional Level	RHB				3900
		In the 1st quarter of the 2nd year of implementation	Woreda Level	WRHO	WOFED			3900
			Town Level	THO				3900
A.7.3	Provision of water quality testing kits	In the 1st quarter of the 2nd year of implementation	Woreda Level	MOH	RHO	Water quality test kits	Number	3000
			Town Level	MOH	RHO		Number	3000
A.7.4	Provision of Chemicals for water quality testing kits	In the 1st quarter of the 2nd year of implementation	Woreda Level	MOH	RHO	Chemicals for Water quality test	Set	300
			Town Level	MOH	RHO			300

B. PILLAR 2 - CREATE DEMAND

B.1	**Prepare, trigger & provide post-triggering follow-up and support**
B.2	**Trigger Schools through School Led Total Sanitation and Hygiene**
B.3	**Sanitation Marketing**
B.4	**Apply rewards and sanctions**

B.1 PREPARE, TRIGGER & PROVIDE POST-TRIGGERING FOLLOW-UP AND SUPPORT

B.1.1 Follow steps to prepare and trigger communities

A considerable amount of work has been carried out in developing the critical steps for successful community led total sanitation and hygiene. The CLTSH manual is awaiting final edit/print preparation (but this is not inhibiting the ongoing triggering/ignition process. Agreement needs to be reached on the cascading facilitation/ToT process: who are the 'best facilitators', the most appropriate follow-up/supervision regime - post triggering, the optimum time/timing of events particularly training and deployment of slab-makers/toilet improvers. In addition, agreement needs to be reached on harmonisation with School Led Total Sanitation to exploit synergies

B.1.2 Provide systematic ignition and post triggering follow-up

The weakest link in the current chain comes post-triggering when systematic supportive follow-up is crucial and funding limited. The chain of command and responsibility needs to be better defined plus the links with artisan training and mobilisation with a suitable default framework

Step	***Task***	***Visit***	***By whom:***
1	*Prepare community*	*1*	*HEW*
2	*Trigger community*	*1*	*Supervisor + HEW+ Natural leaders, facilitator*
3	*Post-triggering follow up*	*1*	*Supervisor + HEW+ Natural leaders+ Keble administrative leaders*
4	*After reaching ODF status: Select, train, equip, deploy artisans/slab-makers*	*1*	*Supervisor + HEW+ Natural leaders+ Woreda health office*
5	*Validate ODF status & train, equip artisans for toilet upgrading*	*1*	*Regional/Zonal team*

B.1.3 Apply ODF validation and recognition measures (protocol)

Considerable work has gone into the preparation of an ODF protocol for Ethiopia (now in its final stages) and its application will link with supportive supervision and monitoring. The essence of the process will be in supporting the community to see the achievement of ODF status as a stepping stone to 100 per cent improved hygiene and sanitation.

B.1.4 Promote village to village exchange visits (encouraging lateral diffusion)

A key element of CLTSH is the impact of peer influence as one village hears of the improvements being made by its neighbour and then through their own initiative visit to learn how the changes have been made inviting neighbours to help them. This process known as lateral diffusion can also be facilitated through the FM radio and influential (particularly religious) leaders.

B.1.5 Mobilise slab-maker and toilet improvers in ODF communities

Experience shows that home grown initiatives have the greatest chance of sustainability and this is particularly true when community leaders identify their own technical solutions, arrange their own supply streams, and seek out the necessary skills. The Woreda will: make the training available; create supply

streams through lines of credit to suppliers (where the Woreda acts as guarantor) of local building suppliers; make simple kits like sanplat moulding kits and tools affordable and available. Artisans will need to be certified and accredited as fit to provide services and their products should also carry a guarantee or warrantee.

B.1	PREPARE, TRIGGER (IGNITE) AND PROVIDE POST-TRIGGERING FOLLOW-UP AND SUPPORT							
OUTPUT	Demand for hygiene and sanitation enhanced with increasing levels of ODF status and households with improved hygiene and sanitation achieved according to national targets.							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
B.1	Community Sanitation and Hygiene calculated based on a Woreda-Scale campaign will include: (i) Pre-planning, (ii) hands-on-training, (iii) triggering, (iv) post-triggering follow up, (v) verification of ODF communities and recognition, (vi) sanitation marketing	50% in the 2nd and the remaining 50% 3rd year of implementation	Rural Kebele Level	HEWs	Their supervisors	Per diem and transport expense per household	Households	10.24
			Urban Kebele Level	HEWs	Their supervisors		Households	14

B.2 TRIGGER SCHOOLS - SLTSH

B.2.1 Facilitate School Led Total Sanitation & Hygiene in schools alongside CLTSH communities

Facilitating improved hygiene and sanitation in schools complements the work of the HEWs in the community promoting model households encouraging the school children, teachers and parents to create a model school. SLTSH has similar components to CLTSH and when the two are done in tandem obvious synergies are activated. Children have been known to become effective ODF monitors blowing their whistles at even the faintest indication that someone is about to drop their trousers.

B.2.2 Set up school sanitation and hygiene clubs – child to child activities – School IEC

Schools provide a captive audience of willing and able learners and many good communicators who can back up and even lead on-going work in the community.

TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
B.2.1	School Led Total Sanitation steps in schools alongside CLTS communities	In the 3rd quarter of the 2nd and 3rd year of implementation	Rural School	Trained teachers	Trained students		Lump sum/per school	100
			Peri Urban School	Trained teachers	Trained students			300
B.2.2	Set up school led Total Sanitation Fund	In the 3rd quarter of the 2nd and 3rd year of implementation	Peri Urban School	Trained teachers	HEW	Finance	Lump sum/per school	**40**
			Rural School	Trained teachers	HEW	Finance		**18**

Note: Urban school clubs will be considered in the urban hygiene and sanitation strategic action plan

B.3 SANITATION MARKETING

B.3.1 Conduct formative research to understand demand triggers, toilet preference, messaging, audiences and communication channels

There are plans to conduct formative research using a commercial company specialising in social marketing in Amhara. The research will cover the full spectrum of factors influencing sanitation and hygiene

behaviours and will therefore straddle all three pillars. It will consider issues of finance and how best to mobilise public and private stream of finance. It will find ways to mobilise the private sector, identify technical preference and improve supply streams. A strong focus will be on the identification of appropriate messages for different audiences through a range of mutually reinforcing communication channels.

B.3.2 Development of mass media programme:

The WASH movement is already using FM Radio Programs - Soap Operas, Phone-Ins, Community Conversation- on-air *approach* to good effect. It will be important to conduct a review of consumer appreciation to check levels of reach and penetration – i.e. how regularly do different approaches hit their target and positively influence behaviour.

B.3.3 Identify best sanitation marketing practice

Planned sanitation marketing initiatives will provide an important learning opportunity, there are also many different approaches already in operation throughout Ethiopia and it will be important to identify best practice which can be taken to scale. To this effect the NSHTF should arrange a study of the full range of different approaches to consider how best to fulfil the demand created by CLTSH. This should also recognise that there are a range of existing approaches such as the WASH movement work with Ethiopian journalists and FM radio stations which have proved highly successful in reinforcing the CLTSH approach.

B.3.4 Use video conference to link regions and to share experience with other countries

This facility would improve interaction, cooperation and information exchange on a regional level while also allowing more widespread interaction with other countries.

B.3.5 Road shows' as effective edutainment tools

Road Shows which provide a mobile promotional opportunity have been particularly successful in other health related behaviour change and marketing related arenas and come under the umbrella of "edutainment" where popular (traditional) songs, stories, figures, topical themes are used to get across messages. The road show as its name implies is generally a mobile unit operated by a skilled group of facilitators and performers

B.3.6 Continue to promote FM Radio Programs - Soap Operas, Phone-Ins, Community Conversation-on-air

The WASH movement will continue using this approach.

B.3.7 Continue to promote TV Programs - Soap Operas, Phone-Ins, Community Conversation- on-air

The WASH movement will continue to use this approach.

D.3.8 Use advocacy and media exposure to mobilise the support of influential leaders

Advocacy will continue to be used to persuade influential leaders from political, religious, sports, and entertainment backgrounds to give up their time and use their influence to back up International and National promotional events such as National Hand washing Day and National Toilet Day

B.3.9 Provide focussed support for the women HEW health support groups - develop guide as to how they support CLTSH and Sanitation marketing

Another innovative approach which will complement the hugely influential work of the HEWs is the identification of women's groups who will support the core preventive health packages at household level. It will be important to consider how these women's groups can engage in CLTS and sanitation marketing.

B.3.10 Develop and roll out school hygiene and sanitation club user guides and materials and promote the establishment of school clubs

A lot of work has already been completed on school led total sanitation as well as other initiatives including: child to child; school health clubs; and children as sanitation monitors (whistling and planting red flags

where they spot open defecation). The NSHTF should collate best practice and create a complementary SLTS approach to fit with the Ethiopian context and to complement existing CLTSH approaches.

B.3.11 Develop and roll out IEC materials

Existing IEC materials will be used and new ones will be developed to strengthen hygiene promotion at all levels.

B.3.12 Printing of approved essential materials – guides, posters, leaflets, games

Ethiopia has many guides, posters, games, picture-based tool kits including a pictorial sanitation ladder which might still have a useful role to play in behaviour change communication. The NSHTF will carry out a review and produce a communication guide for use in CLTSH and sanitation marketing approaches.

B.3.13 Distributing approved essential materials – guides, posters, leaflets, games

Distribution of printed IEC material and SLTS materials distribution takes place at Woreda and town level to reach the end users in the Kebeles.

B.3	**SANITATION MARKETING**							
OUTPUT	**Effective sanitation marketing approaches agreed with the promotion of Hygiene and Sanitation placed on an effective commercial footing through a better understanding of Product, Place, Price and Promotion.**							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
B.3.1	Formative research to understand demand triggers, latrine preference, messaging, audiences and communication channels	In the 1st quarter of the 2nd year of implementation	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	15,200.00
B.3.2	Development of mass media popularization program	In the 1st quarter of the 2nd year of implementation	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	15,200.00
B.3.3	Assess the core ingredients of existing BCC/San Mark approaches to inform the development of san mark strategy for Ethiopia	In the 2nd quarter of the 2nd year of implementation	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	10,600.00
B.3.4	Use video conference to link regions & learn other country experience	Bimonthly for 1 hour starting from the 4th quarter of the 1st year of implementation (24 Hrs)	Federal Level	MOH	NH&S task force	Video communication set up	Hour	100.00
B.3.5	Road show	Quarterly starting from the 2nd quarter of the 2nd year of implementation	Regional Level	RHB	RH&S task force	Show	Number	300.00
			(Woreda Level)					100.00
B.3.6	Radio Programs - Soap Operas, Phone-In,	Three times a week for 30 minutes starting from	Regional Level (Woreda Level)	RHB	RIB	Radio Air time	Hour	200.00
								80.00

B.3	SANITATION MARKETING							
OUTPUT	**Effective sanitation marketing approaches agreed with the promotion of Hygiene and Sanitation placed on an effective commercial footing through a better understanding of Product, Place, Price and Promotion.**							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
	Community Conversation	the 2nd quarter of the 2nd year of implementation (78hrs)	(Woreda Level)					
B.3.7	TV Programs - Soap Operas, Phone-In, Community Conversation	Three times a week for 20 minutes starting from the 2nd quarter of the 2nd year of implementation (52hrs)	Regional Level	RHB	RIB	TV Air time	Hour	150.00
			(Woreda Level)					7,200.00
B.3.8	Motivation of influential leaders	In the 3rd quarter of the 2nd year of implementation	Woreda Level	WRHO	WH&S task force	Transport and DSA expenses	Lump sum	8,600.00
B.3.10	Develop and roll out SLTS and related approved school IHS activities	In the 1st quarter of the 2nd year of implementation	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	250.00
B.3.11	Development of IEC materials	In the 1st quarter of the 2nd year of implementation	Federal Level	Concerned departments at the Ministry of Health	Federal WASH coordination office	Consultancy fee, travel and other expenses	Lump sum	15,200.00
B.3.12	Printing and distribution of school club users guides, IEC and other materials	In the 2nd quarter of the 2nd year of implementation	Regional Level	RHO	RH&S task force	Printing expenses	Set/Woreda or town	15,200.00
B.3.13	Distribution of school club users guides, IEC and other materials	In the 2nd quarter of the 2nd year of implementation	Kebele Level	RHO	RH&S task force	Distribution expenses	Set/Woreda or town	30
			Woreda Level					30
			Town Level					30

B.4 APPLY REWARDS AND SANCTIONS

B.4.1 Make annual WASH 'recognition' awards (certificates and banners)

Establish Hygiene and Sanitation league table at Kebele, Woreda, region and federal level which can be updated as information is received through the national WASH inventory

B.4.2 Assess validity of ODF declarations and devise rewards for achieving ODF status

The ODF validation procedure is still under final development and once complete will need to be rolled out at the appropriate levels of assessment with agreed forms of recognition.

B.4.3 Apply Sanctions for polluters

The public health proclamation has proved a useful tool to invoke full political support for Hygiene and Sanitation in SNNPR and it provides a useful supporting document for advocacy. Enforcing sanitation has been applied to some good effect notably in Bangladesh where children were encouraged to identify OD offenders by blowing whistles and planting flags. Another successful tool is a public display of the community map indicating those households without toilets or names listed at the Kebele office.

B.4	APPLY REWARDS & SANCTIONS							
OUTPUT								
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
B.4.1	Annual WASH Award	Starting from the 2nd year annually end of the 4th quarter	Federal Level	MOH	NH&S task force	Reward	set	3,000.00
		Starting from the 3rd year annually beginning of the 4th quarter	Region Level	RHB	RH&S task force	Reward	set	1,000.00
		In the 4th year at the end of the 3rd quarter.	Woreda Level	WRHO	WH&S task force	Reward	set	200.00
		Starting from the 4th year annually beginning of the 3rd quarter	Rural Kebele Level	KWASH team	KH&S task force	Reward	set	75.00
		On the 4th year annually end of the 3rd quarter	Town Level	THO	TH&S task force	Reward	set	300.00
		Starting from the 4th year annually beginning of the 3rd quarter	Urban Kebele Level	KWASH team	KH&S task force	Reward	set	100.00
B.4.2	Rewards for achieving ODF status	Starting from the 2nd year annually end of the 4th quarter	Federal Level	MOH	NH&S task force	Reward	set	3,000.00
		Starting from the 3rd year annually beginning of the 4th quarter	Region Level	RHB	RH&S task force	Reward	set	1,000.00
		on the 3rd year at the end of the 3rd quarter	Woreda Level	WRHO	WH&S task force	Reward	set	100.00
		Starting from the 4th year annually beginning of the 3rd quarter	Rural Kebele Level	KWASH team	KH&S task force	Reward	set	40.00
		on the 3rd year at the end of the 3rd quarter	Town Level	THO	TH&S task force	Reward	set	200.00
		Starting from the 4th year annually beginning of the 3rd quarter	Urban Kebele Level	KWASH team	KH&S task force	Reward	set	100.00
B.4.3	Sanction	Starting from the 3rd year annually end of the 4th quarter	National Level	MOH	NH&S task force	Reward	set	-1,000.00
		Starting from the 3rd year annually beginning of the	Region Level	RHB	RH&S task force	Reward	set	-300.00

B.4	APPLY REWARDS & SANCTIONS							
OUTPUT								
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
		4th quarter						
		Starting from the 3rd year annually end of the 3rd quarter	Woreda Level	WRHO	WH&S task force	Reward	set	-100.00
		Starting from the 3rd year annually beginning of the 3rd quarter	Rural Kebele Level	KWASH team	KH&S task force	Reward	set	-30.00
		Starting from the 3rd year annually end of the 3rd quarter	Town Level	THO	TH&S task force	Reward	set	-150.00
		Starting from the 3rd year annually beginning of the 3rd quarter	Urban Kebele Level	KWASH team	KH&S task force	Reward	set	-50.00

C. PILLAR 3 – FACILITATE SUPPLY

This section covers:	
C.1	**Provide hygiene and sanitation facilities in schools**
C.2	**Provide hygiene and sanitation facilities at health institutions**
C.3	**Provide hygiene and sanitation facilities at prisons**
C.4	**Facilitate Urban Household, Public & Communal Facilities**
C.5	**Expand sanitation finance**

C.1 PROVIDE HYGIENE AND SANITATION FACILITIES IN SCHOOLS

C.1.1 Construct school toilets & hand washing facilities As with most water points, the straightforward approach is for the Woredas to provide each school with a WASH package but there is also the option of applying the Community Development Fund approach. This has proved very successful but has its real test when provided as a more general WASH option. With the CDF approach, the school management committee would be responsible for managing the contract and part of the conditionality could include artisan training and slab promotion in the wider community. The viability of using the CDF in this context will need to be tested and developed as part of the wider sanitation marketing strategy. The FMoH with UNICEF support has recently developed a new design and construction manual, which has Bills of Quantities and costs.

C.1.2 Rehabilitate toilets & hand washing facilities to improve the existing situations of hygiene and sanitation in school & health facilities

Although most schools in Ethiopia have some form of toilet, standards and numbers vary considerably along with levels of maintenance. There are many existing toilets in poor states of repair or where pits are full in need of relatively low levels of investment.

C.1	**PROVIDE SANITATION & HYGIENE FACILITIES AT SCHOOLS**							
OUTPUT	**Increased access (improved national toilet/student ratio) to improved hygiene and sanitation facilities for both girls and boys (and teachers) in line with national standards**							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
C.1.1	Construct new toilets, hand washing &urinal facilities for schools	From the 2nd to 4th year of implementation	Kebele Level	WWASH team	School WASH committee	Labour and material cost	Lump sum/school	15,919.32
		2nd,4th year	Woreda Level					
C.1.2	Rehabilitation of existing toilets and hand washing facilities per school	From 2nd to 4th year of implementation	Kebele Level	WWASH team	School WASH committee	Labour and material cost	Lump sum/ school	15,919.32
		2nd,3rd year	Woreda Level					

C.2 PROVIDE HYGIENE & SANITATION FACILITIES AT HEALTH FACILITIES

C.2.1 Ensure all Health Centres Hygiene and Sanitation facilities

The provision of health centre WASH facilities is generally considered a straightforward contract initiative but it might be possible consider a more creative approach which involves the HC management committee.

C.2.2 Rehabilitate toilets & hand washing facilities to improve the existing situations of hygiene and sanitation in health facilities

Although some health facilities in Ethiopia have some form of toilet, standards and numbers vary considerably along with levels of maintenance. There are many existing toilets in poor states of repair or where pits are full which are in need of relatively low levels of investment.

C.2.3 Ensure all Health posts have Hygiene and Sanitation facilities

As with schools, the straightforward approach is for the Woredas to provide each health post with a **WASH package** but there is also the option of applying the CDF which could then be used to kick start the sanitation marketing approach. The viability of using the CDF in this context will need to be tested and developed as part of the wider sanitation marketing strategy.

C.2.4 Rehabilitate toilets & hand washing facilities to improve the existing situations of hygiene and sanitation in health post

Although some health posts in Ethiopia have some form of toilet, standards and numbers vary considerably along with levels of maintenance. There are many existing toilets in poor states of repair or where pits are full in need of relatively low levels of investment.

C.2	PROVIDE HYGIENE AND SANITATION FACILITIES AT HEALTH INSTITUTIONS							
OUTPUT	Increased access (improved national toilet/patient-staff ratio) to improved hygiene and sanitation facilities for both clients and staff (Male and Female) in line with national standards							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
C.2.1	Construct new toilets & hand washing facilities for health centres	From 2nd to 4th year of implementation	Rural Kebele Level	WRHO	HEW	Labour and material cost	Lump sum/health post	6,579.97
			Woreda level					
C.2.2	Rehabilitation of existing toilets and hand washing facilities per health posts	From 2nd to 4th year of implementation	Rural Kebele Level	WRHO	HEW	Labour and material cost	Lump sum/health post	1,000.00
		1st to 5th year of implementation	Woreda level					

C.3 PROVIDE HYGIENE AND SANITATION FACILITIES AT PRISONS

C.3.2 Ensure all Prisons have Hygiene and Sanitation facilities

The provision of prison WASH facilities is generally considered a straightforward contract initiative.

C.3	PROVIDE HYGIENE AND SANITATION FACILITIES AT PRISONS							
OUTPUT	Increased access (improved national toilet/prisoners ratio) to improved hygiene and sanitation facilities for both girls and boys (and teachers) in line with national standards							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
C.3.1	Construct new toilets & hand washing facilities for Prison	In the 4th year of implementation	Woreda/Town level	WWASH team	Prison WASH committee	Labour and material cost	Lump sum/school	12,629.33
C.3.2	Rehabilitation of existing toilets and hand washing facilities per Prison	In the 3rd year of implementation	Woreda/Town level	WWASH team	Prison WASH committee	Labour and material cost	Lump sum/ school	2,000.00

C.4 FACILITATE URBAN HOUSEHOLD, MARKET PLACES, REFUGEE CAMPS, PUBLIC & COMMUNAL FACILITIES

C.4.1 Facilitate the construction of Communal toilets

Communal toilets in urban areas should be constructed on the basis of build, operate and transfer (areas without access, transport or treatment facilities should be on eco-san including biogas on-site treatment systems).

C.4.2 Rehabilitate the existing of Communal toilets

Existing communal toilets in urban areas should be rehabilitated.

C.4.3 Facilitate the construction of public toilets under local management

Public toilets in urban areas should be constructed on the basis of build, operate and transfer (in areas without sludge transport and treatment facilities, the focus should be on eco-san including biogas on-site treatment systems). Public toilets should be managed and operated by private company on a basic commercial level.

C.4.4 Rehabilitate the existing of public toilets

Existing run down, overflowing public toilets in a general poor state of repair in urban areas should be rehabilitated.

C.4.2 Arrange collection and transport of sludge and treatment in drying beds

District and municipal authorities will not pay for the emptying of private toilet pits or septic tanks and the full cost of emptying, transport and final treatment is the responsibility of the private individual (house owner or landlord). The private sector must be engaged in managing this process with support in the development of sustainable business models. This approach should discourage the installation of costly, unsustainable sanitation systems and encourage more appropriate dry systems and the exploitation of composted human excreta for agricultural and horticultural production. Most large scale urban centres now have sanitary disposal through drying beds with commercial trucks providing desludging services.

C.4	**Facilitate Urban Household, Public & Communal Facilities**							
OUTPUT	**Increased access (improved national toilet/population ratio) to improved hygiene and sanitation facilities for urban dwellers**							
TASK	**ACTIVITY**	**TIME FRAME**	**LEVEL OF INTERVENTION**	**WHO LEADS**	**WHO SUPPORTS**	**INPUTS**	**UNIT**	**COST in USD**
C.4.1	Construct new toilets & hand washing facilities for public toilet	In the 4th year of implementation	Town level	Town Administration	TWASH team	Labour and material cost	Lump sum/school	18,943.99
C.4.2	Rehabilitation of existing toilets and hand washing facilities per public toilet	In the 3rd year of implementation	Town level	Town Administration	TWASH team	Labour and material cost	Lump sum/ school	3,000.00
C.4.3	Construct new toilets & hand washing facilities for communal toilet	In the 4th year of implementation	Town level	Town Administration	TWASH team	Labour and material cost	Lump sum/school	6,184.48
C.4.4	Rehabilitation of existing toilets and hand washing facilities per communal toilet	In the 3rd year of implementation	Town level	Town Administration	TWASH team	Labour and material cost	Lump sum/ school	1,000.00

C.5 EXPAND SANITATION FINANCE

C.5.1 Establish viable sanitation business model - existing business expansion

Successful demand and supply models which take advantage of local small scale private sector artisans to make sanplat slabs (usually based on the daily paid labour rate) have proved highly effective in assisting communities to make low cost toilet improvements. The NSHTF will conduct its own study of NGO models and their viability as a potential Sani-Mart supply and marketing system.

C.5.2 Develop sanitation fund at Woreda level

In line with various successful funding streams direct to Woredas it is recommended that the NSHTF investigates the possibility of tapping into the Local Investment Grant to develop a dedicated finance stream for sanitation marketing at Woreda level.

C. 5.3 Apply Community Development Fund (CDF) for Hygiene & Sanitation

The community Development Fund (CDF) is a successful funding mechanism used for community driven construction of small scale rural water and sanitation infrastructure. The CDF has proven to be very efficient in creating ownership and sustainable development. For example the government of Finland has jointly with the government of Ethiopia has introduced the CDF mechanisms in Amhara region in the promotion of community led water supply and sanitation activities. The approach has been introduced in Amhara region in 2003 and in Benshangul Gumuz in 2008. As observed from the Amhara experience the CDF funding mechanism has shown good result in terms of fund utilization, construction time, and construction material procurement[53].

C.5	EXPAND SANITATION MARKETING FINANCING INCLUDING THE SANI-MART FRANCHISE							
OUTPUT	Finance options made available for innovate private sector sanitation marketing approaches							
TASK	ACTIVITY	TIME FRAME	LEVEL OF INTERVENTION	WHO LEADS	WHO SUPPORTS	INPUTS	UNIT	COST in USD
C.5.1	Establishment of Sanitation businesses built on viable business model - existing business expansion, school sanitation enterprise centres	From 2nd to 5th year of implementation	Woreda Level	WRHO	WWASH team	Labour and material cost	Lump sum/school	15,000.00
		3rd year of implementation	Town Level					
C.5.3	Sanitary supply streams with incentives	From 2nd to 4th year of implementation/3rd year of implementation	Woreda/Town level	WRHO	WASH team	Consultancy fee, travel and other expenses	Lump sum	200.00

[53] The Community Development Fund (CDF) was developed by the Rural Water Supply and Environment (RWSEP) Project funded by Finnida and is in the process of being adopted as a national approach in the national WASH programme

SECTION 7. TARGETS & PARAMETERS USED FOR COSTING

7.1 TARGETS

7.1.1 100% access to and use of basic hygiene and sanitation

The target in this Strategic Action Plan is to achieve a 100% open defecation free Ethiopia with all households having access to and using a basic 'minimum' standard of toilet as well as practicing hand washing at critical times and observing the safe drinking water chain.

7.1.2 84% access to and use of improved hygiene and sanitation

In line with HSDP IV the target for improved hygiene and sanitation is to raise access and use from the current level of 31%[54] to 84% by the year 2015.

7.1.3 The Scale of the Challenge to achieve IMPROVED access

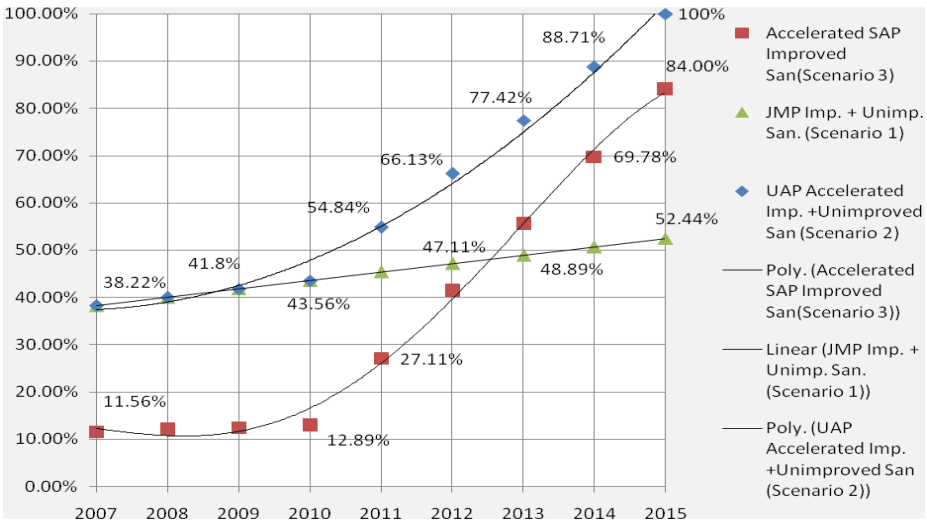
The plan of intervention in improving sanitation for households could be considered in the three scenarios shown in figure below.

Scenario 1: is a status quo scenario based on the JMP forecast that allows growth of improved +unimproved sanitation coverage from 43.56% in 2010 to 52.44% in 2015. This scenario doesn't enable the country to meet the MDGs.

Scenario 2: is an accelerated plan based on universal access that enables improved +unimproved sanitation coverage to grow from 43.56% in 2010 to 84% in 2015 enabling the country to go beyond the MDG target.

Scenario 3: is an accelerated plan based on SAP that facilitates improved sanitation to grow from 12.89% in 2010 to 84% in 2015 enabling the country to satisfy JMP standards and go beyond the MDGs comfortably. This scenario requires upgrading the unimproved toilets and at the same time constructing new facilities. It is expected that discussion with JMP will slightly increase the baseline coverage through having some cleanable (washable) facilities included in the inventory.

Figure 3: Trend of the Three Scenarios in Improving Sanitation



Source: Prepared based on data taken from JMP, UAP and HSDP IV

[54] The baseline improved sanitation coverage is 12.89% in 2010 as per JMP. The 31% figure as per HSDP IV includes cleanable but not washable facilities that belong to unimproved facilities as per JMP standards.

As the table below illustrates, the scale of the challenge is substantial. As per scenario 1, 37,126 latrines should be constructed every month to meet the status quo situation. In the case of scenario 2, over 162,625 latrines should be constructed every month so that 100% coverage can be achieved at household and community level. This figure is without the inclusion of institutional Sanitation and hygiene. Scenario 2 efforts require to be scaled up by 4.38 fold of scenario 1 to achieve the universal access.

Table 12. Summary of existing improved latrine coverage and total number of Latrines required by Region (Scenario 1 and Scenario 2)

Region	2007	2010	2011	2015	No of Latrines Scenario 1 (Status quo)	No. of Latrines to be constructed Monthly Scenario 1 (status quo)	Universal Coverage- Scenario 2 (Improved +Un improved)	No. of Latrines Scenario 2 (Universal Access Scenario)	No. of Latrines to be constructed Monthly - Scenario 2
	Coverage	Base Year Coverage	Coverage	Coverage					
	Urban +Rural(JMP Imp+Un improved)	Urban +Rural(JMP Imp+Un improved)	Urban +Rural(JMP Imp+Un improved)	Urban +Rural(JMP Imp+Un improved)					
Afar	8.12%	9.31%	9.75%	11.66%	9,617	160	100.00%	266,601	4,443
Amhara	36.00%	41.29%	45.16%	52.24%	493,715	8,229	100.00%	2,144,480	35,741
Benishangul Gumuz	46.99%	53.91%	56.43%	65.28%	27,259	454	100.00%	77,651	1,294
Dire Dawa	60.00%	68.82%	72.05%	83.35%	6,034	101	100.00%	10,497	175
Gambella	33.28%	38.18%	39.96%	46.23%	9,479	158	100.00%	43,446	724
Harari	60.00%	68.82%	72.05%	83.35%	4,707	78	100.00%	8,144	136
Oromia	38.00%	47.66%	47.63%	54.00%	758,831	12,647	100.00%	3,509,742	58,496
SNNP	38.87%	44.59%	47.07%	56.95%	620,982	10,350	100.00%	2,081,671	34,695
Somali	13.24%	15.19%	15.90%	18.40%	47,211	787	100.00%	812,361	13,539
Tigray	28.06%	32.19%	33.70%	38.98%	89,093	1,485	100.00%	605,294	10,088
Addis Ababa	70.00%	80.30%	85.00%	94.50%	160,639	2,677	100.00%	197,643	3,294
National	38.22%	43.56%	45.33%	52.44%	2,227,567	37,126.00	100.00%	9,757,529	162,625

Source: prepared based on figure 3 and SAP assumptions

If reference is made to JMP improved sanitation coverage as a baseline data assuming 84% target is to be achieved as per HSDP IV over 191,696 latrines should be constructed every month as shown below.

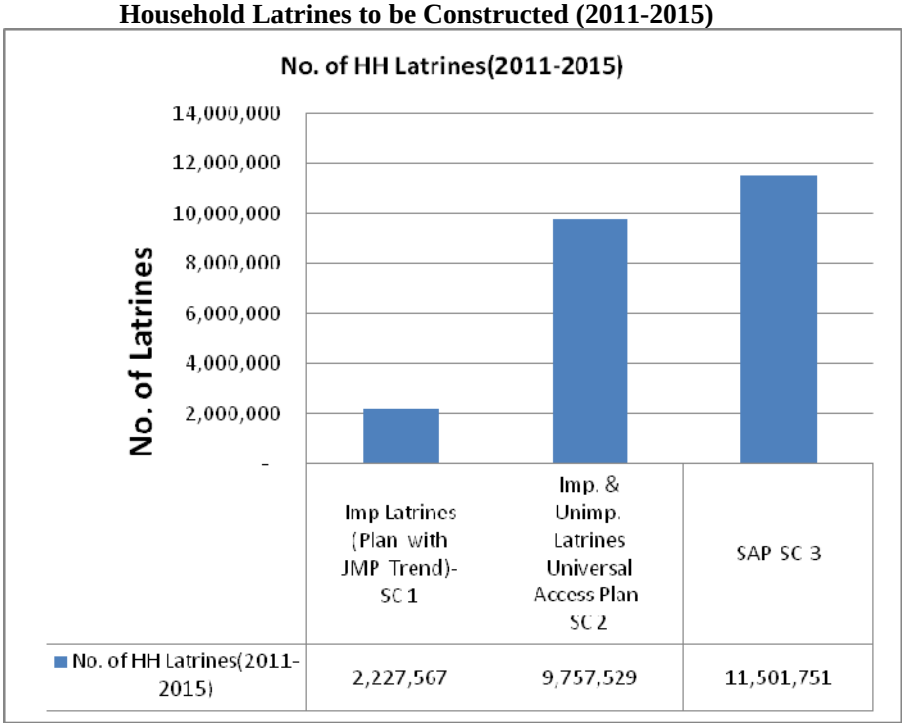
Table 13. Summary of existing improved latrine coverage and total number of Latrines required by Region (Scenario 3)

Region	2010		2015			No. of Latrines by basing on JMP improved latrines	No. of Latrines to be constructed Monthly
		Population	Coverage	SAP Sanitation Target	Population		
		Urban+Rural	Urban +Rural(JMP Imp+Un improved)		Urban+Rural		
Afar	2.76%	1,304,566.00	11.66%	84%	1,454,523.00	237,168	3,953
Amhara	12.22%	15,885,197.00	52.24%	84%	17,282,134.00	2,515,169	41,919
Benishangul Gumuz	15.95%	626,004.00	65.28%	84%	725,710.00	101,947	1,699
Dire Dawa	20.37%	118,429.00	83.35%	84%	133,991.00	17,687	295
Gambella	11.30%	258,380.00	46.23%	84%	315,874.00	47,229	787
Harari	20.37%	90,749.00	83.35%	84%	103,176.00	13,637	227
Oromia	14.10%	25,918,623.00	54.00%	84%	29,901,212.00	4,292,337	71,539
SNNP	13.19%	14,705,426.00	56.95%	84%	16,965,024.00	2,462,076	41,035
Somali	4.50%	4,123,546.00	18.40%	84%	4,688,216.00	750,547	12,509
Tigray	9.53%	3,738,677.00	38.98%	84%	4,229,970.00	639,407	10,657
Addis Ababa	23.76%	2,958,840.00	94.50%	84%	3,364,018.00	424,546	7,076
National	12.89%	69,728,437.00	52.44%	84%	79,163,848.00	11,501,751	191,696

Source: prepared based on figure 3 and SAP assumptions

Though the number of latrines to be constructed under scenario 3 is the highest as shown in the above tables and figure below, it is highly recommended to go for the scenario to meet JMP standards and go beyond the MDGs .

Figure 4: Comparison of the Three Scenarios (Sc 1, Sc 2 & Sc 3) with Respect to the Number of Household Latrines to be Constructed (2011-2015)



Source: prepared based on figure 3 and SAP assumptions

7.2 PARAMETERS USED

7.2.1 Population

Population and housing data of CSA 2007 projects an annual growth rate of 3.1% for the years 2011 to 2015.

7.2.2 Woredas

The number of Woredas in each region has been taken from the 2007 CSA report by comparison with the then regional data sources. Any official change by CSA will be considered in the course of implementation.

7.2.3 Towns

Towns with a population size greater than 10,000 in the year 2007 (according to the CSA report) are considered as urban towns and the urban population figures given in CSA are all assumed to reside in these towns. The other towns are considered as rural towns and are planned accordingly.

7.2.4 Kebele – estimating size

The population size in each Kebele is assumed (according to national consensus) to be approximately 5,000 people.

7.2.5 Regional, Zonal, Woreda Data Used

The table below gives a full breakdown of regions, zones, Woredas, towns with details of urban and rural populations extrapolated from 2007 CSA data.

Table 14. Population, Housing - Town And Woreda Data Used In The Planning Process

Region	No of Zones	Source (for Woreda)	Total # of Woredas	# of rural Woredas	# of Towns above 10,000	2007 Census (CSA)			Projected 2011 Population		
						Population (Total)	Urban Population	Rural Population	Population (Total)	Urban Population	Rural Population
Afar	5	Region	32	30	4	1,390,273	185,135	1,205,138	1,570,850	209,181	1,361,669
Amhara	12	Region	166	153	45	17,221,976	2,112,595	15,109,381	19,458,871	2,386,992	17,071,879
Benishangul Gumuz	3	CSA	21	20	1	784,345	105,926	678,419	886,221	119,684	766,536
Dire Dawa	1	CSA		4	5	341,834	233,224	108,610	386,233	263,517	122,717
Gambella	3	CSA	13	12	1	307,096	77,925	229,171	346,983	88,046	258,937
Harari	1	CSA	9	4	5	183,415	99,368	84,047	207,238	112,275	94,964
Oromia	19	Region	303	265	73	26,993,933	3,317,460	23,676,473	30,500,069	3,748,352	26,751,717
SNNP	14 Zones and 8 SW	CSA	140	125	29	14,929,548	1,495,557	13,433,991	16,868,689	1,689,809	15,178,880
Somali	9	CSA	53	42	13	4,445,219	623,004	3,822,215	5,022,591	703,924	4,318,668
Tigray	6	CSA	47	34	18	4,316,988	844,040	3,472,948	4,877,705	953,669	3,924,036
Addis Ababa	1	CSA	10		10	2,739,551	2,739,551		3,095,381	3,095,381	

7.3 COST OF IMPLEMENTING THE STRATEGIC ACTION PLAN

7.3.1 The Total Projected Cost

Based on the list of activities and tasks, costing tables have been developed for the federal, regional, Woreda, town and Kebele levels which provide cumulative totals based to some extent on parameters developed for the Universal Access Plan which has assured alignment with the GTP. Accordingly, ***an overall gross amount of USD*** **414,184,737.53** is ***required for SAP implementation as indicated in table below.*** The regional costing tables (spread sheets) and summaries are available as ***Annexe 1.1 - 1.7*** in the enclosed CD for further reference.

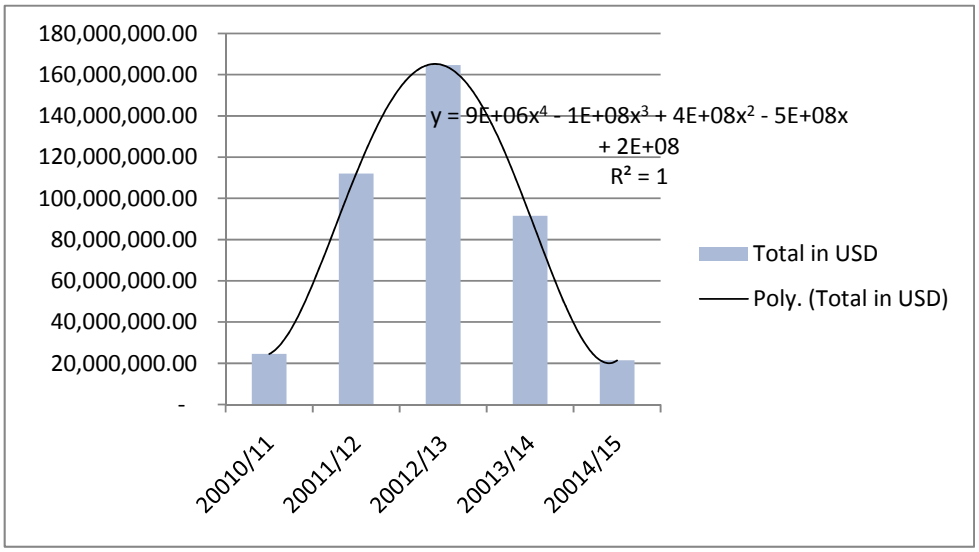
Table 15. Projected Total Investment Required to Meet National Hygiene and Sanitation Targets by Region

	H&S Budget Requirement (USD)					
	Year					Total
	20010/11	20011/12	20012/13	20013/14	20014/15	
Federal	645,880.00	190,809.20	107,467.54	108,542.21	109,627.63	1,162,326.58
Afar	771,685.00	4,248,603.64	4,065,497.98	1,244,382.09	753,303.65	11,083,472.36
Amhara	5,240,222.50	27,633,432.57	42,648,840.86	23,133,303.02	3,983,555.25	102,639,354.20
Benishangul Gumuz	549,207.50	2,846,198.83	3,894,825.90	1,731,752.50	1,638,394.50	10,660,379.22
Dire Dawa	271,968.00	818,713.19	1,116,173.89	471,639.65	387,519.79	3,066,014.52
Gambella	346,667.50	2,097,410.48	2,429,171.45	873,110.81	468,274.41	6,214,634.65
Harari	513,733.00	606,750.18	836,715.92	424,825.87	366,742.57	2,748,767.53
Oromia	8,545,920.50	39,352,494.91	57,529,360.89	31,675,690.24	6,166,186.47	143,269,653.01
SNNP	4,516,242.10	18,457,421.83	25,615,244.25	14,631,045.30	3,441,997.35	66,661,950.82
Somali	1,797,170.80	7,053,011.59	12,046,202.42	7,721,309.55	1,563,006.27	30,180,700.63
Tigray	1,353,242.90	8,758,307.23	14,310,972.29	9,552,778.75	2,522,182.82	36,497,484.00
Total in USD	**24,551,939.80**	**112,063,153.66**	**164,600,473.38**	**91,568,379.98**	**21,400,790.71**	**414,184,737.53**

Source: Strategic Sanitation Action Plan – Financial Analysis

The distribution of the financial requirement through the five planning years displays an inverted parabola with a peak at the middle of the planning period and dips at the initial and end of the planning period as indicated below. Such a distribution could be understood to be realistic and is in conformity with trends of implementation that are usually low during the running in and running out period..

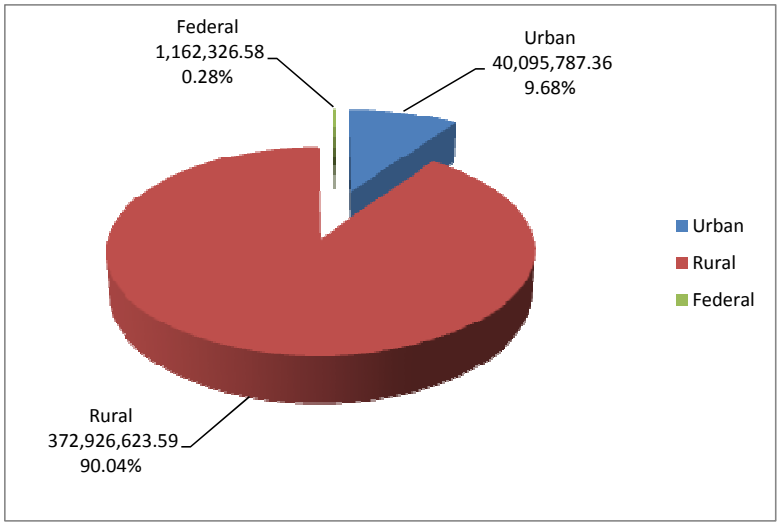
Figure 5: Distribution of the Overall Financial needs Through the Planning Period



Source: Strategic Sanitation Action Plan – Financial Analysis

At a country level 89.88 % of the projected total overall investment requirement will be 90.04% for rural areas while 9.68 % and 0.28 % are expected to be utilized for peri urban areas and federal level respectively as shown in figure below. Urban areas will be addressed in the Urban SAP to be prepared by the ministry of urban and construction.

Figure 6: Overall Financial Requirement proportion by setting

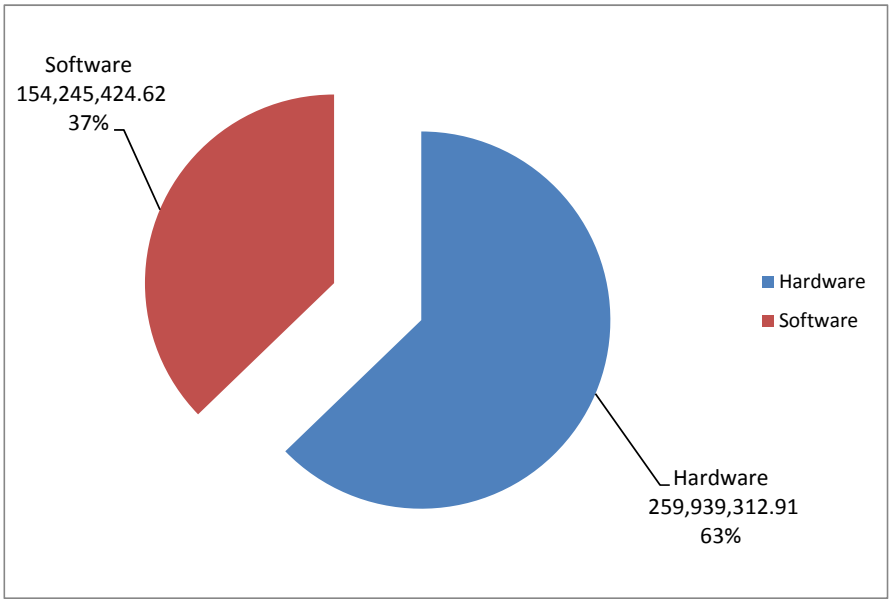


Source: Strategic Sanitation Action Plan – Financial Analysis

Grouping the overall financial needs in two distinct categories, the proportion of SAP activities would be 37% for software and 63% for hardware as shown in figure below. The ratio of software becomes 41% when community labour and material contribution of 15% is taken out from the overall hardware expenses. If the

comparison of software and hardware expenses is limited to the FMoH portion the ratio becomes 61%(software) to 39% (hardware).

Figure 7: Overall SAP Estimated Financial Needs Hardware and Software Proportion in USD

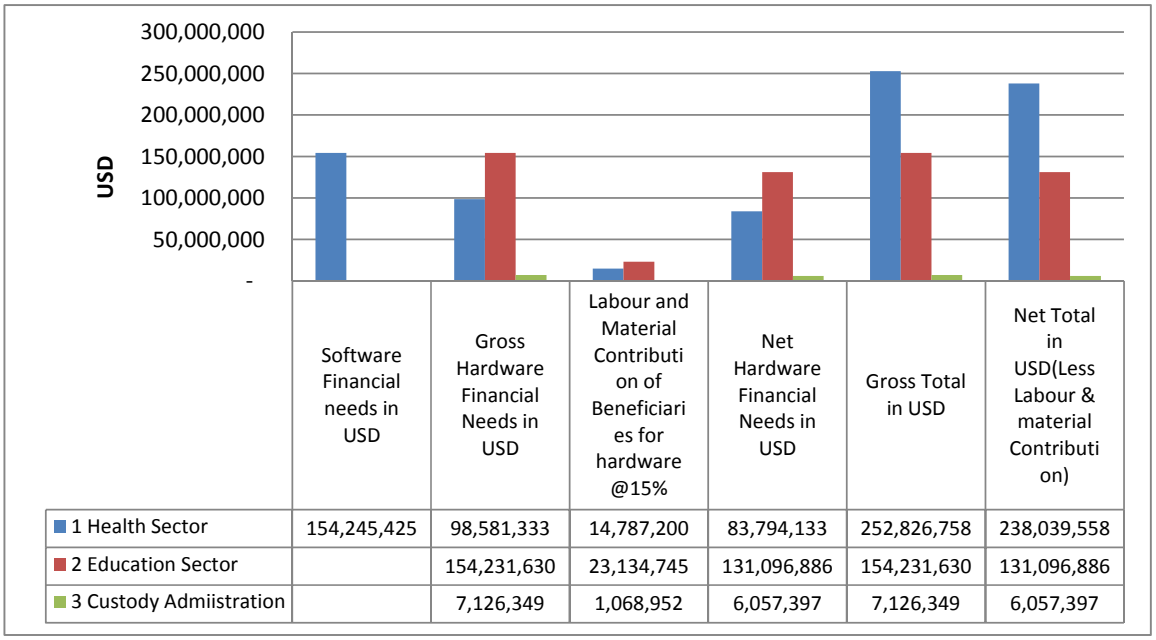


Source: Strategic Sanitation Action Plan – Financial Analysis

Considering **the** estimated 38,990,897 USD labour and materials contribution of beneficiaries, the overall cash required for hardware could be reduced to USD 220,948,416

The breakdown of the sectoral financial needs and contribution of beneficiaries is depicted in the bar chart shown below for showing the sectoral shares in the implementation of the SAP.

Figure 8: Financial SAP Needs by Sector including Contribution of Beneficiaries



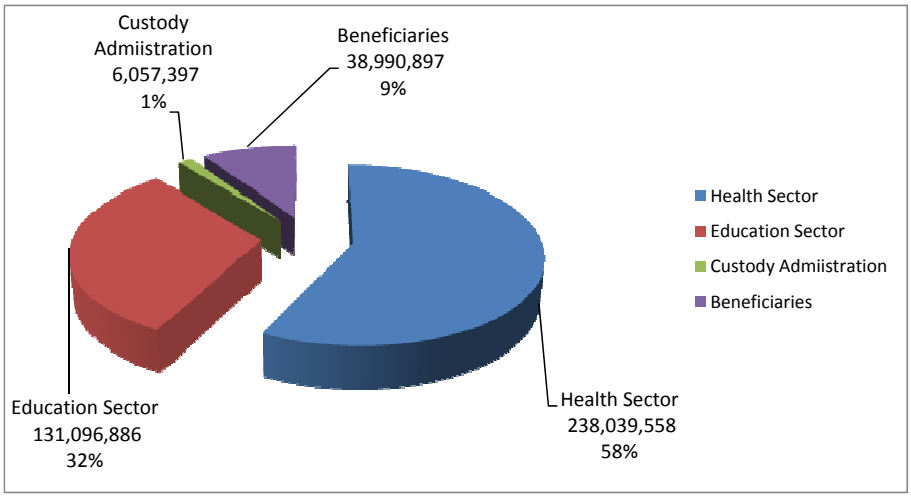
	Software Financial needs in USD	Gross Hardware Financial Needs in USD	Labour and Material Contribution of Beneficiaries for hardware @15%	Net Hardware Financial Needs in USD	Gross Total in USD	Net Total in USD(Less Labour & material Contribution)
1 Health Sector	154,245,425	98,581,333	14,787,200	83,794,133	252,826,758	238,039,558
2 Education Sector		154,231,630	23,134,745	131,096,886	154,231,630	131,096,886
3 Custody Admiistration		7,126,349	1,068,952	6,057,397	7,126,349	6,057,397

Source: Strategic Sanitation Action Plan – Financial Analysis

Accordingly, FMoH, FMoE and custody administration need to generate USD 238,039,558, USD 131,096,886 and USD 6,057,397 respectively. Furthermore, Beneficiaries are expected to contribute about USD 38,990,897 in the form of labour and local materials.

In summary, the overall percentage contribution of the custody administration, beneficiaries, education and health, sectors will be 1%, 9%, 32% and 58% respectively as presented in figure below.

Figure 9: Sectoral Share in USD including Labour and Material Contribution of Beneficiaries



Source: Strategic Sanitation Action Plan – Financial Analysis

7.3.2 The projected investment for the enabling environment and demand creation pillars(Software)

(37%)[55]of the projected investment will be for the enabling environment and demand creation considering overall financial needs that include contribution of labour and materials by beneficiaries. The summary of projected investment for the enabling environment and demand creation **(software)** considering overall financial needs that includes contribution of labour and materials by beneficiaries is indicated below.

Table 16. Projected Total Investment for The Enabling Environment and Demand Creation Pillars(Software) by Region

	H&S Budget Requirement (USD)					
	Year					**Total**
	20010/11	**20011/12**	**20012/13**	**20013/14**	**20014/15**	
Federal	645,880.00	190,809.20	107,467.54	108,542.21	109,627.63	1,162,326.58
Afar	749,810.00	1,398,136.34	1,146,078.17	1,080,589.99	753,303.65	5,127,918.15
Amhara	5,134,622.50	8,914,756.34	7,230,958.27	7,241,573.81	3,983,555.25	32,505,466.18
Benishangul Gumuz	519,832.50	948,912.70	1,404,160.45	1,367,360.79	1,179,097.90	5,419,364.35
Dire Dawa	265,368.00	506,193.16	454,890.18	437,073.05	387,519.79	2,051,044.17
Gambella	329,167.50	640,549.60	571,422.81	524,077.03	453,966.10	2,519,183.04
Harari	507,133.00	460,478.36	416,952.58	402,725.91	366,742.57	2,154,032.41
Oromia	8,128,470.50	14,111,757.96	11,220,180.97	11,379,830.33	6,166,186.47	51,006,426.23
SNNPRS	4,351,242.10	7,257,623.23	5,842,845.09	6,296,591.75	3,441,997.35	27,190,299.53
Somali	1,752,970.80	2,964,838.82	2,463,984.96	2,533,754.51	1,517,011.57	11,232,560.65
Tigray	1,256,355.40	3,689,681.20	3,069,031.47	3,339,552.44	2,522,182.82	13,876,803.34
Total in USD	**23,640,852.30**	**41,083,736.91**	**33,927,972.48**	**34,711,671.82**	**20,881,191.11**	**154,245,424.62**

Source: Strategic Sanitation Action Plan – Financial Analysis

[55] The percentage increases to 41% when only overall cash requirement is considered. On the other hand if only the FMoH portion is considered, the ratio increases to 61% as indicated in section 7.3.1.

7.3.3 The bulk of the investment for institutional latrines – schools, health centres, D and Sanitation Marketing (Hardware)

The overall 63% of the investment will be for the supply of hardware in the form of hygiene and sanitation facilities at schools, health posts, health centres, prisons, public toilets, sanitation marketing(SM), transport and water testing kits. The summary of the financial requirement for hardware portion by region is given below.

Table 17. Projected Total Investment for Institutional Latrines – Schools, Health Centers, Detention Centers and Sanitation Marketing(Hardware)

	H&S Budget Requirement (USD)					
	Year					**Total**
	20010/11	**20011/12**	**20012/13**	**20013/14**	**20014/15**	
Federal	-	-	-	-	-	-
Afar	21,875.00	2,850,467.30	2,919,419.81	163,792.10	-	5,955,554.20
Amhara	105,600.00	18,718,676.23	35,417,882.59	15,891,729.20	-	70,133,888.02
Benishangul Gumuz	29,375.00	1,897,286.12	2,490,665.45	364,391.71	459,296.59	5,241,014.88
Dire Dawa	6,600.00	312,520.04	661,283.71	34,566.60	-	1,014,970.34
Gambella	17,500.00	1,456,860.88	1,857,748.64	349,033.78	14,308.31	3,695,451.61
Harari	6,600.00	146,271.82	419,763.34	22,099.96	-	594,735.12
Oromia	417,450.00	25,240,736.96	46,309,179.92	20,295,859.91	-	92,263,226.79
SNNP	165,000.00	11,199,798.59	19,772,399.16	8,334,453.54	-	39,471,651.29
Somali	44,200.00	4,088,172.78	9,582,217.47	5,187,555.04	45,994.70	18,948,139.98
Tigray	96,887.50	5,068,626.03	11,241,940.82	6,213,226.31	-	22,620,680.66
Total in USD	**911,087.50**	**70,979,416.75**	**130,672,500.90**	**56,856,708.15**	**519,599.60**	**259,939,312.91**

Source: Strategic Sanitation Action Plan – Financial Analysis

The number of institutional facilities to be constructed (determined based on CSA 2007 data given in Annex 2.1 in the enclosed CD) during the planning period is indicated below.

- ✓ ***Consideration is made for prisons, schools and health posts/centers only. It is assumed that other institutions will benefit from CLTSH triggering and post triggering and construct/rehabilitate their own facilities.***
- ✓ ***Furthermore, the SAN MART to be piloted in two selected localities within all Woredas of the country is also expected to help not only communities but institutions in improving the qualities of their sanitation and hygiene facilities***

Table 18. Planned Number of Institutional Facilities to be Constructed and Rehabilitated

CODE	HEADING	Unit	Quantity				
			2011	2012	2013	2014	2015
C.1	**Schools**						
C.1.1	Construction cost of new latrines & hand washing facilities -Schools	No	-	1,738	3,223	1,591	-
C.1.2	Rehabilitation cost of latrines & hand wasting facilities to improve the existing situations of hygiene and sanitation in school	No	-	3,877	7,469	3,599	-
C.2	**Health Facilities**						
C.2.1	Construction cost of new latrines and hand washing facilities for health posts	No	-	2,011	3,778	1,768	-
C.2.2	Rehabilitation cost of latrines & hand wasting facilities to improve the existing situations of hygiene and sanitation in health posts	No	321	2,215	3,857	2,023	29
C.3	**Prison Facilities**						
C.3.1	Construction cost of new latrines and hand washing facilities for prision	No	-	144	179	20	5
C.3.2	Rehabilitation cost of latrines & hand wasting facilities to improve the existing situations of hygiene and sanitation in prision	No	85	83	73	94	10
C.4	**Urban Public/Communal Facilities**						
C.4.1	Construct new latrines & hand washing facilities for public latrine	No	-	-	96	-	-
C.4.2	Rehabilitation of existing latrines and handwashing facilities per public latrine	No	-	-	-	95	-
C.4.3	Construct new latrines & hand washing facilities for communal latrine	No	-	-	408	-	-
C.4.4	Rehabilitation of existing latrines and handwashing facilities per communal latrine	No	-	-	755	566	-
C.5	**Sani-Mart Franchise**						
C.5.1	Payment and establishment cost of material and labour for Sani-mart franchises built on viable business model - existing business expansion, school sanitation enterprise centres, CRS arborloo business model?	No	-	296	350	36	10
C.5.3	Sanitary supply streams with incentives	No	-	296	350	46	-

N:B New latrines construction is limited to existing schools, health posts , health centers that are considered not to have basic sanitation facilities based on recent reports;

Source: Strategic Sanitation Action Plan – Financial Analysis

The summary of corresponding financial requirement by facility types is shown in table below.

Table 19. Summary of Institutional Facilities Financial Requirement

CODE	HEADING	Subtotal					Total (USD)
		2011	2012	2013	2014	2015	
C.1	**Schools**						
C.1.1	Construction cost of new latrines & hand washing facilities -Schools	-	31,773,574	59,260,432	29,402,531	-	120,436,537
C.1.2	Rehabilitation cost of latrines & hand wasting facilities to improve the existing situations of hygiene and sanitation in school		8,712,109	16,892,040	8,190,944	-	33,795,093
C.2	**Health Facilities**						
C.2.1	Construction cost of new latrines and hand washing facilities for health posts	-	15,791,769	29,620,315	13,776,024	-	59,188,109
C.2.2	Rehabilitation cost of latrines & hand wasting facilities to improve the existing situations of hygiene and sanitation in health posts	721,063	2,876,417	4,685,625	2,745,829	76,667	11,105,601
C.3	**Prison Facilities**						
C.3.1	Construction cost of new latrines and hand washing facilities for prision	-	2,565,034	3,275,200	393,657	103,540	6,337,432
C.3.2	Rehabilitation cost of latrines & hand wasting facilities to improve the existing situations of hygiene and sanitation in prision	190,025	187,481	164,874	219,325	27,212	788,917
C.4	**Urban Public/Communal Facilities**						
C.4.1	Construct new latrines & hand washing facilities for public latrine	-	-	2,114,650	-	-	2,114,650
C.4.2	Rehabilitation of existing latrines and handwashing facilities per public latrine	-	-	-	334,899	-	334,899
C.4.3	Construct new latrines & hand washing facilities for communal latrine	-	-	2,946,781	-	-	2,946,781
C.4.4	Rehabilitation of existing latrines and handwashing facilities per communal latrine	-	-	874,226	661,814	-	1,536,040
C.5	**Sani-Mart Franchise**						
C.5.1	Payment and establishment cost of material and labour for Sani-mart franchises built on viable business model - existing business expansion, school sanitation enterprise centres, CRS arborloo business model?	-	8,953,650	10,695,749	1,112,725	312,181	21,074,305
C.5.3	Sanitary supply streams with incentives	-	119,382	142,610	18,958	-	280,950
	Total						259,939,312.91

Source: Strategic Sanitation Action Plan – Financial Analysis

7.3.4 Individual household investment is NOT included

Households will invest in their own toilet, hand washing facility and essential components of the safe drinking water chain and these costs are **NOT** included in the financial analysis. The actual software investment can be adapted to the reality of available funding at Woreda and Kebele level- what is referred to in the strategic action plan - as the minimum acceptable and affordable hygiene and sanitation package.

7.3.5 Assumptions made will be verified and upgraded

In the absence of hard data concerning different levels of Kebele toilet access and hygiene practice, a number of assumptions have been made to inform the financial analysis. As the planned dialogue to improve the overall strategic plan and the financial analysis takes place, it is anticipated that assumptions will be verified, upgraded and where appropriate replaced for example as more rigorous data emerges such as information deriving from the National WASH Inventory.

7.4 ASSUMPTIONS INFORMING ALLOCATIONS

7.4.1 Kebele Allocations

The level of the hygiene and sanitation activities which will be carried out in every region at Kebele level will vary depending on ODF status, the demand for improved sanitation technologies and the capacity of the Kebele to address its own hygiene and sanitation priorities. However it is recognised that Kebeles will require some level of support and provision is therefore made for a consistent Kebele allocation across regions.

7.4.2 Regional variations

Allocations to regions will vary according to the regional variance in terms of economic development, availability of human resources, and distance from Addis which are recognised factors already applied for the UAP. Further adjustments are made by applying the regional 'cost factors as detailed in the table below. The regional cost factor adjusts each unit cost accordingly.

7.4.3 Calculating the number of Kebeles

In reality, the number of Kebeles varies significantly in each Woreda. For the purposes of this strategic action planning process, the average number of Kebeles in each Woreda is calculated by dividing the total number of Kebeles in every region by the number of Woredas. The total number of Kebeles in each region is first calculated by dividing the total regional population by 5,000, which is the assumed size of a Kebele.

7.4.4 Unit Cost factors

Unit costs for activities at Woreda and town level vary depending on the respective average size of Kebele. Similarly activities carried out at Woreda level and town level are the same but work at regional level will vary according to the number of Woredas within the region.

Table 20. Kebeles per Town and Woreda Plus Regional Cost Factors

Region	Average No of Urban Kebeles per town	Average No. of rural Kebeles per Woreda	Cost factor
Afar	10	9	1.25
Amhara	11	22	1.1
Benishangul Gumuz	24	8	1.25
Dire Dawa	11	6	1.1
Gambella	18	4	1.25
Harari	4	5	1.1
Oromia	10	20	1.1
SNNP	12	24	1.1
Somali	11	21	1.3
Tigray	11	22	1.15
Addis Ababa	62		1

7.5 VARIATIONS

7.5.1 Allocation according to level of WASH support

Not all people, communities or Kebeles are currently at the same level of hygiene and sanitation awareness or improvement. To this effect the strategic action plan allocates resources in consideration of those areas which have already benefited from WASH interventions in terms of technical assistance and funding.

7.5.2 Refresher Training

In Woredas where UNICEF has been financing CLTSH through its current programme some facilitation and supervision skills have already been developed at Woreda and Kebele level. Those Woredas with a degree of CLTSH familiarity will receive funding for refresher training.

7.5.3 Focus on Woredas with limited CLTSH exposure

Full blown CLTS and SLTS ToT practical training will be provided to all the other Woredas in each region. Similarly in all Woredas which have been supported by the national WASH programme, office equipment has already been provided so the office equipment provision is for unsupported Woredas only. The table below identifies the number of Woredas already receiving some assistance from development partners supporting the national WASH programme.

Table 21. WASH Supported Woredas

Regions	WASH Woredas				
	UNICEF - EU	WB/DFID	ADB	Finn	Total
Afar	4	6	5		**15**
Amhara	19	30	29	14	**94**
Benishangul	2	6	2	6	**16**

Regions	WASH Woredas				
	UNICEF - EU	WB/DFID	ADB	Finn	Total
Gumuz					
Dire Dawa	1				**1**
Gambella	2	3	2		**7**
Harari	1	2	4		**4**
Oromia	25	84	41		**152**
SNNP	13	41	24		**80**
Somali	6	18	9		**33**
Tigray	5	18	9		**34**
Total	**78**	**208**	**125**	**20**	**439**

7.5.4 The Cost Factor

A unit cost for each activity is estimated using the current rate as shown in the table below and the difference in cost from region to region is also considered by multiplying each unit cost by the government agreed cost factor (applied for the Universal Access Plan) which is shown in the table below. In order to overcome inflation US$ are used for cost calculation and an annual inflation rate of 1% is also assumed.