Draft

National Protocol for Hygiene and "On-Site" Sanitation

To enable
100%
adoption of improved hygiene and improved 'on-site' sanitation in Ethiopia

SAFELY MANAGE FAECES

Your health is in YOUR hands

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APPLY SAFE WATER CHAIN FROM A SAFE SOURCE TO YOUR MOUTH

WASH HANDS WITH SOAP OR A SUBSTITUTE AND WATER AFTER DEFECATION

December 7th 2005

Contents

Acronyms

BIOGAS	-	Methane gas produced from decomposing organic matter
CAP	-	Cascading Advocacy Package
CBO	-	Community Based organisation
CFT	-	Community Facilitating Team
CRP	-	Community Resource Person (formerly Community Health Promoter = voluntary worker)
Gott	-	Hamlet (closest level of local government to the community)
ECOSAN	-	Ecological Sanitation – the full cycle of using diverted urine as fertiliser and composted human faeces as soil conditioner
EHD	-	Environmental Health Division
EPI	-	Expanded Programme of Immunisation
ET.CAL.	-	Ethiopian Calendar
FBO	-	Faith Based Organisation
FINIDA	-	Finish International Development Agency
HEW	-	Health Extension Worker
IHS	-	Improved Hygiene and Sanitation
LC	-	Local Consultant
MIS	-	Management Information System
MoE	-	Ministry of Education
MoGender	-	Ministry of Gender
MoH	-	Ministry of Health
MoRD	-	Ministry of Rural Development
MoU	-	Memorandum of Understanding
MoV	-	Means of Verification
MoWR	-	Ministry of Water Resources
NGO	-	Non-Government Organisation
PBTKs	-	Picture Based Tool Kits (usually PHAST)
PHAST	-	Participatory Hygiene and Sanitation Transformation
Selam	-	Vocational Training Centre (demonstrating technologies)
SmoF	-	Safe Management of Faeces
SNNPRS	-	Southern Nations & Nationalities Peoples' Regional State
ToT	-	Trainer of Trainer
WASH	-	Water Supply, Sanitation and Hygiene (usually campaign)
WASHCO	-	Water, Sanitation and Hygiene Committee
WCDO	-	Women and Child Development Organisation
WSG	-	Woreda Support group

Glossary of Terms

For the purposes of this document any reference to sanitation is deemed to refer to 'on-site sanitation' and primarily the containment of human faeces. The term Improved Hygiene and Sanitation (IHS) refers to 'on-site sanitation' as referred to in the strategy.

0. INTRODUCTION

0.1. The context

This protocol is designed to follow the national strategy[1] for hygiene and sanitation improvement with its focus on 100% hygienic and sanitised households in primarily rural or peri-urban environments. It is centred on the Health Services Extension Programme (within the latest Health Sector Development Programme) with its strong focus on high impact, broad reach, public health interventions. The Health Extension Workers[2] will be the primary point of community contact and the woreda health desk will apply this protocol in all aspects of its Hygiene and Sanitation promotion and will ensure that all development partners and NGOs adhere to the protocol when promoting improved hygiene and 'on-site' sanitation in the woreda.

0.2. The Objective

The primary objective of the Protocol is to improve implementation of the National Strategy for Hygiene and 'on-site' Sanitation improvement at Local Authority Level. The protocol will:

- ✓ Give a clear set of guidelines for all stakeholders promoting Improved Hygiene and Sanitation (IHS) leading to better co-ordination and clearer lines of responsibility at the national, regional and woreda levels.
- ✓ Strengthen the integration of all programmes with an IHS 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 IHS 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

0.3. What is it for?

It is primarily concerned with the safe 'on-site' containment and management of human faeces in the domestic, institutional and public context. It does not cover larger scale drainage, sewerage or solid waste management issues. The national protocol for hygiene and 'on-site' sanitation aims to draw stakeholders into working together within a framework of cost-effective 'best' practice. It builds on the national 'memorandum of understanding' which has been developed by the ministries of health, water and education to present a co-ordinated inter-sectoral approach to realise improved hygiene and sanitation in Ethiopia.

0.4. Who is it for?

It is designed for use by key government, non-government and private sector stakeholders engaged in implementing HS improvements at woreda level in line with prevailing institutional arrangements and guidelines. The protocol is not a replacement for existing strategies or guidelines but is a simple 8 step guide to the improved hygiene and 'on-site' sanitation programme cycle. These steps are to be followed by all those engaged in promoting Hygiene and 'On-Site' Sanitation improvement in Ethiopia. Relevant existing guidelines or manuals are cross-referenced throughout the document and listed in the annex.

0.5. The focus

The protocol aims to support the achievement of minimum improved hygiene and 'on-site' sanitation standards in households, schools, health centres and public places. The focus is on the safe 'sealed' containment of human faeces, hand washing at critical times and preserving a safe drinking water chain from source to mouth.

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[1] National Hygiene and Sanitation Strategy (2005) MoH with WSP support

[2] MoH (2004) Health Extension Worker - Implementation Guidelines

The Protocol Outline

0.6. The 8 step protocol for hygiene and 'on-site' sanitation improvement

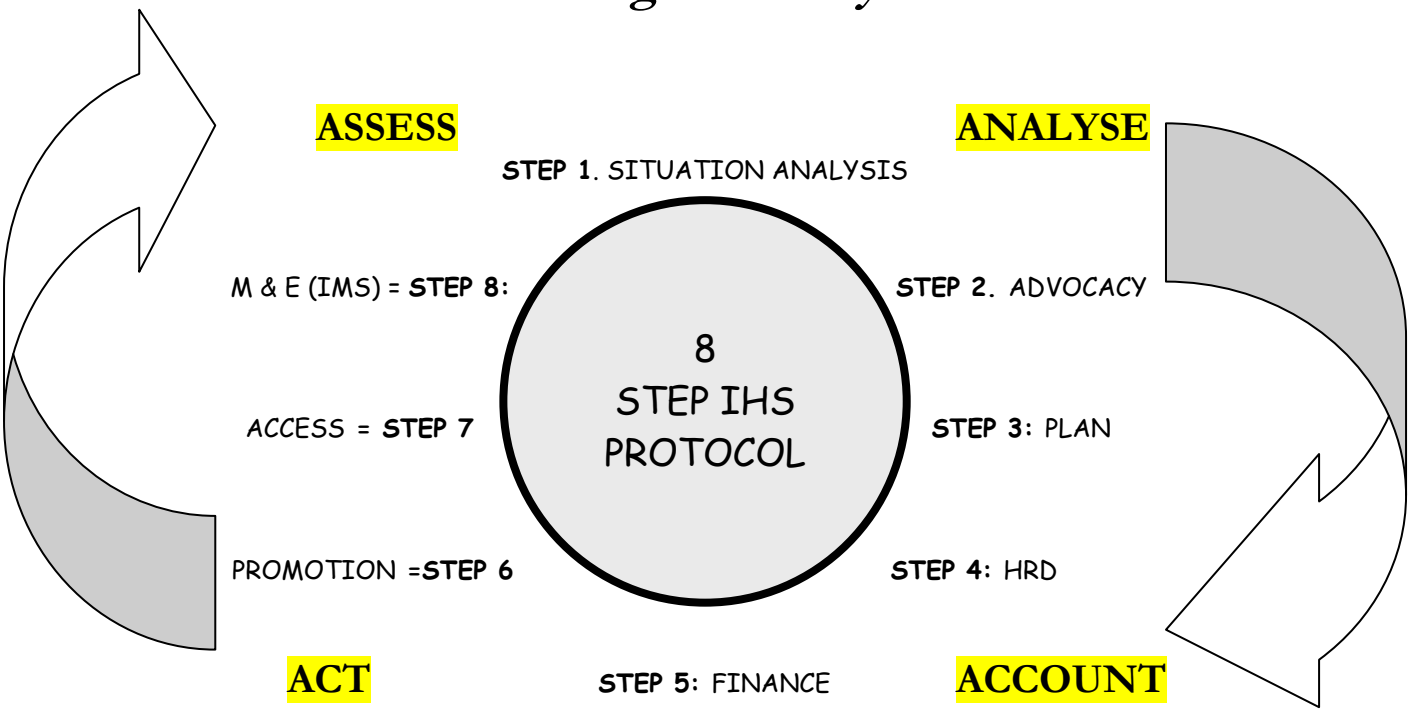
The protocol is a series of **8** steps which require action by stakeholders at national, regional, woreda, kebelle, gott and household level. The steps are backed up by guidelines which are referenced in section 9. The steps are built on the principle of a 'cascade' where information flows from household to gott, to kebelle, to woreda, to region and advocacy flows back from region to household who in turn cascade their plans and targets back to the region

Step 1: Situation Analysis
Step 2: Advocacy and Consensus building
Step 3: Inter-sectoral planning and budgeting
Step 4: Human resource development, supervision, reporting
Step 5: Financing Improved Hygiene and Sanitation (IHS)
Step 6: IHS communication, promotion and enforcement
Step 7: Access to hardware for latrines, HW and SDWC
Step 8: Monitoring and evaluation linked Info. Man.

0.7. The programme cycle

The steps follow the rational planning cycle which encourages stakeholders to join the steps together.

The Programme cycle



STEP 1

1. SITUATION ANALYSIS - BASELINE SURVEY

Step 1: Summary Actions

- ✓ Stakeholder Analysis
- ✓ Participatory Collection of data for planning and monitoring
- ✓ Preparation of cascading baseline data sets from gott to woreda
- ✓ Check Inclusion - Gender, pastoralists, special needs groups – AIDS patients

1.1. Stakeholder analysis

- ***The region/zone will*** give woreda staff support in identifying both current and potential IHS stakeholders including NGOs(CBOs), the private sector, interested councillors (particularly women) and religious based organisations.
- ***The woreda IHS team will*** conduct the stakeholder analysis and call stakeholders for a meeting to discuss their roles in facilitating IHS and agree roles and functions at different stages of the programme cycle.

Box 1. Stakeholder Table - Example

Stakeholders & Contact details	Current H&S Roles	Opportunities for Co-operation
Primary: (*high risk groups - vulnerable, the excluded – HIV AIDS*) • Women with Children <5 • Pastoralist women with children <5	• Total responsibility for family HIS & child survival	• Mothers' mutual support/savings groups funding HIS
Secondary: (*government, NGOs, CBOs – groups, associations, private sector*) • NGOs with IHS experience	• Discreet IHS projects	• Support to woreda for training, developing 'ignition' document
External: *(External support agencies – projects)* • Private Sector Soap Manufacturers/suppliers	• Mass bar soap sales	• Increased focus on behaviour change

1.2. Participatory collection of data for planning & monitoring

- ***The woreda will*** facilitate baseline data collection (with broad-based stakeholder support) at household, gott, kebelle and woreda level using simple participatory methods[3]. It will be collected with, owned by, and used by the community and the different facilitating teams (in partnership)
- The data will relate to the minimum standards and reflect current behaviours with desired replacement behaviours. The data will cascade up from household to woreda

Box 2. Cascading Baseline with targets– Situation Analysis (Example)

Gott: ……..Kebelle:……Woreda……..Date…….			
Minimum Standard	**Now**	**Planned**	**Activities**
• Safe excreta management	• %	• %	• HEW/CRP house to house promotion and guidance to toilet construction
• 4 x hand washing practice	• %	• %	• Behaviour trials

[3] PHAST (Participatory Hygiene and Sanitation Transformation) procedures can be used to collect both qualitative and quantitative information

Gott: ……..Kebelle:……Woreda……..Date…….			
Minimum Standard	**Now**	**Planned**	**Activities**
• Safe water chain	• %	• %	• Procure plastic buckets with lids
• School IHS	• %	• %	• Increase stances, form health clubs
• Public Latrine IHS	• %	• %	• Privatise the management of all public latrines

- The data will be used to set household and community targets, agree strategies and monitor change in line with the Health Extension Worker packages at all levels[4].
- Baseline data collection and methods will feed into the wider planning, monitoring and evaluation process including the evolving Health Information Management[5].

Box 3. Information flow - responsibility

Activity	Gott/Household	Kebelle	Woreda
Collect baseline data on minimum ISH standard	Community Resources Persons ↔ Households	Health Extension Workers	↔ Environmental Health Workers Health desk

- Primary data collected with the community will be complemented/cross-checked by secondary sources such as school and health unit records.

- ***The kebelle (under woreda guidance)*** will recruit volunteer Community Resource Persons (CRP) on the basis of 1 volunteer to 50 households and will be trained by HEWs.
- ***Health Extension Workers (HEWS) will*** facilitate data collection by volunteer community resource persons.

1.3. Preparation of cascading baseline data sets from household to woreda

- ***The MoH with regional and woreda support will*** prepare guidelines for collecting, recording and 'cascading' information from household, via gott, to kebelle, to woreda.

Milestone 1.	Woreda situation analysis report containing cascading data sets from gott and kebelle describing current situation and possible targets

Table: Inclusion Checklist

Inclusion Checklist	Gender	Pastoralists	Special Needs (e.g. AIDS)
Affirmative Action			

[4] The WB supported programme has a 'household motivator' form which will be simplified and widely used by HEWs and CRPs.

[5] MoH (2005/6) - *Health Information Management System* (currently under development by MoH with support from John Snow International)

STEP 2

2. CASCADING ADVOCACY/CONSENSUS BUILDING

Step 2: Summary Actions

- ✓ Deliver CAP from region to gott/village – politicians and technocrats
- ✓ Build consensus and partnership that poor H & S is a key problems at all levels
- ✓ Develop human resources, skills and tools
- ✓ Encourage and increase accountability of stakeholders
- ✓ Check Inclusion - Gender, pastoralists, special needs groups – AIDS patients

2.1. Cascading advocacy

The region will:

- Prepare the cascading advocacy package (CAP). This could be based on the SNNPRS 'ignition' document[6] which offers an example of form and content.
- Facilitate the cascading advocacy package (CAP) to inform and persuade key stakeholders (politicians and civil servants) at all levels (including religious and traditional leaders) of the need for IHS action.
- Agree woreda targets (based on the baseline) to achieve the minimum IHS standards
- Agree performance related contracts for all key regional and zonal stakeholders[7].

The woreda will:

- facilitate the CAP at kebelle and gott level by training the Community Resource Persons and by providing necessary inputs for meetings

2.2. Building consensus & partnership

The primary purpose of the CAP is to achieve consensus among stakeholders that 'high impact', broad reach, preventive health interventions should be prioritised and that different stakeholders work in partnership at household, gott, kebelle and woreda levels.

→ ***The regional governments and woreda councils*** will commit a certain % of the respective grants for health, education and water to achieving stated targets.

→ ***The region will:*** draw up a set of 'minimum rules' for the desired roles of NGOs/CBOs/FBOs and local consultants (LC), in their partnership with Government.

→ ***The woreda and kebelle will*** ensure inclusion of all stakeholder groups in the CAP process

2.2.1. Accountability

Agree cascading 'results based' management system setting out performance related contracts for politicians and civil servants in line with national results based management system. Such systems are already in place in the regions.

2.2.2. Consensus around Minimum Package for interventions

Where funding is available, woreda desks are encouraged to contract the services of Woreda Support Groups (WSGs - local water, sanitation and hygiene consultants) or form partnerships with NGOs to facilitate woreda-level advocacy on the importance and benefits of an integrated multi-sectoral

[6] SNNPRS (2004) - 'Ignition' document explaining the HSDP and the case for high impact, braod reach public health interventions. It has been circulated to all regions for adaptation.

[7] SNNPRS (2004) - The format for the performance related contract (for regional adaptation)

approach to WASH. The focus of this advocacy will be the Woreda Council, Woreda staff, Kebelle Development Committee and community leaders.

The Woreda WASH Team, CFTs, WASHCOs, CRPs and Caretakers will lead by example by always using an improved traditional pit latrine (or better), washing hands with agent (soap, ash or sand) and water at the 4 critical times and keeping their own drinking water safe from collection to use.

Milestone 2.	Broad-based consensus and commitment to a basic IHS standard reflected in cascading **performance related contracts** from gott via kebelles to woreda.

Table: Inclusion Checklist

Inclusion Checklist	Gender	Pastoralists	Special Needs (e.g. AIDS)
Affirmative Action			

STEP 3

3. CASCADING PLANNING

Step 3: Summary Actions

- ✓ One Plan, one budget, one reporting and monitoring system
- ✓ Planning framework guide – regions to provide planning guidelines
- ✓ Capacity for IHS Co-ordination built at all levels
- ✓ Check Inclusion - Gender, pastoralists, special needs groups – AIDS patients

3.1. One Plan, one budget, one reporting and one monitoring system

- On the basis of the situation analysis report, ***woreda inter-sectoral WASH teams will*** prepare INTEGRATED Specific, Measurable, Achievable, Replicable, Time-bound (SMART) plans of action following the framework (below) which outline the primary and secondary objectives. These will be submitted to council and then the regions for approval.
- ***The regions will*** visit woredas to discuss, appraise and ratify plans.
  IHS plans cannot stand alone but must be integrated within the overall woreda strategic plan and be synchronised with health, water and education plans for synergy and economies of scale.

3.2. Planning Framework - Guide

The following table is an example of a logical planning framework – ***regions will*** provide guidelines for the planning framework.

Box 4. Planning Framework – Guide/example

Objectives	Indicator	Means of Verification	Assumptions
Primary Objective: To facilitate x% adoption of sustainable community H & S improvement by 200(?) through realisation of the National IHS Strategy	• > x % of target population practice safe water chain, safe excreta management & hand-washing at critical times • Effective local management, O&M and inter-tier monitoring system established	• Community monitoring against action plan • Quarterly/annual reporting • Supportive supervision	National consensus on strategy and protocol
Objective 1: X% community compliance with > minimum latrine, hand-washing and safe water chain minimum standards	• % of faeces free households, gotts, streets • % of households reporting hand-washing at critical times • Safe water chain observed in use in x% of gotts/villages	• Community monitoring by observation • Woreda H&S Team supervision • Random H'Hld checking	Consensus can be built on 'minimum standards'.
Activities	**Inputs/Costing**	**Process Indicator**	**MoV**
Objective 1: • School H&S • PHAST sessions • Picture based toolkits produced • Skills upgrading for promoters	• Facilitators and artist for Picture based Toolkits • Manuals • Behaviour trails • H & S bounty packs[8] or new mothers	• # of contact sessions • PHAST & PBTKs in use • Promotion reinforced by laminated posters • Households fitting taps to clay pots	Community monitoring House to house visits by HEWs

3.3. Capacity for IHS Co-ordination built at all levels

3.3.1. National WASH Co-ordination Guidelines

The MoU sets out a new inter-sectoral co-ordination structure for water, sanitation and hygiene (WASH) to be established at national, regional and woreda levels:

- → Steering Committee
- → Technical team
- → Co-ordination Unit

[8] Bounty packs include soap, towels, plastic containers (potties) for new mothers

The Donor Assistance Group will provide support to these bodies through the new stakeholder for a to be established at all levels. As well as donors, membership will include NGOs, civil society, the private sector and other interested stakeholders.

At the national level the multi-stakeholder WASH forum will advise the national WASH technical team and steering committee. A dedicated multi-stakeholder sub-forum for HS will provide specialist advice and guidance to respective sector ministries and have responsibility for:

- ✓ Advising WASH teams on IHS issues
- ✓ Mainstreaming IHS in government planning through advocacy (to lever finance for IHS)
- ✓ Ensuring consensus and updating the IHS strategy and protocol
- ✓ Developing a comprehensive (cascading) IHS communication and promotion guideline which is in line with the HSDP and ensures programme and project harmony
- ✓ Guidance to the WASH movement
- ✓ Disseminating examples of best practice (quarterly newsletter)
- ✓ Oversee the development and the implementation of a financing strategy for HS
- ✓ Advice on resource allocation
- ✓ Sub-sector performance monitoring

3.3.2. Regional

All regions will:

- ✓ develop their customised inter-sectoral MoU[9].
- ✓ have an inter-sectoral co-ordinating committee (in line with the Terms of reference of the National HIS forum) with the participation of government officials, NGOs, private sector and religious leaders. The committee will meet quarterly (with agreed quorum) to review regional IHS activities and progress against IHS plan. A quarterly report will be submitted to the national level. Woredas reporting difficulties will be visited and remedial action applied.

3.3.3. Woreda

All woredas will have an inter-sectoral co-ordinating committee with the participation of Government offcials, NGOs, private sector and religious leaders. The committee will meet quarterly (with agreed quorum) to review regional IHS activities and progress against IHS plan. A quarterly report will be submitted to the regional level.

3.3.4. Kebelle

The kebelle WASH committee (WASH Co) will plan, co-ordinate and monitor IHS activities in the kebelle with support from health extension workers or the Community Facilitation Team (CFT). Where there is no WASH Co this role will be carried out by ***the kebelle development or health committee***.

3.3.5. Gott

Gott leaders and CRPs with support from HEWs will co-ordinate activities at gott level.

Milestone 3.	Inter-sectoral woreda teams prepare Specific, Measurable, Appropriate, Realistic, Time bound IHS plans which are integrated, costed and reflect gott and kebelle IHS priorities. The woreda council approves the integrated woreda WASH plans and budget accordingly.

Table: Inclusion Checklist

Inclusion Checklist	Gender	Pastoralists	Special Needs (e.g. AIDS)
Affirmative Action			

[9] Regional MoUs have been developed and signed in Tigray and SNNPRS

STEP 4

4. HUMAN RESOURCE DEVELOPMENT

Step 4: Summary

- ✓ Identify human resource needs
- ✓ Identifying key staff at different levels
- ✓ Defining the training gaps
- ✓ NGOs to held build capacity
- ✓ Inclusion checklist

4.1. Identify human resource needs

4.1.1. New Skills

- The National IHS Strategy reflects a shift from traditional teaching approaches to the process of facilitating people's participation.
- ***Woreda EH workers, Health Extension Workers, community mobilisers and engineers from the MoWR plus school inspectors, teachers (MoE) and extension workers(MoRD) must*** share a common commitment to the task of fostering 'self-motivation for change'. This shift in approach requires new attitudes and competencies.
- ***The woreda will*** ensure appropriate training is provided with regular supportive supervision and refresher 'on-the-job' training where required.

4.1.2. National

The MoH will consider national training curricula needs as well as refresher training to focus on key skills needed for IHS promotion. These will include participatory, social marketing and communication skills to create more accountable, responsive officers and managers committed to teamwork, targets and supportive supervision. The key competencies in hygiene and sanitation promotion; planning, implementation, monitoring and evaluation, are needed ***at federal, regional and local levels for a range of governmental and non-governmental personnel***. They are currently being incorporated and harmonised into existing guidelines, curriculum and materials and articulated through programmes supported by UNICEF, World Bank and others. Part of the training will include an improved understanding of the public health proclamation and positive enforcement measures such as community service orders (obligatory days to work for the community – possibly on IHS activities).

4.1.3. Regional

The regions (with national guidance) will agree a minimum training package including refresher training drawing on tried and tested approaches developed by MoH/EHD, UNICEF/WaSH/WaterAid/etc. ***The region will*** make provision to achieve appropriate **(minimum)** staffing levels (**gender balanced**) with appropriate (H & S) skills and tools to achieve objectives.

4.1.4. Woreda

Under regional/zonal guidance[10] ***the woreda will*** certify all government and non-government staff who engage in promoting hygiene and sanitation in the woreda whether government selected volunteers or NGO staff. Certification will reflect a minimum level of training required fulfilling duties in each step (e.g. PHAST trainer of trainers or artisan trainees).

The woreda (with regional assistance, NGO assistance or contracted inputs from the WSG) will introduce (by using Trainers of Trainers{ToTs}) the necessary new skills and understanding to cover a range of technical options as well as creative promotion methods to encourage behaviour change (negotiating change, mobilisation, and motivation) particularly for HEWs and volunteers.

[10] The region will set standards and guidelines for certifying staff to engage in IHS services

4.1.5. Kebelle

The health extension workers will provide exemplary IHS leadership and will train and support Community Resource Persons to set a positive example and influence others to follow suit, through direct promotion and through modeling key behaviors.

4.1.6. Gott

The CRP will provide the key link to their 50 households and will require a minimum package of incentives (promotion, courses, bicycles) and sanctions (loss of benefits, fines, demotion)

4.1.7. Standardisation

All health promotion materials, tools and products, developed by government, NGOs or the Private Sector, will reflect national and regional guidelines and standards, leading to a "harmonization" of messaging and cleared by the MoH before use.

4.2. Identifying key staff at different levels

4.2.1. Systematic zoning of staff

The woreda will ensure that all staff are allocated a zonal focus and responsibility which will correspond with health unit catchment areas. In this way, HEWs will be supported by dedicated staff and ogether with CRPs form a strong team.

4.2.2. Key Staff

The woreda will identify key staff with key roles to play in promoting HS and take positive action to identify skills gaps and training needs, to build team work and identify viable incentives and rewards for high quality work.

Box 5. Key Staff at different levels (suggested)

Location	Staff Designation	Key Skills required
• Village/gott/ Sub-kebelle	• Community Resource Person (volunteer) • Model women, model farmers	• Understanding minimum IHS package – house to house promotion with basic kits
• Kebelle	• Health extension workers, • Kebelle chair, Local service providers	• PHAST methods, drama, CAP, teamwork
• Woreda	• Head of health, Environmental Health workers, Health unit (staff such as MCH nurses), water, education desks • NGOs, Woreda Support Groups	• Radio chat shows, ToT facilitation, CAP, planning, budgeting, co-ordination, Program management
• Zone	• Zonal bureaux	• Supportive supervision, monitoring and ToTs, strategic planning • Program management
• Region	• Regional Health Bureau Chief • Regional EH, Health Communication	• Inspired leadership, commitment to preventive health
• National	•	•

4.3. Defining the training gaps

4.3.1. Communication skills

- Sanitation and hygiene extension workers – health extension workers, community health volunteers, EH staff, health clinic staff, etc. must receive significant training in one-on-one and group communication and negotiation skills as well as in technical content. On-going performance contracts, supervision, and support are required.
- All Hygiene promotion and behaviour change communication will be done with locally appropriate materials and messages. These must reflect national and regional standards and policies. Libraries of these materials will be kept in woreda health desks and regional health bureaux.

4.3.2. Current Skills gaps

- Participatory hygiene and sanitation transformation methods

- Development and use of picture based toolkits
- Skills to facilitate focus group discussions and key informant interviews, Community meetings (facilitating the community mapping and planning tool)
- Skills for the design of a communication strategy
  - → Audience segmentation, Message positioning, Communication channels, Behaviour trials
- Product development and placement
  - → Options reflecting environmental, technical, social, financial and institutional factors

4.4. NGOs/CBOs and private sector to help build capacity

All NGO and private sector supported IHS programs will:

- → Conform to regional guidelines and ensure staff is suitably qualified for designated IHS tasks.
- → Build local capacity and strengthen local institutions in a planned and co-ordinated manner, identifying gaps. Capacity will be built in community organisations, local health volunteers, school teachers and local artisans to build latrines, support point of use water treatment, promote hygiene behaviour change, etc.

Milestone 4.	Woreda has human resource development plan submitted to the region. Regions prepare an overall HRD and capacity building plan and forward to national level with required skills learning and staff complements. The plan is achieved in 5 years

Table: Inclusion Checklist

Inclusion Checklist	Gender	Pastoralists	Special Needs (e.g. AIDS)
Affirmative Action			

STEP 5

5. FINANCING IMPROVED HYGIENE AND SANITATION

Step 5: Summary

- ✓ Guiding principles
- ✓ Financing the 8 protocol steps
- ✓ Costing the protocol
- ✓ Inclusion checklist

5.1. The Guiding principles

5.1.1. Strategic Subsidy

- Public funds are best used to lever investment by individual households, small scale providers, organisations and larger 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 and regulation.
- Public financing (up to 95% subsidy) should be used to fund the construction of institutional latrines[11]; schools, health centres, market places, prisons, and other community sites.
- ***Woredas must*** ensure all public latrines are constructed and managed to a high standard. Options such as public/NGO/private sector partnership (for both construction and management) with user charges will be encoraged. The private sector should be encouraged to build and manage public latrines.

5.1.2. The Household Standard

The household will take responsibility for investing and constructing a latrine, providing a hand washing facility as well as covered pots or buckets. The CRP and HEW will provide guidance[12]

The woreda will NOT subsidise household latrines except in specific situations (***where gott/kebelle leaders identify*** abject poverty, extreme physical disability or adverse local ground conditions ***confirmed by HEW***). For such cases, ***the woreda will*** establish a 'discretionary' IHS fund with criteria for eligibility[13].

Communal cross-subsidy has proved to work in the total sanitation campaign in Bangladesh. Where the wealthier support the poor.

NGOs/Private sector will make options (see ladder below) available with creative local finance arrangements (e.g. locally managed revolving funds and mutual savings groups such as the Idir).

- Non-subsidised improved traditional latrines with features such as smaller pits, covers, and hand washing facilities will be promoted as the basic option (with non-subsidised incremental improvements for those who want them).
- Subsidies may be required in situations such as loose soil where a pit lining is required, in rocky terrain or in high water table areas where a raised latrine is required. Subsidies should only be introduced where they can be sustained to the point where all needs are met.

5.1.3. Engage private sector and NGOs (with marketing skills)

- The private sector (soap and plastic manufacturers) have a strong commercial interest in IHS and with there considerable (complementary) budget for advertising and promotion should be actively engaged both nationally and locally.
- Some NGOs like PSI have considerable marketing experience and their particular interest in hygiene and water purification products should be harnessed by regions and woredas

[11] Guidelines/standards for institutional latrine construction **under preparation**

[12] MoH (2004) – *Construction Usage and Maintenance of Sanitary Latrines –Extension Package*

[13] Woreda guidelines ***are needed*** for special assistance to the abject poor, physically challenged or where local ground conditions require special building techniques.

5.2. Financing the 8 Protocol Steps

5.2.1. Situation analysis

Woredas will conduct the situation analysis as part of the overall CAP process. The baseline reinforces the 'ignition' document and informs the targets for the performance monitoring.

5.2.2. CAP

Advocacy (CAP) costs are primarily around the production of the 'ignition' document, facilitating the consensus building (mainly meetings) and training at the different levels.

> The cost of the Cascading Advocacy Package (CAP) in SNNRPS to reach all gotts, kebelles, and woredas, was estimated at $ 50,000 and included the cost of the CAP training and the planning which for 14 million people represents a very cost effective intervention given the dramatic impact – pits up to 65% from <20% and EPI >90%. It should be emphasised that the value attached to inspired, committed leadership is priceless!

5.2.3. Planning

The idea behind the 'One plan, one budget, one monitoring system' is to reduce overheads on unnecessarily duplicated actions and to achieve more effective use of resources. Through the 'code of conduct' donors and NGOs will be encouraged to join the simplified decentralised planning, budgeting and monitoring approach.

Steps 1,2 and 3 can ideally be carried out as one 'giant ignition step' in the interests of saving time and resources at gott and kebelle levels

5.2.4. Human Resource Development

Skills upgrading costs can either be covered as part of routine basic training courses such as the current HEW training drive or refresher on-the-job type training which is part of the wider human resource development effort to boost key hygiene competencies. The former entails residential costs while the latter is part of a routine supervision activity.

5.2.5. Finance

All levels will explore multi-sectoral IHS public (government budget) and private funding (households, user fees) options with specific reference to the untapped private sector.

5.2.6. Communication, promotion and enforcement.

There will be costs in developing promotional tools packaged according to the different audiences (most appropriate media) at the different levels – such packages including allowances have been estimated to cost $.20 per head served. The average package will include posters, flyers and a set of picture based toolkits covering the 'f' diagram, a sanitation ladder and key hygiene behaviours (hand washing and the safe water chain).

Private Sector Investment in marketing/advertising

- The private sector invests a wildly varying amount of the retail cost of a given product on actually marketing and selling it (from 12-45%).
- Larger scale private sector operators particularly rotational moulding companies and soap manufacturers/distributors should be engaged in IHS and WaSH campaigns and different options for partnership should be considered.
- Public ownership particularly of public latrines with private management has successful precedents through East Africa and should be adopted as the model for Ethiopia.

Enforcement costs are limited, if creatively handled and fines can be issued on the spot. There will be some investment in getting the public health proclamations updated and widely disseminated. The cost of enforcement can be built into promotion where house to house visits are carried out initially to encourage 'minimum IHS standards' (with an explanation of the penalties for not conforming) and follow up is arranged to check. Although fines should be used sparingly and community service orders encouraged (such as helping to build school latrines) they can be used to fund both promo-

> Examples of creative low-cost preconditions such as needing to build a latrine before obtaining a licence to rent out a property or run a business have already been successfully applied in Oromyia region.

tion and enforcement[14].

5.2.7. Access to hardware

The Woreda will provide the funds for the construction of two demonstration latrines in each Kebelle with attached hand washing facilities. The private sector should be engaged preferably by local community stakeholders[15] to do the work. In this way the public sector builds up 'small scale independent providers' with skills, equipment and supplies to provide sanitary services on a sustainable commercial footing.

5.2.8. Monitoring and evaluation

The monitoring will need dedicated funds but these will be found from public and private sectors.

5.3. Costing the Protocol

The regions and woredas will cost delivery of the protocol according to available sources of funding, including both on and off budget sources.

Box 6. Outline for Costing the Protocol[AK1]

DESCRIPTION	ACTIVITIES	INPUTS	Funding source
	IGNITE[16]		
STEP 1: Situation Analysis } **STEP 2:** CAP } **STEP 3:** Plan }	Baseline } Cascading advocacy } Planning }	Facilitators, allowances, transport, stationery, 'advocacy packs'	Dedicated regional budget for CAP (high impact, broad reach public health)
	ENABLE		
STEP 4: HRD	Skills Assessment, training, supervision	Trainers, consultants, Allowances,	Sector block grants NGOs/Private sector
STEP 5: Finance	The region and woreda will source and lobby for funds	Time and energy	Sector block grants NGOs/Private sector – Banks
	PROMOTE & SUPPLY		
STEP 6: Communication	Identify & develop 6 effective communication channels	Allowances, transport IEC packs, Radio shows, drama, campaigns	Sector block grants Donors, NGOs/Private sector
STEP 7: Access to H/ware	Demonstration units Institutional/public construction	Artisan training, revolving funds, Construction inputs Technology development	Sector block grants Donors, NGOs/Private sector
	VERIFY		
STEP 8: M&E	Routine visits	Allowances, transport, soft hard ware, communication	Sector block grants[AK2] NGOs/Private sector

Milestone 5.	MoH and each region (based on projected woreda IHS financing needs) have a strategic plan with budgeted IHS activities. Woredas have costed Woreda WASH plans.

Table: Inclusion Checklist

Inclusion Checklist	Gender	Pastoralists	Special Needs (e.g. AIDS)
Affirmative Action			

[14] WSP Uganda (2004) *Workshop report on best practices*. In Busia district, Uganda fines were raised against those failing to comply with the local sanitation ordinance. The 'revenue' was used to fund the costs of running motor cycles

[15] Finida (2004) *Annual Report*. In Amhara region Finida have had great success where the community manage the contract for shallow well construction as they ensure value for money

[16] SNNPRS (2004) *Ignition Document*. Cost of cascading advocacy for 14 million = $ 50,000

STEP 6

6. COMMUNICATION, PROMOTION & ENFORCEMENT

Summary

- ✓ Choosing appropriate IHS messages for different audiences
- ✓ Providing manuals, PHAST tool kits and materials
- ✓ Communication channels
- ✓ Promotion backed up by obligation and regulation
- ✓ Inclusion Checklist

6.1. Choosing appropriate IHS messages for different audiences

6.1.1. Participatory Hygiene Evaluation procedures

Information on appropriate messages for different audiences can be collected during the baseline using PHAST style methods (focus group discussions, key informant interviews). ***The woreda will*** enter into partnership with NGOs or the private sector (consultants) to facilitate such participatory research particularly as it is in line with social marketing methods.

6.2. Providing manuals, tools and materials

The regional team will provide each woreda with a simple set of promotional tools and manuals to include:

- ✓ IHS transect walk instruction, community mapping instruction, three pile sorting cards, blocking the routes (5-F's), sanitation ladder, ToT/Facilitator's manual, and IHS household behaviour change forms.
- ✓ Special kits for use with pastoralists and special needs groups.

The woreda IHS team will :

- ✓ supply HEWs and CRPs with basic 'promotion kits' and appropriate training
- ✓ support HEWs and CRPs to use IHS promotion packs and communicate with, and advise households on "small doable actions", set examples and then influence others to follow suit, through direct promotion and through modeling key behaviors.
- ✓ support HEWs and CRPs to assist school teachers to facilitate IHS related lessons with children utilising child-to-child and/or action learning methodology as part of the Community IHS Plan.
- ✓ supply each WASHCO with one set of materials including guided walk instruction, community mapping instruction, three pile sorting cards, blocking the routes (5-F's), and sanitation ladder, CRPs' manuals, household behaviour change forms and four sets of 20 key pictures

At kebelle level HEWs and CFTs/NGOs will:

- ✓ provide support to WASHCOs and CRPs by participating in peer group meetings, household visits, and reporting so that a long-term relationship is developed.
- ✓ be aware of prevailing projects/programmes and attend the CRPs training supporting Intensive sanitation campaigns in one area with local artists performing IHS related dramas and songs in schools and community meetings

6.3. Communication Channels

It is generally recommended that behaviour change is accelerated where messages are consistent, continuous (repetitive) but from a range of respected and trusted sources. Commercial marketing suggests 6 independent but mutually reinforcing channels with repetitive catchy messaging.

6.3.1. Cascading Advocacy Package

- The cascading advocacy package (CAP) will be the primary broad reach promotion method. It is designed to reach through all woredas and kebelles to all gotts in a region and all households in the gott.
- Obtaining a broad-based consensus and commitment to a basic IHS standard is a solid foundation on which to base further promotion and invoke considerable positive peer group pressure.

6.3.2. HEWs/CRPs – Household visits with traditional leaders

- HEWs and CRPs will visit all households on a regular basis in line with 'zoning' where individuals take specific responsibility for a given area.
- HEWs and CRPs (or model women and model farmers) will set an example and encourage their target 50 households to copy
- Household visits with local (political) leaders can be used to promote but also enforce

6.3.3. School IHS – school children

- School teachers teach and facilitate conformity with the minimum IHS standard
- School health clubs/child to child activities reinforce safe behaviours
- School children influence their peers and their parents
- Schools can be closed until all children can produce a certificate from their gott leader that there household conforms to the minimum standard

6.3.4. Religious leaders/traditional leaders/health units

- The religious leaders have untold influence which has not yet been fully exploited – 'cleanliness is next to godliness.'
- Health units and health workers (need orientation and equipping with 'promotion' packs) present a good opportunity for reinforcing messages – new mothers could be given 'bounty packs' containing soap etc.

6.3.5. Mass media - Radio

- Radio has been shown to have a wide audience but is expensive and should be used strategically.

6.3.6. WASH movement – drama, posters, flyers (leaflets), radio, Local Champions (Ethiopian heroines/heroes)

- The WASH campaign uses a combination of many broad reach mass media methods which are consistent with the longer term methods.
- Like Gash Abara Mola, Tirunesh Dibaba or her sister might be persuaded to be IHS champions!

6.3.7. Social marketing – private sector and small scale providers

The private sector is already engaged in providing key inputs to the minimum IHS standard but their products are branded and their motive, profit. The trick is to harness commercial and social interest together with creative concessions and incentives.

6.3.8. Product marketing

The region will engage the private sector (like PSI, Roto Mulder and UNILEVER) to engage in the social marketing of latrine and hand washing facilities and cleansing products. The private sector will be encouraged to promote safe behaviour as part of their marketing approach to boost sales.

6.4. Promotion will be backed up by obligation and regulation

6.4.1. Public health proclamations

Officers will be made more aware of public health proclamations which will be included in training courses for HEWs and a basic form for volunteers. As well as fines, sanctions will include a variety of positive enforcement measures such as community service (building latrines for the elderly).

6.4.2. Name-and –shame

In Bangladesh children were given red flags to mark faeces on a well-known defaecation site. The red flags waving in the wind shamed parents into using latrines. In Tamil Nadu, India the community leaders completed the community map with details of all households with or without latrines. The map was put on display at the local government office and was updated on a monthly basis with the added dimension of proof of use. Houses with a latrine were marked in green and subsequently marked in red if use by the whole family could be confirmed. [AK3]

6.4.3. On-the-spot fines deferred to community service orders

Where householders refuse to construct and use latrines, on-the-spot fines can be administered but preferably deferred to a community service order where the offender has to help with the construction of someone else's latrine.

Milestone 6.	Woredas increase the number of communication channels to achieve 6 methods by ET.Cal. 2000 including enforcement with reach and penetration to all kebelles

Table: Inclusion Checklist

Inclusion Checklist	Gender	Pastoralists	Special Needs (e.g. AIDS)
Affirmative Action			

STEP 7

7. ACCESS TO (APPROPRIATE) HARDWARE

Step 7: Summary

- ✓ All comply with a minimum standard – household, institutions, public places
- ✓ Make options available - latrine, hand washing & safe water chain technologies/products
- ✓ Apply inclusion checklist

This step addresses IHS hardware needs at three levels: Household, Institutional and Communal/Public and considers latrine, hand washing and safe water chain technologies

7.1. All comply with minimum standard

7.1.1. Household

The gott leadership (supported by HEW) will ensure all households conform to the minimum standard (access to a sealed, used, cleaned and maintained latrine with an operational handwashing facility – supplied daily with water + soap/ash or substitute). "Sealed" means that there are covers for the hole in the platform/slab and that any ventilation pipe is screened.

The woreda will provide funds for the construction of two demonstration household latrines (one improved traditional pit latrine with wood and mud slab, cover and hand washing facility; and one improved traditional pit latrine with 60cm x 60cm reinforced concrete slab, cover and hand washing facility) in each Kebelle in appropriate public places as part of CRP and local artisan training, and to show people what they look like. These latrines are not expected to be used. The estimated cost per latrine is about ETB 300. ***The Woreda will*** provide the funds for the construction of these latrines, which will all have hand washing facilities. (***The HEW will*** paint on the side of each demonstration latrine, 'I am a model latrine, and I cost ETB xxx.")

7.1.2. Institutional

The woreda will make '**emptying'** the key feature of all institutional latrine construction. No institutional/public or communal latrines should be constructed without '**guaranteed'** provision for emptying which means a '**manual'** option. (Twin vault, dry (urine diversion) units should be standard).

The woreda will ensure ***all schools*** have separate latrines for girls and boys (with urinals) with hand-washing facilities (with soap and water) in the following stance to pupil ratio:

- ✓ Girls to latrine stance ratio < 50:1
- ✓ Boys to latrine stance ratio < 75:1
- ✓ Boys to urinals ratio < 75:1
- ✓ All have simple hand washing facilities-supplied daily with water, soap/ash
- ✓ All classrooms have safe drinking water from a 'safe chain'.

- ***The woreda/kebelle (with the institution) will*** ensure effective (hygienic) daily management and timely emptying. ***The 'in-charge' will*** be held personally responsible.

7.1.3. Public

Urban woreda and municipal authorities will take responsibility to ensure there are adequate public latrines in public places like markets or bus stands. Public latrines must be built to withstand constant, hard use but must be easy to clean and empty frequently. Ideally public latrines should be built with a combination of public/donor - NGO/private sector investment and managed privately (on a

Latrine pit/vault emptying is a key issue in congested urban areas with restricted access, making ecosan latrines one of the few low cost viable alternatives which can be emptied manually. Diverting urine away from the latrine pit/vault serves a number of purposes in that the smell and the bulk is considerably reduced and the urine can be carried away to be used (or used on-site) as fertiliser. In twin vault latrines, composted faeces can be removed by hand and again used on or off-site as a soil conditioner (99% pathogen die-off in 6 months).

long term cost recovery basis).

7.1.4. Communal

The urban woreda, municipality or Urban Local Government Authority will ensure landlords comply with IHS standards. Where space is short communal latrines will be built and funded by public/private/NGO – landlord partnership. 'Easy to empty latrines' with handwashing facilities will be provided on a family to stance ratio <14:1: with each family group having a key for the locked door sharing responsibility for cleaning and emptying. ***A management committee will*** be held accountable for ensuring hygienic use and timely emptying. A manager/cleaner can be appointed to be paid via user contributions. ***The twin vault, urine diversion units should be standard.*** Both public and communal toilets should have integral hand washing facilities with water (sufficient for multiple use) and soap.

7.2. Make options available

- ***Both rural and urban woredas (with the support of technical colleges, universities and resource centres) will*** develop a range of options suitable for their area. They will develop their own version of hygiene and sanitation ladders as their guide towards the minimum 'faeces free' standard as well as helping people move towards more durable and sustainable options. The ladders will reflect technical requirements in different localities (e.g. high density, congested housing which must consider options to reduce emptying frequency such as eco-san[17]./biogas). .

Box 7. Example On-site Sanitation ladder

Minimum Standard	Higher Cost/lower risk
	• Pour-flush[18] & HW, biogas
	• Eco-pit, slab, vent with Hand-wash
	• Eco-Pit with dome slab 60,80,100,120 cm
	TPL upgraded with 60 x 60 slab and vent
• Traditional Trench – Pit latrine (TPL)	
• Open defecation buried (Cat's method/trench)	
• Designated place for defecation	
• Defecation in the open (indiscriminate)	
• Defecation(young child) in the compound	
High Risk	
	HANDWASHING FACILITY AVAILABLE
× No HW Facility – water container only –	water with ash – water with soap – water container with tap
	SAFE WATER CHAIN IN PLACE
→ Uncovered bucket – covered bucket two cups –	three pot filter system – water filter - chlorination

- ***The National multi-stakeholder WASH forum will*** engage/put pressure on the private sector (plastic tank/latrine and soap manufacturers) to lead social marketing campaigns on all aspects of sanitary hardware, cascading a range of affordable products to regions and woreda. ***The private sector will*** consider creative outlets and retail opportunities such as franchises for women's groups
- ***Urban woredas (UGLAs), municipalities, private sector, NGOs, other stakeholders (landlords) will*** consider a variety of low cost (both capital and recurrent), sustainable urban sanitation options linked to mixed financing options for their 'urban ladder'. Technical options

[17] An important feature of eco-san is the separation of urine from faeces which reduces the overall volume by a factor of 10:1 noting that the average human produces 500 litres of urine per year but only 50kgs of faeces
[18] Pour-flush can either be linked to septic tanks or via small bore sewerage to biogas digesters.

might include small bore sewerage linked to biogas successfully applied in Bangladesh slums[19]. Creative finance might include mutual savings, soft bank loans, private/public sector partnership and user charges! As important urban stakeholders, ***landlords will*** provide the minimum IHS standard in any property for let. ***Woreda staff will*** advise them that a licence to rent is dependent on the provision of sustainable IHS facilities. Failure to comply will result in warnings, withholding licences and ultimately fines or confiscation of property. ***Urban health Extension workers and community resource persons will*** play an important role in promoting urban IHS[20].

7.2.1. Artisan training

The Woreda will provide latrine artisans (one artisan per five selected communities) with latrine promotion materials (laminated booklet with pictures of different household latrine and hand washing designs, and pictures of the tools, materials and labour to construct), tools (digging hoe, saw, chisel, plane, hammer, float, trowel) and a one-week training in order for the latrine artisans to promote and provide improved sanitation options in their local area.

The woreda will ensure that training for CRPs will include the practical construction of an improved traditional pit latrine and hand washing facility at a CRP's home (with materials and labour to be provided by the CRP but the time of latrine artisan paid for by Woreda for the initial training).

The CRPs will link latrine artisans with householders who want to purchase their services rather than do it themselves.

The Community will provide the CRPs with assistance, such as building their latrines and hand washing facilities or reducing their contribution to the water system, subject to the WASHCO being satisfied with their performance and wanting to reward them.

The kebelle will ensure that the renovation/provision of safe, low-cost institutional latrines with hand washing facilities at schools and health facilities within the community is part of the gott/community IHS Plan. All institutional latrines should be in accordance with the appropriate Ministry of Health / Ministry of Education design[21].

The woreda/kebelle will support latrine artisans to build different models of latrines and latrine components such as alternating ventilated improved pit latrines; ecosan with urine separation (use of urine as fertiliser); coloured cement components; and variations on designs for disabled, sick and aged persons, pregnant women, small children.

The region will make a range of technical drawings, pictures and bills of quantities available to WSGs, artisans, CRPs, CFTs and HEWs.

7.2.2. Handwashing

All levels will increase their focus on hand washing. Increasing focus will be on making simple, hygienic handwashing facilities available as a households standard such as pots with taps or plastic containers with a tipping device ('tippy taps')[22]

The private sector will make soap and simple handwashing facilities available for households through increased support for kebelle level retail outlets.

7.2.3. Ensuring water quality

Households will be responsible for setting up and observing the safe water chain from source to mouth). Under regional/woreda regulation, ***the private sector/NGOs will*** make simple, affordable water storage, water filtering and treatment options available to households and institutions, including rainwater harvesting systems. ***The woreda health office will*** ensure all news water sources comply with standards[23] and there is routine point source and point of use testing. ***The region will***

[19] Biogas has been successfully used in schools, prisons, hotels and even public toilets. There are a number of skilled local manufacturers: the selam centre (0911-222781), Ato Yakob (Fiche), Women and Children Development Organisation (0115-153409), wcdo@ethionet.et

[20] MoH - Urban Health Extension Programme - currently under preparation

[21] MoH – Institutional, public, communal latrine design standards

[22] MoH (2004) – *Personal hygiene extension package. An additional guideline on a range of possible technologies to be done.*

[23] MoWR (2005) – *National guideline for drinking water quality*

oversee the procurement and distribution of water testing kits. The ***Woreda will*** develop systems for procurement from regional stores and their effective use.

7.2.4. Research and development

National and regional HS research will be promoted through existing government (universities, technical colleges, resource centres) and non-government institutions (e.g. the Selam centre).
The private sector will be facilitated at all levels to develop a range of appropriate and affordable ISH facilities. ***Academic institutions, local specialist marketing consultants will*** evaluate the effectiveness of different communication channels, IEC materials and methods and provide systematic feedback to improve both advocacy and promotion.

Milestone 7.	Woredas develop rural and urban ladders reflecting appropriate, affordable options, establish artisans with necessary construction skills and build demonstration units in each kebelle.

Table: Inclusion Checklist

Inclusion Checklist	Gender	Pastoralists	Special Needs (e.g. AIDS)
Affirmative Action			

STEP 8

8. MONITORING AND EVALUATION

Step 8: Summary

- ✓ Guiding principles
- ✓ Monitoring will be carried out at 4 levels
- ✓ Inclusion Checklist – gender, pastoralists and special needs e.g. AIDS patients

8.1. Guiding principles

8.1.1. Planning framework = monitoring framework

Baseline information creates the planning framework and provides the indicators as well as the means of verification to monitor and measure progress to deliver specific planned outputs as described in the example below.

8.1.2. Supportive supervision and monitoring

Supportive supervision is an essential part of both process and output monitoring. It is also a quality assurance and human resource development tool which should be carried out to follow up training. No training should be carried out without making provision for structured supportive supervision of the trainees to maximise the value of the skills learning. In addition, supportive supervision is a fundamental aspect of personnel management and quality assurance. It can be linked to the performance monitoring.

8.1.3. Set behaviour objectives with indicators

National and regional health communication and capacity-building strategies will spell out behavioral objectives and how best to achieve them through national support and decentralized approaches. Standardized indicators will monitor progress.

8.1.4. The reporting system

- The reporting system should be aligned with the planning framework so that officers at different levels report on progress towards stated objectives in their plans.
- The reporting system should cascade from gott to kebelle to woreda to region so that managers can monitor performance and make pre-emptive visits.
- In line with the code of conduct it has been proposed that there should be a single narrative and financial reporting system
- Suggesting reporting and frequency:
  - → Regular Progress Reports: This defines the minimum reporting requirements for project implementers.
  - → Financial Report and Audit: A basic financial report should be made transparent at the district level to avoid accusation of mismanagement of funds.
  - → Tour Reports by Field Visits: These will be prepared by field staff. They will give observation and impressions from the field.

8.1.5. Baseline and household visits data gathering formats

Most of the data for the M&E is generated at community, neighbourhood and school level since most of H & S activities are performed at these levels but the data will cascade from village via gott, kebelle, woreda to region and ultimately to the national level. The completed IHS management information system will harmonise each level but also ensure integration with health, water and education data management systems. Data gathering and reporting needs are been developed in a separate paper.

8.2. Monitoring will be carried out at 4 levels

There are four levels of the monitoring system: community/kebelle – woreda – regional - national. Data source specification and data entry procedures will streamline the various levels to be integrated for consistency in content and currency.

8.2.1. Community/Kebelle Level Monitoring and Reporting

Data Collected by HEWs/CRPs will be used to for monitoring at community level. This system will be manual. Analysis will be done on average performance calculation to show progress over time. Full compliance calculation methods will not be used here.

8.2.2. Woreda Level Monitoring and Reporting

At woreda level a simple computerised monitoring system should be used. Data will be supplied from community level monitoring system. The use of computers at woreda level will allow inclusion of full compliance calculations and comparison between communities to identify best practices. Such reports will be disseminated to communities for feed backs. The only data directly entered into this system will be activity reports and indicator values of activities that are carried out at woreda level.

8.2.3. Regional Level Monitoring and Reporting

At the regional level, the monitoring system will be supplied and updated by data from woredas' M&E systems. Woredas will get feed back on best practices. Activity reports and indicator values of activities carried out solely at regional level will be entered to this system.

8.2.4. MoH's Health MIS

Data from Regional Systems will update the national MIS system

Milestone 8.	IHS information captured in sector information management systems reflecting both access to, and use of, the minimum IHS standard Data analysis capacity developed, allowing for sub sector performance evaluation and health impact assessments over time

Table: Inclusion Checklist

Inclusion Checklist	Gender	Pastoralists	Special Needs (e.g. AIDS)
Affirmative Action			

9. REFERENCES

1. National Hygiene and Sanitation Strategy (2005) MoH with WSP support
2. MoH (2004) Health Extension Worker - Implementation Guidelines
3. PHAST (Participatory Hygiene and Sanitation Transformation) procedures can be used to collect both qualitative and quantitative information
4. The WB supported programme has a 'household motivator' form which will be simplified and widely used by HEWs and CRPs.
5. MoH (2005/6) - *Health Information Management System* (currently under development by MoH with support from John Snow International)
6. SNNPRS (2004) - 'Ignition' document explaining the HSDP and the case for high impact, braod reach public health interventions. It has been circulated to all regions for adaptation.
7. SNNPRS (2004) - The format for the performance related contract (for regional adaptation)
8. Bounty packs include soap, towels, plastic containers (potties) for new mothers
9. Regional MoUs have been developed and signed in Tigray and SNNPRS
10. The region will set standards and guidelines for certifying staff to engage in IHS services
11. Guidelines/standards for institutional latrine construction **under preparation**
12. MoH (2004) – *Construction Usage and Maintenance of Sanitary Latrines –Extension Package*
13. Woreda guidelines ***are needed*** for special assistance to the abject poor, physically challenged or where local ground conditions require special building techniques.
14. WSP Uganda (2004) *Workshop report on best practices*. In Busia district, Uganda fines were raised against those failing to comply with the local sanitation ordinance. The 'revenue' was used to fund the costs of running motor cycles
15. Finida (2004) *Annual Report*. In Amhara region Finida have had great success where the community manage the contract for shallow well construction as they ensure value for money
16. SNNPRS (2004) *Ignition Document*. Cost of cascading advocacy for 14 million = $ 50,000
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18. Pour-flush can either be linked to septic tanks or via small bore sewerage to biogas digesters.
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23. MoWR (2005/6) – National guideline for drinking water quality