Sanitation and Hygiene Smart and Targeted Subsidies

Protocol

July 2021

Acknowledgment

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Forward

The Federal Ministry of Health (MoH) is committed to improve the Sanitation, Hygiene, and Environmental Health conditions of its citizens and has developed and is leading the coordination of planning and implementation of Sanitation, Hygiene, and Environmental Health development programs1, and strategies2, in collaboration with various development partner organizations. In the second health sector transformation plan, MoH planned to increase the proportion of households with access to basic sanitation services from 20% (2019) to 60% (2025) through an effective and sustainable market-based system for hygiene, sanitation, and environmental health facilities and services.

This subsidy protocol is prepared to help Ethiopia achieve its goal of achieving SDG 6.2 of universal access to basic sanitation services by 2030 and HSTP II goals by 2025.

The protocol specifies a clear rationale for the need to subsidize sanitation, provides guiding principles and proposes modalities (i.e., selection criteria of beneficiaries and delivery mechanisms) for implementing sanitation subsidies in Ethiopia. The protocol gives special weight to two important features of a subsidy: **smart and targeted**.

A smart sanitation subsidy does not distort or hamper the market-based sanitation and the CLTSH approaches, but rather contributes to the expansion thereof. A targeted sanitation subsidy does specifically address the most vulnerable population groups who are not able to construct improved sanitation facilities on their own due to their extreme poverty and/or impending environmental factors.

Finally, the Federal Ministry of Health is fully committed to making sure this protocol is used by all Sanitation, Hygiene, and Environmental Health stakeholders, and calls upon the private sector, entrepreneurs, and development partner organizations to use the protocols consistently for the improvement of Sanitation, Hygiene and Environmental Health facilities and services across the country.

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1 Federal Democratic Republic of Ethiopia, Ministry of Health, Health Sector Transformation Plan (HSTP I, 2016-2020), October, 2015

2 Federal Democratic Republic of Ethiopia, Ministry of Health, National Hygiene and Environmental Health Strategy (2016-2020), December 2016

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1. Current context

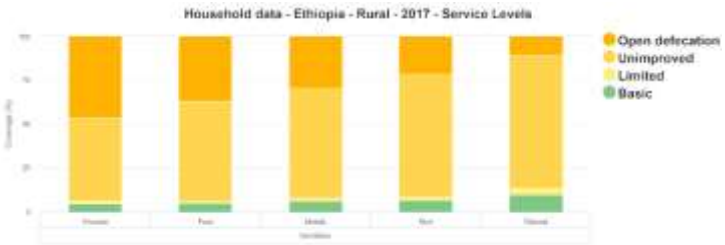
1.1. Inequalities in sanitation and hygiene coverage

Between 2000 and 2017 Ethiopia made a remarkable achievement by reducing open defecation from 79% to 22% (JMP, 2019). Despite this achievement, the country fell short of its ambitious goal of achieving 100% of households properly utilizing latrine facilities by 2020 as stipulated in the Health Sector Transformation Plan I for2015/16 to 2019/20 (HSTP I, 2015). This is largely evident in persisting inequalities in coverage across urban/rural geographies, regions, and household socioeconomic status.

The most recent JMP report (JMP, 2019) indicates an overall low coverage of basic sanitation[3]with stark inequality between urban and rural sanitation in Ethiopia (20% in urban versus 4% in rural areas). The proportion of households with basic sanitation services remained steady at a low level in both urban and rural contexts between 2000 to 2017 (i.e.neglectable increase from 16% to 20% in urban and an increase from 1% to 4% in rural areas).

The target of 82% improved sanitation coverage by 2020 as per the Health Sector Transformation Plan Iwasclearly missed (HSTP I, 2015). The target under the Health Sector Transformation Plan II (HSTP II, 2020) has now been revised to 60% of households with access to basic sanitation services by 2025.

In terms of household socio-economic status, the highest proportion of open defecation is among the rural poor and poorest (36% and 46%, respectively), refer to Figure 1. For the urban poorest and poor, the JMP estimated that 26% and 7%, respectively, practiced open defecation in 2017. While only 2% of urban middle-class households defecate in the open, the rate is higher for the middle-class in rural areas (29%) highlighting the urban/rural disparity despite similar socio-economic status. There are also huge regional disparities in terms of sanitation coverage. According to a Unicef CLTSH progress review report (Unicef, 2017), open defecation practiced by households varies considerably among the regions: Afar (88% open defecation), Gambella (71%), Somali (49%), Tigray (36%), Amhara (31%), Oromia (21%), SNNPR (5%) and Benishangul Gumuz (less than 1%).



[3] Use of improved sanitation facilities not shared with other households. Improved sanitation facilities are those designed to hygienically separate human excreta from human contact. These include wet sanitation technologies such as flush and pour flush toilets connected to sewers, septic tanks or pit latrines, and dry sanitation technologies such as dry pit latrines with slabs and composting toilets.

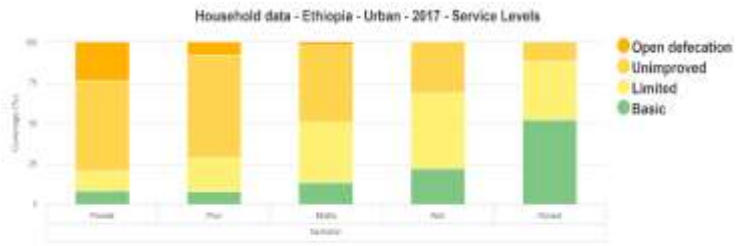


Figure 1 Sanitation service levels disaggregated by rural/urban and wealth quintiles (JMP, 2019)

1.2. Major activities to date to increase sanitation coverage

To eliminate open defecation in Ethiopia, the government has developed and implemented several strategies, plans, capacity building, and community mobilization activities mainly through the community-led total sanitation and hygiene (CLTSH) approach. CLTSH is recognized to have contributed to the sharp decline in open defecation in Ethiopia after formal adoption in 2011. However, most of the newly constructed household latrines during CLTSH campaigns are traditional pit latrines. These latrines are constructed by the households themselves using locally available materials such as wooden logs, stones, and clay. Many of these latrines are not durable and not easy to clean. As such, they are not suitable to separate feces sustainably from human contact; failing to count as an improved sanitation facility and leading to a negative user experience (see Figure 2).[4]

Figure 2 Traditional dry pit latrines usually do not sustainably segregate excreta from human contact.

More sustainable, improved sanitation facilities (e.g., pit latrines with slabs and sealable toilet pans[5]) generally need inputs from outside the household. Therefore, Ethiopia introduced sanitation marketing in 2013 as an approach to better serve post-open defecation-free (ODF)communities with suitable sanitation products and services through the private sector. By 2020, more than 500 businesses had been supported or established (mostly medium and small enterprises) and are now providing sanitation products and services in more than 230 districts(FMoH, 2020). Still,

Commented [EM1]: Better to refer to the document as it is; the change from SM to MBS happened lately in 2020 and it's good to keep track of these changes.

[4] Pit latrines with slabs that only partially cover the pit, or with slabs constructed from materials that are not durable and easy to clean e.g. sticks, logs or bamboo) should be classified as 'pit latrine without slab' and counted as 'unimproved', even if they are covered with a smooth layer of mortar, clay or mud.

[5]Pit latrines with slabs that completely cover the pit, with a small drop hole, and are constructed from materials that are durable and easy to clean e.g. concrete, bricks, stone, fiberglass, ceramic, metal, wooden planks or durable plastic) should be counted as improved. Slabs made of durable materials that are covered with a smooth layer of mortar, clay or mud should also be counted as improved.

the market-based sanitation (MBS)interventions have not yet reached the required scale to increase improved sanitation coverage in Ethiopia to the desired level. In 2020, the market-based sanitation implementation guideline has been revised and launched (FMoH, 2020).

In parallel to scaling up MBS efforts in the country, a major national ODF campaign is being prepared (2021-2024) under the motto of "TSEDU Ethiopia" (a clean Ethiopia). The goal of the campaign is to declare all woredas in Ethiopia as ODF by the end of 2024by creating sustainable behavioral change. The campaign has a broad scope and encompasses human excreta disposal, fecal sludge management services, menstrual hygiene management, provision of materials needed for improved hygiene (e.g., water, soap, sanitary pads), and changing the human behaviors and attitudes related to excreta and its disposal.

According to the action plan document of the National ODF Campaign Ethiopia 2024, the total estimated cost of the campaign is US$923 million over five years, of which 76.6% is earmarked for sanitation products and services(including subsidies for the construction of standard latrines in institutional, household and community setting and upgrading existing ones). While 60% of the budget is targeted to be mobilized locally (government contributions 40% and community contributions 20%), the remaining 40% is expected from international development partners.

1.3. Policies and practices related to sanitation subsidies

The CLTSH approach-related saga prescribes that an intervention should be implemented without subsides except for limited facilitation and awareness creation components. Further, subsidies can have a negative impact on sanitation market development, and promoters of the MBS approach are worried about untargeted and free distribution of sanitation products that can seriously damage the infant market. However, no policy in Ethiopia would hinder the implementation of sanitation subsidies. The ODF campaign"TSEDU Ethiopia" envisages significant resources to be spent on sanitation subsidies as a part of the implementation plan to overcome the affordability challenges. The ODF campaign document indicates a subsidy level of 20% for household toilet upgrading and 10% for commercial and institutional toilet upgrading but does not specify the mechanism of how the subsidies will be delivered.

This subsidy protocol is developed to provide guidance on any sanitation subsidy approach in the country (i.e., including ODF campaign and beyond) through specifying subsidy guiding principles, selection criteria, and delivery mechanisms. Sanitation subsidy approaches must be "smart" and "targeted "to avoid adverse effects on sustainability and sanitation product supply chains.

1.4. Existing social protection schemes and subsidies

Ethiopian social protection schemes primarily focus on five key areas:

i) productive safety net program (PSNP),
ii) employment promotion and livelihood support,
iii) social insurance,
iv) access to basic health, education, and social services, and
v) Addressing abuse, violence, and exploitation.

These social protection schemes (especially the PSNP) are recognized to have been effective in reducing poverty. Ethiopia recorded a sharp decline in the poverty rate[6] from 44% to 27%from2000 to 2016. The PSNP is one of the largest social assistance programs in Africa and helped Ethiopia to reform the ad-hoc humanitarian assistance to a more system-based and predictable scheme since 2005. The PSNP has two types of beneficiaries;

i) public work beneficiaries who receive benefits in exchange for their labor, and
ii) Direct support beneficiaries who unconditionally receive the benefits (i.e., children, the elderly, and people with disabilities).

The rural and urban PSNP accounted for 71% of all social protection spending from 2012/13 to 2015/16. The PSNP is relatively well-targeted and able to reach the poorest households due to its clear focus on drought-prone areas and food-insecure households. The total direct support and public works beneficiaries are around 10 million individuals which represent about one-third of the country's poor population. Nevertheless, there are several challenges reported concerning the PSNP's implementation related to:

i) it's overwhelming reliance on donor funds despite a promising increment of government contribution,
ii) wrong selection and/or untimely graduation of households,
iii) delayed transfers of benefits/payments, and
iv) Weak institutional arrangements and capacity.

ThePSNP has also been challenged by corruption, nepotism, high turnover of government officials, and a tendency to use it for political purposes.

Recognition and counting of most disadvantaged population: Despite the overall reduction of poverty in Ethiopia, there are still an estimated 28 million people (27% of the population) living below the poverty line according to the 2016 Ethiopian poverty analysis report (PDCETH, 2018). Geographically, poverty in Ethiopia is predominantly a rural phenomenon as the number of poor people below the poverty line in rural areas is nearly twice the number in urban areas. While urban headcount poverty declined by more than half from 2000 to 2016 (from37% to 15%), rural poverty only declined from 45% to 26 %(UNDP Ethiopia, 2018), see Figure 3.

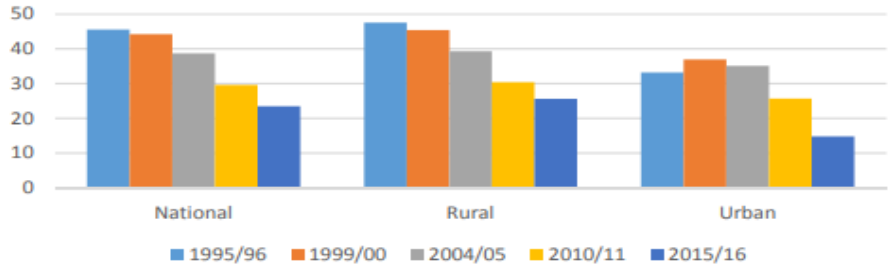


Figure 3 Trends in poverty headcount index (UNDP Ethiopia, 2018)

[6] Based on national poverty line of 7,184 Birrper adult person per year (PDCETH, 2018), based on US$ 1.25 per day and the exchange rate in 2015. Internationally the poverty line was increased from US$ 1.25 per day to US$ 1.90 per day in 2015.(To be confirmed)

2. Rationale

2.1. The need for smart and targeted sanitation subsidies

More than a quarter of the country's population (i.e., 27%, more than 28 million people)remain below the national poverty line of 7,184 Birr per adult person per year (Planning and Development Commission, 2018)which corresponds to about 1,200 Birr per month for a typical family with two adult persons. Despite 20 years of fast economic growth that have substantially reduced poverty levels, the monetary living standards of Ethiopian households remain low. This is especially true in rural areas and mainly for the bottom 40 percent. Ethiopians in the two bottom quintiles of consumption lived on US$1.3 in rural and US $ 2.2 in urban areas (adult/day). Therefore, investments in improved sanitation facilities (which cost at least 200 to 890 Birr) pose a major challenge to many households.

The Ethiopian Health Financing Strategy (EPHI, 2017) recognizes the importance of increasing health service coverage for the poor to protect them from financial risks. A study by the Ethiopian Health Insurance Agency (EHIA, 2020) on the burden of household out-of-pocket health expenditures revealed that a large fraction of Ethiopian households face financial hardship when accessing health services. Access to basic sanitation services is a preventative measure to improve public health by reducing the prevalence of diarrheal diseases.

Assessments supported byUSAIDonthe impact of the price for plastic pans on the willingness of rural households to pay to buy such products highlight the low capacity to pay among majorities of the Ethiopian population (WASH PaLS, 2020). The demand curve for three segments of households based on their income indicated that the majority of Ethiopian households are highly price-sensitive, and demand sharply declines once plastic pans price passed 200 birrs. For instance, at the price point of 400 birrs for toilet plastic pans, the demand from the bottom 40% of households is almost zero while only around 5% of the middle 40% households reported able to afford it (see Figure 4).

Given the evidence above, sanitation subsidies for the poorest seem necessary and justified. Ethiopia is unlikely to reach all households with improved sanitation products and services by 2030 without a targeted and smart subsidy scheme.

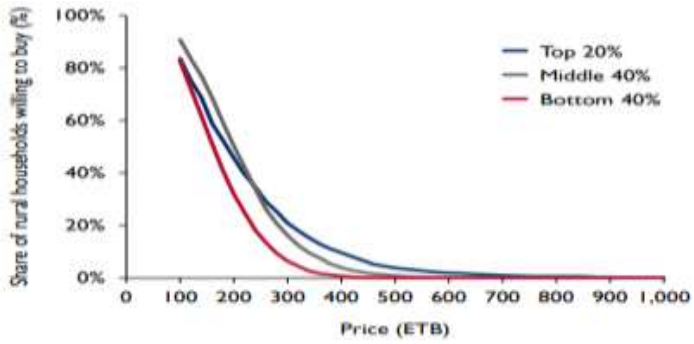


Figure 4potential demands for plastic pans by household income segment (WASH PaLS, 2020)

3. Objective

The overarching purpose of sanitation subsidies in Ethiopia is to increase coverage of improved and affordable sanitation products and services. Therefore, this subsidy protocol provides guiding principles and implementation modalities that serve as the basis for all sanitation subsidy schemes to be implemented in the country towards realizing universal access to basic sanitation services by 2030.

4. Types of smart and targeted subsidies

There are different types of smart subsidies that could be used to make sanitation more affordable for the poorest in Ethiopia. Local context should be considered to choose the most suitable type. Mitigating strategies for potential disadvantages need to be considered in the design as well.

- **Direct targeted subsidies**. Payments are made directly to eligible households in the form of cash or vouchers designated to be spent on specified sanitation products and services. This type of subsidy helps to empower targeted households and stimulates sanitation market development. Ideally, direct targeted subsidies are bundled with other social services. However, the application of this subsidy approach is rather complex to administer which potentially causes issues for scalability.
- **Infrastructure subsidies.** Sanitation products are provided by the public sector or development partners to eligible households, usually with some input in cash or labor from the households. To be "smart" the products need to be sourced through the local private sector offering sanitation products and services (to stimulate sanitation market development), and beneficiaries need to be interested in improving their latrines and understand the real value of the products and services that they receive.
- **Output-based subsidies.** Eligible households receive a cash payment only after the expected outcome has been achieved (i.e., if an adequate improved latrine has been constructed). While also rather complex to administer, it offers the advantage that the subsidy is fully dedicated to improving sanitation facilities. However, some households might find it difficult to find the money to make the up-front investment, and any issues with making the output-based payments might lead to hardship and serious grievances.
- **Subsidized credit.** Subsidies and guarantees are provided to micro-finance institutions (MFIs) that can then lend money to eligible households at a reduced interest rate. MFIs can also work with households' micro-savings and micro-insurance to enable more households to make the needed investments. However, in the Ethiopian context, the poorest (and thus subsidy-eligible) households are expected not to be able to pay the full cost of an improved latrine and therefore this approach is likely more suitable to reach the middle-class. Nevertheless, subsidized credits could be considered in combination with output-based subsidies and might contribute to strengthening providers of sanitation products and services as well as MFIs.

5. Guiding Principles for smart and targeted sanitation subsidies

Ethiopia needs to accelerate the current rate of increasing coverage of improved sanitation and hygiene throughout the country. Subsidies are one of the mechanisms to address affordability issues for households who are not able to cover the full costs to construct or upgrade household latrines. However, subsidies might distort existing markets. The guiding principles presented below are adopted, with some modifications, from Cambodia and India. Both countries have successful experience in using sanitation subsidies to improve national sanitation coverage among the poor and vulnerable.

As a rule of thumb, a subsidy should be both smart and targeted. A subsidy is smart when it minimizes the market distortion, ensures sustainable engagement of the private sector, and delivers products and services through existing sales channels. A subsidy is targeted when it is based on a good understanding of the local context and consumer preferences and reaches the poorest households.

The guiding principles are prepared to provide clear guidance for any subsidy-based sanitation intervention in Ethiopia to maintain consistency in the standard of service delivery and improve sanitation outcomes for poor and vulnerable households. The guiding principles apply to both governmental and non-governmental organizations that provide sanitation subsidies to ensure the specific target groups are reached (as identified and defined in this subsidy protocol under section 4) and that any negative impacts of subsidies are minimized.

A subsidy-based intervention is deemed smart and targeted if the following key features are well incorporated and reflected in the intervention modalities:

1) The subsidy is based on a good understanding of the local context and consumer preferences,
2) targets the poorest households,
3) has clearly defined eligibility criteria for subsidy recipients,
4) is transparent,
5) is easy to administer,
6) is monitored, and
7) Is not a standalone intervention.

A smart and targeted subsidy avoids the risks of distorting the markets for sanitation products and services, does not stifle innovation or create dependencies, and does not supply subsidized products and services in areas where there is no or poor demand.

5.1. Principle 1: Subsidies must be well-targeted.

Sanitation subsidies should only be directed to households that are not able to afford improved sanitation products and services through other means (e.g.out pocket purchase or sanitation loans). Identification of the poor and most vulnerable should be made in line with existing poverty alleviation programs. Therefore, recipients of sanitation subsidies should be enrolled in a productive safety net under the PSNP (in both urban and rural contexts), and/or formally be exempted from agricultural taxes because of their limited landholding size and agricultural produces (rural context).

The only exception to using existing poverty alleviation programs for the identification of subsidy recipients is to be applied in areas where it is more difficult and costly to construct a latrine (e.g. rocky or sandy ground, shallow groundwater level, or crowded slum communities with no access to space for construction), or for internally displaced communities and refugees.

5.2. Principe 2: Subsidies should only target latrine sub-structures.

Subsidy schemes should be designed to reach the maximal number of people with a minimal but acceptable level of sanitation services. Therefore, in the Ethiopian context, subsidies should only target the construction of improved dry pit latrines through the provision of adequate sanitation products and installation services for the sub-structure (e.g. durable and easy-to-clean latrine slabs made out of concrete, plastic, wooden planks, or similar, and products for pit lining in contexts where toilet collapse is common). The justification is that, from a public health perspective, the primary objective of the subsidy is to support households to afford durable, improved sanitation facilities that properly separate excreta from human contact. The construction of a superstructure to provide adequate privacy can be expected to be done by households themselves at a low cost.

The only exception to this principle is to be applied in areas with high population density where more durable (and therefore more expensive) superstructures are required to provide adequate privacy (which is needed to ensure the latrines can be used at any time of the day).

5.3. Principle 3: Subsidies should only cover a proportion of the overall cost

The total monetary value of direct subsidies paid to a household should cover at least 80% of the total cost of the subsidized products/services. In the context of food insecure and chronically poor PSNP intervention districts, the target group should be exempted from monetary payment. Instead, their labor contribution in terms of domestic activities (e.g., digging toilet pit, preparation of other inputs) should be converted to monetary values and they should be exempted from the 20% cash contribution.

Subsidy recipients must understand the full cost of the subsidized items and that they understand why they have received a price reduction. The household contribution is important to foster a sense of ownership. Further, the desire of the household to invest in improving sanitation facilities is deemed to be a prerequisite for sustained use after construction.

Exceptions to this principle might be applied for households that by no means able contribute to the cost and construction of the latrine (e.g.households exclusively consisting of people with disabilities and elderlies). In such a context a 100% subsidy can be justified.

5.4. Principle 4: Subsidies should be prioritized in places with a well-established supply chain

Direct sanitation subsidies should be primarily implemented in places where there is a well-established supply chain with a private sector that offer adequate sanitation products and services. In fact, this does not imply woredas with no or poor supply

chain will be exempted from subsidy implementation. Rather, these woredas will be provided capacity-building interventions to make them ready for the subsidy implementation in the later stage. The subsidies should support the private sector in sustaining their businesses. Increased demand and supply are expected to reduce the costs of sanitation products and services, and therefore households not receiving any direct subsidies will indirectly benefit from the subsidy scheme. Providing sanitation subsidies in the absence of a well-established private sector will be ineffective and unsustainable. An exception to this principle is support activities provided to local businesses in areas without a well-established supply chain. Such indirect subsidies in the form of capacity building and provision of access to finance and/or land are required as an initial step to develop sanitation markets. In the context where it is not feasible to establish a supply chain for different reasons (e.g., harsh environment, security,) the products could be sourced from adjacent or nearest woredas.

5.5. Principle 5: These guiding principles apply to everyone.

All entities subsidizing sanitation products or services are required to comply with the four guiding principles above. The Federal Ministry of Health or the entity that will implement this subsidy protocol under its supervision is mandated with creating an in-depth understanding of the guiding principles and overall sanitation subsidy protocol through actively tracking and engaging all WASH stakeholders in the country.

Direct and indirect subsidies should be identified during the planning, implementation, and documentation and transparently communicated to the Federal Ministry of Health or any other body mandated with overseeing the implementation of the project activities. Justification shall be provided by implementers in case deviation from the guiding principles is required. Consistency among actors is important because the fragmented and ad-hoc implementation of sanitation subsidies might lead to adverse consequences affecting access rates and sustainability. If evidence suggests that changes to these guiding principles are required, the revision process shall be led by the Federal Ministry of Health to further refine the national subsidy protocol.

6. How to introduce a sanitation subsidy

6.1. Selection criteria

Subsidies shall be introduced woreda-wide for urban and rural kebeles alike once the following four criteria are met at the woreda-level:

- **Woreda eligibility.** Per the *Guiding Principle 4*, sanitation subsidies prioritize places with a well-established supply chain. As indicated earlier, woredas without a supply chain should be provided other capacity-building activities as part of creating an enabling environment for MBS before introducing subsidies. CLTSH and MBS interventions shall prepare the ground for woredas to "graduate" and become eligible for sanitation subsidies.
  a. Adequate improved sanitation products and services are available from at least three different suppliers located within the woreda (or from adjacent woredas in cases of special circumstances), all of them being active for more than six months and combined having the capacity to install improved sanitation facilities for at least 10% of the number of households in the woreda.[7]
  b. Coverage of improved sanitation shall be at least 20% and open defecation shall be practiced by less than 10% of the households.
  c. Lists of households eligible for sanitation subsidies have been obtained from the PSNP and verified by the Regional Health Bureau.
  d. Existence of at least one financial institution willing to provide low-interest sanitation loans and final output-based payments.
- **Kebele eligibility:** Residents of a certain kebele become potentially eligible to access sanitation subsidies at the time the woreda becomes eligible (following the guidance provided under "household eligibility"). However, if the woreda health office can demonstrate for a certain kebele that it is more difficult and costly to construct a latrine (e.g.rocky, or sandy ground, shallow groundwater level, or crowded slum communities with no access to space for construction), all residents within the kebele or selected sub-kebeles might become eligible for sanitation subsidies. In that case, at least three different suppliers need to be located or established within the woreda that offers the construction products and services required to build adequate pit latrines.
- **Household eligibility**: Following the *Guiding Principle 1*, sanitation subsidies need to be well-targeted. Identification of the poor and most vulnerable should be transparent through community engagement and in line with existing poverty alleviation programs. There should also be household verification and grievance handling body or mechanism in case there are complaints from community members in the process of household selection. As the general guide, recipients of sanitation subsidies should be either enrolled in productive safety-net under the PSNP (in both urban and rural contexts) or formally be exempted from agricultural taxes because of their limited landholding size and agricultural produces (rural

[7]For example: if a woreda has 24,000 households, the private sector shall have the capacity to provide products and services to install at least 200 improved latrines per month.

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context). Under special conditions, all households are eligible for subsidies (see "kebele eligibility").

6.2. Implementation modalities

Given the existence of the PSNP in Ethiopia, the implementation of direct targeted subsidies is proposed based on a voucher system. The voucher system could be replaced or supported by other modalities or emerging technologies if they provide better transparency, data capturing, and overall efficiency.

The existence of the health extension program (HEP) allows providing timely output verification which can be implemented at a low cost. Based on the lists of eligible households, targeted subsidy beneficiaries shall be invited by the PSNP or other equivalent body in non-PSNP intervention districts to attend a half-day training to learn about the importance of improved sanitation, the types of sanitation products and services available in the woreda, and about how to use the sanitation voucher. After attendance of the training, the beneficiaries will receive a voucher from the PSNPto obtain sanitation products covering the non-subsidized portion of the product cost (i.e., in case the subsidy is not 100%) This is in line with the guiding Principle 3 that subsidies should only cover a proportion of the overall cost. Some households might get a voucher for 100% of the costs (e.g. households exclusively consisting of people with disabilities and elderlies).

With the voucher and a20% down payment, the subsidy recipient can place an order at the registered sanitation service providers for a pre-approved "sanitation service package" which includes the production, transport, and installation of an improved slab (pricing to be revised and approved every six months by the Woreda Health Office). As per the Guiding Principle 2, the sanitation service package should only target the latrine sub-structure (except agreed otherwise due to special local conditions).

Upon receipt of the voucher, the sanitation service provider can claim up to another 40% of the payment from a selected financial institution as a low-interest loan (however, never more than a predefined number of orders can be open at the same time). In case of 100%-subsidy, the service provider can collect a loan of up to 80% of the sanitation service package's value.

Upon installation of the latrine and verification by the Woreda Health Office (through the local HEW) the sanitation service provider can collect the final payment from the selected financial institution (which deducts the interest). If the improved latrine has not been constructed within one year time, the households can claim back the 20% down payment from the financial institution.

An independent ombuds team shall be established at the national level that follows up on reported grievances and actively verifies the correct implementation of the sanitation subsidy scheme based on sampling surveys.

6.3. Proposed timeline

A phased implementation approach shall be applied to help to refine the subsidy protocol with practical lessons learned from the implementation and to further develop a solid monitoring framework. Accordingly, the introduction of sanitation subsidy shall follow the following phases:

- **Phase 1 - pilot phase.** The implementation modalities shall be tested in 3 to 5 eligible woredas in different regions (see selection criteria in section 4.1). During the pilot phase, the process and lessons learned shall be carefully documented by a national team led by the FMoH and involving interested development partners. Ideally, team members could establish the national ombuds team during phase 2. Phase 1 is expected to take 12 to 18 months.
- **Phase 2 – scale-up phase.** Following a refined implementation plan based on lessons learned from the pilot phase, 2 or 3 woredas in each region (if they are eligible!) shall be selected. In this phase, regional teams from the RHBs will take on the responsibility for implementing the sanitation subsidies, while a national ombuds team will provide independent supervision.
- **Phase 3 – full roll-out.** Once sufficient evidence is available that the sanitation subsidies provide a cost-effective approach to increase access to improved sanitation facilities by the poor (expected in 2024 or 2025), sanitation subsidies shall be made available for all woredas that meet the eligibility criteria and as per the availability of funding.

Commented [EM3]: I like the two-phase piloting, but as per comments from the consultative meeting, if there is a time and budget constraints, we can refine this to single pilot phase.

6.4. Estimated budget and source of finance

The direct subsidy costs in each woreda are estimated at a total of approximately 4 million Birr over a period of five years (based on 24,000 households/woreda, 20% of all households are eligible and make use of the subsidy). The budget for the following still need to be determined:

- Pre-implementation verification of household lists by RHB
- Half-day training and voucher distribution through the PSNP
- Training and support to Woreda Health Office to define sanitation service packages and to verify the adequate implementation of the service
- Training and support to financial institutions (partly compensated through interest)
- National ombuds team

In parallel to testing the subsidy implementation approach, financing mechanisms need to be identified. The FMoH currently explores new sources of finance that can be made available specifically for tackling the national sanitation challenge. This might include the introduction of new taxes, funding from the national lottery, international development aid, or the allocation of existing funding for poverty alleviation schemes.

6.5. Proposed roles and responsibilities

- **Government:** The government will be in the lead to finance the subsidy program as well as facilitate its implementation with FMoH as the lead Ministry. The exact institutional arrangements need to be established, transparently documented in subsidy implementation guidelines, and formally approved by all actors involved.
- **Development partners:** Development partners will play a significant role in the provision of technical support, particularly during the pilot phase and through the participation in monitoring and evaluation initiatives in collaboration with the ombuds team. Development partners might also provide co-funding.

- **Private sector:** Businesses offering sanitation products and services will be engaged through a market-driven approach to installing improved sanitation facilities.
- **Communities:** Local administration will be responsible for participatory planning, identification of target beneficiaries, and local institutions for the management of resources and facilities, assessments, and negotiation of local demands.
- **Households:** The individual households are responsible to build their sanitation facility with products and services offered by the private sector. Through the subsidy program, these products and services will be made available at affordable costs for everyone.

6.6. Proposed monitoring and evaluation

The progress of the phased subsidy program implementation should be monitored and evaluated with the direct involvement of all actors. For this, the FMoH shall develop and approve a set of key performance indicators (KPIs) to inform progress and achievements of the sanitation subsidy program. As a minimum, the following KPIs should be monitored and transparently reported on a regular basis:

- Number of woredas found eligible for the subsidy program
- Number of eligible households per woreda eligible to receive a full or partial subsidy
- A number that attended training and received a voucher
- Number of eligible households that installed an improved sanitation facility (to be followed up annually for a sample of households to check for sustainable use)
- Number of grievances received and addressed by the ombuds team

6.7. Revision of the smart and targeted sanitation subsidies protocol

This smart and targeted sanitation subsidy protocol is a living document and expected to be revised on regular basis. A first major revision shall be based on field level empirical experience and implementation outcomes in the pilot phase and shall include consultative meetings with all relevant stakeholders. Following that initial revision, the document shall be updated every five years based on the country's progress towards achieving universal sanitation coverage.

7. List of References

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