

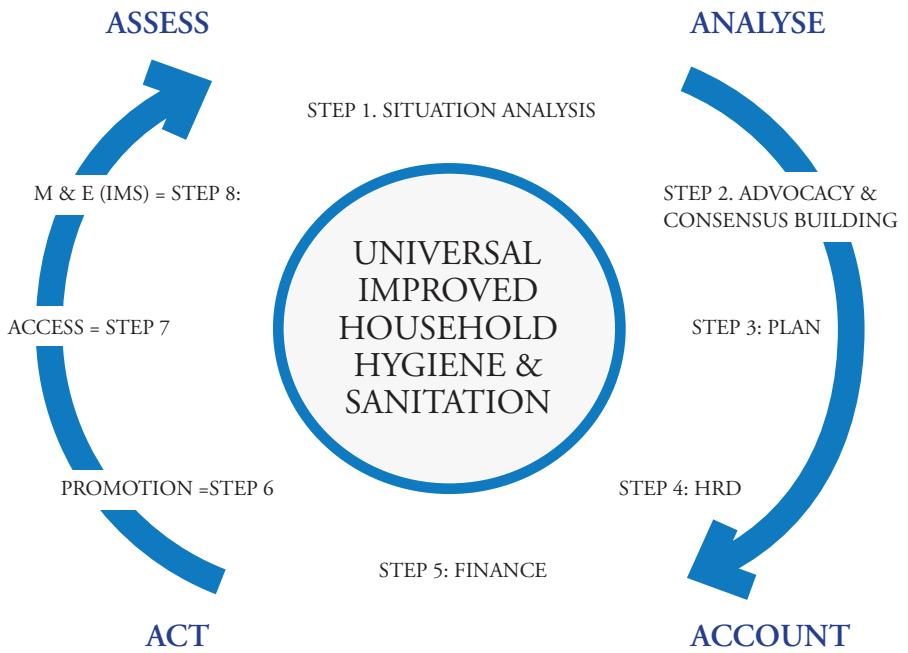


Federal Democratic Republic of Ethiopia Ministry of Health

National Hygiene and “On-Site” Sanitation Protocol

To enable universal coverage of community-led improved hygiene and improved ‘on-site’ sanitation in Ethiopia

June 2006







ACKNOWLEDGEMENTS

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ACRONYMS

BIOGAS	Methane gas produced from decomposing organic matter
CAP	Cascading Advocacy Package
CBO	Community Based Organisation
CFT	Community Facilitating Team
CHP	Community Health Promoter = volunteer
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
RWSEP	Rural Water, Sanitation and Environmental Protection
HEW	Health Extension Worker
HW	Handwashing
IHS	Improved Hygiene and Sanitation
LC	Local Consultant
MDGs	Millennium Development Goals
MIS	Management Information System
MoARD	Ministry of Agriculture and Rural Development
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
Tippy Tap	Plastic container which can be tipped without handling
SDWC	Safe Drinking Water Chain
Selam	Vocational Training Centre (demonstrating technologies)
SMoF	Safe Management of Faeces
SNNPRS	Southern Nations & Nationalities Peoples' Regional State
ToT	Trainer of Trainers
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 excreta. The term Improved Hygiene and Sanitation (IHS) refers to 'on-site sanitation' as referred to in the strategy.



0.1. INTRODUCTION

0.1. The Context

This protocol is designed to follow the national strategy¹ for hygiene and sanitation improvement with its focus on universal access (100% hygienic and sanitised households) in primarily rural or peri-urban environments. Improved hygiene and sanitation when practised by >80% of the population is known to radically reduce diarrhoeal disease and worm infestations². 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 Workers³ will be the primary point of community contact, supported by the kebele health committee (and other extension agents) with supervision by health centre sanitarians and the woreda health office. The protocol will be applied in all aspects of Hygiene and Sanitation promotion. It 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 Process

This protocol, like the strategy, has been developed through an extensive consultative process, which has engaged stakeholders at household, kebele, health centre, woreda, zone, region and national levels. The initial consulting team made up of ministerial and regional health officials, national and international consultants and Water and Sanitation Program (WSP) advisers undertook an extensive briefing at national level before dividing into groups for in-depth woreda and kebele visits and situation analysis in Oromyia, Southern Nations', Amhara, Tigray and Afar regions. Based on the field visits, a zero draft was produced and circulated for comment before a second working draft was presented at a national, broad-based stakeholder workshop with participants from the Ministry of Health (Hygiene and Environmental Health Department, Health Education Centre, Health Services Extension Program Co-ordinator), Ministry of Water Resources, Ministry of Education, Ministry of Agriculture and Rural Development, Regional Health, Water and Education Bureaux, Addis Ababa Water and Sewerage Authority, representatives from Gondar and Jimma Universities, International Organisations and UN Agencies (UNICEF, World Bank, WSP, African Development Bank), bilateral donors and embassies (Netherlands Embassy, SNV, Netherlands Development Organisation), as well as civil society, religious organisations and NGO representatives (PSI, CARE, Ethio Islamic Affairs, Ethiopia Kale Hiwot Church, Islamic Relief, Merlin, Millennium Water Partnership, SUDEA, Water Action, Water Aid). On the basis of workshop recommendations, a final draft document was prepared for a final round of national and regional consultation (including regional stakeholder consultation workshops) and advocacy visits to check consensus, make final adjustments and prepare this final document.

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

2 Cairncross S and Valdmanis V. (2005), 'Water supply, sanitation and hygiene promotion' in Jamison DT, Breman JG, Measham AR et al. (eds.) *Disease Control Priorities in Developing Countries* Washington DC: The World Bank (In press)

3 MoH (2004) *Health Extension Worker - Implementation Guidelines*



0.3. 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, zonal 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

0.4. What is it for?

It is primarily concerned with the safe ‘on-site’ containment and management of human excreta 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, good, replicable, 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.

0.5. 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 eight-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 this document and are listed in the annex.

0.6. The Focus

The protocol aims to support the achievement of minimum improved hygiene and ‘on-site’ sanitation standards in households, schools, health centres, churches, mosques, markets, monuments, eating/drinking establishments and other public places identified as ‘excreta hotspots’. While the majority of Ethiopians live in rural areas, it is widely acknowledged that rural towns and urban slums are heavily contaminated with uncontained excreta of both static and mobile populations. The focus of the protocol will be on the safe ‘sealed, on-site’ containment of human excreta, handwashing at four critical times (After defecation, After cleaning child’s bottom, Before preparing food, Before eating) and preserving a safe drinking water chain from source to mouth. The geographical focus will be rural areas, rural

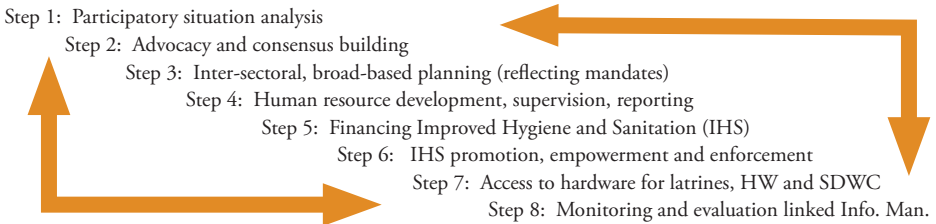


towns and urban slums. The special needs of pastoralists and other groups with special needs will be emphasised and addressed in all steps.

The Protocol Outline

0.7. The eight-step protocol for hygiene and 'on-site' sanitation improvement

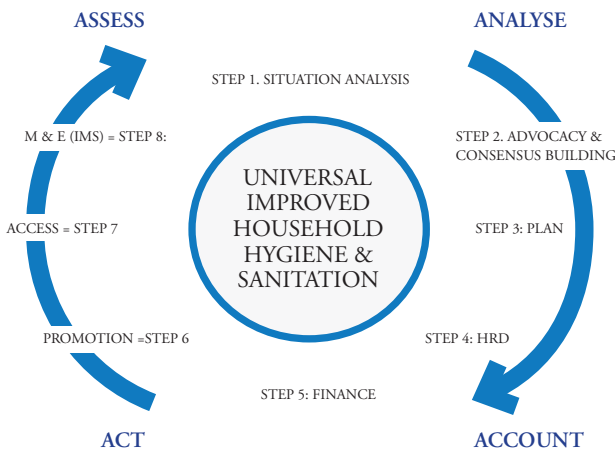
The protocol is a series of eight steps, which require action by stakeholders at national, regional, zonal, woreda, kebele, village and household levels. The steps are backed-up by guidelines, which are referenced in section 9. The steps are built on the principle of a 'cascade' where information flows from household to village, to kebele, to woreda, to region and advocacy flows back from region to households, which in turn cascade their plans and targets back to the region.



0.8. 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 – stakeholder meetings
- Participatory collection of data for planning and monitoring
- Preparation of cascading baseline data sets from village to woreda
- Check inclusion – gender, pastoralists, special needs groups – AIDS patients

1.1. Stakeholder analysis

- The household is the central focus. Women with young children are the primary stakeholders
- The kebele health committee will ensure that the household is the central focus ensuring total inclusion particularly seeking out marginalised groups, but also engaging women’s groups, religious groups and formal societies like the ‘Idir’.
- The woreda health office will help facilitate 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.
- The region/zone⁴ 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. A checklist will be developed, identifying key information to be collected at different levels. The checklist will be standardised and harmonised with other instruments guiding information management e.g. HIMS

BOX 1. STAKEHOLDER TABLE - EXAMPLE

STAKEHOLDERS & CONTACT DETAILS	CURRENT H&S ROLES	OPPORTUNITIES FOR CO-OPERATION
Primary: <i>(high risk groups - vulnerable, the excluded – HIV AIDS)</i> <ul style="list-style-type: none"> ◦ The household - women with children <5 ◦ Pastoralist women with children <5 ◦ Street children ◦ Schoolage children 	<ul style="list-style-type: none"> ◦ Total responsibility for family IHS & child survival 	<ul style="list-style-type: none"> ◦ Mothers’ mutual support/ savings groups funding IHS
Secondary: (government, NGOs, CBOs – groups, associations, private sector) <ul style="list-style-type: none"> ◦ Community health promoters, HEWs, teachers ◦ Women’s groups, Idir ◦ NGOs with IHS experience 	<ul style="list-style-type: none"> ◦ Discreet IHS projects 	<ul style="list-style-type: none"> ◦ Support to woreda for training, developing ‘ignition’ document

⁴ Where there is a zonal office, its assumed that regional and zonal responsibilities are complementary

**BOX 1. STAKEHOLDER TABLE - EXAMPLE**

STAKEHOLDERS & CONTACT DETAILS	CURRENT H&S ROLES	OPPORTUNITIES FOR CO-OPERATION
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 and monitoring

- The kebele health committee will support health extension workers and community health promoters to facilitate baseline data collection (with broad-based stakeholder support) at household, village and kebele level using simple participatory methods⁵. It will be collected with, owned by, and used by the community and the different facilitating teams (in partnership). The emphasis will be on the whole community reviewing their current defecation/hygiene behaviour (mapping, sanitation ladder) to build consensus for collective action to achieve 100% hygienic, sanitised households, villages, kebelles, woredas.
- The woreda health office will provide strategic training and supportive supervision
- The data will relate to the minimum standards and reflect current attitudes and behaviours with desired replacement behaviours. It will include details of available resources (technical/ environmental factors) such as the availability of skilled artisans. The data will cascade up from households to woredas.

BOX 2. CASCADING BASELINE WITH TARGETS – SITUATION ANALYSIS (EXAMPLE)

VILLAGE:	KEBELLE:.....	WOREDA.....	DATE.....
MINIMUM STANDARD	NOW	PLANNED	ACTIVITIES
Safe excreta management (human and animal) Attitudes to latrines	%	%	HEW/CHP house to house assessment, promotion and guidance to toilet construction and locating/digging composting pits for safe animal faeces containment
4 x handwashing practice	%	%	Behaviour trials with soap substitutes, special water dispensers e.g. ‘tippy taps’
Safe water chain	%	%	Use clean, clay pots. Procure plastic buckets with lids
School IHS	%	%	Increase stances ⁶ , form health clubs
Public Latrine IHS	%	%	Privatise the management of all public latrines

- The data will be used to set household, community and institutional targets, agree strategies and monitor change in line with the Health Extension Worker packages at all levels⁷.

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

6 Stances = number of drop holes

7 The WB supported programme has a ‘household motivator’ form which will be simplified and widely used by HEWs and CHPs.



- Baseline data collection and methods will feed into the wider planning, monitoring and evaluation process, including the evolving Health Information Management System⁸.
- Data will be retained in the community and kebele (community map, action plan). It will be aggregated at woreda, zonal and regional levels.
- Feedback will be part of supportive supervision and process/progress monitoring

BOX 3. INFORMATION FLOW - RESPONSIBILITY

ACTIVITY	VILLAGE/ HOUSEHOLD	KEBELLE HEALTH POSTS	HEALTH CENTRE	WOREDA
Collect baseline data on minimum IHS standard	Community Health Promoters	Health Extension Workers	H.C. Sanitarian	Health Office

- primary data collected with the community could include examples of replicable best practice and be complemented/cross-checked by secondary sources such as school and health campaign records (e.g. house to house Polio campaign).
- The kebele (under woreda guidance) will help to identify volunteer Community Health Promoters (CHP) on the basis of one volunteer per 10 households (1:30 maximum standard) who will be trained by HEWs.
- Health Extension Workers (HEWS) will facilitate data collection by volunteer Community Health Promoters in the form of village 'environmental health' maps.

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

- The MoH with regional, zonal and woreda support will prepare guidelines (using existing systems where appropriate) for collecting, recording and 'cascading' information from household via village, to kebele, to woreda.

2.1.1. Situation analysis guideline

A) Demographic Data

- Number of villages (develop a rough map of the woreda)
- Population – demographic structure/distribution
- Woreda profile/main characteristics
- Ethnic considerations
- Main culture, beliefs, gender and religious issues
- Special interest groups, associations, structures – schools with H&S needs

⁸ MoH (2005/6) - Health Information Management System (currently under development by MoH with support from John Snow International)



B) Environmental health issues

- Environmental health problems (Current hygiene practices):
 - » prevalence of communicable diseases (top 10 diseases)
 - » general perception of environmental health problems
 - » handwashing with soap after stool contact
 - » human, child and animal excreta management
 - » drinking water source and storage

C) Sanitation coverage and access

- Household Sanitation (safe excreta management) – systems in use, current design problems, technical options, community preference
- Institutional sanitation: Schools, health facilities, churches, mosques etc.

D) Hygienic practices and risks

- Handwashing behaviour – frequency and use of soap or soap substitute
- Baby/young child stool disposal
- Identification of other high risk practices prevalent in the community

E) Additional information, which needs to be collected

- Key points which might be included when looking back:
 - » Operation and maintenance (sustainability) of H&S facilities, systems and activities – what is their ongoing management?
 - » What has changed (good and bad)? E.g. are latrines still being used? Has water supply remained constant? Is the safe water chain being observed? What are community perceptions?
 - » Are there any key lessons particularly for hygiene and sanitation? i.e. examples of good practice which can be built on.
 - » Are there gaps between what was hoped to happen and what has actually happened?

Milestone 1	Woreda situation analysis report containing cascading data sets from villages and kebelles describing current situation and possible targets
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TABLE: INCLUSION CHECKLIST

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

STEP 2

2. CASCADING ADVOCACY/CONSENSUS BUILDING

Step 2: Summary Actions

- *Deliver advocacy from region to villagel/household – politicians and technocrats*



- *Build consensus and partnership that poor H & S is a key problems at all levels*
- *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 should link closely with the child survival strategy. It could be based on the SNNPRS ‘ignition’ document⁹, which offers an example of form and content, including the links between IHS, poverty reduction and achieving the Millennium Development Goals (MDGs).
- Facilitate the 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 stakeholders¹⁰.

The woreda will:

- facilitate the CAP at kebele and village level by training the Community Health Promoters and by providing necessary inputs for meetings

2.2. Building consensus and 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, village, kebele, health centre and woreda levels. The CAP will require annual review, possible revision and repetition to respond to the prevailing public health situation and level of consensus and commitment built.

- The regional governments (zones) and woreda councils will commit a certain percentage of the respective grants for health, education and water to facilitate achieving stated targets.
- The region (zone) 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 kebele 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 the national results-based management system. Such systems are already in place in the regions.

9 SNNPRS (2004) - ‘Ignition’ document explaining the HSDP and the case for high impact, broad reach public health interventions. It has been circulated to all regions for adaptation.

10 SNNPRS (2004) - The format for the performance related contract (for regional adaptation)



2.2.2. Consensus around minimum package for interventions

Where funding is available, woreda health offices are encouraged to contract services from the private sector¹¹ or form partnerships with NGOs to facilitate woreda-level advocacy on the importance and benefits of an integrated multi-sectoral approach to IHS. The focus of this advocacy will be the Woreda Council, woreda staff, Kebele Development Committee and community leaders.

The Woreda WASH Team, HEWs, CHPs, WASHCOs 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 four critical times¹² and keeping their own drinking water safe from collection to use.

2.3. Encourage and increase accountability of stakeholders

- The region/zone will develop guidelines for performance related contracts drawing on SNNPRS experience. The region/zone will counter-sign with woreda staff
- The woreda and kebele will with the region and the zone set achievable minimum targets, which will be entered into the performance contract they will sign with regional and zonal staff.

BOX 4. PERFORMANCE CONTRACTUAL AGREEMENT

Zone/ Special woreda	Woreda	Latrines	Hygiene HW/SDWC	Immunisation DP3	MCH Service Coverage	Family Planning Service Coverage	Health Post Construction	Out Patient (Malaria)	Signed Woreda/ Zone

Milestone 2

Broad-based consensus and commitment to a basic IHS standard reflected in cascading performance related contracts from village via kebelles to woredas

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 (with budget according to mandate), one reporting and monitoring system
- Planning framework guide – regions to provide planning guidelines

¹¹ Example: Woreda Support Groups (WSGs - local water, sanitation and hygiene consultants) currently supported through the World Bank funded WSSP

¹² Handwashing with soap or substitute and water at four critical times – after defecation, after cleaning child’s bottom, before preparing food and before eating.



- Capacity for IHS co-ordination built at all levels
- Check inclusion - gender, pastoralists, special needs groups – AIDS patients

3.1. One plan, one reporting and one monitoring system

- On the basis of the situation analysis report, woreda inter-sectoral WASH teams will prepare harmonised Specific, Measurable, Achievable, Replicable, Time-bound (SMART) workplans of action in line with the institutional mandates and following the strategic framework of the National Hygiene and Sanitation strategy. Box 4 suggests a possible logical framework outline for action planning.
- The woreda council approve plans.
- 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. Action 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 20XX through realisation of the National IHS Strategy	<ul style="list-style-type: none"> ◦ x % of target population practice safe water chain, safe excreta management & hand-washing at 4 critical times ◦ Diarrhoea/worm infestation/trachoma Other skin/eye infection changes 	<ul style="list-style-type: none"> ◦ 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	<ul style="list-style-type: none"> ◦ % of faeces free households, villages, streets ◦ % of households reporting hand-washing practice at critical times ◦ Safe water chain observed in use in x% of villages/villages 	<ul style="list-style-type: none"> ◦ 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: <ul style="list-style-type: none"> ◦ School H&S ◦ PHAST sessions ◦ Picture based toolkits produced ◦ Skills upgrading for promoters 	<ul style="list-style-type: none"> ◦ Facilitators and artist for picture-based toolkits ◦ Manuals ◦ Behaviour trails ◦ H & S bounty packs¹³ or new mothers 	<ul style="list-style-type: none"> ◦ # 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, zonal, and woreda levels:

- Steering committee,
- Technical team
- Co-ordination unit

The Donor Assistance Group will provide support to these bodies through the new multi-stakeholder fora 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 IHS 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 good, replicable practice (quarterly newsletter)
- Oversee the development and implementation of a financing strategy for HS
- Advice on resource allocation
- Sub-sector performance monitoring

3.3.2. Regional, zonal

All regions will:

- Develop their customised inter-sectoral MoU¹⁴.
- Have an inter-sectoral co-ordinating committee (in line with the terms of reference of the national IHS forum) with the participation of government officials, NGOs, private sector and religious leaders. The committee will meet quarterly (with agreed quorum) to review regional, zonal, 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.

¹³ Bounty packs include soap, towels, plastic containers (potties) for new mothers

¹⁴ Regional MoUs have been developed and signed in Tigray and SNNPRS



3.3.3. Woreda

All woredas will have an inter-sectoral co-ordinating committee with the participation of Government officials, NGOs, CBOs, women’s associations, private sector and religious leaders. The committee will meet quarterly (with agreed quorum) to review regional, zonal, IHS activities and progress against IHS plan. IHS reporting will be carried out within the existing but strengthened reporting structure (Checklist for IHS).

3.3.4. Kebele

The kebele WASH committee or health committee will plan, co-ordinate and monitor IHS activities in the kebele with support from HEWs or the CHPs¹⁵. Where there is no WASH committee, this role will be carried out by the kebele development or health committee.

3.3.5. Village

Village leaders and CHPs with support from HEWs will co-ordinate activities at village level.

Milestone 3	Inter-sectoral woreda teams prepare harmonised Specific, Measurable, Appropriate, Realistic, Time bound IHS plans according to their mandates, which reflect village and kebele IHS priorities. The woreda council approves the integrated woreda WASH plans and budget accordingly within wider five -year strategic plan.
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TABLE: INCLUSION CHECKLIST

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

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 help build capacity
- Inclusion checklis

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.

¹⁵ Community facilitation teams can provide additional support especially in kebelles with no HEWs deployed



- Woreda EH workers, Health Extension Workers, community mobilisers and engineers from the MoWR plus school inspectors, teachers (MoE) and extension workers (Ministry of Agriculture and Rural Development) 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, zonal, 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, zonal*

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 guidance¹⁶, 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, zonal, 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.

4.1.5. *Kebelle*

The health extension workers will provide exemplary IHS leadership and will train and support

¹⁶ The region will set standards and guidelines for certifying staff to engage in IHS services



Community Health Promoters to set a positive example and influence others to follow suit, through direct promotion and through modeling key behaviors.

4.1.6. Village

The CHP will provide the key link to their 10-30 households and will require a minimum package of incentives (free health care, 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 as well as the RHB before use.

4.2. Identifying key staff at different levels

4.2.1. Systematic zoning of staff

The woreda health office 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 together with CHPs 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/ Sub-kebele	◦ Community Health Promoter (volunteer) ◦ Model women, model farmers	◦ Understanding minimum IHS package – house to house promotion with basic kits
◦ Kebele	◦ Health extension workers, ◦ Kebele chair, Local service providers	◦ PHAST methods, drama, CAP, teamwork
◦ Health centre	◦ Sanitarian	◦ PHAST ToT, facilitation skills e.g. focus groups, community mapping, supervision
◦ Woreda	◦ Head of health, Environmental Health workers, Health unit (staff such as MCH nurses), water, education Offices ◦ NGOs, Woreda Support Groups	◦ Radio chat shows, ToT facilitation, CAP, planning, budgeting, co-ordination, Programme management, supervision



BOX 5. KEY STAFF AT DIFFERENT LEVELS (SUGGESTED)

LOCATION	STAFF DESIGNATION	KEY SKILLS REQUIRED
◦ 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	◦ EH Staff	◦ Supportive supervision, co-ordination ◦ Advocacy ◦ Strategic planning

4.3. Defining the training gaps (with reward structure)

4.3.1. Communication skills

- Sanitation and hygiene extension workers – health extension workers, community health volunteers, EH staff, health clinic staff, school teachers 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 with appropriate rewards.
- Basic IHS skills should be included in the curriculum of all health cadre training
- 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 offices and regional health bureaux.

4.3.2. Current skills gaps

- Participatory hygiene and sanitation transformation methods with specific reference to the special needs of pastoralist groups.
- 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

4.3.3. Supportive supervision

- Supportive supervision must be built into all training
- Senior officials, including Cabinet members, should conduct regular supervisory visits.



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

All NGO and private sector supported IHS programmes 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 after proper identification of 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 five years
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TABLE: INCLUSION CHECKLIST

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*
- *Cost implications of the eight protocol steps*
- *Financing 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 large scale private sector organisations. Public financing should be used for public health worker costs and all software activities such as advocacy, social marketing, capacity building, demonstration and regulation.
- Public finance should be available to fund and lever funding for the construction of institutional latrines¹⁷; schools, health centres, market places, prisons, and other community sites.
- Woreda health office must ensure all public latrines are constructed and managed to a high hygienic standard. Options such as public/NGO/private sector partnership (for both construction and

¹⁷ Guidelines/standards for institutional latrine construction under preparation



management) with user charges will be encouraged. The private sector should be encouraged to build and manage public latrines.

5.1.2. The household standard and household contribution

The household will take responsibility for investing and constructing a latrine, providing a handwashing facility, as well as covered pots or buckets. The CHP and HEW will provide guidance¹⁸

The woreda will NOT subsidise household latrines except in specific situations where village/kebele leaders identify abject poverty, extreme physical disability or adverse local ground conditions confirmed by HEW. For such cases, the woreda council will establish a ‘discretionary’ IHS fund with criteria for eligibility¹⁹.

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 handwashing 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 (slab producers – small scale providers, soap and plastic manufacturers) has a strong commercial interest in IHS and with their 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

5.2. Cost implications of the Eight Protocol Steps

5.2.1. Situation analysis

The Woreda health office will facilitate the completion of the situation analysis as part of the overall CAP process. The baseline reinforces the ‘ignition’ document and informs the targets for the performance monitoring.

Box : Communal Cross-Subsidy

Communal cross-subsidy has proved to work in the total sanitation campaign in Bangladesh where the wealthy support the poor to construct latrines.

Source: Kamel Kar (IDS Bulletin 257, 2005)

18 MoH (2004) – Construction Usage and Maintenance of Sanitary Latrines –Extension Package

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



The cost of the Cascading Advocacy Package (CAP) in SNNRPS to reach all villages, kebelles, and woredas, was estimated at US\$ 50,000 and included the cost of the CAP training and 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!

5.2.2. CAP

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

5.2.3. Planning

The idea behind the ‘One planning, one monitoring, one reporting 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 advocacy step’ in the interests of saving time and resources at village and kebele 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 US\$.20 per head served. The average package will include posters, flyers and a set of

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%).
- Large 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.



picture-based toolkits covering the ‘f’ diagram, a sanitation ladder and key hygiene behaviours (hand washing and the safe water chain).

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 promotion and enforcement²⁰.

5.2.7. Access to hardware

The Woreda administration will be encouraged to provide funds for the construction of two demonstration latrines (showing appropriate technologies) per 100 households in each Kebele with attached handwashing facilities. The private sector should be engaged, preferably by local community stakeholders²¹, 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. It is recommended that demonstration units should ideally be provided for vulnerable households, but could also be considered as part of the CHP incentive structure for achieving targets.

5.2.8. Monitoring and evaluation

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

5.3. Financing the protocol

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

Examples of creative low-cost pre-conditions 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. This type of sanction is dependent on political support.

20 WSP Uganda (2004) Workshop report on good replicable practices. In Busia district, Ugandans were fined for failing to comply with the local sanitation ordinance. The ‘revenue’ was used to fund the costs of running motor-cycles

21 RWSEP (2004) Annual Report. In Amhara region, the Rural Water Sanitation and Environmental Protection RWSEP) supported by Finnish government funding has had great success where the community manages the contract for shallow well construction as the community will ensure good value for ‘their’ money



BOX 6. EXEMPLARY OUTLINE FOR COSTING THE PROTOCOL

DESCRIPTION	ACTIVITIES	INPUTS	FUNDING SOURCE
IGNITE²²			
STEP 1: Situation Analysis	Baseline	Facilitators, allowances,	Dedicated regional budget for CAP (high impact, broad reach public health)
STEP 2: CAP	Cascading advocacy	transport, stationery,	
STEP 3: Plan	Planning	‘advocacy packs’	
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 six 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	Households, sector block grants, Donors, NGOs, private sector, user fees
VERIFY			
STEP 8: M&E	Routine visits	Allowances, transport, soft hardware, communication	Sector block grants 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			

STEP 6

6. PROMOTION, EMPOWERMENT AND ENFORCEMENT

Summary

- *Choosing appropriate IHS messages for different audiences*
- *Providing manuals, PHAST tool kits and materials*

²² SNNPRS (2004) Ignition Document. Cost of cascading advocacy for 14 million = US\$ 50,000



- *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 to include community and religious leaders (ensuring gender parity). The woreda health office 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/zonal team will provide each woreda with a simple set of promotional tools (charts) 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 health office will :

- supply HEWs and CHPs with basic ‘promotion kits’ and appropriate training (to include other development extension agents where appropriate.
- support HEWs and CHPs 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 CHPs 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/Woreda Health Committee 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, CHPs’ manuals, household behaviour change forms and four sets of 20 key pictures

At kebele level, HEWs²³, Agricultural/development agents and NGOs will:

- provide support to WASHCO/Woreda Health Committee and CHPs 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 facilitate or attend the CHPs training
- support intensive sanitation campaigns (e.g. local artists performing IHS related dramas and songs in schools and community meetings)

²³ Community facilitation teams can provide additional support especially in kebbelles with no HEWs deployed



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 six 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 villages in a region and all households in the village.
- 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/CHPs – Household visits with traditional leaders*

- HEWs, Development agents and CHPs will visit all households on a regular basis in line with ‘zoning’ where individuals take specific responsibility for a given area.
- HEWs, Development agents and CHPs (or model women and model farmers) will set an example and encourage their target (maximum) 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 (including adequate urinals and handwashing)
- School health clubs/child to child activities reinforce safe behaviours
- School children influence their peers and their parents

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/Mobile IEC units*

- Radio has been shown to have a wide audience, but is expensive and

In Southern Nations’ Region, some schools were closed until all children produced a certificate from their village leader that their household had a latrine



should be used strategically.

- ‘Mini-media’ options to be considered at schools (drama, use of tape recorders)
- Regions will consider viability of using mobile IEC units (possibly in partnership with private sector soap manufacturers etc.)

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 is profit. The trick is to harness commercial and social interest together with creative concessions and incentives.

6.3.8. *Product marketing*

All regions will engage with NGOs (like PSI) and the private sector (Roto Mulder and Unilever) to engage in the social marketing of latrine and handwashing 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/regulations*

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 imposing fines for failure to comply with minimum standards, sanctions will include a variety of positive enforcement measures such as community service (helping to build relatives’ latrines).

6.4.2. *Name-and – shame*

Two positive examples of ‘name and shame’ approaches that could be applied in Ethiopia (with some adjustment for local conditions), particularly in well-known, high volume, high risk defecation sites, come from Bangladesh and India respectively. In Bangladesh, children were given red flags to mark faeces on a well-known defecation 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 used by the whole family and could be confirmed by neighbours. Such community maps have been recommended to be part of community baseline data collection and planning.



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

Where householders refuse to construct and use latrines evidenced by scattered faeces, on-the-spot fines can be administered, but preferably deferred to a community service order where the offender has to construct his own latrine or help a relative.

Milestone 6	Woreda health office, Health Centre Staff and HEWs increase the number of communication channels to achieve six methods by ET.Cal. 2000, including empowerment with reach and penetration to all kebelles.
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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, handwashing & safe water chain technologies/products
- Apply inclusion checklis

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

7.1. All comply with minimum standard

7.1.1. Household

The village 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 and a compost pit for all other organic wastes, including animal faeces). “Sealed” means that there are covers for the hole in the platform/slab and that any ventilation pipe is screened.

The woreda health office will be encouraged to provide funds for the construction of two demonstration household latrines (one improved traditional pit latrine with wood and mud slab, cover and handwashing facility; and one improved traditional pit latrine with 60cm x 60cm reinforced concrete slab, cover and handwashing facility) per 100 households in each kebele. Demonstration units will be constructed in appropriate places (for the vulnerable or as rewards for CHPs) as part of local artisan training to show people some options in practice. The new owners will be expected to report back to



others on their impressions. The estimated cost per latrine is about ETB 300. The Woreda health office 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.’). The latrine wall offers additional public information opportunities.

7.1.2. Institutional

The woreda health office 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 could be adopted as a standard). The woreda health office 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 < 100:1
- » Boys to latrine stance ratio < 150:1
- » Boys to urinals ratio < 150:1
- » All have simple handwashing facilities-supplied daily with water, soap/ash
- » All classrooms have safe drinking water from a ‘safe chain’.
- » All schools have refuse pits
- The woreda health office/kebele (with the institution) will ensure effective (hygienic) daily management and timely emptying. The ‘in-charge’ will be held personally responsible.
- Religious leaders will be encouraged to make facilities available at religious houses.
- Prison authorities will be encouraged to make minimum standard facilities available (biogas units have proved to be very effective for high concentrations of people. The methane gas provides a safe ‘renewable’ energy source).

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

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 six months).



a long term cost recovery basis). It will be necessary for urban authorities to invest in persuading users of the need to pay for a higher quality of service. The viability of such arrangements will need to be closely tested and routinely monitored. People in urban areas are generally willing to pay for hygienic public toilets with water (soap) for handwashing.

7.1.4. Communal

The urban woreda, municipality or urban local government authority will ensure house owners (renters) comply with IHS standards. Where space is short, communal latrines will be built and funded by public/private/NGO – house owners (renters) partnership. ‘Easy to empty latrines’ with handwashing facilities will be provided on a family to stance ratio <10:1: 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 could be adopted as a standard. Biogas units have also been successfully applied in the capital Addis Ababa. Both public and communal toilets should have integral handwashing 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 (drawing on and encouraging local innovations), 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-san²⁴./biogas).
- 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, municipalities, private sector, NGOs, other stakeholders, house owners who rent out rooms 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 might include small bore sewerage linked to biogas successfully applied in Bangladesh slums²⁵. Creative finance might include mutual savings, soft bank loans, private/public sector partnership and user charges! As important urban stakeholders, house owners who rent out houses/rooms will provide the minimum IHS standard in any property. Woreda health staff will advise them that a

24 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

25 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), wcd@ethionet.et



licence to rent is dependent on 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 Health Promoters will play an important role in promoting urban IHS²⁶

BOX 7. EXAMPLE OF ON-SITE SANITATION LADDER

	Minimum Standard	Higher Cost/lower risk
		Pour-flush ²⁷ & HW, biogas
		Eco-pit, slab, vent with handwash
		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
	Minimum Standard	

7.2.1. Artisan training

The Woreda health office 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 health office will ensure that training for CHPs will include the practical construction of an improved traditional pit latrine and handwashing facility at a CHP’s home (with materials and labour to be provided by the CHP, but the time of latrine artisan paid for by woreda health office for the initial training).

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

The community will provide the CHPs with assistance, such as building their latrines and hand washing facilities or reducing their contribution to the water system, subject to the WASHCO/Health

26 MoH - Urban Health Extension Programme - currently under preparation

27 Pour-flush can either be linked to septic tanks or via small bore sewerage to biogas digesters.



Committee being satisfied with their performance and wanting to reward them.

The kebele will ensure that the renovation/provision of safe, low-cost institutional latrines with handwashing facilities at schools and health facilities within the community is part of the village/ community IHS Plan. All institutional latrines should be in accordance with the appropriate Ministry of Health / Ministry of Education design.²⁸

The woreda health office/kebele 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 and small children.

The region will make a range of technical drawings, pictures and bills available to vocational training centres, private sector consultants (e.g. WSGs), environmental health professionals, artisans, HEWs, CHPs and CFTs.

7.2.2. *Handwashing*

All levels will increase their focus on handwashing. 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’)²⁹

The private sector will make soap and simple handwashing facilities available for households through increased support for kebele 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 health office will ensure all new water sources comply with standards³⁰ and there is routine point source and point of use testing. The region will oversee the procurement and distribution of water testing kits. The Woreda health office 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.

28 MoH – Institutional, public, communal latrine design standards

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

30 National guideline for drinking water quality currently under preparation



Milestone 7	Woredas develop rural and urban ladders reflecting appropriate, affordable options, establish artisans with necessary construction skills and build demonstration units in each kebele.
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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 four levels*
- *Monitoring and Evaluation*
- *Inclusion checklist – gender, pastoralists and special needs e.g. AIDS patients*

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 within the framework of ‘the ‘One Plan, One Reporting and One Monitoring and Evaluation System’. The community/ kebele, woreda, region and national levels belong to one system catering for the same set of indicators. This is 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 learning skills. In addition, supportive supervision is a fundamental aspect of personnel management and quality assurance. It can be linked to performance monitoring.

8.1.3. Set behaviour objectives with indicators

National and regional health communication and capacity-building strategies will spell out behavioural 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 village to kebele 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 programme implementers.
 - » Financial Report and Audit: A basic financial report should be made transparent at woreda 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 levels since most of H & S activities are performed at these levels, but the data will cascade from village via kebele, woreda, 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 four levels

There are four levels of the monitoring system: community/kebele – 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/Kebele level monitoring and reporting

Data Collected by HEWs/CHPs 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 a community level monitoring system. The use of computers at woreda level will allow inclusion of full compliance calculations and comparison between communities to identify good, replicable practices. Such reports will be disseminated to communities for feedbacks. 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 /zonal level monitoring and reporting

At the regional (zonal) level, the monitoring system will be supplied and updated by data from woredas' M&E systems. Woredas will get feedback on good, replicable 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

8.3. The M & E System

The system operates on three sets of indicators: process indicators, result indicators, SH improvement indicators. The process and result indicators belong to the eight steps of the programme cycle. Each of these cycles has one or more processes.

8.3.1. Process indicators

The process indicators measure the attainment of process goals while the result indicators measure the degree to which expected results are actually obtained. Processes belong to actors and their supervisors as a device to measure if the selected activities are successful or not. When an indicator value is entered into the system it is broadcasted to upper levels.

8.3.2. Result indicators

IHS result indicators measure behavioural change, access to hardware and health impacts by comparing data obtained from updated community defecation and handwashing maps with baseline data. Like baseline data, IHS indicators emanate from community maps and as in baseline data are cascaded upwards through aggregation.

8.3.3. Suggested process and result indicators

ACTIVITY	PROCESS GOAL	PROCESS INDICATOR	RESULT	RESULT INDICATOR
STEP 1: SITUATION ANALYSIS				
Stakeholder analysis	Broad-based meetings	Number of meetings & attending stakeholders	Consensus on stakeholders roles & responsibilities	Stakeholder roles & responsibilities agreement
Baseline Data Collection	PHAST procedures to collect data used	# of community reporting use of PHAST procedure	Community defecation & handwashing practice map	# of community submitting copy of map to kebele



STEP 2: CASCADING ADVOCACY/CONSENSUS BUILDING				
Facilitate the CAP	Broad-based meetings & sessions to facilitate CAP	# of CAP facilitation meetings	performance related contract signed	# of contracts signed
STEP 3: CASCADING PLANNING				
Plan preparation & ratification	Integrated SMART plan for implementation, reporting & monitoring that reflects village & kebele priorities	# of woredas with plan integrated in the woreda strategic plan	Ratified Plan	# of woredas with plan ratified by council
Establishment of WASH forum & inter-sectoral co-ordinating committees	Participation of government officials, NGOs, private sector & religious leaders	# WASH forum, committees that have government officials, NGOs, private sector & religious leaders as members	National level multi-sector WASH forum, regional & woreda level inter-sectoral co-ordinating committees established	# of regions & woredas that have inter-sectoral coordinating committees
				National level multi-sector WASH forum established
STEP 4: HUMAN RESOURCE DEVELOPMENT				
Minimum training package	Reach appropriate (gender balanced) staffing levels	# of staff by qualification, gender, position	CRP performance	# of latrines constructed/ kebele
Certification of staff engaged in HS promotion	Certification reflects minimum level of required training	# of certificate issued by type & position, gender & employment of holder		
Introduction of necessary new skills		# of training provided by type of training, provider & participants		



STEP 5: FINANCING IMPROVED HYGIENE AND SANITATION				
Financing the eight protocol steps	Public financing used for public health worker costs & all software activities. No subsidy to household latrines except in accordance to established 'discretionary' IHS fund eligibility criteria	Households investing for their own sanitation hardware	# of HH latrines constructed/kebele	
		Woredas funding for institutional latrines	# of institutional latrines constructed/woreda	
		Private sector constructing & managing public latrines	# of public latrines constructed & managed by private sector /woreda	
		Private sector actively participating in advertising & promoting sanitation materials	# private sector actively participating in advertising & promoting SH materials	
STEP 6: COMMUNICATION, PROMOTION AND ENFORCEMENT				
Providing manuals, tools & materials	HEWs & CRPs communicating with and advising households on 'small doable actions'	# of HH latrines constructed/ kebele	Each woreda provided with set of promotional tools & manuals	# of woredas supplied with promotional tools & manuals
Support & supply HEWs, CRPs & WaSHCOs with promotion kits, tools & materials		# of handwashing facility & SDWC set up/kebele	HEWs & CRPs supplied with basic Promotion kits	# of HEWs & CRPs/ kebele supplied with basic Promotion kits
Supporting WaSHCOs & CRPs	Participation in peer group meeting, household visits & reporting	# of peer group meeting conducted/kebele # of HH visits/ kebele		



Step 7: Access to hardware				
All comply to the minimum standard	All latrine types (household, ...) confirm to minimum standard	# of latrines by type/woreda that conform to the minimum standard		
Make options available	Details of pastoral & special needs in sanitation ladder		Rural & urban ladders developed, reflecting affordable options	# of woredas with developed rural & urban ladders

8.3.4. Indicators for Baseline Survey and Sanitation & Hygiene improvements

HEALTH IMPACT INDICATORS

% of children < 36 months of age with diarrhoea in the last month

ESSENTIAL FAMILY PRACTICES

% of population washing hands properly with soap and at appropriate times

% of children whose faeces were disposed safely

% of households that practice safe drinking water management

% of caretakers who practice safe food management

ACCESS TO HARDWARE

% of Households with access to improved water sources

% of Households with access to minimum standard and hygienic latrine

% of Households with access to hand washing place with soaps or substitutes

COMMUNITY WATER SYSTEMS

% of Households that have sufficient quantities of water

% of Households with access to improved water sources during dry and wet seasons

SANITATION AND SOLID WASTE

% of Households that have child-friendly faeces disposal facility



% of Households that have a hygienic solid waste disposal system

HOUSEHOLD TECHNOLOGIES & MATERIALS

% of Households that have soaps or substitute

% of Households that use a safe method for transferring drinking water from a container

% of Households that have covered and narrow neck water storage containers

BEHAVIOUR

% of Households using a properly cleaned toilet facility

% of Households who clean their water storage containers at least once per week

% of Households who have participated in community hygiene promotion activities

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
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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 World Bank supported programme has a 'household motivator' form, which will be simplified and widely used by HEWs and CHPs.
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, broad-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 levied against those failing to comply with the local sanitation ordinance. The 'revenue' was used to fund the costs of running motorcycles
15. RWSEP (2004) Annual Report. In Amhara region, the Finnish Government funded RWSEP has had great success where the community manages 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
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.
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), wcdco@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. National guidelines for drinking water quality are currently under preparation and will to a large extent refer to international WHO drinking water quality standards