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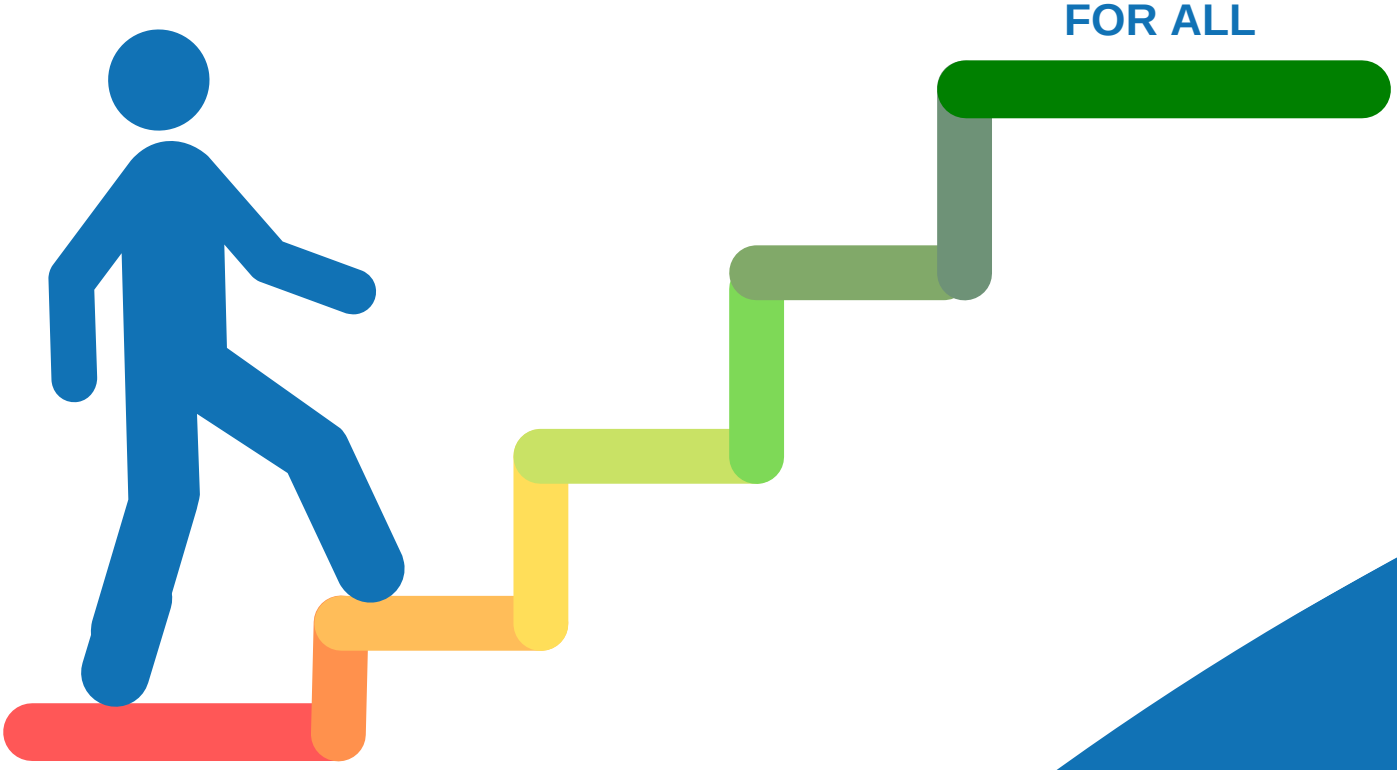
MINISTRY OF HEALTH - ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

NATIONAL SANITATION SUBSIDY PROTOCOL

2030
SANITATION
FOR ALL



May 2022

Addis Ababa, Ethiopia

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FOREWORD

The Ministry of Health (MoH) is committed to improving the sanitation, hygiene, and environmental health status of its citizens and has developed and is leading the coordination of planning and implementation of sanitation, hygiene, and environmental health development programs,[1] and strategies[2] in collaboration with various development partner organizations. In the second health sector transformation plan, MoH plans 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 enable Ethiopia to achieve its goal of attaining Sustainable Development Goal 6.2 - universal access to basic sanitation services by 2030 and Health Sector Transformation Plan 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 for 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 market-based sanitation and Community-Led Total Sanitation and Hygiene (CLTSH) approaches, but rather contributes to the expansion thereof. A targeted sanitation subsidy specifically addresses 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 this protocol consistently for the improvement of sanitation, hygiene, and environmental health facilities and services across the country.

Dr Dereje Duguma

State Minister, Ministry of Health

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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

OPERATIONAL DEFINITIONS

Basic sanitation services: Use of improved sanitation facilities that are not shared with other households.

Improved sanitation facilities: Sanitation facilities that are 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.

Sanitation subsidy: A direct or indirect payment, economic concession, or privilege granted by government or partner organizations to households in order to make improved sanitation facilities affordable.

Smart sanitation subsidy: A subsidy that does not distort or affect market-based sanitation and CLTSH approaches, but rather contributes to the expansion thereof.

Social protection scheme: A system of formal and informal interventions that aim to reduce social and economic risks, vulnerabilities and deprivations for all people and facilitate inclusive social development and equitable economic growth.

Targeted sanitation subsidy: A subsidy that specifically addresses the most vulnerable population groups that are not able to construct improved sanitation facilities on their own due to extreme poverty and/or impending environmental factors.

Unimproved sanitation facilities: Sanitation facilities that do not hygienically separate human excreta from human contact. This includes dry pit latrines without slabs, hanging latrines, bucket latrines, and flush and pour-flush toilets discharging into an open drain.

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1. Current context

1.1. Inequalities in sanitation and hygiene coverage

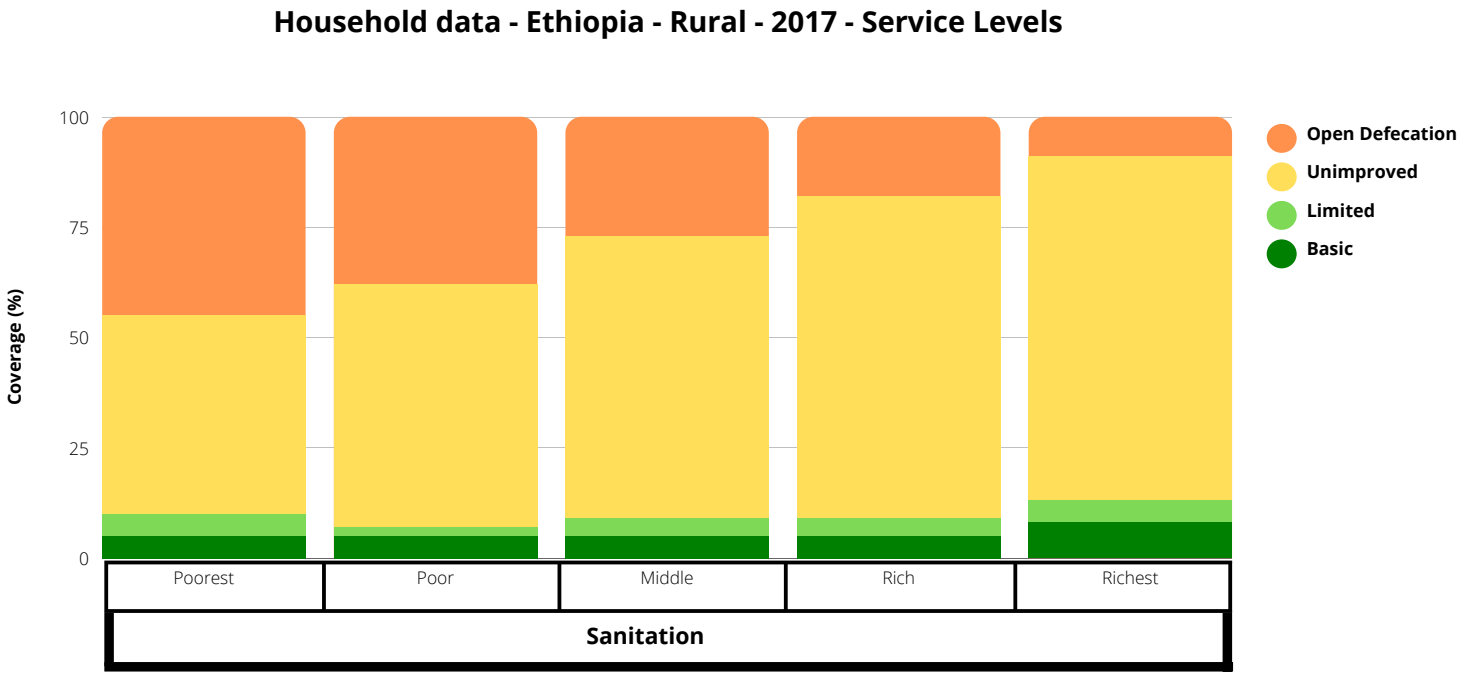
Between 2000 and 2017 Ethiopia made remarkable progress by reducing open defecation from 79% to 22% (JMP, 2019). Despite this achievement, the country fell short of its ambitious goal of achieving 100% of households properly using latrine facilities by 2020 as stipulated in the Health Sector Transformation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

The most recent JMP report (JMP, 2019) indicates an overall low coverage of basic sanitation services[3] with a high disparity between urban and rural sanitation in Ethiopia (20% in urban versus 4% in rural areas). The proportion of households with basic sanitation services remained at a low level in both urban and rural areas between 2000 to 2017 (i.e., negligible 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, I was not attained (HSTP I, 2015). The target under the Health Sector Transformation Plan II (HSTP II, 2020) has now been revised to 60% of households having 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), see 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-income households defecate in the open, the rate is higher for the middle-income households 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%), 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.



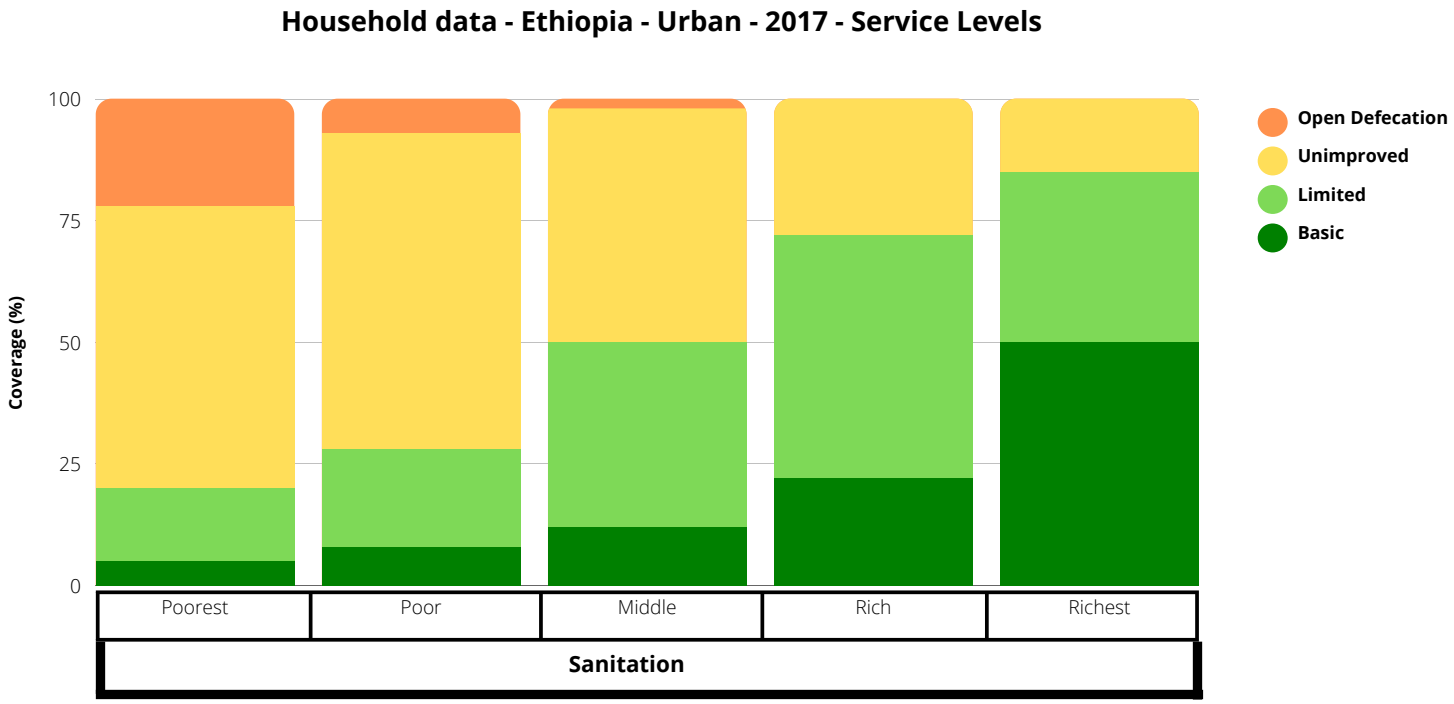


Figure 1 Sanitation service levels disaggregated by rural/urban and wealth quintiles (JMP, 2019)

1.2. Major activities undertaken 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 were traditional unimproved 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 sustainably separate feces 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 outside support. Therefore, Ethiopia introduced sanitation marketing in 2013 as an approach to better serve post-CLTSH open defecation free (ODF) communities with suitable sanitation products and services through the private sector. By 2020, more than 500 businesses have been supported or established (mostly micro and small enterprises) and are now providing sanitation products and services in more than 230 districts throughout the country (FMoH, 2020). Still, 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, to enhance efforts, a market-based sanitation implementation guideline has been revised and launched (FMoH, 2020).

4 Pit latrines with slabs that completely cover the pit, with a small drop hole, 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.

5 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.

In line with scaling up MBS efforts in the country, a major national ODF campaign is being prepared (2021-2024) under the motto “TSEDU Ethiopia” (a clean Ethiopia). The goal of the campaign is to declare all woredas in Ethiopia ODF by the end of 2024 by creating sustainable behavioural change.

The campaign has a broad scope and encompasses human excreta disposal, faecal sludge management services, menstrual hygiene management, provision of materials needed for improved hygiene (e.g., water, soap, sanitary pads), and changing human behaviours 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 settings and upgrading of existing ones). In terms of financing, 60% of the budget is expected to come from local sources (government contributions 40% and community contributions 20%), and the remaining 40% is expected to come from international development partners.

1.3. Policies and practices on sanitation subsidies

The CLTSH approach prescribes that an intervention should be implemented without subsidies 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 affect the market that is still in its infancy. 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 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 how the subsidies should be delivered.

This sanitation subsidy protocol is developed to provide guidance on any intervention introducing subsidies for sanitation in the country (i.e., including ODF campaigns and beyond) through specifying 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 include the following:

- Productive safety net program (PSNP),
- Community Based Health Insurance (CBHI),
- Employment promotion and livelihood support,
- Social insurance,
- Access to basic health, education, and social services, and
- 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[6] rate from 44% to 27% between 2000 and 2016.

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 below the poverty line in rural areas is almost twice as high as in urban areas. While urban poverty fell by more than half between 2000 and 2016 (from 37% to 15%), rural poverty only fell from 45% to 26% (UNDP Ethiopia, 2018), see Figure 3.

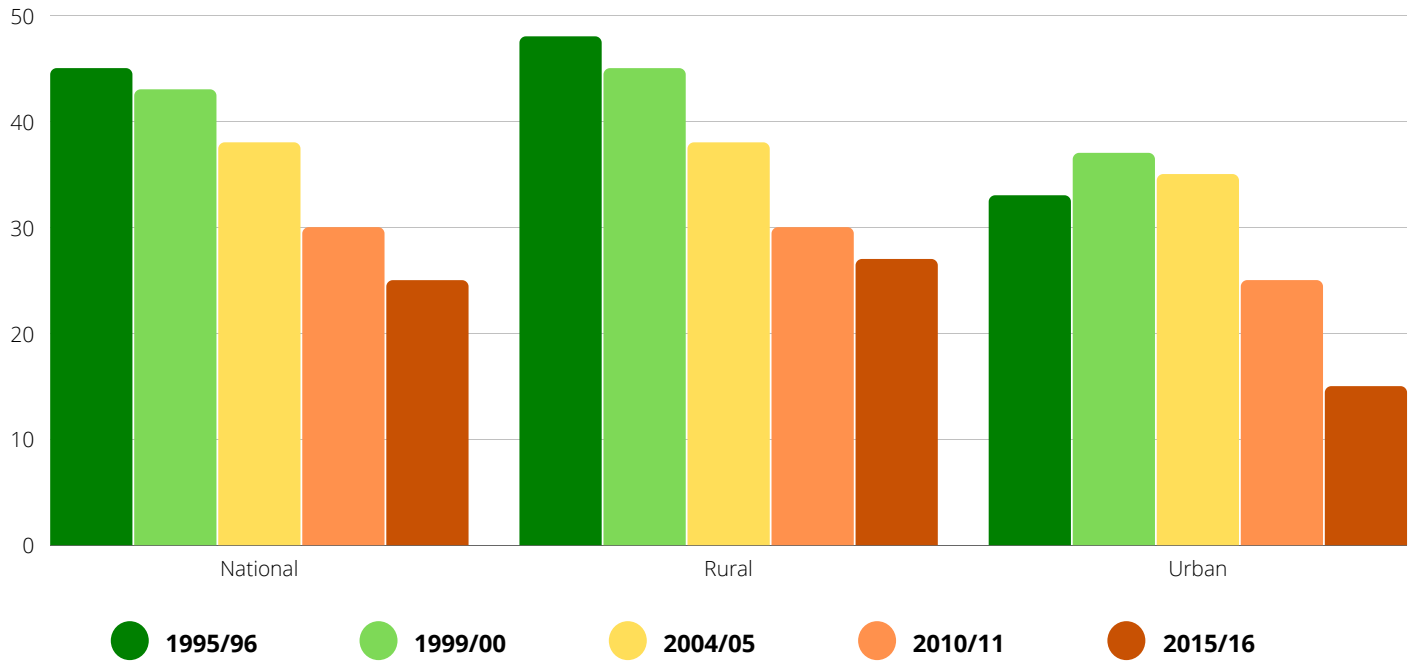


Figure 3 Trends in poverty headcount index (UNDP Ethiopia, 2018)

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

2. Rationale

Nearly 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 an average family of two adults. Despite 20 years of rapid economic growth that has substantially reduced poverty levels, the monetary standard of living of Ethiopian households remains low. This is especially true in rural areas and mainly for the bottom 40 percent. Ethiopians in the two lowest income quintiles lived on US$ 1.3 in rural and US$ 2.2 in urban areas (adult/day). Therefore, investments in improved sanitation facilities (with the flooring solution costing at least 500 to 1,500 Birr) pose a major challenge to many poor 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 proportion of Ethiopian households faces 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 and other diseases associated with poor sanitation.

An USAID-supported assessment, on the impact of the price of plastic pans on the willingness of rural households to pay for such products, highlight the low payment capacity of the majority of the Ethiopian population (WASHPaLS, 2020). The demand curve for three segments of households based on their income indicated that the majority of Ethiopian households are very price sensitive, and demand drops sharply once the price of plastic pans exceeds 200 Birr. For instance, at a price of 400 Birr for plastic toilet pans, demand from the bottom 40% of households is almost non-existent (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.

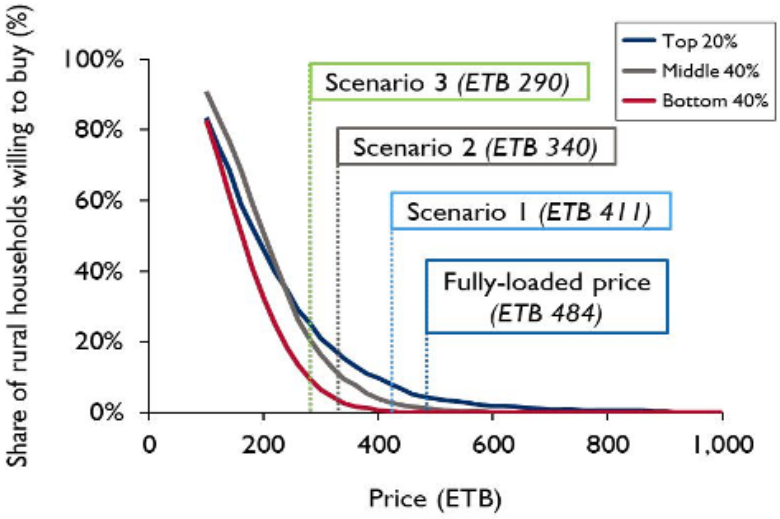


Figure 4 Potential demand for plastic pans by household income segment (WASHPaLS, 2020)

3. Objective

3.1. General Objective

The overarching goal of sanitation subsidies is to increase coverage of basic sanitation services for the poorest and most vulnerable throughout the country.

3.2. Specific Objective

The specific objectives of this sanitation subsidy protocol are:

- To make the case why sanitation subsidies are needed.
- To provide guiding principles for the implementation of sanitation subsidies.
- To propose implementation modalities for sanitation subsidies.

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. The local context must be considered when choosing the most suitable type. The design should also consider strategies to overcome possible disadvantages.

- **Direct targeted subsidies:** Payments are made directly to eligible households in the form of cash or vouchers to be spent on specified sanitation products and services. This type of subsidy helps to empower targeted households and stimulates sanitation market development. Ideally, directly targeted subsidies are bundled with other social services.

- **Infrastructure subsidies:** Sanitation products are provided by the public sector or development partners to eligible households, usually with a contribution of 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 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). Although rather complex to administer, it offers the advantage that the subsidy is fully spent on improving sanitation facilities. However, some households might find it difficult to find the money to pay the initial investment, and any difficulties in making the output-based payments might lead to hardship and serious complaints.

- **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 household micro-savings and micro-insurance to enable more households to make the necessary investments. However, in the Ethiopian context, the poorest (and thus subsidy-eligible) households are not likely to be able to pay the full cost of an improved latrine and therefore this approach is more suitable for middle-income households. Nevertheless, subsidized loans could be considered in combination with output-based subsidies and could contribute to strengthening sanitation product and service providers as well as MFIs.

5. Guiding principles for smart and targeted sanitation subsidies

Ethiopia must accelerate its current rate of increase in coverage of improved sanitation and hygiene throughout the country. Subsidies are one of the mechanisms to address affordability issues for households that are not able to cover the full costs for constructing or upgrading of their household latrines. However, subsidies may distort existing markets for sanitation products and services. The guiding principles presented below are adopted, with some modifications, from Cambodia and India. Both countries have successfully implemented 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, does not stifle innovation or create dependencies, and delivers products and services through existing sales channels. A subsidy is targeted when it ensures that the poorest households are reached (this needs a good understanding of the local context and consumer preferences). There need to be clearly defined and transparent eligibility criteria for subsidy recipients. Smart and targeted sanitation subsidies should be easy to administer, be monitored and not be a standalone intervention.

The guiding principles are 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 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:

- The subsidy is based on a good understanding of the local context and consumer preferences.
- The subsidy targets the poorest households.
- The subsidy has clearly defined eligibility criteria for subsidy recipients.
- The subsidy is transparent.
- The subsidy is easy to administer.
- The subsidy is monitored.
- The subsidy is not a standalone intervention.

5.1. Principle 1: Subsidies must be well-targeted

Sanitation subsidies should only be for households that are not able to afford improved sanitation products and services through other means (e.g., out-of-pocket purchases 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 e.g., be exempted from paying the community-based health insurance contribution, be enrolled in a productive safety net under the PSNP, or be formally exempted from agricultural taxes because of their limited landholding size and agricultural production. Social schemes other than those listed above can also be considered.

The only exception to using existing poverty alleviation programs for the identification of subsidy recipients is 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 space for construction), or for internally displaced communities and refugees. In such cases, additional households could have access to a sanitation subsidy scheme.

5.2. Principle 2: Subsidies should only target latrine sub-structures and flooring solutions

Subsidy schemes should be designed to reach the maximum number of people with a minimum acceptable level of sanitation services. Therefore, in the Ethiopian context, subsidies should only target the construction of improved dry pit latrines by providing adequate sanitation products and toilet installation services (e.g., durable and easy-to-clean latrine slabs made out of concrete, plastic, wooden planks, or similar, products for pit lining in contexts where toilet collapse is common). The justification for this is that, from a public health perspective, the primary objective of the subsidy is to help households 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 at low cost by the households themselves.

The only exception to this principle are 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 must 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 may be exempted from monetary payment. Instead, their labor contribution in terms of domestic activities (e.g., digging toilet pit, preparing for instance gravel and sand) can be converted into monetary value, but it must be the equivalent of a 20% cash contribution.

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

Exceptions to this principle can be made for households that are not reasonably able to contribute financially or in-kind to the cost and construction of the latrine (e.g., households exclusively consisting of people with a disability and/or the elderly). In such a context a 100% subsidy may be justified.

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

Direct sanitation subsidies should primarily be implemented in places where there is a well-established supply chain and a private sector that offers adequate sanitation products and services. However, this does not imply that woredas with no or poor supply chain will be exempted from this subsidy scheme. Rather, these woredas will be provided with capacity building interventions first to prepare them for the subsidy scheme at a 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, therefore households not receiving any direct subsidies will also indirectly benefit from the subsidy scheme. Providing sanitation subsidies without a well-established private sector will be ineffective and unsustainable. An exception to this principle is support activities to local businesses in areas without a well-established supply chain. These indirect subsidies, such as 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 neighboring or nearest woredas.

5.5. Principle 5: These guiding principles apply to all stakeholders

All entities subsidizing sanitation products and/or services are required to comply with the four guiding principles above. The Ministry of Health, or the entity that will implement this subsidy protocol under its supervision, is mandated to get 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 planning, implementation, and documentation, and transparently communicated to the 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 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:** As per Guiding Principle 4, sanitation subsidies prioritize places with a well-established supply chain. As indicated earlier, woredas without a supply chain should be provided with capacity building activities to create an enabling environment for MBS before introducing subsidies. CLTSH and MBS interventions shall prepare the ground for woredas to become eligible for sanitation subsidies.

  a. Adequate improved sanitation products and services are available from different active suppliers located within the woreda (or from neighboring woredas in cases of special circumstances) and together have the capacity to install improved sanitation facilities for all households within a reasonable timeframe.[7]

  b. Generally, coverage of improved sanitation facilities should be at least 80-85% and open defecation should be practised by less than 10% of the households. Regional disparity should be taken into consideration and special attention should be given to pastoralists and mobile households in emerging regions.

  c. Existence of a financial institution or another entity willing to provide low-interest sanitation loans and/or final output-based payments.

- **Kebele Eligibility:** Residents of a certain kebele are potentially eligible for sanitation subsidies at the time the woreda has become eligible (following the guidance provided under “household eligibility”). If the woreda health office can demonstrate to a certain kebele or sub-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 space for construction), a household’s eligibility may be adapted as per Guiding Principle 1. However, this also requires the presence in the woreda of various suppliers that offer products and services for the construction of adequate pit latrines in this more challenging environment.

- **Household Eligibility:** As per Guiding Principle 1, sanitation subsidies need to be well-targeted. Identification of the poor and most vulnerable households should be transparent through community engagement and in line with existing social protection schemes. There should also be a mechanism in place to handle grievances and complaints from community members concerning household selection.

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

As a general guidance, recipients of sanitation subsidies should be either enrolled, exempted from paying for the community-based health insurance scheme, be enrolled in a productive safety-net under the PSNP, or be formally exempted from agricultural taxes because of their limited landholding size and agricultural production (rural context). Under special conditions, all households may be eligible for subsidies (see “kebele eligibility”). Lists of households eligible for sanitation subsidies shall be verified by the Woreda Health Office.

6.2. Implementation modalities

The implementation of directly targeted subsidies is proposed based on a voucher system. The voucher system could be replaced or supported by other modalities if they provide better transparency, data capturing, or increase overall efficiency.

Based on the verified lists of eligible households (see the section on selection criteria), targeted subsidy beneficiaries shall be invited by the implementer 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 attending the training, the beneficiaries receive a voucher for sanitation products at a reduced price from local businesses providing sanitation products and services. This is in line with Guiding Principle 3 that subsidies should only cover a proportion of the overall cost. Some households may get a voucher for 100% of the costs (e.g., households exclusively consisting of people with a disability and/or the elderly).

With the voucher and down payment (usually around 20%), the subsidy recipient can place an order with registered sanitation service providers for a pre-approved “sanitation service package” which may include the production, transport, and installation of a concrete slab (pricing of the package to be revised and approved by the Woreda Health Office). As per Guiding Principle 2, the sanitation service package only covers the latrine sub-structure and flooring options (unless agreed otherwise due to special local conditions).

Upon receipt of the voucher, the sanitation service provider may claim a certain proportion of the payment from a selected financial institution or another suitable entity (either as a low-interest loan or direct payment).

Upon installation of the latrine and after verification by the Woreda Health Office (e.g., through the local health extension worker) the sanitation service provider can collect the final payment from the selected financial institution (or another suitable entity). If the improved latrine has not been constructed within a reasonable timeframe, the households can claim back the down payment.

An independent ombuds team shall be established at the national level to follow up on reported complaints and to actively verify the correct implementation of the sanitation subsidy scheme.

6.3. Implementation timeline

A phased implementation approach shall be applied to help refine the subsidy protocol based on practical lessons learned and to develop a robust monitoring framework. It is proposed to introduce the sanitation subsidy through the following phases:

- **Phase 1 - pilot phase:** The implementation modalities shall be tested in 3 to 5 eligible woredas in all regions. During the pilot phase, the process and lessons learned shall be carefully documented by a national team led by the Ministry of Health and involve interested development partners. Ideally, team members will also establish the national ombuds team.

- **Phase 2 – scale-up phase:** Using an improved sanitation subsidy protocol based on lessons learned from the pilot phase, 2 or 3 woredas in each region (if they are eligible!) will be selected. In this phase, regional teams from the regional health bureaus will take on the responsibility of overseeing or implementing the subsidies, while a national ombuds team will provide independent supervision.

- **Phase 3 – full roll-out:** Once there is sufficient evidence that the sanitation subsidies provide a cost-effective approach to increase access to improved sanitation facilities to the poor, sanitation subsidies shall be made available to all woredas that meet the eligibility criteria, depending on the availability of funding.

6.4. Estimated budget and source of finance

The direct subsidy costs in each woreda are estimated at a total of approximately US$ 125,000 over a period of five years (based on the following assumption: 24,000 households/woreda, 20% of all households are eligible and make use of the subsidy worth approximately US$ 26).

The budget for the following still needs to be determined:

- Pre-implementation verification of household lists by Regional Health Bureau.
- Household training and voucher distribution.
- Training of and support to Woreda Health Office to define sanitation service packages and to verify the adequate implementation of the service.
- Training of and support to financial institutions.
- National ombuds team.

In parallel to testing the subsidy implementation approach, financing mechanisms need to be identified. The Ministry of Health currently explores new sources of finance that can be made available specifically for tackling the national sanitation challenge. This may 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 of stakeholders

- **Government**: The government will be in the lead to finance the subsidy program as well as facilitate the implementation with the Ministry of Health 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, throughout the implementation phase and through the participation in monitoring and evaluation initiatives in collaboration with the ombuds team. Development partners may also provide co-funding.

- **Financial institutions:** MFIs, Saving and Credit Cooperatives, and cooperatives may be engaged in the provision of loans at low-interest rates for both MSE and target households.

- **Private sector:** Businesses offering sanitation products and services will be engaged through a market-driven approach in installing improved sanitation facilities.

- **Communities**: Local administration will be involved in participatory planning, identification of target beneficiaries, and local institutions for the management of resources and facilities, assessments, and negotiations on local demand.

6.6. Monitoring and evaluation framework

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

- Number of woredas found eligible for the subsidy program
- Number of households per woreda eligible to receive a full or partial subsidy
- Number of eligible households that received a voucher
- Number of eligible households that installed an improved sanitation facility
- Number of complaints received and addressed by the ombuds team
- Annual budget allocated and used for the sanitation subsidy
- Number of MBS centres engaged in the provision of sanitation products and services.

6.7. Revision of the national sanitation subsidy protocol

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

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