glaas | UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water

Ethiopia

DEMOGRAPHIC AND ECONOMIC ESTIMATES

Population (2012)[a]	**91.73 M**
Urban population (2012)[a]	**15.82 M**
Rural population (2012)[a]	**75.91 M**
Population growth rate (2012)[a]	**2.57%**
Gross domestic product USD (2012)[b]	**41.61 billion**

[a] World Population Prospects: The 2012 Revision, UNDESA 2013.
[b] World Development Indicators, World Bank 2013.

HEALTH ESTIMATES

Infant mortality / 1,000 live births (2012)[c]	**46.5**
Under 5 mortality / 1,000 live births (2012)[c]	**68.3**
Life expectancy at birth (2012)[d]	**64 yrs**
Diarrhoea deaths attributable to WASH (2012)[e]	**26 088**

[c] Levels & Trends in Child Mortality. Report 2013, UNICEF 2013.
[d] World Health Statistics, WHO 2014.
[e] Preventing diarrhoea through better water, sanitation and hygiene, WHO 2014.

SANITATION AND DRINKING-WATER ESTIMATES

Use of improved sanitation facilities (2012)[f]	**24%**
Use of drinking-water from improved sources (2012)[f]	**52%**

[f] Progress on Drinking-Water and Sanitation – 2014 Update, WHO/UNICEF 2014.

Sanitation, drinking-water and hygiene status overview

Ethiopia has made tremendous progress in providing access to water and sanitation from 1990 to 2012. Access to improved drinking-water supply in Ethiopia increased from 13% to 52% from 1990 to 2012 (JMP 2014) and from 2% to 24% in sanitation. Elements of Ethiopia's success include strong political will, human resources and financing.

Firstly, Ethiopia has strong political will for improving access to water and sanitation. According to the Ministry of Health, "The government has shown demonstrable, high level political commitment to enhanced sanitation coverage over the past few years. This goal is reflected in the national Health Extension Program, the National Hygiene and Sanitation Strategy and a national step-by-step protocol and Sanitation Action Plan (SAP) for achieving universal access by 2015. There has been significant improvement in access to safe sanitation and hygiene in Ethiopia since the Health Extension Program began in 2002/2003." These actions were followed by the publication in 2011 of the National WASH Implementation Framework and the launch, in September 2013, of the One Wash National Program (OWNP), which includes the Ministers and State Ministers from the ministries of Water, Irrigation and Energy, Health, Education and Finance and Economic Development.

Secondly, Ethiopia has the human resources and education institutions needed to implement programmes aimed at ending open defecation. As part of the Health Extension Workers (HEW) programme, 39,000 HEWs educate communities about sanitation and are helping to create a culture where toilets are seen as acceptable.

Financing has also played a role in Ethiopia's success. Ethiopia OWNP has a financing plan/budget that is agreed and consistently followed for rural and urban WASH and institutional WASH. With Community Led Total Sanitation (CLTS) and Hygiene, the government does not provide subsidies for household sanitation. For rural water supply, the government expects users to cover operation and maintenance costs but not the cost of investments while for urban water supply full cost recovery is expected but on a 'stepped approach'. While this approach helps to create a market for sanitation and can lead to more sustainable solutions, operations and maintenance costs remain an issue in urban areas due to low tariffs, low operational efficiency and lack of skilled manpower.

WHO/FWC/WSH/15.14

Design and layout by L'IV Com Sàrl, Villars-sous-Yens, Switzerland.
GLAAS visual identifier design by Ledgard Jepson Ltd, Barnsley, South Yorkshire, England.
Printed by the WHO Document Production Services, Geneva, Switzerland.

UN WATER

World Health Organization

Highlights based on country reported GLAAS 2013/2014 data[1]

I. Governance

The Ministry of Health leads hygiene promotion initiatives and has lead responsibilities in sanitation. Drinking-water is led by the Ministry of Water, Irrigation and Energy.

LEAD INSTITUTIONS	SANITATION	DRINKING-WATER	HYGIENE PROMOTION
Ministry of Health	✔		✔
Ministry of Water, Irrigation and Energy		✔	

Number of ministries and national institutions with responsibilities in WASH: **8**

Coordination between WASH actors includes:
- ✔ All ministries and government agencies
- ✔ Nongovernmental agencies
- ✔ Evidence supported decisions are decentralized down to region and district levels. Decisions made based on the progress reports and Joint Monitoring process.

PLAN AND TARGETS FOR IMPROVED SERVICES	INCLUDED IN PLAN	COVERAGE TARGET (%)	COVERAGE TARGET YEAR
Urban sanitation	✔	*	2015
Rural sanitation	✔	100	2015
Sanitation in schools	✔	*	2015
Sanitation in health facilities	✔	*	2015
Urban drinking-water supply	✔	100	2015
Rural drinking-water supply	✔	97	2015
Drinking-water in schools	✔	*	2015
Drinking-water in health facilities	✔	*	2015
Hygiene promotion	✔	70	2015
Hygiene promotion in schools	✔	*	2015
Hygiene promotion in health facilities	✔	*	2015

* Targets not available in terms of percentages.

There are specific plans for addressing the issues of reliability/continuity of urban and rural water supply, replacing latrines when full and ensuring drinking-water meets national standards.

SPECIFIC PLANS FOR IMPROVING AND SUSTAINING SERVICES[a]	EXISTENCE AND LEVEL OF IMPLEMENTATION OF MEASURES (Low → High)
Keep rural water supply functioning over long-term	
Improve reliability/continuity of urban water supply	
To rehabilitate broken public latrines	
Safely empty or replace latrines when full	
Reuse of wastewater or septage	
Ensure DWQ meets national standards	
Address resilience to climate change	

[a] Including implementation.

[1] All data represented in this country highlight document is based on country responses to GLAAS 2013/2014 questionnaire unless otherwise stated.

II. Monitoring

There is a high level of data availability reported for decision-making for drinking-water.

MONITORING	SANITATION		DRINKING-WATER		HYGIENE
Latest national assessment	December 2011		December 2011		May 2010
Use of performance indicators[a]	●		●		●
Data availability for decision-making[a]					Health sector
Policy and strategy making	✔		✔		✘
Resource allocation	●		✔		NA
National standards	NA		✔		NA
Response to WASH related disease outbreak	NA		NA		✘
Surveillance[b]	Urban	Rural	Urban	Rural	
Independent testing WQ against national standards	NA	NA	✔	✘	
Independent auditing management procedures with verification	NA	NA	✔	✘	
Internal monitoring of formal service providers	✘	●	✔	✔	
Communication[a]					
Performance reviews made public	●	●	●	●	
Customer satisfaction reviews made public	✘	✘	●	●	

[a] ✘ Few. ● Some. ✔ Most.
[b] ✘ Not reported. ● Not used. ✔ Used and informs corrective action.
NA: Not applicable.

III. Human resources

Human resource strategies are developed for sanitation and drinking-water though some gaps and follow up actions have not been identified.

HUMAN RESOURCES	SANITATION	DRINKING-WATER	HYGIENE
Human resource strategy developed[a]	✔	✔	✔
Strategy defines gaps and actions needed to improve[a]	✔	●	✔
Human resource constraints for WASH[b]			
Availability of financial resources for staff costs	●	●	●
Availability of education/training organisations	●	●	●
Skilled graduates	●	✘	●
Preference by skilled graduates to work in other sectors	●	●	●
Emigration of skilled workers abroad	✔	✔	✔
Skilled workers do not want to live and work in rural areas	●	●	●
Recruitment practices	●	●	●
Other	✘	✘	✘

[a] ✘ No. ● In development. ✔ Yes.
[b] ✘ Severe constraint. ● Moderate constraint. ✔ Low or no constraint.

IV. Financing

A financing plan is in place and used for most WASH areas, however, there are reported difficulties in absorption of donor commitments. There is also an insufficiency of funds to meet MDG targets.

FINANCING

	SANITATION		DRINKING-WATER	
Financing plan for WASH	Urban	Rural	Urban	Rural
Assessment of financing sources and strategies[a]	●	✔	✔	✔
Use of available funding (absorption)				
Estimated % of domestic commitments used[b]	✔	✔	●	✔
Estimated % of donor commitments used[b]	✔	✔	●	✔
Sufficiency of finance				
WASH finance sufficient to meet MDG targets[b]	✘	✘	✘	✘

[a] ✘ No agreed financing plan. ● Plan in development or only used for some decisions. ✔ Plan/budget is agreed and consistently followed.
[b] ✘ Less than 50%. ● 50–75%. ✔ Over 75%.

WASH VS. OTHER EXPENDITURE DATA

Total WASH expenditure[1]	
2010–2012	131.95 M.USD
Expenditure as a % GDP	
Education[2]	4.7
Health[2]	4.2
WASH[3]	0.4

[1] Reported WASH expenditure in GLAAS 2013/2014 converted using UN exchange rate 31/12/12.
[2] Expenditure as a % GDP – Average 2010–2012, sources UNESCO 2014, WHO 2014.
[3] WASH expenditure from country GLAAS 2013 response, GDP Average 2010–2012, World Development Indicators, World Bank 2013.
NA: Not available.

V. Equity

As a step towards addressing equity in access to WASH services, six disadvantaged groups are identified in WASH plans. For drinking-water funds are reported to be distributed evenly between urban and rural areas. No disagregated data is available for sanitation.

EQUITY IN GOVERNANCE

	SANITATION		DRINKING-WATER	
Laws				
Recognize human right in legislation	✔		✔	
Participation and reporting[a]	Urban	Rural	Urban	Rural
Clearly defined procedures for participation	✘	✔	✔	✔
Extent to which users participate in planning	●	✔	●	●
Effective complaint mechanisms	●	✘	✔	●

[a] ✘ Low/few. ● Moderate/some. ✔ High/most.

DISADVANTAGED GROUPS IN WASH PLAN

1. Poor populations
2. People living in slums
3. Remote populations
4. Displaced persons
5. Ethnic minorities
6. People living with disabilities

EQUITY IN FINANCE

Figure 1. Urban vs. rural WASH funding

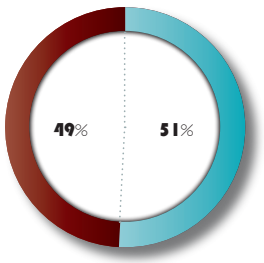


Figure 2. Disaggregated WASH expenditure

[No data available.]

EQUITY IN ACCESS[1]

Figure 3. Population with access to improved sanitation facilities

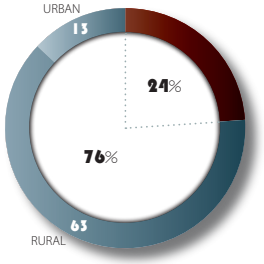
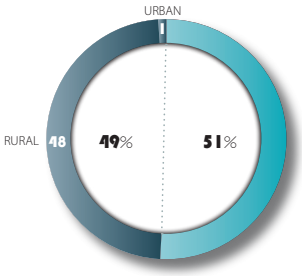


Figure 4. Population with access to improved drinking-water sources



[1] Progress on Drinking-Water and Sanitation – 2014 Update, WHO/UNICEF 2014.