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Federal Democratic Republic of Ethiopia
Ministry of Health

Baby and Mother WASH
Implementation Guideline

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Contents

Acronyms

SBCC	Social Behavioral Change Communication
CLTSH	Community Led Total Sanitation and Hygiene
DA	Development Assistants
ECD	Early Childhood Development
FMOH	Federal Ministry of Health
FMHACCA	Food, Medicine & Health Care Administration & Control Authority
HDA	Health Development Army
IPC	Information Provision Centers
HEP	Health Extension Program
HWWS	Hand washing with Soap
HSTP	Health Sector Transformation Plan
MDG	Millennium Development Goals
MoWIE	Ministry of Water, Irrigation and Energy
NRHM	National Rural Health Mission
SDG	Sustainable Development Goals
STH	Soil-transmitted Helminthes
TSC	Total Sanitation Campaign
WASH	Water Supply, Sanitation and Hygiene
WASHCO	Water Supply, Sanitation and Hygiene Committees

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1. Introduction and Background

The overall desire of the Government of Ethiopia is to have the highest possible level of health quality of life for all its citizen1. The evidence is clear that early childhood development is critical to promoting positive health outcomes for children and for adults life later. Ethiopia's commitment to reduce infant and child mortality, diarrheal prevalence in under five and improving the quality of the citizens is set in the HSTP

This Guide supports organizations working in the WASH, health and nutrition sectors to address interconnected problems of poor water, sanitation and hygiene affecting early child development, especially for babies and small children under 3 years. The Guide makes suggestions on how to work with communities in Ethiopia and also how to integrate Baby WASH interventions into wider WASH, health and nutrition program.

The Guide will be useful for organizations and individuals working on different aspects of early child development, and particularly useful to WASH, maternal, newborn and child health and nutrition sectors .The guideline will also be useful for decision makers working in government offices, aid agencies, NGOs, influential leaders, teachers and health extension workers who work at household and community level .

However the evidence is clear that WASH interventions focusing on children under the age of three years old will have significant benefits for early childhood and later development.

1.1. Baby WASH:

Baby WASH can be defined as a set of WASH interventions that focus on pregnant women, babies and children under 3 years and their parents. It requires close integration with existing interventions of maternal, newborn and child health, early childhood development and nutrition. The aim of Baby WASH is to reduce microbial burden rather to promote children health and to prevent it by decreasing babies and young children in their play and feeding environments

Investing in early child development (ECD) can lead to substantial benefits that include improved school performance, reduced child morbidity and mortality, higher productivity and economic growth, reduce gender-related inequities, and breaking intergenerational cycles of poverty2. However there is growing evidence that poor water, sanitation and hygiene conditions have an impact on ECD outcomes that is larger than previously recognized.

Baby WASH is a relatively new concept developed following a detailed evidence review examining the links between poor water, sanitation and particularly hygiene conditions and early child development, particularly for babies and children under 3 years of age3.

Whilst the relationship between WASH and ECD is not yet fully understood, there is evidence that contamination of the domestic environment with animal and human feces makes infants and young children more likely to suffer from poor absorption of nutrients, under nutrition, stunting and anemia. On average, an Ethiopian child experiences five to twelve diarrhea episodes in a year4. A recently

1 Health Sector Transformation Plan August 2015

2 van der Gaag J. From Child Development to Human Development. Available at: http://www.ecdgroup.com/pdfs/van_der_gaag_paper_CHILDDEV-20_05_2003-18_13_22.pdf

3 Ngure FM, Reid BM, Humphrey JH, Mbuya MN, Pelto G, Stoltzfus RJ. Water, sanitation, and hygiene (WASH), environmental enteropathy, nutrition, and early child development: making the links. Ann N Y Acad Sci 2014 Jan;1308:118-128.

4 CLTSH Implementation Guideline 2012

conducted Ethiopia Nutrition baseline study5 found that sanitation and water supply has a stronger impact on stunting of children age 24-59 months, which is in-line with the study conducted in Mali6. This points to the importance of a strong focus on hygiene and sanitation for pregnant and nursing mothers.

.This guideline has five sections. Section One provides background and overview of Baby WASH issues. Section Two explains the rationale for developing the guideline. Section Three discusses how Baby WASH can fit into the current policy environment as well as potential interventions to inform Baby WASH in practice. Section Four looks at the roles and responsibilities of key actors and organizations. Section Five looks at how to monitor and evaluate Baby WASH activities and suggests potential results frameworks and tools .

The figure below summarizes the causal pathways between Baby WASH and negative effects on ECD, increased child mortality and irreversible blindness through trachoma. The following section summarizes the evidence for specific WASH intervention areas to reduce fecal ingestion by babies and infants

5 FMOH/UNICEF/EU, 2016, Situation Analysis of the Nutrition Sector in Ethiopia 2000-2015

6 Pickering, AJ, Djebbari, H, Lopez, C, Coulibaly, M, and Alzua, ML. 2015, Effect of a community-led sanitation intervention on child diarrhoea and child growth in rural Mali: a cluster-randomised controlled trial. Lancet Glob Health. 2015; 3: e701–e711

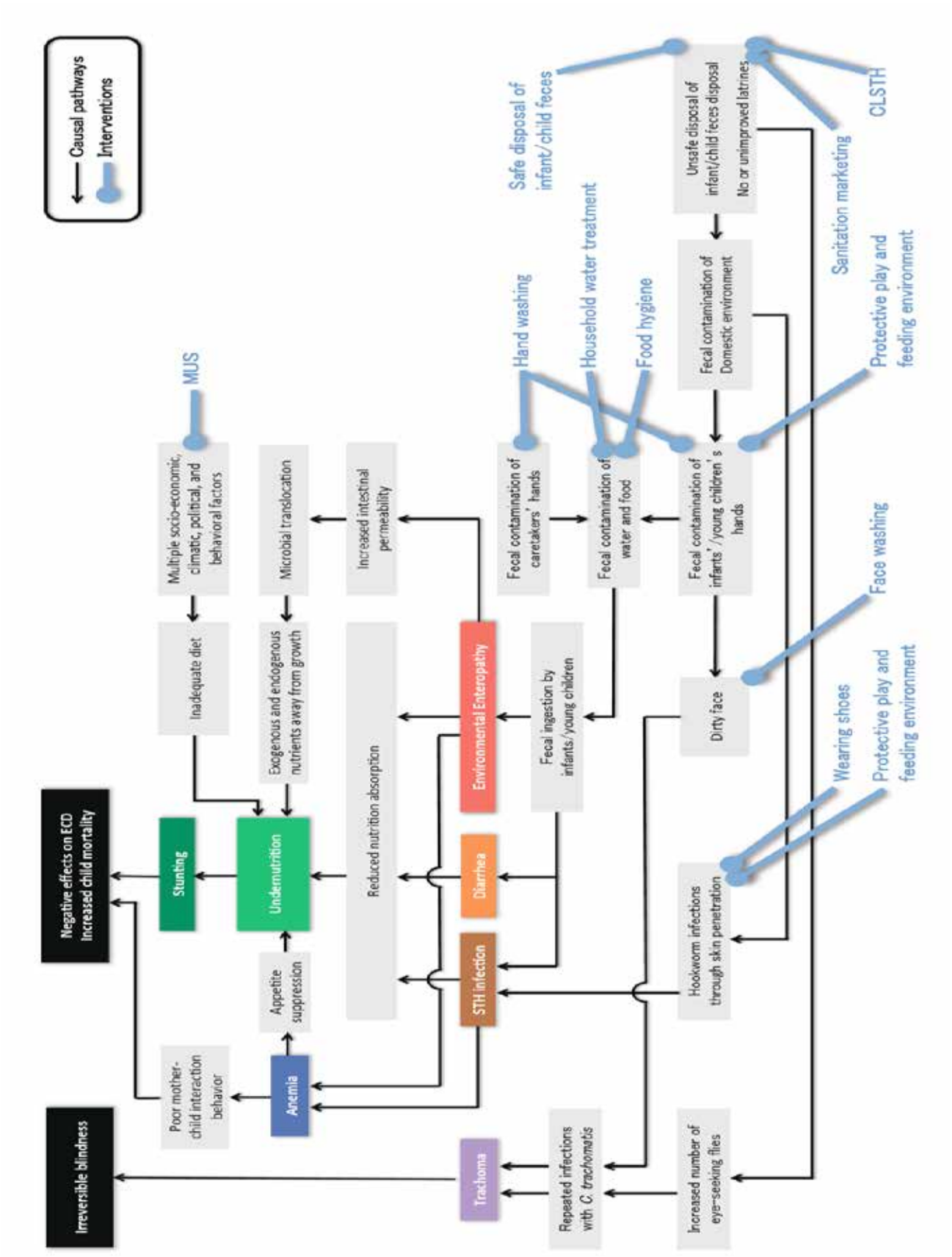


Figure 1. Model of the causal pathways from poor sanitation and hygiene to Soil Transmitted Helminthiasis infection, stunting, child development, and trachoma (Morita, 2015)

The arrowed lines indicate the pathways and the light blue lines denote major interventions assessed in this literature review. (Modified from Humphrey *et al*. 2009 and Ngure *et al*. 2014

1.2. Factors that affect the baby WASH practices

1.2.1 Child Faeces disposal

In Ethiopia, 69% of households with children under the age of three reported unsafe disposal of faeces of children. Furthermore, even among households with improved sanitation facilities, 49% practiced unsafe child faeces disposal, with 24% of the faeces left in open spaces, which is considered as open defecation (WB/UNICEF, 2015). A meta-analysis by Gil et al. (2004) found that the risk of childhood diarrhoea increased by 23% in the population practicing unsafe disposal of infant and child faeces. Another study also found that improving the knowledge of caregivers on the safe disposal of child faeces can have a huge impact on the prevalence of diarhoea(George et al., 2014).

1.2.2. Hand Washing with Soap – HWWS

There is consistent evidence that hand washing with soap (HWWS) at critical times - including before eating or preparing food and after eating, using toilet ,and cleansing children's bottom - can reduce diarrheal risk by about 40-45% (CHERG, 2010; Freeman et al., 2014) and reduces the transmission of acute respiratory track infections (ARIs) by 16-21% (Rabie and Curtis, 2006; Aiello, 2008). The promotion of HWWS remains the most cost-effective hygiene intervention.

1.2.3. Food hygiene

Studies suggest that as much as 70% of diarrhoea cases are due to unhygienic preparation of weaning foods in low-income countries (Islam et al., 2013). Infants are most vulnerable to diarrheal diseases when weaning begins; the likelihood for diarrhoea in infants who had been weaned for the previous two months was 8.4 times greater than exclusively breastfed infants (Marino, 2007). Repeated episodes of diarrhoea contribute directly to the development of EE. The most effective interventions to reduce the incidence of childhood diarrhea include the promotion of exclusive breastfeeding of children until 6 months, and education of caregivers in safe food preparation – hand washing, utensil washing, safe storage and re-heating of cooked food. In the early 1960s, it was first recognized that at the point when children were introduced to weaning food many began to suffer from frequent bouts of diarrhoea and to falter in their growth .

The frequency and severity of diarrhea are aggravated by lack of access to sufficient clean water and sanitary disposal of human waste, inadequate feeding practices and hand washing, poor housing conditions, and lack of access to adequate and affordable health care . Better hygiene practices, particularly hand washing with soap and safe disposal of excreta, could reduce the incidence of diarrhea by 35 percent . In Ethiopia studies have shown that the prevalence of diarrhea both in urban and rural areas was 13%. The prevalence of diarrhea was relatively high among children aged from 6 to 23 months. In southern Ethiopia, 25.5% of children experience diarrhea, (Shikur M,Desalegn T,2014) and, has showed that the prevalence of diarrhea among children was 30.5%.

1.2.4. Protective play

Infants and children less than 5 years are more likely than people to get diseases from animals .This is because young children often touch surfaces that may be contaminated with animal feces(stool) ,and young children like to put their hands in to their mouth. Young children are less likely wash their hands properly and they get sick easily than adults .

Children are exposed to the urine ,blood, saliva, sweat, and mucus of others who have used the equipment before them. The stated facts make playground equipment twice as big of a biohazard as public restrooms. Whether at an educational institution park ,or indoor play areas, parents and guardians should take precautions to protect their children from contracting germs. Without consis-

tent proper hygiene and sanitation, playground equipment can be a breeding ground for a host of bacteria and germs that cause mild to serious illness .Norovirus , E.Coli, salmonella, and hepatitis A common bacterium and illness that can be found in children's grounds (CDC,2003).

In rural households of Ethiopia, human- animal interaction in the house or within the compound is a regular phenomenon , therefore infants and young children are in regular contact with livestock, poultry and their faeces. A study conducted by ENGINE in 4 agrarians of Ethiopia found that 33% of children observed were in contact with animal faeces and 90% of them were in close proximity to faecal matter .As the child crawls and explores his/her environment, faeces-to-mouth episodes are frequent. In a study conducted in Zimbabwe, exploratory ingestion of soil and faeces was found to be the predominant faecal-oral pathway of bacteria in infants and toddlers' 4000 times higher than drinking untreated water (Ngure et al., 2014). Contamination of children's play and feeding areas by animal dung is a constant and cumulative health risk during this critical period of growth, although the evidence for the best intervention to reduce this is limited, and their popularity is very culture-dependent. Some advocate corralling animals and chickens, other studies (such as Shine in Zimbabwe) have introduced playpens and/or door barriers for infants, as well as cleanable play mats. The penning of animals is already promoted as part of the PHC package in Ethiopia.

1.3. Impact of Improved WASH on Child Health

There is a wealth of evidence to show that sanitation – and in particular ODF – has a strong positive impact on child health and stunting. The DHS review by Fink et al. (2011) found that access to sanitation can reduce stunting in children by 27%. The Mali CLTS study also found stunting reduced from 41% to 35% in ODF communities (Pickering et al, 2015). Other studies on water quality and household water treatment have shown a lesser impact on child stunting (eg Dangour et al., 2013), however by far the most significant impact remains with improving sanitation and hygiene. Soil Transmitted Helminthes) infections are associated with malnutrition, impaired growth, and poor school performance STH are among the world's most important causes of physical and intellectual growth retardation. Preschool- and school-ag children are identified as high-risk groups for STH infections that becomes prevalent between 6 months and 2 years of age. Causal relationships between STH infections and child malnutrition, stunting, and developmental retardation have been difficult to prove due to complexly intertwined environmental factors (de Silva, 2003), However ,it is clear that repeated infestation causes chronic diarrhoea, intestinal bleeding and loss of appetite, leading to anemia and malnutrition (Strunz et al., 2014).

In Ethiopia, STH infections are highly prevalent throughout the country except in parts of Somali and Afar regions. Ethiopia has the second highest burden of ascariasis in Sub-Saharan Africa, with the prevalence among school age children estimated at 37%. In addition, Ethiopia bears the third highest burden of hookworm infection; an estimate 11 million people are infected with hookworm, with the national prevalence estimated at 16%. Similarly, Ethiopia has the fourth highest burden of trichuriasis (whipworm), with 21 million people infected, and the national prevalence is estimated at 30% (Deribe et al., 2012).

The systematic review of WASH literature by Strunz et al. (2014) found that improved water treatment, piped water, hand washing and sanitation all impacted on STH infection, with an overall impact of 50% reduction. Wearing of shoes also reduces hookworm infection by 29%. The recommended interventions for reduction of STH infections are therefore improved sanitation coverage, household water treatment and storage, handwashing with soap and the wearing of shoes.

Ethiopia is the most trachoma affected country worldwide, with women and children aged 1-9 at the greatest risk of infection. A 2007 national survey reported that overall prevalence of active trachoma for children in the age group 1-9 year was 40.14%, with considerable regional variations: Amhara

(62.6%) was found to have the highest prevalence of active trachoma, followed by Oromia (41.3%), SNNP (33.2%), Tigray (26.5%), Somali (22.6%), and Gambella (19.1%) (Berhane et al., 2007). There is a national target to eliminate trachoma by 2020. A cross-sectional study conducted in Amhara region assessed the risk factors for active trachoma among children age 1-9 years, which reported that children with unclean faces were about 18 times more likely to have active trachoma than those with clean faces (Ketema et al., 2012). Infection was also found to have a high correlation with illiteracy, lack of hygiene education and a distance of more than 30 minutes from a water source.

Accessing of WASH facilities to the use community has significant positive impact for reduction of trachoma specially to the children and women .For example , Studies have indicated that improved access to water (27% reduction), sanitation facilities (30% reduction) and child facial hygiene (38% reduction) can all reduce trachoma infection rates (Pruss & Mariotti, 2000; Stoller et al., 2011; Ejere et al., 2015).

Mainstreaming and developing Baby WASH is guided by three key principles:

- **Context Specific**: Interventions should be based on rigorous analysis of the specific context (development, humanitarian emergency, work place, schools, health facilities, rurality etc.) and responses should be tailored to meeting the different needs of families in these contexts.
- **Integrated:** The broad strategy for Baby WASH should be to integrate Baby WASH into existing programs in WASH, health and nutrition. This will require coordinated cross-sector action and commitment from a wide range of development partners. Stand-alone Baby WASH programmes are less likely to be successful and his risk of significant duplication. Currently successful messaging channels and programs can be utilized to ensure success.
- **Evidence – Based:** Interventions are more likely to be effective when they are based on high-quality research and evidence. .Bay-WASH is a relatively new concept and interventions require relevant information to inform future efforts and advocacy for effective policymaking.

2. Objective

General Objective

Ensure the health benefits of infant and babies through formatting Baby WASH agenda and improving WASH facilities, personal hygiene and environmental sanitation.

Specific Objectives

1. To increase awareness among the general public on the importance of Baby WASH and its relationship with health outcomes and early childhood development.
2. To mainstream Baby WASH issues into national and regional policies, strategiy and guidelines to ensure that all actors working in areas related to WASH integrate Baby WASH approach into their ongoing programming.
3. To facilitate collaboration across sectors and different actors (Government, Civil Society Organizations, Community Based Organizations, the Private Sector and others)
4. To expand best practices related to Baby WASH

3. Baby WASH Policy Environment and Interventions

Policy Environment

The **National Hygiene and Sanitation Strategy** sets out three pillars to support behavior change efforts.

Pillar 1: An enabling environment to facilitate the scale-up of improvements through policy consensus, legislation, political commitment, inter-sectoral cooperation, and capacity building through contractual agreements. The priority on creating amenable policy to hygiene and sanitation is evident in the design of the national strategy. Onsite sanitation protocol, and in training and deployment of health extension workers.

Pillar 2: Sanitation and hygiene promotion through communication, social mobilization, social marketing, incentives, and sanctions to create demand for products and behaviors.

Pillar 3: Improved access and affordability of necessary products and services, such as household latrines, water for hand-washing, soap or soap substitutes, and locally produced slabs.

Baby WASH needs to be integrated into each of these pillars wherever gaps are found. For Pillars 1 and 2, the messaging to the community by Health Extension Workers needs to include the importance of maintaining barriers between young children and animal feces. For Pillar 3, consideration needs to be given to additional products that are required to implement Baby WASH objectives, which may include potties, sanitary play mats for children, playpens as wel as other innovations to promote handwashing and facewashing with soap at critical times.

The **Health Sector Transformation Plan (HSTP)** is an instrument for achieving the goals set out for health in the Growth and Transformation Plan (GTP II). It sets out the Government of Ethiopia's overall desire to have "the highest possible level of health and quality of life for all its citizens." The HTSP is clear in its commitment to reducing infant and child mortality . Diarrhoea identified as a major cause of under-five mortality, with malnutrition underlying nearly 50% of under-five deaths7.

The Health Sector Transformation Plan calls for 'newborn corners' at all health centers in the country: these newborn corners provide an opportunity to precisely target WASH messaging and interventions8. Similarly the Federal Government also need to collaborate with development partners to ensure that Baby WASH considerations are integrated into their ongoing programs .

Interventions

As a relatively new concept- Baby WASH interventions need to be informed by research and carefully evaluated to assess their impacts. Interventions can be determined by examining the causal pathways towards negative effects on child health. Some key intervention areas are as follows:

Advocacy – The Ethiopian Federal Government has a role to promote a wider understanding of the importance of safe water, sanitation and hygiene practices of parents/guardians and their babies under 3 years old, and simple steps that can be taken to improve hygiene and sanitation. Special consideration should be made for emergency situations where resources may be stretched and children are particularly vulnerable.. The Federal Government has a role to provide guidance to regional

7 Health Sector Transformation Plan August 2015
8 Health Sector Transformation Plan August 2015

governments and to support them to achieve Baby WASH outcomes.

In the Ethiopian context, community health workers already deliver many Baby WASH compatible messages to parents throughout the country. However a sharper focus on Baby WASH – particularly emphasizing the correction of common misconceptions is needed. Similarly organizations working to end open defecation should be mindful that this requires the elimination of unsafe child faeces management and disposal – and need to provide specific strategies to ensure that child defecation is not overlooked.

Integrated programming – ensuring the inclusion of WASH in all health and nutrition interventions targeted at parents/guardians with children under 3 years of age. For example ,during immunization campaigns, provision of complementary feeding, antenatal care follow-ups, in refugee camps etc.

Programming needs to support:

- **Safe disposal of child faeces** – promotion of the importance of safe disposable of child faces and provide especial support on ;

a) potty training for infants,

b) tools for the safe disposal of child faeces (eg scoops, hoes/shovels) and

c) child-friendly toilets, and the likes

Evidences in Ethiopia and some other countries suggest that there is a common misconception that 'children's faeces are not hazardous to health'. Current Sanitation and Hygiene efforts may overlook child faeces when seeking to achieve ODF status. Toilets may not be designed with children in mind, and very young children may be able to use toilets.

In many parts of Ethiopia, young children utilize plastic potties which are easily cleaned and enable parents to safely dispose of child faeces. In some communities, however ,young children defecate in the open space and parents have to clean and dispose faeces to avoid contamination of the environment. Ensuring that proper practices are followed is challenge: compounded by the misbelief that child faeces may not be as harmful as adult faeces.

- **Food hygiene** – Education for new parents/guardians on safe practices regarding feeding babies, and the heating, cooling and storage of food. Hygiene while starting complementary feeding.
- **Handwashing and Face washing with soap** – the promotion of handwashing at critical times is the most important investment that can be made to improve hygiene nationally – both in terms of impact and cost-effectiveness. Re-focusing on HWWS interventions to ensure the child's hands and face are regularly cleaned – both at home and at school. Regular face washing reduces the incidence of trachoma infection.
- **Protective play** – the environmental enteropathy research to date points to the importance of clean play areas for small children that reduce their contact with soil, animal and human excreta, This in turn could minimize their exposure to pathogens that cause diarrhoea, hookworm and soil-transmitted helminth infections, leading to anaemia and stunting. There are several aspects:

a) Promote the use of play-pens and/or easily cleanable play mats and hygienic/sanitary play and/or teething objects for children

b) Encourage the containment/penning of animals in the home.

c) Promote the importance of shoes for children when they begin walking.

Health Facilities – Ensuring that all health facilities have safe water and sanitation; hygiene and handwashing promotion for birth attendants; Promotion of hygiene for new mothers; and practice safe disposal of child feces.

Household sanitation – promotion of CLTSH and the benefits of living in an open defecation free environment, with a particular focus on the safe disposal of child feces and the importance of maintaining an environment free from animal feces for young children to play in.

Links with adolescent girls – promotion of safe WASH practices in schools, particularly targeting adolescent girls - such as promotion of menstrual hygiene management – helps to prepare good hygiene practices in young women and mothers.

Research – to improve our understanding of the causes and routes of infection, and impact of the above proposed interventions on child health and malnutrition. UNICEF has commissioned a national hygiene practices KAP study, completed in April 2017, which will provide a baseline. Preliminary data is shown in the table below. We also call on other organizations to conduct research to determine the significance of Baby WASH to their work and strengthen the evidence base around the impact of WASH provision on early child development.

Table 1: Baby WASH Indicators from the UNICEF WASH KAP Baseline, April 2017

Indicators	Urban	Rural pasto-ralist	Rural non- pas-toralist	Total
% of caretakers of children of age under 3 years reported washing their child's body on a daily basis	57.6%	22.7%	34.3%	35.9%
% of lactating mothers reported taking bath at least once a week	97.7%	100.0%	92.2%	94.6%
% of lactating mothers reported washing hands every time before breastfeeding	3.1%	0%	2.0%	1.9%
% of women with knowledge on health risks from unsafe disposal of child faeces	54.2%	38.7%	50.4%	48.8%
% of households that disposed the youngest child's faeces safely (in to latrine or by burying) the last time the child passed stool	80.2%	23.4%	46.3%	50.0%

4. Implementation arrangement for Baby WASH Guideline

The Constitution of the Federal Democratic Republic of Ethiopia has clearly articulated that every person has the right to live in a clean and healthy environment. The Government has demonstrated significant political commitment to ensuring access to clean water, safe sanitation and promotion of good hygiene practice. A wide variety of government agencies work to further improve the WASH agenda- and this guideline seeks to build and enhance their efforts by providing specific focus on WASH for infants and children under three years of age. This can be achieved without significant financial and resource implications if existing networks and programmes are adapted and modified to include a Baby WASH agenda.

The One WASH national program (OWNP) is a government-led sector wide approach and the main instrument for achieving the goals set out for WASH in the second Growth and Transformation Plan (GTPII); The OWNP brings four ministries together - Health, Finance, Water Resources and Education - to jointly deliver water and sanitation services to the people of Ethiopia, improving the health situation, decreasing the drop-out rates of children in schools, and make financing for Water Sanitation and Hygiene (WASH) more effective.

The One WASH National Program provides an excellent opportunity for effective implementation of the Baby WASH Guidelines. Regions where Agriculture and Rural Development and Women, Children, Youth Affairs are members of the WASH structure can provide further opportunities for mainstreaming the Baby WASH agenda.

In order to achieve the goals of the OWNP, it is crucial that the Baby WASH perspective – considering the specific needs of children under three years of age – is integrated into operations.. Sensitization and awareness creation about Baby WASH is required for Woreda and city/town WASH teams to ensure that it is a prioritised part of their work.

The Ministry of Education will be an important partner in promoting the Baby WASH agenda. They should seek to promote safe WASH practices in schools, particularly targeting adolescent girls to develop good hygiene practices. Children of all ages can become valuable change agents in their communities and should be utilized to further Baby WASH messaging.

The Ministry of Water Resources also has a vital role to play in promoting Baby WASH. Evidence shows that as many as 40% of improved water sources have dried up or are not functional and that 66% of households walk in excess of 1 hour to get access to water . Given this, it is hardly surprising that families may not prioritize hand and face washing against other uses of water such as drinking, cooking and cleaning. Current efforts to improve access to safely managed water supplies will provide critical support to the Baby WASH agenda.

The Women, Children and Youth Affairs Ministry (MoWCYA) is mandated to “coordinate all stakeholders to project the rights and well-being of children”. 9 The Ministry can play an important role in advocating for Baby WASH and bringing together different stakeholders to ensure that Baby WASH is one of the priority programmes in Ethiopia.

The main role of sectoral authorities at federal, regional and zonal level is to focus and highlight attention on Baby WASH issues - developing legislation, plan and strategies for supporting good hygiene practices which specifically target children aged under three years old in the home and in the

9 http://www.mowcya.gov.et/web/guest/Vision,-Mission-and-Objectives

community. Woreda and Kebele level sectoral authorities will be responsible for actual implementation and monitoring of Baby WASH interventions.

The health sector has the primary responsibility and overall leadership in the implementation of the sanitation policy. In addition, FMoH should work closely with other relevant stakeholders and development partners, and including those operating in emergency situations (UNHCR, ARRA) and the private sector. These actors should play important roles in the implementation, monitoring and evaluation of the Baby WASH program

The potential roles and responsibilities of the Ministry of Health are highlighted below.

Federal Level – MOH

- Prepare and disseminate Baby WASH guideline, training materials, manuals and facilitate actual implementation of guidelines including the roll out of trainings, modifications and updates to training materials;
- Coordination and collaboration among other relevant sectors in order to promote an enabling environment for Baby WASH;
- Solicit technical and financial support for Baby WASH including resource mobilization and integration with existing programs on neglected tropical diseases and MNCH;
- Promote and advocate Baby WASH interventions and innovative and traditional Baby WASH products, using different media outlets (both electronic and print media) and through organizing public annual events (MHM day, Global Hand Washing Day, World Toilet Day, World Water Day, Ethiopian Hygiene and Sanitation Festival, EPHA, etc.);
- Tighten standard definitions of ODF to specifically require checks on child feces disposal. Jointly monitor and evaluate the progress of the regions /zones/woredas on a regular basis;
- Facilitate the design, prototyping and standardization of Baby WASH products and services that fit women and girls requirements, with the support of development partners and in close collaboration with the private sector; and,
- Strengthen linkages between Baby WASH, sanitation marketing and Health Extension Workers to ensure that parents are aware of the necessity of providing safe and clean environments for their children.

Regional level – Regional Bureau of Health

- Contextualize the developed guideline, including translation to local languages;
- Provide training for the relevant sectors at Regional and Woreda level;
- Advocate for the integration of Baby WASH interventions into existing efforts – particularly maternal care efforts which target new mothers.
- Conduct a review of existing WASH-related programs and activities to determine where gaps for Baby WASH may exist.
- Undertake promotional activities and events;
- Advocate for resource mobilization jointly with regional sector actors;
- Coordinate all stakeholders and actors at regional level;
- Jointly monitor and evaluate the Baby WASH activities;

- Organize experience-sharing platforms and events among Woredas and Zones;

Woreda level - Health sector and WASH structures

Actual implementation takes place at the Woreda and community level. First and foremost the Woreda Health Office is responsible; but shall be fully supported by the Woreda WASH Team. The Health Office shall:

- Coordinate all stakeholders and actors at Woreda and community levels;
- Facilitate and conduct capacity building activities and provide technical support, assisted by the region/zone;
- Facilitate advocacy and promotion activities at Woreda and community levels; and include Baby WASH as a priority agenda for the Woreda cabinet;
- Solicit technical and financial support at the initial stage of implementation;
- Conduct joint follow up and supportive supervision activities, undertake regular reporting, and increase monitoring efforts specifically looking at whether ODF status is being maintained with respect to child feces.
- Enhance and facilitate strengthening of linkages between the private sector, health extension workers and the health development army to improve the access of rural peoples to WASH-related products.
- Facilitate annual public events like Global Handwashing Day.

Health Center and Health Post

Health Centers and Health Posts have an important and leading role to play to ensure the comprehensiveness of WASH approaches.

- Advise parents who children fall sick from sanitation-related diseases of the importance of Baby WASH practices such as handwashing with soap at critical times, face-washing, maintaining a clean and safe environment for children etc;
- Monitor and report practices which may undermine ODF status and facilitate linkages with woreda office to follow up;
- Create awareness through messaging, posters and other C4D tools of the links between trachoma and low levels of face-washing.

Kebele Level

At Kebele level, existing structures, such as health development armies (HDAs), development assistants (DAs), water sanitation and hygiene committees (WASHCOs), natural leaders, faith based organizations, civil society organizations, youth and women associations and others need to be involved. They can have the following responsibilities:

- Facilitate the promotion of Baby WASH practices through HDA, DAs, natural leaders, school children and others who can reach and influence households;
- Facilitate annual public events like Global Hand Washing Day, World Toilet Day, World Water Day, school celebration days etc. for the promotion of Baby WASH;
- Identify and record any challenge related to Baby WASH – particularly practices around open def-

ecation for children among end users and facilitate linkages with the Woreda for follow up.

Table 2: Suggested Roles and Responsibilities of Key Actors on Baby WASH

Organizations	Roles and Responsibilities
Health	• Provide accurate and user friendly information on the biological and medical facts around the relationship between Baby WASH and improved health outcomes. • Health shall be responsible for monitoring of the Baby WASH guideline implementation by responsible institutions. • Facilitate advocacy and promotion activities on Baby WASH at all levels, • Solicit technical and financial support to at the initial stage of implementation; • Ensure the integration of Baby WASH in hygiene and sanitation policy documents, guidelines and standards • Ensure the incorporation of Baby WASH in existing programs and interventions like service delivery, capacity development and sanitation marketing, WASH in schools, participatory hygiene and sanitation transformation.
Water and Irrigation sector	• Increase focus on functionality of water source. • Facilitate advocacy and promotion activities at all levels on Baby WASH
Education	• Sensitize teachers and students (particularly girls) about the importance of WASH for young children as well as themselves. • Many students will have younger siblings and can play a role of 'change agent' to promote Baby WASH. • Incorporate Baby WASH learning into the school curriculum and professional training for teachers.
Women and Children Affairs	• Advocate for inclusion of Baby WASH focus in relevant policy manuals, guidelines and programmes. • Promote Baby WASH in collaboration with civic societies; monitor progress, • Promote and ensure schools provide girls and boys with relevant information on importance of WASH for children under 3 years old.
Agriculture and Rural Development	• Provide stronger guidance on the importance of keeping livestock and children under the ages of 3 years separate. • Provide stronger guidance on importance of regularly cleaning/removing animal feces or restricting access of animals to child's environment.

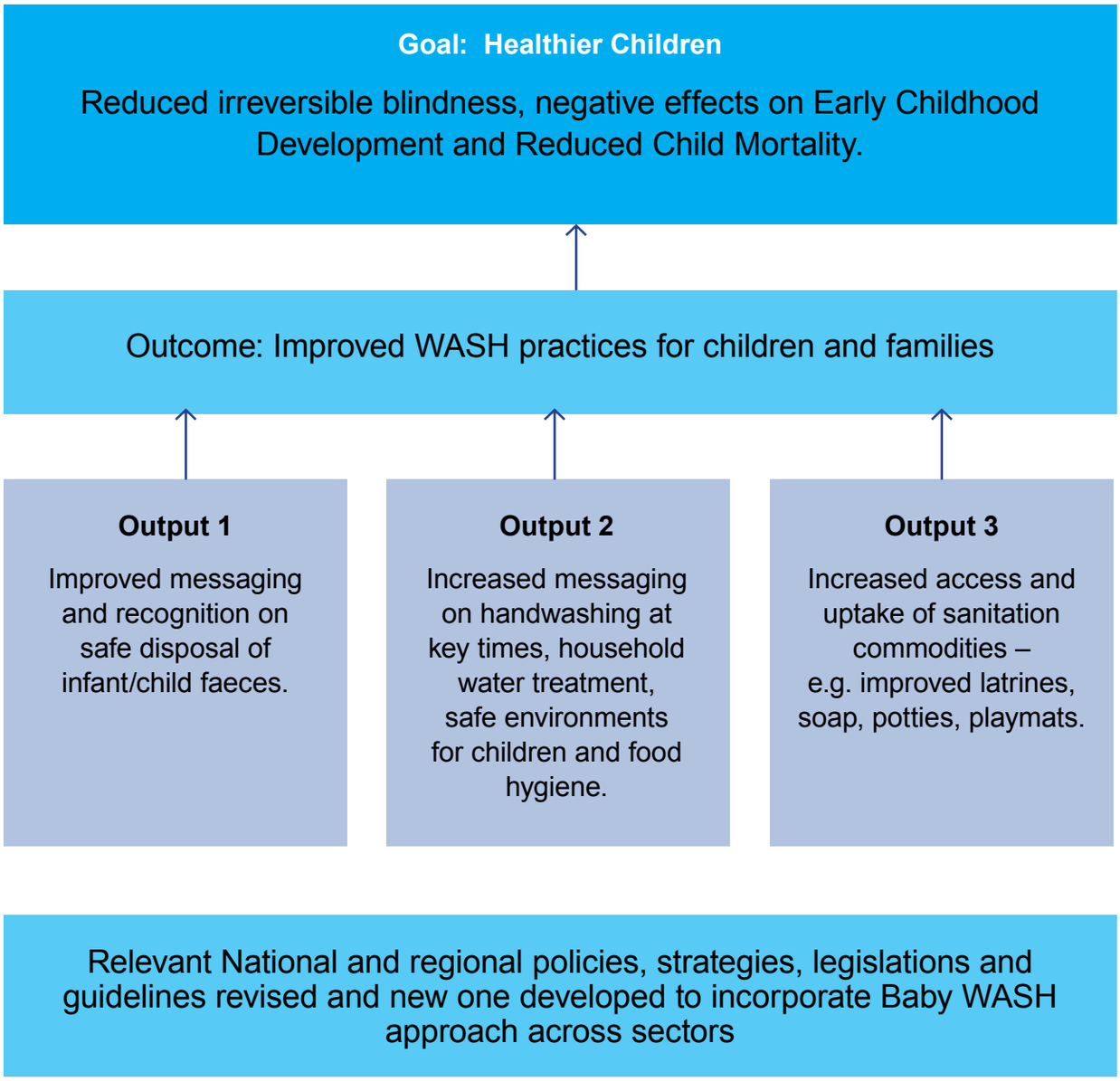
Organizations	Roles and Responsibilities
CSOs/development partners	• Solicit technical and financial support at all stages • Facilitate linkages with different development actors at the local level to address Baby WASH holistically and break dow silos between nutrition, WASH, health and other programmes. • Support community enterprises to provide low cost Baby WASH products – particularly if constructed using local materials. • Promote WASH information to community organizations, particularly those that work with mothers and fathers.
Private sector Partners	• Produce and distribute affordable and appropriate Baby WASH products such as potties, hoes/scoops for child faeces and playmats. • Improve supply chain into rural areas.
Community	• Challenge common misconceptions on health significant to the safe disposal of child faeces. Underline the importance of Baby WASH to achieving 'true' ODF and promote a norm of disgust around improper practices or children with unclean faces. • Encourage all households to have methods or facilities for the safe disposal of child faeces. • Create norms that all children should be potty trained at a certain age. • Share tools or potties where feasible. Share information on good Baby WASH practices. • Ensure equitable and sustainable access to community water and sanitation facilities.

5.

5. Monitoring and Evaluation

Monitoring and evaluation is a process that helps improve performance and achieve results through improving current and future outputs, outcomes and impact. It is mainly used to assess the performance of programs but can also be adapted for policies and policy change. It ensures that programs are focused; enable improving practices; sharing both positive and negative experiences with others.

The below is suggested framework for monitoring and evaluating Baby WASH.



Indicators

The following suggested key indicators can be used in monitoring and evaluating the implementation of the Guideline.

Level of indicator	Indicator	Means of verification
Objective / impact indicator – National level	# of policies, strategies, legislations and guidelines revised to incorporate Baby WASH Existence of framework for integration of sector actors in Baby WASH	# existence of reviewed policies, strategies and legislations # reports / field report
Regional level	# of revised strategies and guidelines revised to incorporate Baby WASH Existence of regional framework for integration of regional sector actors in Baby WASH Reduction of Diarrhea incidences in ODF Woredas. Reduction of trachoma incidence in children.	# reviewed policies, strategies and legislations # reports / field report HMIS Data HMIS Data
Zonal, woreda and kebele level (process indicator)	# of trainings/information sessions given by HEW which include Baby WASH messaging. % of parents who correctly highlight importance of child feces disposal, handwashing and face-washing at critical times	Regional reporting Nationally Representative Survey compared to baseline

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External resources

World Vision – Baby WASH coalition (launch planned for UNGA in Sept 2016) http://babywashcoalition.org/

Water Aid – 'Healthy Start' http://www.wateraid.org/policy-practice-and-advocacy/healthy-start

FHI 360/WASH plus/Alive and Thrive – 'Clean, fed and Nurtured' Community of Practice https://cleanfednurtured.org/