RESEARCH STUDY

Scoping and Diagnosis of the Global Sanitation Fund's Approach to Equality and Non-Discrimination

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GLOBAL SANITATION FUND

About WSSCC

The Water Supply and Sanitation Collaborative Council (WSSCC) is at the heart of the global movement to improve sanitation and hygiene, so that all people can enjoy healthy and productive lives. Established in 1990, WSSCC is the only United Nations body devoted solely to the sanitation needs of the most vulnerable and marginalized people. In collaboration with our members in 141 countries, WSSCC advocates for the billions of people worldwide who lack access to good sanitation, shares solutions that empower communities, and operates the Global Sanitation Fund (GSF), which since 2008 has committed over $117 million to transform lives in developing countries.

About GSF

GSF invests in collective behaviour change approaches that enable large numbers of people in developing countries to improve their access to sanitation and adopt good hygiene practices. Established in 2008 by WSSCC, GSF is the only global fund solely dedicated to sanitation and hygiene.

WSSCC gratefully acknowledges the donors that, through its lifetime, have made GSF's work possible: the Governments of Australia, Finland, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom.

Front cover photos (from top):
Senegal: Adolescent girls discuss their sanitation needs. ©Suzanne Ferron
Nepal: A Dalit woman and her daughter display their improved latrine. ©Sue Cavill
Malawi: A sanitation champion from Lwanda Village, who had polio as a child, displays the sanitation facilities he constructed with the help of Natural Leaders. ©Suzanne Ferron
Togo: A Community-Led Total Sanitation (CLTS) triggering session in Togo. ©WSSCC

Inside cover photo:
Demonstrating effective handwashing in **Benin**. ©WSSCC/Asu Durmus

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Acknowledgements, terminologies and acronyms can be found on pages 126-129.

ABSTRACT

The Water Supply and Sanitation Collaborative Council (WSSCC) established the Global Sanitation Fund (GSF) in 2008. Since then, it has supported sanitation at scale through collective behaviour change in 13 countries in Africa and Asia. In 2016, it initiated a learning process to identify and analyse key factors impacting on equality and non-discrimination (EQND) within the 13 GSF-supported programmes, in order to strengthen programming and contribute to the sector knowledge base. Remote analysis was undertaken of all 13 countries, with country visits to: **Ethiopia**, **Malawi**, **Nepal**, **Nigeria**, **Senegal** and **Togo**. The process particularly focused on learning about the experiences and recommendations of people who may be considered disadvantaged (which includes those who may be vulnerable, marginalized, excluded or actively discriminated against, or experiencing inequalities, inequities or stigma).

GSF has considered EQND in the initial identification of countries to work in and in prioritizing poorer and underserved geographical areas. As a result of this many people living in communities in poorer and underserved areas have gained access to and are using latrines, and people who may be considered disadvantaged within communities expressed a wide range of benefits which relate to safety, convenience, ease of use, self-esteem, health, dignity, improved environment, and in a few cases, income generation. Some have built their own latrines and others have been supported by family or other community members, including other people who might be considered disadvantaged. Also, a number of examples were seen where people who might be considered disadvantaged have taken leadership roles within the process and used the opportunities to break down stereotypes of marginalized groups. But whilst acknowledging a range of positive outcomes and an increasing awareness and interest within programme teams to increase the consideration on EQND, GSF has not yet systematically integrated EQND into its work within communities and throughout the programme components and stages in all of the programmes it funds; although a range of different examples were seen where positive efforts have been made, particularly initiated from 2013/14 onwards.

The complexity of issues relating to EQND has caused barriers to effective responses, and gaps and challenges were also found. It is clear that Community-Led Total Sanitation (CLTS) is not automatically inclusive if difference is not specifically recognized and if people who are disadvantaged are not proactively considered at the forefront of each step. Examples of challenges identified have included that some people who are considered potentially disadvantaged (such as older people, people with disabilities, the poorest or marginalized) have fallen through the gaps or have been put under pressure to build latrines, which has resulted in selling or losing limited assets. Challenges have also been expressed in relation to the sharing of latrines. Whilst it was not possible to establish the scale of these problems, the fact that a range of examples were easily identified within the limits of the number of villages visited in this study, warrants greater attention within GSF and other programmes based on CLTS and associated processes. Other areas that require increased attention by GSF and global actors are: how to engage appropriately with people with mental health conditions and how to facilitate discussions on accessibility options for people with disabilities and mobility limitations. There is a need for GSF to be more systematic in its consideration of EQND. Recommendations have been made for building on the examples of good practice, and responding to the identified gaps and challenges.

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A SANITATION FACILITY IN TOGO. ©WSSCC

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EXECUTIVE SUMMARY

Background

The study – From July 2016 to April 2017, the Global Sanitation Fund (GSF) – a pooled funding mechanism for national sanitation and hygiene programmes under the auspices of the Water Supply and Sanitation Collaborative Council (WSSCC) – commissioned an Equality and Non-Discrimination (EQND) scoping and diagnosis process. This aimed to gain a better understanding of the challenges, opportunities, and implementation approaches used to address EQND within GSF-funded interventions, and how programming has been impacting on and involving potentially disadvantaged individuals and groups (people who may be vulnerable, marginalized, excluded or actively discriminated against, or experiencing inequalities, inequities or stigma). This is a study aiming to learn to improve for the future and is not an evaluation. Participants were encouraged to share both successes and challenges and areas that can be improved to contribute to the ultimate aim of being able to strengthen programme guidance for the future and also to contribute to the global sector knowledge base.

Process – The process involved a desk-based study of documentation and remote key informant interviews with representatives from the 13 countries and external stakeholders; and an online survey with Executing Agencies (EAs) and Implementing Partners (IPs). It also involved visits to six GSF-supported programmes (**Malawi**, **Ethiopia**, **Senegal**, **Nigeria**, **Togo** and **Nepal**). Each country visit incorporated a national workshop with programme implementers and CLTS facilitators, key informant interviews and focus group discussions (FGDs) with sub-national government institutions and sector partners; and at community level FGDs with community leadership and community groups, and household and institutional visits. The methodologies used were mainly qualitative including a number of participatory techniques to promote discussion and debate. The study pro-actively sought to involve and listen to the voices of those considered potentially disadvantaged. This was intended to understand how their needs are being addressed, how they have participated in CLTS[1] and other associated approaches for collective behaviour change, what impact the intervention has had on them and their suggestions for improvement for future programmes.

1 In this report, the term 'CLTS processes' has been used as a shorthand for a number of variations and sub-approaches focussing on collective behaviour change.

People met and areas visited – The team engaged remotely or through the online survey with 101 persons (34/66 percent female/male). Across the six country visits, the team met approximately 1,500 people (45/55 percent female/male). They met people involved in managing and implementing the programme (including CLTS facilitators) and other sector stakeholders at national level and went to 16 districts (or communes), engaged with people from 116 communities and undertook 104 household visits. The team met: people from local authorities/district or equivalent coordination mechanisms; village leaders, village level committee members or community groups, teachers, health workers or others with a key role at community level; 211 older people;[2] 74 people with disabilities; 28 carers of people with disabilities; and 100 children above 5 years, adolescents and youth. In addition, the team also met members of savings and solidarity groups, a sanitation revolving fund, masons and the police, and visited schools, health facilities, as well as an internally displaced persons camp and a brick factory. The communities visited represented diverse and particularly challenging situations, including those that are remote, with sandy soils, have been affected by natural disasters (earthquake) and conflict, as well as those in border areas and hilly, mountainous and peri-urban areas. They also met with a number of key informants from organizations with specialist EQND expertise related to social welfare, disability (including mental health), child workers and sexual and gender minorities (SGMs).

Findings

Global action on EQND – A range of organizations globally have been working on specific elements of EQND most commonly using the terminology 'equity and inclusion', with most focus on disability and accessibility and menstrual hygiene management (MHM). There is limited experience of considering EQND at scale in sanitation programmes; although this is likely to change with the Sustainable Development Goals (SDGs) and their specific focus on including the hardest to reach and water and sanitation for all. As far as we are aware this is the first study looking specifically at a broad range of EQND considerations across a sanitation programme at scale and hence it is hoped it will provide a valuable contribution to the global body of knowledge. One of the most relevant pieces of research over the past few years relating to EQND and CLTS is the CLTS Plus action research undertaken in **Malawi**,[3] which looked at how to practically integrate considerations related to disability into the training of CLTS facilitators.

Government strategies for EQND – There are significant differences in the strategic focus on EQND in the national policies, strategies and plans of the six countries visited. The most comprehensive focus in a national strategic document was found in the **Nepal** Master Plan for Sanitation and Hygiene, 2011,[4] but elements are also considered in the **Malawi** National ODF Strategy[5] and in some strategic guidance in **Nigeria**; although consideration in the national CLTS training manual[6] is limited to awareness of the need to consider men, women and children as distinct groups. Both **Nepal** and **Malawi** allow subsidy support for the most disadvantaged, either near the end of the process to ODF (**Nepal**), or after ODF (**Malawi**). The Government of **Cambodia** (a country not visited by the team) prepared a national guideline in WASH for people with disabilities and older people in 2016.

GSF historical approach to EQND – WSSCC as an organization has strengths in a number of areas of EQND, and its medium term strategic plan includes EQND specific indicators. GSF considered EQND in the initial decisions on country selection and areas within countries to work, but otherwise it initially took mostly a 'hands off' approach to EQND, to enable each country to establish its own considerations and priorities, based on national policies, strategies and plans. A core global indicator was initiated in 2011 which considered *'disadvantaged individuals'*, the interpretation of which was left to the country programmes; but the reporting on which has been inconsistent. Increasingly, GSF has realized that there is a need to support learning opportunities and some form of guidance on EQND, particularly related to issues around people who are disadvantaged within communities and households. Examples of recent progress can be seen in a number of country programmes, particularly after 2013/14, through increased attention in newer programme proposals, the existence of a number of EQND specific learning products, an increase in efforts to disaggregate data, and through the initiation of this study at global level.

GSF-supported organizations and processes – There are fewer female professional staff than male in the ex-

2 The numbers of people met noted here are approximated. They are likely to be under-estimated as the team did not request disaggregated information by age or disability in general group meetings.

3 Jones, H. E. et al (2016)
4 Steering Committee for National Sanitation Action, Nepal (2011)
5 Malawi Government (2015)
6 Federal Ministry of Water Resources and UNICEF (no date)

ecuting agencies and implementing organizations, but there are a number of women in senior positions and a significant effort has been made to ensure that there are both female and male CLTS facilitators and Natural Leaders. Most national partners do not seem to have their own code of conduct, but exceptions exist and elements are reported to be included in administrative regulations. There was limited evidence of EQND being considered in most of the early proposals (with exceptions) but there has been an increase seen in more recent proposals for extensions and new programmes. Some of the international EAs and IPs have access to gender advisors on a part-time basis, but most national organizations do not. The **Kenya** and **Cambodia** programmes are the only programmes that have currently employed staff with a specific EQND-related advisory role, although **Madagascar** has plans to recruit a EQND officer for the programme and **Togo** has plans to recruit an officer to sit in government. The **Cambodia** programme has prepared a very clear and practical EQND framework,[7] which would be positive for replication across all programme countries. The **India** and **Nepal** programmes show a particular awareness of minority and marginalized groups and communities within their programme areas; with a case study exercise and a major sustainability study in **Nepal**[8] both incorporating interesting EQND-related learning.

GSF-supported programme practices – Country programme modalities vary across countries, with some which are considered by the consultants as having the potential to be positive for EQND. Examples from the six countries visited include utilizing the government health structure, which reaches groups of every 30 and then 5 households in the country (**Ethiopia**), splitting larger communities into smaller communities for the purpose of CLTS triggering (**Nigeria** and **Togo**), multiple verification visits (**Nigeria**), employing CLTS facilitators (known as triggerers) from the communities themselves (**Nepal**), establishing partnerships with community-based organizations which already have EQND expertise (**Malawi**) and intensive follow up with capacity building (**Senegal**). It is considered that all of these modalities would be beneficial to EQND because they offer the opportunity for better knowledge of the potentially disadvantaged in specific communities and hence reduce the risk of people falling through the gaps. There has been limited focus on EQND during pre-triggering or triggering to-date, but again with a few exceptions. More action is reported during the follow-up stage of the CLTS process although it does not yet appear to be systematic. The Follow-up MANDONA (FUM) approach developed by the **Madagascar** programme encourages an increased focus on EQND during the follow-up process and has been adopted by a number of countries. Some disaggregation of data is undertaken at community level in the household register or by IPs, but this varies across programme areas and countries and the systematic identification of people who might need support and pro-active follow-up does not appear to be happening.

Outcomes and challenges for the potentially disadvantaged – It is clear that many people who may be considered disadvantaged have benefitted positively from the GSF-supported programmes, particularly in ODF verified areas; and a range of positive outcomes/impacts were reported by people who may be considered disadvantaged across the communities and countries visited. These relate to safety, convenience, ease of use, self-esteem, health, dignity, improved environment and in a few cases income generation. Some people have built their own latrines; some have been supported by family, and others by community members, such as those in leadership positions, youth groups, community-based organizations, neighbours, or in some cases by other people who may also themselves be considered disadvantaged. In some cases, Natural Leaders and WASH committee members have agreed to provide long-term support for the ongoing hygiene and maintenance of latrines for people who are older or visually impaired. Also, a number of examples were seen where people who might be considered disadvantaged have taken leadership roles within the process. Some people with disabilities have been identified as Natural Leaders and are active on some WASH committees, and there are a range of women as well as men who are Natural Leaders. In addition, CLTS facilitators include some people from marginalized groups, and people from a Dalit community visited in **Nepal** used the opportunity of the programme to break down stereotypes.

However, it is also clear that many of the people who might be considered disadvantaged (particularly people with disabilities and older people) did not participate in the pre-triggering or triggering processes and there were a number of barriers to their engagement. The team also met people who they considered to be very vulnerable[9] who had 'fallen through the net' in different ways including being left to dig and

7 CRSHIP (2016)
8 Bikash Shrot Kendra Pvt Ltd (2016, draft)

9 Such as households with adults with mental health or physical disabilities limiting the household's income generating abilities, single older headed households with multiple dependents and ultra-poor households.

bury (including in some cases in ODF communities), vulnerable people who were being pressured to build over long periods of time, or had to wait for two years or longer after the triggering event to be supported with a household latrine. The pressure put on vulnerable people to build is an area that requires urgent attention. This issue is complicated by the difficulty of assessing who is really poor and in need of support or otherwise, and the reservations of implementers not wanting to disrupt community momentum through the provision of subsidy, based on negative historical experience.[10] Some examples were seen or heard of very poor people who have had to sell their land or few assets, or who have lost the title to their land through not being able to pay back loans. Whilst it is not possible to know the scale of these challenges, the fact that these examples have been identified within the limited number of villages that the team were able to visit and short periods in each country, indicates that they are also likely to exist elsewhere and are areas that require increased attention from both GSF and other actors utilizing CLTS approaches.

Another gap seen across all programmes visited related to accessibility of latrines for people with disabilities and mobility limitations. Some adaptations were seen, but most of these had been self-initiated, which is positive and could be argued as in line with CLTS principles of self-help. However, as facilitation on the options for accessibility and other specific needs has not been systematically undertaken in any of the six countries visited,[11] this has resulted in many people with disabilities or mobility limitations currently sitting directly on a mud slab, balancing on a bucket, or defecating on the floor of a house or compound (which is then disposed of by a family member).

Particular challenges are also being faced in relation to sustainability/slippage. People who may be disadvantaged are generally supported with the simple latrines, which are most liable to collapse. This poses a particular challenge for someone who then has to wait for others to help them to rebuild. Challenges were also expressed relating to the sharing of latrines, even with relatives; and in some households not everyone is using the latrine even when it exists.

10 This comment is based on observations made in a country where subsidy is allowed for the poorest, but what is an acceptable level of pressure being put on the most disadvantaged is something that all programmes based on CLTS should pay attention to.

11 Although occasional examples heard of where IPs have initiated this discussion themselves.

FATHER CONSTRUCTED OWN LATRINE AND ONE FOR DAUGHTER, BALAKA DISTRICT, MALAWI

Gringo, who has some difficulty walking, built this latrine and washing area for anal cleansing. He is now building another latrine for his daughter, so that she will not walk in on him (photo: S. House)

FEMALE COMMUNITY HEALTH VOLUNTEER FROM MUSLIM MINORITY COMMUNITY, ARGHAKHANCHI DISTRICT, NEPAL

Habira, from Arghakhanchi District, Nepal, who promotes sanitation and hygiene in the community where she lives standing outside the toilet at her home (photo: S. Cavill)

LATRINE BUILT BY SON WITH LARGER SQUAT HOLE, LOGO DISTRICT, NIGERIA

Uger, the son of Nyion, an older woman probably over 90 years and who is unable to see, built her a toilet with a large square hole so that it is easier for her to use (photo: S. House)

Other areas for attention – The issue of marginalized and minority groups can be a sensitive issue for programme implementers, with not everyone being comfortable to admit some people are in this position. One particular 'blind spot' identified is the inclusion and treatment of people with mental health conditions, or people with addictions (such as alcoholism or drugs), particularly where they are not able to stop the practice of open defecation through traditional triggering tools or logical argument. People who live on the streets and people in low-paid and dangerous employment (including sex workers), including in districts that have been verified as ODF, are other groups who have been paid little attention. Knowledge and confidence is also low in the sector on the needs of, and how to engage with SGMs, a group that faces significant discrimination, which is complicated by the varying legal positions in different countries. Particularly vulnerable geographical areas, such as those with difficult environmental conditions, pose additional challenges; as do those affected by disasters where people also face additional complications from the differing approaches to the use of subsidy. Both require greater flexibility in programming, which GSF has already shown in its response to the earthquake in **Nepal** and to conflict and flooding elsewhere.

Conclusions

A wide range of people who may be considered disadvantaged have benefitted from GSF. This has occurred partly because the Fund has intentionally focussed on poorer or what could be considered otherwise disadvantaged areas, and partly because community support mechanisms have been utilized. However, people have fallen through the gaps or faced challenges that may not be openly apparent when focussing on the community as a whole and the differences within the community and within households have not always been understood. Specifically, the importance of including those who are most disadvantaged in CLTS processes and of enabling their active participation in the programme (rather than simply ensuring that they have access to a latrine) has not been adequately recognized.

Strengthening guidance and capacity building of CLTS facilitators, so they can strengthen the facilitation processes to better integrate considerations related to EQND is needed. In particular, there is a need to strengthen facilitator and community leaders' awareness of the different needs within the community, involve people who may be disadvantaged throughout the process, and use community support mechanisms as part of the CLTS process; all areas where a lack of consistency was seen. Whilst some people may feel that the CLTS process is in itself equitable because all people in communities need to have stopped OD and have access to and be using a toilet before ODF certification is possible, the conclusion of this study is that the CLTS process does not automatically ensure equality and non-discrimination in the programme processes and outcomes. More proactive attention is needed throughout the programme cycle to build on current successes and ensure that people do not fall through the net or come to harm through the actions or omissions of the programme.

However, simple programme adaptations to systematically incorporate those who are potentially disadvantaged into plans, guidance, training, codes of conduct and monitoring, evaluation and learning (MEL), will go a long way to ensure that the process effectively responds to EQND and will increase the benefits for and protect those who need it most. A range of the recommendations should be relatively easy to integrate at limited cost, just through keeping people who are disadvantaged at the forefront of the agenda at each stage, but some additional budget allocation will be required to build capacities, and adequate time will be required to be spent in communities to ensure that people who are disadvantaged are not overlooked. The team found that programmes were eager to improve in this area and keen to receive additional guidance and support, and to build on the learning that has already started, which was very positive.

Recommendations

Disclaimer: The recommendations that follow are made by the consultants to inform further discussion and decision-making by GSF.

The key recommendations are:

R1 SUMMARY OF RECOMMENDATION FOR ACTION BY GSF

Provide basic guidance to the GSF-supported country programmes on minimum programme standards including the introduction of a global code of conduct, continuing to identify good practice in relation to EQND and supporting capacity building and MEL.

Key actions recommended include: The development of global and country level strategies and plans for strengthening EQND at different levels; allocation of budget; provision of guidance and minimum standards; development of and requirement of all EAs and IPs to sign up to a global code of conduct; produce a practical guidance manual with key concepts and practical tips; build own capacity on responding to the dignity, rights and inclusion of people from marginalized groups, including people from SGMs and people with mental health conditions; fund EQND advisor posts for all country programmes; continue to engage with government in national planning and policy-making processes.

R2 KEY PRINCIPLES ON EQND

GSF should develop and share a set of key principles with the country programme teams on which all work should be based.

Key principles suggested for GSF to continue developing include those related to: Recognising difference; 'doing no harm' (including guidance on how to do this); considering and advocating for how those who may be potentially disadvantaged can be more involved in the programme processes; encourage self-action but also recognize where support from the wider community or elsewhere may be required; transparency in provision of external support; collaborate with organizations representing those who may be disadvantaged; continue learning on EQND and feedback into programme.

R3 TERMINOLOGY AND CATEGORIZATION OF DISADVANTAGE

Establish the global terminology to be used by GSF related to disadvantaged individuals and groups and provide guidance on categorization of factors, as a starting point for country programmes to adapt to their own country contexts.

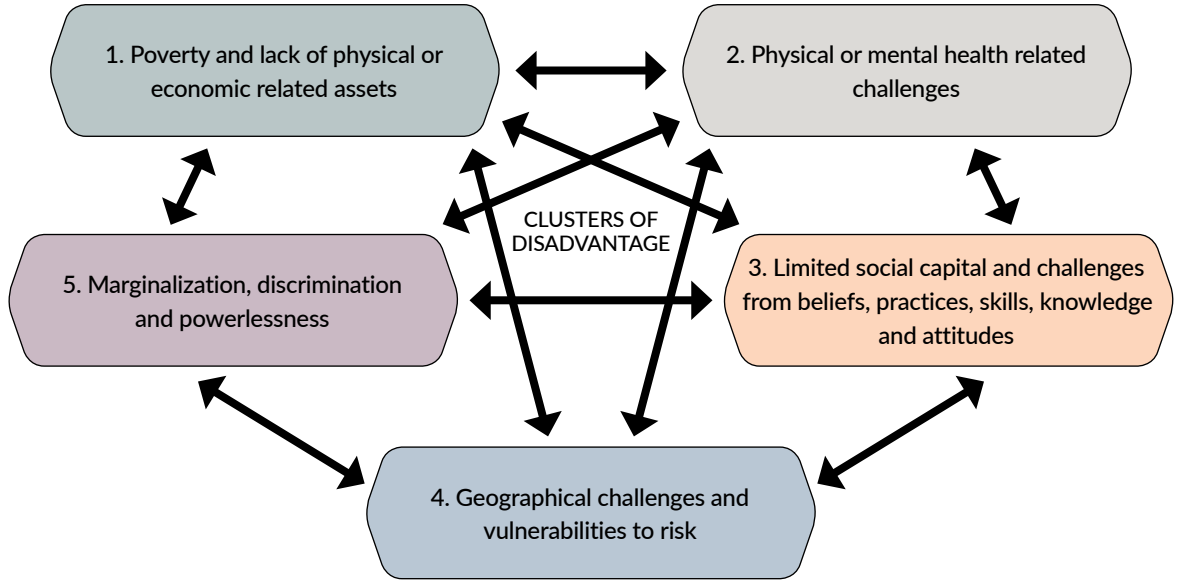
Key actions recommended include: Use the term *'potentially disadvantaged'* as an overview term which includes *'individuals and groups who may be vulnerable, marginalized, excluded or actively discriminated against, or experiencing inequities, inequalities or stigma'* – the term 'potentially' takes into account the fact that not all people who may be considered disadvantaged may actually be so; each country to establish a set of appropriate and respectful terminologies in each country context in all languages used in the programme area. In addition, it is recommended to use the 'Clusters of Disadvantage' in **Figure 1** as a way to simplify the complex web of interlinking factors affecting disadvantage and investigate the use of the categorization of those who may be potentially disadvantaged into three groups as summarized in **Figure 2**.

R4 ENSURING INCLUSION OF MARGINALIZED AND EXCLUDED INDIVIDUALS AND GROUPS

Particular attention should be placed on ensuring that individuals and groups who may be marginalized or excluded, are identified and included in the programme, in ways that ensure their safety and that support their dignity and rights.

Key actions recommended include: Emphasizing the importance of recognition of marginalized individuals and groups, incorporating this issue within capacity building initiatives and where appropriate bringing in experts with experience of working with particular marginalized groups to raise awareness and assist with the development of appropriate strategies for the programme. Pay particular attention to proactively learning about how to engage appropriately with people with mental health conditions; ensuring that people who are sexual and gender minorities are treated with respect and dignity in all country programmes; and that people living on the streets and in poorly paid or dangerous employment are not overlooked in programme areas.

Figure 1: Clusters of disadvantage *



* For further details see Section 9.2 and Annex XIII

Notes:
1. The arrows indicate the interconnectedness of each factor to the other factors.
2. An individual or group affected by more than one factor is likely to be more disadvantaged than an individual or group affected by just one.
3. This figure has been adapted from Chambers, R (1983) analysis of the deprivation trap related to rural communities.

Figure 2: A, B and C categories of households from the perspective of who is likely to need support from outside the family

All who may be considered potentially disadvantaged

(vulnerable, marginalized, excluded or actively discriminated against, or experiencing inequities, inequalities or stigma)

Category A

Those who are likely to be able to construct, access and maintain a latrine themselves

Category B

Those who are not likely to be able to construct, access and maintain a latrine themselves – but either:

1. They have extended family members who can support them
2. They can afford to pay for the materials and someone to do the work

Category C

Those who are not able to construct, access and maintain a latrine themselves – and they:

1. Do not have extended family members who can support them
2. They would find it very difficult to pay for materials and someone to do the work – and are at risk of having to sell some of their few assets if they do, potentially making them more vulnerable

R5 CAPACITY BUILDING AND EMPOWERMENT OF PEOPLE WHO MAY BE DISADVANTAGED

Consider how the programme through its programme processes can support the capacity building and empowerment of people who might be disadvantaged.

Key actions recommended include: Proactively identify and engage emerging Natural Leaders from groups that may be normally considered disadvantaged and aim for gender parity in Natural Leaders where possible; consider mechanisms that could be used to support empowerment of potentially disadvantaged individuals and groups and to contribute to breaking down stereotypes and reduce exclusion and discrimination; consider and provide capacity building to encourage potentially disadvantaged people to take up leadership positions and to be able to sustain their own toilet and handwashing facilities; and consider what training might be needed for staff, partners, community leaders and other actors involved in the programme to support the above.

R6 LIMITS OF METHODS OF INFLUENCE

Clarify the different methods that should be used to influence others to change their sanitation and hygiene practices and establish limits within a Code of Conduct that all staff, partners and community leaders should agree to.

Key actions recommended include: Establishing guidance[12] on the differences between persuasion, and different types of coercion and the limits acceptable under the programme, with practical examples to increase understanding; and establish safeguards and practical suggestions for: a) people who do not understand why it is important to stop OD even after triggering; b) overcoming resistance; c) taking into consideration different forms of disadvantage; and d) assisting the most vulnerable who are unable to construct, maintain and sustain a latrine.

R7 OPTIONS FOR SUPPORTING THE POTENTIALLY DISADVANTAGED

Consider the different methods for supporting the potentially disadvantaged, including the option of receiving a government approved subsidy for the Category C group of households.

Key actions recommended include: Reviewing the range of options that can be available for supporting people who may be disadvantaged. See **Figure 3** for an overview.

It is recommended that wherever possible people should be encouraged to construct their own latrine when they can do so, encouraging self-efficacy and self-confidence, then encouraging family members to support, and if this is not possible then the wider community. As an additional option, it is suggested that targeted government-sanctioned subsidies (labour, materials, finance) from different sources could be made available for the Category C group of people (see **Figure 2**).

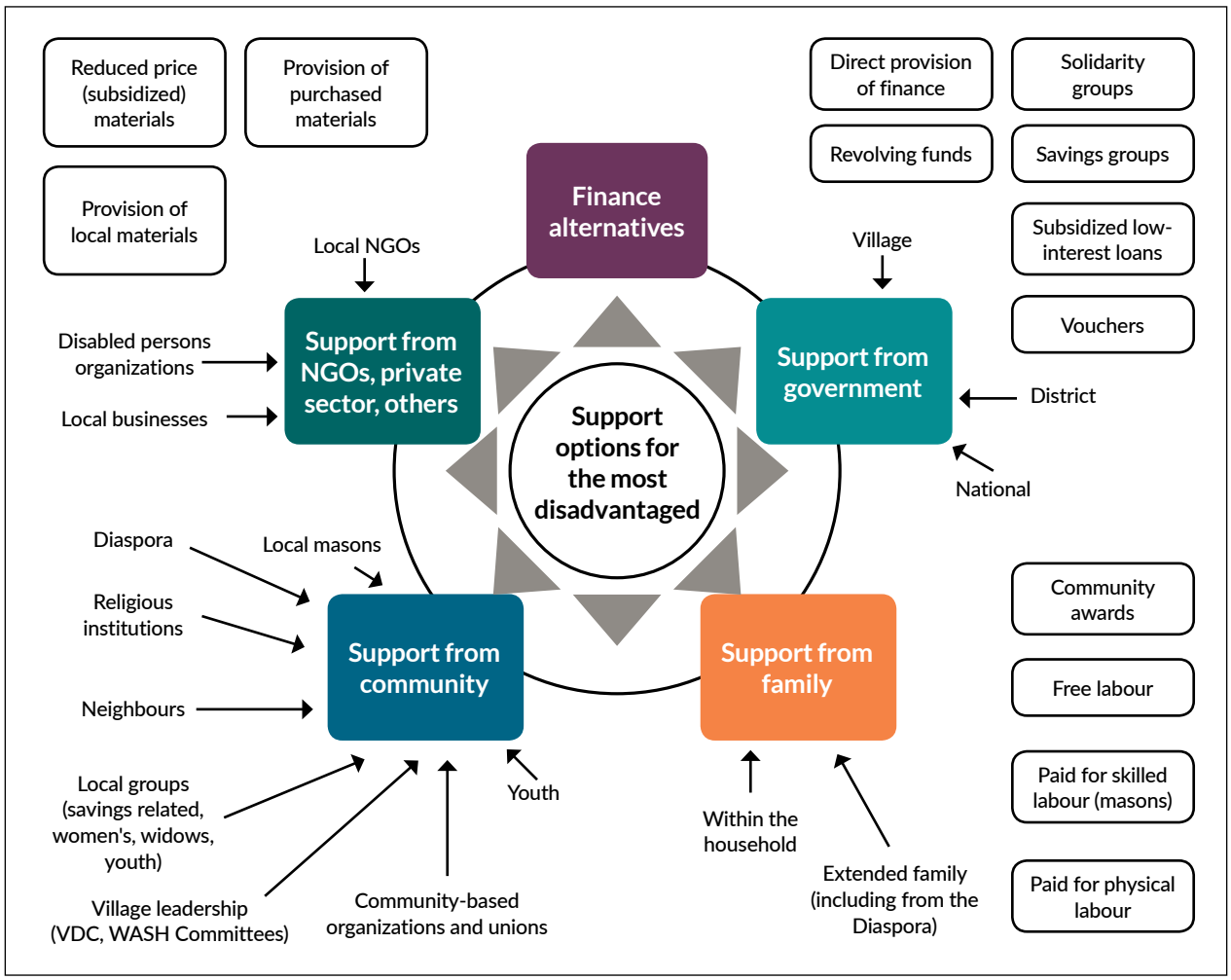
R8 WORKING IN DISASTER AND CONFLICT PRONE AREAS

GSF should have flexibility in its strategies and approaches to programming in areas vulnerable to and affected by natural disasters and conflicts.

Key actions recommended include: Being aware of the programme areas vulnerable to climate change / natural disasters or conflicts during the programme planning phases; integrating this consideration into planning figures, time schedules and budgets; enabling flexibility to manage the impacts of such events on the programme outputs; retaining an emergency preparedness fund at global level that can be called upon by any of the programme countries; considering strategies to rationalize the use of subsidies associated with humanitarian action and the transitions for returning to longer term non-subsidy approaches, including working with humanitarian actors to determine the same; and use the existing knowledge of programmes working in disaster or conflict-affected areas (such as **Nepal**, Nigeria, **Malawi**) to build global competence in appropriate strategies.

12 Some suggested guidance has been provided in the 'Dos and Don'ts' table in Annex XI.

Figure 3: Options for supporting the most disadvantaged



R9 **BROADENING THE IMPACT: DISABILITY, MHM, INCONTINENCE, URINATION AND TO BROADER ASPECTS OF SANITATION AND HYGIENE**

GSF is encouraged to strengthen its programmes and to offer more guidance and support to programmes in the areas of disability, MHM, incontinence and urination, all of which have EQND implications; and to continue to provide ongoing support to communities post-ODF to respond to broader sanitation and hygiene needs and with the added benefit of being able to monitor and reduce the risk of slippage for the most disadvantaged.

Key actions recommended include: a) Disability: establishing partnerships with disabled persons organizations; encouraging country programmes to develop practical guidance by building on existing useful compendiums and including experiences from the country programmes. **b) MHM:** utilizing opportunities from the WSSCC MHM advocacy activities and the existing GSF-supported programmes, such as in **Senegal** for learning, on how to integrate MHM into GSF-supported programmes; using triggering as an opportunity to create positive norms and breaking down myths on MHM; making sure that people understand the need for sanitation facilities that are designed to consider the needs of women and girls; undertaking advocacy including with men and boys; and considering whether efforts could be made in relation to identifying locally available menstrual hygiene protection materials. **c) Incontinence:** increasing programme understanding and capacity in the area of incontinence to be able to provide support and guidance when appropriate for families who have to manage it, including how to improve makeshift latrine facilities for use at night that consider ease-of-use, comfort, safety and as much dignity as possible. **d) Broaden focus on sanitation and hygiene for post-ODF follow-up:** Increase attention on areas of sanitation and hygiene that may be weaker in some

country programmes for stage 1 ODF[13] (such as handwashing with soap; or water quality where latrines have been constructed near water points in shallow water areas); and consider extending programming to cover other elements of sanitation and hygiene using this opportunity to also encourage the community to undertake occasional follow up with people who may be disadvantaged over time, to reduce the risks of slippage.

R10 DOS AND DON'TS OF CLTS IMPLEMENTATION

Prepare guidance and build capacity of GSF stakeholders on the Dos and Don'ts of CLTS and other approaches focussing on behaviour change at scale, to promote and protect dignity, uphold rights and value contributions of all including those who are disadvantaged; and in addition, to contribute to empowering people who may be disadvantaged and increasing community commitment to equity and equality for all.

Key actions recommended include: A series of tables split into the following areas have been provided with suggestions for Dos and Don'ts: a) enabling environment; b) organizational and MEL; and c) programme / community levels – split into 'do no harm', pre-triggering; triggering; post-triggering follow up; and by stakeholder group. A number of complementary annexes providing further case studies and other guidance have also been provided.

R11 EQND RESPONSIVE MONITORING, EVALUATION AND LEARNING (MEL)

Provide guidance to country programmes on how to effectively integrate EQND into monitoring, evaluation and learning and the minimum requirements for this.

Key actions recommended include: Providing guidance on minimum requirements for EQND for all elements of MEL, whilst also allowing some degree of adaptation to local contexts; supporting the systemization of EQND-related data collection in existing household registers, but simplifying information to be collected where possible; and test the A, B, C categories as recommended in **Figure 2**. Recommendations have also been made as to: the different levels of monitoring and information needed by communities, IPs and GSF globally; when each level of EQND considerations should be considered and by whom; more detailed questions have been suggested for baseline and outcome surveys that look further into intra- and inter-household related issues with variations by gender, age and other forms of diversity; and to encourage continued learning on EQND-related issues and the sharing of the same between programmes.

R12 R12 – PROGRAMME MODALITIES

Consider the impact of programme modalities in ensuring EQND when designing new or extensions to programmes.

A number of programme modalities that are considered positive in relation to EQND include: Triggering and follow-up in smaller communities; paying CLTS facilitators from communities themselves; increasing quality of follow-up and also ensuring adequate time for follow-up specifically with people who may be disadvantaged; strengthening rewards for communities that become ODF that could also be utilized to support community projects, including for the most disadvantaged; significantly increasing attention on institutional and public latrines (including whether GSF can support some infrastructure costs); considering the provision of more incentives/ small motivations for key community level actors, including for example shared bicycles to facilitate reaching more people where communities are spread out; encouraging the identification of *natural* Natural Leaders rather than appointed ones and facilitating flexible systems that allow for integration of emerging Natural Leaders; and recommending that all households including potentially disadvantaged individuals should have access to their own household latrine and not be expected to share.

13 Some countries have two stages in their declarations related to sanitation, with the second including additional elements that need to be passed before the community is declared to have met this stage.

NEPAL: JILMAN MIYA, A 70-YEAR-OLD MAN FROM A MUSLIM MINORITY COMMUNITY IN ARGHAKHANCHI DISTRICT, DISPLAYS HIS SANITATION FACILITY, WHICH INCLUDES A BATHROOM AND A TOILET. ©SUE CAVILL

INTRODUCTION AND STRUCTURE OF THE REPORT

2

2.1 BACKGROUND

The Global Sanitation Fund (GSF) is a fund established by the Water Supply and Sanitation Collaborative Council (WSSCC), which is hosted by the United Nations Office for Project Services (UNOPS). It was launched in 2008 in response to more than 2.4 billion people who lack access to basic sanitation. The programme focuses on collective behaviour change to increase access to, and use of, sanitation at scale and improve hygiene behaviours. Its first five country programmes were signed in 2010 and today GSF supports programmes in 13 countries (**Benin**, **Cambodia**, **Ethiopia**, **India**, **Kenya**, **Madagascar**, **Malawi**, **Nepal**, **Nigeria**, **Senegal**, **Tanzania**, **Togo** and **Uganda**); with three more country programmes under development (Lao PDR, Niger and Pakistan); and with 35 countries in total identified in the WSSCC Medium-Term Strategic Plan (2012-2016). The typical budget per country is approximately USD 5 million for the first 5 years. However, this has varied considerably across programmes. Additionally, GSF aims to provide support to countries to ensure sustainable change, with support expected to continue beyond the initial 5 years, although the exact length is under discussion.

The GSF funding mechanism has been learning as it progresses, both as to what works structurally as well as through its engagement on the ground. Between 2013 and 2016, the WSSCC commissioned a series of Mid-Term Evaluations (MTEs) for 10 of its country programmes. The Mid-Term Evaluation (MTE) Synthesis Report of 7 countries identified areas where GSF could strengthen the programme guidance it provides to its Executing Agencies (EAs) and Implementing Partners (IPs). These include the ongoing monitoring of the GSF-supported country programmes as well as how to ensure equity and inclusion throughout the programmes it supports. An in-depth diagnosis of GSF's Monitoring and Evaluation (M&E system) also pointed out weaknesses in how GSF-supported programmes measure and report on issues related to EQND. This study is one action committed to in response to the MTE.

GSF-supported programmes aim to achieve collective behaviour change and build strongly on CLTS and variations thereof. If facilitated well, CLTS as an approach has the ability to identify and also respond to some inherent processes of marginalization within communities and thereby strengthen people's ability to realize their rights. However, sometimes

CLTS-type processes have failed to properly identify vulnerabilities or marginalisation and may have inadvertently exacerbated existing unequal power relations. Although some GSF-supported country programmes have developed potential good practices in addressing vulnerability and ensuring EQND, others have faced challenges in assuring equitable (and sustainable) behaviour change at scale and in understanding the practical implications of rights-based programming. GSF aims to systematically identify, analyse and document both these positive and negative experiences to be able to better inform partners on potential strategies to ensure EQND.

Sustainability and universality are key concepts for GSF and both are highly dependent on the extent to which programmes and policies can ensure EQND, an area in which many other sector actors are also known to face challenges. With the targets for the SDGs aiming to reach 100 percent of the population, to focus on the 'hardest to reach' first and ensure that 'no-one is left behind', there has also been increased motivation within the global sector as a whole to find more evidence of effective EQND approaches that work at scale. This study aims to contribute to this process through both feeding into the design of the next phase of GSF, as well as contributing to the global body of knowledge.

2.2 PURPOSE AND TERMS OF REFERENCE

The purpose of the EQND scoping and process is indicated below. See **Annex IV** for the terms of reference.

PURPOSE

To identify and analyse key factors impacting on equality and non-discrimination within the GSF-supported programmes, to strengthen programming guidance and contribute to the sector knowledge base.

AIM

To gain a better understanding of how the programming and implementation approaches, methodologies and processes used in the various GSF-supported programmes involve and impact on the most marginalized, vulnerable and disadvantaged within programme countries, programming areas and communities, and whether and how rights-based approaches are being applied.

NIGERIA: JOSEPH CANNOT SEE AND USES HIS BROTHERS' PIT LATRINE. HIS CHILDREN BRING WATER TO THE LATRINE EACH DAY, AND HE CAN FIND HIS OWN WAY TO THE LATRINE BY FEELING HIS WAY WITH HIS CANE. HE WANTS TO BUILD A LATRINE INSIDE HIS HOUSE BUT HE CURRENTLY DOES NOT HAVE THE MONEY TO DO SO. ©SARAH HOUSE

2.3 STRUCTURE OF THE REPORT

Section 3 – Provides an overview of the methodologies and process undertaken for the EQND scoping and diagnosis process and highlights the scope and limitations of the process.

The findings have then been split into the following categories:

- **Section 4** – Findings – External to GSF – Action on EQND in sanitation
- **Section 5** – Findings – GSF – Structural
- **Section 6** – Findings – GSF – Programme practices
- **Section 7** – Findings – Outcomes, issues and challenges
- **Section 8** – Findings – GSF – Monitoring, evaluation and learning

The findings are followed by Section 9 – which discusses a number of key issues that came from the findings, and **Section 10** – which provides recommendations for the way forward.

A range of Annexes also provide supporting information and additional case studies:

- **Annex I** to **III** – Included with this report
- **Annex IV** to **XVI** – Available online

2.4 FOCUS OF EXAMPLES IN THE REPORT

The findings section includes what was learnt and observed during the process, including from the six country visits and the remote learning from the other seven countries and external stakeholders; with comments from the consultants at the end of some of the sub-sections.

More examples have been highlighted from the six countries visited than from the seven countries which were not visited, particularly in the area of challenges and gaps, as these were more difficult to identify remotely.

The report aims to provide GSF with valuable opportunities for identifying ways to improve EQND across all areas of its work. Unless the gaps and challenges are acknowledged and discussed honestly, it will be difficult to make positive progress in this complex area; and ultimately to benefit and protect some of the most disadvantaged people in the world. If done well, it can not only reduce vulnerabilities but also contribute to breaking down stereotypes and building confidence and capacities at the same time.

A CLTS TRIGGERING SESSION IN TOGO. ©WSSCC

3

METHODOLOGY AND PROCESS

3.1 STAGES IN PROCESS AND SCHEDULE

The EQND scoping and diagnosis process was undertaken in three phases. See **Figure 4** below.

The EQND scoping and diagnosis process was undertaken between June 2016 and April 2017.

3.2 PRINCIPLES

The team undertook this consultancy in line with the following principles:

1. **Learning exercise** – The scoping and diagnosis process was understood as a collaborative learning exercise, building on the knowledge and experience of GSF staff and partners. It was not an evaluation.

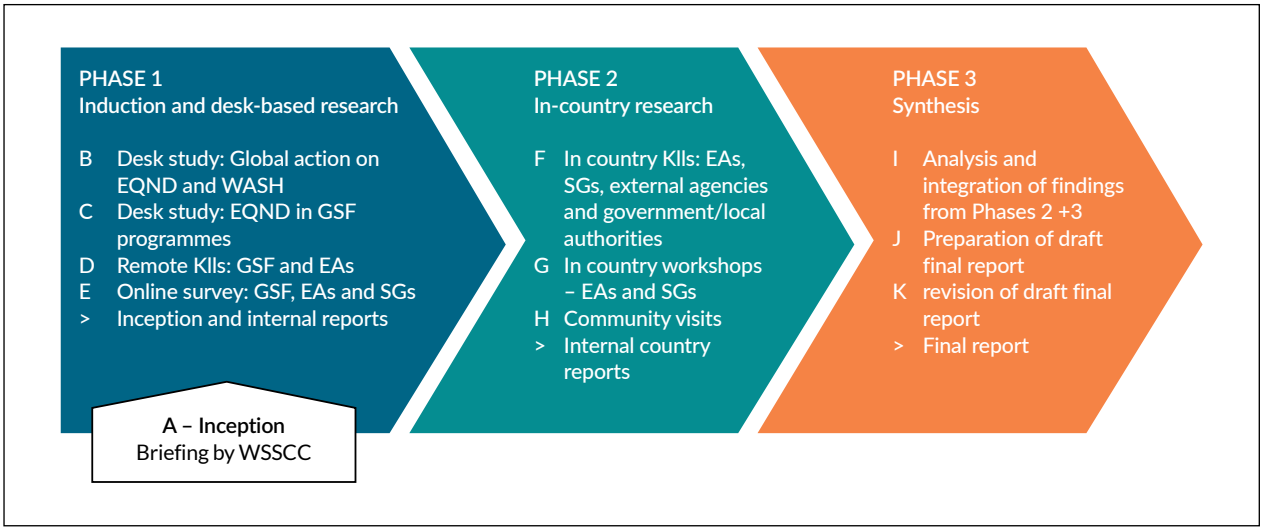
2. **Respect** – The team values and respects the knowledge and experience of all stakeholders involved in the process, including in particular the people who are from disadvantaged (vulnerable or marginalized) groups. It made every effort to facilitate discussions and debate to contribute to establishing practical recommendations that will strengthen the programme and respond to identified concerns.

3. **Recognition of the complexity of EQND** – The team understands the complexity of EQND issues and recognizes that many stakeholders globally are learning in this area and few have attempted to respond to EQND issues at scale. Hence, challenges as well as successes were expected, both of which are seen as valuable learning opportunities both for the GSF-supported programmes and wider global sanitation and hygiene actors.

4. **Diversity** – An effort was made to reach a range of contributors reflecting the diversity of communities including people from a range of disadvantaged groups and to involve them in the process.

5. **Do no harm** – Care was taken when identifying and engaging with people of disadvantaged groups to ensure their dignity and to not put them in a difficult position as a result of this study, for example if they shared negative experiences of the GSF-supported programme approaches or staff.

Figure 4: Phases of EQND scoping and diagnosis process



3.3 CONCEPTUAL FRAMEWORK

Hypotheses

The EQND scoping and diagnosis process started with the following hypotheses:

1 There are simple ways that the GSF-supported programme CLTS processes can be adapted to help improve the way that disadvantaged people can most effectively participate and benefit.

2 It will be possible to identify this good practice from the current programme stakeholders and communities, from the external global WASH context and through discussions as part of this process.

3 If the GSF financing mechanism provides guidance on the good practices/ successful approaches/ minimum standards this will lead to improved practices at scale.

4 Strengthening the GSF-supported programmes in relation to EQND, will result in multiple benefits for the most disadvantaged people and will contribute to ensuring that they attain their human rights.

Figure 5 describes the barriers to engagement of people who are disadvantaged in CLTS processes and the potential impacts of effectively supporting disadvantaged groups as part of the CLTS process.

Learning focus areas

The following learning focus areas were established for the process:

- **Learning focus area – 1: Understanding EQND and WASH** – Understanding EQND and global action on EQND and WASH
- **Learning focus area – 2: GSF-supported programmes – structural** – Processes, documentation, data; capacities and confidence
- **Learning focus area – 3: GSF-supported programmes** – field practices & outcomes – Good practices and challenges / gaps
- **Learning focus area – 4: Recommendations** – Recommendations and resources

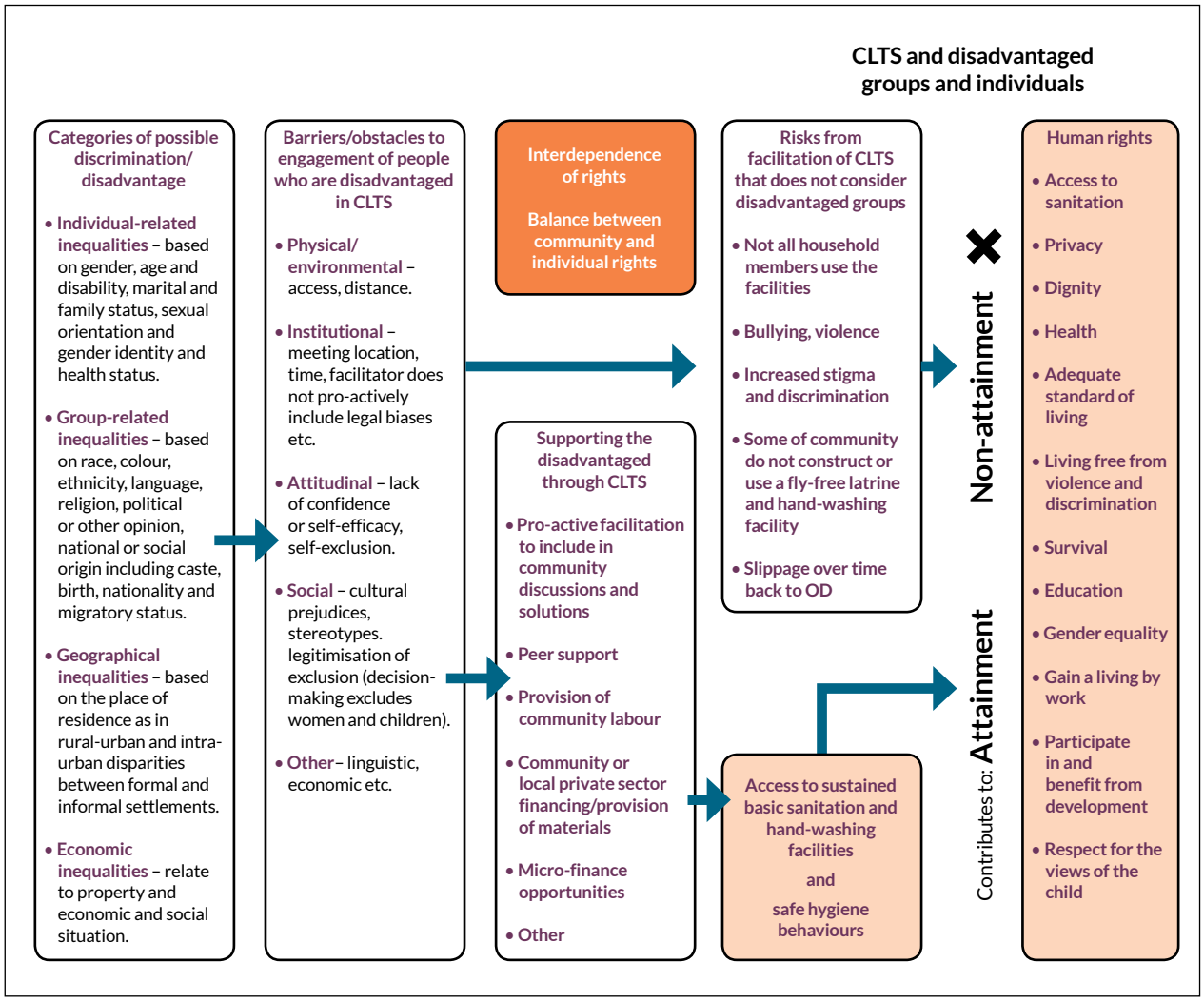
Against these learning focus areas a series of guiding questions were established and a series of research tools developed for different stakeholder groups, which were further adapted as the process progressed. Refer to **Annex V** for the guiding questions against each learning focus area.

3.4 METHODOLOGIES

Methodologies – The research methodologies used during this consultancy were:

- Desk review of documentation and global experience in EQND

Figure 5: Simplified hypothesis of the impacts of effectively supporting disadvantaged groups and individuals as part of the CLTS process



- Key informant interviews (KIIs) – face-to-face and remote
- On-line survey – involving GSF staff, EAs and IPs
- In-country workshop – involving EA, IPs, PCM and invited participants with specialism's in EQND
- Participatory exercises – a range were used in both the national workshops and in communities
- Photographs were taken of some of the consultations but only when appropriate and with the prior consent of the people we meet.

Participatory exercises – Examples of participatory exercises used during the process included:

Country workshops, in meetings with the local government authority and Implementing Partner teams:

- Agree/disagree and least/most disadvantage scaling exercises in response to specific statements
- Group and plenary discussions
- Scoring and ranking
- 1 minute case studies
- Role play

At community level:

- FGDs
- Household visits
- Transect walks and observations
- Three pile sorting
- Sanitation ladder
- Gender analysis – using a scale and images of males and females of different ages, abilities and status
- Games for younger children – 'smiley faces' ice breaker; drawings; stand-up / sit down questions
- Exercises for older children and adolescents – drawings and discussions; sanitation ladder
- Use of original community map to prompt discussion
- Reviewing data collection records and formats

There is a trade-off between undertaking more of the shorter, but usually still very productive, household visits and FGDs (where you can probe and cover a range of issues) and carrying out other participatory exercises that are fun and put people at ease. The latter can be more time-consuming but can prompt interesting discussions and sometimes bring up issues that may not have been thought of before. Hence a mixture of approaches were used as and when appropriate in a particular context.

It was expected that there would be limited EQND-related data available and limited EQND-related evidence documented under GSF. Whilst not collecting primary quantitative data, the consultants sought to triangulate findings by speaking to as many representatives of different disadvantaged groups in as many different contexts as possible; whilst also ensuring that discussions were not superficial.

Tools – A number of learning focus areas and guiding research questions were established. From these a series of tools were developed for use with a range of different stakeholders; images appropriate for each country context were prepared for the participatory exercises.

NEPAL: A LATRINE ADAPTED FOR A MAN WITH A BROKEN LEG. THE HOSPITAL SUGGESTED HE USE A PLASTIC CHAIR AS A COMMODE WHILE HIS LEG IS IN A CAST. HIS WIFE (SHOWN HERE) PUTS THE CHAIR OUTSIDE WHEN SHE USES THE TOILET. ©SUE CAVILL

Testing and refining – The consultants piloted the various methodologies during the first two-week country visit to **Malawi**. The usefulness of the tools was reviewed and revised where appropriate for the subsequent trips. The selection of methodologies and tools was based on each consultant's decision as to what would provide the most useful information in the particular context.

3.5 SELECTION CRITERIA FOR COUNTRIES AND COMMUNITIES TO VISIT

Selection criteria for countries to visit

The following criteria underpinned the selection of countries: a) a mixture of English and French speaking countries covering West Africa, East and the Horn of Africa and Asia; b) countries that have different levels of engagement in EQND and in different programme components; c) countries that had not been visited recently for other global learning processes; and c) willingness of the country programmes to host the visits.

Malawi, **Ethiopia**, **Senegal**, **Nigeria**, **Nepal**, and **Togo** were selected for a country visit (between 5 to 15 days engagement in country) for each of two consultants (except **Togo** which was undertaken by one consultant).

Selection criteria for communities to visit

The selection criteria for community visits within each country included:

1. Communities both successful and so far unsuccessful at becoming ODF
2. Time since project completion
3. Where there is interesting/ innovative practice
4. Communities with varying social (ethnic, cultural, religious) backgrounds
5. Communities living in extreme poverty
6. Communities in particularly challenging contexts – including difficult technical conditions; communities affected by disasters; remote rural and peri-urban communities

Table 1: People met during country visits

Country visits	Malawi		Ethiopia		Senegal		Nigeria		Nepal		Togo		Total	
Days engagement in country – by consultant	*11 days 11 days*		*5 days 5 days*		*10 days 10 days*		*10 days 5 days*		*15 days 13 days*		*5 days –*			
	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Total number of people met during the country visits	200	170	16	31	115	102	102	134	229	333	13	44	675	814
	370		47		217		236		562		57		1,489	

3.6 PEOPLE MET DURING COUNTRY VISITS AND INVOLVED IN KIIS AND ON-LINE SURVEY

Table 1 summarizes the time spent in each country and the number of people met during each country visit.

Figure 6 overleaf provides an overview of the people met and who contributed to the learning process.

Across the 6 country visits, the team:

- Ran 6 national workshops (1 to 1.5 days in length)
- Went to 16 districts (or in **Senegal** communes) and engaged with people from 116 communities
- Undertook 104 household visits

Throughout the whole process the team engaged with the following people:

- Remotely or through the online survey – 101 (34/66 percent female/male)
- In total during the country visits – around 1,500 (45/55 percent female/male)[14]
- People involved in managing and implementing the programme (PCM, EA, IPs, CLTS facilitators) and other sector stakeholders at national level – 289 (100f, 189m)
- Representatives from local authorities or district or equivalent coordination mechanisms – 64 (9f, 55m)
- Village leaders, village level committee members or community groups, teachers, health workers or others with a key role at community level – 311 people (89f, 222m)
- Older people – 211 (93f, 118m)[15]
- People with disabilities – 74 (27f, 47m); and carers of people with disabilities 28 (24f, 4m)
- Children above 5 years, adolescents and youth 100 (86f, 14m)

In addition during the country visits, the team also met:

- Members of savings and solidarity groups, a sanitation revolving fund, masons and the police, and visited schools, health facilities, as well as an internally displaced persons camp and a brick factory.
- The team pro-actively visited communities living in diverse and particularly challenging situations, including those which are remote, with sandy soils and high water tables, have been affected by natural disasters and conflict, as well as those in border areas, hilly, mountainous and in peri-urban areas.
- Representatives of a number of organizations with specialist EQND expertise related to social welfare are, disability (including mental health), child workers and sexual and gender minorities.

Refer to **Annex I** for more details on who was met during the process and **Annex II** for a list of contributing organizations from district level and above.

14 The number of people met was approximated. The data only includes people who contributed to discussions, not all in the larger meetings.

15 Estimated for people assumed to be over 65 years old.

Figure 6: People met who contributed to the EQND scoping and diagnosis process

3.7 CHALLENGES AND LIMITATIONS

The main challenges and limitations of the process were:

- Limitations in the number of days spent in each of the six countries visited, limiting the number of communities it was possible to visit in each country and the number of people it was possible to meet.
- The complexity of the issue and the wide range of sub-components that the team looked at, which limited the amount of time possible to look in more depth in some of the case studies.
- The challenge of how to make people at all levels comfortable in a short time period to share difficulties and challenges as well as successes and to understand that challenges are very valuable to learn from for improving the programme in the future.
- Every effort was made to triangulate findings. This was not possible in all cases, but it is hoped that the examples identified will still be useful as a starting point for continued learning to enable to programme to strengthen EQND as it moves forward.

DOROTHY'S BROTHER BUILT AN ACCESSIBLE LATRINE AND BATHING SHELTER FOR HER, WITH A SMALL RAMP AT THE ENTRANCE. ©SARAH HOUSE

4

FINDINGS – EXTERNAL TO GSF: ACTION ON EQND IN SANITATION

4.1 GLOBAL ACTION ON EQND IN SANITATION PROGRAMMES

Human rights, equality and non-discrimination are fundamental to the vision of the SDGs.[16]

Specific SDG targets of particular relevance to GSF-supported programmes include:

- **Target 6.2** – By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying specific attention to the needs of women and girls and those in vulnerable situations.
- **6b** – Support and strengthen the participation of local communities in improving water and sanitation management.
- **SDG 4a** – Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all.

Others that have relevance are related to: ending discrimination against women and girls; and eliminating all forms of violence against women and girls.

A variety of terminologies are used by WASH sector actors to cover issues related to vulnerability, marginalisation and disadvantage. The handbook on the human rights to water and sanitation by the UN Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation,[17] has noted that 'disadvantaged individuals and groups' is a useful term to *'refer to all people who are discriminated against, experience inequalities or inequities, or are marginalized, vulnerable or stigmatised'*. 'Equity and Inclusion' (E&I) is used by WaterAid[18] and the Water, Engineering and Development Centre (WEDC), who have been highly engaged in the area of disability; and has been one of the most common terms utilized by those working on vulnerability related issues. The United Nations High Commissioner for Refugees (UNHCR) uses the terms 'Age, Gender and Diversity' (AGD)[19] when encouraging attention on EQND related issues.

A 'Frontiers of CLTS' publication on Human Rights,[20] concluded that CLTS is compatible with a human rights based approach to sanitation – but there is also a potential for violation of human rights through bad

16 United Nations (2015)

17 De Albuquerque, C. (2014)
18 Jansz, S (2012)
19 UNHCR (2011)
20 Musembi, C.N and Musyoki, S. M. (2016)

practice in name of CLTS. WSSCC summarizes the human rights-based approach as one that builds on *"a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights."* A human rights-based approach is guided by human rights standards and principles. The main human rights principles are: Equality and non-discrimination; Participation; Transparency and access to information; Sustainability; and Accountability. A human rights-based approach identifies rights holders and their entitlements and duty bearers and their obligations. It works towards strengthening the capacity of rights-holders to participate in decision-making and claim their rights, and that of duty-bearers to meet their obligations.

The South Asia WASH Results Programme, led by Plan International and which supports sanitation at scale through CLTS, has worked to try and collect EQND related data at scale and is considering how it can strengthen the use of this data and the EQND related learning on the programme as it continues to move forward.[21] This offers opportunities here for mutual learning with GSF going forward.

For the poorest people, a number of WASH agencies have been developing solutions to support people who are disadvantaged to be able to stop open defecation and move up the sanitation ladder; including through a range of community solidarity mechanisms, smart finance mechanisms etc.[22] As part of this process, the development of the supply side, commonly focussing on sanitation marketing, is being trialled, including establishing options for low cost latrines that can be marketed by local suppliers and technicians.

Actors have tended to focus on dealing with hardware solutions related to disability, probably as they are easier to see and easier to respond to than the softer behaviour related components. Involving people with disabilities in the process and in identifying solutions is still an area of weakness. WaterAid and WEDC, amongst others, have built capacities and confidence in how to consider E&I, particularly in relation to disability. For example, this has included training on how to facilitate discussions on disability and provide ongoing support (such as on-the-job learning and peer support). It is generally accepted that where cultures / religions / norms support discriminatory practices, the process of change and capacity building is likely to be a long-term process. WEDC and WaterAid has engaged with non-traditional actors such as from the Disability sector, to strengthen experience and skills in responding to EQND related issues and have also developed a number of simple practical tools and advice on what can practically be done.

The Sanitation and Hygiene Applied Research for Equity (SHARE) Consortium funded by the UK Government has supported a core body of research and good practice related to sanitation and hygiene over the past 5 years; and a range of research by the WSSCC, WaterAid and the London School of Hygiene and Tropical Medicine has been funded through this channel. Likewise, the Australian Government has also shown a significant commitment to EQND related issues linked to WASH, and funded the CLTS Plus project mentioned later in this section.

The incorporation of gender issues has also undergone quite a lot of transition over the past decades. Twenty years ago, sector stakeholders often resisted discussions on differences in relation to men and women and their differing needs, skills and perspectives. The arguments would often be that a) *"the head of the household (often male) would represent the household"*; b) that *"working with communities was working with everyone"*; c) *"when women come to a meeting they don't speak – so what is the point?"*; and d) *"it just gives them extra work when they already have a high workload"*.[23] Today this has changed in the sense that it is more common that organizations are expected to incorporate gender in their work and donors expect to see an analysis of how the programme will respond to this issue in funding proposals. There are still challenges and arguments still persist related to the fact that when women are part of WASH committees they don't always speak or make decisions; but at least they are more likely to be committee members and are hence receiving information, which is a step in the right direction. There has also been progress in women taking on leadership roles in some programmes and in some countries, it is government policy that women are always the Treasurer of WASH Committees, due to expectations that women are more trustworthy. Comparatively less attention has been given to considering the needs of people who are SGMs and other particularly vulnerable or marginalized groups that are discriminated against, to ensure that they are not put in further danger because of WASH programmes. To date, the humanitarian sector has taken more steps to reduce the risk of sexual and other forms of exploitation by aid workers, to in-

21 South Asia WASH Results Programme team (2016) KII
22 Robinson, A. and Gnilo, M. (2016); Wapping, L (2014); and Evans, B et al (2009)
23 Observations by consultant S. House over the past twenty five years

crease awareness on this issue and introduce systems and sanctions for inappropriate behaviour. Some humanitarian agencies have established feedback and complaint systems for community members to be able to feedback on the programme and any potential abuses of power. Those delivering sanitation programmes have given less guidance on protection related problems that may be faced at community level, including those related to the standard procedures for staff and facilitators to know how to manage difficult situations, such as the abuse of children or people with disabilities.

MHM is an area where there has been a significant increase in attention over the past 10 years.[24] Today there are a huge number of documents illustrating some of the progress in this area. There are many formative studies on MHM in a wide range of contexts, although they vary in size and rigour. Most have been undertaken in relation to MHM in the school context, but some focus on MHM in the community setting. A few examples exist, of national policies or guidelines to support MHM, for example the Government of **Kenya** has a policy to provide all schoolgirls with sanitary pads. A wide range of organizations are engaging in MHM, and are attempting to break the silence through global, national and local advocacy with some level of success. But most remain at relatively small scale. Organizations particularly active include WSSCC, Plan International, UNICEF, Save the Children, WaterAid and a range of universities, such as Emory University and Columbia University in the USA. As an indication of the increasing interest and action in MHM, over 500 organizations had signed up to the Menstrual Hygiene Day campaign run by WASH United (as of 2015); although more of these are engaged in the provision of some form of menstrual hygiene protection materials, than in the area of improving infrastructure to make it more 'MHM-friendly' or on the disposal of menstrual hygiene materials. More action has been undertaken on MHM in Asia (including in **India**, Bangladesh and Pakistan) and also in a few key countries in Africa (**Uganda** and **Kenya**) than in other parts of the world. But action is also increasing elsewhere.[25] An increasing range of practical guidance[26] is now available on MHM and increasingly it is being integrated into national school WASH technical guidelines and policies, along with other initiatives related to making school WASH accessible.[27] [28] More work is needed to determine how to best respond to menstrual hygiene in WASH and through the CLTS process.

24 House, S et al (2012)
25 Badloe, C. Et al (2015)
26 Grow and Know (2015) www.growandknow.org/books.html
27 Government of the Republic of Tanzania (2010)
28 Roose, S et al (2015)

*CLTS PLUS – MAKING CLTS MORE INCLUSIVE**

A randomised control trial carried out in **Malawi** aimed to find out if CLTS facilitators could change their practice to focus more on disability after a short three days training. On the last day of the training an action plan was developed by the facilitators themselves to identify additional pre-triggering, triggering and post triggering actions that would help to make their work more inclusive. This included (amongst other things) specifically inviting people with disabilities to come to 'triggering' sessions, marking households where people had disabilities on the community map, adding a squatting demonstration to the triggering session and suggesting design modifications that could be made to toilets.

The findings to date suggested that this had made a difference with a significant increase in awareness of the needs of people with disabilities, actual modifications made to toilets and even unintended benefits such as the formation of disability groups and links with community based rehabilitation (CBR) networks, and increased success rates for attaining ODF overall. Discussions with the authors suggested the following learning points:

1. At minimal extra cost in terms of time and resources it was possible to improve awareness of disability issues and to illustrate changes in practice
2. More follow up with facilitators is needed to develop their confidence in engaging people with disabilities in the CLTS process and in making adaptations responsive to their specific needs
3. It may be useful to focus on training more experienced facilitators first who can then help to train others
4. People's perception (both facilitators and communities) of the cost of making modifications for people with disabilities far exceeded the actual cost. It may be useful to emphasise this point more in training
5. Care needs to be taken to ensure that the identification of people with disabilities does not lead to the reinforcement of stereotypes
6. It may be useful to provide a specific list of 6-10 design modifications that could be used rather than expect facilitators to facilitate people with disabilities to find their own solutions

More work is needed to examine how the learning from this training could be incorporated into the current training for CLTS practitioners.

* White, S et al (2016); and White, S (2016) KII; and Jones, H (2015) KII

4.2 FINDINGS – GOVERNMENT CLTS STRATEGIES IN PROGRAMME COUNTRIES

4.2.1 EQND in CLTS strategies

The governments of the six countries visited as part of this process have considered EQND to varying levels in their national policies, strategies and plans. The **Nepal** Master Plan for Sanitation and Hygiene (2011) was the strategic document with the most comprehensive consideration of EQND. See the box that follows.

The Master Plan in **Nepal** supports a non-subsidy approach, but makes an exception for the ultra poor and excluded, who can receive subsidy at the discretion of the district, VDC and municipal coordination committees. The ultra poor and excluded are currently only being told they have the possibility of subsidy after a large proportion of the households in the community (more than 90-95 percent) have built a latrine.

In **Malawi**, the National ODF Strategy (2011) also mentions EQND-related issues: *"To be in line with the national policy, the zero-subsidy approach shall be adopted and applied by all implementers except for the case of vulnerable people, who shall need to be given subsidies after attaining ODF status in their area... The less damaging way to use subsidies after being declared ODF includes identifying the vulnerable people in communities (elderly without support, chronically ill/disabled, child headed households and female- headed households). It also involves finding suitable systems to identify the vulnerable; community members and traditional leaders shall collaborate to identify the vulnerable in their respective areas, using existing systems and structures like the VDCs".* It also identifies role for traditional, religious and Natural Leaders to ensure that the vulnerable are supported.

In **Nigeria**, The *National Policy (draft, 2004) on Water [related] Sanitation*, includes a number of references to EQND including a focus on the poor, building on existing socio-economic norms, sanitation programmes taking a gender-sensitive approach, willingness and ability to pay, and the need to take into consideration approaches that would improve the representation and voice of the poor and disadvantaged. EQND-related guidance in the national CLTS training manual recommends to separate men, women and children for triggering; but other than this no mention is made of people with disabilities or other marginalized groups, or the need to specifically encourage and support disadvantaged groups to come to the triggering event and to encourage community support where this is required. **Nigeria** has a no subsidy approach and does not make exceptions for the disadvantaged, although the Road Map to *'Making Nigeria ODF by 2025'* states a lack of uniformity in the provision for subsidy at household level. It suggests appropriate credit mechanisms may be required. It also discusses specific challenges in high density slum areas where people may not have access to land; and provides some suggested solutions, including sharing or public latrines. It also provides some analysis of wealth levels and willingness and ability to pay.

NEPAL MASTER PLAN FOR SANITATION AND HYGIENE, 2011

This plan integrates considerations related to EQND in a range of sections:

It identifies the following groups as needing particular attention and support: *Children; Gender and in particularly women and female-headed families; Elderly people; Differently-abled groups; People disadvantaged by caste or ethnic group; and other needy families;* and it also discusses excluded groups including: *Landless; Ultra-poor; Squatters; Slum dwellers; and People in remote areas.*

In the **terminology** section, it describes: *'Child, gender and differently-abled (CGD) features'* and also provides proxy indicators to identify poverty and ultra-poor households:

1. Households having food sufficiency (security) for less than six months
2. Households having daily wages as the main source of income
3. Female-headed households and / or households without adult members and / or households have physically disabled persons; and
4. Other relative indicators agreed by the community

The Master Plan also considers EQND in the sections on: the **socio-economic context**, the **lessons learnt** and **operational strategies**, providing guidance on specific strategies to respond to EQND related issues. It notes that the provision of financial support is crucial to ensure the access of socially disadvantaged communities to sanitation facilities; and discusses issues related to community contribution, strengthening partnerships to support the poor, gender mainstreaming and a flexibility that is needed to respond to the needs of excluded groups and people in remote geographical areas. For more details – see **Annex X**.

In **Ethiopia**, there is no specific guidance on considering people who are disadvantaged in the national CLTS and Hygiene (CLTSH) implementation guideline, the verification guideline or the facilitators training guide. The verification checklist does not note the specific need to check households who might be disadvantaged; but the implementation guideline mentions the need to disaggregate into: men, women, children and the elderly and the *'Field Monitoring of ESHIP – June 2016 Checklist'* includes considerations related to the disadvantaged and people who might need support. **Ethiopia** has a no subsidy approach and does not make exceptions for the disadvantaged, although its urban sanitation and hygiene policy acknowledges the need for cross-subsidy and other related EQND issues and it has developed a national policy and operational strategy on MHM but this has not yet been integrated into the CLTSH programme. Discussions held by the consultancy teams in **Togo** and **Senegal** indicated that issues related to EQND were a relatively new concept in national strategies and policies. In **Togo** policies are being updated to emphasise EQND and the non-use of subsidies, particularly in relation to the rural context. But at the present time, some actors in both **Senegal** and **Togo** are still using subsidies.

The team did not visit **Cambodia** but the Ministry of Rural Development of the Government of **Cambodia** has prepared a *'National Guideline on WASH for People with Disabilities and Older People'* that has considered different elements of WASH and the CLTS processes. It also introduces participatory barrier analysis and solutions to help the sector determine the barriers to the involvement of people with disabilities and older people and how to prevent or overcome them.

Comment: There is a significant difference in the focus on issues facing people who might be disadvantaged in relation to their sanitation needs in policies and strategies across the countries visited; and also whether external subsidies can be provided. In both Nepal and Malawi where subsidies are permitted for the most disadvantaged, both recommend that they are only given near the end of the process (in Nepal) or after ODF declaration (Malawi).

4.2.2 Integration of hygiene and other behavioural practices into the CLTS process

Most government strategies have incorporated an indicator related to handwashing into the ODF criteria, but the means of verification and stage that hand-washing is expected to be universal varies between countries. For example, in **Malawi** Level 1 ODF has no criteria for hand-washing, but Level 2 criteria expects all latrines to have handwashing facilities with soap or an alternative (noting that it is understood that nationally no communities have yet been verified to level 2). **Nepal** also has a two-stage approach which only 'encourages' the *'availability of soap and soap case for hand washing in all households'* for the first stage of ODF, and a more stringent requirement for hand-washing within the focus on Total Sanitation as the second stage. In **Senegal** Level 1 ODF verification requires toilets to have a handwashing station and also *'each household must be able to show that they are using soap to wash their hands'*. GSF analysis indicates that twelve out of the thirteen countries specify handwashing with soap as part of their ODF criteria for different stages of ODF.

Other hygiene practices are variously incorporated into the ODF criteria, including environmental sanitation, personal hygiene (broader than just hand-washing) and household level water treatment. The **Ethiopia** programme has specifically included hygiene in its national approach title referring to CLTSH rather than just CLTS. See **Annex VI** with overview of ODF criteria for more detailed information for the six countries visited.

SENEGAL: ADOLESCENT GIRLS DISCUSS THEIR SANITATION NEEDS. ©SUZANNE FERRON

5

FINDINGS – GSF: STRUCTURAL

5.1 GENERAL APPROACH OF THE GLOBAL SANITATION FUND TO EQND

The WSSCC Medium Term Strategic Plan (MTSP), 2012-16 includes equity as one of 5 key outcomes and the GSF Results Framework has a specific output and 2 indicators related to EQND, one of which is included in the GSF priority indicators. These focus on all members of programme communities benefitting from programme interventions in an equitable manner and on progress for **'disadvantaged individuals'**. See Section 8.3 for more details.

The framework stresses the need to define disadvantage locally and to apply the output-related indicators. The results framework also recommends that baseline data be collected on disadvantaged households and it suggests additional studies to explore this issue in more detail. Neither the MTSP nor the framework specifically disaggregates by gender, age or ability choosing to refer to 'people' or groups in general.

However in practice the pro-active engagement of the GSF programme on EQND over the initial years has been limited with many making the general assumptions that: a) ODF must mean that everyone in the community has access to and uses a latrine and therefore the programme will have responded to everyone's needs; b) communities have internal support mechanisms and these will automatically respond to the needs of people who are disadvantaged; and c) where identification of the disadvantaged is required, the village leadership will be capable of doing this on their own or with the support of district level government.

More recently greater attention has been paid to the issue of EQND: some respondents have started to acknowledge that the last people to gain access are often the old and frail and that communities may not fully understand the challenges faced by specific individuals or groups; an EQND-related session was included in the learning event held in **Madagascar** in 2015; and a number of programmes started to include specific initiatives related to EQND. For example: the **Cambodia** programme – employed a part-time EQND Advisor in 2016, has developed an EQND framework and has developed a Participatory Social Assessment Mapping tool (PSAM); the **Kenya** K-SHIP programme – has made EQND a learning theme for the programme, recruited an Equity Project Officer and has considered EQND comprehensively in its baseline study; and the **Senegal** programme – has started to monitor its programme processes against a number of gender related indicators; and has

> *Good that Geneva has recognized this aspect was missing, but it seems very late. We wish it had been at the beginning."*
>
> (Comment from respondents in Malawi, but similar sentiment repeated a number of times in different countries)

integrated menstrual hygiene management (MHM) into its programme. Also other country programmes have included considerations related to EQND in their country proposals (such as **Nepal** and **Tanzania**) with more likelihood of more comprehensive inclusion for newer proposals (such as **Kenya**). This EQND scoping and diagnosis process was also initiated in 2016.

Comment: Leaving the country programmes to determine what is meant by a 'disadvantaged individual' seems to have caused some confusion at country level, with limited reporting against these indicators and varying definitions being use, leading to data that is not comparable.

5.2 EQND IN PROPOSALS AND GEOGRAPHICAL TARGETING

The original country proposals varied in their consideration of EQND. Almost all identified criteria for the selection of programme areas reflecting regional disparities and geographical inequities. These included: a) Under 5 years mortality and morbidity rates; b) Levels of access to sanitation and hygiene; c) Poverty levels; and d) Other criteria related to diversity and equity. But overall the proposals reviewed made minimal reference to EQND issues, particularly the older programme proposals where its absence was significant. Notable exceptions were: **Malawi** (which included a budget allocation for training on EQND for the District Coordination Teams), **Tanzania** (specified the need to identify methodologies to reach and support the most vulnerable) and **Nepal** (included learning on the need for special consideration for the ultra poor, disadvantaged and high risk groups; stimulating community action and support and ensuring cost sharing and access for poor and disadvantaged communities).

More recent proposals and proposal extensions (some starting in 2013/14) have been more likely to at least mention EQND and include some strategies to address disadvantage and exclusion (e.g. **Cambodia**, **Madagascar** and **Kenya**). In the second phase of the programme in **Cambodia** (CRSHIP2) equity and inclusion is a distinct intervention with specific indicators and a separate budget. A recent cost extension proposal from **Malawi** also states as an explicit aim, 'to make available low interest loans to the poor' but has limited, analysis on who the 'poor' are, the differences within this broader group or the potential risks to 'the poor' from loans if they are unable to pay them back and how these risks will be mitigated. The **Kenya** Country Proposal (2013) also has a significant focus on EQND and has a separate budget line for this. The programme has a dedicated full time Equity Officer and they intend to develop a training and sensitisation plan for Natural Leaders on vulnerability. The subsequent technical proposal for expansion of the proposal in **Nepal** (2013) talks in general terms about a focus on the poor and marginalized; but attention to EQND is missing in the third funding round instructions for potential sub grantees and in the terms of reference (ToR) for new staff, although it is understood that the country team have started to include EQND related questions in the interview process for new IPs. The **Uganda** and **Madagascar** proposals for the next phase have also included a number of specific actions and frameworks to respond to EQND.

Comment: A discussion on EQND and identification of strategies to respond to EQND should be required as a compulsory element of all country proposals; and these should be evaluated as an integral consideration in the proposal and budget evaluation process.

5.3 PCM, EA AND IP ORGANIZATIONS AND PERSONNEL

5.3.1 Gender balance of staff and key programme stakeholders

Whilst overall the team met approximately equal numbers of male and female staff working in the EAs, and a significant number of women working for the Implementing Partners, the team had pro-actively requested including a good mix of both male and female staff in the national workshops, which has probably led to bias in the collated data (see **Annex I**). Discussions with a number of IPs reported that they have more male staff than female, which is typical of the WASH

sector, globally. However, of note are three countries of the six that have female EA leads: **Nepal**, **Senegal** and **Ethiopia**. In **Ethiopia**, the Director of the Health Education, Public Health and Sanitation Division team in the Ministry of Health, who heads the EA for GSF is female, but otherwise most other staff in leadership roles are male. But balancing this to some degree, at community level the 'Health Development Army' ('1:30 leaders' who provide leadership for 30-40 households) who have also taken on key roles as Natural Leaders, are mostly women. From the countries not visited it is reported that there are female Programme Managers in the EAs in **Benin** and **Uganda** and a female chair of the PCM in **Madagascar**.

5.3.2 EQND-related advisors

Only two of the 13 countries have so far employed an EQND-related advisor working in a dedicated role in the programme: **Kenya** and in **Cambodia** (part-time). Some others have access to the EA's organizational gender advisors, such as Plan in **Malawi** and **Tanzania** who also have additional engagement and support from gender advisors in Plan Canada. But organizational advisors also have multiple responsibilities outside of GSF limiting the time they can contribute to the programme. Large IPs, such as United Purpose (previously Concern Universal) in **Malawi** also report having access to their own organizational advisors; but no national NGOs reported having access to an EQND-related advisor. **Madagascar** is planning to recruit an EQND Advisor and it is reported that **Togo** is also planning to recruit an EQND Officer to be based in the Ministry of Health and Social Protection.

5.3.3 EQND-related policies, Code of conducts

Of the national NGOs who were asked,[29] none reported having specific EQND-related policies or codes of conduct; except for Samaj Utthan Yuwa Kendra (**SUYUK**) in **Nepal**, which has a *'Code of Conduct to Prevent Discrimination, Harassment and Sexual Harassment in the Workplace'*.[30] Some others noted they have some clauses in their staff employment policies.

29 Only a random selection were asked.
30 SUYUK (no date)

5.3.4 Capacities and confidence to consider EQND

Capacity and confidence to consider and respond to EQND in the programmes varied. 55 percent of the English-speaking respondents (E) and 60 percent of the French speaking respondents (F) felt that lack of knowledge on equality issues was a challenge (with 35 percent and 25 percent respectively saying it was an important challenge). Of the 53 respondents of the on-line survey, seventy one percent (E) and 61 percent (F) noted that they felt 'confident' or 'extremely confident' about working with people with disabilities, and only 5 percent said they were extremely unconfident about working with this group. A similar order of confidence was expressed in relation to working with older people and working on menstrual hygiene. More expressed that they were confident/extremely confident with working with children and youth; and less, only 16 percent of the English respondents and 11 percent of the French respondents felt confident or extremely confident working with people who are lesbian, gay, bisexual, transgender, intersex or questioning (LGBTIQ).

It was clear that most staff had not had comprehensive training on EQND; although there were exceptions. From the respondents of the online survey just over 50/91 percent (E/F) of respondents said they had had only 2 days or less training on EQND. This was mainly workshop based but included on the job training and information provided during meetings. Online training was rare in both surveys. Six respondents in total felt they had had no training on EQND issues but the majority had had some training although most of this had been provided by other organizations and was not specific to the GSF-supported sanitation programme (41/44 percent E/F). An IP in **Ethiopia** noted: *"The little we know we know from experience"*. In **Senegal**, it was noted that the recent trainings carried out on MHM, triggered positive transformation not only related to community habits, but also to the mind set of IP staffs, and paved the way for deepening the reflection around how to mainstream EQND in the GSF-supported programme.

During the national country workshops, participants shared a range of observations related to EQND in their programme areas. It was clear that the level of participant's understanding varied, with some having good capacity and others limited experience in this area. Feedback on the workshops indicated that having the opportunity to think about the issue in more detail and to learn from others through discussion was valued. During each country visit, the country teams noted that

they had learned a number of useful new ideas and perspectives from the process.

A number of implementers expressed some limitations in their capacities to address EQND and there was a strong demand for more guidance and support in this area. Some felt that there were limited facilitation skills amongst trained CLTS facilitators to address the needs of marginalized groups; that the national guidelines / manuals do not currently provide enough guidance in this area; and that some of the country team senior staff themselves need training before they would be able to develop an appropriate guideline. One senior staff member said that the engagement during the workshop helped to give him confidence in what he knows, helped to organize his thoughts, and gave ideas of the types of EQND related questions to ask.

The discussions around how to respond to – and communicate with – people with mental health conditions, also led to discussions on the skills and capacities of different people engaged in the CLTS process. It was acknowledged that not all people working on CLTS will be sensitive to the most vulnerable or marginalized; they may not know how to be respectful and ensure dignity. This might also be a particular challenge for some men communicating with vulnerable women and girls (although some may be skilled in this area). One example of this occurred when a male programme representative took the team to the house of an older women who is sight impaired. On arrival, the woman was found to be only partially dressed. The male staff member had to be asked twice by the female team members to leave, in order to offer the woman some dignity.

Comment: Although some staff expressed a confidence in their ability to consider EQND in the programme, there was a high demand for additional support in the area of EQND (see Section 10-R1).

5.4 PARTNERSHIPS WITH EQND SPECIALIST ORGANIZATIONS

None of the programmes in the country visits have established partnerships with EQND specialist organizations; although some have organizations with EQND-related experience on their PCMs. For example, in **Ethiopia**, both WaterAid and SNV are on the PCM and both have experience in working with people with disabilities. In **Cambodia**, WaterAid is the GSF-supported programme's Learning and Development partner and it is reported that they extend support on the disability front in the form of training, access to experts, networks and guidance.

Comment: This appears to be a significant missed opportunity for the GSF-supported programmes, particularly in the area of disability, but also with specialist organizations working with people from other groups. Most countries have a national federation of disabled person's organizations, which can share details of disability organizations across the country.

5.5 FINANCES FOR EQND

Specific budgets for EQND were not common; only having been identified in the older **Malawi** proposal; and in the more recent **Kenya** and **Cambodia** proposals. EQND was also included in the **Tanzania** proposal and hence integrated into its budget, although the EQND related costs not separated out from within broader budget lines and hence could easily become overlooked. GSF noted that the supported programme in **Madagascar** also has a specific budget line for cross-cutting actions on EQND and for recruiting an EQND Advisor. However, the budget available to the consultants seems to be very general and not possible to see EQND-related specific budget lines.

Comment: Whilst EQND should be integrated throughout the programme activities, it would be positive to also have a specific budget for EQND to cover costs such as for an advisor, development of strategy, capacity building, guidance and ongoing learning.

A FAMILY IN BALAKA DISTRICT, MALAWI, PROUDLY DISPLAY THEIR DOUBLE PIT ARBORLOO LATRINE CONSTRUCTED BY A COMMUNITY-BASED ORGANIZATION. ©STEVEN KAMPONDA

6

FINDINGS – GSF: PROGRAMME PRACTICES

6.1 COUNTRY PROGRAMME MODALITIES

The **six countries visited** as part of this process operate using different modalities. This section discusses a number of these that have particular relevance to EQND.

6.1.1 Executing agencies (EA)

The **Ethiopia** programme is led by the Federal Ministry of Health as the Executing Agency and it operates through its regular health structure, systems and staff and **Senegal** is led by a parastatal entity. **Nepal** and **Togo** are led by UN agencies, UN-Habitat and UNICEF respectively (although **Togo** will in the future hand-over to a government ministry); and **Malawi** and **Nigeria** are led by international non-governmental organizations / civil society entities.

6.1.2 Implementing Partners (IPs)

Ethiopia and **Nigeria** utilize the local government teams to implement the programme, with **Nigeria** also utilizing some non-governmental organizations; whereas the other four countries use non-governmental organizations as Implementing Partners. **Table 2** provides an overview of the management and Implementing Partner types for the six countries visited.

6.1.3 CLTS facilitators

Across the programmes **in the countries visited**, the CLTS facilitators come from a range of backgrounds:

- In **Malawi**, the CLTS facilitators are mainly Health Surveillance Assistants (HSAs) from the local government, but can also be any extension worker such as those with community development, agriculture or water related responsibilities. They do not get any additional salary for their work on the programme. They get paid allowances for trainings, meetings and visits away from their own areas, but not for follow-up activities.

- In **Ethiopia**, the CLTS facilitators are mainly government health staff working at *Woreda* (District) level in extension or health facility roles. They are not given any additional payment for this work.

- In **Nepal**, the triggerers are identified through a public recruitment process. Two from each village are selected for training and at the end of the training they are both given an interview / test and one is recruited. In principle, the triggerer should

Table 2: GSF-supported country programme implementation structures

Role	Malawi	Ethiopia	Senegal	Nigeria	Nepal	Togo
Executive Agencies (EA)	Plan International	Ministry of Health	Agence d'Exécution Travaux d'Intérêt Public (AGETIP)	United Purpose	UN-Habitat	UNICEF
Implementing Partners (IPs)	NGO / civil society	Local Government (Woredas)	NGO / civil society / private entity	Local Government Area / NGO / civil society	NGO / civil society	NGO / civil society
Chair of Programme Coordination Mechanism (PCM)	Ministry of Health	Water and Sanitation Programme (WSP), World Bank and UNICEF Overseen by FMoH	Sanitation Directorate Ministry of Health	Federal Ministry of Water Resources	Ministry of Water and Sanitation	Ministry of Health

come from the village they are to trigger so that they will be committed / motivated for change in their own community. But in some exceptional cases, the good triggerers are also mobilised in other villages that are not their own. And in some cases, the best triggerers are also teamed with the weaker triggerers to improve results. They receive a small monthly allowance of USD 150 for their work.

- In **Nigeria**, the CLTS facilitators were initially mostly from either the Local Government Area (LGA) or the NGO Implementing Partner, but as the programme has progressed, Natural Leaders and Chiefs have also started to take on the role of the CLTS facilitators and as 'Community Consultants' (CC), who also work in neighbouring wards and communities. None of the LGA or NGO staff or Community Consultants are paid salaries from the programme, only transport and food allowances when working in Wards other than their own. The payments to the CCs are only made when a community becomes ODF.

- In **Senegal**, the CLTS facilitators are a mixture of IP staff members and community members. There is no formal involvement of government extension workers – although some active community *'relais'* or community health liaison workers are paid a small incentive to cover several villages.

The team did not see data on the general gender mix of CLTS facilitators, but of those met the balance varied by programme country and area, with overall a higher proportion of male facilitators. Whether EQND issues had been integrated into the standard CLTS facilitators training or provided for the NLs varied, but most respondents from 5 of the 6 countries felt it had not been included or was just touched upon. Only in **Nepal** and **Senegal** it was felt to have been well integrated for the more recent trainings. One District Council in **Malawi** noted that they had supported a five-day training on gender and WASH for various extension workers (some of whom are also CLTS facilitators); but it was reported that the CLTS training only covers the elements of gender, HIV and gender based violence. In Nigeria, only the need to separate men, women and children is incorporated into the CLTS training, but no other focus on disadvantaged groups. But it is reported that gender is incorporated into the short trainings for the WASHComs.

6.1.4 Natural Leaders and Community Consultants

The mechanism for identifying Natural Leaders (NLs) also varies across the programmes. In **Malawi**, a NL may be identified during the triggering, but may also be appointed by the Chief. In **Ethiopia**, they are mainly the 1:30 household leaders (who are leaders for 30-40 households and are also leaders of the *'Health Development Armies'*) and who are mostly women. In **Nepal**, it was quite difficult to establish who was a NL as nobody in meetings stated that this was their position, rather noting their role in village leadership or a community based group. In **Nigeria**, it was also difficult to identify who was a NL, as all NLs become members of the WASHComs and would identify themselves as such when met. The team probably met approximately equal numbers of male and female NLs (considering the above limitations in knowing who they were) during the process.

Capacity building for NLs is an area that can and should be strengthened, but because of the scale of

the programme and number of NLs across all villages, how this should be implemented will need quite a lot of thought. One IP in **Malawi** explained that they have worked in more than 200 communities and if each community has 10 NLs this means that across the communities in which they have worked, they now have more than 2,000 NLs. They run occasional update meetings but because of the scale of their programme, they only invite a proportion of the NLs to participate. The consultancy team were not fully convinced that the argument that capacity building should be cascaded down through on-the job training, from CLTS facilitator to NLs is working in practice.

6.1.5 Size of communities

In **the countries visited**, the sizes of the communities that have been triggered seem to have varied quite significantly and often only one representative from the household is expected to attend the triggering:

- In **Malawi**, some of the communities were reported to be quite large. In one example a Senior Group Chief called people together for a re-triggering event (after a changeover in IP). This consisted of 11 people from each of 38 villages, so only a small number of village households took part. They were then expected to go back to their villages and motivate all households to build latrines, which seemed to be mainly using traditional arguments related to health impacts and costs for health care.
- In **Nepal**, whether triggering is undertaken at ward or village level will depend on the size and population as well as number of households. Generally, triggering happens at ward level, but in smaller villages, village level triggering is undertaken; and similarly, with the monitoring for verification. In some cases, the ODF is declared by ward but generally, it is village level verification that is validated by the District WASH Coordinating Committee (D-WASH-CC). As part of the process, the achievement of reaching ODF is monitored by ward, which leads to competition between wards.
- In **Nigeria**, the programme divides up 'Mother communities' into smaller 'CLTS communities' of between 20 to 50 households. In urban areas where they may have up to 16 'CLTS communities', they try to trigger all in one day and hence form what is known as a 'triggering mob' which might be 60 or more CLTS facilitators coming from the LGA WASH Unit, CSOs, Natural Leaders and Chiefs. This was explained to the consultants as because the smaller sub-communities are close together that if they did them over time they would probably lose the element of surprise, although it is also understood it also has value to promote competition between CLTS communities.
- In **Togo**, it was reported that communities are divided up for triggering, as communities can be as big as 5,000 people.
- In **Ethiopia**, the Natural Leaders include the 1:30 household leaders, who are usually women. They have been appointed to this role due to their leadership skills and have demonstrated that they keep their houses in good condition. As part of the process they share information with, and monitor, all 30 (to 40) houses within their group.
- In **Senegal**, at least one representative is invited from each household in the village. Large villages are divided into smaller zones and triggering conducted in each.

IDENTIFICATION OF NATURAL LEADERS, ESTABLISHING WASH COMMITTEES AND COMMUNITY CONSULTANTS

In **Nigeria**, the strategy was to first let the Natural Leaders emerge and then upon achieving or close to reaching ODF status to bring them together in a formal WASH Committee (WASH Com) with a 50/50 male/ female representation to sustain ODF status. This enables emerging NLs to also be incorporated into the leadership structure.

As the programme has progressed some of the most committed NLs went on to become Community Consultants (CC), who work in wards and villages other than their own.* A number of NLs and WASH committee members and one CC met had disabilities. Male and female NLs and WASH Committee members were met, but only male CCs (although it was not confirmed if female CCs exist elsewhere).

* From discussions with CCs in Nigeria and: https://www.globalcitizen.org/en/content/championing-clts-in-conflict-affected-communities/, as well as from the EA, IPs and CCs.

6.1.6 Working in partnership with local CBOs and community groups

Partnerships with – and engagement of – local community based organizations (CBOs) also varied across countries. One IP in **Malawi** had developed a partnership with a CBO that has worked for years in the area of support for people with HIV and the programme was starting to engage with Women's Village Savings Groups.

In **Nepal**, a range of CBOs and community groups have engaged with the process of the communities becoming ODF, including but not limited to: Forest User Groups; Youth Groups; Women's Groups; Ward Citizen's Forums; and Savings and Credit Groups. No examples were heard of any relationships being formed with or engaging with community based disabled persons organizations (DPOs) in any of the six countries visited.

6.1.7 Multiple verification visits

The national strategy in Nigeria is that a community must have 5 or more visits by verification teams to confirm that a community has become ODF. This is positive both for sustainability and also offering opportunities for identification of challenges being faced by people who may be disadvantaged.

Comment: The programme modalities that the team consider offer particularly positive opportunities to respond to people who are disadvantaged include: Utilizing a comprehensive cascading government health structure which goes down to 30 and 5 households in the country (Ethiopia); splitting the communities into smaller communities for the purpose of CLTS triggering and multiple verification visits (Nigeria and Togo); employing CLTS facilitators (known as triggerers) from the communities themselves and who have time to dedicate to the efforts (Nepal); establishing partnerships with community based organizations that already have EQND expertise (Malawi); and intensive follow-up accompanied by capacity building (Senegal). The consultants consider that all of these modalities would be expected to be beneficial to EQND because they offer the opportunity for better knowledge of the potentially disadvantaged in specific communities and hence reduce the risk of people falling through the gaps. Identifying and engaging with community based organizations that involve or support people who might be considered disadvantaged is also currently a significant missed opportunity.

DISABLED PERSONS ORGANIZATIONS (DPOS)

In Nkotakota District in **Malawi** the team met Edward and Constance who are brother and sister and both have disabilities. Edward is on the Village Development Committee (VDC), which has three people with disabilities on it. All three of the people with disabilities on the VDC are also part of the leadership of a local DPO. Both he and his sister are members. The DPO has 30 members from 10 group village areas and they were previously meeting twice a month. But the leadership has recently changed and the DPO has become inactive. They are keen to keep having meetings but would like a facilitator to guide them.

Comment: The GSF-supported programme has not yet engaged with any DPOs, but this seems like an excellent opportunity to engage with a range of people with disabilities in the issue of sanitation and how to make it more accessible and to share and test out ideas.

6.2 STRATEGIC PLANNING ON EQND

Cambodia EQND Framework

The only programme that the team are aware of that currently has a programme focussed strategy, framework or plan on EQND-related issues (apart from the **Kenya** programme which is relatively new) is the **Cambodia** programme. The *'Cambodia EQND Framework'* provides an overview of the key principles of the EQND approach in **Cambodia** as well as providing some practical suggestions and entry points for staff and partners to help integrate EQND into both their work and their organizations.

The framework recognizes the opportunity to address both practical (access and use of sanitation) and strategic needs (shifts in power and status) of marginalized individuals and groups. It draws on the five dimensions for achieving substantive equality as identified by the WSSCC:[31]

1. Redressing disadvantage
2. Accommodating and embracing difference

31 WSSCC (2016) Concepts and Definitions for Equality and Human Rights towards a Common Understanding in WSSCC.

3. Addressing stigma, stereotyping, humiliation and violence
4. Facilitating social and political participation in society
5. Achieving structural change

Figure 7 – provides an overview of the components within the **Cambodia** EQND framework and identifies some of the practical strategies within it. For more details refer to **Annex XI**.

Comment: This is an excellent example of a clear, comprehensive and practical EQND-related strategic framework that all programmes can learn from. It is recommended that GSF should require such a strategy from all the country programmes that it funds.

6.3 GOVERNMENT LEADERSHIP, SECTOR COORDINATION AND OPPORTUNITIES FOR INFLUENCE

The GSF-supported programme was seen to have a strong relationship with national governments in the countries visited. In **Ethiopia**, the Federal Ministry of Health is the Executing Agency and the programme is implemented through the existing health system utilizing its cascading structure. In **Nigeria**, the Ministry of Water Resources chairs the PCM and its IPs are both the Local Government Authorities (LGAs) and NGOs. In **Nepal**, **Senegal**, **Malawi** and **Togo**, the government chairs the PCM.

In **Ethiopia** as the Federal Ministry of Health is the EA, there is a significant opportunity for the programme to influence national policies and approaches related to EQND and sanitation. In **Senegal** and **Togo**, programme staff felt that the work that they have started to do on EQND will influence wider action in the sector and in **Togo** UNICEF as the current EA is planning to hand over to government to lead the GSF-supported programme and leading to opportunities to influence. In **Nepal**, the GSF-supported programme is a clear sanitation leader in the country, being one of the largest programmes supporting the CLTS approach. The success of the programme has been such that they have been asked to take on a number of additional districts in the most challenging areas of **Nepal** and lead the national approach to achieving ODF in the Terai area. If the **Nepal** programme continues to build on and strengthen its existing work on EQND, it has a significant opportunity for wider influence at national level.

In all of the countries visited, the GSF-supported programmes were active stakeholders in district (or associated) level coordinating mechanisms, sometimes providing key support to district leadership, being a key member of district WASH or sanitation related committees or task forces. In **Nepal**, the programme is supporting the setting up of District Resource Centres and the District Coordinator sits in the District government offices. In the mountainous districts, it also acted as Joint Cluster Coordinators for the earthquake response.

At community level the village leaders / Chiefs, Village Development Committees and various forms of WASH Committees as well as Elders Councils, community and facility based health workers, teachers and a range of community based groups, were seen to be highly engaged in the process of become ODF. Ownership of the process at village level was clear in most of the villages visited, as was the level of pride shown by village leaders and community members whose villages had become ODF.

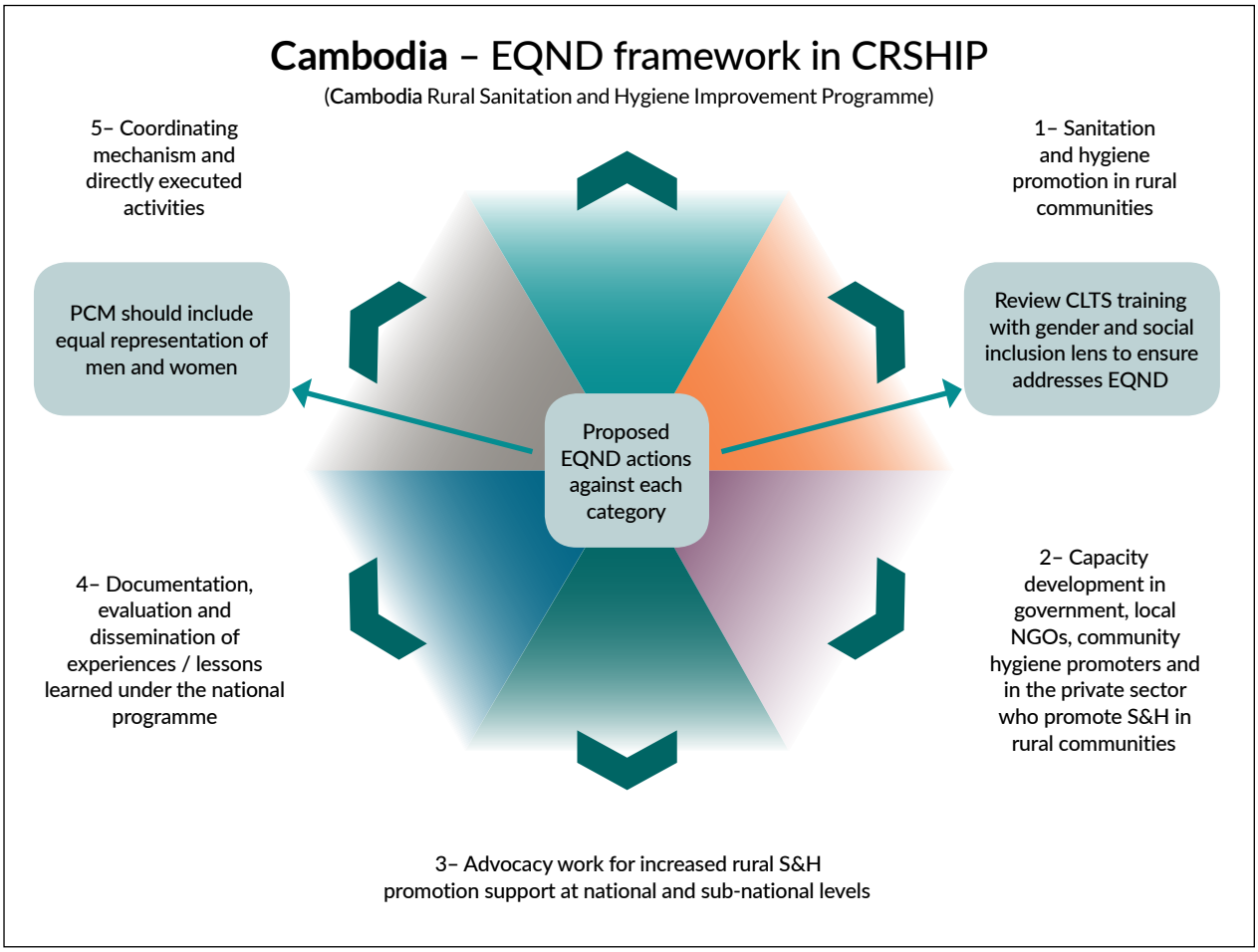
Comment: Due to the existing positioning of the GSF-supported programme in relation to government, if GSF continues to strengthen its work in the area of EQND, there is a positive opportunity for the GSF-supported programmes to influence government policy (and not just limited to the ministries of water and health) and also the wider sector on EQND-related considerations and practices. However, it has been clarified by GSF that influencing the government in the area of EQND would need to be integrated under the wider umbrella of the WSSCC rather than by the GSF-supported country programmes on their own.

6.4 PRE-TRIGGERING

6.4.1 Planning and communicating with the community about the mass triggering event

Various CLTS facilitators and triggerers described having a planning meeting before the mass triggering event. Most indicated that this did not tend to involve

Figure 7: The EQND framework components



people who might be disadvantaged, although occasionally some indicated that people from different community groups were represented.

Some CLTS facilitators / triggerers from **Malawi** and the mountainous region in **Nepal** indicated that part of the pre-triggering process was to go house to house to make sure that everyone knew about the event. In **Nigeria** and **Malawi**, a community person would go around the village shouting information on the event inviting everyone to attend.

6.4.2 Process for ensuring people who might be disadvantaged participate in the triggering

The consultants understand that currently there are no systemized processes in any of the six countries visited to identify people who may be disadvantaged to ensure that they are invited to the triggering event.

The exception is the **Cambodia** programme which has developed a Participatory Social Assessment Mapping (PSAM) approach. This is facilitated by the CLTS facilitator as part of the pre-triggering process and includes identification of who may be the most vulnerable and poorest. It has been discussed in Section 6.6.4.

We met more than 50 CLTS facilitators during the country visits.[32] The majority across all countries visited said that they do not specifically emphasise the need to invite people who are disadvantaged to the triggering event, although there were a small number of facilitators who said that they do specifically encourage this. This is seen as a major gap by the consultants.

A group of men and women in an ODF village in **Nigeria** and the same in **Malawi**, who either had a dis-

32 It is not possible to put an exact number as many of the CLTS facilitators were also recorded as IP staff members.

CONFIDENCE TO SPEAK IN MASS MEETINGS

A simple gender analysis undertaken by leaders of a community Youth Forum and a Women's Forum in an ODF village in Bekwarra District (as an exercise during a FGD as part of the EQND process in **Nigeria**). This indicated who is most likely to speak during a mass meeting such as the triggering event. People with disabilities, pregnant women and young children were least likely to speak; whereas men, elders both male and female, were felt to be able to speak. The youth were also noted to be able to speak out but female youth a little less so.

In general, whether women would speak during mass meetings varied across communities visited. The larger meetings held during the EQND scoping and diagnosis process, tended to be dominated by male voices. However, women seem very active in the CLTS process and many have taken on leadership positions on committees or as Natural Leaders.

One respondent in **Togo**, noted that sometimes when people with disabilities speak they can be mocked for doing so. But in **Malawi**, it was said a number of times, that when people with disabilities spoke they were often listened to more intently and they could be very influential.

GENDER ANALYSIS OF WHO IS MOST / LEAST LIKELY TO SPEAK DURING A MASS MEETING, BEKWARRA, NIGERIA ©S. HOUSE

ability or were old, said that a number of them heard about the triggering meeting because a person calling out to (like a town crier) inviting everyone. However, other older persons and people with disabilities met in other contexts did not all know about the event.

An ongoing and staged process of identification of people who might be disadvantaged is recommended by the consultants. This can be seen in the recommendations for Dos and Don'ts in **Annex XI**.

6.4.3 Challenges of considering EQND during pre-triggering

The box below highlights examples of challenges identified in responding to EQND in the pre-triggering phase. These were identified by the workshop participants in the **six countries visited**.

EXAMPLES OF CHALLENGES IN CONSIDERING EQND DURING PRE-TRIGGERING

- Level of community knowledge on the involvement of all groups
- Difficulty of identifying people who are vulnerable, marginalized or disadvantaged
- How to involve the disadvantaged in the planning
- Lack of basic mapping of disadvantaged people
- Poor mobilisation of disadvantaged people / ensuring they have information about the triggering
- How to identify the norms, values, customs
- How to overcome misconceptions about disadvantaged groups
- The issue of marginalized groups not discussed during pre-triggering
- No coordination amongst stakeholders in the community.

Comment: Ensuring that people who may be disadvantaged are invited to the mass triggering event is an area that requires specific attention across the GSF-supported programme. A range of strategies to improve the way that EQND is incorporated into pre-triggering were suggested by participants of the workshops in the six countries and are integrated into the Dos and Don'ts in Annex XI.

6.5 TRIGGERING

6.5.1 The mass triggering event

The team faced some difficulties in trying to establish whether people had attended the mass triggering event. In some communities, this was because the triggering had occurred several years prior to the visit. In **Nepal**, the term 'triggering' was used to refer to all activities that led to people to build and use a latrine, and not specifically the mass triggering event; and in the Terai districts, it was explained that as the mass triggering events had not proven successful they now focus more on household visits to persuade people on a house by house basis. In **Ethiopia**, and other locations visited, it was not clear that the standard triggering tools were used, with more emphasis seemingly placed on traditional health based messages.

6.5.2 Engagement of different groups of people in triggering

However, for the communities where the event was well remembered, between 25 to 50 percent of the people with disabilities and older people met in FGDs (depending on FGD), said that they had attended the mass triggering event. Reasons given for not attending, mentioned across a number of countries, included:

- That they did not feel worthy, were old and near to death, could not see or could not read and write.
- They were sight impaired and their children were in school so there was no-one to take them.
- They did not know about it, they were away, or another family member went.

Some heard about what was discussed when family members came home or during the follow up, but not everyone heard about what had been talked about after the event.

In **Malawi**, it was clear that more women than men attended the mass triggering event. In **Nepal**, many working age men had migrated for work and so are no longer regularly present in the communities and in **Senegal** it was also said that many men were either working or looking for work during the triggering event.

It was also clear from discussions with children met across countries, that most had not attended the triggering event. Most said they were in school at the time. However, most children met were aware of good sanitation and hygiene practices and said they had learnt about them in school.

One older woman met in a community in **Nigeria** was very passionate about the programme. She went to the triggering and although her family have always had latrines she really appreciates the improvement in the general environment and the health of the community members.

6.5.3 Discussion on needs of the potentially disadvantaged during triggering

The amount of emphasis at the mass triggering event for discussing the need to support people who might be disadvantaged is not fully clear to the consultants. It is probably being discussed / raised in some contexts as part of the facilitation process at the mass triggering event, but it does not seem to be done, or done effectively in all. For example in discussion in **Malawi**, it was only occasional partners who confirmed that they specifically discussed the need for support for the disadvantaged during the triggering session; and that where support has been provided it has tended to come later during follow-up after recognition that some people were unable to construct their own latrine.

When considering (as discussed elsewhere in the report): a) the gap identified in the training for the CLTS facilitators re EQND; b) not pro-actively involving people who may be disadvantaged in the pre-triggering and triggering phases; c) some gaps in the follow up phases; and d) lack of pro-active support for ensuring accessibility of latrines, this indicates that if it is being discussed during the triggering, then it isn't being emphasized enough and hence is an area that needs to be strengthened.

6.5.4 Challenges in considering EQND during triggering

The following box highlights examples of challenges identified of responding to EQND in the triggering phase as identified by the participants of the workshops **in the six countries**. See **Annex IX** for more examples.

EXAMPLES OF CHALLENGES IN CONSIDERING EQND DURING TRIGGERING

- Poor turn-out of people who may be disadvantaged including those who are marginalized
- Lack of self-confidence by people who may be disadvantaged e.g. limited engagement / not speaking
- Limited facilitation skills amongst trained facilitators to address marginalized groups and to consider the point of view of disadvantaged people in decision-making
- Village protocol limits ordinary people, especially the disadvantaged, from speaking or participating
- How to foster an understanding of the critical importance of achieving social cohesion to achieve ODF
- How to manage expectations [i.e. support / subsidy]
- Guidance manual / training / training manual does not address disadvantaged / marginalized groups
- Language barriers – interpretation and communication with people who are sight, hearing or speech impaired
- Community sanctions established for non-compliance [sanctions present a number of difficulties and risks for the disadvantaged]
- Not knowing how to use appropriate terminology
- Political dominance by some individuals / parties
- Geographical barriers / reaching all groups particularly those living in remote or spread out communities
- How to ensure the venue is accessible to all

Comment: Ensuring that people who may be disadvantaged are able to physically attend the mass triggering event, are pro-actively involved in this and drawing on community support mechanisms to facilitate this is an area that requires specific attention across the GSF programme. A range of strategies to improve the way that EQND is responded to at this stage suggested by participants of the workshops in the six countries are integrated into the Dos and Don'ts in Annex XI.

6.6 POST-TRIGGERING FOLLOW-UP

6.6.1 Following up with the potentially disadvantaged

Post-triggering follow-up is the time when most CLTS facilitators, WASH Committees, Natural Leaders and others said that they identified people who might need support and sometimes facilitated that support. But the pro-active identification of people who might struggle to build, access, use and maintain a latrine, as well as the prioritisation of follow up with these households is not systematically undertaken and appears to be more ad hoc.

Follow-up MANDONA – The Follow-up MANDONA approach developed in **Madagascar** aims to provide more systematic guidance to the follow-up stage and has been adopted by a number of countries. See **Annex X**.

*FOLLOW-UP MANDONA (FUM)**

The Follow-up MANDONA approach in **Madagascar**, builds on an existing tradition of collective community work (*'asam-pokonolona'*) and a spirit of solidarity. With the help of a facilitator, the community is enabled to review the progress of what has been achieved following triggering, make adjustments where required and ensure that disadvantaged sections of the community are also involved. Collective community visits to examine sanitation and hygiene provision in the household or other parts of the village can include reviewing whether a toilet is accessible for someone with a disability, for older people or for children. The process also aims to encourage those who are disadvantaged to participate in the programme.

* Fonds d'Appui pour L'Assainissement, Madagascar (2016)

6.6.2 Challenges in responding to EQND in follow-up

The box below highlights examples of challenges in responding to EQND in the follow-up phase as identified by the participants of the workshops in the six countries. See **Annex IX** for more examples.

EXAMPLES OF CHALLENGES IN CONSIDERING EQND DURING FOLLOW-UP

- Weak monitoring mechanisms to ensure meaningful participation and lack of long term monitoring
- Lack of appropriately designed checklist
- Not enough time for official visits / follow up activities
- Community not being willing to help / provide support
- Community solidarity reducing / people are busy – *"abled bodied people do not refuse to assist – but it's the time it takes and facilitators have to be persistent"* (IP, **Nigeria**)
- Difficulties communicating with hearing and speech impaired people and people with mental health conditions
- Marginalized people might not want to turn up to follow up activities because of shyness / stigma / lack of confidence / fear
- How to manage exaggeration of vulnerability and misconceptions (e.g. in relation to subsidy)
- How to manage a household's failure to meet deadlines
- Resistance because of expectations of subsidies
- Limited knowledge of latrine adaptations to make them more accessible or gender-friendly
- Limited joint planning / coordination and follow up with others with overlapping responsibilities (such as DPOs or local government departments with responsibilities for social welfare)
- Limited focus on EQND in community exchange visits
- Difficult terrain or distances with no transport, long days with no food or water, restrictions travelling in the rainy season due to dangerous mountain roads

For examples and discussion on the issue of pressure being put on people who may be disadvantaged to build latrines, see **Section 7.4.2**.

OLDER SINGLE WOMAN WITH NO FAMILY – FALLING THROUGH THE GAPS

The team undertook a FGD with older women in **Malawi** in a community that was not yet verified ODF, but where the senior village chief indicated that they felt they were ready for verification.

During the discussion, each member of the group was asked if they used their own toilet, used a neighbours' or did not use a toilet. About half of the group had their own toilet, about half shared with a relative but one older woman noted that she did not have access to a toilet so she had to dig and bury in her courtyard. She was a widow with no children and she was clearly very distressed to have been left behind and that no-one had offered to support her.

OLDER MAN WHO IS SIGHT IMPAIRED AND HIS WIFE WITH NO TOILET – IN ODF COMMUNITY

The team undertook a FGD with people with disabilities and older people in a community in **Nigeria** that had been declared ODF for a couple of years. During the discussion, each member of the group was asked if they used their own toilet, used a neighbours' or did not use a toilet. There was a mixture of responses, with a number reporting that they had their own toilets and others who shared with relatives. But one older man who was also sight impaired, said that he didn't have a toilet.

Later that day the team located him in his home and he explained that he and his elderly wife had lived in the house for 40 years, had never had a toilet and do not have children and so have no-one to support them locally. Another relative who lives elsewhere had said he would help them construct a latrine and started digging the pit, but it was never finished. So he and his wife still have to practice dig and bury, even though the village was declared ODF some time ago.

6.6.3 Competitions between villages or wards

In some areas competitions have been established between villages or wards. In Arghakhanchi District in **Nepal**, there was a competition in some VDCs for the first, second and third wards to become ODF with monetary rewards. This incentive was reported to have increased motivation and got the people to construct quickly. The team did not investigate how the award was spent or if disadvantaged groups were involved in these decisions.

6.6.4 Identification of the disadvantaged – falling through the gaps

In most countries, the identification of the disadvantaged and those needing support has been fully left up to the VDC, WASH Committee or Natural Leaders with no follow up from the IPs. The leadership of the VDC or the WASH committee will usually know who needs support, but the lack of a systematic identification and follow up has led to some people falling through the gaps, even in ODF communities. The box on page 43 provides examples.

Identification of the disadvantaged for subsidy support in Nepal

The **Nepal** visit was particularly useful in relation to learning how people who are potentially disadvantaged are identified, as the national strategy states that the ultra-poor and disadvantaged can be supported with external subsidy. The identification of the vulnerable has been left up to the VDC and Village WASH Coordinating Committee (V-WASH-CC) to recommend to the D-WASH-CC and District Development Committee (DDC) for approval. The team was shown documentation including the original list and the final (much shorter) approved list (in Nepali), but it was not clear how it was decided who to exclude. The lists had also been drawn up in secret in response to the concern (as expressed by actors at all levels) that if people know there is a potential subsidy it will derail the process as people will wait for this support. Discussions with a range of actors identified a number of considerations in identifying who is disadvantaged enough to need support, but there was no consistency across responses and no documented evidence of these criteria, except the proxy indicators offered as guidance in the national sanitation and hygiene master plan (see **Annex X**). The range of considerations noted by respondents included: *Live on daily wage; Monthly income and savings; Have little land; How many gold chains; Do they have a mobile phone; Do they have a TV; Are the children in school; Backward / marginal-*

PARTICIPATORY SOCIAL ASSESSMENT MAPPING (PSAM)

The **Cambodia** programme has developed a process of community assessment known as PSAM, which draws on some common Participatory Rural Appraisal (PRA)/Participatory Learning and Action (PLA) tools such as poverty ranking, seasonality analysis, social mapping and causal diagrams. It is used during the pre-triggering phase and these tools use visual diagramming to enable communities to explore, discuss and analyse their own situation and to identify who in the community might be vulnerable and why. Following the piloting of a variety of tools with Implementing Partners and some uncertainty about the value of some of them, the number of tools was reduced to four.

All IPs are now required to use this approach. There have however been some mixed views on PSAM being expressed in interviews and documentation provided to the consultancy team, some positive and some concerns; with GSF expressing a more positive view that all IPs and the Ministry of Rural Development support its use.

There are several challenges revealed in the programme documentation that require further investigation. For example, the social mapping tool that is part of PSAM in **Cambodia** seems to suggest that communities identify vulnerable people on a public community map and provides a photograph illustrating the location of someone who is HIV positive. However, one PSAM experienced staff member explained that only a number denoting the wealth category is indicated on the map. It is possible therefore that the way that this tool is used is not consistent which could be problematic. Whilst in many rural communities secrets are hard to keep between villagers, people have a right to confidentiality and identifying those who are vulnerable – either by identifying those with HIV or even publicly displaying their wealth group – could compound their vulnerability and encourage stigmatisation.

Concern has also been raised on whether the approach is scalable. A recent 'short narrative' report on the experiences of using PSAM also highlight some 'teething' problems with the approach:* *"Of the four PSAM tools, the one that seems to be causing the biggest challenge for IPs to facilitate...has been the Causal Diagram tool... Reasons for this are in part due to poor community participation (as described above) and the need for improvement on IP's facilitation skills."*

However, others felt its use was positive and in particular because Plan tends to work in communities for some time and on a range of cross-sectoral issues and hence the information is also valuable to link people into other areas of support.

The PSAM approach is discussed further in Section 9.2

* Ref: Short Narrative – Experiences from Implementing PSAM July 2016

ized groups; Dalits; Female-headed households; Single women; Disabled; Sons out of village; Ultra-poor; Food for 6 months, 3 months, 1 month.

Government identification of the disadvantaged and poverty levels

Some governments have recently introduced safety net programmes aimed at the poorest. Examples of how poverty / vulnerability have been assessed in two programme countries are included in the box below. These have not been used so far by the GSF-supported programmes, but provide an insight into how government stakeholders are currently assessing disadvantage.

Comment: Some positive action is clearly happening during the follow-up phase, but ensuring that people who might be disadvantaged are systematically identified and followed up in a supportive manner, requires more attention within the GSF-supported programmes. Various strategies to improve the way that EQND is responded to at this stage were suggested by participants of the workshops in the six countries and are integrated into Section 10 and Annex XI.

PARTICIPATORY SOCIAL ASSESSMENT AND MAPPING (PSAM) IN ACTION, CAMBODIA. ©WSSCC/RHIANNON JAMES

*EXAMPLE 1 – IDENTIFYING THE 'ULTRA-POOR – WITH LABOUR CONSTRAINTS' IN **MALAWI***

The Ministry of Gender, Children, Disability and Social Welfare of the Government of **Malawi** has been piloting a new system to pay very small cash transfers through the **Social Cash Transfer Programme** to the 'Ultra-poor – with labour constraints'. This payment is currently being rolled out across **Malawi**.

The so-called **'Ultra poor – with labour constraints'** represent 10 percent of the population of **Malawi** and they are identified through a multi-stage process involving a committee of health extension workers and community representatives. The list is then verified with the community and people can dispute people who they feel should not be on the list, or if people think they should be added.

The 'ultra-poor with labour constraints' includes households that: a) Cannot afford a meal; b) Have no assets; c) No land; d) Have [own?] no house; e) The house is uninhabitable.

And these households also include: a) People above 64; b) Child headed households [orphans]; c) Chronically ill; d) Female headed households with more than 3 dependents; e) People with disabilities.

They are paid approximately 4 USD per month per person – which indicates just how poor they are.

*EXAMPLE 2 – GOVERNMENT PAID ALLOWANCES TO PEOPLE WITH DISABILITIES IN **NEPAL***

In **Nepal**, the Government also pays a similar social security allowance to people with disabilities, using the following categories:

- **Completely disabled** – such as visually impaired – entitled to approx. USD 19 per month
- **Severely disabled** – wheelchair users, need others to help – approx. USD 5.5 per month
- **Partially physically disabled** – one limb, one eye – can manage on their own – no allowance
- **Normally disabled** – may have a deformed leg or foot but can function normally.

This also provides an indication of the level of poverty where people with disabilities have no additional means of income.

6.7 'DO NO HARM'

6.7.1 The concept of 'do no Harm'

The concept of 'do no harm' was discussed during the workshops in the six countries. A few examples came to light where people have potentially been made more vulnerable as a result of the programme or could have led to the abuse of rights, even though the intention may have been positive. These examples included:

- People who were very poor had to sell assets (such as their only plot of land) to build their toilet (see **Section 9.1** for more discussion).
- Two examples where older men had taken out a loan to build a toilet using their land as surety, they were unable to pay back the loan and hence lost their land (see **Section 9.1** for more discussion).
- Examples relating to people with mental health conditions: one man was banished by the community (it is not clear for how long) because he would not stop OD, affecting their ability to be verified ODF; another was told that the community would find him a wife if he stopped OD and he was then found a wife – also with a mental health condition; and a woman was informed by a facilitator that if she stopped OD he would marry her. These are discussed further in **Section 7.6.8** and **Section 9.3**.

In addition, a few examples became apparent where those working to promote CLTS were faced with aggression or violence, including a case in **Nigeria** where a householder became violent and another in **Nepal** where a man started taking a sharp implement with him when he went out for OD to threaten anyone who approached him (see case study in **Annex IX**).

6.7.2 Challenges of ensuring the programme 'does no Harm'

The box below highlights examples of challenges of responding to EQND in ensuring that the programme *'does no harm'* by the participants of the workshops in the six countries.

There may also be some challenges where national legal frameworks support processes that may do harm. GSF will need to consider where this may be the case and ensure that under the programmes that it funds, that doing harm is not acceptable.

Comment: The concept of 'Do No Harm' was new to quite a few of the participants in the national workshops. It is an area where the country programmes would benefit from guidance, as well as the setting out of minimum standards of behaviour in a code of conduct. A number of strategies to improve the way that the programme 'Does No Harm' were suggested by participants of the workshops and integrated into the Dos and Don'ts in Annex XI.

EXAMPLES OF CHALLENGES IN ENSURING THAT THE PROGRAMME 'DOES NO HARM'

- How to overcome pressure on time – which may lead to human rights abuses / exclusion? [such as the man with mental health conditions who was banished from the community]
- How to prevent the creation of dependence and expectation amongst the community [related to the provision of support or subsidy for some]
- How to help facilitators understand the concept of 'do no harm' and ensure that they understand their responsibilities to ensure people do not become worse off during interventions
- How to help communities understand the concept of 'do no harm'?
- How to identify people who need support without further stigmatisation?
- How to always use the right / inoffensive language to address vulnerable groups?
- Not to isolate / set apart vulnerable persons from the group during community activities
- How to not make assumptions or interventions on behalf of someone without asking and involving them
- How to ensure that you do not consider disability as an obstacle
- To not interrupt marginalized persons as they speak
- Humiliation of children of disadvantaged parents, such as when congratulating other pupils for the achievements of their parents
- Telling children to shout and throw stones while a person is practicing OD
- Conflicts over by-laws to limit OD or displaying names of people who are still practicing OD in public
- Lack of respect by facilitators for community social norms and lack of value of the community's opinion
- How to ensure proper mobilisation of local bodies which can then mobilise households, rather than giving, or threatening to gain action

A WOMAN PROUDLY DISPLAYS HER LATRINE IN ARGHAKHANCHI, ONE OF NEPAL'S ODF DISTRICTS. ©SUE CAVILL

7 FINDINGS – GSF: OUTCOMES, ISSUES AND CHALLENGES

7.1 PROGRESS TO ODF

People reaching ODF and who have an improved latrine

Table 3 – Provides an overview of the progress on ODF made by GSF in the **6 countries visited** during this study. Note that the ODF verification criteria, the contexts and the operating modalities vary in each country, so the comparison between countries is not fully linear. Data for all 13 countries can be seen in **Annex VII**.

In some countries, whole districts have become ODF, with significant support from GSF. In **Nepal**, national sanitation coverage has risen from 6 percent in 1990 to 87 percent today with 35 ODF districts out of 75; 2274 districts out of 3157; and 122 municipalities out of 217. The GSF-supported programme has had three phases since 2010, with 4 of its original districts now ODF. At least 5 of the GSF-supported districts were badly affected by the earthquake and **Nepal** faces multiple other challenges due to: the terrain, migration; and cultural acceptance of OD in the Terai areas of the country. In **Ethiopia**, 42 percent of the country's 16,000 *Kebeles* (equivalent to village) have been declared as ODF, 684 supported by GSF; and in **Nigeria** the GSF-supported programme has supported the first LGA (equivalent to a District) out of the 774 in **Nigeria** to become ODF.

Table 3: GSF progress made to ODF and improved sanitation in the 6 countries visited

Data to end 2015	Malawi	Ethiopia	Senegal	Nigeria	Nepal	Togo	Total
Year programme started	2010	2012	2010	2012	2010	2013	
Communities triggered	3,198	16,151	892	850	21,873	99	43,063
Communities declared ODF	2,115	14,269	585	556	10,693	197	28,415
Individuals who are living in ODF environments	712,933	2.85 mill	380,451	235,874	1.55 mill	152,930	5.8 mill
Individuals who have an improved latrine in programme communities*	154,220	994,573	121,860	53,535	1.43 mill	80,801	2.8 mill

* This data includes people who had improved latrines before the GSF-supported programmes as well as new improved latrines

Estimation of the most disadvantaged who have stopped OD from the totals

Table 3 – Shows that in the 6 countries visited for this study 5.8 million people were living in open defecation free communities by the end of 2015 and 2.8 million had access to an improved latrine. If we assume, as is often said that *"because it is CLTS, everyone in the community will have access – which means this also includes the disadvantaged"* and attempt to make a very rough calculation, a rough estimate can be made of the number of the most disadvantaged who may have benefitted from the programme. In **Malawi**, the government estimates that approximately 10 percent of the population are *'ultra-poor – with income constraints'*. This would mean that it could also be estimated that over 70,000 people who are the most disadvantaged or *'ultra-poor – with wage constraints'* as per the Government of **Malawi** definition, will have gained access to and are using a latrine as part of the programme. Of course, this is based on many assumptions, but it does indicate that through the programme a large number of people who may be considered disadvantaged will have gained access to a household or shared latrine. Although it is more difficult to make an estimate of whether it is being used and maintained.

Comment: The fact that large numbers of people now live in ODF communities and have access to household latrines, including whole districts and those in remote and culturally challenging areas, is a huge achievement. Given the very real challenges the most disadvantaged people can face in building and accessing a latrine, it can be assumed that GSF has provided a positive benefit for many poor, marginalized and vulnerable individuals and households across the communities in the countries we visited.

However, the disadvantaged are often the people who might be expected to share, who might build or be supported to build last, often with the most basic technologies, be expected to use a bucket, or in some cases left to dig and bury. The team undertook over 140 household visits and met a wide range of people in FGDs who might be considered disadvantaged, including more than 211 older people, 74 people with disabilities, 100 children over 5 and youth and a range of other community leaders and members of community based groups. The following sections provide examples of people met, reflections on what GSF has meant for them and their views on the benefits and the challenges that they have faced.

IN APRIL 2017, THE OBANLIKU LOCAL GOVERNMENT AREA (LGA) IN NIGERIA PUBLICLY CELEBRATED BECOMING THE FIRST OF THE 774 LGAS IN THE COUNTRY TO ACHIEVE ODF STATUS. A KEY FACTOR IN THIS ACHIEVEMENT WAS ENSURING COMMUNITIES WERE EMPOWERED TO COME UP WITH THEIR OWN SOLUTIONS TO ADDRESS EQND ISSUES. ©UNITED PURPOSE

7.2 METHODS USED TO INFLUENCE PEOPLE TO BUILD, ACCESS AND USE A LATRINE

7.2.1 Methods used to influence people to build, access and use a latrine

The following table provides an overview of methods that were seen or claimed to have been used to influence people to build, access and use a latrine in varying combinations **across the 6 countries visited**.

Table 4: Methods used to influence people to use a latrine

Motivation	Method of influence
Disgust, social norms, working with others	• Triggering event – some using CLTS /SLTS standard techniques • Follow up discussion and activities
Encouragement / pressure / threats	• House to house follow up or community 'patrols' • Influence / instruction / coercion from the Chief or community leaders • Encouragement or threats by the police (depending on whose opinion is asked)
Role models and champions	• Role models and champions of different kinds: NLs, politicians, religious and other leaders, community members who act early including people who may be disadvantaged, etc.
Reward	• Competitions between Wards and villages – with monetary rewards for the Ward (**Nepal**) • Rewards for households with a green sanitation card (**Nepal**) • ODF ceremony and prizes for Natural Leaders and special achievements • Individual rewards – see **Section 7.6.8** on people with mental health conditions • Demonstration latrines for some individual households
Individual shame	• Posting names of people who have been seen practicing OD on a notice board (**Ethiopia**) • Children watching for people who practice OD – and blowing whistles or emptying anal cleansing water containers
Community pride / shame	• Triggering event – some using CLTS /SLTS standard techniques • ODF certification and ceremony • Community level training • Coloured flags used to indicate OD status of a community – red (not OD), green (OD), white (Total Sanitation) (**Ethiopia**)
Coercion	• Establishment of local by-laws – fining of a chicken, a goat; monetary fines • Sanitation cards – to indicate a household having no latrine, a basic latrine, a biogas latrine: and restrictions from services such as not issuing a birth certificate (**Nepal**) unless you have a latrine – although the National Government has recently issued a memo to instruct this practice to stop, suggesting to instead use the cards for positive rewards • Temporary or permanent confiscation of property
Making ODF easier	• Building public toilets – one for every 30-40 households (**Ethiopia**) • Fishermen's toilets (**Malawi** lake shore) • Children's potties (**Senegal** and **Nepal**) • Modifications to toilets (some, most self initiated)
Material/financial support	• Solidarity funds • Village savings schemes of different kinds • Demonstration latrines (**Senegal**)

In general, the success of whole villages in becoming ODF appears to have been influenced by the use of a range of different methodologies, from collective decision, encouragement, peer pressure, rewards and coercion, particularly from strong community leadership and also from the use of fines.

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Edwin (above) lives in Ere-Agiga VDC in Bekwarra LGA, **Nigeria** and is seen sharing the community action plan and community maps. He was at first a Natural Leader and then the Chair of the CLTS community area and then became the Chair of the Ward WASHCom. He is very active even though he faces some mobility challenges. The WASHCom go out every week mobilising the community – at least once per week, sometimes 2-3 times. The Ward WASHCom also manage a revolving fund; the funds from which can be used for any purpose.

Cecilia is a female politician and champion and has been making significant effort to ensure that Bekwarra becomes an ODF LGA. She is the Vice Chair of the Local Government Council and the Chair of the Local Task Group on Sanitation (LTGS). She is very passionate about getting the LGA to ODF status and the benefit it has already and will bring and has been very influential in the sanitation action in the LGA. (Bekwarra Local Government Area, **Nigeria**)

Tila (right) was ahead of her time in more ways than one. She was a pioneer of improved sanitation in her community, constructing a safe toilet in 1997, after she used one on a visit to Kathmandu. She wanted to have one at home and so organized all the parts to be delivered. She is also a trendsetter, inspiring others to adopt improved sanitation at home too.

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Ngoma VDC members (right) in Katimbira have been very active in mobilising their community to become ODF.

They live along the Lake Shore in **Malawi** and noticed that the fishermen did not have easy access to a toilet. With the help of the fishermen they constructed a public latrine made of brick and held together with local mortar. They have plans to build another toilet now for the women fish sellers.

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7.2.2 Strong leaders and role models

The team met a range of community leaders who explained how they had motivated people in different ways to build and use a latrine. We heard a range of reports about women, older people and people with disabilities who became role models and influenced others in their communities. A few examples are included in the box on the left. For other examples see **Annex X**.

7.2.3 Role of the police

The involvement of the police was generally seen as positive by implementers and encourages any problems to be resolved (e.g. such as when someone became violent during the process of trying to convince him to build a latrine in **Nigeria**). The team met with a police team in Bekwarra, **Nigeria**, who were very enthusiastic about their role in promoting sanitation and the benefits they saw in communities. Other examples were shared in a national workshop indicating that support from the police is appreciated when problems occur. But in discussions in **Nepal**, opinions varied as to whether police involvement was encouraging or threatening.

> *An older woman from a historically marginalized Terai Dalit community in Nepal, who has a son with mental health condition and looks after young grandchildren, has brought two concrete rings but cannot afford to complete the latrine. She explained how she is regularly pressurised by the people who come to her house and has been threatened to be taken away by the police, to which with frustration she said "that's fine, take me away with you then!".*

Comment: The benefits of engaging the police need to be assessed on a community by community basis and some safeguards need to be in place to prevent the abuse of power e.g. code of conduct, training/ orientation. The police station could also be a focus for institutional triggering to make sure that appropriate latrines are provided for those in custody in all stations. For discussion on the different methods for influence, risks and limits see Section 7.2.1.

7.3 WAYS PEOPLE HAVE BUILT AND ARE USING AND MAINTAINING LATRINES

7.3.1 Ways people who are potentially disadvantaged have built, accessed and maintained latrines

The ways that people who are potentially disadvantaged have built latrines are summarized in the following table. Those met who have built their own latrines have included women headed households, older people and people with disabilities amongst others.

Table 5: Ways that people who may be disadvantaged have accessed a latrine

Self-built or funded	Built with support from others	Sharing, dig and bury, public latrines
• Sold produce • Did piece work to fund construction • Physically constructed myself • Selling goats or livestock • Used social security payments • Taken out a loan • Collected own stones • Sold land or other assets • From remittances [70 percent of households in the Terai, **Nepal** have a family member abroad]	• Family members dug pit, man with disabilities cut logs and made slab • Parent built latrine for children with disabilities • Local triggerers facilitating support for vulnerable • Community forest user group – loans, provided wood for doors and superstructure construction • Women's cooperatives – provided loans and land to build toilets and wood for a chair for a person with disabilities • Supported by youth groups or women's groups • V-WASH-CC – allocated matching funds • D-WASH-CC – allocation of donor and government matching funds for pipes, pans etc. • Private donors (occasional examples – one who provided 26 sets of pans and rings) • Village solidarity funds, village savings groups • IP funding	• Sharing with neighbours • Dig and bury in compound • Dig and bury when at farm • Use a public latrine (**Ethiopia, Malawi**)

MEMBERS OF A CLTS COMMITTEE IN AKLOTSI VILLAGE, TOGO, RAISE THEIR HANDS TO SHOW THEIR COMMITMENT TO MAINTAINING ODF STATUS IN THEIR VILLAGE. ©CADI-TOGO

7.3.2 Self-built latrines

The case studies to the right provide examples of people who may be considered disadvantaged who have built latrines themselves.

There were a number of reports of people who could be considered disadvantaged who were offered support but refused it or handed it back.

In addition, some people have sold limited assets such as their only plot of land or last goat to build a latrine, or have used their social security allowance. These are the people who may be made more vulnerable through the CLTS process, as they may be less able to resist future shocks if they have depleted their assets.

For more examples see **Annex IX** and **X**.

Comment: A key lesson is that some people who might be considered disadvantaged are capable and will want to build their own latrines. Reducing reliance on others is likely to be empowering and contribute to feelings of self-efficacy and self-confidence. Hence it is to be encouraged; whilst at the same time implementers need to be aware that some people will need support, particularly where they are not able to construct, and only have limited assets. Listening and showing respect for the opinions of people who might be considered disadvantaged will be core to being able to make this judgement appropriately.

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Atumika, a grandmother looking after 6 grandchildren – dug her pit and constructed all of latrine so far – almost complete (Malawi)

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Kelvin and his brother Paulycap are both visually impaired. They live together as a family with their wives, children and mother, who is also visually impaired. They built their own latrines because they didn't want to continue open defecation as they didn't like stepping in other peoples' faeces, which they cannot see. (Nigeria)

7.3.3 Supported by others

The case studies to the right provide examples of how people have been supported.

For more examples see **Annex XII**.

7.3.4 Financing mechanisms

The team met a women's Village Savings Group in **Malawi**. They were very successful in increasing their groups' savings through their small businesses. They had also set up a small savings fund internally so that each member would slowly build an improved latrine, so that they could be role models in the community. So far, all 30 members have constructed a cement slab for their latrine and are also soon to manage a revolving fund supported by the GSF-supported programme. The **Malawi** programme is also in the process of setting up a Sanitation Revolving Fund at Traditional Authority level (with interest at 10 percent for households and 20 percent for businesses), coupling this with sanitation marketing activities.

In **Nigeria**, a WASHCom reported having set up a revolving fund of loans for the Ward WASHCom members but as of yet this has not yet been used for latrines. Solidarity funds are being used in **Senegal** to support those less able to construct a latrine for themselves and on average each solidarity fund has supported 1-2 households (usually with a bag of cement to smooth over a traditional latrine slab). They also provide loans to households but data on how many loans have been made is not available. See the case study in the box below.

In **Ethiopia**, a range of community based financing mechanisms exist such as an *"Equb"* which is a savings scheme where members put in a set amount of money and each member takes the full sum in turn. There is also an *"Edir"* social insurance scheme also exists that usually supports funeral expenses, although it is not known to have yet been used to support the poorest with sanitation. In **Togo**, it is reported that community savings groups (*'Tontines'*) and women's groups are utilized to support people (through cash, in-kind or labour).

In **Nepal**, the taking of loans was reported to be common practice. In the sustainability study (2016 draft), **provisional** data indicates that one in ten households were found to have taken out loans for their toilet construction. Women's Cooperatives and Community Forest User Groups have provided loans at interest

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Tabieni doesn't know exactly how old she is but she is currently looking after her three young grand-children after their mother died. Her husband had also died. The VDC recently helped her to build a latrine. Previously she was just using the bush and was troubled by this, because there was no privacy. (**Malawi**)

Through facilitation by one IP, a Natural Leader volunteered to continually ensure that his neighbour's latrine is kept neat at all times. His neighbour, Mr Iorver became blind as a result of glaucoma. Ashes are regularly replaced in a container inside the latrine for his use with a handwashing station strategically positioned. (study provided by an IP, **Nigeria**)

A husband and wife and their children all have disabilities. They are ultra-poor and financially not able to build a latrine. But the husband made mud bricks and gave them to a brick factory, which then gave him burnt bricks in return. Together with support from the IP of a pan and pipe, he was able to build a latrine including a handrail. (study provided by an IP, **Nepal**)

Baba is a 74-year-old man with a wife of a similar age and whose children live away in urban areas. During a follow-up, the team discovered that his was the only household without a latrine as he had no-one to construct one for him. The community leader provided food for the WASHCom and they built him a latrine. Since this time, he has become a CLTS champion who has been instrumental in sustaining CLTS in his community. He supports the WASHCom with contributions for their transport costs to conduct monitoring in difficult to reach households.
(case study provided by an IP, **Nigeria**)

levels of between 12 to 20 percent. But when a household is so poor that they are unable to put down any surety, they will take loans from their neighbours and landlords at very high levels of interest (women from a marginalized group mentioned 48 percent). Cases were also heard of CLTS triggerers giving loans (at an interest rate of 24 percent), which also poses a conflict of interest. Problems have occurred when the person taking out the loan has been unable to pay it back. See the case study in **Section 6.7.1**.

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Mariam borrowed money from the solidarity fund to build her improved toilet. Her family are quite poor but she had managed to save about 100,000 CFA (160 US$) and borrowed 40,000 CFA (64 US$). She hopes to pay it all back in one go after the harvest. It is brick lined with an offset pit that can be easily desludged. She also constructed a bathroom at the same time. She knows someone who has used a similar design and this has lasted ten years and she is still using it. There are about 15 people in her HH and so sometimes there is a queue but she is very happy with her new toilet.

7.4 BENEFITS, CHALLENGES AND RISKS FOR PEOPLE WHO ARE POTENTIALLY DISADVANTAGED

7.4.1 Benefits of the programme

See the benefits as expressed by people who may be considered disadvantaged across countries in **Table 6**.

The following box shows examples of the positive impacts and results. For more examples see **Annex X**.

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Ama, a mother who uses a wheelchair in **Togo** said: "I can now use the latrine while I used to crawl amongst the teak trees. During the rainy season, open defecation was tough for me as I had to crawl in the mud. It is now comfortable. They have put a wooden mortar bowl, which they drilled and that I use as a seat. I have noticed that I have less belly ache. I have to thank the facilitator because I had really no idea that things could be different."

MHM awareness raising at community level in **Senegal**, has led to the situation where it's now acceptable to hang up pads on a line in front of male members of the household (see the washing line that is used to hang and dry pads).

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A number of programme respondents also noted the benefits of increased capacities and empowerment: *"But there is an important aspect of enlarged capacities resulting from these CLTS interventions, which result in a potential for greater community development. For instance, teams of leaders have stronger capacities to work with peers and NGOs"* and *"It can really solve social conflicts. It is the only time in my whole career that I find an approach that promotes social cohesion"* (KII respondents, **Togo**). See **Section 9.1** for more discussion.

7.4.2 Challenges and risks faced by the most disadvantaged in GSF-supported programmes

See **Table 7** for challenges and risks expressed by people considered disadvantaged across countries.

In addition, the respondents of the online survey indicated follow-up challenges faced by the most disadvantaged. See **Figure 8**.

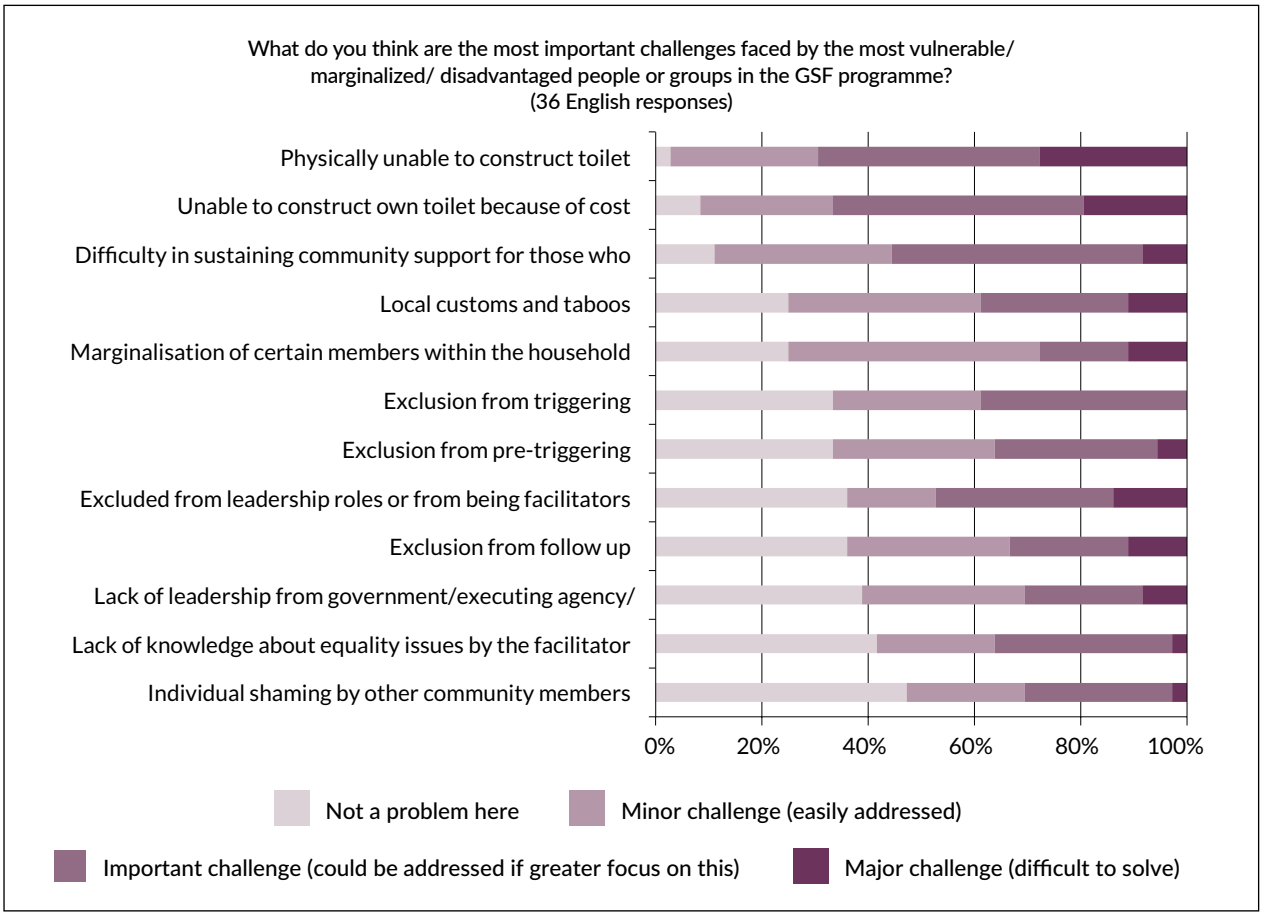
Table 6: Benefits of the programme for people who may be considered disadvantaged

Benefits
• **Safety:** Safety for women; Worried about rape cases for girls and women when practicing OD • **Convenience:** Easy to defecate in the rainy season and at night; Easy to manage child's faeces • **Ease of use:** Easy to use; Needed during pregnancy and [after] delivery. • **Pride / no embarrassment / self-esteem:** When have guests it feels nice to show them the toilet; Pride in our household; *"The toilet is an ornament in our house – it brings us prestige".* • **Health:** Prevention of disease / health • **Dignity:** Dignity; Social dignity; It is humiliating to use other's toilets, more privacy, easier to manage periods; No longer stepping in other people's shit [noted by people who are sight impaired and older]. • **Environmental:** Reduce flies; Reduce smell; Reduce environmental pollution • **Other:** Stop eating each other's shit (although not commonly mentioned); Not good to defecate outside; It's a natural process so we have to build one • **Income generation:** Through use of land for growing vegetables that used to be used for OD. • **If practice OD:** Face risks from snakes and insects; Have to stand up if someone comes in-between; No good aspects – people see you naked; Women and girls can only go morning and evening – men and boys can go anytime; Don't eat so don't need to go to the toilet
Potential positive impacts from the above – expressed by various respondents
• Empowerment of disadvantaged groups • Breaking down stereotypes • Can encourage a feeling of being part of the community • Increased respect and confidence • Resolving conflicts • Increased sense of community / social cohesion • Change in gender roles • Increased harmony in the household (noted by a woman in a polygamous household) • Leads to further community development activities – such as total sanitation, immunization

Table 7: Challenges and risks from the programme to people who may be considered disadvantaged

Challenges
• Can require poor people to sell assets (cattle, land) • Taking loans at high interest rates • Losing surety on loans • Constructing shallow pits (to give appearance of having a latrine) that fill up quickly • Poor quality construction so latrines regularly collapse • Lack of adaptations for those with disabilities
Potential negative impacts from the above
• Stress / distress • Frustration / anger • Increased stigma of disadvantaged groups • Increased vulnerability to risks • Unable to farm and feed family due to loss of land

Figure 8: Online survey result (English speaking) – Challenges for the most disadvantaged



The French speaking responses were similar with only slight variations. See **Annex VIII**.

The box below shows examples of some of the challenges and risks.

Two old men took out (separate) loans from the cooperative to build their latrines, but they could not pay them back so the cooperative have taken the land title from them (**Nepal**)

A poor family sold their only piece of land to be able to build a latrine (**Nepal** GSF case studies report, 2014)

In more than one of the communities visited, the CLTS triggerer also offered households a loan to construct a toilet, at very high interest rates (24 percent) (**Nepal**)

Samba is sixteen years old and cannot walk so uses a wheelchair. He doesn't go to school as it is difficult to get there. Samba has 10 people in his immediate family and they have 2 toilets in the compound – both traditional style (wood slab covered with concrete and roofless straw/corrugated iron superstructure).

However, Samba has to use a potty outside the latrine as the door is not wide enough for his wheelchair and his mother usually has to help him. At night, they put the potty on the veranda and Samba can just about manage to get out and use it on his own. He would prefer to have more independence and use a seat in the latrine. A commode at night would also be more comfortable. (**Senegal**)

In a number of countries community-led follow-up teams or patrols were reported to undertake the follow up to check on general progress and encourage action. This is understood to be a critical activity in encouraging people to build latrines. However, it is not without challenges. See box below.

Pressurising everybody in the community to build a latrine means that even the poorest and most disadvantaged are placed under this pressure and stress. Examples of people met who were in this position included, a man with a very small house built in the gap between two larger houses and who only had a patch of land at the front that was only the width of a toilet. It also included a number of women headed-households with responsibility for a number of other family members and no male or only a young male to support the family. Families including a person with disabilities said they struggle to even get enough to eat and one woman was visibly upset talking about her situation. Several families had men with mental health conditions that were not able to work. The team met one very vulnerable family with several members with mental health problems and only the wife and one son who do not. They live on the old age pension of the grandfather. In one family, where both husband and wife had a disability (the wife with leprosy and the husband who lost his leg due to gangrene), the husband defecates on the floor of his house and his wife collects it up and disposes of it outside. The strategy of not informing people of the available subsidy has been developed because of a real fear that this will undermine motivation to build, but is this level of pressure really reasonable or necessary? If it is harmful to let people know that they are entitled to subsidy, then more effort is needed to facilitate support internal to the community so that the most vulnerable are not put under such stress for long periods of time. This area requires increased attention to find alternative solutions. See **Annex IX** for more details of this example.

PRESSURE TO BUILD – APPROPRIATE OR GOING TOO FAR FOR THOSE WHO ARE PARTICULARLY DISADVANTAGED?

In the Terai district in **Nepal** the team participated in a 'patrol' in a non-ODF community, which had been triggered two years previously. The population belonged mainly to the *Musahar Dalit* community, one of the most marginalized and historically excluded communities in **Nepal**. Many of the households have little or no land on which they can build a latrine and many are clearly very vulnerable and very poor. Some are entitled to a contribution for their toilet from the government, being considered as 'ultra poor'.

But despite the fact that they are entitled to support, pressure is brought to bear on even the poorest households until over 90-95 percent have built a latrine. This is because of the concern (widely expressed by all involved in implementation from national level government to triggerers), that if the availability of subsidy for the poorest becomes widely known at the start of the process, then many people will stop construction in order to ask for support.

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See **Section 9.5** for discussion on this case study.

Photo above: Female community member sharing the challenge she has in constructing a latrine, given her family's lack of land ownership.

The only land this woman (pictured above), her family and a relative's family own is the internal courtyard (no more than twice the size of what is seen in this image) between two small buildings with a few rooms that they share. Hence, she has started to build her pour flush latrine *inside* one of the small rooms in her house.

The provision of communal latrine blocks with allocations of individual toilet units per household is being considered as a solution by the government, but households have not been informed of this plan.

7.5 ISSUES AFFECTING OUTCOMES

7.5.1 Sustainability/slippage from the perspective of quality of latrine infrastructure

Various stakeholders raised the issue that the risk and subsequent implications of slippage (in relation to the quality of latrine infrastructure) were greatest for people who are disadvantaged. This was echoed by people who may be considered disadvantaged and confirmed by field observations where most people who needed support only had the most basic latrine that was often prone to collapse and was said to have a very limited lifespan. In most cases seen where people have been supported to build latrines, the latrines have been built using local materials, with unlined pits and local wood and mud slabs. When the pit collapses, people who need support have to wait for someone to come and help them rebuild. Many of the people met during the process noted that they had rebuilt their latrines several times in the past (including those who had latrines before the GSF-supported programme). This confirms that rebuilding is likely to be needed. Concern was raised over the delays to rebuilding and whether people will get tired of providing support repeatedly over time.

> *The biggest challenge for me is when my latrine collapsed – having to wait for someone to come and help me build another one."*
>
> (Man who had a stroke, Malawi)

> *We have had to struggle two years working in a community without reaching ODF due to constant collapsing of the latrines. It is only a few well-off people who can afford reinforcing their pits with these 200 litres metal drums"*
>
> (KII respondent, Togo)

Fifty-five per cent of the English on-line survey respondents felt that an important challenge was sustaining support for those who were disadvantaged. Forty-nine per cent of the French survey respondents felt that this was also 'an important challenge' and 22 percent of this group felt this was 'a difficult problem to solve'. In **Malawi** and **Togo**, comments were made by older women and programme stakeholders that noted a decline in solidarity, particularly with regards to supporting older people. In **Malawi**, in particular in areas of sandy soils and areas at risk of flooding, there were repeated requests for financial support for materials to prevent collapse.

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Florida did piece work to get the money to pay someone to construct a toilet for herself and her elderly mother. Whilst the family had one toilet she felt it was more dignified and private for her mother to have a separate toilet. She had made a raised slab and placed a pot of water in the toilet so that her mother is able to wash herself more easily. She has had to rebuild this toilet five times as it keeps collapsing in the sandy soil (**Malawi**).

Even basic technical guidance on options could reduce frequency of collapse, such as use of ring beam and partial lining. In **Senegal**, the traditional slab is being cemented over, but this doesn't significantly lengthen the lifespan of the toilet, just makes the slab easier to clean. In **Nigeria**, the programme is trialling 'Innovation Workshops' where people are encouraged to calculate the real cost of having to rebuild against the cost of building a stronger latrine to start with. For some examples of methods currently being used to line latrines see **Annex X**, although the poorest are unlikely to be able to afford such options.

In **Malawi**, the issue of deforestation was raised, particularly in relation to challenges in building latrines, lining the latrines (wood is also needed to burn bricks) and the effects of having to re-build.

*SLIPPAGE IN **NEPAL***[33]

Nepal is the only one of the six countries where the national strategy strongly recommends (noted by most people as being a requirement) of a permanent structure up to ground level. The **Nepal** sustainability study (2016 draft) defined slippage as a) households that have toilets but any or some members go for OD; and b) toilets that are not in use because of breakage, being full, or do not have a roof, wall, door, safety or privacy. **Provisional** data from the ODF districts indicated that 11.2 percent of households had slipped off using a toilet as per the **Nepal** definition.[34] The more historically marginalized groups had a higher slippage (Dalits 20.6 percent, Janajati 13.5 percent, others 7.6 percent), although interestingly both the poorest and richest wealth quintiles had higher slippage than the middle wealth quintiles. Seventy nine percent of the households in **Nepal** that had returned to pre-ODF habits (i.e. 79 percent of the 11.2 percent overall who were noted to have slipped) were using an unimproved toilet (which is not accepted by national strategy in **Nepal**).

***Note from consultants** – If the use of unimproved toilets were not considered slippage (as would be the case in other countries) the actual slippage rate would have been 2.3 percent. The length of time after the districts had become ODF varied, but this is a very low rate of slippage (as would be defined in other countries). It is possible that the requirement that the latrines should have a permanent lining and slab, has aided in keeping the slippage rate low against what has been seen in other countries.*

33 Bikash Shrot Kendra Pvt. Ltd. (2016, final draft)

34 In Nepal, a toilet that is considered acceptable as per the national ODF definition of 'improved' should be permanent up to ground level and utilise a pour flush mechanism, i.e. should have a lined pit, concrete slab and a pour plush pan.

7.5.2 Sharing

The poorest and most vulnerable individuals in the community are often obliged to share toilets with their neighbours if they are unable to construct their own facility. Whilst this ensures that the community achieves ODF status, it brings with it a number of indignities and constraints and an increased likelihood of slippage. It was reported that sharing was inconvenient especially at night and particularly if the toilet was not close. One woman admitted digging and burying her stools at night behind her house if she needed to go. Other concerns raised were about lack of privacy, poor hygiene, being expected to be the cleaner and being treated as a second-class citizen. All of these reasons could lead to people eventually reverting to open defecation. See examples in the boxes below.

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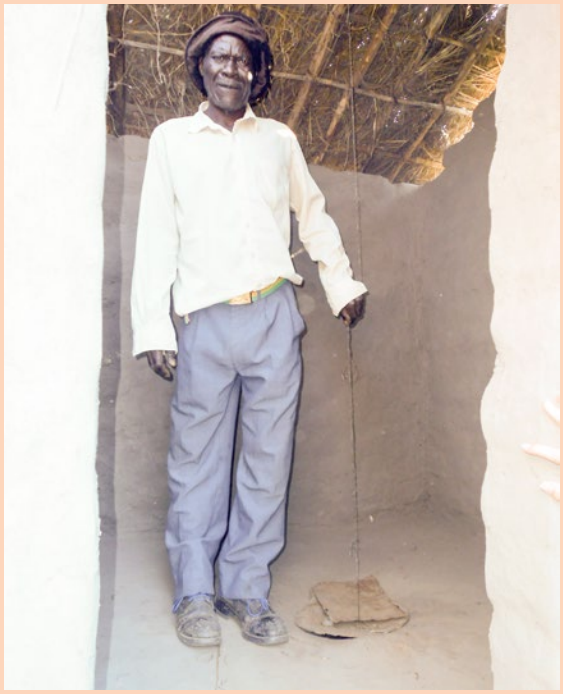
Bintou (above) from **Senegal** lives with her two sons who both have the same disability that started when they were young. They are both able to walk but with difficulty and slowly and have some developmental delay but have been to the koranic school. Aladji is now 25 years old. He uses the latrine with difficulty during the day but at night she helps him to use a bucket. He is also often ill so has to use the bucket at this time also. They sleep in the same room.



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I built my own latrine and washing area a few years ago. I am now building another for my daughter as I don't want her to walk in on me when I am using the latrine."

Gringo (above) who has difficulty walking (Malawi)

Some older women in **Malawi** told us that they did not like to be dependent and beholden to others, even their relatives. They said it made them feel bad – like second-class citizens.

In return they might have to be responsible for cleaning the toilet and if they complained about the lack of cleanliness they would be told to go in the bush or build their own latrine.

Others said there is sometimes pressure when needing to go in the morning and also the toilet can be locked so you don't have access.

A man who is hearing and speech impaired from a village in **Malawi** had just constructed the family their own latrine including a very deep pit so that it would last a long time. His wife explained that their family used to share a latrine with 5 other families, but it was difficult. The best thing about having their own latrine is being able to keep it clean.

7.5.3 Cultural practices and intra-household use or non-use of latrines

The non-use of latrines by some members of the household (intra-household use) is sometimes considered as slippage. However, it is not clear to the consultants whether gaps identified in use within the household are really due to 'slippage' or whether intra household use was not rigorously checked during verification and hence some people were also not using them at the time of verification. In the **Nepal** sustainability study (2016 draft), provisional data has indicated that a total of 5.6 percent of households had at least one family member who did not use the toilet. Of those who did not use the toilet, the reasons given included: foul smell (36 percent); did not like the toilet (13 percent); broken door/windows and roofs, collapsed toilet (5 percent); choking of the toilet (full) (5 percent); or water scarcity (4 percent). Elders in one community in **Nigeria** explained how at first, they struggled to persuade women to use the latrines as they felt that the hot air that rises up out of the hole would give them infections. This issue seems to have been resolved by putting small holes in the latrine cover (too small for flies to exit), which then allows the hot air to dissipate.

It is a cultural norm; it is shameful if you go outside the house to shit. You will be asked if you are unwell if others do not see you go outside?"

(An old man who has had a latrine for a number of years but prefers to practice OD, Terai area Nepal)

A few examples came to light where there were restrictions on people using latrines. For example, some women and girls living on the lake shore in **Malawi** were not allowed to use latrine during their menses, and in the far western areas of **Nepal** the practice of *Chhaupadi* still exists (although illegal) which restricts some girls or women from sleeping in the house during their menstrual period and using the same latrine as the family. In **Nepal**, there were also some examples where father and daughter-in-laws are not allowed to share latrines and some older people reported that they found it difficult to start using pour flush toilets. The team also visited a household in the Terai area of **Nepal** where the male head of the household had built a well-constructed brick latrine (although as of yet without a door). But it came to light that this was built specifically for the wife of his son so that she would not have to leave the house, i.e. would

remain in seclusion. The man, his elderly mother and other family members said they usually still go out for OD. The **Nepal** country programme noted that there are also significant differences in culture towards OD between people living in different ecological areas in **Nepal**, with people living in the Terai area of **Nepal** near the Indian border where the culture generally accepts and is not ashamed of the practice of OD. This is understood to be *'related to beliefs, values and norms about purity, pollution, caste and untouchability. Many people consider having and using a toilet ritually impure and polluting ... Open defecation is seen as a wholesome activity that is associated with health, strength and masculine vigour'*.[35]

UPGRADED TOILET PARTIALLY CONSTRUCTED WITH EXTERNAL DONOR FUNDS, FOLLOWING ODF DECLARATION. ©SUZANNE FERRON

Rose (above) lives on her own and can't remember how old she is, but others thought she must be over eighty years old. She remembers going to the triggering but can't remember what happened exactly as it was a long time ago. The VDC members constructed a toilet for her a few months ago. (**Malawi**)

Diamirou is 75 years old and he had a stroke a few years ago and now he can't walk. He also has arthritis and cataracts and cannot see very well. He has pain in his shoulder and his skin feels very sensitive, so that often he can't even wear clothes as they make his body feel like it is burning. He can transfer from his bed to the bucket shown in this picture (potty), but he often has constipation and finds it very uncomfortable to balance on. (**Senegal**)

35 The South Asia Collective (2016)

7.5.4 People who have slipped through the net or where support is delayed

A range of people who are vulnerable or marginalized were seen to have 'slipped through the net' or their needs have been overlooked in different ways. For example, where older people including those with disabilities are still digging and burying even in communities that are ODF or awaiting verification (see **Section 6.6.4**); older people who have been supported with latrines but a long time after the triggering had happened; and people who are not able to use the latrines because of a disability or mobility problem and hence are either defecating on the floor or into a bucket without the assistance of a commode chair, which is uncomfortable and difficult. See the boxes on the left.

7.5.5 Institutional and public sanitation

The provision of institutional latrines and public latrines is very relevant to EQND. The lack of public toilets particularly affects women and girls, people living on the streets and people who are sexual and gender minorities (SGMs). The lack of adequate toilets in schools is also understood to affect girls' attendance, whether for parts of days or whole days, particularly during their menstrual period.

SLTS – Some countries noted that they undertook School Led Total Sanitation (SLTS), but the team did not establish if this is full SLTS, where the school is the starting point for influencing the community to change its practices, or simply involved school based activities such as hygiene clubs. Most children met said they had not attended the mass triggering event in their communities as they were in school at the time, but they understood good and bad hygiene practices and confirmed that they learnt about these in school.

National ODF criteria – **Ethiopia**, **Togo**, **Nigeria** and **Nepal** all include various combinations of institutional (schools, offices, health centres, places of worship) and public latrines (markets) in their first phase ODF criteria. **Ethiopia** is the only country which specifically requires public latrines for the use of travellers and in public gatherings in its first phase ODF criteria. **Malawi** includes religious institutions, market centres and health centres in Level 2 ODF, but at present **Senegal** does not include institutional sanitation in either its ODF or post-ODF stages. See **Annex VI** for more information.

Infrastructure – GSF does not fund infrastructure for institutional latrines, including schools, although it was reported in various contexts that other international partners supporting CLTS do. GSF-supported programmes instead report that they facilitate discussions on the need for funding for institutional sanitation with communities and governments as the main duty bearers. One case study was shared where the community in **Malawi** built toilets for a school (see box below) and a health facility staff member in **Nigeria** reported that she had previously lived in a community that had also built a traditional latrine for the health centre's use. The team did not visit many institutions, but a number of gaps were apparent in the few visited. A number of respondents across countries noted that it is now more common for gender-friendly and sometimes accessible latrines to be built in schools.[36]

It was reported that in one community in Balaka District, **Malawi**, children started demanding their community build toilets and they found out that in one school there was no toilet. They arranged a meeting with the children and school management and gave the parents a deadline for building the toilets and it was reported that they built one within 9 days. (by an IP representative)

A school visited in **Malawi** that has 1,000 pupils only had two blocks of two latrines – two cubicles for girls and two for boys. The latrines had no doors just with a spiral structure.

Adolescent girls said: "It is very difficult to manage our periods with so few facilities [at school]. We often ask the teacher's permission to go home".

A school was visited in an ODF village in **Nigeria** that is in an area that has been affected by conflict. There are currently 112 students (many others have left due to the conflict). The school has a latrine block but it is currently being used by the military that are stationed at the school and so is off-limits for the students. They therefore have no toilet that they can use at school.

Another school in **Nigeria** (in a community that is not yet ODF) has 200 pupils and a latrine block with two separate sides. One side is kept locked and the other side is used by girls, boys and male and female teachers. It has two cubicles inside the side that is being used, but is locked and pupils have to ask for the key (reported to be kept in each classroom) before use.

36 But as the GSF-supported programmes do not fund infrastructure, these examples are likely have been funded from other sources.

Health posts – One health post and birthing centre visited in **Nepal** had water in the birthing room and soap at the sink, but there were a number of infection control related issues. A filthy towel was hanging from the wall for drying hands and another on a bed, re-used rubber washing up gloves were hanging over a light and women had to walk outside to use the toilet. In another two health posts visited in **Nigeria**, one (in a village not yet ODF) there was no toilet available for use, although two were in the early stages of construction; and in another (in an ODF village), the facility had a flush toilet with water inside the facility for staff who reside on the premises, but the latrine outside the centre for use of patients and visitors was locked and the staff were not sure where the key was. They said they would have to bring water out for hand-washing if it was to be used.

Workplaces – The team only visited one workplace (other than health facilities), which was a brick factory in **Nepal**. The brick factories are temporary factories that are run for a few months of the year and tend to employ seasonal labour from Bihar in **India** and from the Western areas of **Nepal**. The brick factories tend to employ both adults and children and hence access by outsiders is often restricted, as child labour is illegal in **Nepal**. The conditions in the brick factory are very difficult, dusty and dangerous and people live in makeshift shelters on the site. The owner of the facility visited had recently taken over the factory and had built a new latrine block. Another block of two toilets also existed, but the block was in a poor state of repair and both blocks were very dirty with faeces piled up in the pour flush pans. It is very likely that OD is also still occurring outside the boundary of the factory. The owner noted that some effort had been made to get the workers to use the latrines and CCTV has been installed partly to monitor this; but it was clear from the state of the latrines that the users did not know how to use the facilities and no maintenance systems had been established. There are over 50 seasonal brick factories in this one district and hundreds more across other districts in **Nepal**. The GSF-supported programme teams have had mixed success in working with the owners of the brick factories, with one case study shared from another district where the programme had succeeded in gaining access and influencing change; but others reported they had not even been given permission to enter. The brick factory visited was in a district that had been ODF before the earthquake. The visit highlighted the challenge of ensuring effective institutional sanitation, in particular in private workplaces, which may be an overlooked area for the declaration of whole ODF districts. It also highlighted the vulnerability of people working in low paid, dangerous and marginalized jobs and workplaces where the basics such as sanitation are more likely to be overlooked.

Public institutions and government offices – As a sub-set of workplaces, it is important to also highlight the need for appropriate and accessible toilets in public institutions and government offices that are open to the public and have soap and water available. This is particularly important when the government is leading the campaign to stop open defecation. See example in box.

> A senior local government area (LGA) leader and champion of the CLTS process in her district shared the embarrassment that was felt when they started the CLTS campaign; when communities reported to the LGA that an LGA office did not have toilets and staff were seen relieving themselves behind the building. (Nigeria)

Public latrines – The lack of public latrines also came up on a regular basis during the visits. The only country visited where the GSF-supported programme has been facilitating the construction of public latrines was **Ethiopia**. The lack of appropriate, accessible and gender-appropriate public latrines, were highlighted as being particular issues for:

- People living on the streets, who are highly vulnerable, who have no-where to go to the toilet or bathe.
- People from sexual and gender minorities, particular people who are transgender or intersex, who may face abuse or harassment when using latrines, which are split only by male or female. See **Section 7.6.7**.
- People with disabilities who may struggle to use a latrine that is not designed to be accessible or user friendly (cubicles too small, nowhere to hang bags etc.) and people who are sight impaired, who are not able to see soiled or unhygienic facilities.
- Women and girls who have to withhold urination and defecation when there are no public facilities.

Comment: Gaps related to institutional latrines and particularly those for schools, health facilities, for public use and in workplaces, are issues that need further consideration and attention as part of the GSF-supported programmes.

7.5.6 Handwashing, menstrual hygiene, incontinence and broader sanitation

As previously highlighted most government strategies have incorporated a handwashing indicator into the ODF criteria although what is expected varies between countries, with some expecting handwashing facilities with soap (or an alternative) next to every latrine, and others considering that the presence of soap in the household or next to the latrine is an adequate indicator.

In **Malawi**, tippy taps with water and soap or ash as well as latrine covers were present at the majority of latrines visited and appeared to be in use. Activities with school children and youth seemed to confirm this fact although it was claimed that it was difficult in some villages off the beaten track, to convince people to construct, use and maintain handwashing facilities. In **Senegal**, a tippy tap or just soap was also seen to be present at the majority of latrines. In some areas, it was said that the water in tippy taps becomes too hot to use for handwashing and so handwashing facilities are not always appropriate. Schoolchildren seemed to confirm the presence of facilities or soap in most locations and this testimony was thought to be reliable as they were honest enough to admit that they did not always wash their hands before eating. In **Nepal** handwashing facilities were not so obvious outside latrines, although most latrines had water inside the latrine for anal cleansing and soap was visible in the doors of some latrines.

In **Senegal** menstrual hygiene management (MHM) has been promoted with significant success. Training for IP staff and various community members has led to visible changes in practice with women feeling able to dry their sanitary towels in the sun and men talking openly and supportively about menstrual hygiene. The **Nepal** sustainability study (2016 draft) looks at menstrual hygiene practices and challenges and girls reported being taught about it in school; and in **Ethiopia** the government has developed a menstrual hygiene policy and implementation guideline[37] but menstrual hygiene has not yet been integrated into the GSF-supported CLTSH programme.

There does not appear to have been a focus on sanitation and hygiene for people who are incontinent. The team met an old man who was bedbound whose room / bedding smelt of urine; and people said that usually relatives or elders take people who are bed bound to the toilet and clean their sheets. Some people, in **Malawi** said that it is possible to get gloves from the clinic if caring for someone who is incontinent. Some talked about using a 'can' as a bed pan and a range of people described how they used buckets, which were uncomfortable and difficult to use. A health facility in **Nigeria** showed the team a plastic bed pan that is used in the facility. See photo in **Annex X**.

Environmental clean ups had also been incorporated as part of the sanitation effort in **Senegal** and **Nepal** is now moving on to post-ODF Total Sanitation in the ODF Districts, which includes environmental and personal hygiene as well as water safety.

Comment: If GSF is to reach all and in particularly the most vulnerable, the issue of incontinence is one that needs further attention and integration into the programme. See also Section 9.6.

7.5.7 Disasters and conflicts

During the six country visits the team visited areas that had been affected by a major earthquake (**Nepal**), conflicts and displacement (**Nigeria**); and also heard about a number of places affected by flooding (**Malawi** and **Nigeria**). It is clear that the impact of natural disasters requires flexibility and modification to programme practices.

In **Malawi** one IP shared data from one of their programme areas, where there were a total of 26,827 household latrines, but where 8,629 had collapsed in 2015 due to flooding. The team visited an area in **Nigeria** where people had been displaced due to conflicts when their villages were attacked. People left their homes and communities and new people arrived in other villages. This posed a challenge in maintaining ODF status as latrines had been abandoned and sometimes people only returned years later. New arrivals, who had been displaced from their own homes, had also not always been exposed previously to CLTS and sometimes there were also language challenges, as they may speak other languages. In some places, NLs emerged and organized themselves into CCs and the EA encouraged the LGA (large grantees) to provide further (practical) training and allow them to trigger communities, especially in hard to reach areas. Community Consultants have been helpful in support-

37 Federal Democratic Republic of Ethiopia, FMoH (2016, final draft).

ing progress in villages which were in conflict affected areas where the IPs were unable to travel.[38]

The team also visited three districts in **Nepal** that had been affected by the major earthquake in 2015, which affected 14 Districts and destroyed an estimated 600,000 homes and 300,000 toilets; 20-30 percent of which it was estimated needed to be reconstructed. It was reported that only 5,000 were re-built with humanitarian support. One mountainous district, Rasuwa, had been very badly affected. Some villages were completely destroyed and some communities have not been allowed to remain due to the instability of the mountains.

A major challenge in the earthquake-affected areas was the influx of humanitarian actors who provided subsidy of differing degrees, which then distorted the ability of the programme to utilize a non-subsidy approach. However, it could be argued that this support was needed and appreciated by communities, and could be considered like a form of 'insurance'. Many had lost their homes and toilets; some had lost their cattle and assets, some their livelihoods and some also lost family members. In addition, there was an increase in the number of people with disabilities following the earthquake (in one village the number of people with disabilities increased from 18 to 30 and in another village from 12 to 60-65).

There are also people still living in temporary accommodation such as camps and also in temporary homes as they have not yet been told where they can reconstruct. This poses challenges for households to construct permanent latrines. Households have been permitted to share during this period.

The GSF-supported programme pulled out of two districts where the influx of humanitarian actors was too high and provided co-ordination support to the government in other districts, starting the programme a few months after the earthquake. Two villages were visited in the mountainous area and the team met triggerers from four villages, two of which have become ODF and two are working towards this status. The triggerers in two villages had managed, together with the community leadership and support of the IPs, to convince people to rebuild their latrines without subsidy despite most of them having been damaged or destroyed during the earthquake. The people in these two communities were reported to have re-built their toilets before their homes. When asked why, one old woman said, *"because it's natural – we have to go to the toilet!"*

Comment: It is clear that working in disaster vulnerable areas requires a modified approach from the usual GSF-supported programme; with particular flexibility to understand the programme risks and likely impact on outcomes and adapting to the changing situation and providing ongoing support outside of the original plan. It has been noted that GSF has been flexible in this regard and is encouraged to continue to be so.

7.5.8 Urban areas

Particular issues that are likely to be important in urban areas related to people who may be disadvantaged include: renting of accommodation and no power to make landlords construct latrines; over-crowded high density areas with no space to build latrines; lack of land tenancy; costs of emptying latrines; vulnerable and marginalized groups being 'hidden' within programme areas (such as people living on the streets; people in low paid employment; sexual and gender minorities – all discussed in other sections). Also the lack of local materials makes construction more difficult.

7.6 FINDINGS FOR SPECIFIC GROUPS

As many of the issues for specific groups have been discussed elsewhere in the report, this section just summarizes key issues and provides details where the issues have not been discussed elsewhere.

7.6.1 Involving people with disabilities and challenges with accessibility

Whilst there are numerous examples of how people with disabilities had been supported in the study, the household visits revealed that few toilets had adaptations for people with disabilities or mobility constraints. The cost of such adaptations is often perceived to be high, when in fact there are numerous low cost options and ideas available. A limited number of adaptations, such as a slightly raised seats and chairs with holes in or commode chairs were seen: another adaptation was to use bricks on either side of the squat hole. Some households had also raised

38 https://www.globalcitizen.org/en/content/championing-clts-in-conflict-affected-communities/

the seat with compacted soil around the squat hole or squatting pan.

In most cases these had been self-initiated by the user or household and not from pro-active discussions facilitated by the GSF-supported programme. This could be argued is in line with CLTS philosophy; but the gap in facilitation has resulted in many people with disability or mobility limitations not having access to accessible toilets. Most communities and agency staff seemed unaware of the range of modifications available. Occasional examples were seen where individual IPs had made an effort to facilitate discussions on options, such as in **Malawi**, and also other partners who had experience of responding to accessibility through their work with other organizations such as WaterAid, but it wasn't clear that this knowledge had been capitalized on by the GSF-supported programmes. In **Senegal**, some masons had experimented with adaptations, but we believe that this was not included in their training from the GSF-supported programme,[39] and the initial model tried was not yet successful.

People were often obliged to either sit on the floor of the latrine or to try and balance on an uncomfortable bucket. If they needed to balance on a bucket they would usually need someone to support them and were thus denied privacy when using the toilet. Some complained of constipation – partly because they avoided going to the toilet as it was so undignified. One young person in a wheelchair was unable to enter the latrine as the doorway was not wide enough. He was obliged to struggle to use a potty placed on the floor outside instead – an embarrassing situation for an adolescent.

> An IP shared how they facilitated discussions with a man and his two wives, all of whom are deaf, by writing on paper. (Gwer East LGA, Cross River State, Nigeria)

People with visual impairments reported using a variety of methods to find the latrine such as: depending on a (often very young) family member to guide them; holding onto a pole, using a stick; using a guide rope or string hung between the house and the latrine. One woman shared how she put her shoes on her hands to be able to locate the latrine. Slightly raising the edges of the seat was also a method used to help people with visual impairments to be more easily locate the seat. A few latrines were also seen with larger than normal sized squat holes to prevent soiling. See the images below and more examples in **Annex X**.

As discussed elsewhere in the report, people with disabilities and mobility limitations are less likely to attend and participate in the triggering event than other community members and less likely to speak when there. Only a few CLTS facilitators said they make a particular effort to make sure that people with disabilities or mobility limitations attend the triggering. Representatives from disabled persons organizations, encouraged that GSF should ensure that it's IEC is also accessible for people who are hearing impaired, such as through including sign language. The **India** programme noted that it has been working to ensure that their IEC was more accessible. The team did not see examples, but it would be positive for the **India** programme to share its experiences with other country programmes.

7.6.2 Gender issues

In all the programmes visited women were active as Natural Leaders, on WASH Committees and many examples were shared with the team of women who have become sanitation champions in their communities. In most programmes, roughly equal numbers of men and women were Natural Leaders. However, it was noted in **Malawi**, **Nepal** and **Senegal** that men still often made the decisions about household expenditure on sanitation. For instance in **Nepal**, wives or daughters had to call husbands or fathers who were working overseas to get permission to construct a latrine and to check the design and how much to spend; although adolescent girls met in one area of **Nepal** said that their families discussed together when deciding on constructing a toilet.

In **Malawi** and **Senegal** working age men's limited attendance at triggering does not seem to have prevented achievement of ODF and there is usually at least some male representation from leaders. However, whilst we have no conclusive evidence one way or the other, it is possible that men who don't attend are less convinced by the arguments for ODF and hand washing but comply in the short term because of pressure from the leadership. Women questioned felt they were able to convince their husbands who had not come to the triggering to engage in building and using latrines and men also claimed to be engaged in the process. It may be worth investigating further to understand the differential impact this might have.

39 This would need confirming with the Senegal programme.

The **Senegal** programme has focused on women's empowerment and has provided training in soap making for women's groups to improve access to soap but also in the expectation that this will provide an income generating potential for the women in these groups. Women in **Senegal** also run the community solidarity funds (that have been set up to support sanitation for disadvantaged families). The membership is exclusively women – although there is often some oversight from key male community leaders. The village savings and loan group met in **Malawi** was also women only.

In the north of **Nigeria** (outside of the GSF-supported programme area – shared by a PCM member) and in Tigray and Afar in **Ethiopia**, the CLTS process is facilitated separately for women and men, because of the difficulties of the two groups meeting together and women not being able to speak openly in front of men. *"Due to religious and cultural barriers, women lack assertiveness, particularly in public settings. As a result, we organize separate session for women"* ... *"In the rare occasions when they speak [in front of men], it is perceived as going against the culture. They are expected to be shy and thus they prefer to keep silent"*. (**Ethiopia**)

A very old woman who is also blind can squat but she finds it difficult to hit a standard sized hole. This hole has therefore been made larger by her son who built the latrine for her. (**Nigeria**)

Slightly raised latrine hole that can be sat on or squatted over, constructed for N'ingmayo who is visually impaired. It helps her position herself over the drophole (**Togo**)

Wooden toilet chair made for Ram who is unable to walk, using wood provided by a Forest Users Group (**Nepal**)

Comode chair and walking stick with four prongs used to get to the chair, purchased from the hospital by Bishu and her family after she had a stroke (**Nepal**)

Plastic pre-formed toilet chair with a chute brought in the local market (**Nepal**)

In **Togo**, it is quite common for households sharing a compound to build two latrines, one for females and one for males. In polygamous households in **Togo**, it was reported to be common for different latrines built for each of the wives and their respective children.

Women in **Nepal** stressed problems of not being able to squat when pregnant and that even hospital latrines in major cities such as Kathmandu were not designed to be accessible. One other issue that would be useful to investigate further is how support can be given for women who want to take on leadership / active roles but are breastfeeding. This issue was raised as a challenge faced in her work by a female CLTS facilitator. She has a supportive husband who enabled her to breastfeed while she was working in her own village, by taking their child to her, but it may be more of a challenge for others who do not have such supportive families.

Ideal latrine drawn by a group of adolescent girls in **Malawi**, with door, water, washing room and drying line

Male youth group met in **Malawi**

7.6.3 Older people

Much has been said on older people elsewhere in the report on and the challenges they can face in accessing sanitation. It is clear that older people who have no-one to support them are some of the most vulnerable people within communities and those that are least likely to be able to construct and access latrines on their own. If being older is also coupled with a disability such as sight loss or mobility problems, the challenges they face become even greater. They should be a key target group for the programme to ensure their participation and engagement and for support when considering EQND. Older people also reported it more likely to use makeshift arrangements for toilets at night.

7.6.4 Youth and adolescent girls

The interpretation of 'youth' can be very varied and is often used to refer to someone who is not yet married rather than someone under a certain age. The team met several groups of adolescent girls and also met with male youth in a few contexts.

Adolescent girls were able to place latrines and options for defection into an accurate 'sanitation ladder' during an exercise run in some FGDs. It was interesting to see in one village visited in **Nigeria** the lack of doors on latrines and for some latrines in a village visited in **Ethiopia** that the toilets either had thin walls that could be seen through, or the door flap was not to the ground. This meant that the users lower body would be visible under the door when they squat. The users, including women, said that they were comfortable to use the latrines, including in the day, but this is quite surprising. Drawing exercises and discussions with adolescent girls indicated that a door on a latrine is important, including in locations where it was not common to have doors on latrines such as in some villages in **Nigeria**. This is an area that needs further investigation.

Managing menstruation at school was said to be difficult where latrines were not adequate. The girls highly appreciated having latrines in their houses, which enable them to go whenever they needed rather than having to wait until after dark and having to go in groups.

Youth, both male and female were often involved in promoting ODF and supporting others to dig or build latrines. However, it was reported in **Malawi** and **Senegal** that many working age youth did not attend the triggering. In some villages in **Senegal** the youth needed significant convincing that the CLTS pro-

A temporary household latrine in Rasuwa, **Nepal**, shared by two families after the devastating earthquake. Next to the latrine is a child's potty.

Two children's 'mini latrines' in **Nigeria**. The lower one (which is raised from ground level) was constructed by Margaret, a member of the WASHCom.

gramme concerned them also. In **Malawi**, a group of older women also lamented that young people these days no longer want to support their elders and do voluntary work and did not feel they could ask their grand-children to help other neighbours. In **Nigeria** youth sometimes undertook an enforcing role.

7.6.5 Babies and children

Women in several villages in **Malawi** explained how they usually allow young children to defecate in the open but will then use a hoe to pick it up and dispose of in the latrine. The numbers of potties for children in **Senegal** is said to have increased significantly due to the GSF-supported programme. In some families, each child has their own potty and these come in different sizes. Women in one village in **Senegal** explained how they attempt to potty train at a very young age even before bowel control is achieved and a very small potty is often held under the bottom even of a baby who is breastfeeding to get them used to the sensation.

In **Nepal**, several examples were seen of children's potties being placed immediately outside of a latrine, presumably to get the child used to the idea of going to the latrine to defecate. In **Nigeria**, a wonderful idea has been developed to construct children's mini latrines, which are the same as adult latrines in superstructure but do not have a pit, only a bucket under the hole. This is to reduce fear and risks of a child falling into the pit. Even the young children present indicated that they use the mini latrine.

Boys and girls taking part in an FGD in **Nigeria**, noted that they were confident to use their household latrine during the day; but a number of girls said they were frightened to use it at night.

7.6.6 Marginalized, minority or excluded groups

A number of marginalized and minority groups were identified during the process who may be overlooked by programmes or in some cases not acknowledged. Examples of these included:

Sex workers and drug users – In **Nigeria** some sex workers and marijuana smokers have also become Natural Leaders once their enthusiasm and influence within their own marginalized communities and outside was recognized.

Employees of brick factories (including children) – The situation of children and adults working in low

paid, dusty and dangerous work environments as highlighted by the seasonal brick factories in **Nepal**, has been discussed in **Section 7.5.5** on institutional sanitation. People working in dangerous, informal and sometimes illegal employment may be particularly difficult to identify and engage in sanitation programmes, with challenges in ensuring that employers undertake their responsibilities towards their employees.

Migrants and foreign labourers – Migrants and foreign labourers were mentioned in a number of country contexts. In **Togo**, it was explained that they often live on the land of their employer and live in precarious shelters (as described in the brick factories). As they often do not settle, this becomes an obstacle to them building a latrine. People may also not have been present during the triggering.

Pastoralists – The challenge of convincing pastoral communities to stop OD was raised in **Ethiopia** and **Togo**, particularly because of the wide spaces in which they travel; but which can also have impacts on OD status of communities to which they migrate. A respondent in **Togo** shared: *"We have examples of villages where Peuls [pastoralists] are settling and the chief is telling them: "either you settle and install a latrine or you don't come". When there is a big group of Peuls, we seek to work with their chief first and to build on his success as he becomes a model"*. Another respondent described how they sometimes bring Peul leaders living in cities to come and resolve the conflicts that can occur between Peuls and settled communities over the practice of OD and that usually communities manage to find common ground and they agree to build latrines.

People who have albinism – People who have albinism can be highly vulnerable to violence and death from people who wish to take their body parts for witchcraft.[40] People with albinism were mentioned as a vulnerable group in **Senegal**, but no specific case studies were highlighted. However, as people with albinism are extremely vulnerable people in a number of countries in Africa (East Africa and **Tanzania** and **Malawi** in particular), the GSF-supported programme should consider their needs in relation to sanitation. It is particularly important that they have household and school latrines that will mean they do not have to walk far from where other people are present, as a protection measure.

People living on the streets, orphanages and day centres – People living on the streets was discussed in **Nepal**, but also applies to other contexts and will be increasingly important to consider as CLTS programmes move into urban areas. In **Nepal**, the government is making an effort to keep children from the streets and place them in hostel/hotel accommodation, but youth and adults still remain, some living in tents and basic shelters. It is very difficult for them to access to water, toilets and facilities where they can bathe, particularly, because there are so few public toilets and facilities open to the public and the few that are available have a charge to use. People on the streets faced high level of harassment and violence and managing menstruation is very difficult for women and girls. This issue seems to be an overlooked issue even in ODF districts. In **Senegal** one example was shared of a Koranic school which taught children who live on the street and provided toilets for their use.

Women and girls with fistula – In **Senegal**, **Malawi**, **Ethiopia**, **Togo** and elsewhere some women and girls can be affected by fistula where a hole forms between the vagina and the anus or the vagina and the urethra, leading to constant leaking of urine or faeces. This is sometimes caused by childbirth and related to practices of early childhood marriage and female genital mutilation/cutting (FGM/C). This consequently leads to severe incontinence and women and girls who are affected are often rejected by their communities and forced to live separately as they find it difficult to manage their incontinence effectively and to prevent the associated urine smell. The issue of fistula and women being excluded came up a few times during the country visits, although the availability of operations also seems to be more common. Field workers may be nervous about broaching such issues, but should be aware of them and should try to facilitate a response to each individual's specific sanitation and hygiene needs.

Domestic workers, slaves and people living in slave like conditions – The issue of a community with masters and slaves came up in one country visit, where it was noted that particular effort had to be made to trigger both groups and for the masters to understand the importance of everyone stopping OD. The consultants have also come across this issue before in other contexts (in West Africa), and confirm that it is still a current issue, even if limited in scale and location. It was also confirmed that in some places domestic workers are not always able to use the latrine of their employer, so this is also an area for attention when triggering.

40 Herijnen, T . V . Ritchei, S, Eaton, J . (2016).

7.6.7 Sexual and gender minorities

People who are SGMs are often highly discriminated against and face multiple challenges to attain their rights. They often face violence and exclusion and may be ostracised by their families. They may have faced discrimination at school, affecting their education, often find it difficult to obtain an income, as it is difficult to get and retain employment, and they may face difficulties getting accommodation due to prejudices of landlords which can in turn lead to them becoming homeless. They may also face difficulties in getting loans, particularly if their identity is different to that on their ID card or they need co-signers, which is difficult for those who have been excluded from their families.

Importance for sanitation and hygiene:

- People who are SGMs and in particular people who are transgender or intersex, may face bullying or harassment when using 'gender-binary' toilets, i.e. male or female specific; and so they may avoid drinking or eating when on long journeys or in public so as to not to have to use a public toilet.

- Transgender people often end up migrating to cities after being excluded and may live with other trans-people, sometimes in crowded accommodation, with several people living in one room. They may have limited power over landlords to ensure appropriate sanitation and limited purchasing power to have a latrine constructed.

- SGM people may face a range of challenges receiving humanitarian aid during times of disaster, related to their ID card not being the same as their identity, being frightened to queue up in public places, not being part of what is considered a traditional family structure, on the basis of which aid is sometimes distributed, and there may only be male and female toilets available.

- People who are SGMs may also work for the EA, IP and other partners, but because of risks of harassment and discrimination and a lack of clear policy on inclusion, may be uncomfortable to disclose their status to others or face harassment and bullying.

The majority of respondents of the online survey indicated they are not confident in working with people who are SGM and there is a level of nervousness about this issue, although when the issue did come up or was discussed, the team found respondents were interested to discuss and to learn how to work in a respectful manner. The nervousness is partly because some countries have criminalised same sex relationships. It is useful to note however that even where laws do or do not exist, that the social experience of people who are SGMs, can vary based on political, social, cultural, ethnic and religious factors.[41]

See **Section 9.3** for discussion and **Section 10-R4** for recommendations related to SGMs.

7.6.8 People with mental health conditions

During the EQND study visits, the issue of people with mental health conditions came up a number of times, as a challenge for facilitators, particularly where the person was not able to understand or stop open defecation. CLTS facilitators shared their approaches and approaches they have seen for addressing challenges associated with individuals with mental health conditions. Some examples include:

1. A person was banished from a community because they could not stop him practicing OD.

2. Natural Leaders found shit at the house of a woman with mental health issues. Neighbours wouldn't let her use their toilet. A CLTS facilitator told her that if she built a toilet he would marry her and he gives her a small sum of money each time he sees her. Now she uses the latrine every time.

3. A Natural Leader persuaded one person with mental health conditions to use a latrine by saying that if he doesn't he won't be able to have a child. The Natural Leader, together with the community, found a woman (also with mental health issues) for him to marry provided he kept using a latrine. They now have a child.

4. In an ODF village there was a mentally ill man who had his own toilet but who could not help defecating in the open. The community therefore had to organize a sort of vigilance or sentinel on a rota basis to prevent this from reoccurring [although it was not specified what this entailed].

5. In addition, people with addictions to drugs and alcohol, whose cognitive reasoning may be impaired, can also need additional support in the CLTS pro-

41 West, S (no date)

cess. A facilitator said a young marijuana user refused to build or use a latrine. He was eventually persuaded to build a good quality latrine by the facilitator saying that his shit could be used for magic if it is left in the open.

In relation to the examples above on the previous page, the intentions were positive, trying to find inventive ways to encourage the person to stop OD. But unintentionally a number of the actions were risking or abusing a number of other rights. In the first example, it wasn't clear how long the banishment was for or if it was just for each ODF validation day, but people should be entitled to a safety and security at home; and when the man returned to the community he would probably still be practicing OD, which would still jeopardise the ODF status and health of the community. In relation to the example where the facilitator said he would marry the girl, the facilitator's intention was to find a positive way to persuade the woman to stop OD. But it needs to be recognized that people with mental health problems are particularly vulnerable to sexual and other abuse, so guidance is clearly needed to ensure that nobody is put at risk. For the third example, it is not known whether the new wife of the man was willing to marry him, but this example puts her rights at risk if she has no say in the situation. For the fifth example, the team found an innovative way to convince the young man to build a latrine in line with common local beliefs, but there was some concern raised by other colleagues that if the man found the argument was made up, he may have become angry. Hence the team then continued to build a relationship with him, to prevent this happening.

For a divorced man who has a mental health condition, we triggered the smallest child (13 year old son) and he triggered his father … I suggested to the Village Development Committee that they should provide a pan and pipe to the family and also tried to persuade the community to support them. But the father refused the support and said he would collect stone and build it himself."

(One young female facilitator in the mountainous district of Rasuwa, Saroswoti, said she uses the strategy to trigger the parents or children who then trigger the person with mental health conditions. The facilitator knew that the people closest to the person with mental health conditions are those most likely to be able to convince and support them.)

In addition, it was clear when the team started to specifically ask to meet particularly vulnerable or disadvantaged households, it was found that people with mental health conditions are often considered disadvantaged. This particularly relates to the situation where the person who may otherwise be a key income earner has a mental health condition; or they have to care for someone with a mental health condition, both of which prevent or limit them from earning an income. A range of families met who were clearly very poor and vulnerable had people with mental health conditions within them, some of whom were still being pressurised to build a latrine over long periods of time, when they clearly did not have the resources and when they were also entitled to support (see **Section 7.4.2** and **Annex IX**).

However, the example highlighted in the box above shows how CLTS has also been used to build pride and contribute to the inclusion and empowerment of people with mental health conditions, which shows that the process to ODF also offers opportunities.

DEVELOPING A COMMUNITY ACTION PLAN TO ACHIEVE AND SUSTAIN OPEN DEFECATION FREE STATUS. ©WSSCC

8

FINDINGS – GSF: MONITORING, EVALUATION AND LEARNING

8.1 DATA COLLECTION – UNDERTAKEN BY COMMUNITIES / WITH SUPPORT OF IPS

8.1.1 Community EQND-related data collection through household register

For some of the countries visited, the team requested to see the record keeping at community level to understand what information is being collected, the level of disaggregation and how the information is being used. Some disaggregated data is being collected by the CLTS facilitators / triggerers, community based health extension workers, Natural Leaders or others, but there is quite a variation in the amount and type of data being collected. In **Malawi**, the household register record book of a Health Surveillance Assistant (HSA) included disaggregation by gender and age, and updates on sanitation and hygiene facility status, but nothing on disability or likelihood of needing support. In **Nepal**, it was noted several times that the Village Development Committee (VDC) and the Village WASH Coordination Committee (V-WASH-CC) have detailed data, but the team were not able to view any.[42] The data collated by two triggerers (CLTS facilitators) was written by hand in their notebooks and included a summary of data on female headed households; people with disabilities and Dalits; as well as the number of people with disabilities before and after the earthquake. Standard formats for collection of data and

42 It was not clear if this was because it did not exist or if the team just did not put enough time into following up.

data tracking were not very common and only one IP was able to produce these. In this instance, data was disaggregated by household and included a column for female-headed households and 'backwards/ marginalized groups'. In addition, a standard format for post ODF progress was also seen. In **Nigeria**, some disaggregated data was being collected by some WASHComs – which included disaggregation by gender and age as well as a column for persons with disabilities and another for the 'disadvantaged'.

It was suggested that those responsible for completing the household registers may sometimes avoid completing columns related to potentially disadvantaged groups, as doing so would make them responsible for facilitating the support, which would require a big-time commitment. Recognising that most people undertaking this activity are volunteers and not paid and have their own family and income generating responsibilities, this could be a risk for going forward. In **Nigeria**, the IPs, CLTS facilitators and Natural Leaders are also tracking involvement of people from some disadvantaged backgrounds in their triggering event reports.

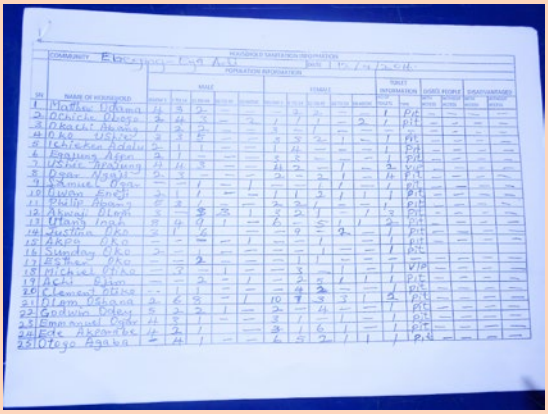
8.1.2 Record keeping during follow-up

Some of the record keeping noted above is being used for recording follow-up and in particular updating the status of the latrine, the latrine cover and hand-washing facility by household. But no specific lists were physically seen of the people who might need support and the specific follow up that had been done. This does not mean that such lists do not exist in some countries or communities, but it does not appear to be common practice. In **Togo**, where a few new EQND-related indicators were identified in October 2016, one person noted that *"There is some work that we have done in our organization to update the database of vulnerable people in our zone of intervention to measure the extent to which they have benefitted from the programme"*, but the team did not ask to physically see the database.

In **Ethiopia**, the 'Field monitoring of ESHIP (June 2016)' includes some EQND-related questions:

- What mechanisms are employed to identify the vulnerable group?
- How are issues of sanitation facilities construction for the poor and vulnerable handled?
- What are the gender specific WASH issues and how are [these] handled?

WASHCom monitoring form on household sanitation form with disaggregation by gender, age, disabled people and disadvantaged (Nigeria)



©S. HOUSE

Natural Leaders with their household register with disaggregated gender and age data by household and updates on latrine and hand-washing facility status (Malawi)

©S. HOUSE

Comment: The household registers that have been developed by a variety of community based stakeholders, CLTS facilitators and / or IP representatives are useful tools. The efforts to start to disaggregate data at this level are also positive. However, with increased guidance and support they could also become an even more useful tool for identifying and tracking the progress for people who may be disadvantaged. See Section 9.9.

8.2 DATA COLLECTION – UNDERTAKEN BY EXTERNAL STAKEHOLDERS

8.2.1 Baseline study and outcome evaluations

Some countries have occasionally included EQND-related indicators in their baseline and outcome evaluations, but the quality and depth of the analysis varies.

The baseline data study in **Nepal** included considerations of EQND related to access for particular marginalized groups, analysis of school toilets by gender and cultural barriers. In **Nigeria**, the baseline study (2014) included data on people with disabilities and some disaggregation by gender. It noted: *'The studies recorded 335 physically challenged or disabled persons in the six LGAs. The proportion of the disabled that practiced OD was 75 percent of the population'*; which compared with 68.4 percent in the wider population.

In **Kenya**, baseline data has been collected to determine estimates of disadvantaged (in terms access and use of sanitation and hygiene facilities) people in each sub county, and the extent of vulnerability based on physical disability, age and illnesses including chronic illnesses and infection where discrimination and stigmatization features. The M&E system diagnosis (2015)[43] also notes that some outcome surveys (**Madagascar**, **Cambodia** and **India**) have included analysis of data disaggregated by wealth quintile.

Comment: Increased guidance from GSF on the EQND-related questions and considerations to be integrated into the externally supported Baseline and Outcome evaluations would resolve the inconsistencies and gaps in the qualitative and quantitative data being produced in some programmes. It is understood that the provision of more guidance on EQND requirements in these studies is already in process.

8.3 INDICATORS

The WSSCC's 2012-2016 Medium-Term Strategic Plan includes equity as one of five key outcomes. Outcome 2 states: *"Among those who gain access, poor and marginalized people and groups are identified and preferentially supported"*. The GSF Results Framework also has a specific output and two indicators related to EQND, one of which is included in the GSF priority indicators:

- Output 1.3: *"All members of project communities benefit from project interventions in an equitable manner"*
- Generic indicators: 1.3.1. *"percent of disadvantaged individuals living in households changing from open to fixed place defecation"*; and 1.3.2. (one of GSF's 12 priority indicators) *"percent of disadvantaged individuals living in households changing from open or fixed place defecation to use of improved sanitation facilities"*

In **Kenya** monitoring indicators include the following (with narrative monthly reports):

- Number of socially excluded populations supported to actively participate in S&H activities.
- Number of community structures supported to reach out to socially excluded groups.
- Number of Natural Leaders, NGOs, CSOs and Government personnel sensitized on equity and inclusion.

In **Senegal**, the team were not able see any data formats to verify how the data was collected, but disaggregated data was included in a presentation for a range of indicators:

- Data on number of people benefitting from specific trainings such as girls (8 to 15) and boys and men sensitised on MHM
- Data on accessibility of communities
- Data of displaced villages supported by the programme
- Data on people of disabilities registered by the census and integrated into the programme (presumably data taken from village census data in programme areas)
- Tracking of solidarity funds created
- Tracking of persons involved in activities – disaggregated by gender and age
- Tracking of women in leadership positions

43 Messina, M and Bostoen, K (2015)

> *We have started to collect data around these indicators, which is not always easy because it requires a lot of work from the field workers. The difficulty we have is that it would be good to have other indicators because certain widows are not vulnerable and thus there is a risk of generalisation."*
>
> A respondent from **Togo** highlighting one of the challenges with assessing vulnerability

In **Togo**, it was noted that there has not been a clear definition for EQND and also not a clear baseline. But in 2016 UNICEF facilitated about 1 day's discussion on EQND, including establishing indicators. These include:

- Number of vulnerable persons in the village
- Number of vulnerable persons having access to a latrine in ODF villages
- Number of persons in a situation of physical disability with access to a latrine in ODF villages
- Number of visually impaired persons having access to a latrine in ODF villages

The UMATA programme in **Tanzania** had also undertaken work to improve the EQND focus of its M&E system.

Comment: The global indicators focussing on the progress for people who are disadvantaged are useful and should be retained in a modified format. Increased guidance from the Global Secretariat on minimum requirements for data through the identification of common indicators, with more specific expectations on when they should be monitored, would also help to ensure EQND-related issues are not left behind. The team did not see enough evidence on how indicators were used to be able to comment on their value. For further discussion see Section 9.9 and Annex XIII.

8.4 REPORTING ON EQND

8.4.1 Reporting of qualitative information

A number of country quarterly or annual reports have included specific case studies related to EQND, such as the **Malawi** report where the introduction of child-friendly latrines was mentioned.

8.4.2 Reporting on quantitative data and disaggregation of data

In the responses to the on-line survey, the review of documentation and remote KIIs, most countries reported having some level of disaggregation of data, although it is clear that there is a lack of consistency and the disaggregated data is not reported upwards to GSF at the WSSCC Secretariat.

There is some inconsistency with the country reporting on the *'disadvantaged individuals'* indicators – whether they are reporting on it at all (even for the compulsory disadvantaged related indicator) and also a lack of clarity on the interpretation of the data. This is seen to be partly related to the level of uncertainty / confusion and variation in understanding what constitutes a *'disadvantaged individual'* and associated with the complexity of the factors that affect disadvantage.

In **Malawi**, the indicator on 'disadvantage' has not been reported on yet. They had been planning to report on it using the findings from a Knowledge Attitude Practice (KAP) survey, but this has been delayed by the work on the global M&E framework. In **Nepal**, the number of disadvantaged individuals supported is calculated as 5 percent of the total population supported. In **Nigeria**, there is some reporting on disadvantaged households in the quarterly reports but a 'disadvantaged individual' is taken to mean a person with someone with a disability. The **Nigeria** baseline study (redone in 2014) also has some data on people with disabilities and some mentions of gender, but otherwise is lacking in EQND-related data.

It was also observed that at least some IP/EAs may be collecting data by asking the CLTS facilitators or community representatives who have the household registers for their collated data, but without checking the data at ground level. In at least one case reporting in the narrative of the annual report has included cumulative figures for support given (i.e. covered the total number of those supported over multiple years rather than the year being reported on).

Comment: Increased guidance from the Global Secretariat on minimum requirements for data through the identification of common indicators as noted above would also help to ensure more consistency in reporting.

8.5 LEARNING

8.5.1 Learning on EQND across programmes

A number of positive examples of learning on EQND were identified across programmes.

The **Cambodia** programme funded a desk based study on the use of subsidies in sanitation with some references to EQND;[44] supported the process to develop an EQND strategic framework (see Section 6.2); and developed a Participatory Social Assessment Mapping (PSAM) tool as a mechanism for identifying the vulnerable (see **Section 6.6.4**).

The **Madagascar** programme undertook a small gender study; and developed the Follow-up MANDONA approach, which has integrated an increased focus on EQND. Refer to **Section 6.6.1** for more details.

GENDER STUDY, MADAGASCAR[45]

Madagascar conducted a gender study in 4 villages (2 GSF-supported, 2 control) and examined the following key issues:

1. Gender-linked engagement challenges in the CLTS approach
2. Gender-linkages in sanitation outcomes
3. Whether there is evidence that the intervention influenced empowerment of any gender

This study found that women participated less in meetings and were not as actively engaged in decision-making and triggering and that the CLTS approach does not adequately incorporate women's suggestions nor adequately address women's needs in devising solutions. However, the practical outcomes (in terms of access to toilets) were positive for both men and women and there was some evidence of women taking on leadership roles in the community.

The **India** programme carried out a field study on the link between lack of toilets and violence against women; and also research on access to toilets and Behaviour Change Communication (BCC) for people with disabilities.

In **Malawi**, some Implementing Partners have been working on ways to improve their consideration of EQND in their work. Useful learning outside the GSF-supported programme includes the 'CLTS plus' research[46] that has been undertaken in the GSF programme area to look at how to better train CLTS facilitators to consider disability into their work (see Section 4.1); and WaterAid have been training masons on accessible design.

The **Nepal** programme prepared a very useful case study document (2014) with a range of EQND-related case studies; and also included a range of useful EQND-related considerations in the sustainability study (draft, 2016),[47] including undertaking analysis of slippage and the provision of subsidies[48] by geographical area (which also aligns with cultural differences) and wealth quintiles.

The **Senegal** programme undertook two studies on MHM in two different regions[49] shedding light on some gender issues in WASH and resulting in programmatic changes. And the **Kenya** and **Nepal** programmes have participated in a WSSCC training on MHM.

Comments: The initiation of EQND-related studies supported by GSF-supported programmes is encouraging. There is much to learn in this area, so continuation and expansion of this practice should be encouraged. In particular, when there is the opportunity to include EQND-related indicators in substantial studies such as the sustainability studies recently undertaken, as this is a very valuable opportunity to learn more about EQND at the same time as learning about broader issues.

44 Emerging Markets Consulting (2016)
45 Davis, I. (2015)
46 Jones et al (2015)
47 Bikash Shrot Kendra Pvt Ltd. (2016, draft)
48 The reporting on subsidies also included those provided prior to the CLTS approach being implemented in Nepal; and subsidies are permitted for the ultra-poor and disadvantaged under the CLTS approach in Nepal.
49 WSSCC and UN Women (2015) – 2 reports

THE CLTS TRIGGERING PROCESS IS KEY TO INCLUSIVE SANITATION. ©WSSCC

9 DISCUSSION

This section looks in more depth at a number of key issues identified during the process, which are felt to be key for GSF to move forward. Recommendations then follow in Section 10.

9.1 HAS THE PROGRAMME INCLUDED AND BENEFITTED THE DISADVANTAGED?

Overview of outcomes

It is clear from the findings in Section 7 that many people who are potentially disadvantaged have gained access to and are using latrines within the programme supported villages and have expressed a range of benefits. Some have built their own latrines, others have been supported by family members, or other community members, and others have sold assets to pay for construction. In some cases, Natural Leaders and WASH committee members have agreed to provide long-term support for the ongoing hygiene and maintenance of latrines for people who are older or visually impaired.

But whilst acknowledging a range of positive outcomes, it is also clear that CLTS is not automatically fully inclusive in its practical application, with people who may be disadvantaged not being pro-actively considered at each stage and some people falling through the gaps. Examples were seen where some very poor and vulnerable people have been put under pressure to build and some have sold limited assets such as land, or have lost assets through defaulting on loans, and particularly vulnerable groups such as people with mental health conditions are currently an overlooked group in the global sanitation sector as a whole. Whilst the consultants cannot specify the scale of such problems, the fact that they did identify a number of different examples within the limitations of this study, indicate that there are likely to be multiple cases across the GSF-supported programmes and also probably in other CLTS or sanitation programmes. These are clear areas where more learning and attention is needed by GSF and the wider global WASH sector.

Many people with disabilities have also not been fully engaged in the process and do not currently have accessible latrines, although some, mainly self-initiated, examples exist where families have improved latrines themselves to make them more accessible.

As GSF has an in-built mechanism for adaptation and flexibility to reorient supported programmes, there is an opportunity to address such issues including through actions that do not necessarily need to be costly.

Participation – at what level?

The box on page 80 provides definitions for terms used in the participation continuum, which is often depicted as having empowerment as its goal.

To some extent all development initiatives could be seen as promoting 'empowerment' whether intentional or unintentional. It is a process and a programmatic decision as to the extent of investment in empowering goals, strategies and approaches. An emphasis on community empowerment also represents a way to contribute to addressing exclusion and discrimination through pro-active attention on this issue.

In many ways, it was felt that the programme has been empowering, but there are also gaps and areas where it could improve its analysis and attention on EQND; particularly considering increased opportunities for capacity building for community members and people who may be disadvantaged in particular.

Examples of empowerment seen as part of the study process:

- The team met a number of communities in all countries and heard of others, who had got to ODF through significant effort on the part of a wide range of people within the community, including community leaders, Natural Leaders and households, and there was a clear community level commitment. There was obvious pride in what they themselves had achieved, determination to not go backwards and the community moving on to other things – such as total sanitation in the case of **Nepal** or fully immunized, totally literate and totally indoor smokeless villages etc.

- The team met people in a mixed community in the Hill ecological zone of **Nepal** where Dalits had been the first to build latrines, they wanted to break the stereotype that they are always last – they supported each other in groups and they provided motivation for the Brahmins to build. See top photo on page 81.

- The team met a range of people across the countries we visited, and heard of multiple others, who may have been considered, vulnerable, marginalized or disadvantaged (such as people with disabilities, widows, older persons) but have built their own latrines, or participated actively as leaders in their own communities, or in some cases engaged in promotion and advocacy in other communities.

- The team met female and male community members in **Senegal** who had been provided with skills training in soap making, or as masons, and they either were already or intended generating income from this. One group of masons had tried to design a latrine slab with a raised pedestal (although the initial attempt at this had failed). Women in most of the villages had also set up solidarity funds with the express purpose of supporting others to build latrines or to generate more income for their community.

- The team met inspiring female triggerers in the mountains in **Nepal** who come from the village they trigger who have a lot of pride in their work. They expressed how they liked to both learn from and with the people they are triggering and trying to convince people to build and use latrines. One was a Dalit woman in a mixed community, who was praised during the FGDs for her efforts in helping the community get to ODF. See photo opposite.

- IPs, CLTS facilitators / triggerers, Community Consultants and Natural Leaders across all country programmes almost unanimously felt proud of the work they had done and felt that it had been much more successful than other approaches – giving them a sense of job satisfaction.

Examples of gaps seen in empowerment:

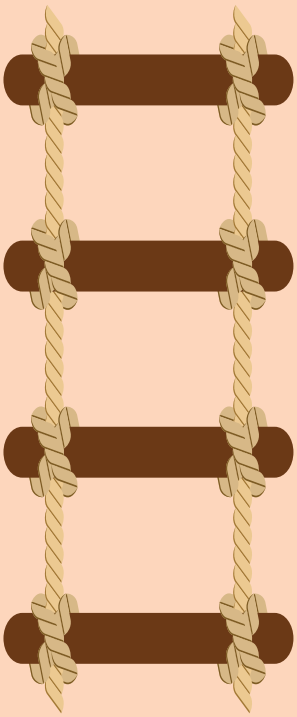
- One IP representative in **Malawi** said that he felt the process was not 'Community-led' but was 'Facilitator led' and when discussing the participation ladder, some participants at the workshop said that whilst it aimed at empowerment (i.e. the top of the ladder) they felt that it fell short of this.

- More pro-active effort could be made to ensure that people who might be considered disadvantaged are encouraged to become leaders and play a formal active role in the process. Some examples exist where this has been the case (see **Section 9.1** and **Annex X**), but there are also many cases where more could be done. See the example of Loya below.

See recommendations in the **Section 10-R5**.

PARTICIPATION LADDER

- **Empowerment** – is the process of becoming stronger and more confident, especially in controlling one's life and claiming one's rights; and includes enabling people to be involved in decision-making and making decisions for themselves, but not at the expense of and to the detriment of others. It is a journey not a destination and can happen at an individual and group level. Empowerment leads to greater confidence, insight, understanding, trust, caring and tolerance for all – not just for some at the expense of others. It is transformational in that it aims to alter the structural inequalities that lead to and perpetuate marginalization and exclusion.
- **Collaboration** – Implies partnership and working together to achieve mutually defined goals
- **Involvement** – Implies limited engagement in defining goals and the means to achieve them
- **Consultation** – Seeking community members view points on proposals and plans that have already been drawn up
- **Inform** – Information about previously devised plans is shared with the community



9.2 UNTANGLING THE WEB OF COMPLEXITY AROUND DISADVANTAGE

Overview term for disadvantage

Common terms for people who may be in a disadvantaged position include: vulnerable, marginalized, disadvantaged, excluded and ultra-poor. The problem with listing all of these terms – is that sentences become very unwieldy and documents become long. During the six country workshops the question was asked whether there is one single term that would encompass all aspects of poverty and disadvantage. In some countries 'disadvantaged' was felt to be the most appropriate and least negative term, but participants thought that all terms could have negative connotations to some degree. In other countries, the differences in the meaning of the words meant that opinions varied.

> *Even if people try to use respectful words in English, in Nepali many of the words can still be hurtful."*
>
> A senior DPO representative from Nepal who is also deaf

The recommendations of the consultants is to use the term **'potentially disadvantaged'** and where necessary in the longer form: **'Potentially disadvantaged'** which includes: *individuals and groups who may be vulnerable, marginalized, excluded or experiencing inequities, inequalities or stigma.* The terms 'potentially' and 'may' take into account that not all people in the categories of individuals or groups may actually be in a disadvantaged position.

Other terminologies

The different terminologies representing different potentially disadvantaged groups across countries and contexts were discussed. To note:

- It is important to establish a set of appropriate and respectful EQND terminologies in each country and context – both in the international and all local languages used in the programme area. However, even if appropriate and respectful international or national terms are agreed, there may not be a comparative word in the local language and hence inappropriate words may still end up being used and programme staff need to be mindful of this.
- Sometimes there are differences of opinion on whether a term is acceptable or otherwise. For example, some disability activists feel that the word 'deaf' is no longer acceptable and the term 'hearing impaired' should be used. But a woman who is

©S. CAVILL

SHASHI FROM KHANA VDC IN ARGHAKHANCHI NEXT TO HIS LATRINE

A Dalit community in Khana VDC in Arghakhanchi District **Nepal** used the opportunity of the sanitation campaign to break down stereotypes. They formed groups to help each other (4-5 households per group) to build latrines and supported those who were not able. They were motivated to win the competition between wards, to show that they were not always to be last. They succeeded in completing their latrines before many people of traditionally higher castes.

THE TEAM VISITED SUNITA'S VILLAGE AND PEOPLE REPEATEDLY PRAISED HER EFFORTS AND WORK IN THE SANITATION CAMPAIGN

Sunita is a young woman whose family is from the Dalit caste from Thulogaun VDC and Thumka is from Dadagaun VDC and her family is from the Janajati ethnic group. They are enthusiastic and hard-working local triggerers who live and work in their own communities that they know well, are paid a token salary and work full-time on promoting change. They led the process of their two VDCs becoming the first two VDCs to become ODF in Rasuwa, a remote mountain district in **Nepal**. Both villages were badly affected by the earthquake only the year before, with most houses and latrines being damaged or completely destroyed. No subsidy was given out in either VDC.

©S. HOUSE

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*LOYA FROM NKHOTAKOTA DISTRICT IN **MALAWI** STANDING IN FRONT OF HIS LATRINE*

Loya had polio as a child and now has to walk with a stick, but he can squat quite easily. Loya said he'd been to the triggering and was one of the few people who mentioned 'eating shit'. He had been very active in motivating his neighbours. He provides a clear example of a natural Natural Leader but was not selected to be one.

If the programme included more systematic efforts to encourage empowerment of people who might be considered disadvantaged, Loya might have been selected as a Natural Leader.

Also, where people are appointed rather than being Natural Leaders, there is also an increased chance of overlooking someone like Loya.

herself deaf and heads an organization for people who are deaf and hard of hearing, said the term is fine and is still used by the global World Federation of the Deaf.

- Sanitation programme actors must partner and take advice from organizations representing disadvantaged groups for context specific guidance on this. The Sanitation and Hygiene Master Plan in **Nepal** uses the term '*differently-abled*' and stakeholders are making a positive effort to try and use this term. However, it was made clear in a meeting of representatives from Disabled Persons Organizations in **Nepal** that this term is not appreciated by people who have disabilities, particularly because of the word 'different' within it. This highlights the importance of remembering: **"Nothing about us, without us!"** and including people whom the words refer to when deciding which words are appropriate.

- In general a principle that was shared by one DPO representative was that in general if you use the phrase... *"A person with...a speech impediment, a mental health condition etc"* or *"A person who uses...a walking aid, a wheelchair etc"* then you are likely to be more respectful. Tone is also important.

- For some words however, it is clear that they are unacceptable such as: retarded, dumb, backward.

A list of EQND terminologies in English that are recommended for GSF at the global level has been included in **Annex XVI** as well as a list of terms that are not considered respectful. It is suggested that these should be adapted by the country programmes to suit the local context but hopefully will be a useful starting point.

Handling the complexity of factors affecting disadvantage

Throughout the remote desk study and interviews, the on-line survey and each of the country visits the team investigated people's opinions and experiences of disadvantage – what it means; what factors affect it; who is likely to be disadvantaged; and also how the factors might inter-relate. Then the team considered a range of different ways to group and organize the factors affecting disadvantage; with the aim to, as much as possible, simplify the issues in a way that will hopefully be most understandable across programmes and also be most useful to a sanitation programme for moving forward.

The proposal is to use the 'Clusters of Disadvantage' in the following image (Fig 9). These have been modified from Robert Chambers' analysis of the 'deprivation trap'[50], to consider factors of disadvantage that affect an individual or groups' ability to construct, access or maintain a latrine through the CLTS process, as observed through the learning during this process. When using this proposed arrangement, it is important to recognize that:

a) The factors overlap and affect other factors

b) No arrangement of clusters and factors will provide a perfect solution to simplify what is a complex array of factors that can affect disadvantage

c) That people who fall into more than one group are likely to be most disadvantaged (e.g. an older woman with limited or no savings and no regular income who is a widow looking after grandchildren alone and living in a flood affected area)

Further notes on the factors that affect the Clusters of Disadvantage and the groups and individuals who might fit into each can also be seen in **Annex XII**.

Levels of disadvantage and identifying who might be disadvantaged

The purpose of identifying who might be disadvantaged is:

1. To be aware of who might not be able to manage to construct, access, use or maintain a latrine without external support.

2. To reduce risks for the most disadvantaged that building or maintaining a latrine may make them more disadvantaged such as through selling their limited assets, and hence less able to cope with future threats.

3. To be able to monitor the progress of the process on the people who might be considered disadvantaged and to ensure their inclusion and participation in the programme.

50 Chambers (1983)

It is clear that there are a wide range of people who might be considered disadvantaged, but not everyone will need external support for building, accessing or maintaining a latrine, because:

1. They may be able themselves to construct, access or maintain a latrine

2. They may have adequate financial resources, such as from a business, that can be used to pay someone to construct one

3. They may have family members who are willing and able to support them

It is the people who **don't fit into any of these three categories** who particularly will need support.

A few considerations:

- Many of the controversies during the country visits concerned whether people who might be considered disadvantaged actually needed support.

- It is very complex to establish actual income levels and savings – this would be an extremely difficult task to undertake at scale.

- People within communities tend to know who is really the poorest and most vulnerable – although some excluded groups may be overlooked and their exclusion accepted as normal (e.g. women with fistula, lower castes, religious minorities, etc.).

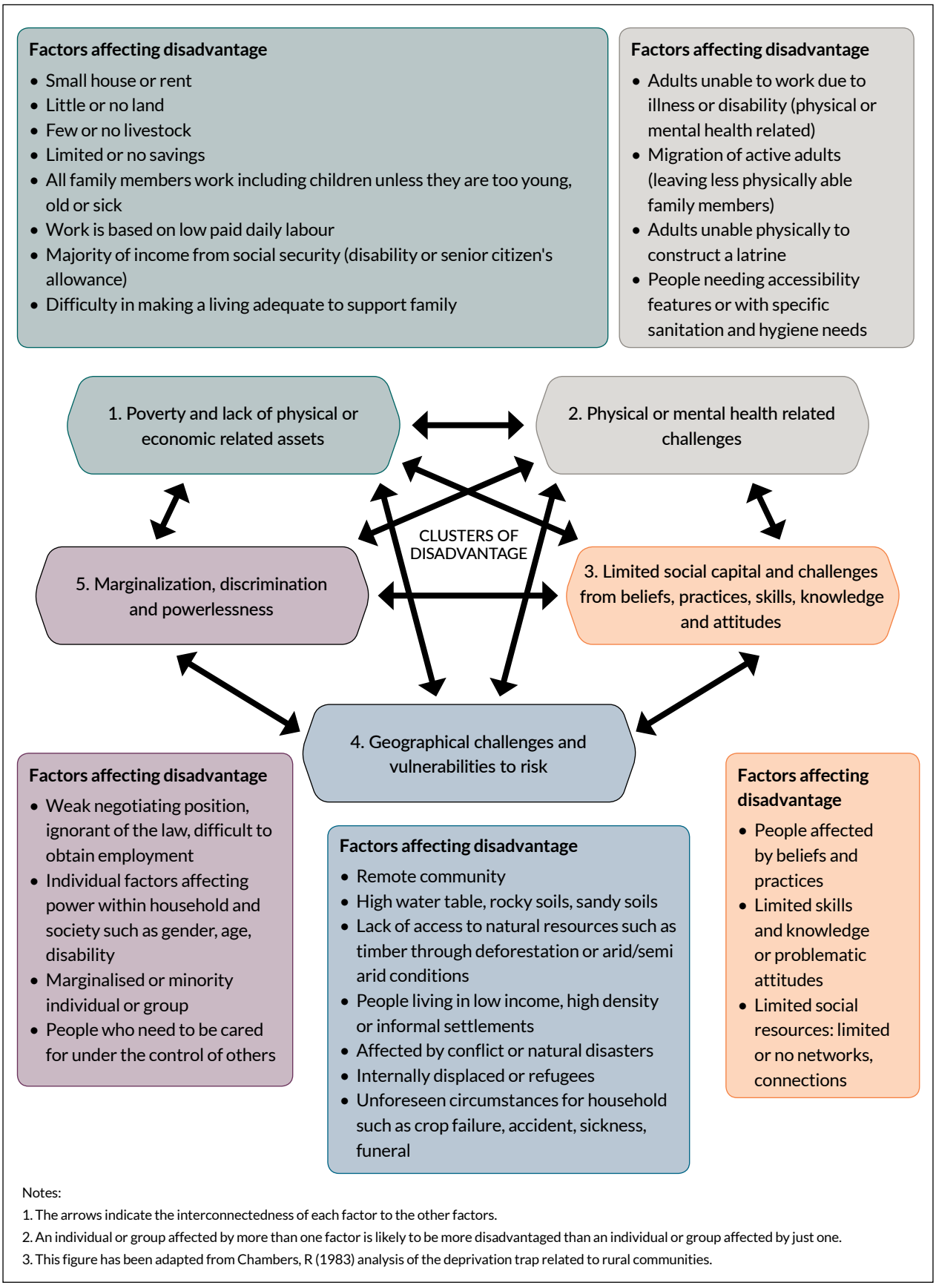
- Not everyone trusts those in leadership positions to act in their best interests.

- There is a difficulty of defining who is heading the household when one or more of the family members are migrants working away in other countries. It is sometimes believed that such families will have a good income, but this is often not the case as they may have had to take out big loans to send the family member away and it might take some years to benefit from their remittances.

- Countries may have their own visible indicators of the level of poverty – e.g. if someone has a mobile phone or TV they are considered to have enough income to construct a latrine.

MOTHERS AND CHILDREN EXPLAINED HOW THEY OFTEN HAD SEVERAL POTTIES OF DIFFERENT SIZES FOR ONE FAMILY. ©SUZANNE FERRON

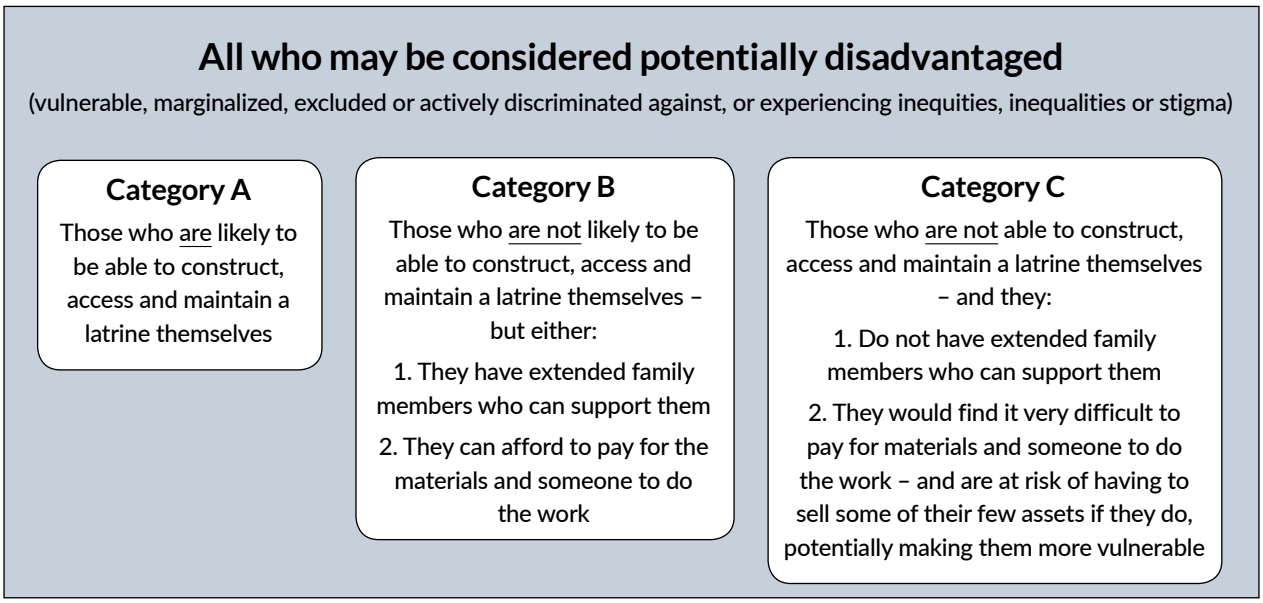
Figure 9: Clusters of disadvantage



Notes:

1. The arrows indicate the interconnectedness of each factor to the other factors.
2. An individual or group affected by more than one factor is likely to be more disadvantaged than an individual or group affected by just one.
3. This figure has been adapted from Chambers, R (1983) analysis of the deprivation trap related to rural communities.

Figure 10: A, B and C categories of households from the perspective of who is likely to need support from outside the family



Whilst a range of factors affect whether a household is disadvantaged and whether this impacts on their ability to participate in the process, construct, access / use and maintain the latrine; it is clear that **physical ability, access to income and assets** and if you **have support of family members** has a significant impact on whether a person will need support from within or external to the community. For example, if you are a person with disabilities or an older person heading a household but have a business or a lot of savings, you are likely to be able to construct a latrine that you can access and use. Hence it is proposed to make a distinction between A, B or C categories within the wider categories of 'potentially disadvantaged groups'.

This then will enable the programme to identify:

- Who is most likely to need support from outside the household (C)
- Who it should also be important to follow up in case they do not manage (B)
- And those who it is hoped will be able to manage on their own (A)

It is proposed to use these categories in the process of identification of people and households that might be disadvantaged as well as for the MEL systems. It should be modified to suit each country context and the information collected / judgements made by community members. See **Annex XIII** for more details.

WHO DEFINES VULNERABILITY?

This suggested guidance on identifying those who are potentially vulnerable does not imply that community knowledge and understanding of vulnerability is ignored and indeed it is vital that communities are involved in the identification of who might need support. However, it does provide a framework to inform discussions with and within communities and to also help ensure some groups are less likely to be overlooked.

Table 8: Framework for level of EQND considerations

	Level of EQND consideration	When should this be considered	By whom
1	**Global** Differences in level of disadvantage between countries	• Before deciding on new country programmes to support	GSF and Steering Committee
2	**Country** Differences in level of disadvantage between areas within a country	• Before proposals are developed and submitted • When reviewing proposals	PCM, government, EA and GSF
3	**Community** Differences in level of disadvantage between communities	• In EQND related training for country level stakeholders • During the planning and prioritisation processes in-country • When monitoring and reporting	EA, IPs and community leadership
4	**Inter-household** Differences in level of disadvantage and barriers to access and use of latrines between households	• In EQND related training for country and community level stakeholders • During all stages of the CLTS and other behaviour change processes • In monitoring and reporting – with the key global indicator relating to progress for disadvantaged households; and more detailed disaggregation and analysis undertaken at community level and in baseline and outcome surveys • In ongoing learning at country and community level	EA, IPs and community leadership
5	**Intra-household** Differences in level of disadvantage and barriers to access and use of latrines between individuals within households	• In EQND related training for country and community level stakeholders • During all stages of the CLTS and other behaviour change processes • In monitoring and reporting – with more detailed disaggregation and analysis undertaken at community level and in baseline and outcome surveys	EA, IPs and community leadership
6	**Programme / institutional** Related to programme organizations, staff and establishment of programme modalities	• During selection of members for the PCM and selection of the EAs and IPs • During recruitment of programme staff and training and establishment of systems and processes • In ongoing learning at country and community level	GSF, PCM, EA and IPs

Framework for levels of EQND considerations

Table 8 provides a summary of the different levels at which EQND should be considered in relation to the GSF-supported programmes, when these considerations should be made and by whom.

Comment on PSAM approach

The team did not travel to **Cambodia** and so the following comments are made based on the documentation of the PSAM approach and key informant interviews. The team greatly appreciate the effort made by the **Cambodia** programme to develop the PSAM methodology to try and ensure participatory assessment of levels of vulnerability. The intention is clearly positive, but some elements have been identified which pose challenges for its scale up.[51] Without having seen the tools used in practice, the team encourage the **Cambodia** team to continue adapting the approach based on their ongoing learning in country and also the findings and suggestions from this EQND study. Suggestions include:

51 Although GSF has expressed a more positive outlook on the tool and its acceptance by all actors

a) To reconsider the identification of disadvantaged individuals on a public map (such as people with HIV) because of the risk of further stigmatisation. Even if only general poverty or vulnerability categories are put on the map which is in a public place, this could also still potentially lead to stigmatisation of the poorest families.[52] Consider whether adding the details to the household register that is available to be seen and used to identify who might need support but not publicly displayed may be more sensitive but still fulfil the same role?

b) To consider whether the tools are the ones those are most useful for the IPs and the community to practically use in a sanitation and hygiene programme (although in the case of Plan **Cambodia** they work in communities for longer periods of time and on a range of sectoral areas). For example, would a barrier analysis in line with the guidance in the **Cambodia** government's national strategy on WASH for people with disabilities and older people perhaps be easier to utilize rather than the causal analysis?

See **Section 10-R3** and **Annex X** for suggestions and further details.

9.3 ENSURING MARGINALIZED AND EXCLUDED GROUPS ARE INCLUDED

Marginalized groups

Suggested definition for marginalized individuals or groups:[53]

Marginalized individuals or groups are those who are excluded from social, economic, cultural and political life, because of who they are or where they live. This term may refer to a cultural, religious, or ethnic minority, or people suffering from particularly stigmatised diseases. In some countries, marginalized individuals and groups can include a significant proportion of the population e.g. women.

Particular issues to consider in relation to marginalized or excluded groups:

1. Some historically marginalized or excluded groups may already be identified and acknowledged in a country's constitution – such as the Dalits in **India** and **Nepal**; and already have some affirmative action towards them. Here the provision of targeted support may be less controversial.

2. Others may not be known or openly acknowledged, particularly where the issue is sensitive or embarrassing, such as: a) People living and working in slave like conditions; b) Child workers (also often living and working in poor conditions); c) Sex workers; d) People living on the streets; e) People living on refuse heaps; f) Sexual and gender minorities; g) People with mental health conditions; h) Women and girls with fistula (because of its links to FGM and under-age marriage); i) Slaves or domestic workers not entitled to use the latrine of their employer.

It is unlikely that people from these groups will be represented in the programme team – and thus, the GSF programme needs to emphasise the importance of the recognition of marginalized individuals and groups within the programme and ensure that the challenges they may face are identified and responded to. This issue should be included as part of capacity building on EQND-related issues. It may be useful to bring in experts who have expertise in supporting particular marginalized groups in the country as part of EQND training, to raise awareness on their existence and issues they may face.

Sexual and gender minorities

The issue of sexual and gender minorities (SGMs) is a sensitive issue, but an important one for the GSF programme globally to recognize and respond to. In particular, there is a need to establish an explicit set of global values that support people who are SGMs and other discriminated minorities, so that staff worldwide know of these values even when they cannot be discussed explicitly in their country. This might be through a code of conduct, or an EQND or anti-bullying and harassment policy.

There is a need to recognize the high level of discrimination and marginalisation that people who are SGMs face and to ensure that all staff and partners respect that the United Nations, under which the GSF programme falls, does not support discrimination or

52 Maybe it is useful to consider a map were draw of all the households in your own community and all of the poorest households who receive government social security were marked on it and it was hung in a public place. Do you think the people who receive the social security payments would be happy to be highlighted in this public way?

53 Adapted from: De Albuquerque, C (2014)

violence against any people; and that service delivery must be non-discriminatory and respect the inherent dignity and value of all people. For CLTS it is required that 100 percent of the community stop OD and have access to sanitation, with the SDGs also Emphasizing the need to leave nobody behind and ensure that people are not excluded from services; this applies even if a person does not agree with another person's lifestyle. There is a need to provide capacity building for staff on this issue to help ensure professionalism and to build confidence on how to be respectful and inclusive to all, even in challenging country contexts.

It is important to also emphasise in the capacity building that heightened visibility on people who are SGMs can make them more vulnerable. Hence there is an important need for staff to understand that it is recommended to not pro-actively seek people who are SGMs out or make them reveal their identity. But to realize people who may be SGMs can be present in communities and should be treated with respect and included equally with others. The only instance where it could be positive to identify if people who are SGMs are present in the programme area, may be where communities of trans people live together in urban areas, to ensure they are where they have an opportunity to engage with programme processes. But in this case contact should be made through a specialist SGMs organization, so as not to put them at more risk.

In **Senegal**, an IP shared an example where an 'effeminate drama actor' was running shows for the ODF celebrations and was highly successful and community members found him very funny, which boosted attendance. But the programme judged his excessive effeminate behaviour risky and the collaboration with the artist was brought to an end.

The above example engendered debate amongst the consultants with some interpreting what was happening and discrimination in different ways – either:

1. It was discrimination to fire someone from a SGM or who is effeminate by nature; which also limits that individual's opportunity for employment and his rights to be himself, entertain and be accepted as a professional.

2. Or the community members finding him funny, was discrimination as it was making fun of homosexuality (particularly in a country where homophobia is common).

It is quite a complex issue. The suggestion is that such an issue needs to be debated in each specific context taking into account the views of people from SGMs.

People with mental health conditions[54]

Scale of the issue – WHO defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Mental health conditions are *"characterized by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others"*.[55] There are many different mental health conditions including: depression, bipolar affective disorder, schizophrenia and other psychoses, dementia, intellectual disabilities, such as Down's syndrome, and developmental conditions, including those on the autistic spectrum. Mental health conditions are widely prevalent: globally, an estimated 350 million people are affected by depression; 60 million people by bipolar affective disorder; 21 million by schizophrenia; and 47.5 million by dementia. In low- and middle-income countries, between 76 and 85 percent of people with mental conditions receive no treatment for their condition and there are very few mental health professionals. Mental health conditions affect people differently at different points in their life. Adolescents may face a variety of challenges in growing up that lead to stress-related conditions, while deteriorating mental health often accompanies aging. Mental health has a gender component, with women more likely to be affected by depression, but a larger proportion of men successful in attempts to commit suicide. Mental health is therefore a 'jeopardy' factor, which adds another layer on top of existing vulnerabilities, such as age, gender and poverty.

Mental health, vulnerability, and sanitation – As efforts increase to ensure that the most vulnerable and marginalized have access to sanitation, it is important to pay special attention to people with mental health conditions in both policy and practice. According to WHO,[56] people with mental health conditions are recognized as a vulnerable group: they are subjected to stigma and discrimination; experience extremely high rates of physical and sexual victimization; face disproportionate barriers in exercising their rights as well as in participating in public life and accessing public

54 Cavill, S et al (2017, upcoming)
55 WHO, 2016
56 WHO, 2010

services. Vulnerability itself is also an important risk factor for developing mental health conditions: stigma and marginalization generate poor self-esteem, low self-confidence, reduced motivation, and result in less hope for the future as well as isolation.

The stresses associated with the lack of sanitation can also negatively affect mental health. Gender specific risk factors for common mental disorders that disproportionately affect women include poor sanitation. Recent literature highlights the potential stress, fear and anxiety around using sanitation facilities.[57] Sahoo et al (2015) categorize these stressors as: environmental (barriers to access, discomfort at defecation site, animals and insects), sexual (peeping, revealing, sexual assault) and social (privacy, social restriction, social conflict). The impact of these mental health stressors disproportionately affects the most vulnerable, marginalized, and stigmatized women. Addressing mental health problems in vulnerable groups can facilitate development outcomes, including improved participation in economic, social, and civic activities'.[58]

There are two main sets of challenges for CLTS:

1. Where people have a cognitive impairment that affects how they process conscious reflective behaviours (those that require reflection – and may be influenced by rational knowledge, emotions, social norms) – which CLTS targets – as well as unconscious reflexive habits (i.e. those that are done by reflex action).[59] For example, those with severe dementia will be less capable of being 'triggered' and then forming positive habits. Excreta related behaviours occur in several conditions, including intellectual disability, dementia and psychoses (for instance, eating, smearing, or throwing faeces or involuntary faecal incontinence). Many people with mental health conditions find this extremely distressing. Intentional defecation in inappropriate places, when bowel control is normally expected, is also associated with several psychiatric conditions.

2. Where people's reflective and reflexive cognitive faculties (which relate to processes of perception, memory, judgment and reasoning) are functional, but their participation in social life and decision-making is affected by mental health conditions (anxiety, depression, for example); these mental health conditions may be less visible to facilitators, the community, or both. People with depression are less likely to participate during CLTS activities or else may not have the motivation to build a latrine or to change their behaviour, due to low mood or a lack of interest. People with anxiety may find it difficult to attend the triggering or other community meetings due to panic attacks or wanting to avoid people. This could be the result of a combination of low self-esteem, feelings of isolation, disconnection (opting out of participation) or social stigmas. 'Toilet anxiety' and fears of public urination are also recognized conditions.

People with physical symptoms may face external barriers to participation (e.g. due to stigma compounded by different layers of vulnerability), and those with 'invisible' conditions that affect their self-esteem may opt out of participating in community initiatives like CLTS and resist change, which in turn can affect the ability of a community to reach ODF status. In addition, families with people with mental health conditions may also be poorer than their peers, because of lack of ability to earn an income due to the mental health condition or having to care for someone with a mental health condition. **Table 9** identifies the key challenges and opportunities confronting CLTS facilitators related to people with mental health conditions.

It is clear that this is an area that is under-acknowledged issue globally, which affects some very vulnerable people in the communities in which the sector works. The sanitation sector needs to learn more about the issues and to develop appropriate strategies for response. For recommendations see **Section 10-R4** and suggested practical actions in **Annex XI.3**.

9.4 PERSUASION OR COERCION – WHAT LIMITS?

Methods to influence

The differences between methods used to influence such as persuasion, coercion, manipulation and intimidation and if and when these practices become unacceptable has prompted much discussion. See the box for suggested definitions.

The CLTS process tries to influence and persuade communities through a process of self-learning to stop the practice of OD. But as part of that process a range of coercive methods are sometimes utilized, particularly fining or punishing people or encouraging children to

57 Henley, 2014; Lennon, 2011 and WSSCC/SHARE, 2015
58 WHO, 2010
59 Neal et. al 2016; Sigler et al. 2014

Table 9: Challenges/risks and opportunities related to people with mental health conditions

Challenges/risks	Opportunities
• Difficulties changing behaviours and building positive habits • Facilitating active participation where people with mental health conditions are stigmatized • 'Doing no harm' where the use of shame or community reprisals can lead to abuse • Families of a person with mental health conditions, may be poorer, face challenges leaving the person they care for, or not have someone in their family able to support construction	• Addresses a contributing factor to mental health stressors • Empowers, and increases self-confidence in abilities to contribute and succeed • Entry-point for community members to confront their own prejudices

shame people by blowing whistles at them when defecating in the open. However, governments around the world use a range of coercive methods to prevent anti-social behaviour, and it could be questioned whether society could function effectively without such coercion. Parents also use coercion with their children, but ideally voluntary change should be preferred where it is possible. But to some, coercion can also be seen as a regressive social control strategy that works contrary to freedom and dignity.

It is important to recognize that we may do harm by using coercion – any type of coercion – 'coercion creates dependency, helplessness, powerlessness' but it may sometimes be justified. We need to be aware of the harm it can cause and only use it where absolutely necessary and where there is no alternative or where we have exhausted the alternatives. For example, where people with mental health conditions are concerned, we should ensure that they have as much independence and freedom as possible – and not automatically apply coercive, punishing strategies, which is what people are often tempted to do. It is possible that incentives may be more effective, less controversial and have less negative impact.

It would also be important to consider these issues in the context of the sanitation enforcement and regulations within each country e.g. where uniformed police officers or sanitation police, would traditionally collect fines from people who do not have latrines. At the start of the RUSHPIN, these officers who become part of the WASH units, would go to trigger wearing uniforms, but when they understood the CLTS approach they instead started to wear plain clothes, stopped collecting fines and started doing FUM.

Examples of risks of harmful use of coercion:

- Forcing someone who is poor to sell their poultry, livestock or land in order to build a latrine when this will mean that the family will go hungry and be more vulnerable to shocks

METHODS USED TO INFLUENCE:

- **Persuasion** – Is a process in which communicators try to reason with and convince others to change their attitudes or behaviour in the spirit of free choice.
- **Coercion** – Is a technique in which someone in a position of relative power or authority seeks to control and influence the other person by fear through the use of force, threats, manipulation or intimidation. There are various forms of coercion that have different legal, social and ethical implications.
- **Difference between persuasion and coercion** – When people believe that they are free to reject the communicator's position, as a practical matter they are free, and the influence attempt falls under the persuasion umbrella. When individuals perceive that they have no choice but to comply, the influence attempt is better viewed as coercive.
- **Convince** – Cause someone to believe firmly in the truth of something – persuade someone to do something.
- **Manipulate/manipulation** – Control or influence a situation cleverly – often unscrupulously – control something or someone to your advantage – often at another's expense. Manipulation usually involves elements of persuasion and coercion.
- **Intimidation** – Is to frighten or threaten someone, usually in order to persuade them to do something that you want them to do. It is to compel or deter, often with the use of threats and an unlawful act of intentional coercion.

- Promising to find a marriage partner for someone with a mental health problem if they use the latrine (thereby potentially denying the rights of the other individual)

- Imposing fines on families that do not have enough money to pay for food

It is sometimes challenging to establish where to draw the line between acceptable and unacceptable persuasion – especially with the huge numbers of people involved in the CLTS process at different levels including communities themselves. We therefore believe this is a clear area where guidance is needed from GSF to the programmes it funds. A number of recommendations have been made in **Section 10-R6** as to the considerations needed and where the limits should be placed.

9.5 TO SUPPORT OR NOT TO SUPPORT – THAT IS THE QUESTION?

CLTS and subsidies

The CLTS approach was developed in 1999 by Kamal Kar working with the Village Education Resource Centre (VERC) and supported by WaterAid in response to global subsidized latrine programmes that increased coverage, but didn't necessarily result in use and also in response to only portions of communities constructing and using latrines. From the beginning the emphasis was on no direct hardware subsidies and the *'Handbook on Community-led Total Sanitation'*, noted: *"It is fundamental that CLTS involves no individual house- hold hardware subsidy and does not prescribe latrine models. Social solidarity, help and cooperation among the households in the community are a common and vital element in CLTS"*.

Subsidies and external support continue to have been provided for a range of activities that support progress in relation to sanitation from the funding and subsidization of the software / mobilization activities; to setting up revolving loans; or subsidizing low-interest loans and financial mechanisms to spread the investment costs of sanitation (such as by WSP in **Cambodia**); or funding sanitation marketing. Some countries have continued to give financial subsidies to households, including **India** (as post construction payment to all households) including some countries in West Africa where not all actors have fully moved to the non-subsidy approach. Institutional sanitation continues to be regularly subsidized or fully funded in many countries, in institutions such as in schools or health facilities.

Also increasingly, some countries and programmes have started to provide subsidies in terms of materials or labour support to the poorest households: such as in Bangladesh (provided post ODF declaration), in **Nepal** (pre-ODF but only after 90-95 percent of the households in the community have constructed and also approved for use in difficult geographical / marginalized areas); and it is also approved in the policy in **Malawi** (post-ODF).

Opinions on supporting the most disadvantaged expressed during this process

The process identified a range of ways that the most disadvantaged have been or can be supported. These are incorporated into Fig 11 later in this section.

In addition to understanding how support has been provided, the team also facilitated multiple discussions on the benefits and challenges that might be faced in the GSF-supported programme in the future if they were to provide support to the most disadvantaged households (such as in the form of materials, labour or other). As expected this debate provoked controversy, as it did within the EQND scoping and diagnosis process team.

To put the comments below in context it might be useful to understand which countries that were visited have government sanctioned household subsidies:

- **Togo** and **Senegal** – both countries are moving towards a no subsidy approach; in **Togo**, the national strategy is generally accepted as being no subsidy allowed for household latrines in rural areas. This is in the process of being clarified formally as the national strategies are being updated. But in both countries some actors are still currently using subsidies;

- **Nepal** and **Malawi** – both allow for subsidy for the most disadvantaged, near to or after ODF declaration;

- **Nigeria** and **Ethiopia** – national CLTS strategies do not allow for subsidy.[60]

60 Although the urban sanitation and hygiene strategy for Ethiopia includes provision for support to be provided to the poorest.

In general, the responses were as follows:

Opinions expressed for providing support from inside or outside of the community for the most disadvantaged:

- Even though the vast majority of people involved in implementation had a high level of concern about the potential impact of subsidies; a proportion, still agreed that for the most disadvantaged there is still a role for subsidy, but noting that its use would need to be managed very carefully. See box on subsidy in **Nepal** in Section 7.4.2.

- A number of the poorest and most disadvantaged people also indicated that even a small amount of support could help. For example: *"Even a bag of cement would help a lot. We would still contribute to construct but it would allow a smooth floor that would reduce the need for my sister to smear the floor which is difficult for her"*. (brother of woman who crawls on the floor, **Malawi**)

Opinions expressed against providing support from outside of the community for the most disadvantaged:

1. The vast majority of the many people with whom this discussion was held across the six country visits who have a role in implementing the programme – from CLTS facilitators and triggerers, Implementing Partners, EAs and District coordinating committees to Federal government representatives, expressed concern about the possible introduction of subsidies to the programme (although see below comments on providing support to the poorest).

2. The main concerns about giving household level support, particularly from sources external to the community (materials, labour, financial) to the most disadvantaged, revolve mainly around a belief (based on previous experience of using subsidies) that this will undermine people's motivation and lead to many claiming to be eligible, holding up progress and ability to get to ODF status. There is also the risk that providing financial or material support to some may cause conflict in communities where many people consider themselves to be struggling and entitled.

3. **Malawi** was the country where a request for subsidies was most apparent from communities (whereas it did not come up as such an issue in other countries). This was particularly in communities that were vis-

EXAMPLE QUOTES FOR EXTERNAL SUBSIDY

Togo:

"In my own personal view, following a zero-subsidy approach is not a good thing if we want to have improved, quality latrines: there is a minimum [level of] subsidies that can be used if only to provide example... There are zones where you need to give a boost to help people climb up the ladder, for instance in areas where there are negative factors, such as climatic. It is a very controversial issue. We have thought that it was going to be a negative practice, and we brought subsidies for sanplats, but this has not affected the community dynamic at heart of the CLTS. It is about inspiring and giving a little nudge to comfort people in the conviction that their efforts will be worth it."

"Partial subsidies of sanplat is an option, especially since people, and mostly children are afraid of collapsing. They need to be reassured."

Senegal:

"The use of subsidies has not been adequately regulated in Senegal and the programme has sometimes struggled to operate in areas where other NGOs are providing unregulated subsidies. However, in one case, AGETIP insisted that JICA wait (for a year) until the communities were certified as ODF before agreeing that they could offer subsidies."

"The use of subsidies in this instance does not seem to have undermined the communities' capacity or willingness to engage on sanitation issues."

Ethiopia:

"There is resistance amongst the ultra- poor due to the time it takes them to dig the latrine because they have to be engaged in work for daily subsistence."

"[The] Ultra-poor cannot build without external assistance. Their options are either to practice OD, ask their neighbours, or use a public latrine."

EXAMPLE QUOTES AGAINST EXTERNAL SUBSIDY

Nepal:

"If we enter the community with subsidy – 70-80 percent will now consider themselves eligible for subsidy."

"This area is not so easy to deal with."

"I recommend to not give subsidy – as it creates conflict amongst community people."

Malawi:

"If subsidy it will create dependence."

"It can cause intention to become dead."

Togo by an organization which still provides subsidy as part of its programme

"We undertook an analysis of the cost of our investment in household sanitation, comparing a subsidies approach and a CLTS approach. [We found out that CLTS] makes it possible to boost sanitation for the whole community as opposed to [traditional subsidy-based approaches which only benefit] the happy few."

Ethiopia:

"Bear in mind that poor does not necessarily mean labour poor. Someone can be financially poor but can use the workforce available in the family. They can also use local materials. As far as they have their own house, they can build their latrine, because a local latrine is much cheaper than a house, it is within their reach. It is a mental set up and has to do with the way they prioritize things."

ited with sandy soils. But the EA and PCM were still of the opinion that despite the difficulties, that giving subsidy to households would be too damaging to the process and they would rather give subsidy to services such as the revolving fund for sanitation they are supporting or sanitation marketing. They highlighted that one of the first communities which reached ODF was one with sandy soils along by the lake shore, highlighting that success was more about attitude than the physical challenges.

Overview on options for supporting the most disadvantaged

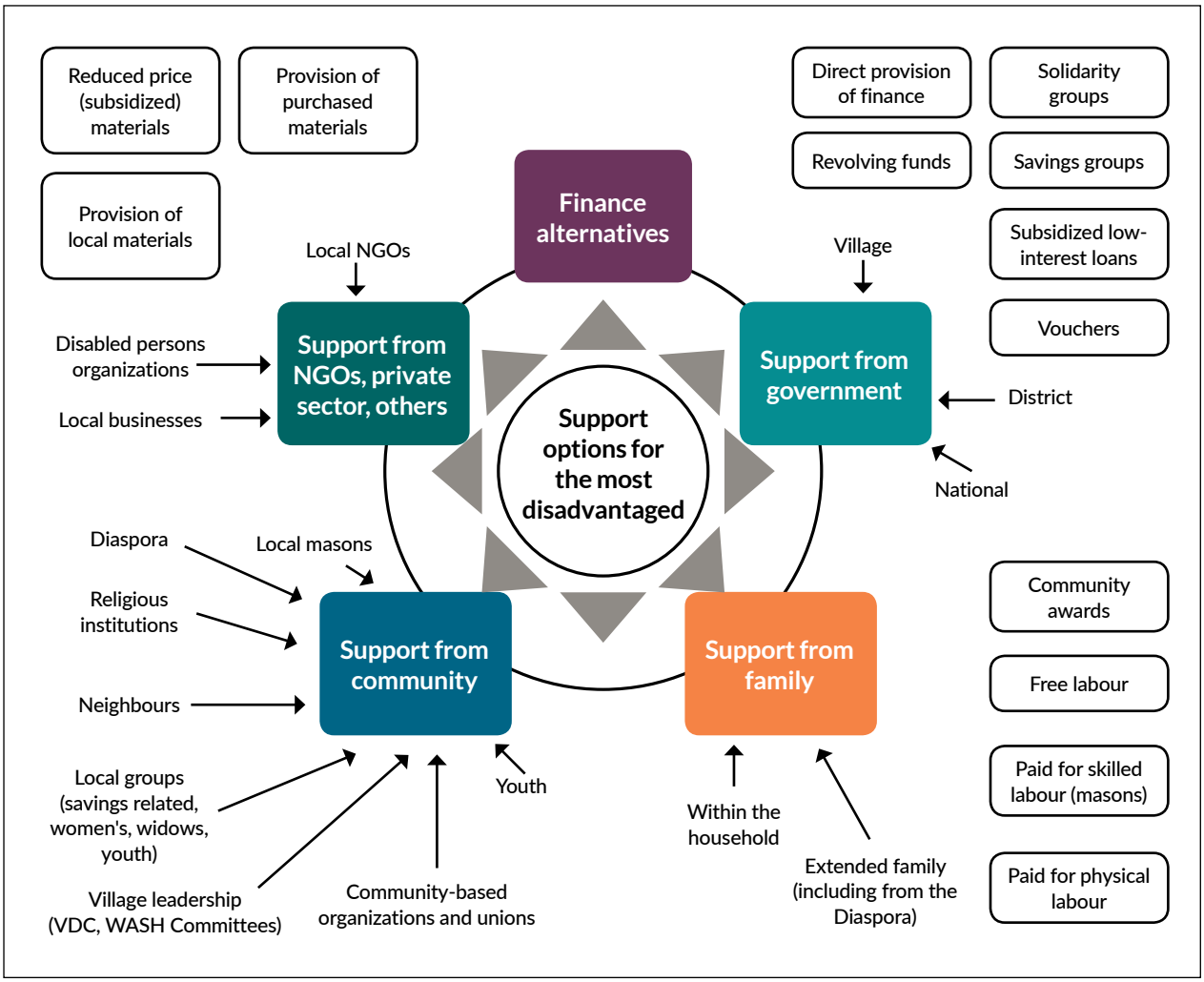
Refer to **Figure 11** for an overview of options for supporting the poorest that have been seen in programme countries. This image highlights the range of options for support that can be drawn upon, whether from family the wider community, from the government or from NGOs, private donors or others.

A number of finance options are being utilized, but there are limitations for the poorest and most vulnerable who may not be able to pay back loans.

Support internal to the community is generally seen to be a positive option, but it also has its limitations, such as whether it can be sustained over time with the expected challenges from collapsing latrines and slippage and also whether people who are disadvantaged always feel comfortable being beholden to others for support.

In some areas, support from within the community has been a strong part of the programme, but in other areas visited, such as in the Terai district in **Nepal**, support was obvious by its absence (although it should be noted that both communities visited were not yet ODF). One question posed in this instance is whether this is related to the historical caste system, which is no longer constitutionally supported, but which still exists in reality on the ground? As many of the people who are marginalized and struggling to meet the minimum standard of latrine in **Nepal** tend to be from the lower and historically marginalised castes, has this had an impact on the likely willingness for other community members to support them? Or is it the fact that there are large numbers of people in some communities who potentially need support, putting people off providing support? Or is it that support would involve input of finances due to the minimum standards for latrines required in **Nepal**? Such questions are issues for increased learning and consideration in all country programmes, when considering the option of support from within communities.

Figure 11: Options for supporting the most disadvantaged



Should external support be provided for the most disadvantaged?

It is proposed that targeted, government-sanctioned subsidies (labour, materials, finance) could be made available for Category C group of people who might be disadvantaged. These are the individuals and households who are a) unable to construct a latrine on their own; b) do not have extended family members to assist; c) do not have adequate savings or income to pay someone to do the work; and d) are at risk of selling some of their limited assets if they are forced to construct a latrine using their own resources (see **Figure 7**).

The main reasons for this recommendation that support should be allowed for the most disadvantaged, particularly to support construction of a solid latrine up to ground level, are because:

1. It was clear that in countries where no basic minimum standard of latrine is required that when people were supported by others to build a latrine, they were often the most basic with no lining to the pit and a slab made out of local materials. This means that the latrine is prone to collapse and the person may have to wait for someone to assist them again, sometimes on multiple occasions over time; which can also lead to donor fatigue. See **Section 7.5.1** for case study examples.

2. The team heard of examples of where people have had to sell or forfeit their limited assets due to not being able to repay loans, such as their only piece of land, animals or other small assets. See **Section 7.3.4** for case studies. This has the potential to make the most disadvantaged more vulnerable to risks in the future.

3. The team saw that the poorest of the poor or ultra poor are unable to build a latrine on their own (In **Malawi** a government cash transfer programme is transferring around USD 4 per month to the ultra poor with labour constraints, which indicates the level of poverty); either because of limited time to physically work on it because they need to do day labour to pay for basic bills like food; or because they live on very small sums of money, such as government allowances (see **Section 6.6.4**).

However, some people who might be considered disadvantaged are able to build, access and maintain their latrines and this is very positive and empowering. It is therefore recommended that the priority order of action (1 to 4) should be for:

1. Encouraging people who can to construct their own to do so
2. Encouraging family members to support
3. Facilitating other support and resources from within the community
4. Some government specified targeted external subsidy for those in category C

The introduction of any form of external subsidy is likely to be disruptive (see the comment on the provision of subsidy in **Nepal** and the comments below), so it is recommended that a range of country based considerations would be needed, including those related to the process to identify the disadvantaged and communication on this issue with the wider community.

The example of provision of subsidy support for the ultra-poor and most disadvantaged in **Nepal** as highlighted in the box in **Section 6.6.1** and in **Annex X**, has both positive and negative aspects. The positive aspects are that people who are the poorest and least able to afford the permanent latrine up to ground level are entitled to support and that people are still motivated during the process because they are not waiting for subsidy (as they do not know about it). The negative aspects are that people who are most disadvantaged are being pressurised throughout the process to build a latrine themselves, which is very stressful and might lead to them selling some of their few assets thus making them more vulnerable. Also, the process of identification and the criteria for selection are not transparent and anyone not deemed eligible cannot challenge the decision. Whilst the team fully understands the real concerns and stresses for the government and implementing teams of introducing subsidy early, the amount of stress that the poorest and most disadvantaged are being put under does not seem reasonable when they are entitled to external support. All country programmes are encouraged to wrestle with this challenge of establishing mechanisms that do not put marginalised and vulnerable people under unnecessary stress, without derailing the CLTS process.

Subsidy support in disaster situations:

The response to the earthquake in May 2015 in **Nepal** lead to a massive influx of humanitarian actors who provided latrines free of charge which was challenging to manage and disruptive to the CLTS no subsidy approaches. But the GSF-supported programme in **Nepal** proved that it is possible for communities to rebuild without subsidy. The first two VDCs to get to ODF in Rasuwa District after the earthquake did so by rebuilding / building their latrines without any subsidy.

In reality it is unlikely that the humanitarian sector will stop giving subsidies. Provision of support in a humanitarian setting can also be considered like 'insurance' to rebuild something that is broken when houses and assets are damaged, livelihoods disrupted, and people may be injured or killed; and people are highly stressed. But the use of such subsidies can be disruptive to longer term development approaches if not applied with care. A good practice would be to consider time limits for humanitarian support and that any blanket subsidies should have a timetable to transition back to the longer term developmental CLTS approach. But even such recommendations are challenging when, as in the case of **Nepal**, people may still be in temporary accommodation for several years after the earthquake awaiting government confirmation of where they can live and are not yet in receipt of their entitlements to help them rebuild their houses.

The humanitarian sector is also concerned with sustainable responses and in becoming more accountable to communities. Collaboration and advocacy with them could lead to better ways of working with communities and of applying subsidies.

Refer to the recommendations for supporting the most disadvantaged in **Section 10-R7**.

9.6 JUST SHIT – OR BROADENING THE IMPACT WITH AN EQND PERSPECTIVE?

Disability

As identified in the findings section the pro-active inclusion of people with disabilities in the programme processes and facilitating discussion on options for improving latrines to be more accessible, has not been systematically incorporated into any of the 6 countries visited. There were examples of people with disabilities in leadership positions, which were particularly apparent in **Nigeria**, but also examples elsewhere, and also examples of where households themselves had come up with a number of adaptations to make latrines more accessible. But the facilitation as part of the programme has not ensured that the issue has been specifically highlighted, leading to many people with disabilities and mobility limitations not having been supported to have dignified, safe and accessible sanitation facilities. The majority of programmes use a variety of BCC materials. Whilst some try to challenge gender stereotypes, few have been designed to meet the different needs of people with disabilities (e.g. those who have visual or auditory impairments) and few depict people with disabilities in a positive light, although the **India** programme is working in these areas.

This gap of not facilitating awareness on disability options is somewhat surprising, since there has been a lot of work undertaken in the WASH sector globally to improve in this area, including particular work by WaterAid and WEDC of Loughborough University in the UK, with useful practical guidance now being available for over 10 years. Perhaps a lesson as to the gaps that can occur if a mostly 'hands off approach'[61] by the global leadership is used in relation to EQND in line with CLTS philosophy to rely only on local solutions. It is a clear gap and priority for GSF to strengthen across all programmes.

In addition, the **Nigeria** team were the only country team to pro-actively invite people with disabilities to their national EQND workshop, and it was clear that this was very beneficial for the sharing; learning and quality of the discussions on issues related to disability and disadvantaged groups. In addition, the **Nepal** WASH sector has been making a major effort to use respectful terminology and their National Master Plan for Sanitation and Hygiene uses the term 'differently-abled'. But in discussions with people with disabilities and representatives of disabled persons' organizations they pro-actively noted that they did not like this terminology. GSF is encouraged to make partnerships with organizations with experience and represent people with disabilities and also issues related to other marginalised or vulnerable groups in each context.

Just shit or broadening the impact?

Handwashing has been incorporated into ODF verification criteria and into the programmes visited to different degrees (i.e. whether it is required for ODF verification or otherwise or just encouraged). **Senegal** has also focussed on MHM, some programmes have incorporated elements of environmental sanitation and **Senegal** is planning to incorporate a nutrition element. Training community members on soap making in **Senegal** has served the dual purpose of enabling handwashing with soap – even for the poorest who may not be able to afford branded soap – as well as encouraging income generation for a number of women.

Several programmes have a broader definition of sanitation and hygiene integrated into the programme, as a post-ODF or second stage ODF focus, including personal hygiene, environmental hygiene, water quality and an increased attention on institutional sanitation. Some have had a broader focus from the start as per the national ODF definition and others have started with a broader focus and then simplified to reduce the areas focussed on.

The evolution from the main focus on communities becoming ODF and on hand-washing, to also cover other areas of sanitation and hygiene also considered positive from the EQND perspective. As well as having specific benefits it also prolongs the programme time in individual villages; and in turn provides the opportunity for continued monitoring to support the community.

The following statement should become a mantra for GSF as it works to strengthen EQND in its work:

"Nothing about us, without us!"

61 Noting that it has been reported by the GSF that individual discussions on some EQND related issues have been undertaken at various times in some countries.

However, whilst there is the opportunity to incorporate many different hygiene and health issues, there may also be risks in trying to incorporate too many issues at one time; therefore having the two-phased approach to focus initially on ODF and handwashing and to promote community-led action and achievement is still encouraged and then building on this with other issues.

Menstrual hygiene

MHM is not included in national criteria in ODF or in the higher levels of ODF verification and certification, as households move up the sanitation ladder (for example in Level 2 ODF); although the National Master Plan for Sanitation and Hygiene in **Nepal** specifically identifies this as an issue for the design of school latrines.

As CLTS aims to motivate communities and schools into constructing latrines to achieve ODF status, it is logical to ensure the needs of menstruating women and girls are also considered part of the process and in latrine construction, as MHM is a sanitation and hygiene issue for half of the world's population. If well facilitated, CLTS has the potential to rapidly break down taboos and silence around discussing menstruation publicly and promote MHM alongside their promotion of ODF and associated hygiene practices. Post-triggering and school activities are opportunities to discuss knowledge, attitudes and practices relating to menstruation and highlight the challenges faced by women and girls. Involving boys and men can also reduce teasing of girls by boys and help fathers to be more supportive of their daughters and wives. Girls in **Nepal** reported that having good facilities in schools enabled them to manage their menstruation more effectively at school.

A few examples of practices limiting use of latrines during a girl's period also highlight the practice's potential impact on OD, with some girls in **Malawi** being expected to defecate in the lake during their period and girls in the Western region of **Nepal** not being able to use family facilities or live in the same house as family members during their period. Whilst such practices may not be common, it is important for teams to learn about local practices and taboos, particularly any that may be inappropriate or negative.

In schools in **Nepal** both children and their teachers encouraged to discuss, share knowledge and experiences on MHM. This is not part of the national curriculum but based on the particular interest of the teachers and may sometimes have been triggered by the GSF-supported programme.[62] Discussions also highlighted that attention is also needed for disposal options as the girls reported carrying the used materials around with them all day and burying them when they got home. There are also opportunities in other countries such as **Ethiopia** where the government has developed a national policy and operational strategy on MHM and it is integrated into the guidance materials for health extension workers across the country. In **Senegal**, the training of staff and community members has led to a tangible impact on MHM with minimal inputs and hence can be used as a learning opportunity for other country programmes.

Girls in **Nepal** reported buying commercially made pads and these were available in the community shops. Community-based sales systems can provide a sustainable solution for the distribution of sanitary protection materials, such as low-cost reusable pads.

Communities, partners and staff may have limited knowledge on menstruation and menstrual hygiene practices. Training on MHM has been supported by the WSSCC in **Kenya**, **Senegal** and **Nepal**. Sanitation committees should also receive training on MHM to ensure good facilitation and dissemination of factual information.

Incontinence

Whilst the programme has focussed on the issue of constructing latrines and encouraging people to access and use them, there are people for whom regular and constant use may not be a practical option, particularly when the facilities are not designed to be quickly accessible. This includes people with incontinence. Incontinence is a complex health and social issue, which involves the involuntary loss of urine or faeces or both. It can affect a wide range of people including:[63]

- Older people;
- Men, women, and children with physical, intellectual, and/or psychosocial disabilities;
- Women and adolescent girls who have given birth;
- Women and adolescent girls who have suffered fistula due to giving birth too young, from prolonged/obstructed childbirth, or from sexual assault;

62 Although it is believed that MHM is not currently part of the standard GSF-supported activities in schools.
63 *Multiple sources in Hafskjold* et al (2015)

- People with certain types of illness (such as cancer, diabetes, arthritis, and asthma) or who have had an operation (such as the removal of the prostate);
- People who have experienced highly stressful situations, such as conflict or disasters, and develop night-time bed-wetting;
- Men, women, and children of all ages who simply have malfunctioning bladders or bowels.

The issue of incontinence was discussed with a number of respondents, including methods currently used for its management and frequent urination was reported by both men and women. At night, older people reported using a potty for urination or in some cases where they shared a latrine with other households, to practicing dig and bury at night. Training for EQND in CLTS should incorporate a discussion on incontinence, frequent urination and fistula and efforts made to establish good practices in terms of support for people who face incontinence. This would also add to the global body of knowledge on this issue.

Should ending open urination be part of the CLTS process and ODF?

After seeing men openly urinating in communities and also hearing from a woman who defecated in her latrine but urinated outside of the latrine, the question was raised as to whether stopping public urination should come under the definition of ODF or as a minimum be an integral aspect of all ODF campaigns?

The Joint Monitoring Programme (JMP) defines sanitation as the provision of facilities and services for safe management and disposal of human urine and faeces. But urination is not mentioned in either the definition or ODF guidance provided in the CLTS handbook. It is an issue broader than EQND, but has EQND relevance because of its gender dimensions. In most cultures, it is acceptable for men and boys to urinate in public, whereas women and girls report forcing themselves to not urinate, due to the lack of facilities in a variety of settings (including in the work place, in public places and when travelling) and/or withholding liquids so that they won't need to go, risking urinary tract infections. Public indecency and protection concerns from men and boys exposing themselves in public have also been voiced. In some countries, there are also laws that prevent people from using a toilet that reflects their gender identity if that does not match the sex stated on their birth certificate,[64] which may lead to transgender or intersex people having to go in places that subject them to violence.

Open urination also has hygiene, health and environmental implications – a man holding his genitals and not washing his hands – and then shaking his contaminated hand with someone, touching a door handle or other actions. Even if urine is believed to be mostly sterile, some studies indicate the presence of bacteria[65] and contaminants can also be present from poor personal hygiene, and also potentially from illness or disease. Urine can also start to smell and attract rats if left on the ground.

Public urination is partly the result of lack of provision of public toilets, which is a particular challenge that also can affect ODF status. A lack of public toilets is partly the result of most decision-makers in senior positions being male. The **Ethiopia** programme has found one solution to the lack of public toilets, by local government requiring that each set of 30 households build and maintain one public toilet. This is a very positive intervention but it will be interesting to see how well the communities manage to maintain and clean the toilets over the longer term.

In a number of countries globally, there are penalties against public urination as lewd behaviour with fines. Some GSF-supported programme countries prohibit indiscriminate urination, including **Malawi**[66] and **Kenya**[67] with public urination also being considered part of Prime Minister Modi's Clean **India** Campaign and in **Nigeria**, efforts have been made in Lagos to promote behaviour change against open urination.[68]

In **Nepal**, UN-Habitat and the GSF-supported programme has also been working on the promotion of urine diversion toilets to use urine and fertilizer since **Nepal** is an agricultural based nation, and also promoting the "Struvite" technology i.e. extracting phosphorus from urine and utilized as fertilizer in form of powder. They have also been linking to this the campaign promoting open urination as social shame and against dignity. This is part of Post ODF initiative towards total sanitation and some districts had already taken initiatives with a district code of conduct and provisioned penalty in this matter. See box above. See recommendations in **Section 10-R9**.

64 Such as The North Carolina Law, HB2 in the USA

65 A study found that bacteria are present at low levels in the urine of healthy people not suffering from a urinary tract infection - Wolfe, A. J et al (2015)

66 Government of Malawi (2008)

67 Government of Kenya (2016)

68 http://www.vanguardngr.com/2014/04/open-urination-defecation-stir-debate-artisans-forum/

Chairman of a village in SNNPR region of **Ethiopia** standing outside a public latrine (under construction) which has been built and will be managed by a group of 30-40 households

"It seems that you have also copied my style."

Poster advocating for stopping public urination through encouraging human dignity, being used by the GSF-supported programme in Dhanusha District, **Nepal**

(UN-Habitat, Nepal)

But stopping the widespread practice of urination will be challenging, as highlighted by a case study from Bekwarra District, **Nigeria**:

...successful efforts have been underway as part of the district-wide ODF campaign to improve the hygiene in a public market. A man spotted another man urinating in the area of the market and forced him to pay a fine.

But later that same day the man, who had been fined, saw the man who had done the fining also urinating in public!

9.7 SHOULD GSF PROVIDE GUIDANCE ON EQND?

GSF, guided by the Steering Committee, had for the early years mainly left country programmes to their own devices to decide how they would respond to a range of issues, including EQND, without providing guidance from the global level. The aim was to ensure country ownership and programmes appropriate to the local context. However, considering the learning through this EQND scoping and diagnosis process, both the gaps and the good practices, and in response to the UN commitments to non-discrimination and upholding rights and the SDGs to leaving no-one behind, it is recommended that guidance, capacity building and support should be provided and has been requested on EQND. This should focus on all stages of the programming cycle – through planning, capacity building, implementation, monitoring, review and learning.

CLTS is fundamentally about human dignity.[69] CLTS programmes can be designed in ways that promote and protect health (both physical and mental) and self-esteem (rather than result in stigmatization and discrimination). CLTS could therefore also be an opportunity to 'trigger' for greater equity between individuals and groups and to increase respect and the value of diverse contributions, by triggering a collective self-understanding that not supporting disadvantaged (vulnerable, marginalised) people to access appropriate sanitation that suits their needs is shameful, as they are everyone's relatives, friends and neighbours. This is critical if a community is to become ODF in a manner that is not only respectful of people's capacities, needs and rights, but also increases the self-confidence to be able to act (agency) and listens to the voice of marginalized and vulnerable groups. Another key outcome for CLTS is for the community to confront their own prejudices and identify ways to help their neighbours. This means ensuring that people who may be disadvantaged in diverse ways are welcome and included in the process as well as supported to ensure defecation occurs in the appropriate place (or if not that their faeces are safely disposed of) and that no group is blamed or scapegoated by the community for failure to reach ODF. High-quality facilitation is necessary to create a space where the community takes the lead to confront the special needs of disadvantaged groups by building on its strengths.

While the mantra of *'community problem, community solution'* is the guiding principle of CLTS, the facilitator has an ethical obligation to ensure that these solutions do not result in making vulnerable and marginalised people worse off. Programme staff, Natural Leaders, community-level sanitation committees, CLTS facilitators and community health workers can play a role in building general awareness to combat stigma. In many cases, this process

69 Cavill, (2017, paper pending)

must begin by confronting some of the attitudes and practices of CLTS facilitators themselves. It is often said that in order to facilitate CLTS, you need to change your own behaviour and be triggered and the same principle applies to this issue. As CLTS inevitably works within community power structures, it is the ethical obligation of the facilitator to step-in when there are risks that can lead to human rights abuses, which deepen stigma and discrimination against persons who are vulnerable or marginalised.

Whilst respondents may initially state that *"it is covered because this is CLTS and ODF means everyone has access to a toilet"* or *"there is no discrimination in our society"*, once you start asking questions and digging a little below the surface, it is clear that awareness on what EQND means and what it takes to ensure the programme effectively responds to EQND varies; and there are clear areas where the programme can and should be strengthened.

Promoting the concept of 'Do No Harm' (i.e. ensuring interventions do not make vulnerable or marginalised groups worse off) should be done through providing guidance materials and training on EQND throughout the programme cycle, use of terminology that doesn't promote stigma, M&E and targets that measure progress on this issue, and ensuring a code of conduct for stakeholders involved in the CLTS process. This will ensure a shared understanding of acceptable or unacceptable actions in preventing OD.

A range of the recommendations should be relatively easy to integrate at limited cost, just through keeping people who are disadvantaged on the agenda at each stage, but some additional costs will be required to build capacities and adequate time is spent in communities to ensure that people who are disadvantaged are not overlooked.

See **Section 10-R1** for recommendations for GSF.

9.8 MAKING MONITORING, EVALUATION AND LEARNING (MEL) DO-ABLE AT SCALE

Key learning from the EQND perspective

Some work on collecting EQND-related disaggregated data is being attempted in a number of country programmes, but the focus and mechanisms vary and it is not fully clear how the data is used. A number of countries have incorporated a few EQND-related issues or data in their proposals, baseline and outcome surveys and a few have included individual case studies in their quarterly and annual reports; but there are many gaps and there is a need for more consistent reporting on EQND-related issues in regular reports. A number of programmes have pro-actively undertaken learning on EQND-related issues or developed a strategic framework. All have value for GSF learn-

MONITORING AND EVALUATION IN NKHOTAKOTA DISTRICT, MALAWI. ©SARAH HOUSE

ing globally but the **Cambodia** EQND Framework is particularly impressive and the **Nepal** case study compilation (2014) and sustainability study (in draft form, 2016) are particularly interesting from the EQND perspective.

Biggest challenges for MEL related to EQND

The biggest challenges for MEL related to EQND seem to be:

1. Confusion over terminology and who should be included under the term 'disadvantaged'

2. Confusion over people who might be considered disadvantaged – but are able to build, access and maintain a latrine themselves and what this means for the definition of disadvantage

3. No requirement from GSF for regular reporting on this issue, including to report on the compulsory 'disadvantaged individual' indicator

4. The fact that most programmes are leaving identification of who might be disadvantaged up to the community leadership and there is no systematic follow up to understand what is happening on the ground or if anyone is falling through the net

5. The time that it takes for community leaders, or health extension workers to update a household register with all households, considering that most are undertaking the task on a voluntary basis

Rationale behind recommendations

The rationale behind the MEL recommendations which follow in the next section include:

1. As already described in **Section 9.2** – It is proposed to distinguish between A, B or C groups within the wider category of 'potentially disadvantaged groups'.

2. Collecting data from all households is a time-consuming task – one HSA in **Malawi** noted that for the three villages / areas she covers it takes her a full week to get around all households (she also collects other health related data). Therefore, such level of data collection should only be recommended on an occasional basis and if possible some form of support or motivation provided, particularly if the data is required for donor purposes. The ideal situation is where the community (community leaders, NLs etc.) collect, own and use the data themselves but are supported to ensure systematic processes, to enable consolidation upwards for the programme by the IPs.

3. Collating data from hand-written records to report upwards is also time-consuming, but hand-written data is a method that can be managed, owned and used by the community. The team understand in one VDC in **Nepal** that they were in the process of transferring their data to a computer – but were not able to see the data as the people met did not have access. Alternative digital methods require tablets or mobile phones can be useful to manage huge databases of information but these are expensive, need replacing at intervals and require a high level of ongoing external support. In addition, the data is analysed and controlled by people outside the community – taking away ownership and making the data less available within the community where it can be used to effect change.[70]

4. For disability, the recommendation is that detailed analysis of the kinds of disability is **not** done (such as using the Washington Protocol). Analysing types and degrees of disability is complex even for disability specialists and the information in not particularly relevant to the sanitation programme, except for making a judgement on who may have problems constructing, using or maintaining a latrine. This means that for monitoring purposes we are recommending that people should self-declare if they have a disability of any kind or level and that all people with a disability are pro-actively followed up to check that they have been able to construct, use and maintain a latrine and that they are aware of options for modifications to improve accessibility.

5. A range of other MEL related recommendations applicable to gender, age and other forms of marginalisation are also made.

Note that the programmes generally try to link into national monitoring systems, so it may be important for GSF to work with the government to improve the national monitoring systems in respect of EQND.

See recommendations in **Section 10-R11** and more details in **Annex XIII**.

70 The South Asia WASH Results programme headed by Plan International has used tablets for data collection on a sanitation programme at scale so would be good for learning from if the GSF decides to move in this direction.

SCHOOL CHILDREN PRACTICE EFFECTIVE HANDWASHING IN ARGHAKHANCHI DISTRICT, NEPAL. ©SUE CAVILL

10

RECOMMENDATIONS

Disclaimer: The recommendations that follow are made by the consultants to inform further discussion and decision-making by GSF.

Each main recommendation is followed by a number of actions which will assist GSF to implement the recommendation.

R1 SUMMARY OF RECOMMENDATION FOR ACTION BY GSF

Provide basic guidance to the GSF-supported country programmes on minimum programme standards including the introduction of a global code of conduct, continuing to identify good practice in relation to EQND and supporting capacity building and MEL.

This recommendation can be implemented through the following key actions:

1. Develop a global strategy and plan for strengthening EQND in the GSF-supported programmes and require that all countries also develop the same for their specific contexts. Consider EQND at the levels: a) global; b) national and sub-national; c) between communities; d) within communities between households; e) within households; and f) related to programme organizations, staffing, programme modalities and processes.

2. A budget should be specifically allocated to EQND both globally and in each country programme, as well as requirements for integration into all components of the programme's work.

3. Provide guidance to country programmes on the minimum standards for integrating EQND throughout the programme at sub-national, community, inter-household and intra-household levels.

4. Require all EA and IPs to sign up to a global code of conduct before approving the allocation of funds; and the country PCM to establish an associated local code of practice for all working implementing the programme to be aware of and commit to.

5. Produce a global practical guidance manual with key concepts and practical tips for adaptation by country programmes.

6. Continue to build its own capacity on how to ensure dignity, rights and inclusion of people from marginalized groups including people from sexual and gender minorities (SGMs) and people with mental health conditions. Provide guidance on the same to the country programmes.

7. Although it came low on the priorities of the country teams in the ranking exercise for support, the consultancy team sees significant value in each country programme recruiting a specialist EQND advisor, particularly as many national IPs will not have access to their own. This is to be able to support the development and implementation of a country based EQND strategy and to support the ongoing capacity building of staff, partners and communities and make sure that EQND considerations do not fall through the gap and get left on the bottom of the priorities. Considering the scale of the country budgets and the range of EQND related issues that affect the most disadvantaged people in the communities supported by GSF, this would be an effective use of resources and would allow GSF to be more consistent in its EQND approaches across programmes.

8. Continue to engage with the government to influence its focus on EQND in national planning and policy making processes.

PRIORITIES FOR SUPPORT

The priorities for support on EQND as identified during the 6 country workshops and the on-line survey can be seen in **Annex XV**. The top ten priorities overall in order or preference, were:

1. Guidance manual
2. Special budget for EQND
3. Review of programme with recommendations
4. On-the-job training
5. Workshop based training
6. IEC messages tackling these issues
7. Minimum standards
8. Linking with other organizations with expertise in this area
9. Access to specialist experts
10. Checklists

R2 KEY PRINCIPLES ON EQND

GSF should develop and share a set of key principles with the country programme teams on which all work should be based.

The recommendations for key principles for GSF to continue developing are:

1. Recognize difference in all communities and look for those who might be excluded from the programme

2. Do no harm by:

   i. Ensuring that the programme regularly listens to the voices of those who are potentially disadvantaged

   ii. Promoting the confidence and self-efficacy of those who are potentially disadvantaged by involving them in decisions and encouraging their *active* and not passive participation

   iii. Ensuring that field staff seek and are open to feedback from community members – particularly those who might be disadvantaged

   iv. Providing practical training/ discussion/ guidance to all field staff and Natural Leaders on EQND issues

   v. Being as transparent as possible about programme decisions and seeking input and direction from community members where possible

   vi. Ensuring confidentiality and people's right to privacy

   vii. Monitoring the process, outcomes and impact for those who are potentially disadvantaged

   viii. Providing information in a form that can be understood and used by all

3. Consider and advocate for how those who are potentially disadvantaged (including carers) can be involved in both the process of the sanitation programme (as staff, Natural Leaders, committee members, advocates, etc.) as well as benefitting from the outputs (use of latrine and handwashing facility, skills training etc.); and have their concerns listened to.

4. Encourage people to undertake tasks themselves wherever possible to contribute to empowerment and building self-confidence; but also recognize where external support is required, whether from the community or external, ensuring that people who are disadvantaged are not put under unnecessary levels of stress.

5. External support should be provided transparently and should identify ways to enable community members to be involved in decision making on how it should be used / who should be supported.

6. Collaborate with organizations representing those who are disadvantaged and seek their advice and engagement with the programme.

7. Continue learning and building on your experience as to how to best include and benefit from the skills and knowledge of people who may be disadvantaged and share with others.

R3 TERMINOLOGY AND CATEGORIZATION OF DISADVANTAGE

Establish the global terminology to be used by GSF related to disadvantaged individuals and groups and provide guidance on categorization of factors, as a starting point for country programmes to adapt to their own country contexts.

This recommendation can be implemented through the following key actions:

Terminology:

1. Use the term **'potentially disadvantaged'** as an overview term for people who may face additional barriers to participate in and benefit from the programme; and where necessary in the longer form: **'Potentially disadvantaged' includes:** *individuals and groups who may be vulnerable, marginalized, excluded or actively discriminated against, or experiencing inequities, inequalities or stigma.* The terms 'potentially' and 'may' takes into account that not all people who may be considered disadvantaged may actually be so.

2. Establish a set of appropriate and respectful EQND terminologies in each country and context – both in the international and local languages used in the programme area. If you use the phrase... *"A person with...a speech impediment, a mental health condition etc"* or *"A person who uses...a walking aid, a wheelchair etc"* you are likely to be more respectful.

3. Partner and take advice from organizations representing disadvantaged groups for specific guidance. Remember: "Nothing about us, without us!"

Categorization of those who may be disadvantaged:

1. Uses the 'Clusters of Disadvantage' identified in **Figure 9** and **Annex XI**.

2. Those who may be considered potentially disadvantaged (vulnerable, marginalised, excluded, experiencing inequities, inequalities or stigma) should also be categorized into the Group A, B and C as indicated in Fig 10, to simplify the process of establishing who might require support.

3. It is proposed that the categorization should initially be undertaken by community leaders with support of the IPs to build their capacity to assess appropriately and that the process should be as simple as possible. But then the initial identification should be cross-checked by a secondary community representative group such as a citizen's forum or equivalent where possible.

4. The process should include only self-reporting on disability with no indication of level or severity apart from whether the person may find it difficult to build, access or maintain a latrine; and that a detailed wealth ranking is not appropriate nor necessary, but a list of simple indicators can be referred to as a guide as well as relying on community knowledge of the level of poverty of the particular household.

For further details refer to:

- The full list of recommended terminologies in **Annex XVI**.
- For more details of how categorization of households into groups could be undertaken see **Annex XIII**.

R4 ENSURING INCLUSION OF MARGINALISED AND EXCLUDED INDIVIDUALS AND GROUPS

Particular attention should be placed on ensuring that individuals and groups who may be marginalised or excluded, are identified and included in the programme, in ways that ensure their safety and that support their dignity and rights.

This recommendation can be implemented through the following key actions:

Marginalised groups:

1. GSF needs to emphasise the importance of recognition of marginalised individuals and groups within the programme and ensure that the challenges they may face are identified and responded to.

2. Recognize that staff may not automatically acknowledge the presence of marginalised groups. This issue should be included within capacity building on EQND-related issues.

3. Bring in experts with experience of working with particular marginalised groups from the particular country as part of EQND training, to raise awareness on their existence and issues they may face and to recommend appropriate strategies to respond.

People with mental health conditions:

1. The GSF-supported programmes need to start to pro-actively learn about issues affecting people with mental health conditions in their sanitation programmes and to document and share examples of good practice for solutions to: promote the communities' role in respecting the rights and needs of people with mental health conditions, to include and encourage them in the processes, where possible to contribute to building their confidence and empowerment and to minimise any risks of harm.

2. Minimum standards for the inclusion and protection of people with mental health conditions should be provided in a global code of conduct and included in training of staff, partners, CLTS facilitators and community leaders.

3. A range of practical recommendations for working with people with mental health conditions and their families / carers have been included in the Dos and Don'ts tables in **Annex XI**.

Sexual and gender minorities:

1. GSF globally should establish an explicit set of global values that support SGMs so that those working on the programme know of these values even when they cannot be discussed explicitly in their country. These are principles and values such as non-discrimination and respect for all human beings who are born free and equal in dignity and rights; and that respect should be shown towards all staff, partners and community members. This could be included in a global code of conduct or diversity and inclusion policies.

2. GSF should engage a specialist SGM organization to establish a clear picture of the legal situation in all countries in which GSF operates and to establish how daily life might be different to how the law says; so that it can work out how to ensure equal rights and respect for all in its programmes even where the issue is difficult to talk about.

3. To ensure that policies in all programme countries ensure non-discrimination, dignity and respect towards all staff, partners and people in the programme areas as a minimum standard and that a code of conduct exists supporting the same.

4. Provide opportunities for building the capacity of staff and partners to be able to better understand SGM issues and how to treat staff, partners and community members who are SGMs with respect and to not put people at greater risk by heightening their visibility.

CONTINUED OPPOSITE ▼

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R4 ENSURING INCLUSION OF MARGINALISED AND EXCLUDED INDIVIDUALS AND GROUPS

Particular attention should be placed on ensuring that individuals and groups who may be marginalised or excluded, are identified and included in the programme, in ways that ensure their safety and that support their dignity and rights.

5. Pay greater attention to the provision of public toilets and understand the importance of having a gender-neutral toilet option as well as male and female toilets. UNHCR has developed a strategy of including a gender-neutral accessible unit in addition to male and female units, as is also common in high income countries. The gender-neutral unit can be used by any person including someone with a disability or mobility limitations, parents with a young child, people who are SGMs and any other user.

People living on the streets and in poorly paid and dangerous employment:

1. Pro-actively learn about the sanitation and hygiene needs of people living and working in precarious conditions and work with government institutions and other partners to ensure that their sanitation and hygiene needs are supported.

2. Work with specialist organizations working with particularly marginalised people to establish appropriate strategies.

R5 CAPACITY BUILDING AND EMPOWERMENT OF PEOPLE WHO MAY BE DISADVANTAGED

Consider how the programme through its programme processes can support the capacity building and empowerment of people who might be disadvantaged.

This recommendation can be implemented through the following key actions:

1. Pro-actively identify and engage emerging NLs from groups which may be normally considered disadvantaged and aim for gender parity in selection of NLs whenever possible.

2. Consider the quality of training that is provided to community members (such as Natural Leaders) and ensure that adequate time is devoted to this.

3. Consider what mechanisms, as part of the CLTS process, could be used to: support the empowerment of potentially vulnerable, marginalized or disadvantaged groups; and contribute to break down stereotypes and reduce exclusion and discrimination.

4. Consider the training, support or encouragement that might be needed to enable people who might be potentially vulnerable, marginalized or disadvantaged to: take up leadership roles and be members of committees; undertake community advocacy; and be able to maintain and sustain their own toilet and hand-washing facilities.

5. Consider what training staff, partners, community leaders and other actors involved in the programme might need to be able to support the above (and draw on the Senegal emphasis on community level training for inspiration).

R6 LIMITS OF METHODS OF INFLUENCE

Clarify the different methods that should be used to influence others to change their sanitation and hygiene practices and establish limits within a Code of Conduct that all staff, partners and community leaders should agree to.

This recommendation can be implemented through considering the follow guidance on limits:

1. **Persuading and convincing** different individuals and groups are acceptable communication techniques – if people are accorded 'free' choice and given the option of disagreeing with the proposition.

2. **Physical coercion** (i.e. threats of or actual violence) is *never* acceptable.

3. **Coercion**, as a means to force community members against their will to safely dispose of faeces should be used with caution and should ensure that those who might be vulnerable are not made more so e.g. fining/punishment of the most vulnerable. It is about recognising that we may do harm by using coercion – any type of coercion – coercion creates dependency, helplessness, powerlessness, but it may sometimes be justified. It is important to be aware of the harm it can cause and only use it where absolutely necessary and where there is no alternative or where we have exhausted the alternatives.

4. Safeguards need to be in place to ensure that methods employing coercion (such as fining) are used responsibly and that excessive use of coercion is not employed on anyone, but with particular care with respect to the most disadvantaged who are likely have less ability to respond.

5. Recognition/discussion of the risks of the harmful use of coercion could go some way to limiting excessive use and recognising its impact.

6. Each programme will need to establish practical suggestions for: a) persuading those who do not understand why it is important to stop OD even after triggering; b) overcoming resistance from different people, and c) taking into consideration different forms of disadvantage; and d) assisting the most vulnerable who are unable to construct, maintain and sustain a latrine or pay for the same.

See the Dos and Don'ts table in **Annex XI** and the section on working with people with mental health conditions in Section 9.3 for ideas of positive strategies which can be utilized.

R7 OPTIONS FOR SUPPORTING THE POTENTIALLY DISADVANTAGED

Consider the different methods for supporting the potentially disadvantaged, including the option of receiving a government approved subsidy for the Category C group of households.

This recommendation can be implemented through the following key actions:

1. A wide range of options should be considered for supporting people who are potentially disadvantaged. See **Figure 11** for an overview.

2. Targeted, government-sanctioned subsidies (labour, materials, finance) from different sources could be made available for Category C group of people who might be disadvantaged – these are the individuals and households who are a) unable to construct a latrine on their own; b) do not have extended family members to assist; c) do not have adequate savings or income to pay someone to do the work; and d) are at risk of selling some of their limited assets if forced to construct a latrine using their own resources (see **Figure 10**)

3. The priority order of action (a to d) should be for:

   i. Encouraging people who can to construct their own to do so – encouraging a feeling of self-efficacy and self-confidence

   ii. Encouraging family members to support

   iii. Facilitating other support and resources from within the community

   iv. Some government specified targeted subsidy for those in category C above

R8 WORKING IN DISASTER AND CONFLICT PRONE AREAS

GSF should have flexibility in its strategies and approaches to programming in areas vulnerable to and affected by natural disasters and conflicts.

This recommendation can be implemented through the following key actions:

1. Be aware of the programme areas that are vulnerable to natural disasters / climate change or conflicts during the programme planning phases.

2. Integrate into planning figures, time schedules and budgets, the flexibility to manage the impacts of such events (such as displacement, collapse or flooding of latrines etc.) on the programme outputs.

3. Retain an emergency preparedness fund at the global level that can be called upon in any of the programme countries.

4. Subsidies provided during and after a humanitarian emergency can be disruptive to CLTS. Whether GSF decides to provide subsidies during a period of humanitarian response or not, will be a strategic decision for the programme. But whether or not GSF provides support or subsidies in an emergency period (which can be considered like a form of insurance), it is unlikely that the humanitarian sector will stop giving subsidies. Hence the programme needs to develop a strategy to adapt programme approaches during the emergency period to enable a smooth transition back to longer term development strategies. The Nepal programme has significant experience in this area and this experience should be shared more widely.

5. Use the knowledge of the programmes that are experienced in working in conflict areas, for example Nigeria, using NLs and CCs to access areas that IPs are less able because of conflict.

6. It would be positive for GSF to continue collaborating with humanitarian agencies to find solutions for the transition.

R9 BROADENING THE IMPACT: DISABILITY, MHM, INCONTINENCE, URINATION AND TO BROADER ASPECTS OF SANITATION AND HYGIENE

GSF is encouraged to strengthen its programmes and to offer more guidance and support to programmes in the areas of disability, MHM, incontinence and urination, all of which have EQND implications; and to continue to provide ongoing support to communities post-ODF to respond to broader sanitation and hygiene needs and with the added benefit of being able to monitor and reduce the risk of slippage for the most disadvantaged.

This recommendation can be implemented through the following key actions:

Disability:

1. Establish partnerships with Disabled Persons Organizations to develop a strategy to improve the involvement of people with disabilities and accessibility of latrines at household and institutional level in villages supported by GSF.

2. Provide guidance to country programmes on how to incorporate people with disabilities more effectively in the programmes to pro-actively facilitate discussions during triggering on possible solutions but also to make the most of the existing practical materials already available.[71] Develop compendiums of simple designs for use in communities to share options as a supporting strategy.

3. Make sure that people with disabilities are involved in the GSF-supported programmes at all levels and all stages, ensuring that GSF follows the principle: **"Nothing about us, without us!"**

4. Support trainings of masons to develop and understand options for designs and how to work with people with disabilities.

Menstrual hygiene management (MHM):

1. Utilize opportunities from the WSSCC MHM advocacy activities and GSF for learning and integration of MHM in GSF-supported programmes.

2. Use triggering to create positive norms and breaking down myths on MHM e.g. myths and taboos that prevent women from using latrines during their menstrual period.

3. Use institutional triggering for advocacy on MHM and to support cross-sectoral collaboration and confident staff able to engage and provide support on MHM.

4. Make sure that sanitation facilities are accessible for women and girls providing: privacy, access to water supply (for bathing and washing materials), disposal and drying options (where appropriate) and space for changing, washing and cleaning the body.

5. Investigate the availability of hygienic, affordable and culturally and age appropriate menstrual hygiene protection materials and providing information on the same.

6. Provide information, awareness-raising and opportunities for dialogue with women and girls, men and boys within the GSF-supported programme.

7. Document examples of how MHM interventions have been incorporated into CLTS and School-Led Total Sanitation (SLTS) programmes, also learning from existing innovations and experiences globally.

Incontinence:

1. Investigate how the issues have been dealt with by other (national and global) sanitation programmes, if there is experience in this area, and find national partners with expertise on incontinence to seek their advice and support.

2. Work with health facilities and HEW to train sanitation committees and Natural Leaders on causes of incontinence and involve them in community wide efforts to reduce stigma, and explain methods to manage incontinence that can be used by community members.

71 Such as: Jones and Reed (2005); and Jones and Wilbur (2015)

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R9 BROADENING THE IMPACT: DISABILITY, MHM, INCONTINENCE, URINATION AND TO BROADER ASPECTS OF SANITATION AND HYGIENE

GSF is encouraged to strengthen its programmes and to offer more guidance and support to programmes in the areas of disability, MHM, incontinence and urination, all which have EQND implications; and to continue to provide ongoing support to communities post-ODF to respond to broader sanitation and hygiene needs and with the added benefit of being able to monitor and reduce the risk of slippage for the most disadvantaged.

3. Identify appropriate ways to deal with the waste of incontinent people e.g. use of mattress protectors; use of materials for soakage; buckets with seat; 'dig and bury'; or to scoop up and dispose in a latrine.

4. Find ways to target specific individuals, households or groups with information and advice related to managing incontinence i.e. those with medical conditions (such as stroke or neurological conditions), disability or life-course status (i.e. age, pregnancy or menopause).

5. Suggest makeshift arrangements for people who cannot make it to a latrine at night. These arrangements include commode seats over deep and open receptacles like potties, buckets or pots, and potentially screens, that provide ease-of-use, comfort, safety from spillage and as much dignity as possible.

6. Consider the water security implications for hygiene related to incontinence – i.e. water needed for bathing and washing materials and clothes – to avoid being, feeling and smelling dirty and soiled.

Urination:

1. Place more attention on open urination in GSF – some of the same arguments apply for urination as for defecation i.e. privacy, safety, dignity and hygiene.

2. Be clear that toilets are meant for urination as well as defecation and make sure that open urination is included in CLTS triggering and follow up.

3. Review appropriate technologies i.e. urinals for girls in schools or women in public places may not always be appropriate i.e. for menstruating women and girls or for adolescents expected to share with much younger girls; urine diversion toilets may not always be user-friendly.

4. Advocacy for increased attention on public toilets including on roadsides and markets and urban areas (also important for general use to stop OD and for particular groups such as people who live on the streets, people with disabilities, SGMs, etc).

Broaden focus on sanitation and hygiene for post-ODF follow-up:

1. Increase attention on areas of sanitation and hygiene which are currently weaker in some country programmes, such as hand-washing with soap or ash; and increased attention on institutional sanitation and hygiene. Increase attention on water quality, particularly where latrines have been constructed near to water points in shallow groundwater areas.

2. Extend the GSF-supported programmes' post-ODF status to include more of the broader elements of sanitation and hygiene, such as personal hygiene (wider than hand-washing) and environmental sanitation. Utilize this opportunity to continue follow-up post-ODF to prevent slippage and to ensure that the most disadvantaged are effectively managing over time to continue to access and use a latrine.

3. If possible consider supporting funding for water supply as a post-ODF reward, as a motivation for reaching and sustaining ODF, as well as to make sanitation and hygiene more effective.

R10 DOS AND DON'TS OF CLTS IMPLEMENTATION

Prepare guidance and build capacity of GSF stakeholders on the Dos and Don'ts of CLTS and other approaches focussing on behaviour change at scale, to promote and protect dignity, uphold rights and value contributions of all including those who are disadvantaged; and in addition, to contribute to empowering people who may be disadvantaged and increasing community commitment to equity and equality for all.

A series of tables in **Annex XI** provide suggestions for Dos and Don'ts for working with people who might be vulnerable or marginalised. It has been developed through the experiences and ideas shared during the EQND learning process as well as the published literature. The Dos and Don'ts have been split as follows, with sub-sections relating to specific stakeholder groups where applicable:

1. Enabling environment
2. Organizational and MEL
3. Programme / community:
    i. 'Do no Harm' – Applicable to all stages
    ii. Pre-triggering
    iii. Triggering
    iv. Post triggering – Follow-up
    v. By stakeholder group

Two further complementary Annexes – include further case studies highlighting: Challenges that people have faced – **Annex IX**; and examples of good practice – **Annex X**.

R11 EQND RESPONSIVE MONITORING, EVALUATION AND LEARNING (MEL)

Provide guidance to country programmes on how to effectively integrate EQND into monitoring, evaluation and learning and the minimum requirements for this.

This recommendation can be implemented through the following key actions:

1. Provide guidance to EAs and IPs on minimum requirements for EQND for all elements of MEL, whilst also allowing some degree of adaptation to local contexts.
2. Support the systemization of EQND related data collection into the existing household registers; but keep the assessment of key factors such as a) disability and mobility limitations and b) ability to earn an income and assets as simple as possible; with self-reporting for the first, and using community knowledge with guiding criteria for the second.
3. Utilize the A, B, C categories for distinguishing between people who might be disadvantaged but A) are able to construct, access and maintain, B) with those who can manage with family support or by paying someone to do the work, with C) those who are not able to construct, have no-one to assist them, do not have savings or ability to earn adequate income and would be likely to have to sell off some of their limited assets to build a latrine. These categories are to be used to establish who will need support from outside the family.
4. Establish and report on those affected by geographic or disaster related challenges separately to those affected by individual, household or group related challenges or barriers.
5. It is recommended that there should be three levels of monitoring:

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R11 EQND RESPONSIVE MONITORING, EVALUATION AND LEARNING (MEL)

Provide guidance to country programmes on how to effectively integrate EQND into monitoring, evaluation and learning and the minimum requirements for this.

i. **Undertaken internal to community – used by community on an ongoing basis:** The household register set up and updated by the community leadership for sub-sections of the community, on an ad hoc basis for different areas within a community – focuses on every household in the community.

ii. **Undertaken internal to the community – also to be reported to GSF:** An update of the whole of the household register and the situation of every household in the community once a year – undertaken by the community leadership with the support of the IP if needed, and funded or incentivised due to the amount of time it is likely to take.[72] This will then provide more accurate and disaggregated data from community level, including on progress in relation to EQND. This information can be used by the community and GSF.

iii. **Undertaken by external actors – but with results fed back to the community** – The baseline and outcome surveys that are sample based quantitative and qualitative surveys which go into greater detail and analysis but only take a sample of the population.

6. Continue to encourage targeted learning on EQND-related issues and the sharing of the same between programmes; paying particular care to ensure that EQND is well integrated into all broader and large-scale studies such as the sustainability studies, so as to not to miss the opportunity to gain more knowledge on the scale of EQND-related issues.

7. The core global quantitative indicators should focus on 'households with disadvantaged individuals' rather than 'disadvantaged individuals' because whether a potentially disadvantaged individual has been able to build or access a latrine will be affected significantly by the situation of their household.

8. Discussion on a range of qualitative questions and associated indicators to understand more about participation, opportunities for leadership, how people managed to build, access and use a latrine, intra-household use and the outcome both positive and negative, and variations by age, gender and disability can be found in **Annex XIII**.

For more detailed recommendations including on the recognition of disability see **Annex XIII**.

72 Note that GSF-supported programmes are currently asking for this data every quarter; but that it is not clear whether the data is accurate or checked by the IPs. By making it once yearly, it would hopefully make it more achievable to produce accurate data.

R12 PROGRAMME MODALITIES

Consider the impact of programme modalities in ensuring EQND when designing new or extensions to programmes.

The following modalities are recommended as being supportive of EQND:

1. To trigger and follow-up in small communities (including sub-divisions of larger ones), enabling increased likelihood of knowing the disadvantaged households and effective support and follow-up.

2. Consider supporting more paid CLTS facilitators who come from the communities they are triggering (as per the Nepal model, but with increased salary) where they know their communities and can commit more time to follow up. This is not to replace the NL system but to increase the amount of time available for follow-up and establish a focal person for coordinating action at community level.

3. Focus on ensuring good quality follow up that has a pro-active focus on EQND but that also considers the increasing the amount of time allowed for follow-up by IPs and the numbers of CLTS facilitators where appropriate, to enable more direct follow-up and support for people who may be considered disadvantaged (which in some communities can involve large distances between each household).

4. Consider strengthening rewards for communities which become ODF as a motivator, which could also be used to support community projects and including for the most disadvantaged (for example to purchase toilet seats for people with mobility problems or bed pans or bed protectors or other hygiene items for people managing incontinence).

5. Significantly increase attention on public and institutional latrines through advocacy and technical support and also considering whether GSF could support some infrastructure costs.

6. Consider the provision of more incentives / small motivations for key actors such as CLTS facilitators, Natural Leaders, WASH committees etc. who spend significant time working on follow up and supporting – requests made for shared bicycles, bags / t-shirts for identification etc. In particular, the shared bicycle option would be worth consideration to facilitate more regular follow-up over long distances.

7. Encourage the ongoing identification of *natural* Natural Leaders rather than just ones appointed during triggering and establish flexible systems that allow for emerging Natural Leaders to join leadership activities under the programme.

8. GSF should recommend that all households (including those with disadvantaged members) should have access to their own household latrine and not be expected to share.

DISPLAYING AN ARBORLOO LATRINE IN MALAWI, CONSTRUCTED WITH THE HELP OF A COMMUNITY-BASED ORGANIZATION. ARBORLOO LATRINES SUPPORT THE HARVESTING OF MANURE FOR AGRICULTURAL ACTIVITIES. ©STEVEN KAMPONDA

ANNEXES

LIST OF ANNEXES

The following Annexes can be found online at wsscc.org**:**

ANNEX I: PEOPLE MET DURING THE COUNTRY VISITS

*Table 10: People met during the country visits**

Remote KIIs and on-line survey					F		M		Other		Prefer not to say			
KIIs – External stakeholders – global					10		4							
KIIs – Secretariat; EAs; SGs					12		20							
On-line survey					12		42				1			
Remote engagement total					34		66				1			101
Country visits	**Malawi**		**Ethiopia**		**Senegal**		**Nigeria**		**Nepal**		**Togo**		**Total**	
Days engagement in country – by consultant	*11 days 11 days*		*5 days 5 days*		*10 days 10 days*		*10 days 5 days*		*15 days 13 days*		*5 days –*			
	F	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Total number of people met	200	170	16	31	115	102	102	134	229	333	13	44	675	814
	370		47		217		236		562		57		1,489	
PCM members	1	3	1	5	0	1	4	3	0	2	0	8	6	22
EA (+GSF in Ethiopia)	2	10	1	7	4	0	2	4	8	7	3	1	30	29
SG representatives	5	18	0	13	9	17	21	35	18	24	5	16	58	123
Other sector stakeholders	1	–	In PCM		1	5	0	2	3	4	1	4	6	15
Number of districts (or communes) visited	2		1		6		2		4		1		16	
Number of villages / communities engaged	70**		3		16		16		10		1		116	
Number of household visits	26		5		10		15		44		4		104	
District coordinating mechanism / Local authority / other stakeholders	1	2	1	3	1	9	1	3	5	28	0	10	9	55
CLTS facilitators	10	8	In SGs		–	–	In SGs		9	9	–	–	19	17
Community consultants	–	–	–	–	–	–	0	6	–	–	–	–	0	6
Village leaders (VLs) (Chief, village committees, WASH-Committees, various community group leaders; health extn. workers)	14	24	5	5	4	14	28	39	38	139	0	1	89	222
Natural Leaders	28	20	5	0	28	18	1	18	In VLs		–	–	62	56
Members of savings group	14	0	–	–	28	4	–	–	–	–	–	–	42	4
Sanitation Revolving Fund	1	2	–	–	–	–	–	–	–	–	–	–	1	2
Masons	–	–	–	–	–	–	–	–	0	16	–	–	0	16
Older persons	41	35	2	3	10	2	11	20	26	57	3	1	93	118
Children 5-18 + youth	29	2	–	–	11	0	12	8	34	4	–	–	86	14
Child < 5 years	5	5	–	–	0	0	2	0	8	1	0	2	15	8
People with disabilities	2	11	–	–	0	5	6	19	18	11	1	1	27	47
Carers of people with disabilities	8	1	–	–	6	0	6	1	4	2	–	–	24	4
Person who is ill	0	1	–	–	0	1					–	–	0	2
Schools	2		–		–		2		3		–		7	
Health facilities	1		–		–		2		4		–		7	
Religious institutions	–		–		–		1		–		–		1	
Workplaces	–		–		–		–		1		–		1	
IDP camps	–		–		–		–		1		–		1	

* Some of the categories overlap – such as SGs and Local authorities, where many of the local authority staff are also SGs, but which are not identified in the SG category.

** The number of villages from which people engaged is much larger in Malawi than in the other countries as many of the original villages (now known as 'group villages') have been sub-divided into smaller villages. Representatives from a number of the newer smaller villages participated in the meetings. This number is the number of villages from which people engaged in the process, not the number of villages visited.

ANNEX II: LIST OF CONTRIBUTING INSTITUTIONS AND ORGANIZATIONS

A wide range of individuals and organizations contributed to the EQND Scoping and Diagnosis Process, in particular at community level, as part of district coordinating teams, or in the national workshops. As part of the ethical protocol for this process, to encourage openness and so that specific findings cannot be attributed to specific persons or communities, acknowledgements below district level have been made in generalised form. Please refer to the acknowledgements at the beginning of the main report.

The following is a list of contributing organizations and institutions from district level and above, that were involved in contributing to the process through taking part in: a) the national workshops; b) KIIs; c) hosting parts of the process; or d) taking part in meetings.

Table 11: Contributing institutions and organizations – Ethiopia, Malawi, Nepal, Nigeria, Senegal and Togo

Ethiopia

- Amhara Regional Health Bureau
- Chole Woreda Health Office, Oromia Region
- Dugna Fango Woreda Health Office, Southern Nation Nationalities and People Region
- Federal Ministry of Health
- Kedida Gamela Woreda Health Office, Southern Nation Nationalities and People Region
- Ministry of Water, Irrigation and Electricity (MoWIE)
- Netherlands Development Organisation (SNV)
- Oromia Regional Health Bureau
- Raya Alamata Woreda Health Office, Tigray Region
- Sekela Woreda Health Office, Amhara Region
- Southern Nation Nationalities and People Region, Regional Health Bureau
- Tahtay Koreho Woreda Health Office, Tigray Region
- Tigray Regional Health Bureau
- UNICEF
- WaterAid
- World Health Organisation (WHO)
- Wogedi Woreda Health Office, Amhara Region
- World Bank

Malawi

- Balaka District Council (Community Development, Social Welfare, Health)
- Chikwawa District Health Office (DHO)
- Concern Universal
- Design Management Consultants /A Self-Help Assistance Programme
- PE District Health Office
- Feed the Children
- Hygiene Village Project
- Ministry of Agriculture, Irrigation and Water Development
- Ministry of Gender, Children and Social Welfare Federation of Disabled Organisations in Malawi (Fedoma)
- Ministry of Health
- Mzuzu University
- Nkhotakota, District Council (Education, Community Development, Forestry, Irrigation, Water)
- NRB BDC (Balaka)
- Participatory Development Initiatives (PDI)
- Plan International Malawi
- Project Concern International
- Rumpi District Council
- Synod of Livingstonia Development Dept (SOLDEV)
- Training Support for Partners (TSP)
- WESNET
- Wildlife and Environmental Society of Malawi (WESM)
- World Relief Malawi
- World Vision International

Nepal

- Birgunj Sub Metropolitan City
- Blue Diamond Society
- Child Workers in Nepal (CWIN)
- Community Development Forum Nepal (CODEF)
- Community Family Welfare Association (Nepal) (CFWA)
- District Development Committee, Arghakhanchi
- District Development Committee, Dhanusha
- District Development Committee, Rusawa
- District Development Committee/ Rural Water Supply and Sanitation Project in Western Nepal Phase II (RWSSP-WN II)
- District Education Office (DEO) Dhanusha
- District Health Office (DHO) Dhanusha
- District WASH Coordinating Committee (D-WASJ-CC), Arghakhanchi
- Environment and Public Health Organisation
- Environment and Public Health Organization(ENPHO)
- Environment, Culture, Agriculture, Research and Development Society (ECARDS)
- Friends Service Council Nepal (FSCN)
- Integrated Development Society (IDS), Nepal
- International Development Enterprises (IDE), Nepal
- Janaki Women Awareness Society (JWAS)
- JSMC
- Langtang Area Conservation Concern Society (LACCoS)
- Lumbini Social Development Center (LSDC)
- Manekor Society Nepal
- Ministry of Water Supply and Sanitation
- Multi- disciplinary Services & Rehabilitation
- National Association of the Deaf and Hard of Hearing (NADH)
- Nepal Disabled Women Association (NDWA)
- Nepal Educational Support Trust (NEST)
- Nepal Red Cross Recovery Program
- Nepal Red Cross Society (NRCS)Nepali Army, Rasuwa
- OXFAM
- Panchawati Rural Development Centre (PRDC) Nepal
- Participatory Research and Action Group (PRAG) Nepal
- Patan Community Based Rehabilitation Organisation (Patan CBR)
- PRAAPS
- Professional Development and Research Center (PDRC), Nepal
- Renaissance Society Nepal
- Renaissance Society Nepal / Development and Environment Conservation Center Nepal (DECON)
- Rural Development Centre (RDC) Bara, Nepal
- SSIC
- OXFAM
- Panchawati Rural Development Centre (PRDC) Nepal
- Participatory Research and Action Group (PRAG) Nepal
- Patan Community Based Rehabilitation Organisation (Patan CBR)
- PRAAPS
- Professional Development and Research Center (PDRC), Nepal
- Renaissance Society Nepal
- Renaissance Society Nepal / Development and Environment Conservation Center Nepal (DECON)
- Rural Development Centre (RDC) Bara, Nepal

Nepal (cont)
• SSIC • Social Development Path (SODEP) • Society for Youth Activities (SOYA) • Suaahara II • Support for Technical and Allied National Development (STANDS Nepal) • Suyuk Dhanusha • UN-HABITAT • UNICEF • USSDORDF • Water Supply and Sanitation District Office (WSSDO), Arghakhanchi • Water Supply and Sanitation District Office (WSSDO), Bhaktapur • Water Supply and Sanitation District Office (WSSDO), Dhanusha

Nigeria
• Abi LGA • Action for Rural Development (AFRUD) • Advocates for Community Vision and Development (ACOVID) • Agatu LGA • Benue State, Rural Water Supply and Sanitation Agency (BE-RWASSA) • Bwekarra LGA (Administration, WASH Unit) • Community Development for Social Justice (CDSJ) • Cross-River State, Rural Water Supply and Sanitation Agency (CRS-RUWASSA) • Federal Ministry of Water Resources • First Step Action • Gender and Rights Initiative (GERI) • Green Health Initiative (GHI) • Gwer East LGA • Hope and Care Foundation • Hope and Care Foundation (HCF) • Inclusive Friends • Jessy Odama Development Foundation (JODED-F) • Life Empowerment Foundation (LEF) • Logo LGA (Administrator, Health Dept, WASH Unit) • Nigeria Police Force, Bekwarra • Obanliku LGA • RAMBERG Child Care Initiative (RACSI • United Purpose

Senegal
• AGETIP – Agence d'Exécution Travaux d'Intérêt Public (Implementing Agency for Public Works) • Comité d'Appui et de Soutien Au Développement Economique et Social en Casamance, Matam • Eau Vie Environnement, Kédougou • Handicap International • Local Authorities, Goudiry • Local Authorities, Kael • Local Authorities, Mbacke • Mairie Touba Mbout (Town Hall) • Malick Sow et Associés, Goudiry • Ministry of Health, Hygiene Services Directorate OXFAM • Sanitation Directorate • Sous-Prefecture, Kael • USAID • Women's Health Education and Prevention Strategies Alliance

Togo
• Appui au Développement et à la Santé Communautaire (ADESCO) – Support to Development and Community Health • BØRNEfonden (Danish NGO) • Communication pour un Développement Durable (CDD) - Communication for Sustainable Development • Coopération pour l'Appui au Développement Intégral du Togo (CADI TOGO) – Cooperation for Support to Integral Development in Togo • Croix Rouge Togolaise (CRT) – Togolese Red Cross

Togo (cont)
• Direction de l'Hygiène et de l'Assainissement de Base au Ministère de la Santé et de la Protection Sociale (DHAB) - Directorate of Hygiene and Basic Sanitation in the Ministry of Health and Social Welfare • Directions Régionales de la Santé (régions Savanes, Kara et Plateaux) – Regional Health Directorate (Savanes, Kara and Plateaux regions) • Programme d'Aides pour le Développement Economique et Social PADES Programme of Support to Social and Economic Development • Association de Femmes pour la Santé (ALAFIA) – Association of Women for Health • Organisation pour le Développement et L'Incitation à l'Auto Emploi (ODIAE) – Organisation for Development and Promotion of Self-employment • United Nations International Children's Emergency Fund (UNICEF) • Division de l'Assainissement de Base, Direction de l'Hygiène et de l'Assainissement de Base (DAB/DHAB) – Basic Sanitation Division, Directorate of Hygiene and Basic Sanitation • Handicap International • Ministère de l'Action Sociale de la Promotion de la Femme et de l'Alphabétisation (MASPFA) – Ministry of Social Affairs, Promotion of Women and Literacy • Fédération Togolaise des Associations de Personnes Handicapées (FETAPH) – Togolese Federation of Disabled Persons Associations

Table 12: Contributing institutions and organizations – other programme countries

Benin, Cambodia, India, Kenya, Madagascar, Tanzania and Uganda
Benin • MCDI – Medical Care Development International • BorneFonden **Cambodia** • Santi Sena • Plan International • WaterAid • Emory University **India** • Indian Development Foundation (IDF) • Network for Enterprise Enhancement and Development Support (NEEDS) • NR Management Consultants (NRMC) **Kenya** • Amref Health Africa in Kenya **Madagascar** MCDI – Medical Care Development International **Tanzania** • Plan International, Tanzania **Uganda** • Uganda Sanitation Fund

Table 13: Contributing institutions and organizations – global KIIs and provision of information

Global KIIs and provision of information
• London School of Hygiene and Tropical Medicine • Plan International (UK and Canada) • Stonewall • UNHCR • UNICEF • Water Engineering and Development Centre (WEDC), Loughborough University • WaterAid

ANNEX III: REFERENCES

3.1 Countries visited

Ethiopia

- BDS- Center for Development Research (2016) *Final Report Outcome Evaluation of CLTSH Programme in Ethiopia from 2012-2015*. Federal Ministry of Health, UNICEF Ethiopia and WSSCC-GSF. Addis Ababa, Ethiopia
- Federal Democratic Republic of Ethiopia FMoH (2013) *Ethiopia Rural Sanitation and Hygiene Improvement Program (E-SHIP) Third Semi-Annual Narrative Report 1 July 2013 to 31 December 2013*
- Federal Democratic Republic of Ethiopia (2015) *Integrated Urban Sanitation and Hygiene Strategy*
- Federal Democratic Republic of Ethiopia, FMoH (2011) *Community-Led Total Sanitation and Hygiene (CLTSH) Facilitators Training Guide*, January 2011
- Federal Democratic Republic of Ethiopia, FMoH (2012) *Implementation Guideline for CLTSH Programming*, January 2012
- Federal Democratic Republic of Ethiopia, FMoH (2014) *National Sanitation Marketing Guideline*, June 2014, Addis Ababa, Ethiopia
- Federal Democratic Republic of Ethiopia, FMoH (2015) *Health Sector Transformation Plan (HSTP), 2015/16 – 2019/20 (2008-2012 EFY)*
- Federal Democratic Republic of Ethiopia, FMoH (2016) *Field Monitoring of ESHIP*: June 2016
- Federal Democratic Republic of Ethiopia, FMoH (2016, final draft) *Menstrual Hygiene Management in Ethiopia, An Inter-sectoral Issue: Policy and Implementation Guideline*, Addis Ababa, July 2016
- Federal Democratic Republic of Ethiopia, FMoH (no date) *Community-led Total Sanitation and Hygiene Implementation and Verification Guideline*
- Federal Democratic Republic of Ethiopia, Ministry of Health, National Hygiene and Sanitation Taskforce (2012) *Ethiopia Sanitation and Hygiene Improvement Programme Proposal* Submitted to WSSCC, Global Sanitation Fund January 2012
- Global Sanitation Fund (2016) *Ethiopia Sanitation and Hygiene Improvement Programme (E-Ship)*

Malawi

- Concern Universal (2016) Global sanitation fund project – quarterly report form
- Holm, R (2016) Can Community-Led Sanitation be more inclusive of the needs of people with disability: A case study from Malawi, Centre of Excellence in Water and Sanitation, Mzuzu University, P/B 201, Mzuzu 2, Malawi, 13 September 2016 [prepared for the GSF EQND workshop]
- Holm, R, Gwayi, S, Singini, W, Kasulo, V and Wanda, E (date) Looking ahead for sanitation initiatives: Community Led Total Sanitation versus Sanitation Marketing in Malawi, Centre of Excellence in Water and Sanitation, Mzuzu University, P/B 201, Mzuzu, Malawi
- Jones. H.E., Singini, W., Holm, R.H., & White, S (2016) CLTS Plus – making CLTS ever more inclusive, 39th WEDC International Conference, Kumasi, Ghana, 2016
- Malawi Government (2008) National Sanitation Policy, December 2008
- Malawi Government (2015) ODF Village Verification Guideline; Working together toward ODF Malawi 2015
- Malawi Government (2015) *Open Defecation Free (ODF) Malawi, 2015*, Strategy Document, September 2015
- Malawi Government (shared 2016) Forms: Malawi Government – *Village ODF Verification Form*; Government forms adapted for GSF programme: CLTS Form #1 – *Process Record Form*; CLTS Form #2 – *Follow up – All original households*
- Ministry of Irrigation and Water Development, Department of Sanitation and Hygiene & Water Supply and Sanitation Collaborative Council (2010) Accelerated Sanitation and Hygiene Practices in Malawi, *Country Programme Proposal* November 2010 Annex C
- Plan International (2013) *ASHP programme – Technical/Narrative Annual Report* 2013
- Plan International (2014) *Accelerated Sanitation and Hygiene Practices Programme (ASHPP) in Malawi, Year 4 Annual Technical/Narrative Report*, (1st January – 31st December, 2014)
- Plan International (2015) *A technical and financial proposal for provision of EA services covering an 18-month extension component of the GSF Programme in Malawi,* (Accelerated Sanitation & Hygiene Practices Programme – ASHPP), final Nov 2015 – June 2017
- Plan International (2015) Global Sanitation Fund, *Accelerated Sanitation and Hygiene Practices Programme (ASHPP) in Malawi, Annual Technical/Narrative Report*, (January 1 – December 31, 2015)
- Plan International (2015) *Integrated sanitation marketing, micro financing information, education & communication strategy*, ASHP programme

- Plan International, Canada (2016) *GSF Malawi Program Documentation Review of Gender Equality and Inclusion Integration*
- Plan Malawi (2016) *Community baseline and monitoring sheet*
- White, S, Danquah, L, Jones, H, Itimu-Phiri, A, Holm, R, Chungu, J, and Biran, A (2016) Making Community-Led Total Sanitation More Inclusive, *WASH Futures*, Water, Sanitation and Hygiene Conference, 2016, Brisbane, Australia
- White, S, Kuper, H, Itimu-Phirir, A, Holm, R and Biran, A (2016) A qualitative study on barriers to accessing water, sanitation and hygiene for disabled people in Malawi, *PLOS One*, DOI:10.1371/journal.pone.0155043, May 12, 2016

Nepal

- Bikash Shrot Kendra Pvt Ltd. (2016, draft) *Sustainability of ODF in the GSF Programme Districts of Nepal*: Final Draft Report
- Development Resource Centre (2011) *Updating and Verification of Baseline Data for Implementation of Global Sanitation Fund Programme in Nepal*, Final report, CO/RFP/2011/007
- Diane Coffey, Aashish Gupta, Payal Hathi, Dean Spears, Nikhil Srivastav, Sangita Vyas. (2017) Understanding Open Defecation in Rural India Untouchability, Pollution, and Toilet Pits. *Economic & Political Weekly EPW* January 7, 2017 vol lII no 1
- Government of Nepal, Arghakhanchi District (2017) *Presentation on ODF progress in Arghakhanchi District*
- Government of Nepal, Ministry of Planning and Works (2009) *National Urban Water Supply and Sanitation Sector Policy*, Final Draft
- GSF (2014) *Nepal Case Study Compilation,* June 2014
- His Majesty's Government, Ministry of Physical Planning and Works (2014) *Rural Water Supply and Sanitation, National Policy, 2004 and Rural Water Supply and Sanitation*, National Strategy, 2004 (Unofficial translation)
- Luff, R and Sevekari, P (2016) Rebuilding household toilets after the Nepal earthquake: an emergency or an interruption to development, *Waterlines*, Vol 35, No 2
- National Planning Commission and Government of Nepal and UN in Nepal (2013) *MDG Acceleration Framework Improving Access to Sanitation* January 2013
- Shrestha, S (2017) PPT: *Global Sanitation Fund Programme Nepal. Sector Status and Programme Progress Review*
- Steering Committee for National Sanitation Action (2011) *Sanitation and Hygiene Master Plan*, Government of Nepal
- SUYUK (no date) *Code of Conduct to Prevent Discrimination, Harassment and Sexual Harassment in the Workplace*
- The South Asia Collective (2016) *South Asia State of Minorities Report 2016, Mapping the Terrain* South Asia State of Minorities Report Collective, Books for Change
- UN-Habitat (2010) *Global Sanitation Fund for Nepal Proposal for Executing Agency Services*, June 2010
- UN-Habitat (2013) *Technical Proposal for GSF Expansion from Executing Agency*, August 2013
- UN-Habitat (2015) *Reviving Sanitation Campaign, Nepal Earthquake 2015, Global Sanitation Fund Lessons*, UN-Habitat, GSF, WSSCC
- UN-Habitat (2017) Sanitation Update of the District, Dhanusha District Open Defecation Free Campaign, Dhanusha District, 8 January 2017
- UN-Habitat, Nepal (2014) *GSF Programme in Nepal Annual Report 2014*
- UN-Habitat, Nepal (2015) *GSF Programme in Nepal Annual Report 2015*

Nigeria

- Cole, B (2015) *Going beyond ODF: Combining sanitation marketing with participatory approaches to sustain ODF communities in Malawi*
- Concern Universal (2013) *Rural Sanitation & Hygiene Promotion in Nigeria (RUSHPIN) Programme Year 2 Semi-Annual Report (October 2013 – March 2014)*
- Concern Universal (2013) *Rural Sanitation & Hygiene Promotion in Nigeria (RUSHPIN) Programme Year 2 Annual Report (October 2013 – September 2014)*
- Concern Universal (2014) *Rural Sanitation & Hygiene Promotion in Nigeria (RUSHPIN) Programme Year 3 Semi-Annual Report (October 2014 – March 2015)*
- Concern Universal (2015) Rural Sanitation & Hygiene Promotion in Nigeria (RUSHPIN) Programme Year 3 Annual Report (October 2014 – September 2015)
- Concern Universal (2015) *RUSHPIN, Year Four – First Quarterly Report – October – December 2015*
- Concern Universal (2016) *RUSHPIN, Year Four – Second Quarterly Report – January – March 2016*
- Concern Universal (2016) Various forms for M&E: *RUSHPIN Checklist for verification and certification of ODF and total sanitation in communities; RUSHPIN Community progress report on CLTS; RUSHPIN CLTS triggering report template; RUSHPIN household commitment list; Community follow up; RUSHPIN Post triggering confirmation of household status*

- Concern Universal (2016) Various images used for the WASHCom training – for gender analysis
- Concern Universal (2016) *WASH Capability Statement,* 2016
- Ebony Ivory Integrated Services Limited (2014) *Rural sanitation and hygiene promotion in Nigeria (RUSHPIN), Global Sanitation Fund (GSF), KAP survey report,* May 2014
- Ebony Ivory Integrated Services Limited (2014) *RUSHPIN – GSF Baseline Survey Report*, April 2014
- Federal Ministry of Water Resources (no date) *Making Nigeria Open-Defecation-Free by 2025, A National Roadmap*
- Federal Ministry of Water Resources and UNICEF (no date) *CLTS Training Manual*
- Federal Republic of Nigeria, Federal Ministry of Water Resources, Department of Water Supply and Quality Control (Draft final, 2004) *National Water Sanitation Policy*, Nov 2004
- Government of Nigeria, UKAID, EU and UNICEF (no date) *Protocol for certification and verification of open defecation free and total sanitation communities*
- Government of the Federation of Nigeria and UNOPS (2014) *MoU*
- Price Waterhouse Coopers (2016) *Global Sanitation Fund (GSF) – Rural Sanitation programme in Nigeria, Case study 1 – Is the RUSHPIN leaving anyone behind?,* January 2016
- Programme Coordinating Mechanism (2011) *Rural Sanitation and Hygiene Promotion in Nigeria Country Programme Proposal (CPP) for the Global Sanitation Fund (GSF) programme in Nigeria (Nov 2011)*
- UKAID, EU and UNICEF (no date*) Community Led Total Sanitation, Training of Trainers Manual*
- https://www.globalcitizen.org/en/content/championing-clts-in-conflict-affected-communities/

Senegal

- GSF Senegal (2016) *Bi-annual report #12,* July 2016
- Government of Senegal Ministry of Water and Sanitation (2016) *PEPAM Plan of Action and National Rural Sanitation Strategy* final report May 2016
- GSF (2012) *Etude de référence zéro dans les zones d'intervention du Fonds Mondial pour l'Assainissement, GSF au Sénégal.* Rapport Final
- GSF Senegal (2016) *Presentation of GSF Senegal* (Jun 2016) PPT file
- GSF Senegal (2016) *ToRs for the implementation of BCC activities in GSF/Senegal/phase 3*
- H2O Engineering (2014). *Evaluation a mi-parcours dans les zones d'intervention du Fonds Mondial pour l'Assainissement, GSF au Sénégal.* GSF Senegal
- Ministère de l'Hydraulique et de l'Assainissement (2016) *Présentation du programme GSF* Sénégal. Powerpoint présentation prepared with the support of AGETIP and presented in Sept 2016.
- Ministère de l'Hydraulique et de l'Assainissement, AGETIP, GSF, WSSCC (2016) République du Sénégal Mecanisme de Coordination Du Programme, Fonds Mondial Pour L'Assainissement, Phase 2
- Ministère de l'Hydraulique et de l'Assainissement, AGETIP, GSF, WSSCC (2016) *Bi-annual report #12,* July 2016
- Swiss TPH (2015) *Enquête ménage: comportements en matière d'hygiène et d'assainissement et volonté de payer en milieu rural au Sénégal. Appui à la Direction de l'Assainissement.* Rapport final. Programme Eau et Assainissement, Banque Mondiale.
- WSSCC and UN-Women (2014) *Menstrual Hygiene Management: Behaviour And Practices In The Louga Region, Senegal*
- WSSCC and UN-Women (2015) *Menstrual Hygiene Management: Behaviour And Practices In The Kedougou Region, Senegal*

Togo

- Government of Togo (2016) *Document Programme Pays pour le transfert de Gestion au Ministère de la Sante et de la Protection Sociale et la mise à l'échelle du programme GSF 2017-2018* ; Novembre 2016
- GSF Togo (2016) *Tableau de SUIVI ONGS KARA DEC 2016 TANDAOU*
- Mécanisme de Coordination du Programme GSF (2012) *Projet de Programme d'activités GSF 2012-2016, Pour la Promotion de l'Hygiène et de l'Assainissement en République Togolaise*
- UNICEF & Government of Togo (2015) *Togo Progress report Dec 2015*
- UNICEF & Government of Togo (2015) F*onds-Mondial-pour-l'Assainissement-Rapport-d'Avancement-2015*
- UNICEF & Government of Togo (2016) *Global-Sanitation-Fund-Progress-Report-2015*, WSSCC
- UNICEF & Government of Togo (2016) *Rapport annuel GSF 2016*, draft 29 Déc 2016
- UNICEF & Government of Togo (2016) R*apport semestriel, Togo sans Défécation à l'Air Libre, Fonds Mondial pour l'Assainissement, 1 Jan – 30 June 2016*

3.2 Countries not visited

Benin

- Medical Care Development International (2016) *Baseline Study of GSF-funded PAPHYR* – July 2016
- Medical Care Development International (2016) *Rapport semester 1 – Year 2* (Jan-June 2016)
- Ministry of Sanitation, GSF, WSSCC (2014) *Programme d'amélioration de l'accès à l'assainissement et des PratiQUes d'Hygiène en milieu Rural (PAPHyR) au Bénin* – Country Proposal (April 2014)

Cambodia

- CRSHIP (2014) *Report on Annual Learning Event: Cambodia Rural Sanitation and Hygiene Improvement Programme (CRSHIP)*
- CRSHIP (no date) *CRSHIP2 Conceptual Framework*
- CRSHIP (2016) *Equality and Non-discrimination in CRSHIP: An adaptive, context driven, inclusive approach [EQND Framework],* July 2016
- Emerging Markets Consulting (2015) *CRSHIPII Baseline and Feasibility Study, Final report*
- Emerging Markets Consulting (2016) *Study on Smart Sanitation Interventions in Cambodia,* Draft Report, July 15, 2016
- Global Sanitation Fund and Plan International (2015) *Participatory Social Assessment and Mapping (PSAM) Guidelines and Tools,* Cambodia, CRSHIP
- Lempho, S. and Dumpert, J. (2016) *Short Narrative – Experiences from Implementing PSAM Cambodia Rural Sanitation and Hygiene Improvement Programme (CRSHIP)* Plan Cambodia and WaterAid Cambodia, July 11, 2016
- Ministry of Rural Development, Department of Rural Health Care (2013) *National Guidelines on CLTS; including: Annex 1 – Participatory Village Assessment; Annex 2 – 7 CLTS triggering tools; Annex 3 – CLTS Facilitators Notes and Performance Quality Checklist; Annex 4 – National Guidelines on ODF verification;*
- Ministry of Rural Development, Department of Rural Health Care (2016) *National Guideline on WASH for Persons with Disabilities and Older People*
- Plan International (2015) *CRSHIP Progress Update* PPT, Sept 2015
- Plan International (2016) *CRSHIP Consolidated Annual Report,* April 2015 to March 2016
- Plan International (2016) *CRSHIP Semi-Annual Report,* Oct – March 2016
- Plan International (no date) *CRSHIP 2 Implementation Strategy & Design*, PPT, Government of Cambodia, GSF, WSSCC
- Programme Coordinating Mechanism, Cambodia (2014) *CRSHIP Country Proposal 2013* (updated Feb 2014)

India

- JFW (no date) *Study on Lack of toilets more than just a sanitation problem…. Women having to defecate in the open, at odd hours, not only threaten their dignity, but their safety as well…..*Field study report
- NRMC (2015) *Annexure 8: Compendium: Local accelerators: promoting sustainable sanitation* [case studies]
- NRMC (2016) *Global Sanitation Fund in India, Annual Report 2015*
- NRMC (no date) *Annexure 12: GSF India Spurring Action & Dialogue for Health & Hygiene*, Toilet Talk newsletter

Kenya

- AMREF Kenya (2015) *Annual Technical Narrative Report*
- AMREF Kenya (2015) *Baseline survey for Kenya Sanitation and Hygiene Improvement Programme*
- Programme Management Committee, Government of Kenya (2013) *Country Proposal Water Supply and Sanitation Collaborative Council Global Sanitation Fund Kenya Sanitation and Hygiene Improvement Programme (K-SHIP),* Edited Version 13 November 2013

Madagascar

- Fonds d'Appui pour L'Assainissement, Madagascar (2016) *Follow-up MANDONA, A field guide for accelerating and sustaining ODF communities through a CLTS approach*, GSF
- Davis, I (2015) *A gender case study of the experience and outcomes of Fonds D'Appui pour l'assainissement (FAA) Community-led Total Saniattion (CLTS) interventions in Madagascar*, Final Project, School of Chemical Engineering, The University of Queensland
- GSF, WSSCC (2016) *Country Proposal for expansions of GSF from 2016-2020*
- GSF, WSSCC (2016) *Guidelines for the expansion of GSF programme*

Tanzania

- Programme Coordination Mechanism (2011) *WSSCC, Global Sanitation Fund (GSF) Tanzania Country Programme Proposal*
- Cross,P., Biran, A. Binamungu, D., Coates, S. and Keen, M. (2015) *Mid-Term Evaluation, WSSCC Global Sanitation Fund, December 2015, Tanzania Country Report: Short Version*, IOD Parc
- Plan International (2016) *Annual Report Submitted by Executing Agency in (TANZANIA) to The Country programme Monitor and to UNOPS*
- Roma et al (2014) *Process evaluation of the sanitation campaign of Tanzania*, Research report, SHARE
- UMATA (no date) *1: Supplementary Form A-1 Monitoring tool for Household Sanitation and Hygiene at Sub-Village level*

Uganda

- GSF and WSSCC (2015) *Cover letter and Executive Summary: Sustainability Review for the Uganda Sanitation Fund*
- Ministry of Health (2016) *Extension and Expansion of the Uganda Sanitation Fund Programme, Concept Note*
- SNV (2015) *Uganda Sanitation Fund, Draft Baseline Survey,* January 2015
- Uganda Sanitation Fund (2015) *Semi-Annual Report for financial year 2015-16*
- Uganda Sanitation Fund (2016) *Programme Annual Report for Financial Year 2015/16*
- Uganda Sanitation Fund (2016) *Programme Annual Report, March 2015*

3.3 Global Sanitation Fund and WSSCC

- GSF (2012) *GSF Monitoring & Evaluation Guidelines*, Version 1 (Final draft), February 2012, WSSCC
- GSF (2014) *Progress Report*
- GSF (2015) *A catalyst for results at scale,* Meeting background document, Nov 2015 (Theory of change)
- GSF (2015) *Global Sanitation Fund: A catalyst for results at scale, Background document,* Meeting of the Advisory Committee
- GSF (2015) *Progress Report, A catalyst for large-scale results*
- GSF (2016) *Catalytic programming for scale and sustainability: Conversations, reflections and lessons from the 2016 Global Sanitation Fund Learning Event*
- GSF (no date) *The GSF Results Framework*
- GSF, WSSCC (2015) *Progress Report, A catalyst for large-scale results,* GSF / WSSCC
- GSF, WSSCC (no date) *Follow-up MANDONA, A field guide for accelerating and sustaining open defecation free communities through a Community-Led Total Sanitation Approach*, GSF / WSSCC
- GSF, WSSCC (no date) *Learning, progress and Innovation, Sanitation and Hygiene Promotion in Madagascar*, GSF / WSSCC
- Jerneck, M, van der Voorden and Rudholm, C (2013) (2016, draft) *Sanitation and hygiene behaviour change at scale: Understanding slippage*
- Keen, M and O'Reilly, S (2015) *Global Sanitation Fund (GSF): Mid-Term Evaluation, Synthesis Note for Tranche 1: Madagascar, Nepal, Senegal, Malawi, India, Cambodia and Uganda*, IOD PARC
- Messina, M and Bostoen, K (2015) *Global Sanitation Fund Monitoring & Evaluation System – Diagnosis Report,* 5 October 2015, Monitoring4Change
- WSSCC (2012) *Medium-Term Strategic Plan,* 2012-2016, WSSCC
- WSSCC (2015) *WSSCC Management Response to the Global Sanitation Fund Independent Mid-Term Evaluation Synthesis Report,* WSSCC
- WSSCC (2016) *Concepts and Definitions for Equality and Human Rights Towards a Common Understanding in WSSCC,* Equality and Non-Discrimination Team, 12.5.2016
- WSSCC and Freshwater Action Network (2016) *Leave No-one behind, Voices of Women, Adolescent Girls, Elderly and Disabled People, and Sanitation Workers*

3.4 Global documentation

The team reviewed a wide range of global documentation related to EQND and sanitation during the Inception stage of the process. A proportion of the documentation reviewed is included below:

- ADCAP (2016) *Minimum standards for age and disability inclusion in humanitarian action*, Pilot version, HelpAge International
- Badloe, C, Dutta, D, Lee, H and House, S. (2016) *Realities, Experiences and Opportunities on Menstrual Hygiene Management in the East Asia and Pacific Region*, UNICEF EAPRO http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/MHM_Realities_Progress_and_OpportunitiesSupporting_opti.pdf

- Bartram J., Charles C., Evans B., O'Hanlon L. and Pedley S. (2012) 'Commentary on community-led total sanitation and human rights: Should the right to community-wide health be won at the cost of individual rights?' *Journal of Water and Health*, 10.4: 499–503.
- Bongartz, P. (2012) *Emotional triggers: Shame? Or shock, disgust and dignity*, CLTS website blog, http://www.communityledtotalsanitation.org/blog/emotional-triggers-shame-or-shock-disgust-and-dignity, [accessed 15 February 2016].
- Cavill, S. England, P, House, S and Ferron, S (2017, publication pending) Understanding, respecting and including people with mental health conditions as part of the CLTS process, *40th WEDC International Conference*, Loughborough, UK, 2017, Local Action with International Cooperation to Improve and Sustain Water, Sanitation and Hygiene Services
- Cavill, S. Roose, S., Stephen, S. and Wilbur, J. (2016) Putting the hardest to reach at the health of the Sustainable Development Goals, Chapter 15, in: Bongartz, P., Vernon, N. and Fox, J. (eds) *Sustainable Sanitation for All, Practical Action Publishing*, http://www.developmentbookshelf.com/doi/book/10.3362/9781780449272
- Chambers (1983) *Rural Development: putting the last first*. Routledge
- Chambers, R. (2012) *Discrimination, Duties and Low-Hanging Fruit: Reflections on Equity*, CLTS website blog, http://www.communityledtotalsanitation.org/blog/discrimination-duties-and-low-hanging-fruitreflections-equity, [accessed 15 February 2016].
- CHS Alliance, The Sphere Project and Group URD (2015) *Core Humanitarian Standard*; CHS Guidance Notes and Indicators, CHS Alliance, The Sphere Project and Group URD
- Coe, S. and Wilbur, J. (2015) *WaterAid Nepal, Equity and Inclusion Review, A review of the rights, equity and inclusion work of WaterAid Nepal*, WaterAid
- Danquah, D. (2014) *Mid-term review: Undoing Inequity: inclusive water, sanitation and hygiene programmes that deliver for all in Uganda and Zambia*, WaterAid, London, available at: http://www.wateraid.org/uk/what-we-do/policy-practice-and-advocacy/research-and-publications/view-publication?id=25633f29-8f85-4f0e-9a54-ffe2ca085fce, [accessed 16 February 2016].
- Davis, I. (2015) *A gender case study of the experience and outcomes of Fonds D'Appui pour l'assainissement (FAA) Community-led Total Sanitation (CLTS) interventions in Madagascar*
- De Albuquerque, C. (2014) *Realising the human rights to water and sanitation: A Handbook by the Special Rapporteur*
- Evans, B, Colin, J, Jones, H and Robinson, A (2009) *Sustainability and equity aspects of total sanitation programmes, A study of recent WaterAid-supported programmes in three countries, Global synthesis report*, WaterAid
- Global WASH Cluster (2014) *'WASH Minimum Commitments for the Safety and Dignity of Affected Populations'* – range of documents: summary; questionnaire; presentation
- Global WASH Cluster (2014) *WASH Minimum Commitments for the Safety and Dignity of Affected Populations, Pilot project, Analysis of the first questionnaires to monitor the minimum commitments' implementation (December 2014)*
- Gosling, L (2010) *Framework: Equity and inclusion, A rights-based approach*, WaterAid
- Government of the Republic of Tanzania (2010) *School WASH Guideline, Tanzania* [several parts]: Version for piloting [which integrates MHM and accessible WASH], http://washinschoolsmapping.com/projects/Tanzania.html
- Greaves, F (2016) *CLTS in Post-Emergency and Fragile State Settings*, Frontiers of CLTS: Innovations and Insights, Issue 09, July 2016, CLTS Knowledge Hub, Institute of Development Studies
- Grow and Know (2015) Website including examples of menstrual hygiene books for girls from a number of countries http://www.growandknow.org/books.html
- Hafskjold, B. Pop-Stefanija, B. Giles-Hansen, C. Weerts, E. Flynn, E. Wilbur, J. Brogan, K. Ackom, K. Farrington, M. Peuschel, M. Klaesener-Metzner, N. Pla Cordero, R. Cavill, S. House, S. (2016) 'Incompetent at incontinence – why are we ignoring the needs of incontinence sufferers?' *Waterlines*, volume 35, issue 3, July 2016, http://www.developmentbookshelf.com/toc/wl/35/3
- Health Policy Project (2015) *A Facilitators Guide for Public Health and HIV Programmatic Gender and Sexual Diversity Training*, Washington Futures Group Policy Project
- Herijnen, T. V. Ritchei, S, Eaton, J. (2016) *Security guideline for people with albinism*, CBM
- House, S and Cavill, S (2015) Making Sanitation and Hygiene Safer: Reducing vulnerabilities to violence, *Frontiers of CLTS: Innovations and Insights*, Issue 05, May, 2015
- House, S, Mahon, T, Cavill, S (2012) *Menstrual Hygiene Matters; A resource for improving menstrual hygiene around the world*, WaterAid/SHARE (co-published by 18 organizations), http://www.wateraid.org/what%20we%20do/our%20approach/research%20and%20publications/view%20publication?id=02309d73-8e41-4d04-b2ef-6641f6616a4f
- House, S. Ferron, S, Sommer, M, and Cavill, S. (2014) *Violence, Gender & WASH: A Practitioner's Toolkit – Making water, sanitation and hygiene safer through improved programming and services*. London, UK: WaterAid/SHARE (co-published by 27 organizations) http://violence-wash.lboro.ac.uk
- http://www.vanguardngr.com/2014/04/open-urination-defecation-stir-debate-artisans-forum/
- International Rescue Committee (2014) *The IRC Way, Standards for Professional Conduct*
- Jansz, S (2012) *Equity and Inclusion Toolkit*, WaterAid

- Jones, H (2013) *Mainstreaming disability and ageing in water, sanitation and hygiene programmes, A mapping study carried out for WaterAid*, WaterAid
- Jones, H and Wilbur, J (2014) *Compendium of accessible WASH technologies*, WEDC, WaterAid, SHARE
- Jones, H. (2013d) *Equity and inclusion in WASH provision – using the social model of exclusion –facilitators notes (Version 2).* UK: WaterAid and WEDC, Loughborough University.
- Jones, H. (2015b) *CLTS+ triggering Rumphi District Malawi*, Unpublished Research Report.
- Jones, H. and Reed, R.A. (2005) *Water and sanitation for disabled people and other vulnerable groups: designing services to improve accessibility.* WEDC, Loughborough University, Loughborough, https://wedc-knowledge.lboro.ac.uk/details.html?id=16357, [accessed 15 February 2016].
- Jones. H.E., Singini, W., Holm, R.H., & White, S (2016) CLTS Plus – making CLTS ever more inclusive, 39th *WEDC International Conference*, Kumasi, Ghana, 2016
- Kar, K and Chambers, R (2008) *Handbook on Community-led Total Sanitation*, Plan International
- Musembi, C. N. And Musyoki, S. M. (2016) CLTS and the Right to Sanitation, *Frontiers of CLTS: Innovations and Insights*, Issue 8, March 2016
- Office of the High Commissioner for Human Rights (no date) *Integrating non-discrimination and equality into the post-2015 development agenda for sanitation and hygiene: Summary of the Report of the Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation of the UN General Assembly (A/67/270)*
- Oxfam (2012) *Joint Code of Conduct*
- Plan International (2012) *Research on the Impact of Gender on Community-Led Total Sanitation Processes*, Final Report, Plan Uganda, http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Gender%20and%20CLTS%20report%20final.pdf, [accessed 15 February 2016].
- Robinson, A. And Gnilo, M. (2016) Promoting choice: smart finance for rural sanitation development (2016) Putting the hardest to reach at the health of the Sustainable Development Goals, Chapter 15, in: Bongartz, P., Vernon, N. and Fox, J. (eds) *Sustainable Sanitation for All, Practical Action Publishing*, http://www.developmentbookshelf.com/doi/book/10.3362/9781780449272
- Roose, S, Rankin, T and S. Cavill (2015) Breaking the Next Taboo: Menstrual Hygiene within CLTS, *Frontiers of CLTS: Innovations and Insights*, Issue 6, July 2015 http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Frontiers6_MHM.pdf
- Satterthwaite, M (2012) *JMP Working Group on Equity and Non-Discrimination*, Final Report
- Satterthwaite, M (no date) Background Note on MDGs, Non-Discrimination and Indicators in Water and Sanitation, *JMP Working Group on Equity and Non-Discrimination*, Final Report
- Tremolet, S, Kolskey, P and Perez, E (2010) *Financing On-Site Sanitation for the Poor, A six country comparative review and analysis*, January 2010, WSP, World Bank
- UNHCR (2003) *Code of Conduct and ST/SGB/2003/13 on Special Measures for Protection from Sexual Exploitation and Sexual Abuse*
- UNHCR (2011) *Age, Gender and Diversity Policy, Working with people and communities for equality and protection*, UNHCR
- United Nations (2015) *Transforming our World: The 2030 Agenda for Sustainable Development*: A/RES/70/1, https://sustainabledevelopment.un.org
- United Nations General Assembly *(2012) Report of the Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation, Stigma and the realization of the human rights to water and sanitation*, Catarina de Albuquerque (A/HRC/21/42)
- Wapping, L (2014) *Undoing Equity: Water, sanitation and hygiene services that deliver for all in Uganda and Zambia*, WaterAid
- WaterAid (2013) *Terminology guidelines to support WaterAid's equity and inclusion framework*, Feb 2013, WaterAid
- WaterAid (2016) *Undoing Inequity*, http://www.wateraid.org/what-we-do/our-approach/research-and-publications/view-publication?id=25633f29-8f85-4f0e-9a54-ffe2ca085fce&sc_lang=en
- WaterAid and Epic Arts (2016) Films on how to integrate equity and inclusion in WASH from Cambodia – For the project chapters, full films and evaluation – https://www.youtube.com/playlist?list=PLc-oawSTlDS1lcW-bmvp2cLNdlp9__hXF; For the 'How to guides' –https://www.youtube.com/playlist?list=PLc-oawSTlDS2ht3B_Es7MEr3acVo8geV3
- West, S (2012) *Global working, supporting lesbian, gay and bisexual staff on overseas assignments*, Global Workplace Guides, Stonewall
- West, S (no date) *Global values, getting started with LGB equality worldwide,* Global Workplace Guides, Stonewall
- White, S, Danquah, L, Jones, H, Itimu-Phiri, A, Holm, R, Chungu, J, and Biran, A (2016) Making Community-Led Total Sanitation More Inclusive, *WASH Futures*, Water, Sanitation and Hygiene Conference, 2016, Brisbane, Australia
- Wilbur, J. And Jones, H (2014) *Disability: Making CLTS Fully Inclusive*, Frontiers of CLTS: Innovations and Insights, Issue 03, July 2014
- Wolfe, A. J, and Brubaker. L. (2015) "Sterile Urine" and the Presence of Bacteria. *European Urology*, 2015; DOI: http://www.europeanurology.com/article/S0302-2838(15)00206-7/pdf

A FAMILY IN KAMPOT PROVINCE, **CAMBODIA**, PROUDLY DISPLAYS THEIR IMPROVED TOILET. ©WSSCC/RHIANNON JAMES

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c) Regional, district, sub-prefecture level authority leadership; district development and WASH or sanitation coordinating committees; sanitation task forces; sanitation revolving fund committees; CLTS facilitators / triggerers; and the Implementing Partners which facilitated the sub-national visits.

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For disaggregated data on the number of people met at different levels during the process refer to **Annex I**. For a list of contributing institutions and organizations from District (or Commune) level and above see **Annex II**.

TERMINOLOGIES

Source: GSF

Community-Led Total Sanitation (CLTS)[73] is an integrated approach to achieving and sustaining ODF communities. CLTS entails the facilitation of a community's analysis of its sanitation profile, including practices of open defecation and its consequences, leading to collective action to become ODF. CLTS focuses on igniting change in sanitation and hygiene behaviour within whole communities, rather than constructing toilets through subsidies. Approaches in which outsiders 'teach' community members are not considered as CLTS in the sense of this report.

Executing Agencies (EAs) are jointly appointed by GSF and the PCM, and are contracted by UNOPS. EAs receive grant funds and manage the GSF-supported country programme. A diverse range of EAs have been appointed, representing government entities, international NGOs, United Nations agencies and the private sector. The EA selects, supervises, and supports Implementing Partners.

The Global Sanitation Fund (GSF) is based in the WSSCC Secretariat in Geneva, Switzerland. The Fund is led by a Programme Director and comprises grant management teams and technical staff supporting monitoring and evaluation, financial management, learning and documentation, and advocacy and communications.

Implementing Partners (IPs) generally implement the country programme activities within communities, and provide technical services in some cases. They are comprised of NGOs, government entities, associations and private companies. GSF currently supports over 300 Implementing Partners.

Institutional Triggering involves implementing the methods used in community triggering to ignite change at the institutional level, for example within national and local government entities. This can be a powerful advocacy approach to foster commitments among influential actors and decision makers to improve sanitation and end open defecation.

Open defecation free (ODF) refers to a state in which no faeces are openly exposed to the air. A direct pit latrine with no lid is a form of open defecation, but with a fly-proof lid it can qualify as an ODF latrine. In many countries, ODF criteria goes significantly beyond the absence of faeces in the open environment. Within GSF-supported programmes ODF criteria is defined according to national standards.

Programme Coordinating Mechanisms (PCMs) are nationally-recognized, typically government-led coordinating bodies for sanitation and hygiene within GSF-supported countries. They set the vision and strategy of GSF-supported programmes. PCMs include representatives from government, civil society and international organizations from across the WASH sector and related sectors. In addition to leading the development of Country Programme Proposals, they also provide strategic guidance to Executing Agencies and ensure that the work supported by GSF is consistent with national policies and activities of National WASH Coalitions. Where possible, PCMs are sub-sections of existing national WASH sector coordination mechanisms. The existence, or creation, of a PCM is a requirement for GSF funding.

Scale: In the context of GSF-supported programmes, working 'at scale' refers to going beyond villages to facilitate sanitation and hygiene behaviour change at higher administrative levels. These levels range from local to regional administrative divisions, as defined by country governments. Determinants and definitions for working at scale vary according to the context. For GSF-supported programmes, planning to work at scale requires incorporating relevant approaches into the design of the programme.

Slippage refers to a return to previous unhygienic behaviours or the inability of some or all community members to continue to meet all ODF criteria. Types of slippage include: non-compliance with ODF criteria;

73 Definitions for CLTS and ODF adapted from Kar, Kamal with Chambers, R. (2008). Handbook on Community-Led Total Sanitation. Retrieved from http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/cltshandbook.pdf

community members returning to open defecation; seasonal slippage; members of ODF communities defecating in the open outside their own community; slippage caused by outside communities and communal conflict; and institutions contributing to a reversal in sanitation and hygiene gains.

Triggering, in the context of CLTS, refers to a journey of self-realization where a community identifies faeces in the open environment, and through a facilitated understanding that they are unknowingly ingesting faeces, community members take action to end open defecation and improve their sanitation and hygiene behaviour. Central to the triggering methodology is the provocation of disgust and shock. Within GSF-supported programmes, communities are triggered prior to other CLTS activities through a community meeting or event, using a range of tools and approaches. Triggering can also be facilitated throughout the CLTS process, to achieve and sustain behaviour change. Triggering is often preceded by pre-triggering. This phase aims to analyze and understand community dynamics and sanitation and hygiene practices, as well as identify potentially disadvantaged people and households, in order to inform the triggering and follow-up processes.

ACRONYMS

CBR	Community based rehabilitation
CPM	Country Programme Monitor
DPO	Disabled Person's Organisation
E&I	Equity and inclusion
EA	Executing Agency(ies)
EQND	Equality and non-discrimination
FGD	Focus group discussion
FGM/C	Female genital mutilation / cutting
FUM	Follow-up MANDONA
GBV	Gender based violence
GSF	Global Sanitation Fund
IP	Implementing Partner
KII	Key informant interview
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex and questioning/queer
MHM	Menstrual hygiene management
MTE	Mid-term evaluations
MTSP	Medium-term Strategic Plan
PCM	Programme Coordinating Mechanism
SDGs	Sustainable Development Goals
SGBV	Sexual and gender based violence
SGM	Sexual and gender minorities
SHARE	Sanitation and Hygiene Applied Research for Equity
SLTS	School Led Total Sanitation
VSL	Village Savings and Loans group
WASH	Water, sanitation and hygiene
WSSCC	Water Supply and Sanitation Collaborative Council

Table 14: Acronyms and terminologies used by specific country programmes

COUNTRIES VISITED		
Ethiopia	ESHIP	Ethiopia Sanitation and Hygiene Improvement Programme
	FMoH	Federal Ministry of Health (EA)
	WSP and UNICEF	Water and Sanitation Program of the World Bank and UNICEF (Lead for PCM)
	CLTSH	Community led total sanitation and hygiene
	Woreda	Equivalent to district
	Kebele	Equivalent to village
	LGA	Local Government Authority
Malawi	ASHPP	Accelerated Sanitation and Hygiene Practices Programme
	Plan	Plan International (Malawi) (EA)
	MoH	Ministry of Health (lead for PCM)
	HSA	Health Surveillance Assistant
	DCT	District Coordinating Team
	GVH	Group Village Head [Chief]
	TA	Traditional Authority
	VHC	Village Health Committee
	VDC	Village Development Committee
Nepal	GSF programme Nepal	Global Sanitation Fund Programme Nepal
	UN-Habitat	United Nations – Habitat (EA)
	MoWS	Ministry of Water Supply and Sanitation (lead for PCM)
	VDC	Village Development Committee
	V-WASH-CC	Village WASH Coordination Committee
	DDC	District Development Committee
	D-WASH-CC	District WASH Coordination Committees
	SUYUK	Samaj Utthan Yuwa Kendra (IP referred to in a case study)
	Triggerer	CLTS Facilitator from the communities in the programme area
Nigeria	RUSHPIN	Rural Sanitation and Hygiene Promotion in Nigeria
	UP	United Purpose (EA)
	FMoWR	Federal Ministry of Water Resources (lead for PCM)
	NTGS	National Task Group on Sanitation
	LTGS	Local Task Group on Sanitation
	LGA	Local Government Area
	CC	Community Consultants
	WASHCom	WASH Committee
	Chief	Community leader
	Mother communities	Village
	CLTS communities	Sub-sections of a larger mother community

Senegal	FMA	Programme of GSF Senegal
	AGETIP	Agence d'Exécution Travaux d'Intérêt Public (EA)
	MoH	Ministry of Health (Lead for PCM)
	Commune	Resembles the size of a district in urban areas but a parish in rural areas
Togo	FMA	Fonds Mondial pour l'Assainissement
	UNICEF	United Nations Children's Fund (EA)
	MoH	Ministry of Health and Social Protection(Lead for PCM)
	Concession	Compound
COUNTRIES NOT VISITED		
Kenya	KSHIP	Kenya Sanitation and Hygiene Improvement Programme
Cambodia	CRSHIP 1 and 2	Cambodia Rural Sanitation and Hygiene Improvement Programme
	PSAM	Participatory Social Assessment and Mapping
Madagascar	FAA	Fonds d'Appui pour l'Assainissement
India	GSF in India	Global Sanitation Fund in India
Benin	PAPHyR	Le Programme d'amélioration de l'accès à l'Assainissement et aux Pratiques d'Hygiène et d'Assainissement en milieu Rural (programme for improved access and better sanitation and hygiene practices in rural areas)
Tanzania	UMATA	Usafi wa Mazingira Tanzania
Uganda	USF	Uganda Sanitation Fund

THIS LATRINE, BUILT WITH BRICK AND CEMENT IN KUMPELEMBE VILLAGE, MALAWI, HAS LASTED FOR NINE YEARS.
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PROUD OWNERS OF AN IMPROVED TOILET IN KAMPOT PROVINCE, CAMBODIA. ©WSSCC/RHIANNON JAMES

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