Sustainable Sanitation and Hygiene for All (SSH4A)

PERFORMANCE MONITORING FRAMEWORK

Part 2. Outcome indicators (February 2019)

SNV, 2019. *SSH4A Performance Monitoring Framework, Part 2. Outcome indicators*. The Hague: SNV.

Authors

This document is a result of joint efforts and thinking across a range of SNV staff and partners.

Acknowledgements

SNV would like to thank all former and current staff and partners who have contributed to this document, over the years. In particular, Erick Baetings for his support to Nepal and Bhutan in 2014, and the staff of UTS-ISF and CBM Australia for providing inputs on this version. Special thanks to Gabrielle Halcrow, Anne Mutta, Antony Ndungu, and Antoinette Kome of SNV for shaping this framework, and its practical applications over the years.

Cover photo: Evidence-based monitoring by Kasama DWASH members collecting data for SSH4A RP's household survey in Zambia (© SNV).

Contact information

Antoinette Kome
SNV WASH Global Sector Coordinator
akome@snv.org
www.snv.org/sector/water-sanitation-hygiene

Contents

Tables

Figures

Boxes

1 Introduction

With this document, we aim to share our rural sanitation and hygiene performance monitoring framework, and to contribute to the ongoing discussion on sustainable and equitable sanitation services and hygiene. This framework was originally developed in 2010 for our work in Asia, and focussed on rural districts predominantly at household and school levels. It has since been applied by more than seven projects[1] in 18 countries across Asia and Africa. This latest version aims to capture the different iterations and reviews, based on feedback from SSH4A implementing countries, as well as the ambitions of the SDGs.

The performance monitoring framework is part of our Sustainable Sanitation and Hygiene for All (SSH4A) programme.

Similar to our performance monitoring framework for urban sanitation and hygiene, the objective is to support stakeholder learning and reflection about the programme, and their progress towards sustainable services. It is not designed as an externally applied, stand-alone monitoring system. Monitoring at regular intervals helps to improve a programme, and engages staff to move in the right direction.

The monitoring framework measures both impact, in terms of access and use of safely managed sanitation services and safe hygiene practices, as well as outcomes.

The outcomes are related to capacities and/ or performance at different levels, which together contribute to a sustainable service delivery system for rural sanitation and hygiene. Impacts are measured by ladders largely aligned with the JMP definitions, whereas the measurement of outcomes includes both ladders as well as scorecards. The ladders and scorecards allow the capture of many qualitative aspects of capacity development and the aggregation of qualitative information over time in quantitative scores.

Box 1 Capacity building

SNV is dedicated to a society in which all people are free to pursue their own sustainable development. We have an actor-oriented vision of change, i.e., we do not envision change as a result of abstract forces, but as a result of actions by people individually or collectively. Infrastructure, laws, systems, while necessary, are insufficient conditions for change; and only relevant when they are used. We assume that if we support people to build their capacities, performance, collaboration and their (use of) systems – all this together will lead to change.

We consider three levels of capacities and related performance:

- Individual or professional capacity
- Organisational capacity
- Capacity of organisations to work together (interinstitutional capacity)

Understanding who the stakeholders are in rural sanitation and hygiene, is the basis for this monitoring framework. These could include: municipalities, line ministry departments including health services, local leaders, regulators, users, but also pit emptiers, masons and civil society organisations.

While we work on systems, for example, information systems such as a customer database, we do not consider this an outcome unless there is an organisation owning that customer database, and there are people capable to work with it. The outcome would then be the capacity of that organisation to manage and implement the data base.

[1] Including several multi-country projects.

The performance monitoring framework consists of two parts:

Part 1 Introduction and impact measurement details the monitoring approach followed by a description of the impact indicators.

Part 2 Outcome measurement details the outcome indicators focussed on changes in the capacity and performance of relevant stakeholders (professionals, organisations and interinstitutional collaboration) in the rural sanitation sub-sector.

With the development of Phase 2 of SSH4A (see figure 1 on next page), a specific framework for Phase 2 outcome measurement will be developed in 2019.

This document reflects experiences to date. It also takes into account the higher service levels and ambitions of the SDGs, post-ODF thinking, and recent learning from SNV's Urban Sanitation and Hygiene for Health and Development (USHHD) programme, including monitoring in schools and healthcare facilities. While the common indicators and definitions will have to be applied by all SSH4A countries in order to ensure standards and make cross-country comparisons, adaptation to different country contexts is essential for meaningful measurement. In this framework, a minimum set of shared outcome indicators is presented. Additional indicators may be included depending on the demands of the context.

2 Sustainable Sanitation and Hygiene for All (SSH4A)

2.1 Sustainable Sanitation and Hygiene for All, Phase 1

SNV's Water, Sanitation and Hygiene (WASH) programmes are based upon the belief that access to water and sanitation is a human right, and that governments are the duty-bearers of the progressive realisation of this right in their jurisdiction. Depending on roles and responsibilities in a specific country, this could mean that a district government is responsible to realise the right to sanitation for all people in the entire district. The area-wide approach that is at the crux of our work obliges us to think about the capacity and systems in an area, to achieve sanitation and hygiene for all. It also obliges us to think about private sector roles, different needs and cultures in the district, and how to best use scarce public resources, with attention to equity.

The SSH4A programme works together with local authorities to develop a service delivery model for their area. This is not done in theory, but through a hands-on approach, working collaboratively towards improved sanitation and hygiene, and continuously reflecting and learning about it. The integrated approach to sanitation has proven to be successful. It has been implemented in more than 160 districts, and has contributed to over five million people gaining access to and using improved sanitation over the past five years alone.

Users are at the centre of the SSH4A framework. Ultimately, rural sanitation and hygiene is about sustaining behavioural change of users, and the conditions that support that. In a rural context, these users may access services in residential premises (households), educational premises (schools), health facilities or public places. Understanding users, their diversity and their needs is essential for sustainable sanitation.

Figure 1 SSH4A area-wide access and usage for all
Source: SNV, 2018.

As can be seen in Table 1 (on next page), the supporting conditions for behavioural change of users are organised under four integrated components, with a fifth component focussing on learning, documenting, and sharing. The four components are all related to capacity development.

Table 1 Four components of capacity development

Component	Expected outcome
Improving capacity for steering and implementing sanitation demand creation	Local organisations are capable to implement and steer sanitation demand creation at scale, with quality.
Developing sanitation supply chains and finance	Appropriate market-based solutions for a variety of sanitation consumer needs are implemented at scale.
Building capacity for behavioural change communication (BCC)	Progress in the commitment and capacity of local organisations to implement behaviour change communication, with quality.
Strengthening WASH governance	Improvements in local WASH governance in terms of alignment of stakeholders, sector planning and monitoring, transparency, and social inclusion.

The assumption of the SSH4A programme is that if all these capacities are in place, and performance is enhanced, these will accelerate progress in sanitation and hygiene in a sustainable and inclusive way. These relations are tested in the performance monitoring cycle, when both outcomes and impacts are measured and discussed with stakeholders.

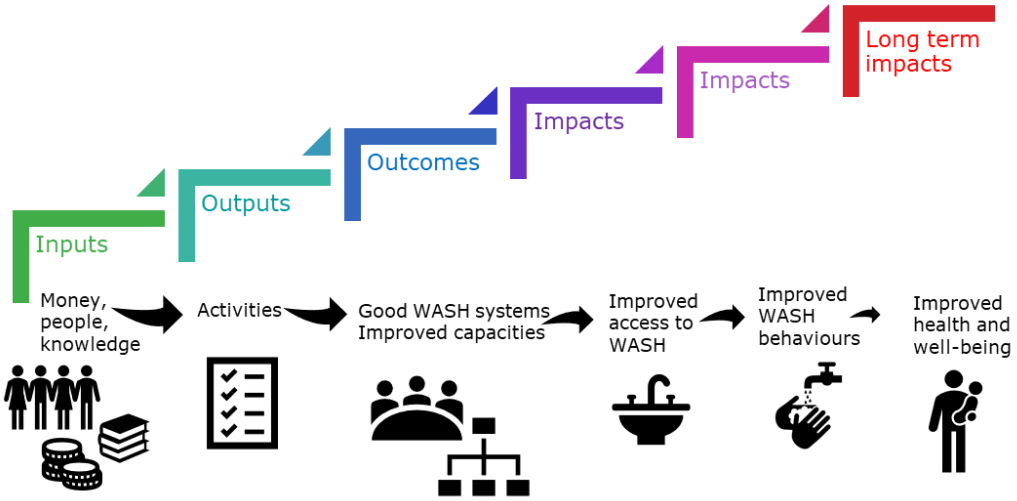

Figure 2 Simplified WASH results chain
Source: Kome, 2018.

2.2 Sustainable Sanitation and Hygiene for All, Phase 2

With the success of the SSH4A programme, more communes, sub-districts, districts, and in some cases, regions, are achieving full coverage for all. In some cases, full coverage means open defecation free (ODF) areas, whereas in other cases, these are areas with full basic sanitation coverage. We realised that the focus of the first phase of SSH4A had been on building the capacities for increasing coverage, access, and use for all. However, those are not necessarily the same capacities and service delivery models required for post-full coverage situations.

Similar to the rural water supply sub-sector many years ago, the realisation came that in a situation of full sanitation coverage, activities, roles and responsibilities will need to shift[2]. Instead of focussing on achieving full coverage (the "finish line"), the focus will need to be on sustaining and regulating sanitation, environmental health surveillance, responsive behavioural change

[2] In rural water supply, we call this the functionality issue, i.e., looking at post-construction support. While many people feel that it is too early to ask these questions for rural sanitation, or that a post-coverage service delivery model will emerge spontaneously, once achieving full coverage, our experience is that this is not the case. Our experience shows that individual districts achieving full coverage do need a new perspective beyond coverage.

interventions, and developing new types of sanitation service provision. This we have called "SSH4A Beyond the Finish Line", or Phase 2, as illustrated in Figure 3.

Figure 3 Professionalising sanitation and hygiene services

Source: Halcrow, 2018.

We are not suggesting that there is a strict division between these two phases or that they are completely mutually exclusive. We are emphasising however, that post-full coverage requires a new perspective, and a shift in roles.

3 Methodological aspects: outcome indicators

3.1 Data collection

Information for the outcome indicators is collected in dialogue with the concerned people and organisations for each of the capacity or performance aspects. This is done through guided self-assessments, multi-stakeholder discussions, unit discussions and focus group discussions (FGDs). It is important to be aware about how each method differs, who participates and why.

Table 2 Four methods of participatory outcome measurement

Method	What is measured?	Who participates?
Guided self-assessment	Individual capacity with regards to one's role or function	Individuals responsible for the role or function
Focus group discussion (FGD)	Individual capacity with regards to one's role, function to perform, or to make use of a right or a service	A sample of individuals responsible for the role or function, or a sample of individuals who are targeted for a service or who have the right to participate
Unit discussions	Organisational capacity with regards to a role or function	People of the department or unit that is responsible for this function
Multi-stakeholder discussion	Inter-institutional capacity with regards to their collaboration around a role or function	The different stakeholders in an area who are collectively involved in the role or function

An important consideration is the minimum number of meetings and participant threshold required for valid measurement. For guided self-assessment this can cover all individuals performing this role (if the number is small), or a sample. For FGDs, this will almost always be a sample (see next section). For unit discussions, it is important that the conversation is not limited to the head of the unit alone; though it may be unreasonable to expect all staff to participate. In the case of multi-stakeholder discussions, it is generally assumed that at least 80% of all stakeholders participate for measurement to be considered valid. Ensuring the right mix of people, in sufficient numbers, requires significant motivational efforts.

Due to the emphasis on area-wide approaches, nearly all outcome indicators in this framework are measured at the level where local responsibility for rural sanitation lies. This is usually at district level, but can also be at sub-district, commune, or sub-county levels. This means that unit and multi-stakeholder discussions are conducted in every district, or in every sub-county. An exception can be made in situations where the responsible stakeholder operates at a level higher than the district. For example, if the responsible unit or department for behavioural change communication operates at national or regional level, or if private sector stakeholders are operating in an area that goes beyond the district.

3.2 Sampling of FGDs

A focus group is a small discussion group of 6 to 10 people per session, facilitated by a skilled moderator. Over time, the programme started applying two approaches of sampling focus groups:

- Selecting participants with certain characteristics on the basis of information from the household survey.
- Inviting participants through village leaders or local authorities.

There are pros and cons to both approaches.

Selection based on information from a household survey often results in a larger variation of participants. Moreover, people who are selected, do not usually participate in such conversations, or have never participated before. This results in new, sometimes confronting stories. Utmost care should be taken to properly manage expectations. Participants may not know each other. When vulnerable groups are involved, it may be beneficial to enable them to bring a family member or friend for support.

Good facilitation should be ensured to help people feel at ease, to encourage them to freely share their opinion. This includes applying "do no harm principles" throughout the process. Logistically, this approach to sampling is more complex and time consuming. Considerable efforts should be made to ensure that each participant receives and understands the reason behind their invitation. Reasonable accommodation support should be given for travel. Sampling at higher levels, e.g., at district level or above, has proven to be challenging for vulnerable groups, even when travel support is made available. This should be avoided.

Selection by invitation through village leaders or local authorities, in particular for FGDs at community level, tends to gather people who are more familiar with this type of discussions, as well as with each other. Logistics are more manageable. A challenge may be that not all will feel free to speak in the presence of each other. Certain groups or individuals may be excluded from the process. High-quality facilitation remains essential.

Another question to ask is how many FGDs can be considered representative for the programme area. In theory FGDs should be conducted until no new information is found. This is a difficult and somewhat subjective limitation, and it is better to agree on a number of discussions per indicator based on the diversity within an area. In some countries, there may be a need to consider two distinct zones for sampling because the situation differs, for example, in Rwenzori and the West Nile Region of Uganda, or in the hill/ mountain districts and Terai districts of Nepal. This will increase the number of FGDs. The decision to include additional groups in the measurement, such as people belonging to lower castes, certain ethnic groups, or the elderly, would also increase the number of FGDs.

3.3 Facilitation of measurement of outcome indicators

Sessions for unit discussions and multi-stakeholder discussion should be conducted as much as possible, and as part of regular existing meetings. For example, if monthly district stakeholder meetings are held, these would be ideal moments to hold a session on measurement. Also, it is preferred for self-assessments to take place during existing trainings or come-back days.

Facilitation of measurement is preferably done by programme staff together with focal persons in government. This helps to build the internal knowledge and understanding, which is needed to move from findings to recommendations and actions afterwards.

As explained in part 1 of our rural sanitation and hygiene performance monitoring framework, we use ladders and scorecards to compare and aggregate data. Facilitators should have a detailed understanding of the wording in the ladders, and the different criteria set within the score card. They should be able to explain the meaning of different scores in relation to each other, and to the programme. During the training and guidance of teams, a detailed description on the wording is provided.

Follow the "trust but substantiate" approach where facilitators motivate participants to support their scores with evidence and examples.

3.4 Process of measurement through guided self-assessments

The measurement — through guided self-assessments — is intended to take place individually and anonymously. We do not want people to rank themselves against each other, or to be affected by a score. Rather, it is a self-reflection for the person involved, and the averages provide information to the programme about the overall level of capacity.

Anonymous scoring assumes that the people involved are literate and are able to fill in the self-assessment sheet themselves. It is recommended to hold a group discussion about the different criteria to guide people before filling the sheet, preferably as part of a larger reflection process. If people are unable to fill the sheet themselves, alternative methods, such as pocket voting, should be explored.

Over time the people involved in this task or function may change. This means that the people involved in scoring might not all be the same people as those who scored during baseline. This is not considered a problem as the indicator measures available capacity, not the capacity of specific persons.

The process of measurement should at least consider the following steps:

- Explain the objective and process of guided self-assessments.
- Explain how information is going to be used and processed.
- Share average scores or highlights from earlier assessment (if applicable).
- Discuss individual criteria.
- Conduct scoring (individual).
- Discuss/ address any comments or feedback (in plenary).

3.5 Process of measurement through FGDs

As mentioned above, the measurement through FGDs involves a discussion in a group of 6 to 10 people. Depending on the sampling method and location, these people may be more or less familiar with each other.

The focus group participants should have consented in advance to their participation in the discussion. Participants should be helped to prepare for the meeting through a letter of invite that clearly states the date, time, and venue of the meeting, available compensation, and the purpose of the meeting. It should be clear that the invitation is personal.

Facilitators should prepare for the FGD, ensuring that there is relevant data to share, e.g., information about household access to sanitation or the type of issues faced in the area, as well as disaggregated data relevant to the group of participants. Care should be taken to not overdo the amount of information, and to present information in a way that can be easily understood by participants. The facilitator should be aware of power relations and social bias in the group, and should use this knowledge to facilitate space for everybody to express their views. Where possible,

Disabled People's Organisations (DPOs) should be involved in training facilitators on considerations when consulting people with disabilities, and in providing support and feedback.

The FGD should start with an explanation of the purpose of the meeting, and what will be done with the information. Ground rules should be established to ensure an open and respectful conversation. Time should also be given for an introduction round, and for participants to express their expectations. Expectations beyond the scope of the discussion should be clarified by the facilitators.

The facilitator should aim to bring out genuine reflection. Offering guidance questions, as suggested in the annexes, may help manage the steps of understanding, reflection, scoring and recommendations in distinct moments.

3.6 Process of measurement through unit and multi-stakeholder discussions

The process of measurement for unit and multi-stakeholder discussions should consider the following steps:

- Explain the objective of the session.
- Present previous scores and previous stakeholder recommendations (not for baseline).
- Present relevant household, school, health survey data (and/ or other data).[3]
- Discuss per criteria.
- Conduct individual scoring (*optional*).
- Agree on final scores and justification.
- Formulate stakeholder recommendations.
- Record and document scores, justification, and stakeholder recommendations.

It is important to remain focused in the discussions to ensure that participating stakeholders come up with realistic recommendations that can be implemented within existing time and resource constraints. The recommendations, ideally, should consider both short- and long-term measures. Recommendations are not necessarily limited to what the programme can support, but rather, what is within the remit of the multi-stakeholder group.

3.7 Programme recommendations per indicator

In the outcome measurement report, there should be a summary of stakeholder recommendations for each indicator. Stakeholder recommendations are part of the findings. Based on these findings, programme staff should also conduct their own analysis, and formulate their own recommendations on what needs to be improved in capacity development work. Stakeholder and programme staff recommendations are not necessarily the same. This is not a problem. There is a tendency for stakeholders to overestimate their own capacities at baseline, when they are not yet fully aware of the complexity of improving sanitation, or they refuse to accept certain weaknesses for political reasons.

In these cases, trust has to be built over time, to be able to discuss sensitive gaps and weaknesses. Programme staff may be surprised at some of the scoring by stakeholders, and they should be aware and open to the possibility of receiving critical feedback themselves.

[3] This should not be too much either.

Figure 4 Clear steps: from findings to actions and recommendations
Source: Kome, 2018b.

3.8 Programme recommendations per component

After a good understanding of the situation and recommendations per indicator is obtained, these should be combined to reflect on the SSH4A programme component, and to formulate overall recommendations per component. Of course, the indicators only tell part of the story per component. Hence, it is expected that the team reflect upon the scores, the activities conducted, and the overall objective of each component in order to develop recommendations.

3.9 Confidentiality and data protection

Personal data is any data that can be used to identify a person, such as: names, photos/ videos, email, telephone numbers, GPS locations/ addresses/ geo-shapes, village name, sex, marital status, income and ethnicity, including data on disabilities, health status, computer IP addresses, etc.

Within monitoring and evaluation processes, all programmes should collect data applying a "Privacy by Design" principle. This means:

1) Data is collected only with consent from respondents – no consent, means no data collection from that respondent.

2) Personal data is only collected if there is a real need – we only collect names, phone numbers, email addresses and/ or GPS locations/ addresses, etc. from respondents if there is a clear need for this data. For instance, when internal or external verifiers need to verify the data we collect to release funds, or we need to ensure the quality of data collection by external consultants, or the sampling methodology used. Always reflect on the purpose behind collecting personal information.

3) Personal data can only be accessed by those who need to see it (in line with roles and responsibilities) – those project staff that do not need to see personal information, should not be able to access it. This means only people charged with handling or verifying personal data should be able to see this. Data from respondents should be made anonymous before being shared with other (project) staff, e.g., by assigning numbers to respondents or aggregating data.

4) Personal data is kept as long as it is needed and no longer – as soon as personal data is no longer needed, it is deleted completely. Anonymised data sets can be kept indefinitely.

In particular the SSH4A household surveys collect sensitive personal information, such as address/ GPS location, family composition, assets and personal hygiene practices, and also names, disabilities, and health status. Before the start of each survey, the enumerator is expected to read out the permission statement. The permission statement explicitly states to the respondent what the data will be used for. This means that the data cannot be used for purposes other than stated in the permission statement, and cannot be shared with others. When the menstrual hygiene management module in the questionnaire is applied, for example, an additional permission statement is used.

4 List of outcome indicators

Table 3 presents the overview of outcome indicators for Phase 1 of SSH4A.[4] Outcome indicators with an asterisk are considered optional.

Table 3 SSH4A Phase 1 list of outcome indicators

Programme components	Outcome indicators
Demand creation	1 Progress in the capacity of local government or line agencies to steer sanitation demand creation processes, with quality, in their area.
	2 Progress in capacity in the area to implement sanitation demand creation, with quality.
Sanitation supply chains	3 Progress in private sector engagement in sanitation hardware and services.
	4 Progress in availability of affordable sanitation options for the poorest wealth quintiles.
Behaviour change communication	5 Progress of responsible line agencies to institutionalise BCC for sanitation and hygiene.*
	6 Progress in the capacity of staff to implement improved practice in BCC for sanitation and hygiene.
	7 Progress in local multi-stakeholder rural sanitation and hygiene sector alignment.
	8 Progress in the capacity of agencies to pro-actively mainstream gender and social inclusion in rural sanitation and hygiene services.*
WASH governance	9 Progress in the capacity of local government to provide sustainable social support mechanisms for rural sanitation and hygiene.*
	10 Progress on the influence of women in rural sanitation and hygiene programmes.
	11 Progress on the influence of poor households in rural sanitation and hygiene programmes.
	12 Progress on the influence of people with disability in rural sanitation and hygiene programmes.

[4] Note that this is the list of outcome indicators for Phase 1 of the SSH4A programme. The list of outcome indicators for Phase 2 is different because other capacities are needed.

5 Component one: Sanitation demand creation

Expected outcome. Local organisations are capable to implement and steer sanitation demand creation processes at scale with quality.

Sanitation demand creation can be done through Community-Led Total Sanitation (CLTS) or other tools, depending on the situation. The aim of demand creation is to create a sense of urgency about improving the sanitation situation, and to provide the population with practical ideas on how to address that situation.

Implementation and steering of demand creation for sanitation are not necessarily done by the same people or organisations, nor do they involve the same capacities. Whereas implementation requires strong community facilitation skills and a good knowledge of sanitation, steering involves working with different stakeholders, making agreements, and setting benchmarks. Due to these distinctions, the component has two main attention areas.

Firstly, this component involves building the capacity of facilitators to implement activities, taking into account differences between communities in terms of income, ethnicity (and caste in some countries), as well as differences in leadership styles. Demand creation methodologies have to be adjusted to the local context. Throughout the years of SSH4A implementation, one of our key lessons learnt has been that more attention is needed to ensure that there is informed choice of sanitation technologies. Furthermore, facilitators need to give specific attention to addressing the needs of the elderly and people with disabilities. They will need to be trained in technical alternatives, link up with specialist groups, e.g., DPOs, and consider the accessibility and location of activities. Therefore, building the capacity of facilitators should not be organised in a one-off training workshop, but should take place in regular moments of reflection and learning from practice.

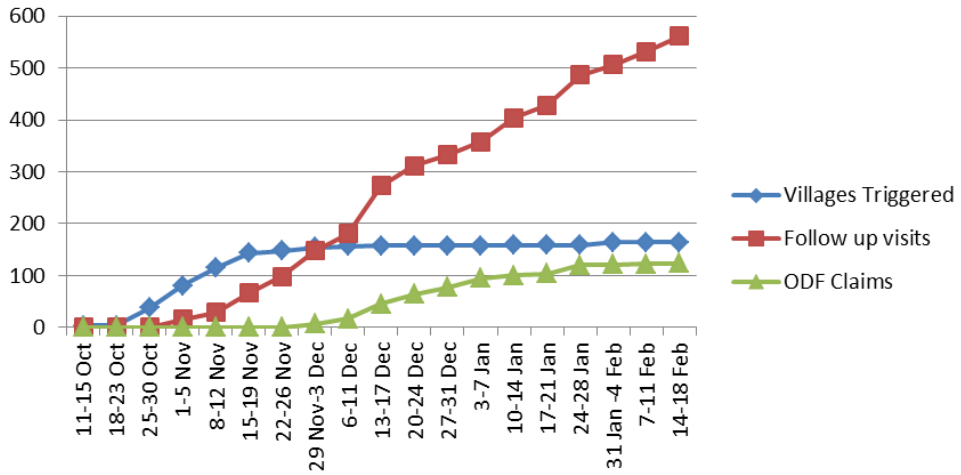

Figure 5 Illustration of the impact of follow-up visits and ODF claims in Siaya district, Kenya in 2009
Source: Tiwari, 2011.

Follow-up is essential to ensure that progress is made, this was learned early on. For example, in 2009 in Kenya, SNV facilitated district-level learning for CLTS facilitators in both local government and line agencies across six districts.[5] The learning process involved on-the-job coaching of district staff and CLTS facilitators, process monitoring (pre-triggering, triggering, post-triggering) with facilitators, and the development of joint recommendations. As a result, the gap between triggering and post-triggering was detected. As illustrated in figure 5, the number of ODF-declared villages increased dramatically as the number of follow-up visits increased.

Secondly, this component involves working with local authorities at different levels (province/ region, district, sub-district/ commune, and community) to organise and steer demand creation activities.

Some of the questions that need to be addressed in this process include:

- Who are the main implementing organisations?
- How much in-house capacity is there within local government or line agency, and which other local organisations should be engaged?
- How to ensure outreach, and what type of support is needed from district and sub-district level to achieve adequate outreach?
- Do the proposed organisations have the technical capacity to assume the envisioned roles?
- How will quality be controlled, and learning ensured?

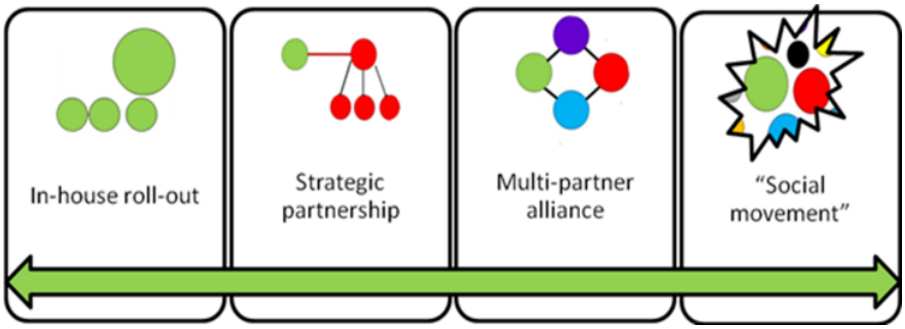

Figure 6 The range of outreach strategies for scaling demand creation

Source: Kome, 2012.

Depending on the context, these questions will have different answers. For example, in Nepal, sanitation is characterised as a social movement, which involves (under local government leadership) all types of organisations and individuals to ensure outreach to remote areas. In many African countries, including Tanzania and Kenya, scaling is most effectively done in-house, within the relevant ministry, whereas in other countries such as Vietnam, a strategic partnership is required between the line ministry and the women's union for greater outreach. Figure 6 provides an example of the range of outreach and implementation strategies that countries use to roll out demand creation.

When increasing the scale of a programme, the steering and quality control of sanitation demand creation activities are crucial. This generally requires a rethink of the way steering was organised during pilots, or during small-scale activities. Simply doing more of the same (horizontal scaling) rarely works. Not only is clarity needed on ODF standards and certification, but also in the type of support needed at different stages of progress. This involves a level of formalization and institutionalisation (vertical scaling).

[5] Bondo, Busia, Kisumu West, Nyando, Siaya, and Rachuonyo in Western and Nyanza provinces 2009.

Inevitably, there will be unresponsive villages or even sub-districts within a district, which may require different demand creation activities, or even some formative research to adjust the approach to new contexts or target groups (functional scaling).[6]

The two outcome indicators for this component are:

Outcome indicator 1. Progress in the capacity of local government or line agencies to steer sanitation demand creation processes, with quality, in their area.

Outcome indicator 2. Progress in capacity in the area to implement sanitation demand creation with quality.

Outcome indicator 1: Progress in the capacity of local governments or line agencies to steer sanitation demand creation processes, with quality, in their area

This indicator is measured with the lead agency responsible for sanitation demand creation at district, county, sub-district, or sub-county level, depending where the responsibility for rural sanitation lies in the country.

Outcome indicator 1	**0**	**1**	**2**	**3**	**4**
Has plan for implementing demand creation activities covering the entire district (even if in phases).					
Ensures that there are human and financial resources to implement demand creation activities in line with its plans (in-house or other).					
Promotes quality standards and regularly assesses the performance of organisations engaged in demand creation.					
Has a monitoring system that measures progress on demand creation targets and results at village and sub-district level.					
Ensures that follow-up happens at the most appropriate times of the year.					
Ensures that information on progress is shared, analysed, and discussed with relevant sub-district and district level stakeholders.					
Ensures that monitoring includes data that assesses inclusion of all groups within the villages, including people with disabilities.					
Uses data from monitoring and experiences to adjust or improve implementation of sanitation demand creation, where relevant.					
Uses a differentiated approach for hard-to-reach villages and for those lagging behind.					
Mobilises local government and other local leadership around sanitation.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

[6] SNV's thinking and work on scaling rural sanitation has been inspired by the theory and strategies of the ExpandNet methodology developed for public health. See in particular the "Practical guidance for scaling up health service innovations", WHO2009 and tools on www.expandnet.net. Another inspiration has been: K. Hardee, L. Ashford, E. Rottach, R. Jolivet, and R. Kiesel. 2012. The Policy Dimensions of Scaling Up Health Initiatives. Washington, DC: Futures Group, Health Policy Project.

Outcome indicator 2: Progress in capacity in the area to implement sanitation demand creation with quality

This second indicator monitors the available capacity for sanitation demand creation facilitation within a district. Measurement should be done as part of a larger reflection process with facilitators.

This reflection does not necessarily take place at district level, but at the most appropriate level (regional or provincial, for example).

Outcome indicator 2	**0**	**1**	**2**	**3**	**4**
Facilitates, does not lecture.					
Ensures that workshop timing and invitations are done adequately so as to ensure inclusive participation of different genders, ethnic groups, people with disabilities, and wealth groups.					
Monitors attendance and makes additional effort to reach groups who do not attend (if needed).					
Demonstrates a respectful attitude towards participants, and adapts to local customs.					
Gives specific attention and/ or uses methods to enable the active participation of different genders, ethnic groups, people with disabilities, and wealth groups.					
Starts post-triggering activities within three weeks of the triggering.					
Includes informed technology choice activities, and ensures that there is understanding of sanitary quality of toilets during post-triggering.					
Includes hygiene and handwashing in post-triggering.					
Gives attention to special needs during triggering and/ or post-triggering (e.g., barriers for people with disabilities, elderly, poor, etc.).					
Clarifies agreements, roles and responsibilities of the community as well as of outside organisations (does not create false expectations).					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

6 Component two: Sanitation supply chains and finance

Expected outcome. Appropriate and affordable market-based solutions for a variety of sanitation consumer needs are implemented at scale.

Toilet construction is a considerable investment in both time and money for a rural household, while toilet maintenance also has labour and cost implications. However, guidance and information on investment options is messy and underdeveloped in most countries, even for Do-It-Yourself (DIY) toilet construction schemes. Demand creation is not sufficient to sustain behaviour change. Informed choice on toilet options is needed to reduce the risk of failure and wastage of households' already scarce resources. DIY options – using exclusively local materials and labour– are often the most affordable and sustainable alternatives, as long as these are durable and hygienic. Yet, in many countries, a significant portion of rural households will prefer to purchase some toilet parts, e.g., bricks, sanplat or pan, door, and in some cases, even the whole structure itself, depending on income and availability. There are also climate and soil conditions in which simple pit latrines are not sustainable.

Suppliers selling hardware and masons building toilets exist in all countries, but they are usually tailored to high-end consumers. The challenge is to reach many more customers across the socio-economic and geographical spectrum. Most toilets in developing countries are "custom made" by masons, in the sense that each is built on the spot, which makes it very expensive, e.g., US$ 100-300.

In addition to the quality of information, constraints in the sanitation markets may lie in:

- The existence of affordable and appropriate technology options for sanitation hardware and services.
- The lack of outreach of suppliers of toilet parts or services, and/or limited accessibility.
- The fact that potential buyers need to visit several shops or suppliers for different parts and negotiate a price in each of them, making the buying process difficult.
- The lack of finance options for household sanitation purchase.
- Poor quality of services and workmanship: you pay a lot for a "shit" latrine.
- Experience of masons is very limited to specific technological options in their area (including in addressing "mistakes").
- Access to new toilet types or innovation is limited, including in options for people with disabilities.
- Marketing approaches may not reach the poorest wealth quintiles.

SNV developed its approach to this component, based on its experience in value chain development and inclusive business, and integrating the work done on sanitation marketing by WaterSHED and IDE in Cambodia. The component includes consumer studies and sanitation supply chain analysis to understand both supply and demand within the sanitation market. One of the lessons learnt from sanitation marketing work in Cambodia is the need to target different consumer segments. It was found that while the "Easy Latrine"[7] would boost sales, it did not result in district-wide coverage: customers belong mainly to the middle and lower-middle classes across

[7] The "Easy Latrine" is a low-cost pour-flush latrine with one off-set pit. It was designed by IDEO in 2010 in collaboration with WaterSHED, IDE and Lien Aid in Cambodia. The design brought the cost of the sub-structure back to nearly one-third, making pour-flush latrines more accessible to large groups of households. It has now been taken up by many organisations, and also linked to a marketing/ outreach model of sales agents.

a number of districts. Adjusted products, outreach strategies, and finance options are needed to reach lower-income groups.

Even when there is a strong supply, good informed choice activities (and if possible regulation) are needed because masons will start to take shortcuts if there are no incentives to comply with standards. Households do not have the knowledge to demand for better quality standards, including in relation to emptying practice.

Innovation in the sanitation market does not always revolve around latrine/ toilet design. In some cases, where affordable options are available, the market structure was found to be dysfunctional. For example, when there is no outreach of supply, this can be addressed by developing a network between central hardware stores and existing small shops in remote areas, and/ or organising bulk supply or promoting product bundling. SNV uses inclusive business tools, such as the business model canvas,[8] to develop business models for rural sanitation. A big lesson learnt is that technology design and innovation should commence after understanding the broader supply chain and market context.

Another important lesson from previous work is around timing of demand creation and supply chain activities. Firstly, for affordable supply to be made available to households at the moment of triggering, work to improve the supply side should start well before triggering. Secondly, in many countries, the right timing for demand triggering is seasonal, and relates not only to accessibility of villages but also to households' availability of labour and money. In some cases, migration affects timing. Generally, the right timing is after the harvesting season, which is a dry season when people have time and money. This means the production of hardware, such as rings, should take place during the harvesting season. But generally this is not possible due to seasonal labour shortages during harvesting season. During these instances, credit facilities for producers become essential so that they can build up their stock before the harvesting season, to ensure that there is a match between demand and supply.

Increasing access to sanitation in markets without subsidy or payment of incentives requires that we work closely to support private sector engagement in the supply of sanitation products, and with government to ensure that barriers are addressed, where possible. The nature of the private sector varies depending on the context. For some, a highly organised market that involves several actors in the supply chain is needed, and in some instances, one person will suffice. In many of the rural areas we work in, the private sector market is nascent and more so for sanitation products. Most of the actors who deal with sanitation products also sell other household goods in the same space. The role of women within these markets is not always visible.

Timed with our demand creation work, we expect that there will be need for sanitation products in the market that are:

- varied in range to provide options for the various target groups;
- suitable for local environmental conditions;
- affordable;
- of good quality (can last long); and
- able to be safely managed/ emptied.

As seen above, the scope of supply chain development and the finance component is broad and highly dependent on the context and market potential. For measurement, we're bringing it down to two outcome indicators:

Outcome indicator 3. Progress in private sector engaging in sanitation hardware and services.

[8] See https://canvanizer.com/new/business-model-canvas.

Outcome indicator 4. Availability of affordable sanitation options for the poorest wealth quintiles.[9]

Outcome indicator 3: Progress in private sector engaging in sanitation hardware and services

This indicator is measured during an FGD, or during interviews with a range of sanitation and hygiene supply chain-related private entrepreneurs and small and medium-sized enterprises (SMEs) in the programme areas:[10] in terms of providing construction services, sanitary products and materials.

Currently, the measurement does not extend to emptying and reuse services, nor menstrual hygiene products. The supply chain analysis conducted during the start-up of the programme will have information about the challenges faced by the market, which can then feed into baseline measurement of this outcome indicator.

Recording the numbers of entrepreneurs active in sanitation within an area is challenging, unless there is a reliable and up-to-date chamber of commerce registration that mentions sanitation.[11] This is not common practice. Inevitably the measurement of this indicator may not include all entrepreneurs within the area (unless there are very few).

It should be noted that the number of entrepreneurs alone does not give an indication of the available services for consumers, as business may vary widely in size. Similarly, the number of female entrepreneurs as such does not provide an indication of their market share or empowerment. In some cases, businesses might even be registered under the name of husbands.

Outcome indicator 3	
0 No private sector involvement in sanitation	No private sector actors involved in sanitation hardware or services in the area.
1 Private sector involvement only at district HQ	Private sector involved in sanitation hardware or services in the area.
2 Private sector marketing sanitation	Private sector involved in sanitation hardware or services in the area, and actively marketing sanitation hardware or services.
3 Marketing and outreach to communities	Private sector involved in sanitation hardware or services in the area, is actively marketing sanitation hardware or services, and has outreach to communities.
4 Marketing, outreach, and reaching the poor	Private sector involved in sanitation hardware or services in the area, is actively marketing sanitation hardware or services, has outreach to communities, and its products or services are reaching the poorest wealth quintile.

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

[9] Note that this indicator focusses on the affordability for one specific vulnerable group: the poor. There are affordability issues for other groups, like people living with disability being able to afford needed toilet adaptations. This has not been included, but could be added if the team observes access of this group to be a gap (from the household survey data).

[10] Note that large programme areas might need to be divided meaningfully, looking at the reach of other products and services in the market. This may be along district lines, but depending on the road network may also include several districts or cut across district lines.

[11] If required, programmes can decided to record the number of entrepreneurs including female entrepreneurs, male and female staff, and potentially of different ethnic backgrounds.

Outcome indicator 4: Availability of affordable sanitation options for the poorest wealth quintiles

This indicator is measured by combining information from the wealth module of the household survey and the costs of a latrine sub-structure. Information is validated as part of the FGD process for the measurement of outcome indicator 11 (influence of poor households in rural sanitation and hygiene).

- Affordability is defined in relation to the value of three (3) household assets.
- The assets are chosen from the wealth module of the household survey, selecting those that are commonly owned by the two poorest wealth quintiles.
- The cost of these assets is obtained from the consumer price index or another reliable source.
- The measurement is validated during the FGD for outcome indicator 11. During the FGD, a broader conversation must be had on key assets, including how households in the poorest wealth quintiles are financing these.

Outcome indicator 4 compares the cost of the underground structure (up to the slab or pan), against selected household assets. Costs should be disaggregated for different elements, such as the lining, slab, labour, etc. The comparison excludes the cost of the superstructure because this varies greatly and can be constructed in many different ways. However, in some contexts, including the cost of the superstructure could prevent errors in data collection. If this is done, findings should be presented as two totals:

- complete toilet cost; and
- cost of underground structure up to slab or pan.

If local materials are used these should also be costed unless these materials are truly always free for everybody. Labour[12] should be costed because very poor households often lack access to labour. If an area receives subsidy, this should not be considered a reduction in the cost of the toilet.

Outcome indicator 4	
0 Beyond reach	Value* of the 1st three key assets is beyond the cost of latrine substructure
1 Is unaffordable	Value of the 1st three key assets < the cost of latrine substructure
2 Is barely affordable	Value of the 1st three key assets ≤ the cost of latrine substructure
3 Is affordable	Value of the 1st two key assets ≥ the cost of latrine substructure
4 Is easily affordable	Value of the main key asset > the cost of latrine substructure

[12] The cost of labour needs to be pegged on the daily rate of a casual, unskilled labourer in rural construction sites, if any.

7 Component three: Behavioural change communication

Expected outcome. Progress in the commitment and capacity of local organisations to implement behaviour change communication, with quality.

With the focus on CLTS, hygiene promotion and broader behavioural change are receiving even less priority from many local governments – making planning and monitoring quite "ODF-centred". In some cases, the promotion of handwashing with soap has become a simple add-on activity to post-triggering. This is a risk, because long-term hygiene promotion and behavioural change are essential to sustain health benefits: one-off messaging has limited effect in habit formation. Without the integration of effective long-term hygiene promotion, health benefits will be largely absent.

Hygiene promotion methodologies have evolved considerably over the past 5-10 years. There is now increased understanding that hygiene promotion should start from understanding behaviour and behavioural motivators, and that hygiene promotion can learn from marketing and other persuasive forms of communication – and should also seek to reflect inclusive messaging.[13] However, at local level, most hygiene promotion is still characterised as "material-centred" rather than "behaviour-centred." This means that most attention, time, and resources go into the production of leaflets and radio spots. Less attention is given to understanding the specific motivators behind persistent hygiene behaviours.

The most commonly used motivator for hygiene promotion at local level is still "health" and knowledge as a barrier, which rarely triggers for behavioural change. Another challenge is that many hygiene promotion programmes aim to address too many behaviours all at once – e.g., handwashing with soap, food hygiene, safe water handling, use of bed nets, etc. – without much coherence. Even when hygiene messages are defined centrally based on formative research, quality may be lost due to limited understanding of implementing staff. There is a need for local innovation in hygiene promotion practices, and to translate international insights into local understanding for better quality results.

Since 2008, SNV has been working to introduce behavioural change communication methodologies at local level: working with agencies (both local and national) to create awareness that understanding behaviour and behavioural motivators is the first step in designing more effective hygiene promotion. For this, SNV has been using different frameworks.[14] The approach consists of a participatory review of existing Information, Education and Communication (IEC) materials or hygiene promotion work, definition of priority behaviours based on survey data, formative research, development of BCC strategies, and consequently, the design of messages, campaigns and monitoring effectiveness. An essential component in this is the involvement of local and national agencies in hygiene promotion.

From this work, we have learnt that local formative research involving stakeholders contributes to a much better understanding of behaviours, and a change of hygiene promotion practice. While frameworks such as FOAM and SaniFOAM, and barrier analysis are helpful, their application

[13] Inclusive messaging has three key aspects. Firstly, people with disabilities must be able to receive and access WASH messages. Secondly, BCC messages must be inclusive of, and relevant to, people with disabilities, e.g., showing them as active members of their communities. Thirdly, communication should aim to contribute to greater general recognition of people with disabilities in society.

[14] Frameworks used include FOAM and SaniFOAM from WSP, as well as the barrier analysis from Food for the Hungry and Child Survival Collaborations and Resources Group (The CORE Group), and more recently BCD (Behavioural Centred Design) from LSHTM.

requires strong support during the analysis phase. Without this support, research findings are not translated into changed practice. But, simply the same list of activities (leaflets, workshops) will be proposed.

We have thus started to simplify the frameworks for local use, going through a first phase of limiting behavioural determinants. We have also learnt that national line agencies are not necessarily better informed about BCC, and may still continue with the same practice as mentioned above for local agencies. Exposure and engagement in the field is essential to change these attitudes towards hygiene promotion. In reviewing the effectiveness of hygiene promotion for handwashing, we found the importance of using positive messages to be one of the main factors for success.

Within SSH4A, BCC activities focus on a range of behaviours. Priority behaviours are agreed with the lead agency on the basis of available data. These priority behaviours change over time. Often the priority behaviours will include handwashing with soap at critical times, as well as toilet use and maintenance. Specific formative research to understand the range of difficulties (e.g., mobility, seeing, hearing) and barriers people may face in toilet use is a common need, including for the elderly.

Hygiene behavioural change communication should not be a one-off intervention, but should be anchored in local or national sanitation plans. A BCC strategy linked to local planning is more likely to be resourced in the long term. In addition to local campaigns, some countries may also engage in regional or national campaigns – all countries work in collaboration with other development partners to promote hygiene behaviour, and to align with national promotion plans. BCC is new for most responsible agencies. Within this component, we look at two different aspects, namely, if the enabling conditions for BCC within rural sanitation exist, and the improved practice itself:

Outcome indicator 5. Progress of responsible agencies to institutionalise BCC for sanitation and hygiene.

Outcome indicator 6. Progress in the capacity of staff to implement improved practice in BCC for sanitation and hygiene.

Outcome indicator 5: Progress of responsible line agencies to institutionalise behaviour change communication for rural sanitation and hygiene

This indicator is about organisational capacity: to ensure that the enabling conditions for BCC within rural sanitation and hygiene work in the district or county exist. It is measured under the leadership of a line agency for health or a local government department, depending on who is responsible for the design and/ or implementation of BCC activities. This can be at district, county, provincial, or even national level, depending on context.

Outcome indicator 5	**0**	**1**	**2**	**3**	**4**
Has a unit or staff with the mandate to design and/or implement BCC for rural sanitation and hygiene.					
Has clearly defined internal roles and responsibilities to design and/or implement BCC for rural sanitation and hygiene.					
Has sufficient and qualified human resources for the required tasks.					
Has adequate financial resources to design and/or implement BCC.					

Outcome indicator 5	**0**	**1**	**2**	**3**	**4**
Develops a BCC strategy or action plan that clearly articulates priority behaviours and target groups					
Ensures that other agencies working in sanitation agree on the priority behaviours and target groups.					
Generates information about behaviour change priorities and outcomes for monitoring and review.					
Updates its BCC strategy or action plan with regularity, or at least every three years.					
Works with other stakeholders in sanitation to explain and create buy-in for BCC work.					
Ensures that BCC work has the support of superiors, and is integrated into broader WASH planning, such as a local sanitation plan.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Outcome indicator 6: Progress in the capacity of staff to implement improved practice in behaviour change communication for rural sanitation and hygiene

The indicator is about organisational capacity: to implement innovative/ improved BCC practice. It is measured with the staff directly responsible for design and/ or implementation of BCC activities.

Outcome indicator 6	**0**	**1**	**2**	**3**	**4**
Identifies priority behaviours and target audiences based on evidence.					
Develops behavioural interventions based on formative research or other evidence of motivators.					
Ensures communication objectives are clearly articulated.					
Ensures messages and behavioural interventions are tested with the target audience.					
Ensures use of language and imaging is appropriate for the capacities and culture of the target audience.					
Ensures that the design of BCC is inclusive, as well as language and imaging is respectful and does not reinforce stereotypes.					
Manages and oversees the quality of implementation/ roll-out according to design and planning.					
Ensures training and follow-up to facilitators or other implementers is provided to an adequate standard.					
Has a process for monitoring and gathering feedback on outcomes.					
Adapts or improves implementation based on monitoring information, on the changing context, and/ or other feedback.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

8 Component four: WASH governance

Expected outcome. Improving local WASH governance in terms of alignment of stakeholders, sector planning and monitoring, transparency and social inclusion.

A core part of the SSH4A approach is to support local governments to make the shift from a village-focussed-triggering programme, to a coherent district-wide approach for rural sanitation and hygiene service delivery. Common challenges occur when conflicting approaches are implemented within the same district, or when there are insufficient resources to take the approach district wide. SNV overcomes these by bringing together stakeholders at sub-district and district level to share their approaches and develop a sanitation plan for their district. Both governmental and non-governmental stakeholders need to be involved, including representative groups such as Disabled People's Organisations (DPOs),[15] where present. Furthermore, SNV supports local government to take the lead in planning, and for everyone to take pride in incremental progress made in their district through basic monitoring.[16]

A district-wide approach does not mean that the entire district will immediately become ODF. But, a district-wide approach changes the dynamics and mind-set of the stakeholders involved, because the perspective is reaching full coverage in that area. With a focus on villages, a lot of attention goes into the methodological details of triggering and handwashing promotion. As a result, the tendency is to go for the easier villages, and to divide villages among stakeholders without addressing the bigger institutional picture that is essential for scaling and behaviour change. The joint district sanitation plan and the area-wide perspective incentivises stakeholders to:

- Discuss the needs and approach to reach different geographical areas (remote), and to reach poorer households.
- To set clearer standards (ODF certification for example) and eliminate contradictions among their approaches.
- To discuss the best use of resources and apply approaches that fit within existing constraints.
- To engage a much broader group of stakeholders because a district-wide commitment becomes a political commitment, as opposed to a concern of the health agency alone.

Box 2 Potentially disadvantaged

When the SNV programme speaks about people or groups who are 'potentially disadvantaged' or those who 'may be disadvantaged,' we emphasise that not all people who could be disadvantaged actually are disadvantaged in relation to other people. For example, we may expect people to be disadvantaged due to their economic situation, ethnic background, mental or physical abilities, gender or sexual orientation. Whether this happens, and whether people need additional support, should be understood rather than assumed.

The concept of reasonable accommodation[17] is applied, which involves supporting individuals with disability to participate equal to others. This can be done, for example, by adjusting the way an activity is implemented (location, duration, method), or by providing extra support to ensure they do not face a disproportionate burden, e.g., transport.

Source: House, et al., 2017, adapted from de Albuquerque, 2014.

[15] DPOs can represent individual or groups of disabilities, where possible a diverse range of perspectives and disabilities is encouraged.

[16] Note that strengthening local government monitoring is one of the aims of the approach, but most programmes do not rely exclusively on these data to measure progress, because the quality and detail may not (yet) be sufficient. It's good practice to compare the data with survey data from the programme.

[17] Reasonable Accommodation is defined as part of the UN Convention on the Rights of People with Disabilities (CPRD). Read more here: https://www.ohchr.org/en/hrbodies/crpd/pages/conventionrightspersonswithdisabilities.aspx

Within the SSH4A programme, an area-wide approach and multi-stakeholder engagement are considered essential elements for sustainability. This does not mean that SNV will be directly involved in all sub-districts and villages. Rather SNV will be working at district level as well in a number of selected sub-districts with lower levels of government. This allows for an in-depth understanding of both realities. Under this component, links are made with national level policies as well.

In addition to supporting district sanitation plans, ODF certification, regulation and stakeholder alignment, the WASH governance component of the SSH4A approach works with stakeholders to strengthen pro-poor support mechanisms. For this, it is essential to facilitate dialogue between representatives of potentially disadvantaged groups and decision makers. Such dialogue does not immediately show strong engagement and negotiation from the part of specific groups, but the process does increase visibility and awareness about their needs and reduces stereotypes. This is essential to integrate their specific needs into district sanitation plans.

There is often insufficient capacity or resources within for example minority ethnic groups or DPOs to engage strongly: building that capacity is part of this component and is measured through the outcome indicators focusing on the influence of women, the poor or potentially disadvantaged households, elderly people, and people with disabilities. Because there are many barriers that inhibit their participation and influence, the programme also seeks to understand how they experience social inclusion efforts by duty bearers – including any negative outcomes – and also reflect on their own potential to make themselves heard and influence decisions.

Governance is a broad area, which is why there are several outcome indicators for this component. The indicators look at multi-stakeholder engagement, capacity of lead agencies to integrate Gender, Equity and Social Inclusion (GESI) indicators, as well as the capacity of potentially disadvantaged groups themselves to influence decision making. Outcome indicators are:

Outcome indicator 7. Progress in local sector alignment around rural sanitation and hygiene.

Outcome indicator 8. Progress in capacity of local line agencies to pro-actively mainstream gender and social inclusion in rural sanitation and hygiene.

Outcome indicator 9. Progress in the capacity of local government to provide sustainable social support mechanisms in rural sanitation and hygiene.

Outcome indicator 10. Progress on the influence of women in rural sanitation and hygiene programmes.

Outcome indicator 11. Progress on the influence of poor households in rural sanitation and hygiene programmes.

Outcome indicator 12. Progress on the influence of people with disability in rural sanitation and hygiene programmes.

Outcome indicator 7: Progress in local sector alignment around rural sanitation and hygiene

This indicator is measured in a multi-stakeholder discussion. It should aim to involve all stakeholders working in sanitation and hygiene in the area (district or county) to enter into a conversation, under the leadership of the lead agency. Hence, it can involve different departments, as well as civil society groups and private sector stakeholders, depending on who is active in the area. Note that relevant civil society groups can include also DPOs, youth groups, ethnic or religious groups. If considered useful, this can be measured at both the district and sub-district levels (or county and sub-county).

Before the meeting, facilitators should prepare some inputs, including relevant household survey data, relevant district plans, stakeholder mapping, and earlier recommendations in case this indicator had been measured before.

Outcome indicator 7	**0**	**1**	**2**	**3**	**4**
A multi-stakeholder dialogue has started on rural sanitation and hygiene.					
All relevant local government sector stakeholders are involved in the dialogue.					
All relevant donor (or funding) agencies are involved in the dialogue.					
Relevant civil society groups, rights holder groups (including DPOs), and private sector stakeholders are involved in the dialogue.					
Information and data (evidence base) are shared in the group.					
Sector priorities for rural sanitation and hygiene are set jointly by stakeholders.					
Sector targets for rural sanitation and hygiene are set jointly by stakeholders.					
Plans for rural sanitation and hygiene are made jointly.					
Approaches for rural sanitation and hygiene are aligned.					
Standards and norms related to rural sanitation and hygiene are aligned.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Outcome indicator 8: Progress in capacity of local line agencies to pro-actively mainstream gender and social inclusion in rural sanitation and hygiene

This indicator is measured with the lead agency responsible for the rural sanitation and hygiene sector at district/ sub-district level. Within the governance component, we look at both the capacity of government agencies to mainstream gender and social inclusion, as well as the capacity of individuals from potentially disadvantaged groups to influence decision making. This twin-track approach should complement each other.

Outcome indicator 8	0	1	2	3	4
Uses disaggregated data to monitor and inform approaches for different vulnerable groups.					
Has a strategy or plan in which the different needs for different groups (e.g., women, people with disabilities, minority groups, etc.) are identified.					
Has specific activities, budget, and resources for these.					
Works with relevant specialist organisations and social services when needed (e.g., DPOs, social service providers, etc.).					
Incorporates gender and social inclusion considerations in training of programme implementers.					
Reviews tools and approaches for attention to gender and social inclusion, and positive and inclusive messaging.					
Reaches out and creates space for direct dialogue with different potentially disadvantaged groups.					
Considers the specific needs of staff members, e.g., female staff, people with disabilities.					
Promotes equal opportunities for all staff members.					
Reviews approaches and progress for both positive and negative outcomes for different groups.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Outcome indicator 9: Progress in the capacity of local government to provide sustainable social support mechanisms in rural sanitation and hygiene

This indicator is measured during a unit discussion, as the responsibility lies with a specific agency or local government. However, pro-poor support generally requires broad support and alignment of district stakeholders. This is thus one of the conditions that needs to be ensured by the responsible agency or local government. The unit discussion should engage the lead agency, but it can also involve different departments, as relevant. The indicator measures local government capacity to ensure long-term social support mechanisms for rural sanitation, and to a lesser extent, hygiene. Support can involve specific technical assistance and guidance, in-kind or financial support. However, for sustainability, any support should:

- Be part of the formal mandate and implementation mechanisms of the responsible agency.
- Be scalable across the area (district) and is possible to sustain within the existing resources.
- Contribute to good governance and social justice in the area (avoiding corruption, favouritism or non-transparent decision making).
- Contribute to the empowerment and broader social acceptance of vulnerable groups, making a relevant and significant difference in their ability to practice safe sanitation and hygiene behaviours.
- Do no harm to other social groups or to market development in the area (distorting prices or market incentives).

While it may not be possible to quantify all these, it is recommended to add these topics into the reflection. Before the indicator is measured, facilitators should have clarity about the main groups

requiring support, and their needs – using survey data among others, and mapping existing support mechanisms, their outreach, costs and uptake.

Outcome indicator 9	**0**	**1**	**2**	**3**	**4**
Has an overview of the availability and uptake of different support mechanisms in the area.					
Ensures alignment and coherence of different forms of support in their jurisdiction.					
Identifies a target population based on transparent, and verifiable characteristics.					
Defines a combination of support mechanisms and target population that can be sustained at scale, within existing resource constraints.					
Funds support mechanisms through regular budget.					
Uses monitoring information to evaluate uptake and effectiveness, and subsequently improve.					
Identifies and monitors risk areas for misuse, and subsequently improves.					
Uses support mechanisms, which do not distort prices or market incentives.					
Implements support mechanisms at the lowest possible level (subsidiarity principle), linking responsibilities to accountability for results.					
Ensures transparent and clear communication to the target group and wider population about support mechanisms.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Outcome indicator 10: Progress in the capacity of local government to provide sustainable social support mechanisms in rural sanitation and hygiene

This indicator is measured with female-headed households and/ or adult women from different types of households[18] who are identified through the household survey. The FGDs should be diligently prepared. Facilitators should be aware about the level of access and use to sanitation, as well as the type of (sanitation and hygiene) issues faced in the area. A woman is preferred for the facilitation of this FGD.

As for all these three indicators, focus is on influence. It is important to facilitate the meeting in such a way that general statements can be illustrated with specific examples. For example, asking in which type of meetings women generally participate, but also in which meetings the women within the group have participated in the last two years. Similarly, which type of issues and needs women generally raise on rural sanitation and hygiene, examples of the issues raised by the women within the group and whether/ how these influenced decisions.

The objective of this guided reflection is to score the level of influence women have in rural sanitation and hygiene programmes, but more importantly, to formulate stakeholder recommendations. (See also the reporting guidance.)

[18] It is preferable to measure the influence of female-headed households separately because their needs and position tend to be different from other adult women.

Outcome indicator 10	
0	No participation of women in meetings and events.
1	Women attend meetings (but do not speak).
2	Women attend meetings and speak (but do not feel they influence decisions).
3	Women attend meetings, speak and feel that they influence decisions.
4	Women attend meetings, speak and feel that they influence decisions, as well, the decisions made reflect and respect their needs and perspectives.

Outcome indicator 11: Progress on the influence of poor households in rural sanitation and hygiene programmes

This indicator is measured during an FGD, with participation of household members from the two poorest wealth quintiles, as identified in the household survey. During the FGD, it is important to illustrate general statements with specific examples from the people in the group themselves. The objective is to score the level of influence, but also, to formulate stakeholder recommendations.

Discussions on this indicator should be linked to discussions about outcome indicator 4 – presence of affordable sanitation options for the poorest wealth quintiles. This means that information about key assets, their costs, and distribution across wealth quintiles, as well as latrine costs, should be collected before the FGD.

Care should also be taken to present this type of information, also, making it accessible for the FGD participants. In the reporting guidance, further discussion questions are suggested. Care should also be taken to not stigmatise participants.

Outcome indicator 11	
0	No participation of households from the poorest wealth quintiles in meetings and events.
1	Households from the poorest wealth quintiles attend meetings (but do not speak).
2	Households from the poorest wealth quintiles attend meetings and speak (but do not feel they influence decisions).
3	Households from the poorest wealth quintiles attend meetings, speak, and feel that they influence decisions.
4	Households from the poorest wealth quintiles attend meetings, speak, and feel that they influence decisions, as well, the decisions made reflect and respect their needs and perspectives.

Outcome indicator 12: Progress on the influence of people with disabilities in rural sanitation and hygiene programmes

This indicator is measured during an FGD with people with disabilities, which may include elderly people. It is assumed that when age progresses, people tend to face issues of limited mobility, limited hearing and/ or sight, and self-care challenges. However, the social status and influence of elderly people can be very different from younger people living with disabilities who may face

additional barriers and stigmatism. Hence, it is often more appropriate to conduct separate FGDs with elderly. Also, where relevant, support from DPOs should be sought.

Box 3 People with disabilities

In this document, the term "people with disabilities" is used. However, some people may not associate themselves as to having a disability, may not wish to be identified as such, or may "just" face difficulties due to mobility limitations. This may apply, for example, to older people who may consider their mobility limitations a normal part of ageing. This could also be due to some reticence to admit the presence of a disability, especially if it is considered highly stigmatising in a particular community or area.

For different contexts, it is useful to explore what people consider as the most appropriate and respectful term to use when classifying "people with disabilities". As a principle, always put the word 'person' first. Some alternatives, for example, include:

- To talk about people with disabilities
- To talk about people with disabilities and older people
- To talk about people who face difficulties in hearing, seeing, walking, remembering, communicating, being understood or with self-care

The same principles apply as for outcome indicator 10, i.e., to illustrate general statements with specific examples from the group themselves. The objective is to score the level of influence, but to also formulate stakeholder recommendations.

Outcome indicator 12	
0	No participation of people with disabilities in meetings and events.
1	People with disabilities attend meetings (but do not speak).
2	People with disabilities attend meetings and speak (but do not feel they influence decisions).
3	People with disabilities attend meetings, speak, and feel that they influence decisions.
4	People with disabilities attend meetings, speak, and feel that they influence decisions, as well, the decisions made reflect and respect their needs and perspectives.

References

Halcrow, G., 2018. *Diversity in SSH4A and its evolving emphasis*, [blog] July 2018. Available at: <http://www.snv.org/update/diversity-ssh4a-and-its-evolving-emphasis> [Accessed 5 February 2019].

House, S., Ferron, S. and Cavill, S., 2017. *Scoping and Diagnosis of the Global Sanitation Fund's Approach to Equality and Non-Discrimination.* [online] Geneva: WSSCC. Available at: <http://wsscc.org/wp-content/uploads/2017/08/GSF-EQND-Study-EN.pdf> [Accessed 2 February 2018].

Kome, A., 2012. *Full Summary D-group discussion*. Scaling up Rural Sanitation and Hygiene D-Group list serve discussion. 23 October-19 November 2012. Online discussion.

Kome, A., 2018a. Payment by Results 101. *World Water Week 2018: Water, ecosystems and human development.* Stockholm, Sweden, 26-31 August 2018. The Hague: SNV.

Still, D., and Foxon, K., 2012. Tackling the challenges of full pit latrines, Volume 2: How fast do pit toilets fill up? A scientific understanding of sludge build up and accumulation in pit latrines, *Report to the Water Research Commission*, WRC Report No. 1745/2/12, 2012.

Sijbesma, C., and Postma, L., 2008. Quantification of qualitative data in the water sector: the challenges, *Water International*, [e-journal] 33(2). Available through: Taylor & Francis Online website <https://www.tandfonline.com/doi/abs/10.1080/02508060802022209> [Accessed 5 February 2019].

SNV, 2018. *Sustainable Sanitation and Hygiene for All, Capability Statement*. [online] Available at: <http://www.snv.org/public/cms/sites/default/files/explore/download/2018q3-ssh4a-cap-stat-euro-w.pdf> [Accessed 15 January 2019].

Tiwari, C., 2011. *Role of district level reflection and government leadership in scaling up CLTS: lessons on process monitoring in Kenya.* The Hague: SNV.

Annexes: reporting sheets

SSH4A performance monitoring framework
Part 2. Outcome indicators

OI 1 REPORTING SHEET

PROGRESS IN THE CAPACITY OF LOCAL GOVERNMENTS OR LINE AGENCIES TO STEER SANITATION DEMAND CREATION PROCESSES WITH QUALITY IN THEIR AREA

Name of the responsible agency:

District or county:

Date:

Location of the meeting:

Outcome indicator 1	**0**	**1**	**2**	**3**	**4**
Has plan for implementing demand creation activities covering the entire district (even if in phases).					
Ensures that there are human and financial resources to implement demand creation activities in line with its plans (in-house or other).					
Promotes quality standards and regularly assesses the performance of organisations engaged in demand creation.					
Has a monitoring system that measures progress on demand creation targets and results at village and sub-district level.					
Ensures that follow-up happens at the most appropriate times of the year.					
Ensures that information on progress is shared, analysed, and discussed with relevant sub-district and district level stakeholders.					
Ensures that monitoring includes data that assesses inclusion of all groups within the villages, including people with disabilities.					
Uses data from monitoring and experiences to adjust or improve implementation of sanitation demand creation, where relevant.					
Uses a differentiated approach for hard-to-reach villages and for those lagging behind.					
Mobilises local government and other local leadership around sanitation.					

0=no/ never; 1=rarely; 2=occasionally; 3=mostly; 4=always

Reasons for giving the overall score (where relevant with reference to documents):

What has been the most significant progress made over the past 2 years?

Stakeholder recommendations:

OI 2 INDIVIDUAL SELF-SCORING SHEET FOR FACILITATORS

PROGRESS IN CAPACITY IN THE AREA TO IMPLEMENT SANITATION DEMAND CREATION WITH QUALITY

District or county:

Date:

Location of the meeting:

Outcome indicator 2	**0**	**1**	**2**	**3**	**4**
Facilitates, does not lecture.					
Ensures that workshop timing and invitations are done adequately so as to ensure inclusive participation of different genders, ethnic groups, people with disabilities, and wealth groups.					
Monitors attendance and makes additional effort to reach groups who do not attend (if needed).					
Demonstrates a respectful attitude towards participants, and adapts to local customs.					
Gives specific attention and/ or uses methods to enable the active participation of different genders, ethnic groups, people with disabilities, and wealth groups.					
Starts post-triggering activities within three weeks of the triggering.					
Includes informed technology choice activities, and ensures that there is understanding of sanitary quality of toilets during post-triggering.					
Includes hygiene and handwashing in post-triggering.					
Gives attention to special needs during triggering and/ or post-triggering (e.g., barriers for people with disabilities, elderly, poor, etc.).					
Clarifies agreements, roles and responsibilities of the community as well as of outside organisations (does not create false expectations).					

0=Never; 1=rarely; 2=occasionally; 3=mostly; 4=always

Reasons for giving this score:

What was the most important thing you learned over the past 2 years?

What would you feel should be improved further?

OI 3 REPORTING SHEET

PROGRESS IN PRIVATE SECTOR ENGAGING IN SANITATION HARDWARE AND SERVICES

District, county, or other:

Date:

Participants:

What type of hardware or services do you provide?

Who are your customers?

Outcome indicator 3	
0 No private sector involvement in sanitation	No private sector actors involved in sanitation hardware or services in the area.
1 Private sector involvement only at district HQ	Private sector involved in sanitation hardware or services in the area.
2 Private sector marketing sanitation	Private sector involved in sanitation hardware or services in the area, and actively marketing sanitation hardware or services.
3 Marketing and outreach to communities	Private sector involved in sanitation hardware or services in the area, is actively marketing sanitation hardware or services, and has outreach to communities.
4 Marketing, outreach, and reaching the poor	Private sector involved in sanitation hardware or services in the area, is actively marketing sanitation hardware or services, has outreach to communities, and its products or services are reaching the poorest wealth quintile.

Reasons for giving this score:

What has been the most significant progress in sales made over the past 2 years?

How to improve outreach and sales with poor households in 2016/2017?

Other recommendations or comments:

OI 4 and OI 11 DISCUSSION REPORTING SHEETS

OI 4: AVAILABILITY OF AFFORDABLE SANITATION OPTIONS FOR THE POOREST WEALTH QUINTILES
OI 11: PROGRESS ON THE INFLUENCE OF POOR HOUSEHOLDS IN RURAL SANITATION AND HYGIENE PROGRAMMES

Location of the discussion:

Time and date of the discussion:

Number of participants:

Selected key assets[19] identified for comparison:

SUMMARY OF THE DISCUSSION *(SUGGESTED QUESTIONS)*

1. In the group how many people have a latrine and who does not yet have a latrine?

2. For those who have a latrine, how did you decide to build one?

3. Where did you get the information about how to build a latrine?

4. What type of latrine is it, and how did you find the resources to build it?

5. How much did it cost?

   - For labour
   - For the materials (what type of materials)
   - For the superstructure

[19] Key assets are assets from the wealth analysis/modules that 60% of people and people across wealth quintiles have. In principle, the cost of key assets is compared against the cheapest option of building a toilet. However, if felt appropriate, certain low-cost toilet types can be excluded for being inappropriate, unsafe or unhygiene.

6. Are you happy/ satisfied with your latrine?

7. In this area are there many people who have [key asset]? How do they pay for those?

8. What would be good ideas to make it easier for households to buy a latrine?

9. Are there other barriers and needs mentioned related to sanitation and hygiene?

10. Do you feel that these issues are taken into account by local government?

11. Are you aware of possibilities to participate and voice your needs to local government?

12. Do you usually participate (attend and/or speak) in these meetings? Why/ Why not?

13. Are your suggestions taken into account? Why, why not?

14. Do you feel that there is more attention for your needs in sanitation than two years ago?

15. What would be your recommendations to make sure that your needs are heard?

OI 4 CONSOLIDATED FINDINGS SHEET[20]

Latrine costs

Latrine type	**Construction materials used**				**Cost**				**Comments**
	Pit lining	Slab/ pipe(s), pan	Walls	Roof	Materials		Labour		
					Pit (lining)	Slab	Pit (digging)	Slab	

What is the total costs of the underground structure? (Including slab) (refer to question 5)

How do people pay for this? (refer to question 4)

Is the latrine more or less expensive than some of the key assets? (refer to question 7)

	Cost
Key asset 1	
Key asset 2	
Key asset 3	
Cost of latrine (underground)	

(continued on next page)

(continued, OI4 Consolidated findings sheet)

[20] This sheet will be used after the focus group is finalised. Make sure that you collect the relevant information in the FGD.

0 Beyond reach	Value* of the 1st three key assets is beyond the cost of latrine substructure
1 Is unaffordable	Value of the 1st three key assets < the cost of latrine substructure
2 Is barely affordable	Value of the 1st three key assets ≤ the cost of latrine substructure
3 Is affordable	Value of the 1st two key assets ≥ the cost of latrine substructure
4 Is easily affordable	Value of the main key asset > the cost of latrine substructure

** The type, value and the quantity of the key asset to use will be determined by the country based on the current market price.*

Notes

- The price of key assets, where possible, will be extracted from the consumer price index or a similar reliable source.
- Key asset(s) – most commonly owned HH good – to be determined from the HH survey. We shall use the assets from the lowest wealth quintile group which can be movable or non-movable assets and livestock e.g. beds, animals, bicycles.
- A key factor in reviewing the value of the asset would be to determine how the key asset is acquired. This will be part of the discussion under SI 8 as it determines the financing of the asset and therefore the payment options available for the HHs.

Stakeholder recommendations to improve affordability
use responses to questions 2, 3, 6 and 8

OI 11 CONSOLIDATED FINDINGS SHEET[21]

District or county:

Date:

Location of the meeting:

Outcome indicator 11	
0	No participation of households from the poorest wealth quintiles in meetings and events.
1	Households from the poorest wealth quintiles attend meetings (but do not speak).
2	Households from the poorest wealth quintiles attend meetings and speak (but do not feel they influence decisions).
3	Households from the poorest wealth quintiles attend meetings, speak, and feel that they influence decisions.
4	Households from the poorest wealth quintiles attend meetings, speak, and feel that they influence decisions, as well, the decisions made reflect and respect their needs and perspectives.

Reasons for giving this score
refer to questions 11, 12 and 13

What has been the most significant progress made over the past 2 years?
refer to questions 9, 10, 14

What recommendations will you like to make to enhance your participation in rural sanitation and hygiene in the coming year?
refer to question 15

[21] Though this outcome indicator belongs to component 4, we are including it here because the measurement is conducted linked to outcome indicator 4.

OI 5 REPORTING SHEET

PROGRESS OF RESPONSIBLE LINE AGENCIES TO INSTITUTIONALISE BEHAVIOUR CHANGE COMMUNICATION FOR RURAL SANITATION AND HYGIENE

Name of the responsible agency:

District, county or other:

Date:

Location of the meeting:

Outcome indicator 5	**0**	**1**	**2**	**3**	**4**
Has a unit or staff with the mandate to design and/or implement BCC for rural sanitation and hygiene.					
Has clearly defined internal roles and responsibilities to design and/or implement BCC for rural sanitation and hygiene.					
Has sufficient and qualified human resources for the required tasks.					
Has adequate financial resources to design and/or implement BCC.					
Develops a BCC strategy or action plan that clearly articulates priority behaviours and target groups					
Ensures that other agencies working in sanitation agree on the priority behaviours and target groups.					
Generates information about behaviour change priorities and outcomes for monitoring and review.					
Updates its BCC strategy or action plan with regularity, or at least every three years.					
Works with other stakeholders in sanitation to explain and create buy-in for BCC work.					
Ensures that BCC work has the support of superiors, and is integrated into broader WASH planning, such as a local sanitation plan.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Reasons for giving the overall score (where relevant with reference to documents):

What have been the most significant improvements made in institutionalising hygiene promotion over the past two years?

Which challenges have been encountered?

Recommendations for improvements:

OI 6 REPORTING SHEET

PROGRESS IN THE CAPACITY OF STAFF TO IMPLEMENT IMPROVED PRACTICE IN BEHAVIOUR CHANGE COMMUNICATION FOR RURAL SANITATION AND HYGIENE

Name of the responsibility agency:

District, county or other:

Date:

Location of the meeting:

Outcome indicator 6	**0**	**1**	**2**	**3**	**4**
Identifies priority behaviours and target audiences based on evidence.					
Develops behavioural interventions based on formative research or other evidence of motivators.					
Ensures communication objectives are clearly articulated.					
Ensures messages and behavioural interventions are tested with the target audience.					
Ensures use of language and imaging is appropriate for the capacities and culture of the target audience.					
Ensures that the design of BCC is inclusive, as well as language and imaging is respectful and does not reinforce stereotypes.					
Manages and oversees the quality of implementation/ roll-out according to design and planning.					
Ensures training and follow-up to facilitators or other implementers is provided to an adequate standard.					
Has a process for monitoring and gathering feedback on outcomes.					
Adapts or improves implementation based on monitoring information, on the changing context, and/ or other feedback.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Reasons for giving this score:

What specific behaviours have been addressed in hygiene promotion over the past two years?

What have been the most significant improvements made in hygiene promotion over the past two years?

Which challenges have been encountered?

Recommendations for improvements:

OI 7 REPORTING SHEET

PROGRESS IN LOCAL SECTOR ALIGNMENT AROUND RURAL SANITATION AND HYGIENE

District or county:

Participating stakeholders:

Date:

Location of the meeting:

Outcome indicator 7	**0**	**1**	**2**	**3**	**4**
A multi-stakeholder dialogue has started on rural sanitation and hygiene.					
All relevant local government sector stakeholders are involved in the dialogue.					
All relevant donor (or funding) agencies are involved in the dialogue.					
Relevant civil society groups, rights holder groups (including DPOs), and private sector stakeholders are involved in the dialogue.					
Information and data (evidence base) are shared in the group.					
Sector priorities for rural sanitation and hygiene are set jointly by stakeholders.					
Sector targets for rural sanitation and hygiene are set jointly by stakeholders.					
Plans for rural sanitation and hygiene are made jointly.					
Approaches for rural sanitation and hygiene are aligned.					
Standards and norms related to rural sanitation and hygiene are aligned.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Reasons for giving the overall score:

What has been the most significant progress made over the past two years?

Recommendations for improvement:

OI 8 REPORTING SHEET

PROGRESS IN CAPACITY OF LOCAL LINE AGENCIES TO PRO-ACTIVELY MAINSTREAM GENDER AND SOCIAL INCLUSION IN RURAL SANITATION AND HYGIENE

Name of the responsible agency:

District, county or other:

Date:

Location of the meeting:

Outcome indicator 8	**0**	**1**	**2**	**3**	**4**
Uses disaggregated data to monitor and inform approaches for different vulnerable groups.					
Has a strategy or plan in which the different needs for different groups (e.g., women, people with disabilities, minority groups, etc.) are identified.					
Has specific activities, budget, and resources for these.					
Works with relevant specialist organisations and social services when needed (e.g., DPOs, social service providers, etc.).					
Incorporates gender and social inclusion considerations in training of programme implementers.					
Reviews tools and approaches for attention to gender and social inclusion, and positive and inclusive messaging.					
Reaches out and creates space for direct dialogue with different potentially disadvantaged groups.					
Considers the specific needs of staff members, e.g., female staff, people with disabilities.					
Promotes equal opportunities for all staff members.					
Reviews approaches and progress for both positive and negative outcomes for different groups.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Reasons for giving the overall score:

What has been the most significant progress made over the past two years?

Recommendations for improvement:

OI 9 REPORTING SHEET

PROGRESS IN THE CAPACITY OF LOCAL GOVERNMENT TO PROVIDE SUSTAINABLE SOCIAL SUPPORT MECHANISMS IN RURAL SANITATION AND HYGIENE

Name of the responsible agency:

District, county or other:

Date:

Location of the meeting:

Outcome indicator 9	**0**	**1**	**2**	**3**	**4**
Has an overview of the availability and uptake of different support mechanisms in the area.					
Ensures alignment and coherence of different forms of support in their jurisdiction.					
Identifies a target population based on transparent, and verifiable characteristics.					
Defines a combination of support mechanisms and target population that can be sustained at scale, within existing resource constraints.					
Funds support mechanisms through regular budget.					
Uses monitoring information to evaluate uptake and effectiveness, and subsequently improve.					
Identifies and monitors risk areas for misuse, and subsequently improves.					
Uses support mechanisms, which do not distort prices or market incentives.					
Implements support mechanisms at the lowest possible level (subsidiarity principle), linking responsibilities to accountability for results.					
Ensures transparent and clear communication to the target group and wider population about support mechanisms.					

0=no/ never; 1=incipient; 2= basic; 3=mostly; 4=always/ advanced

Reasons for giving the overall score:

What has been the most significant progress made over the past two years?

Recommendations for improvement:

OI 10 REPORTING SHEET

PROGRESS ON THE INFLUENCE OF WOMEN IN RURAL SANITATION AND HYGIENE PROGRAMMES

District or county:

Date:

Location of the meeting:

What kind meetings / events do women generally participate in?

Are there any specific WASH events / meetings that the women in this group have participated in the past 2 years?

Outcome indicator 10	
0	No participation of women in meetings and events.
1	Women attend meetings (but do not speak).
2	Women attend meetings and speak (but do not feel they influence decisions).
3	Women attend meetings, speak and feel that they influence decisions.
4	Women attend meetings, speak and feel that they influence decisions, as well, the decisions made reflect and respect their needs and perspectives.

Reasons for giving the overall score:

What progress has been made in the participation of women in sanitation over the past 2 years?

What kind of issues have women raised in the meetings? Are there any specific WASH issues?

Have these issues been heard and/or resolved?

Which examples or evidence was given that women have influenced decisions?

Stakeholder recommendations for improving the participation of women and assuring their needs are addressed:

OI 12 REPORTING SHEET

PROGRESS ON THE INFLUENCE OF PEOPLE WITH DISABILITIES IN RURAL SANITATION AND HYGIENE PROGRAMMES

District or county:

Date:

Location of the meeting:

What outreach methods are used to ensure people with disability hear about meetings or events in your community?

Are there any specific WASH events / meetings that the people in this group have participated in the past 2 years? What are people's experience in these?

Outcome indicator 12	
0	No participation of people with disabilities in meetings and events.
1	People with disabilities attend meetings (but do not speak).
2	People with disabilities attend meetings and speak (but do not feel they influence decisions).
3	People with disabilities attend meetings, speak, and feel that they influence decisions.
4	People with disabilities attend meetings, speak, and feel that they influence decisions, as well, the decisions made reflect and respect their needs and perspectives.

Reasons for giving this score:

What progress has been made in the participation of people with disability in sanitation over the past two years?

What kind of issues have people with disability raised in the meetings? Are there any specific WASH issues?

Have these issues been heard and/or resolved?

Which examples or evidence was given that people with disability have influenced decisions?

People with disabilities recommendations for improving the participation of people with disability and assuring their needs are addressed:

DPO/ Stakeholder recommendations for improving the participation of people with disability and assuring their needs are addressed:

Your recommendations for improving the participation of people with disability and assuring their needs are addressed: