

Scoping and diagnosis of the Global Sanitation Fund's approach to Equality and Non-Discrimination (EQND)

Final Report

(Online Annexes)

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Cover photo details:

Saroswoti and Saroswoti, CLTS Triggerers working in their own communities in neighbouring villages in Rasuwa District, in the mountainous ecological zone of Nepal (photo: S. House)	Loya, outside his latrine constructed with support of the community. Loya was affected by polio as a child. He has become a sanitation champion in his community influencing his neighbours to stop open defecation. Nkhotakota District, Malawi. (photo: S. Ferron)	A child demonstrating how she washes her hands using the hand-washing facilities outside of the children's 'mini-latrine' that has been constructed by a relative. Logo District, Cross River State, Nigeria (photo: S. House)

Annexes – Contents

The following Annexes are attached to the main report:

Annex I – People met during the country visits

Annex II – List of contributing institutions and organizations

Annex III – References

The following Annexes are included in this document:

Tables

Figures

Annex IV - Terms of reference

The following summarises the key features of the terms of reference (ToR) for the consultancy.

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

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

Focus: While GSF recognises that marginalization and vulnerability are to an extent context-specific, at the very least the investigation should focus on gender, age and disability and on income-poverty, as well as additional vulnerabilities / factors of marginalization. While marginalization occurs on many levels in society, the main focus will be on how this plays out at the community and household level. Particular attention will be made on visiting communities to listen to the experiences of people who are marginalized or more vulnerable and enabling them to make recommendations on how GSF should be improved for the future.

Objectives:

1. To gain an in-depth overview of factors and or drivers as well as strategies, approaches, tools and methodologies employed by GSF Executing Agencies and particularly Implementing Partners to identify marginalized groups and marginalization within communities and programme areas, to address these processes of marginalization and to support these groups to achieve equitable access to and use of sanitation facilities and to practice hygienic behaviours.
2. To understand how processes led by the Programme Country Managers (PCM), Country Programme Monitors (CPMs) and the GSF programme at the WSSCC secretariat affect and/or support the implementing partners' ability to address processes of marginalization in their field implementation work.
3. To identify best practices developed by as well as common obstacles and challenges faced by GSF implementing partners related to ensuring EQND.
4. To conduct a review of practices outside of GSF, and identify which strategies and best practices can be utilized to strengthen implementation of GSF-supported programmes.
5. To feed into a GSF strategy to addressing marginalization (for reaching the most vulnerable/marginalized / disadvantaged).
6. To make recommendations regarding a plan to address identified challenges, capacity gaps and learning needs (which might include specific applied research and/or impact evaluations on key questions).
7. To feed into ongoing work to revise the GSF Result Framework and strengthen the M&E system as it relates to measuring equality and reaching the most vulnerable.

Deliverables:

i. Inception meeting
ii. Inception report – including conceptual framework taking into account experience from other programmes; suggested questionnaires / stakeholder survey tools and consultancy work plan
iii. Desk review of GSF-supported programmes documentation and phone interviews / stakeholder surveys with GSF EAs / selected Implementing Partners
iv. Country visits with on-site interviews, IP workshops and fieldwork in up to 6 GSF countries
v. Draft assessment report + annexes, including set of strategic and operational recommendations
vi. Final report

Annex V - Key research questions

The following framework provides an overview of the focus areas for learning during the scoping and diagnosis process and the guiding research questions.

Table 1 - Framework for scoping and diagnosis process including guiding research questions

	Learning focus area (LFA) and guiding research questions	
1	**Understanding EQND and WASH**	
	1.1	**LFA: Understanding EQND and WASH**
		<u>Defining EQND in relation to WASH:</u> 1. What are the key factors related to disadvantage of relevance to WASH? 2. How do different organizations: a) Currently perceive vulnerability and marginalization?; b) Consider/ determine who people that are most likely to be disadvantaged (vulnerable or marginalized)?; and c) Approach the issue of broader needs of people who are disadvantaged in a sanitation and hygiene programme? 3. Differences between inter-community EQND and inter- and intra-household EQND? 4. Differences in vulnerability and marginalization between and within groups? 5. Inter-relations between different types of and influencing factors for EQND & trade-offs for considering one type of vulnerability over another (for example focus on PWDs)? 6. What terminology should the GSF-supported programmes use? <u>Linkages between EQND and broader issues:</u> 7. How do the components & terms fit within wider framework of human rights & the SDGs? 8. Links between EQND, human rights and CLTS? (positive/risks) 9. Linkages between slippage/sustainability/resilience/partial usage and EQND? 10. Scale: Examples of successes taken to scale on CLTS or other programmes e.g. spontaneously replicated by other households or communities; organized replication by the IP or uptake promoted by government in an institutionalized way (e.g. in a policy or plan) 11. Linkages between EQND and moving up the sanitation ladder from ODF to an improved latrine / affordability / supply issues? 12. For countries where ODF does not mean 100 percent practice ODF or where they do not stipulate that all households have to have their own latrine (i.e. sharing is acceptable) – how does this impact on EQND and including people who may face disadvantage? 13. Considerations re Value for Money (VfM), costs, EQND and WASH? 14. Does focus on household vs the workplace or public facilities (schools) have EQND issues? 15. Consider if there are particular EQND issues for sanitation workers / pit emptiers or other groups who are specifically discriminated against in the wider context.
	1.2	**LFA: Global action on EQND and WASH**
		1. Who is doing / planning to do what on EQND related to WASH? 2. Examples of successes? 3. Limitations / challenges being faced? 4. Lessons for GSF? 5. How can GSF contribute to global knowledge? What is our role?
2	**GSF-supported programmes – structural**	
	2.1	**LFA: Processes, documentation and data**
		1. How well is EQND integrated into current GSF processes? 2. How well are EQND issues documented in the GSF-supported programmes? 3. How well has the learning been shared/disseminated within and outside GSF 4. What monitoring and evaluation has been undertaken on EQND issues? 5. Key gaps and recommendations?
	2.2	**LFA: Capacities and confidence to integrate EQND**

		1. How much commitment / capacity / confidence do GSF staff and partners have to respond to EQND issues? a) Do they understand importance of considering EQND?; and b) Do they know how to practically integrate it into their work? 2. What training / capacity building support has been provided? 3. What learning / sharing has occurred in relation to EQND? 4. What are the issues that most concern staff and partners about responding to EQND? 5. What are the variables, factors and/or drivers affecting the IPs ability to address EQND? 6. Recommendations for support needed?
3	**GSF-supported programmes – field practices & outcomes**	
	3.1	**LFA: Good practices**
		1. What good practices exist of the GSF-supported programmes responding to EQND – what, how, where, involving whom, how widespread? 2. Which types of disadvantaged groups of people have been reached (by stage of process)? 3. How much can be attributed to the GSF-supported programmes processes and how much by the approaches of partner organizations / individuals' commitment and drive? 4. How much opportunity has been made of traditional community mechanisms for supporting the most vulnerable and marginalized? 5. What have the outcomes/ impacts been for different stakeholders in the community – particularly for the disadvantaged? 6. Appropriateness of the good practices for integration into standard programming <u>at scale</u>? 7. Examples of successes being taken to scale e.g. spontaneously replicated by other households / communities; organized replication by the implementing agency or uptake promoted by government or others in an institutionalized way (e.g. in a policy/ plan) 8. Opportunities for building on WASH EQND activities to work on broader challenges faced by the disadvantaged / i.e. can sanitation be a strategic entry point for reducing wider discrimination and strengthening voice & agency?
	3.2	**LFA: Challenges / gaps**
		1. What are the main challenges / gaps being faced in responding to EQND? 2. Which disadvantaged groups of people have not been reached? 3. Examples of rights being abused / misuse of shame / bullying etc? 4. Challenges ensuring affordable services for most disadvantaged (without relying on charity) 5. How much have these challenges / gaps been influenced by the GSF-supported programme processes, or by approaches of partner organizations or individual attitudes and beliefs? 6. What have the outcomes/impacts been for the most disadvantaged? 7. What recommendations do community members, including the most disadvantaged, implementers and other stakeholders have for how to improve in the area of EQND? 8. What would be needed to respond to the challenges / gaps?
4	**Recommendations**	
	4.1	**LFA: Recommendations**
		1. Community level engagement for consideration of EQND – that: a. Enables the voices of people who might be disadvantaged to be heard b. Are 'doable' at scale? c. Are linked to specific stages in the CLTS process d. Limit expectations of what the GSF-supported programmes can do [in relation to multiple and in relation to what can be realistically measured] e. Can also influence change through 'institutional triggering' 2. Further learning, research needed 3. What capacity / confidence building support/ practical tools are needed for stakeholders? 4. Processes, documentation, data (including disaggregation), possible indicators (M&E)? 5. Work plan & time-frame for addressing identified needs and challenges
	4.2	**LFA: Resources**

		1. Most useful resources for GSF to draw on to take forward EQND

Annex VI - Country requirements for verification and certification of ODF

Table 2 - Requirements for verification and certification of ODF (Part 1)

	Requirements for verification and certification of ODF
Ethiopia (Community-led Total Sanitation and Hygiene Implementation and Verification Guide)	First phase: ODF: • 100 percent of latrines constructed by the community (of any design) are in use. • Latrines have squatting hole cover • Latrine with superstructure • All institutions have gender friendly latrine • Latrines have been constructed for use of travellers and in public gathering areas and are in use • No trace of open defecation Second phase: ODF (fulfils the criteria set for primary ODF and additional criteria set below) • 100 percent of latrines are in use (squatting hole cover and superstructure) • All institutions have gender friendly latrine • Hand-washing facilities are on working order and have water and soap or a soap substitute • Household safe water handling • Latrines have been constructed for use of travellers and in public gathering areas and are in use with hand washing facility • Existing water source / are well protected from potential contamination by livestock and others, with good drainage • No trace of open defecation
Malawi (ODF Malawi Sanitation Strategy, 2015)	Level 1- ODF: • Every household uses a latrine with privacy • There is no shit in the bush • (100 percent latrine coverage; sharing acceptable) Level2 – ODF++: • Every household has a latrine with cover and hand-washing facility (100 percent coverage, sharing is acceptable) • All religious institutions, market centres and health centres in catchment area have latrines with covers and hand-washing facilities (100 percent coverage)
Nepal (Sanitation and Hygiene Master Plan, 2011)	ODF:- • There is no OD in the designated area at any given time; • All households have access to improved sanitation facilities (toilets) with full use, operation and maintenance; and • All the schools, institutions or offices within the designated areas must have toilet facilities • In addition, the following aspects should be encouraged along with ODF declaration process:

	• Availability of soap and soap case for hand washing in all households; and • General environmental cleanliness including management of animal, solid and liquid wastes is prevalent in the designated area. Total sanitized post ODF situation: Includes a wider array of hygiene and sanitation behaviours around use of: • Toilets, hand-washing with soap or other cleaning agent, safe handling of drinking water, maintenance of personal hygiene and proper solid and liquid waste management • It also provides a range of requirements for both household and institutional sanitation
Nigeria (Protocol for certification and verification of ODF and total sanitation communities)	ODF: Does not provide specific criteria but provides guidance on what the verifiers should look for: • Latrines completed have been used • Latrines are well maintained • Hand-washing materials are available in or near the latrines • Latrines not close to groundwater drinking sources (30 meters) • No faeces seen in open • Materials for anal cleansing dropped in pit • Schools have separate toilets, hand-washing facilities and urinals • Community market has a public toilet and hand-washing facility • Health centre has toilet • Paths are used and shit is need in latrine (i.e. latrine is used) Total sanitation: Has a broader range of requirements focussing on: • Hygienic and clean latrines; hand-washing being practices with soap, ash and water; food and drinking water hygiene • Sanitation and hygiene facilities in schools • Sanitary water points; and location of latrines 30m from groundwater • Sanitary households, abattoirs and community environment • Proper disposal of solid and liquid waste and safe disposal of wastewater
Senegal (No official government CLTS strategy at the present time)	ODF:- • Each compound has at least one functional latrine with superstructure that is also used for babies' faeces • All members of the compound with the latrine(s) use them to defecate • Each latrine has a drop-hole cover and a hand-washing device • Cleanliness of the village and good hygiene around the water points including having waste and wastewater management • No faeces visible in the open Post ODF:

	• Declaration of the community for ODF • Communities use the existing latrines in the village to defecate, including babies' faeces and improve and increase the numbers of latrines until each household had its own latrine • Handwashing with soap is effective in the village, existing latrines shall have a hole cover • Cleanliness of the village and good hygiene around water points including having waste and wastewater management • No faeces visible in the open • Drinking water management
Togo (Politique Nationale D'Hygiéne et D'Assanissement 2016 et Le PANSEA, 2016)	<u>ODF:</u>- • 100 percent of the concessions has and uses the latrine (Sharing is not accepted [outside of the compound]) • Each latrine is equipped with a handwashing facilities and water, soap or ash • All latrines have ash to remove odour and keep flies away • Each latrine slab must have a cover • 100 percent of old OD sites are destroyed (No open defecation site in the community) • School have and use latrines • Health centre has and uses a latrine • The market has and uses a latrine • Worship (Church; Mosque……) place must have and use latrines • No trace of OD around the concessions or in the village <u>Total sanitation post ODF situation: Integration of other aspects of hygiene and sanitation:</u> • Waste water management • Waste household management

Table 3 - Requirements for verification and certification of ODF (Part 2)

	Malawi	Ethiopia	Senegal	Nigeria	Nepal	Togo
How many times verification required for certification	One	One	As many times as needed	Minimum of 4 times by the LGA and then a national level visit over a period of 6 months	One	Two
Subsidy from external to the community acceptable for the poorest / most vulnerable?	Yes After declaration of ODF	No	There is no formal policy and cannot currently be generalised across the whole country as some small areas where specific actors work it is being used	No	Yes Currently being informed of entitlement after 90-95 percent of the village households have latrines	No
Sharing is accepted?	Yes	No	Yes – usually between extended family in a compound	Yes maximum of 15 people (often between extended family members in a compound)	Only as an exception – such as affected by earthquake or as a temporary measure	Only between families in a compound
Dig and bury is accepted?	Yes	No	No	Yes as a temporary measure	Yes such as when in fields	Yes as a temporary measure after the community triggers; but after ODF it is only accepted if at the farm
Minimum requirements for latrine construction?	No	yes	No	No	Yes – strongly recommended to have pour flush and lined pit	No

Annex VII - Country programme overview – data to Dec 2015

Table 4 - GF progress – country programme overview – data to 2015

Country	Fr/E	Dates	Implementing Agency	ODF percent	Coverage improved (Total/ Rural/ Urban) (from JMP, 2015)	Target year	People with improved latrines (Achieved / target)	People living in ODF villages (Achieved / target)	HW facilities (Achieved / target)	Communities triggered (Achieved / targets)	Communities declared ODF (Achieved / targets)	GSF commitment / disbursement (USD)
French speaking												
Benin	Fr	2014 – 2019	Medical Care Development International	53	20/7/36	2019	0 972,000	0 1.75 million	0 1.75 million	0 8,100	0 7,300	6.63 million 1.13 million
Madag-ascar	Fr	2010 – 2016	Medical Care Development International	40	12/9/18	2016 (+ expansion)	357,335 2.0 million	1.64 million 5.25 million	3.05 million 1.61 million	17,271 28,000	13,712 18,000	12.90 million 11.64 million
Senegal	Fr	2010 – 2016	AGETIP	14	48/34/65	2016 (+ expansion)	121,860 104,150	380,451 432,370	468,970 272,000	892 861	585 689	6.07 million 5.70 million
Togo	Fr	2013 – 2016	UNICEF Togo	52	12/3/25	2016 (+ expansion)	80,801 1.21 million	152,930 1.51 million	80,801 911,250	197 2,200	99 1,980	8.32 million 3.38 million
English speaking												
Cambodia	E	2011 – 2019	Plan International Cambodia	47	42/30/88	2019	429,928 1.46 million	518,175 1.72 million	1.63 million 480,000	2,027 3,494	630 2,096	13.05 million 7.10 million
Ethiopia	E	2012 – 2016	Federal MoH	29	28/28/27	2016 (+ expansion likley)	994,573 1.0 million	2,85 million 1.60 million	2.93 million 1.00 million	16,151 20,000	14,269 8,000	5.43 million 4.02 million
India	E	2010 – 2017	NRMC India PVT Ltd.	44	40/28/63	2017	2.04 million 2.70 million	726,698 1.95 million	3.24 million 3.62 million	6,035 6,339	972 1,730	6.98 million 6.25 million
Kenya	E	2014 – 2019	Amref Health Africa Kenya	12	30/30/31	2019	0 377,700	0 755,400	0 377,700	5 200	0 200	7.44 million 2.54 million
Malawi	E	2010 – 2017	Plan International Malawi	4	41/40/47	2017	154,220 243,000	712,933 1.20 million	442,563 729,000	3,198 4,300	2,115 4,300	8.10 million 6.45 million
Nepal	E	2010 – 2017	UN-Habitat	32	46/43/56	2017	1.43 million 2.07 million	1.55 million 3.04 million	1.62 million 2.04 million	21,873 23,535	10,693 21,018	13.82 million 8.91 million
Nigeria	E	2012 – 2017	Concern Universal	25	29/25/33	2017	53,535 1.3 million	235,874 2.2 million	244,518 2.0 million	850 2,000	556 1,000	6.75 million 4.76 million
Tanzania	E	2012 – 2018	Plan International Tanzania	12	16/8/32	2018	34,303 850,000	7,515 1.0 million	99,054 900,000	176 221	4 221	6.11 million 4.78 million
Uganda	E	2011 – 2016	Ministry of Health	7	19/17/29	2016 (+ expansion)	920,665 1.96 million	2.08 million 5.60 million	1.88 million 4.40 million	7,270 9,327	3,474 9,327	10.42 million 8.88 million

Annex VIII - Online survey results

Introduction

Fifty-four online survey responses were received out of a total of 228 invitations sent out. The survey was available in English and French and the data has been analysed by language. The comparison of the Anglophone and Francophone responses throws up both interesting similarities and differences.

Limitations of the online survey

The sample size for the response to the online survey was relatively small with only 18 replies from the French survey (4 countries) and 36 from the English survey (9 countries).

Whilst most of the responses were from Implementing Partners, the survey did not ask for the job title of the respondent. It is possible that many respondents were mangers of the programme and not field workers who might not always have an in-depth knowledge of exactly what is happening on the ground in terms of the most vulnerable community members.

It is also possible that the people who made the time to respond were also those more interested in the issue of EQND issues. This may have led to a variation in responses than if all individuals and organizations engaged in the GSF-supported programme been represented.

Country and agency representation

The respondents from the two surveys were from the following countries: Madagascar – 8; Togo – 7; Malawi – 6; Uganda – 6; Tanzania – 6; Kenya – 5; Nigeria – 5; Nepal – 3; Benin – 2; Cambodia – 2; Ethiopia – 2; Senegal – 2; India – 1; Global – none

The majority of responses were from sub grantees (83 percent of the French survey and 91 percent of the English survey). There was only one reply from WSSCC staff and no replies from CPMs or PCMs.

Seventy five percent of the English responses and 91 percent of the French responses were from NGOs (including INGOs, CBOs and faith based organizations). Twenty two percent of the English survey responses were from Government (including local authority). There were no Government respondents from the French survey. There was one private sector respondent in the English and one in the French surveys.

Gender and age

The majority of the respondents were male (80 percent – Anglophone and 72 percent – Francophone) with the majority between the ages of 35-54 (61 percent – Anglophone and 71 percent Francophone). However, the majority of agencies (83 percent in both the French and English surveys) claimed to have a gender policy in operation in their organizations.

Ability/disability

Forty one percent (E) and 37 percent (F) of the respondents reported having at least some difficulty in one or more of the areas of the Washington criteria (seeing, hearing, walking, remembering, self-care and communicating), although only 11.1 percent (F) and 11.4 percent (E) of the respondents considered themselves to have a disability. This is in alignment with the global average proportion of people with a disability of 15 percent.

Programme Interventions

EQND in programme

When asked whether they agreed that: **"Drawing on my own experience of the GSF programme, I think the most vulnerable/ marginalized/ disadvantaged people have been able to easily participate in the sanitation programme. They have been able to improve their sanitation with dignity and without being stigmatised or being bullied by other community members:"**

- The English survey respondents gave an average rating of 79 percent with a range from 5 to 100 with 8 respondents selecting 60 or below and the majority selecting between 80 and 100.
- The average rating for the French survey was 75 percent with a range between 30 and 100 and 6 respondents selecting 60 or below.

Eighty percent of respondents in the English survey and 44 percent of respondents in the French survey said they were working on menstrual hygiene management.

As has been noted above the majority of agencies said they used a gender policy but only 63 percent (E) and 22 percent (F) had a feedback and complaints policy – although 21 percent (E) and 16 percent (F) of respondents did not know if such a policy existed. A feedback and complaints mechanism that is designed with the community and well publicised is one strategy to contributing to ensuring that abuses of power are identified and acted upon.

Disaggregation of data and identifying disadvantage

In order to understand and respond to difference and to know whether different groups are benefitting from the programme interventions, it is important to collect disaggregated data. The survey asked if this was being done in GSF supported programmes. Ninety four percent of the English survey respondents and 83 percent of the French survey respondents claimed to collect gender-disaggregated data but the collection of data disaggregated by age and disability was less common.

One English survey respondent indicated that disaggregated data was collected on gender, age and ability but went on to explain that:

> *"The aged, physically challenged and female and child headed households are grouped as disadvantaged households"*

This indicated that it was possible that there was some lack of clarity over the term disaggregation.

The majority of respondents said that they collected data on disadvantaged groups during:

- Pre-triggering (91 percent E and 77 percent F)
- Invited disadvantaged community members to triggering (77 percent E – missing value for the French survey)
- Followed up with disadvantaged community members (88 percent E and 55 percent F).

One respondent however stated that:

> *"The GSF programme activities maintain gender parity and social exclusion. All the members of the communities are treated equally. We request different agencies including local government for the additional support required for these people."*

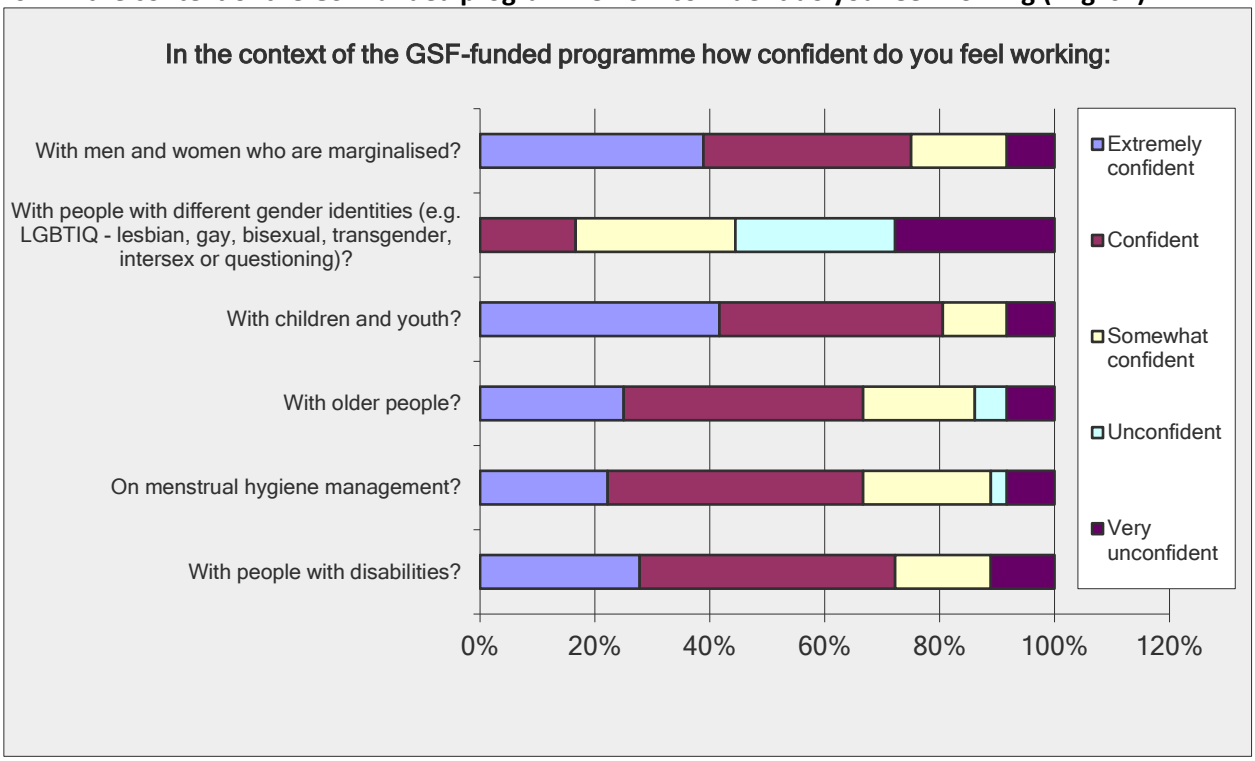
It should be noted however that despite the claims above, that in another question, exclusion was noted in relation to:

- Pre-triggering (30 percent of English survey respondents, 38 percent of French survey respondents); and
- Triggering (38 percent of English survey respondents and 27 percent of French survey respondents)

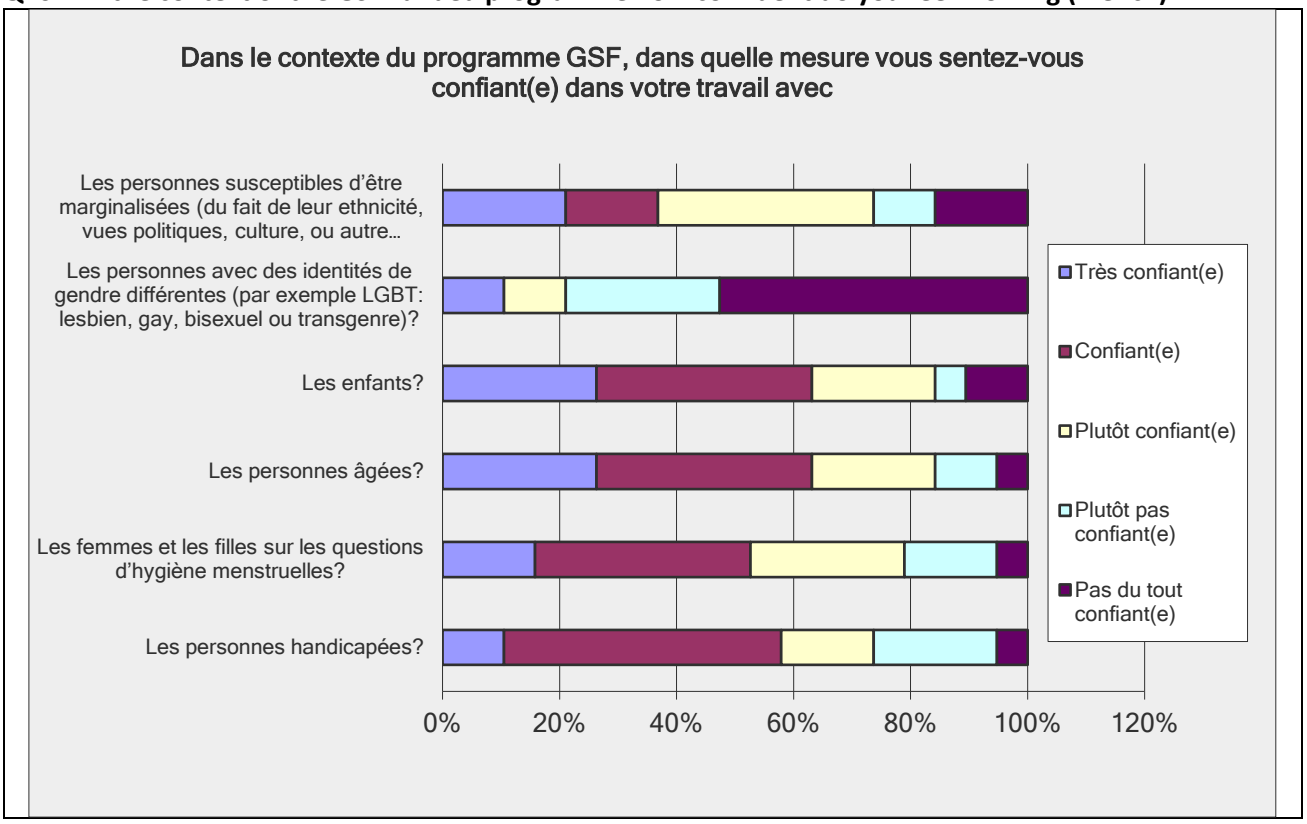
Perceived confidence in working in EQND

Seventy one percent of respondents in the English survey and 61 percent of respondents in the French survey felt either 'confident' or 'extremely confident' about working with people with disabilities and only 5 respondents in total claimed that they were 'extremely unconfident' to work with this group.

Q10 – In the context of the GSF-funded programme how confident do you feel working (English)



Q10 – In the context of the GSF-funded programme how confident do you feel working (French)



Sixty six percent (E) and 65 percent (F) felt 'confident' or 'extremely confident' working with older people. One respondent mentioned the fact that older people and those with disabilities were so happy to be included in the programme as usually they were ignored. Eighty percent of respondents (E) and 61 percent (F) said they felt 'confident' or 'extremely confident' working with children and youth.

However, only 16 percent (E) and 11 percent (F) felt 'confident' or 'extremely confident' about working with people who were LGBTIQ and most of the additional comments for this question were related to this issue. Several respondents pointed out that LGBTIQ was not legal in their country. Another reason given for the lack of confidence was that it was difficult to know where LGBTI groups and individuals are. *"I feel very unconfident working with LGBTIQ because most often these groups are not open".*

Only 8 respondents in total (4 from each survey) stated that they felt 'unconfident' or 'very unconfident' working on menstrual hygiene management, but 22 percent were only 'somewhat confident' about working on this issue (in both surveys).

What outcomes are there for communities?

When asked whether the GSF-supported programme had had positive consequences for marginalized people, most responses focused on increased awareness about hygiene, changes in hygiene behaviour and the prevention of sickness.

Respondents mentioned the:

- Building of toilets and support from other community members to do this (several respondents).
- An increase in awareness of the affordability of building a toilet.
- Encouraging menstrual health.
- Ensuring privacy and dignity.
- One respondent also mentioned that marginalized groups were enabled to be part of decision-making and that they could become masons or team leaders.

Only four respondents recognised that there might be other barriers for marginalized people that could be addressed during the programme and noted the following:

> *"The community recognizes the situation of those who are marginalized and vulnerable and takes specific actions to support them. Marginalized groups no longer have an inferiority complex after reaching their ODF status and they became proud of this and develop confidence in themselves."*
>
> *"They may be taught how to overcome their challenges"*
>
> *"Through policy formulation and systems reformation"*
>
> *"Such being the case strategies for improved equity and inclusion are being tried at all levels starting from the grassroots (community) to top policy makers."*

How are marginalized people supported to access sanitation?

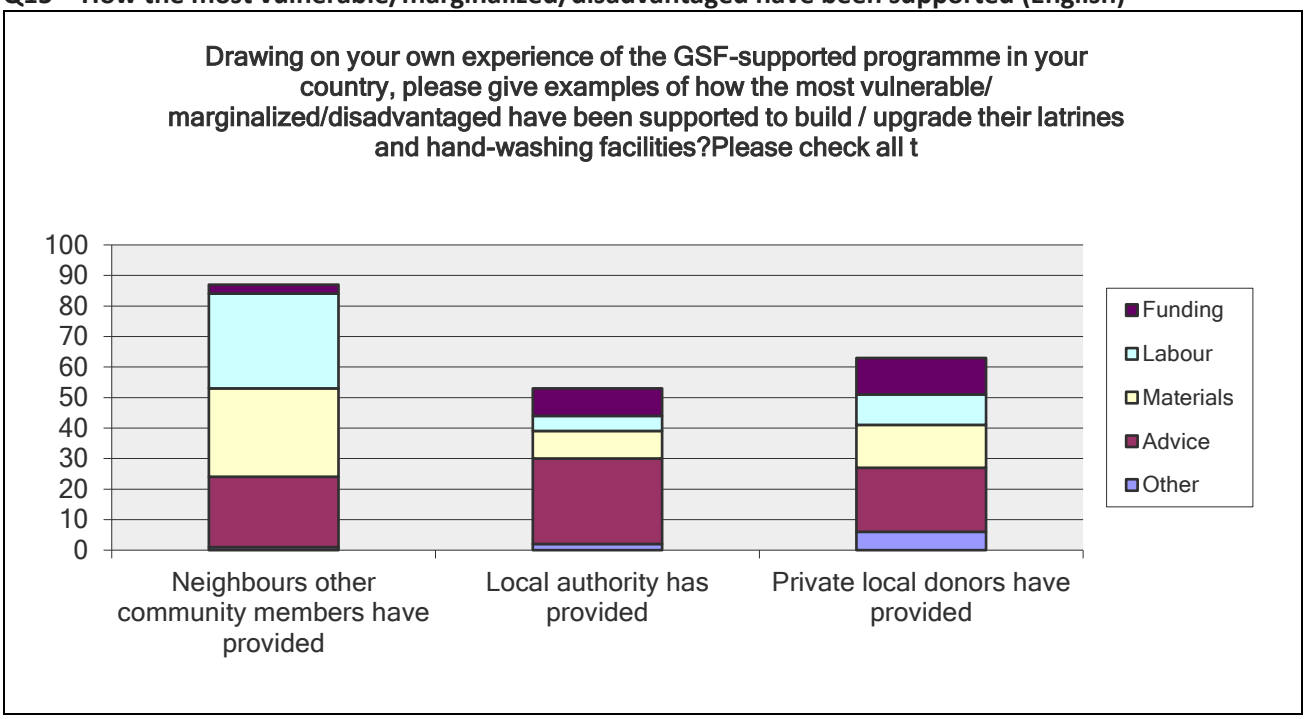
Neighbours or other community members were believed to have provided most support for disadvantaged people with most providing labour (86 percent of respondents in the English survey and 61 percent in the French survey) or materials (80 percent – E and 44 percent -F) but neighbours also were seen to have provided advice (63 percent – E and 72 percent – F).

A quarter of the respondents in the English survey felt that local authorities had provided funding and materials with 77 percent stating that they also provided advice. However, in the French survey only 5 percent of respondents felt the Government had provided funds and 11 percent had provided materials. This difference could partly be explained by the absence of government respondents in the French survey.

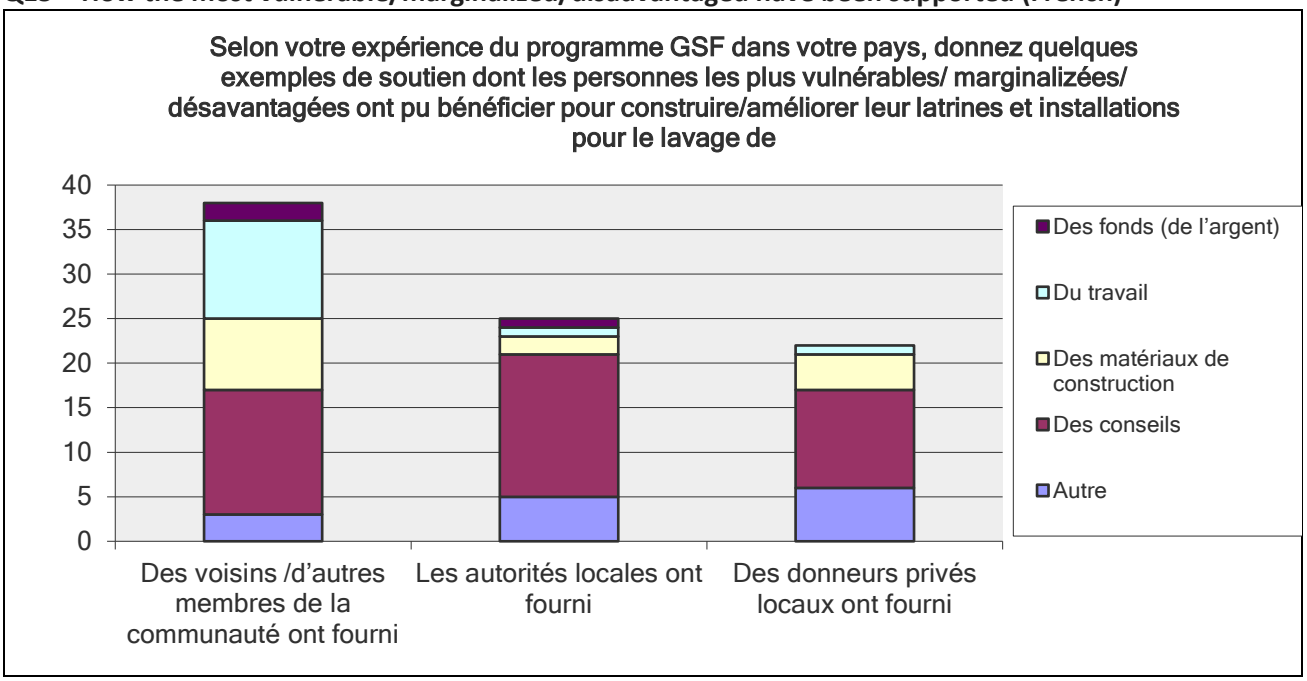
In the English survey, private donors were also considered to have made a significant contribution providing either funding or labour or materials or a combination of these, in most programmes. One respondent noted that other NGOs had also provided funding in some cases. By contrast there was no private funding in the

responses to the French survey although 22 percent of respondents felt that private donors had provided materials.

Q15 – How the most vulnerable/marginalized/disadvantaged have been supported (English)



Q15 – How the most vulnerable/marginalized/disadvantaged have been supported (French)



Challenges and how difficult they are to solve

Respondents were asked to identify the degree of challenges faced by the most vulnerable/marginalized/ disadvantaged on the GSF-supported programme and to indicate how difficult they are to solve, from 'no problem here' to 'a major challenge that is difficult to solve'.

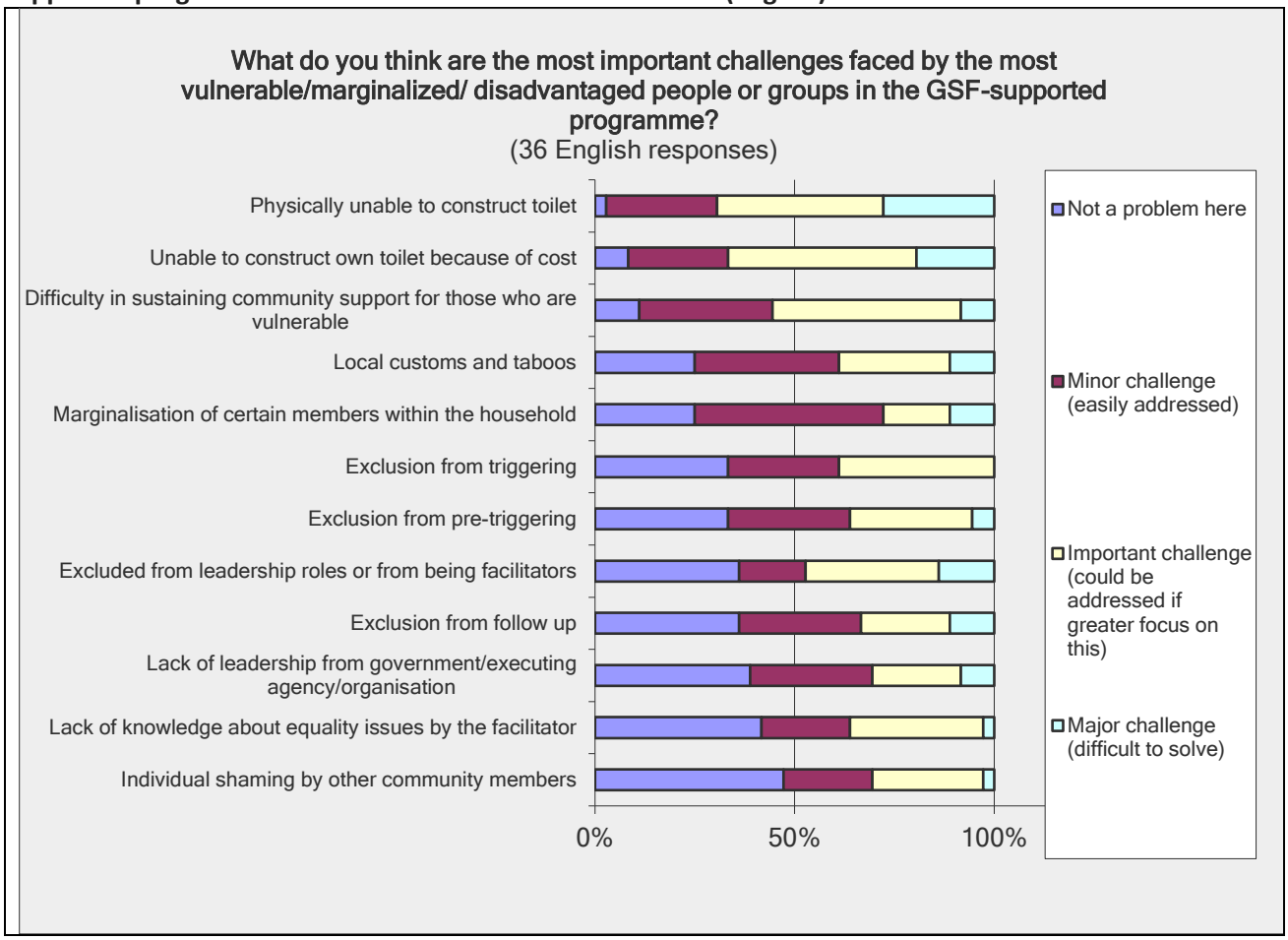
Whilst 36 percent (E) and 33 percent (F) of respondents felt that exclusion from leadership roles for disadvantaged groups was 'not a problem here', almost 47 percent (E) and 55 percent (F) felt that it was 'an important challenge' with 13 percent (E) and 22 percent (F) of those believing that it was 'a major challenge that was difficult to solve'.

The biggest challenges as seen by respondents revolved around the construction and sustainability of toilets for marginalized groups with the majority of respondents considering that this had been 'an important challenge' in their programmes.

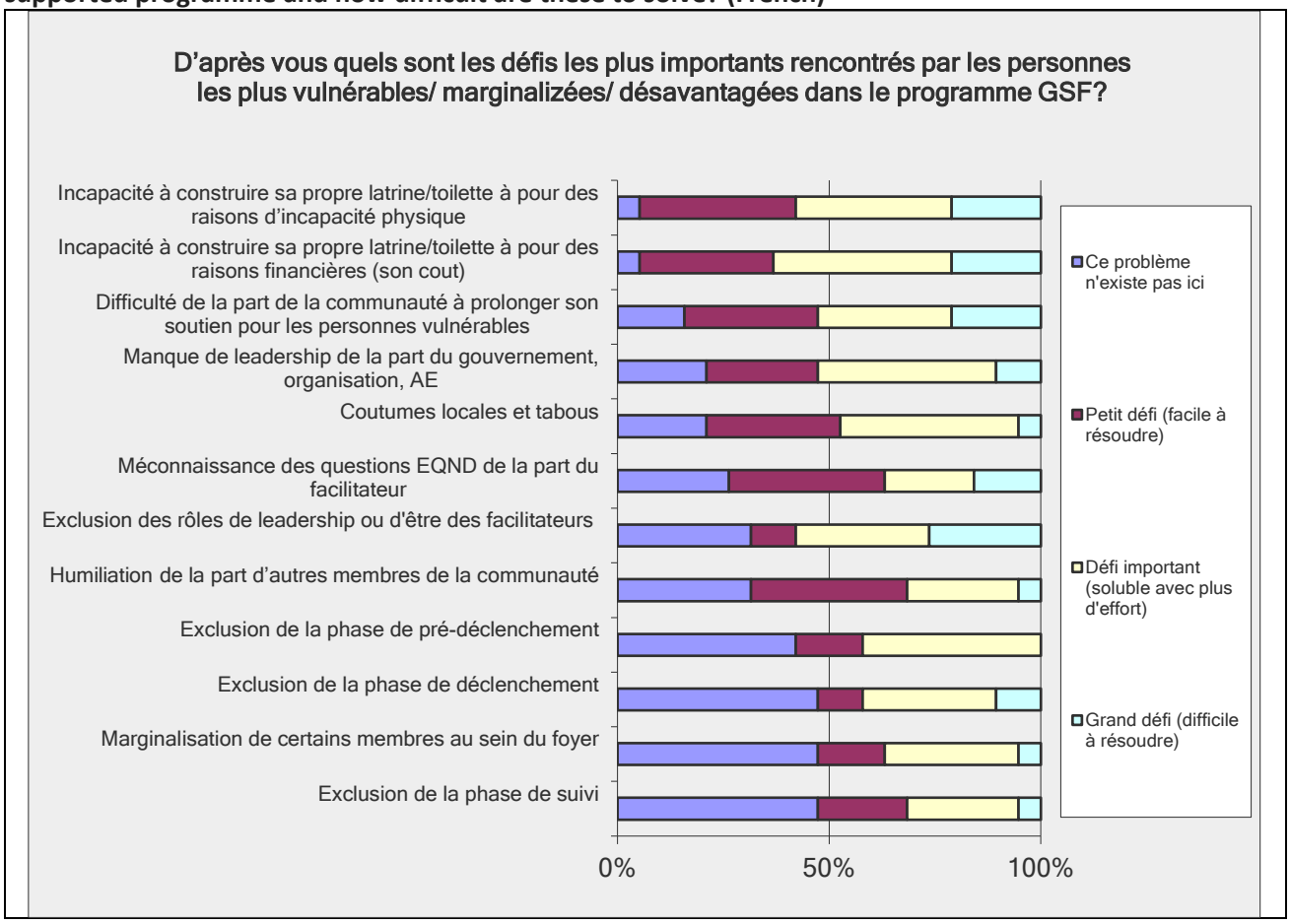
Sixty six percent (E) and 60 percent (F) perceived the cost of toilets as an important or major challenge and 19 percent (E) and (22 percent) of those felt that this was a challenge that was very difficult to solve. Fifty five percent of the English survey respondents felt that another important challenge was sustaining support for those who were disadvantaged. Forty nine percent of the French survey respondents felt that this was also 'an important challenge' and 22 percent of this group felt this was 'a difficult problem to solve'.

Physical inability to construct a toilet amongst marginalized groups was also surprisingly seen as an important challenge (68 percent (E) and 60 percent (F) of respondents) with 27 percent (E) and 22 percent (F) saying that this was 'a major challenge that was 'difficult to solve'.

Q16 – Most important challenges faced by the most vulnerable/marginalized/disadvantaged on the GSF-supported programme and how difficult are these to solve? (English)



Q16 – Most important challenges faced by the most vulnerable/marginalized/disadvantaged on the GSF-supported programme and how difficult are these to solve? (French)



This is in contrast to the confidence with which respondents another question when asked to what extent the needs of marginalized groups were being met. However, marginalization within the household was seen as 'a minor challenge' by 53 percent of respondents and 'an important challenge' by only 11 percent of respondents.

Forty seven percent (E) and 33 percent (F) of respondents felt that shaming of community members was 'not a problem' in their programmes with 27 percent (E and F) as 'an important challenge' and 22 percent (E) and 33 (F) as 'a minor problem' that could be easily addressed.

Fifty five percent (E) and 60 percent (F) of the respondents noted that the lack of awareness of equality issues was a challenge with 35 percent (E) and 25 percent (F) saying this was 'an important challenge'. However, 41 percent (E) and 27 percent (F) felt that this was 'not a problem'.

<u>Suggestions to address challenges</u>

A variety of suggestions were made to address the needs of people who were marginalized including:

- 'Promoting a greater focus and time spent on this by natural leaders'
- 'Better latrine designs'
- 'Capacity building in EQND'
- 'The use of economic empowerment strategies'.

One respondent suggested a more holistic response:

"Lobbying from County governments to allocate funds to these groups especially for capacity building on their constitutional rights on access to resources."

Another suggested challenging conventional stereotypes of those who are often considered as vulnerable and broadcasting their achievements:

"Disseminate the positive results that vulnerable people have achieved, their innovations and latrine adaptations.....convey these innovative, positive and dramatic results using local radio, the press and other audio visual methods. The radio generates [greater] visibility of those who are vulnerable and increases societies' accountability to them. Vulnerable people can become community leaders and act as CLTS facilitators."

Several respondents (15 in total) mentioned the need for targeted subsidies:

"Targeted sanitation fund to those that are vulnerable in order to help them have improved latrines that suits their vulnerability e.g. the physically challenged."

"The vulnerable/ marginalized/ disadvantaged persons and households have the right to receive support from local government and support agencies. Despite of triggering and self-construction of sanitation facilities, they become further deprived of resources as they invest in the construction of sanitation facilities. Thus, a local support mechanisms should be in place for the identified vulnerable families."

"Provide direct subsidy as a reward to motivate most vulnerable. Some reward points could be; 1. complete vaccination for children 2. children going to school regularly 3.no reported incidence of domestic violence."

Others suggested various funding mechanisms such as savings groups and mutual societies.

Collaborating with other organizations, such as DPOs was also mentioned by some informants as well as involving disadvantaged groups more in the monitoring of programmes.

Training and support

When asked to what extent the current training on collective behaviour change focused on EQND, the average rating was 63 out of 100 with the range from 6 to 100 in the English survey. Approximately 30 percent of respondents rated the current extent of EQND training as 50 or less in this English survey.

In the French survey, the average rating was 51 out of 100 with a range from 0 to 100. Over 50 percent selected a rating of 50 or less in this survey.

Just over 50 percent (E) and 91 percent (F) of respondents said they had had 2 days or less training on EQND. This was mainly workshop based but included on the job training and information provided during meetings. Online training and was rare in both surveys.

Six respondents in total felt they had had no training on EQND issues but the majority had had some training although most of this had been provided by other organizations and was not specific to the GSF-supported sanitation programme (41 percent E and 44 percent F).

See **Annex XV** for details of preferred types of support to build capacities and competence on EQND.

Key issues from the online survey

Whilst respondents appeared confident that they were meeting everyone's needs it is clear that there are challenges in their programmes and the needs of the most vulnerable and disadvantaged are not always being met. The graphs acknowledging the challenges that people who might be disadvantaged have faced are particularly enlightening.

On the whole, there was a limited view of the breadth of focus on EQND with only a very few respondents expressing the opinion that it could not only meet the practical needs of marginalized and disadvantaged

individuals and groups, but could also address strategic needs such as challenging power dynamics and the status quo and enabling such groups to have a voice and influence over decision making.

A variety of challenges were evident in programmes with most concern focussing on the practical issues of construction, cost and sustaining support for disadvantaged individuals and groups.

Training and guidance on EQND appears to be a significant gap. On the job training does not seem to be perceived as the most effective way of learning – although the response might be influenced by the financial incentives associated with attending workshops.

Most training is provided outside of the GSF-supported programme and this might mean that it is more generic and not specific enough to the sanitation and behaviour change programme to be effective.

It is encouraging to see that so many programmes are doing some work on MHM, but this focus does not identify the scope of what is being done or mean that programmes are gender sensitive. This needs to be explored further.

The most notable differences between the French and English responses concern the absence of government and private donors' financial subsidies in the French survey responses and also the greater preference for 'on the job' training in the French responses.

Annex IX - Case studies – EQND in CLTS – Challenges

The main report includes a number of case studies highlighting challenges that potentially disadvantaged people have expressed that they have faced or that implementers have reporting seeing during the GSF-supported programme. This Annex provides additional examples grouped by particular types of challenges highlighted through the process grouped into the following areas:

- Problems faced before latrine construction, access and use
- Challenges of facilitation and involving people who are disadvantaged
- Refusal of support and not involving users in the design of facilities
- Pressure on vulnerable groups
- Disadvantaged people taking out loans and selling assets
- Challenges for access and maintenance
- Gaps for institutional latrines
- Sharing and decision making related to sanitation
- Slippage
- Cultural practices, non-use of latrines, incontinence, menstrual hygiene

Problems faced before latrine construction, access and use

The following examples highlight some of the challenges that people who may be considered disadvantaged faced before being able to construct, access and use a latrine.

Difficult journey and abuse

Lamboni is 65 and lives with a physical disability. He explains: *"prior to the construction of latrines in the village, I suffered a lot because I had to leave the house to go and defecate on the hill. As I am disabled, there were times when I stumbled on stones. In most cases, I defecated in the fields of the neighbours and often next to the vegetables they were growing. The women of the landlord used to shout at me. When I recall my situation in these days, I often shed tears. But now, with the help of my brothers and of the leaders, I have a latrine at home."*

(Savanes Region, Togo – shared by IP)

Old man died falling down a slope

Mr. Pandit has lost his both legs. We have motivated him to construct the toilet by saying to him if he constructs the toilet he would not face other difficulties while going to toilet. We have also shared the bad incident of another VDC where a local old man died by falling from a slope while going for open defecation in jungle. Immediately afterwards, he hired mason to construct the toilet and after 4 days he completed the toilet. Now he seems very happy.

(Nuwakot Distict, Nepal – shared by IP)

Stepping in shit and bad smells

An old man about 75 years old is visually impaired. He said that before CLTS triggering, he defecated in the open under a baobab tree. Sometimes he trampled his own poo that he brought home. He was very disturbed and had no solution. When the village was triggered, he asked his children to build a latrine which they did. Today he feels at ease. The latrine is built 15 m from his resting place. The latrine does not give off any bad odour given the permanent use of the ash.

Local authorities of the village explain that people were afraid that the visually disabled would slow down their progress towards ODF status. But today they have realized that he really uses his latrine, which is kept clean and has nothing to envy of the latrines of others

(Savane Region, Togo – shared by IP)

Being left behind

"Most of the people that were keeping the village from achieving ODF were the elderly and vulnerable."

(IP representative, Malawi)

Challenges of facilitation and involving people who are disadvantaged

The following examples highlight some of the challenges that face facilitators in trying to engage people who may be disadvantaged in the CLTS process and facilitating support.

<table>
<tr>
<td>Limitation in number of people who can attend the triggering

“It is impossible to have 100 percent of the community participate, but there is a representative from each family”

“It is not everyone that can attend as up to 70 persons can participate in the triggering process, otherwise with a greater number of people the triggering process is not manageable. The disabled, blind and other people come as representatives of these groups, but all of them cannot come. And the other point is that they hardly voice their views”.

(IPs, Ethiopia)</td>
<td>Identification of people who are disadvantaged

“We might meet people by chance in the community rather than going pro-actively to find them”.

(CLTS facilitator, Nigeria)

“Vulnerable people are shy to be identified – how can we strengthen their capacity to come out and make decisions for themselves?”

(IP, Nigeria)</td>
</tr>
<tr>
<td>Women less likely to speak in front of men

“Due to religious and cultural barriers, women lack assertiveness, particularly in public settings. As a result, we organize separate session for women.”

“In all cases the women tend to stay silent and men speak on behalf of them. They never speak equally. It is the culture and the taboo”. “In the rare occasions when they speak [in front of men], it is perceived as going against the culture. They are expected to be shy and thus they prefer to keep silent”.

(IPs, Ethiopia)</td>
<td>Difficulties to facilitate support

“It is not easy to facilitate the community to assist the vulnerable – people are busy and it’s a challenge to find the time” ... “Most communities with strong able-bodied persons do not refuse to assist – but it’s the time it makes and facilitators have to be persistent”.

(IP, Nigeria)</td>
</tr>
<tr>
<td>Threats of violence

A single man of 56 years has sufficient land and properties but didn’t want to construct a toilet. He became aggressive due to announcement of charge after open defecation as mandatory of the V-WASH-CC. He used to go for open defecation in the early morning and people didn’t have success to catch him. But one day a child club succeeded to catch him while he was defecating openly in the road. He started scolding them and also told them he would kill them with the weapon which used to cut grass and for 2 days he went for open defecation by carrying that weapon. But one day 10 to 12 triggerers went in group with an influential leader to his home. The group requested him that toilet construction is for his betterment of his heath and society and we that they would support to construct the toilet. The triggerer group said to him if you feel toilet construction is not good for you then you can kill us immediately. After saying that, he started cry and apologised to them that he was wrong and after that conversation he constructed toilet within a week.</td>
<td>Resistance to stopping OD

“Who do you think you are! You are just one of us”

(Natural leaders in Malawi reporting challenges faced from the community; community members had not participated in the re-triggering which was limited to a few representatives per village)</td>
</tr>
</table>

(Siaraha District, Nepal – shared by IP)

Complications on when to support the disadvantaged

"We have not yet supported anyone with a latrine, because we are first waiting to see if family members will support them"

(WASHCom member, Nigeria)

Cultural norms

"Some people still think [a] toilet should [only] be used in rainy season. If used earlier it will be filled and they have to clean which is waste of money"

(VDC secretary, Nepal)

Challenging logistics in mountainous areas

Materials (pan, pipe, cement) have been allocated by the district government for the poorest in a remote mountainous area in Nepal. However, the village is 2-3 days walk away from the District centre and hence the materials have not yet been collected. The community have said: *"Why can't it be brought in by helicopter like the tourists use?"*

(Rasuwa District, Nepal – shared by IP)

Declining solidarity

Solidarity is declining in the country, particularly with regard to elderly people – People do not look after the elders as they used to. Elderly people used to be able to bring the whole family together and the daughters used to organize to support the mother all through the day. This is a key finding from a study we carried out.

(KII respondent, Togo)

Pastoral communities

Peul people are present in minority in all three regions of intervention and they frequently refuse to adhere to ODF principles. This creates conflicts with community people. *Peuls* sometimes live 1km from community. We try to promote dialogue, the results of which are varied. Most of the time, communities manage to find a common ground. *Peuls* have accepted to build latrines, and we have also found *Peul* leaders living in cities to come and solve conflicts with rural *Peuls*. Conflicts stem from the fact that the community cannot be declared ODF unless the *Peuls* also build latrines. Their cattle already bring flies to the communities so community people cannot stand the fact that they themselves keep defecating in the open as their cattle do. In some villages, they have been banned/were asked to move. In the Plateaux region, there are maybe 10 communities which have met this kind of problem.

(KII respondent, Togo)

Refusal of support and not involving users in the design of facilities

The first box below highlights how sometimes people will not want to take support. In some cases, this is positive in that they would like to and feel able to build their own latrine; although one case study relates to a refusal because of religion. Facilitators and leaders need to be careful when offering support to be ready to have it refused and should take this positively where the person or family prefers to build their own latrine. The second box highlights the need to involve users in the design of facilities.

Refusal of support and sympathy *"For example, some people of one religion won't take support from people of another one" (Community leaders, Nepal)* *"We have had some bitter experiences of this – in one area a donor offered to support but when trying the people they offered to support refused to take the support and handed it back"* (IP, Nepal) A woman who is blind is married to a man who is deaf. They are an ultra-poor family. All community members had built toilets, but due to this family not having constructed, the ODF was not declared. Other community members showed sympathy to them, which the wife didn't like. But she also understood that her husband was deaf and he could be attacked by a wild animal at any time because he couldn't hear the sound of the wild animal. So, the wife built a toilet for her dignity as well as the security of her husband. Afterwards they were declared as a sanitation champions. (Bardiya District, Nepal – shared by EA)	**Not involving users in the design of facilities** In Senegal demonstration latrines have been constructed in the homes of people who are disadvantaged. Such families are identified through a village selection process. However, the demonstration latrines – although welcome, may not always be exactly what people would have chosen. For example, in Senegal one female headed household was given a VIP latrine where most people in the village would have chosen a pour flush model in preference. In one community in Malawi the VDC decided to construct a hand-washing facility for a woman who was unable to walk but the design was not suitable, as they had not consulted her on what would be appropriate. (IPs, Senegal and Malawi)

Pressure on vulnerable groups

The following case study provides an example of the challenges of pressures on both implementing teams to support communities to get to ODF along with the risks of putting unreasonable pressure on people who are particularly disadvantaged and vulnerable.

Pressurising the most disadvantaged until the last stages of the process

Two communities were visited which were not yet ODF which had been triggered 1.5 and 2 years previous to the team's visit. One was progressing towards ODF, but one ward was far behind the others and holding up progress. This was a ward mainly inhabited by a historically marginalized and very poor community. The team joined a patrol that was undertaken to encourage action and met with women from the community later in the day on their own, as well as visiting a number of houses. The team also visited households in a second community also in a marginalized ward.

The policy in Nepal is that the ultra-poor and disadvantaged can be supported with external subsidy, but that they are not told this until 90-95 percent of the households have constructed a latrine. The Terai area of Nepal is known for being the most difficult area culturally to persuade people to stop OD. There was a real fear that if people know there may be some subsidy then people will refuse to build waiting for subsidy.

But this leaves a situation where people who were being pressurised for long periods of time to build who were in very vulnerable situations. Examples include:

- Very vulnerable family with several members with mental health problems and only the wife and one son who do not – they live on the old age pension of the grandfather.
- One woman has a mentally ill son and she said she struggles to buy clothes;
- One said she works as a daily labourer and works on others' lands – earns very little even to buy food;

- Other said their sons were migrant workers and they could not afford to build one – one woman said they had taken out a loan for 170,000 to be able to send their son abroad and were still paying off this loan with its high rates of interest;
- Man with a very small house and a very small patch of land in front of his house – he had started to build a toilet, the ring from which filled the whole width of the front of his house
- Women headed households with responsibility for a number of others and none or only a boy/young man to support with income – sometimes also including people with disabilities in the family – some said they struggle to get enough to eat – one was visibly upset talking with us about her situation
- Family of husband and wife both with disabilities – sold land to pay for operation to cut off husband's leg – wife has leprosy. He currently defecates on the floor in their house and his wife takes it to dispose of it.
- Wife of man with a mental health condition – she supports the family and the children

The strategy of not informing people of the available subsidy has been developed because of a real fear in delaying pro-active action, but is this level of pressure acceptable on the most disadvantaged?

Disadvantaged people taking out loans or selling few assets

This section highlights some of the people who are taking out loans and selling their small number of assets to construct a latrine. Whilst some may feel this is acceptable and they feel proud of their own achievements, it may also leave people more vulnerable and unable to cope with future risks.

Selling only goat

Shanti, 65 years, lives with her only daughter, and son in law. She is a single lady who was been really influenced by GSF – open defecation free campaign. Being a single lady and with only her effort, she has built a toilet by managing some amount by selling her only goat to build the toilet. She is now happy to use the toilet as she is being free from polluting the community and free from the diseases. She is also raising her grandchild to use the toilet and other community people.

(Parsa District, Nepal – shared by IP)

Using social security, selling land and child constructing toilet

Ways some people who are disadvantaged have managed latrine construction:

- Some older people have used their social security allowances to build a toilet.
- One family sold their gold earrings which the wife had brought from selling her goat, after she could not get a loan.
- One very poor family which did not even eat twice some days, sold their land to build a toilet and now only have their house.

Impact of disasters and need to take loans

An older woman who lives with a 17-year-old lost her home during the earthquake and now lives in a home constructed of corrugated sheets. A local NGO supported with some of the sheets. She also took out a loan to construct this temporary home.

She had taken a loan 3-4 years ago to build her toilet. It was 20,000 NRS and she has now paid it back. She paid it back by selling several goats (5 or 6) and some rabbits.

But when the earthquake struck she lost most of her cattle. Her and her daughter lay on top of two of their goats to save them. All of the

- A day labourer who used his day wages even though it was not enough to feed his family and some materials provided by a trader who he used to work for.
- A 14-year-old child who lives just with his mother built a toilet.

(Nepal case study document, 2014)[1]

Impact of loans

"Loans are worsening the situation – as it multiplies"

(Dalit woman, Nepal)

others were lost. She now has one cattle and a few goats and is trying to build her stock up again. She took out a loan to buy the cow.

Her latrine was damaged with cracks. She is still using it but is planning to take out another loan to repair it properly. No-one has offered support. [although it is possible she will be entitled to some materials, but in Nepal people who are entitled are not informed until after 90-95 percent of the households have constructed a latrine]

(Cracked latrine, Rasuwa District, Nepal)

(photo: S. House)

Spending social security payments on a toilet

A woman's husband and sons are also disabled and now she cannot work because of her hand. She is a carer for them and gets social service security from the VDC. She gets 2,000 NRS/month/person and she spent some that money on the toilet. During the campaign, it took her 1 month to construct a toilet and she saved for 4 months and she also borrowed some money from her neighbours – she is still happy she spent the money on the toilet although it was difficult to save the money.

(Arghakhanchi District, Nepal)

Challenges for access and maintenance

The following case studies highlight challenges that people with disabilities or mobility limitations are having with accessing a toilet.

Would prefer a chair

We met a young man who crawls along the floor. He runs a small shop in front of his house selling palm wine. He knew about the triggering meeting from the town crier and his brother but did not attend because no-one would be present to look after his shop. He said that no-body came and told him about the meeting after the meeting.

But before the meeting happened the family did not have a latrine and they instead used to bury their shit in a hole and cover it with soil just behind the house. His father built a temporary latrine – which has grass walls, no roof, a cloth door, a metal cover for the hole, a handwashing water bottle as well as a bucket inside the latrine with a container to use with the bucket. There are no adaptations to the slab. He said he can use it and showed us how, but after we asked if having a chair would be useful, he said he would prefer a small chair if it was possible. The slab around the hole had started to collapse.

Challenges for privacy

"I would like to have my own toilet as I don't like other members of the family seeing me go"

(Older woman, Senegal)

"Previously I was just using the bush and this troubled me as it was dirty and not private. I am grateful to the VDC for their help. I usually sit on the floor as I can't squat down but I use the bamboo poles of the shelter to push myself up"

(Older woman in Malawi recently supported by VDC although triggering was a few years previously)

Physical difficulty to manoeuvre teenage girl

A woman was very concerned about her niece, now 13, who has cerebral palsy. It is difficult to

[1] GSF (2014)

His father was also in the process of building a more permanent latrine, a VIP, but has become sick so has not been able to complete it.

(Bekwara District, Nigeria)

move her and to get her into the latrine. They do not have wheelchair, only a wooden chair.

(CBO, Nkhotakota District, Malawi)

Lack of privacy for teenage boy

Samba is sixteen years old and cannot walk so uses a wheelchair. He doesn't go to school as it is difficult to get there. 23 people live in the whole compound and Samba has 10 people in his immediate family.

They have 2 toilets in the compound – both traditional (wood slab covered with concrete and roofless straw/corrugated iron superstructure). Samba has to use a potty outside the latrine as the door is not wide enough for his wheelchair. His mother usually has to help him. At night, they put the potty on the veranda and Samba can just about manage to get out and use it on his own. He would prefer to have more independence and use a seat in the latrine. A commode at night would also be more comfortable.

(Senegal) (photo: S. Ferron)

Simple addition of cement

"If we just had a bag of cement to cover the slab this would reduce the difficulty of her having to keep smearing the slab"

(Brother of women who has to crawl on the floor due to a disability – in Malawi)

Difficult access to latrine down slope

We met a very old woman (probably over 80 years old) who walks slowly with a stick. She is a widow and the community members said that she does not have any family to support her, although she said that she has a son that built her toilet, but works collecting palm oil.

Her latrine is a hundred meters or so behind her house down a slope and over rough ground. She walked part way with us to the latrine but then asked us to walk to the rest of the distance alone. She said that she cannot use the latrine as it is, as there is no handrail to help her squat. So, she uses a 'rubber' (bucket) in her house (we understood she uses it both day and night) and then carries it down the slope to empty it and flush it away. It was difficult to imagine how she manages to carry the bucket with the wastes in down the long slope to the latrine, although we were told by a neighbour that she cleaned the whole compound that morning and that to get to the latrine she just takes her time.

When asking her for recommendations as to how the programme could help older people be able to access a latrine more easily, she said having a handrail would make it easier and also having a proper building around the latrine would be preferred.

(Bekwarra, Nigeria) (photos: S. House)

Gaps for institutional latrines

Need to support institutions in sanitation campaign for user-friendly sanitation facilities	**Local authorities should be institutional role model**
Two latrines and one urinal constructed for a church (in a community that is not yet ODF). They have metal sheet walls but, no doors, no roof and were not gender segregated. The latrines were also not fully clean inside and no-hand-washing unit, but clearly used. Urinal just had space for urine to flow into ground outside of unit. Shit also seen on ground outside of one of the latrines. (Logo District, Nigeria)	It was reported that in the LGA Offices there are only internal latrines in people's offices, but none for visitors. (KII, Nigeria)

Sharing and decision making related to sanitation

The following examples highlight some opinions on sharing and also comments on men making decisions about sanitation.

Decision making on sanitation	**The shame of sharing**
Three families live together in one household, but they only have one toilet but brick lined and pour flush with roof. Women would like to have more but the men in the household make decisions about buying another. (Senegal)	*"Sharing a latrine with a passer-by is okay, but sharing [with] another household should bring shame on that other household"* (Men's FGD in Malawi)

Slippage

The following examples highlight problems of collapse of latrines.

Need to rebuild latrine many times	**Problems of collapse**
She can walk and squat but needs her very young granddaughter to lead her to the toilet. Her latrine was built by her grandson 'many times'. Has had a latrine for a long time. It has a grass superstructure with handwashing. She uses her shoes on her hands to find the hole. (Malawi)	*"Yes, we are very proud of all we have done but we also need more help to stop our latrines from collapsing"* (Chairman of VDC in Peri-urban area in Malawi)

Cultural practices, non-use of latrines, incontinence, menstrual hygiene

The following case studies highlight a number of practices that affect the use of latrines, the management or incontinence and menstrual hygiene.

Use of bucket as a toilet

Bucket called a 'poo' (pronounced 'poe') or 'rubber' used by an old woman who is blind. She leans on a bench to be able to use it and her family empty it into a latrine.

(Nigeria) (photo: S. House)

Isolation of women who have fistula

Because of the smell [of the constantly leaking urine or faeces] women with fistula are often segregated from the village and stays at home.

The MoH is now supporting fistula camps where they can have an operation. The project on this is through the Fistula Foundation and study grants are given and an amount to help start business [to help re-integrate the woman / girl into society].

(shared by IP, Malawi)

Privacy of latrine superstructures and doors

Latrine reported to be used by all in the family including female family members, but thin walls could pose challenges for females to use during the day. Other latrines were seen with sack doors which did not reach the floor so you would be able to see the person using the latrine.

(Ethiopia) (photo: S. House)

Challenges to dry menstrual cloths

"Don't want father or brother to know or to see the [menstrual] cloths – they might want to have sex with them"

(Women's FGD in Malawi)

Uncomfortable to use potties/ buckets

Maseya looks after her brother in law who has not been able to walk for 2 years since an illness. He can sit up and move from the bed to the chair and is mentally alert. He is 75 years old. He uses a potty (bucket with lid) and he manages but he is very grateful for the help of his carer. He thought that a commode would be more comfortable.

(Senegal)

Intra-household use of toilets during a girl or woman's menses

"There are still myths that toilets used by menstruating women should not be used by men"

(Village WASH Committee Member, Nepal)

Annex X - Case studies – EQND in CLTS – Good practice examples

The main report includes a number of case studies highlighting examples of good practice have been seen during the EQND scoping and diagnosis of the GSF programme. This Annex provides additional examples grouped around:

- Government strategies
- Strategic planning
- Staff as role models
- CLTS training
- Identifying people who are disadvantaged
- Involving people who are disadvantaged in programme processes
- Follow-up MANDONA
- Community level leadership and role models
- Innovations to make latrines more user-friendly and accessible
- Pit linings / modifications for sustainability
- Built or contributed to building own latrine
- Supported by others outside of the family
- Comments on outcomes and impact
- Institutional
- Incontinence / unable to use latrine

Government strategies

The Nepal Master Plan for Sanitation and Hygiene, 2011, was the strongest government strategic document in relation to the consideration of EQND that was seen during the 6 country visits. See the box below.

Nepal Master Plan for Sanitation and Hygiene, 2011

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

- It identifies the following groups as needing particular attention and support:
    - *Children; Gender and in particularly women and female-headed families; Elderly people; Differently-abled groups; Disadvantaged by caste or ethnic group; and other needy families*
    - It also discusses excluded groups including: *Landless; Ultra-poor; Squatters; Slum dwellers; and People in remote areas*
- In the terminology section – It describes: *'Child, gender and differently-abled (CGD) features'* and also provides proxy indicators to identify poverty and ultra-poor households:
    1. Households having food sufficiency (security) for less than six months
    2. Households having daily wages as the main source of income
    3. Female-headed households and / or households without adult members and / or households have physically disabled persons
    4. Other relative indicators agreed by the community
- In the socio-economic context – Discusses issues around land holding, poverty and socio-cultural taboos.
- In the section on lessons learnt: It notes that the ultra poor and disadvantaged groups need special consideration for their access to hygiene and sanitation promotion. Provision of financial support is crucial, especially to ensure the access of socially disadvantaged communities to sanitation facilities.

- In the operational strategies – it discusses:
    - The need for participatory approaches to involve the whole community, *including 'inclusive and gender sensitive stakeholder organizations at work such as mothers' groups, FUGs, child clubs...';* the Department of Education to ensure schools have Child Gender and Differently-abled friendly toilet facilities.
    - It also discusses issues around community contribution and notes that *'special consideration should be given to the ultra-poor, disabled people, female headed households, and other needy marginalized people in consultation with the local community'.*
    - And it discusses strengthening partnerships to support the poor: *'Likewise, the youths and volunteers will be mobilized for collecting local resources, fund raising and toilet construction for poor, elderly people, female-headed families and other needy families in the community. Importantly, FUGs, saving and credit groups and women's groups may be mobilized for soft loan support to the needy families to build toilets, preferably durable and hygienic toilets'.*
    - It also discusses strategies for gender mainstreaming (female as well as male engagement in committees and all activities and gender sensitivity in all components of the programme)
    - Strategies to respond to the situation of excluded groups and remote geographical areas (suggests support can be given at the discretion of the district, VDC and municipal coordination committees).

The Ministry of Rural Development in Cambodia has also recently produced *'National Guidelines on WASH for Persons with Disabilities and Older People'* which also considers EQND in CLTS.

Strategic planning

The following strategic framework for EQND has been developed by the Cambodia programme. It provides an excellent example of how to logically consider the different elements of EQND and establish practical actions for implementation and monitoring.

Cambodia EQND framework

The Cambodia EQND framework provides an overview of the key principles of the EQND approach in Cambodia as well as providing some practical suggestions and entry points for staff and partners to help integrate EQND into both their work and their organizations. The framework recognises the opportunity to address both practical (access and use of sanitation) and strategic needs (shifts in power and status) of marginalized individuals and groups. It draws on WSSCC's articulated five dimensions for achieving substantive equality:

1. Redressing disadvantage
2. Accommodating and embracing difference
3. Addressing stigma, stereotyping, humiliation and violence
4. Facilitating social and political participation in society
5. Achieving structural change

But it also recognises the limits of what it can achieve and notes that *'CRSHIP recognises that in some instances, the root causes of inequality, including some social norms, cultural beliefs, and values are beyond the ability or scope of CRSHIP to address. In these instances, CRSHIP will aim to identify links or partnerships that can provide a more comprehensive approach to addressing issues of inequality and exclusion. CRSHIP also recognises the need to make strategic choices about the ways and depth to focus on marginalized groups, as well as which particular groups to focus on as a programmatic approach'.*

It includes a very useful analysis of the EQND situation in the programme areas and issues which need to be considered including key barriers related to EQND in WASH; and then moves on to providing guidance into how to integrate EQND into the programme under the sub-areas noted in the first table below.

An example of one sub-section and some of the suggested actions and those responsible see the second table below.

Table 5 - Proposed intervention areas for the Cambodia EQND framework

	Intervention areas and key strategies
A	**Strengthening CRSHIP capacities and systems**
	• Increase staff competence to plan and manage equality and non-discrimination results • Provide adequate resources to implementing partners to enable smooth operations for female staff • Develop recruitment and retention initiatives targeted for female and disabled staff for CRSHIP and IP staff
B	**Integrating EQND in programme design and activities**
	1 – Sanitation and hygiene promotion in rural communities • Proven and tested community-led approaches to stop open defecation (see more details below) • Development and marketing of sanitation and hygiene products and services • Development of access to rural credit for sanitation and hygiene • Establishment of community-based and commune based sanitation and hygiene monitoring systems • Behaviour change promotion focussing on 3 key hygiene behaviours, i.e. constant use of latrines, hand-washing with soap, and drinking only safe water
	2 – Capacity development in government, local authorities, local NGOs, community sanitation and hygiene promoters and in the private sector who promote sanitation and hygiene in rural communities • Capacity development of relevant government, commune councils and local NGO partner's staff • Capacity development of private sector on construction, use and maintenance and marketing of improved sanitation, drinking water treatment, and hand-washing products and services. • Develop/ improve manuals and guidelines on key approaches and methods in improving sanitation and hygiene
	3 – Advocacy work for increased rural sanitation and hygiene promotion support at national and sub-national levels • Develop, strengthen, and support advocacy activities for political support at national and sub-national levels • Develop and establish a legal framework for the sanitation and hygiene sector • Support sanitation and hygiene advocacy work of the TWG-RWSSH with development partners • Advocacy for gender balance
	4 – Documentation, evaluation, and dissemination of experiences/lessons learned under the National Programme • Monitor, document, and evaluate all supported projects, linked to the output "all GSF activities incorporate capturing and sharing lessons learned"
	5 – Coordinating mechanism and directly executed activities • PCM activities: coordination and consultations and facilitation at government level • Directly executed activities • Audits and other work
C	**Supporting an enabling environment**
	• Includes general statements of commitment

The table which follows provides some examples of the proposed EQND actions against a few of the sub-components. For more details refer to the full programme documentation.

Table 6 - Examples of proposed actions and persons responsible in Cambodia's EQND Framework

	MAIN ACTION AND SUB-ACTION	PROPOSED EQND Actions	Responsibility
1	**Sanitation and Hygiene Promotion in Rural Communities**		
1.1	**Proven and tested community-led approaches to stop open defecation**		
	CLTS	Review CLTS training with a gender and social inclusion lens to ensure that the training material addresses EQND	TA (technical assistance sub-grantee)/EA
		Increase number of female CLTS trainers and facilitators	TA
		Adhere to the 'National Guidelines on WASH for Persons with Disability and Older People (MRD)'	IP
		Identify vulnerable groups including women, people with disabilities, poor, landless, and other marginalized groups and ensure they are able to participate and contribute to the planning and decision-making, are able to access the programme and its benefits. If they are unable to attend, effort must be made to ensure they receive the information and have the opportunity to contribute.	IP
		Ensure the Community Committee includes a diverse group of participants (men, women, people with disability, elderly) including or linked to children's groups	IP
	Hygiene Promotion	Review HP training with a gender and social inclusion lens to ensure that the training material addresses EQND	TA/EA
		Conduct hygiene promotion sessions with men and women	TA/IP
		Provide materials related to hygiene promotion to support household level discussions including developing specific messaging for men	IP/TA
	Menstrual Hygiene Management	Train CRSHIP staff and partners on MHM within CLTS and SC-WASH	TA/EA
		Incorporate MHM into CLTS and SC-WASH post-triggering activities	TA/EA
		Include considerations for specific sanitation and hygiene needs of women and girls in the community and school plans	IP/TA
		Identify sustainable chains for production and/or supply of sanitary protection materials and link with target areas	EA/IP
1.4	**Establishment of community-based and commune based sanitation and hygiene monitoring systems.**		
	Commune Database	Establish EQND specific monitoring domains and develop core indicators	EA/IP
		Conduct all M&E activities with men, women, children, elderly, people with disabilities, the poor, and other vulnerable groups	IP
		Support village and commune chiefs track the EQND related information	IP

Staff as role models

The following example highlights how staff who have a disability, are women or people from minority groups can act as role models for others.

" I have a disability and I use this to try and inspire community members" (IP staff member, Senegal)	Gabrielle is a senior staff member in his LGA working on CLTS and the GSF-supported programme. He has a disability with only one arm, and is a strong role model for others. He also shows the capacities of people with disabilities to undertake professional roles. (Nigeria)

CLTS training

The following box highlights some very interesting action research that was undertaken in Malawi in 2015 by Mzuzu University and SOLDEV, Malawi, the London School of Hygiene and Tropical Medicine and the Water Engineering and Development Centre (WEDC), UK.

CLTS Plus – making CLTS more inclusive[2]

A randomised control trial carried out in Malawi aimed to find out if CLTS facilitators could change their practice to focus more on disability after a short three days training which was added on to their standard CLTS training. The trained CLTS facilitators facilitated CLTS in 15 villages (known as the 'CLTS+' villages) and other CLTS facilitators who had not received the additional training, facilitated CLTS in 15 control villages.

On the last day of the additional training an action plan was developed by the facilitators themselves to identify additional pre-triggering, triggering and post triggering actions that would help to make their work more inclusive. This included (amongst other things):

- Encouraging community leaders to specifically invite people with disabilities to the triggering session
- Hold the triggering in a location that is easily accessible
- To help people with disabilities to get to the triggering area where they may have otherwise found it difficult to do so
- Invite people with disabilities to come to sit at the front during the mass meeting
- Marking households where people had disabilities on the community map
- Adding a squatting demonstration to the triggering session
- Facilitating discussions on possible design modifications that could be made to toilets
- Looking for people with disabilities to include as Natural Leaders and members of the WASH Committee
- Specifically visit people with disabilities in their homes to carry out an accessibility audit

The research team observed the triggering event and the follow-up being undertaken and then assessed the outcomes.

The findings suggested that the additional training for the CLTS facilitators had made a difference with:

- More people attended the CLTS+ triggering sessions
- Some people were supported by family to participate in the meetings and in some cases village leaders loaned people bikes
- A significant increase in awareness of the needs of people with disabilities
- More pro-active follow up visits were undertaken to follow up with people with disabilities
- Three villages had people with disabilities included in committees (so only considered moderate success)
- Increased number of modifications made to toilets

[2] White, S et al (2016); and White, S (2016) KII; and Jones, H (2015) KII

Unintended benefits also occurred. This included:

- After approximately 200 days, the ODF rate in the control villages (where the facilitators have not had the additional training) the ODF rate was 33 percent; whereas in the CLTS+ villages it was 53 percent.
- What started out predominantly as a trial about disability, ended up becoming more relevant to the whole community by reminding them that a range of people have diverse needs.
- The formation of disability groups and links with community based rehabilitation (CBR) networks.

Discussions with the authors suggested the following learning points:

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

Identifying people who are disadvantaged

The Cambodia programme has developed an approach to community self-assessment that includes identification of people who might need support.

Participatory Social Assessment Mapping[3]

The Cambodia Programme has developed a process of community assessment and mapping known as PSAM for the purpose of assisting communities and implementing partners to develop an initial understanding and self-analysis of their social-environmental context. It is undertaken during the pre-triggering phase and it aims to achieve the following:

- To better understand the geographical situation of each village, feature, income, expense, and community seasonal activities, opportunities and vulnerabilities;
- To analyse root causes and impacts of problems at community level;
- To define poverty, vulnerability, discrimination, isolation and gender equity from the perspectives of the communities themselves;
- To establish a 100 percent participatory baseline (in every village) to complement the "sample based" conventional baseline study;
- To provides a first step to mapping, understanding and monitoring Inequality and non-discrimination in each village on 3 dimensions: Poverty, vulnerability, and gender & inclusion;
- To generate the initial elements (data, information, analysis) necessary to understand the needs of the communities and possible resolution to develop collective sanitation and hygiene plan for behaviour change.

[3] GSF and Plan International, Cambodia (2015) and Lempho, S and Dumpert, J (2016)

The aim is that this information will in turn provide a solid ground to activities such as CLTS, school WASH, BCC, Sanmark, and learning & monitoring.

The tools used:

It draws on some common Participatory Rural Appraisal (PRA)/Participatory Learning and Action (PLA) tools such as poverty ranking, seasonality analysis, social mapping and causal diagrams. These tools use visual diagramming to enable communities to explore, discuss and analyse their own situation and to identify who in the community might be vulnerable and why.

- **Poverty ranking analysis tool** – To understand the meaning of poverty, vulnerability and gender defined by local community; and to identify the poor, vulnerable group, discriminated group, exclusion group and gender issues in community.
- **Seasonality analysis tool** – To understand seasonal activities (includes vulnerabilities) and migration of local community people; determine the sources of household income in community; learn how community address their food shortage in specific months of the year; and explore the feasibility of community on [responding to the] sanitation situation.
- **Social mapping tool** – To understand of the geographical situation and features; draw and put significant information on the map (physical infrastructure) of the village; and update information occurring/happening in village regularly.
- **Causal diagramming tool** – To analyse the roots of problems and impacts of the problems.

Initial challenges with the approach:

Following the piloting of a variety of tools with Implementing Partners and some uncertainty about the value of some of them, the number of tools was reduced to four.

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

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

Concern has also been raised on whether the approach is scalable. A recent 'short narrative' report on the experiences of using PSAM also highlight some 'teething' problems with the approach[4]: *"Of the four PSAM tools, the one that seems to be causing the biggest challenge for IPs to facilitate...has been the Causal Diagram tool... Reasons for this are in part due to poor community participation (as described above) and the need for improvement on IP's facilitation skills."*

Comments from consultants:

Refer to **Section 9.2** in the main report for some suggestions from the consultants on possible considerations for moving forward with this approach.

[4] Ref: Short Narrative – Experiences from Implementing PSAM July 2016

Involving people who might be considered disadvantaged in programme processes

The following case studies highlight ways in which people who might be considered disadvantaged have been involved in the programme processes.

Involving man who was speech and hearing impaired in triggering meeting

A man who is hearing and sight impaired engaged in a triggering in Malawi. A facilitator who was able to communicate with him interpreted the discussions so he could understand.

(shared by an IP, Malawi)

Woman with disabilities a role model for others

Prior to triggering the team identified people who are disabled. They also came in front of the community. The community gave their ideas and the people with disabilities became more interested as the natural leaders spoke. During the triggering time, one mother who was disabled and using a wheelchair wanted to construct a latrine. She was very active and leads CLTSH activities in the *kebele*. She said, *"if I can construct this [latrine] then why not others?"* She was a model to others.

(shared by IP, Tigray Regional State, Ethiopia)

Communicating by writing on paper

Mr Mfetor is deaf, he lives with his two wives – Iveren and Annas who are also deaf.

At the community triggering meeting we always facilitate for the youth and Natural Leaders to help the disadvantaged in their respective communities to build their own latrine facilities. We were able to help facilitate for him to own his own latrine by communication with him by writing on paper. It was discovered that although he has a challenge [of hearing] that he understands the importance of not defecating in the open and hand-washing at critical times.

(Gwer East LGA, Cross River State, Nigeria – shared by IP)

Involving marginalized communities

Trained local entrepreneurs to make drop hole covers – also involved marginalized communities and they are selling them.

(shared by IP, Phalombe District, Malawi)

Making public latrines accessible and employing people with disabilities

In our policy statement – everybody has the right to sanitation and water. Together with colleagues we did some small research and found most public latrines not accessible for people with disabilities. We saw that the latrines were not looked after when used by others and also people with disabilities often had less opportunity for income and some were begging.

We organized people with disabilities – who managed the latrines and charged a small fee. The *kebele* supported them to make sure that people pay; so, this improved access to the latrine for them and provided employment so they no longer need to beg; and also, they kept the latrine clean for others to use as

Pro-active invitation to person with disabilities

It was during a learning exchange event and his village was earmarked for a visit. The Team of IPs and visitors arrived and waited for people to gather, but the turnout was poor. The leader of the visiting team requested all to go around the entire village singing and urging people in the houses to come out and meet at the village square. I observed Undie sitting in his wheelchair in front of his house and waving at us as we pass by singing.

I stopped talking with him and urged him to also come along to the village square where we will be meeting. It was then I realized I need to do more that urge him. So, I asked a colleague to support Undie and ensure he too can get to the place of the meeting.

Undie joined us and heard all the discussions on the community's renewed commitment to end open defecation. When homes were being selected to be visited, Undie's home was also selected. The team met with his parents and shared how they have tried to build a latrine to accommodate him

well. The public latrine was nearby the church. (Shared by PCM member, Ethiopia – example from outside of GSF programme)	since the triggering. However, whenever Undie finishes easing himself and washes his hands, he soils it again as he tries to come out of the latrine. The team then facilitated a discussion and together with the parents, made a tippy tap that was hung outside of the latrine rather than inside. Undie now can wash his hands with soap and water just outside the door of his latrine. And with this his hands are no longer soiled after from having to use his hands to support himself out of the latrine. (Obanliku LGA, Cross-River State, Nigeria – shared by EA)

Follow-up MANDONA

The Follow-up MANDONA (FUM) approach was developed by the Madagascar programme is an action-oriented approach for accelerating community-wide sanitation and hygiene behaviour change following the initial triggering session.

Follow-up MANDONA[5]

The Follow-up MANDONA approach in Madagascar, builds on an existing tradition of collective community work (*'asam-pokonolona'*) and a spirit of solidarity. With the help of a facilitator:

- The community is enabled to review the progress of what has been achieved following triggering
- Make adjustments where required through *'small immediate, doable actions'* (SIDAs) and ensure that disadvantaged sections of the community are also involved.
- Collective community visits to examine sanitation and hygiene provision in the household or other parts of the village can include reviewing whether a toilet is accessible for someone with a disability, for older people or for children.
- The process also aims to encourage those who are disadvantaged to participate in the programme.

Examples of how the approach supports those who are potentially disadvantaged:

Facilitate collective self-analysis (p27):

With the permission of the latrine owner, ask everyone to view inside the latrine. The team member acting as the Environment Setter should encourage those standing on the periphery to become engaged, and ensure that women, children, and other community members that are often left out (female-headed households, widows, the elderly, and people living with disabilities or HIV/AIDS) are actively participating.

Never leave anyone behind (p42):

The FUM session should help the community get as close to ODF status as possible. Don't stop facilitating when only one or two community model latrines have been created! Everyone should be triggered and take immediate action to ensure that their community does not eat shit.

Do's and Don'ts (p52):

Do	Don't
Encourage disadvantaged sections of the community to participate	Discount women, children and others who often get left out
Encourage support for community members who are less able	Overlook existing or emerging community support systems

[5] Fonds d'Appui pour L'Assainissement, Madagascar (2016)

Encouraging community self-support (p38):

Follow-up MANDONA is not only an effective method for reinforcing and sustaining behaviour change, it is also a powerful approach for ensuring that those that often get left behind are able to receive support. This story illustrates how facilitators from Famonjena – a local NGO and Sub-grantee of the FAA programme – encouraged community self-support during a Follow-up MANDONA session in Andrakomasina village, central Madagascar.

Razafindalana Raphael, also known as 'Dadabe' ('Grandad'), is one of the oldest people in his village, and greeted the Famonjena team as they arrived to start their Follow-up MANDONA session. Since the triggering session, the village made significant progress in becoming ODF: their open defecation area was closed, and everyone used pit latrines, many of which were fly-proof with handwashing facilities. The facilitators encouraged everyone to congratulate themselves, and Dadabe volunteered to show his own latrine.

Once the village arrived at Dadabe's latrine, the facilitators first applauded his accomplishment. However, he was aware that he had not yet made his latrine fly-proof, and had not yet built a handwashing station. Dadabe was very old, having lost both his wife and children, and was recovering from recent ill health. When community members began to suggest ways that he could improve his latrine, Dadabe insisted, *"It's is better to deal with the others first. I am not able to do it. I am old, and you can see that I am not feeling well. It will be difficult for me; I can no longer dig, deal with the mud, or fetch water. Plus I cannot afford the materials!"*

Facilitated by the Famonjena team, everyone agreed that Dadabe's latrine was causing everyone else to eat shit. Nobody thought this was acceptable. Neither did Dadabe, so he suggested that he would make the improvements once he recovered. *"So, is it acceptable to continue eating shit in the meantime?",* asked Son, the lead facilitator. Again, nobody accepted this. *"So as a community that refuses to eat shit any longer, what can we do right now?"*

Three energetic youths immediately stepped up to help. They fetched water, mixed the mud to fill gaps in the latrine floor, and gathered local materials for a handwashing station and squat-hole cover. In only a few minutes, these Natural Leaders helped Dadabe make his own model latrine. He also learned that he could use ash to clean his hands rather than buying soap, and smiled as he gathered ash from his kitchen to test out his new handwashing facility. *"And I had to pay nothing!",* he exclaimed.

After congratulating the community for this accomplishment, Son asked: *"But are there other people in the village like Dadabe that can't make these improvements on their own? Is it acceptable for us to continue to eat shit from their latrines too?"* Led by the Natural Leaders, everyone split up to help those that were least able to replicate Dadabe's model latrine. When the facilitator left that afternoon, the village was ODF.

Community level leadership and role models

The following examples highlight how people who might be considered disadvantaged have become community leader and role models influencing others.

Female natural leaders

"Mrs Ukeh was the first women that I saw digging her own toilet". She went on to explain that the triggering meeting had made Mrs Ukeh reflect that she could be seen going to the toilet in the open by palm wine tappers looking down from the palm trees and she was indignant!

People with disabilities as leaders and supporting others

A person with disabilities (one leg) also built latrines for others.

(Phalombe District, Malawi – shared by IP)

Her husband spent long days in the bush as he was a timber merchant and she couldn't afford to wait for him to come home so she set about constructing the toilet herself. *"Now she is a natural leader and she encourages others to build latrines – not just in her own community but also in neighbouring communities."*

(Obanliku LGA, Cross River State, Nigeria – shared by IP)

A woman who built latrines for others

In one village, a lady constructed a latrine on herself – has also built 3 or 4 latrines for other households.

(Chikwawa District, Malawi – shared by IP)

Sunday Ochefu a disabled man was triggered and he built and put to use his toilet. He also champions the mobilisation of the people in his community as WASHCom member.

(Nigeria – shared by IP)

Anthony, a disabled man with one arm was triggered in 2015. He asked, *"what can I do to own and use a latrine knowing that I cannot dig with one hand?"*

Natural Leaders and youth promised to help him. They jointly provided a latrine. Now Anthony is happily using his latrine and he has also emerged as the secretary of WASHCom in his community.

(Obanliku LGA, Cross River State, Nigeria – shared by IP)

Man with disabilities influencing others

Viashima is married and has a disability. He said that he decided to dig toilet in order to stop defecation in the bush and also to avoid the transfer of flies that carry shit from one place to another despite the challenge of who would dig one for him. Rather he took a step forward to dig latrine by himself due to the knowledge he had during the triggering that open defecation will makes us ill.

He said that as a disabled man he had not been comfortable using the toilet. But now he no longer perceives the smell of shit and also does not need to share toilet with his elder brother or to walk the distance to go to it. As the toilet [is] in his house he goes to the toilet any time he wants.

He now moves from house to house to encourage his people and sensitized them the more not to defecate openly he does this 1 to 5 households in a day in order to conserve his energy and do his work effectively.

"I want my community to stop eating shit by taking for that I encourage them to dig toilet. I also want my community to be neat and maintain cleanliness as a high moral value in the community".

(Logo LGA, Cross River State, Nigeria – shared by IP)

Male natural leaders with disabilities

Aloysius and Dominic were both identified as Natural Leaders on the day of triggering.

What prompted the emergence of these two people who are physically challenged was their passion and commitment on the day of triggering.

Aloysius championed the process of creating more awareness to his community members using his position as a church leader. He will announce in the church and will lead natural leaders to households to ascertain the level of compliance. Today, Aloysius is the chairman of WASHCom. While Dominic being an elder in the community ensured that the community stakeholder embraced CLTS and today he is the secretary of the WASHCom in the community.

(Gwer East LGA, Cross River State, Nigeria – shared by IP)

A woman with disabilities was very active and led the activities in her Kebele. She said, *"if I can construct this then why not others?"* She was a model to others.

(Ethiopia – shared by IP)

Women leading the process for change and supporting others

In the Moyen-Moyo, women mobilized massively from pre-triggering to certification, through the triggering, construction and maintenance of sanitation facilities. They were the first to be triggered and made decisions to end the OD. ... They built latrines and the latrines of the vulnerable people, cleaning former OD sites and sometimes triggering their own husbands. The first latrines built following triggering were the work of the women. This is the case of Konfo, who built three latrines on her own in three days.

(Plateau Region, Togo – shared by IP)

Innovations to make latrines and going to the toilet more user-friendly and accessible

The following examples highlight ways that people found to make going to the toilet with dignity easier.

Use of potties for children

The Senegal programme has encouraged the use of potties, which are now widespread, with some families having several of different sizes and sometimes one for each child (Senegal)

(photo: S. Ferron)

Keeping toilet paper handy

Cecilia, an older woman who is sight impaired has developed a great way of making sure she had toilet paper close at all times – she keeps it in the top of her hat!

(Nigeria) (photo: S. House)

(photo: S. House)

Brother supporting sister with latrine with small ramp and bathing facility

Chadrick has built a latrine and a bathing shelter for his sister Dorothy who moves by crawling across the floor. He has built her a latrine before but the last one collapsed so he built the new one. It had a small ramp at the entrance.

The bathing shelter had a low-level wood for hanging cloths on and a toothbrush is located at low level in the grass wall.

(Nkhotakota District, Malawi) (photos: S. House)

Raised seat and larger squat hole

An older man who walks with a stick, had been displaced by conflict with the *Fulani* people when the whole community had to leave for several years. He still lives away but some of his children returned and he was back to see them. They had built a latrine for him to use when he visits – it has a small raised seat made with mud and a larger oblong hole with a wooden frame and a cover.

(Nigeria) (photo: S. House)

Larger squat hole

Nyion is an older woman (probably over 90 years) and is unable to see. Her son, Uger, guides her using a stick which they both hold at different ends. He also guides her to the toilet at night. He built her a toilet more than once when old ones collapsed. The toilet has a raised floor and a large square hole with a small wooden frame around the hole on which the cover sits. The large square drop hole has been installed so that she is able to hit the hole as the small one was too difficult. She finds the latrine easy to use and she showed us how she gets in using her stick to find the location and that although she is old she is still able to squat.

(Nigeria) (photos: S. House)

Pedestals made from soil

Through other projects I learnt to promote a burnt soil pedestal to help people squat. Many elderly people have problems squatting so some masons are making pedestals from soil, which is burnt and then painted. It is intended for older people but some other people also prefer it.

People buy these from masons for almost 9,000 NRS. It doesn't have a cover so we are working to improve the design. Have temporarily been using a cloth to cover.

(Phalombe District, Nepal – shared by IP)

Rope to guide to latrine

In this village, Bilaye, the head of household, who is also blind, has understood well the importance of ODF and the need to sustain this status in the village where he lives.

His domestic latrine was built by his children, but access remained an issue for him. His younger boy, aged 6, guided him each time he needed to go to the toilet. But the day before the school started, he realized that his boy had to abandon him to attend school… He found a solution to his problem, allowing him to reach his latrine on his own, thus contributing to keep his community ODF, whilst make it possible for his son to go to school. He simply attached a string from the mango tree of his backyard to the latrine and uses this string as a guide. This simple innovation has meant that he is no longer dependent on others to access the latrine. (See photos on next page)

Moulded earth pedestal

Because of his physical disability (stiff knee and resulting incapacity to fold the leg) a man elevated the drop-hole of his latrine to adjust it to his situation. He built an earth moulded seat on top of the slab. He can sit on it whilst keeping his leg straight.

(Plateau Region, Togo – shared by IP)

(photo: K. Fagnon, ONG Odiae)

Moulded earth pedestal

Lamboni is 65 and lives with a physical disability. Because he could not squat to defecate, Lamboni elevated the drop-hole in such a way that he can sit. He finds this position comfortable and does not need to worry anymore anytime he feels the need to go to the toilet. This improvement also allowed all family members to use the toilet without any form of discrimination.

(Savanes Region, Togo – shared by IP)
(photo: S. Akakpo/CDD)

(Kara Region, Togo – shared by EA)

(photo: N. Yabouri/UNICEF)

Foldable commode chair

Mangal was injured during the earthquake and now has some difficulty walking. She is living in a temporary internally displaced persons camp because her home was destroyed and it has not yet been possible to rebuild.

She uses the communal latrines during the day, which are just outside of the walled compound where everyone lives. But at night she uses a pot from the commode chair on the floor in her daughters shelter which is a few doors from her own. She was given a foldable comode chair by HI with the removable pot.

But the foldable part of the chair is hung up on the wall in plastic. She said that she just uses the pot on the floor. She said she likes to keep using her legs to try and make sure they do not get worse [and hence is OK squatting]. The other reason not to use the chair is that it takes up too much space and the shelters are very small.

(Bhaktapur District, Nepal) (photo: S. House)

Child's commode chair

Child's commode chair brought in local market

(Bekwarra LGA, Cross-River State, Nigeria)

Children learning through play

In one community in Malawi it was observed that the handwashing facilities were out of reach of the children in several households. The parents said they had done this on purpose because the children were playing with them. The extension workers told them that it was a good thing if their children played with the handwashing facilities as they were showing an interest. In the end, the design of the handwashing facility was changed to make it more robust so that it wouldn't break so easily.

Children contributing to make latrine covers

In some communities, children have been tasked with finding old materials with which to make latrine covers.

(Malawi – shared by IPs)

Pit linings / modifications for sustainability

The following examples highlight ways that communities have found solutions to the problem of pit collapse in unstable soils. Pit collapse and slippage are particularly difficult problems for people who have to rely on others for support.

The government of Nepal strongly recommends in its National Master Plan for Sanitation and Hygiene (2011) that all pits should be lined and have a permanent slab. Other countries visited do not have a minimum standard for pit lining.

Corbelled latrine lining with burnt soil blocks[6]

Collaboration between UNICEF and Mzuzu University has led to the development of a new technology for use in difficult soils in Malawi which aims to prevent a latrine from collapsing but which does not require cement.

They have been using blocks with no mortar for most of the lining. Then they corbel in the bricks to smaller and smaller diameters until a dome shape is formed at the top on which the traditional slab can sit. They use mortar at top but it doesn't require cement or rocks.

They have trained 100 masons in localities in 15 districts in Malawi to undertake this methodology. They charge 5-6000 (USD 7 to 8) Malawi Kwacha for the lining.

(shared by SOLDEV, Rumphi District, Malawi)

Smaller pits

A VDC are constructing two fisherman's toilets by the lake shore. They are using a narrow pit because of sandy soil. They are planning to set up rota for the fishermen to clean the toilets with fines if they don't.

(Nkhotakota District, Malawi)

(photo: S. House)

Fatsileni had just built her latrine using a basket lining because of the sandy soils, but has not yet started using it.

(Nkhotakota District, Malawi) (photos: S. Ferron)

Basket lining seen nearby

(Nkhotakota District, Malawi)

(photos: S. Ferron)

Pit linings using rings or rough stone lining

Pits in the mountainous areas in Nepal, tend to be lined with local stone; whereas in the flatter Terai areas, the pits tend to be lined with cement rings.

Pit linings using car tyres

Some pits have used car tyres to line their pits. (Senegal)

Ecosan arborloo

Ecosan latrines with shallow double pits which are emptied on an alternative basis have been used in some communities. As well as providing fertiliser they are also helpful in situations with sandy soils to prevent risks from pit collapse. See example below. (Malawi)

[6] Cole, B (2015)

(Rasuwa and Dhanusha Districts, Nepal) (photos: S. House)	

Built or contributed to building own latrine

The following examples introduce people who may be considered disadvantaged or their families who have either built their own latrine or contributed to building one.

Father constructed latrine for his children

Constance is unable to walk and her brother Edward has problems with his hand and some mobility limitations. Their father, Siprano (above), has built a latrine plus hand-washing station with cover and soap. His daughter uses this latrine. It does not currently have adaptations but Constance has never complained to him about it being difficult for it to use. (Nkhotakota District, Malawi)

(photo: S. House)

Young man constructed part of his latrine

Edward now has his own house near to that of his father and sister and has decided to build a latrine. The senior chief had encouraged a relative to help dig a pit for Edward. The pit has been dug and Edward had cut the logs himself for the slab.

(Nkhotakota District, Malawi)

(photo: S. House)

Father constructed latrine for daughter

(Nkhotakota District, Malawi) (photos: S. House)

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

Latrine built by son

Very nicely constructed toilet – with *"please use me and please clean me"* in English and Chichewa.

Very clean like had not been used with hand-washing facility and cover. Her son who is about 20 years old built this latrine. Only 3 people are using it. The family had a toilet before triggering.

(Nkhotakota District, Malawi)

(photos: S. Ferron)

Money from son working overseas

67 years old man, built a toilet and shower facility. His son helped him build with money he has earned overseas.

(Arghakhanchi, Nepal) (photo: S. Cavill)

Varied ways people constructed or influences construction of latrines

- A couple – one of whom cannot see and the other cannot hear built their own toilet with no subsidy. They became a model couple for the sanitation campaign.
- Women saying they will only get married if their potential husbands build a toilet.
- Woman headed household (widower) who built a toilet herself.

(Nepal case study document, 2014)

Son built gender-separated latrine

A son has built a gender-segregtaed latrine for his older mother and family with the support of a mason. It is made of a concrete slab, concrete block walls, and metal sheet roofing. Bricks have been laid to ease squatting over the drophole and ease anal cleaning. A bucket of ash and tippy tap allow users to wash their hands. The temporary curtains, which do not provide sufficient privacy, are going to be replaced by proper doors (wooden frame and metal sheet) shortly.

(Plateau Region, Togo) (photo: J.E.Tiberghein)

Supported by others outside of the family

The following case studies provide examples of how people who may be considered disadvantaged have been supported with latrines by people outside of the family.

Support provided by community

An older woman lives with her son who has a mental illness and her grandchildren.

Their latrine was supported by community. It is a basic latrine with traditional slab and a hand-washing facility and ash. There is a flap door but it isn't down to the ground. The children and girls would like a concrete slab. The pit was thought to be between 3-5m deep.

(Kedida Gamia Woreda, Ethiopia)

Carer family builds latrine and bathing units

Evan is a father who takes care of two young men, Gbanan and Vendaga who cannot hear or speak. Their parents died so he adopted them. He built them a latrine and bathing unit – with concrete slabs and pour flush. Neither have doors or a roof yet, but both were clean and are being used.

(Logo LGA, Nigeria)

Ecosan latrine supported by CBO

The father of the family is old and not able to walk well and mostly bed-bound.

A CBO built an ecosan latrine for her father/ their family. See the three pictures above and to the left. The open and closed shallow pits are shown here. The design is useful for unstable soils as the pits are not large. The latrine was very clean and tidy but obviously used because of the fertiliser stacked up outside.

(Nkhotakota District, Malawi)

(photos: S. House)

Support for construction and on-going care provided by Natural Leaders and WASHCom

During the triggering session, David who is an older man who is also blind with his wife listened and asked questions.

After triggering David shared latrines facilities with neighbours until Natural Leaders constructed his own pit latrine. WASHCom members always visit his latrine to ensure that sanitation facilities such as hand washing station, fly proof and use of ash are maintained. In order to access the latrine a rope linking the edge of his house and the latrine is

Varied support for people to construct latrines

- 80-year-old woman with no family being supported by youth and women's group and the V-WASH-CC.
- A teacher who has become a hardware trader and has tried to provide construction materials to poor families at the cheapest price.
- A landowner who allowed a landless woman to build a latrine on their land.

provided. This enables him to trace the path to his latrine even when there is no one to guide him. David feels that owning a latrine is better, because most times the facility was being locked by neighbours when he was sharing. (Obanliku LGA, Cross River State, Nigeria – shared by IP)	• One man made about 35 rings and dug the pits for 12 toilets for people who could not manage themselves. (Nepal case study document, 2014)

Wooden toilet chair over bucket  (Arghakhanchi District, Nepal) (photo: S. Cavill)	**Orphan-headed household building latrines** A 35-year-old woman is looking after her children and siblings after their parents passed away and they became orphans. Had a latrine in brick but it had collapsed. Her son had built a temporary replacement with grass superstructure. They were in the process of building another one. Her 12-year-old son had dug the hole (about 3m deep). She could not afford the logs as she had to buy them because the trees around are few and small in diameter. No-one was assisting. [Afterwards the VDC said they had already discussed her situation and were saving up to assist her. They also had also found her a job in the primary school]. (Malawi)
The house built a safe toilet but Ram (above top left) cannot reach it. His room is upstairs and during the day he sits on a platform on a mattress. He urinates in a plastic bottle and when he needs to shit 3 people have to carry him over a balcony to the chair they have built. He lives with his wife and son. His son was working abroad for 6 months but couldn't earn enough and so came back. They have experimented with different types of commode: he had cut holes in 3 different plastic chairs to use for defecation. But they all broke and so they decided they decided to make one of wood. He shits into a bucket and his wife carries it down to the safe toilet. There are some towels/cloths arranged to give him some privacy when he uses the toilet. When he needs to bathe – people carry him down the narrow stairs cut into the hill side to the washing area and wash him there. His legs are paralysed after an operation went wrong. Their financial situation is very bad – his wife works on farming jobs and other sources but they don't have a lot of money and they didn't get a subsidy for building the toilet. Jedu can't get into the centre of the village but people came to the house to do the triggering and the Ward WASH CC and the Ward Citizen Forum and the Female Community Health Worker goes door to door. How did they afford a safe toilet? They bought the siphon and the pan and the pipe and 3 bags of cement themselves and they had support from their neighbours for the labouring and the Community Forest Users Group provided them with some wood for the door and toilet. Stone is available locally and so they went down to collect stone.	

Comments on outcomes and impacts

The following comments were made on outcomes and impacts of the programme.

Utilizing previous defecation sites for income

After triggering, the community and especially the women organized to clean up the village. ODF sites were cleaned and today these areas provide sources of income for farmers, a real business opportunity.

Adjo, mother of 5 children, a housewife, expresses her joy, *"I welcome the coming of CLTS in our village. Our village used to have that shit stench and notably in our house: you could not even stay under the hut to rest and even eat there because we are [the concession is] just nearby the place where the whole neighbourhood used to defecate".*

"After the triggering, our neighbourhood was the very first to end OD. We cleaned the defecation sites outdoors. In the same year, my husband and I farmed the former OD plot near our house. We farmed corn during the first rainy season and chilli, eggplant and gboma during the second rainy season. We consumed part for food and sold the remaining..."

"As my children no longer fall sick, this money has allowed me to save regularly in my savings group and to educate our children including 1 in college and 3 in elementary school. Now, because of my recipes there is peace with my husband because he is polygamous. I say thank you to CLTS, CADI-TOGO and all those who allowed the arrival of CLTS in my village".

(Plateau Region, Togo – shared by IP)

This Dalit woman has a toilet in her house, a drying rack and she has also build a pit for collecting the rubbish, which is burned – part of the total sanitation campaign

(Arghakanchi District, Nepal) (photo: S. Cavill)

Impacts seen by health staff

We visited a health post and met with 5 staff, one Principle Community Health Extension Worker (CHEW), one other CHEW, a ward orderly, an intern and a cleaner. We spoke with the two CHEWs.

They were very positive about the sanitation programme – one had seen it in another community where she worked before this current one. Both staff said there has been a visible improvement in the health of people in the communities particularly in reduction of typhoid and diarrhoea. They also said the environment is much nicer with no faeces, less flies etc.

(Bekwarra District, Nigeria)

Impacts seen by health staff and the local authorities

When asked, a variety of community groups confirmed that they were washing hands at key times with soap (or a soap alternative, such as ash) and soap was present at latrines in the majority of cases. This was confirmed by the nurse, who undertakes regular visits of all households as part of the vaccination campaign. She also noted the systematic use of potties for children and a drastic improvement of both domestic hygiene and cleanliness of villages. This also coincides with the views shared by the local authorities, one of whom stressed that if *"nothing is fully rosy"*, the results nonetheless seem very positive.

(Senegal)

"Even a six-year-old boy will come home and ask for soap for handwashing now"

(Male, Senegal)

"Before we thought we shouldn't wash during menstruation but we learned that we can wash during those days, we should bath daily and we should keep clean" (Adolescent girls, Nepal)

Impact on gender roles from MHM training

The recent training on MHM has proven very effective leading to practical changes. It is also reported that the engagement of men in this activity has proven very beneficial. GSF has triggered constructive discussions around the prevailing gendered distribution of roles and responsibilities regarding water, sanitation and hygiene, which it is understood has led to the adoption of new practices in many villages (e.g. men accept to take their part in the cleaning of the village to reduce the prevalence of malaria and the risks of bushfires). (Senegal)

Institutional or public latrines

The following provide examples of institutional or public latrines.

Public latrine at government offices

This latrine is one of the public latrines that have been constructed under the GSF-supported programme. It is outside the village government offices. It has a strong door, a concrete slab and hand-washing inside including soap on a string.

(Kedida Gamia Woreda, Ethiopia) (photo: S. House)

Koranic schools and support for children who live on the streets

It was reported that there has been an increase of the number of latrines achieved in a **Koranic school**, where the community focal person of the programme is the wife of the religious leader.

Thanks to the programme, the number of latrines accessible to the 50 street children raised in this non-formal school has increased from 4 to 7.

A routine of cleaning has been put in place and the environment is now clean.

(Mbaké Region, Senegal – shared by IP)

Incontinence / unable to use latrine

The following picture shows a plastic bed pan used in a village health post, that could also potentially be used at household level where someone is unable to leave their bed.

Plastic bed pan in health post

Health worker with a plastic bed pan used in a village health post (Bekwarra District, Nigeria) (photo: S. House)

Annex XI - Recommendations – Do's and Don'ts

This Annex provides a listing of Do's and Don'ts for the CLTS process and for specific potentially disadvantaged groups. The tables of Do's and Don'ts are organized as follows:

1. Enabling environment
2. Organizational and MEL
3. Programme/ community level:
    a. Applicable to all stages – 'Do no harm'
    b. Pre-triggering
    c. Triggering
    d. Post triggering- Follow-up
    e. By stakeholder group

General Do's and Don'ts for all stakeholder groups are integrated into the Do's and Don'ts for each stage of the CLTS process. But in addition, specific recommendations have also been grouped by stakeholder in the final table for easy access. Particular attention has been made on working with people with mental health conditions in this final stakeholder table, because people with mental health conditions can be particularly vulnerable and as a sector globally there is limited knowledge on how to engage with them respectfully and ensuring their dignity and rights.

XI.1 Do's and Don'ts – Enabling environment

Disclaimer: The suggestions which follow are made by the consultants for discussion and decision by GSF as to which ones will be taken forward.

Table 7 - Do's and Don'ts – Enabling environment

Do's	Don'ts
1. Advocate with government, donors and other organizations to ensure that EQND is incorporated into all WASH policies, strategies, guidelines, national training guidance and programmes (not just CLTS) including Country Programme Proposals and amendments. 2. Collaborate with organizations that represent or work with people from different disadvantaged groups to: a. Help establish the different terminology preferred by potentially disadvantaged groups b. Advocate for improved attention to EQND in the WASH sector c. Advocate for improved WASH through other sectors and specialist networks (disability; health; IPM etc.) d. Ensure appropriate practical training on this issue 3. Advocate for the preparation of national practical guidance on how to integrate EQND into the CLTS process, which can be used to complement existing guidance until it is updated, at which point EQND should be integrated 4. Invite key government stakeholders to EQND in CLTS training where possible 5. Advocate for increased attention on public latrines – including those with male, female and gender-neutral accessible facilities – and those that are available for use by people living on the streets 6. Advocate at sector level for the collection of disaggregated data and monitoring disaggregated indicators 7. In relation to the provision of external subsidy to the most disadvantaged, strategic considerations should include: a. The process to identify the most disadvantaged who need support [Category C as per the recommendations in this report] will be critical and who from communities, and how they will be involved, in such a process? b. How much subsidy should be provided and in what form? c. What is the goal – for potentially disadvantaged people to have a latrine that will be as sustainable as possible – considering risks of slippage with the simplest latrines?	1. Don't make assumptions about the terminology that should be used to refer to disadvantaged groups 2. Don't assume that others in the sector are conversant and confident on issues related to EQND – specialist EQND organizations may need assistance to understand CLTS processes and WASH; and people with some experience on elements of EQND may not be confident in all areas, or how to translate what they know into practice

d. How to communicate the limitations in external support / subsidy to the general population in a way that does not lead to people stopping pro-active action on building their own latrine with the hope / expectation of subsidy themselves e. When it should be applied – upfront at the beginning of the CLTS process; nearer the end of the CLTS process; after construction: Each of these have implications for the disadvantaged f. How it will be applied (i.e. in ways that are transparent and accountable) g. What can be scaled up in the long term given that governments and donors have limited resources available to achieve behavior change and to ensure sustained use of sanitation facilities?	

XI.2 Do's and Don'ts – Organizational and MEL

Table 8 - Do's and Don'ts – Organizational and MEL

Do's	Don'ts
<u>Policies, strategies and guidance:</u> 1. Prepare a EQND related policy and a Code of Conduct which provide staff and partners with guidance on what is expected, minimum standards and behaviours that are required when working on the programme 2. Develop an EQND strategy / framework to guide actions and against which actions and outcomes can be monitored <u>Proposals and MEL:</u> 3. Include EQND in proposals, budgets and regular reporting as standard components 4. Undertake learning on EQND, facilitate regular discussion with partners and communities and feedback into programme strategies 5. Integrate EQND into baseline data collection, outcome surveys, sustainability studies and topic specific studies 6. Ensure that EQND is incorporated into monitoring forms and reporting – and that: a) It is a compulsory element of reporting; and b) Requirements for data collection and reporting are realistic and practical to collect and analyse and the data will be used <u>Staff, partners and capacity building:</u> 7. Recruit an EQND specialist to support the integration of EQND into the programme processes and learning 8. When assessing options for Implementing Partners – analyse their commitment to EQND and basic knowledge on the same – which can be built upon as part of the programme processes 9. Establish links and collaborate with organizations supporting or representing disadvantaged groups 10. Consider the possibility of operational modality where the CLTS facilitators come from the community to be triggered itself and are paid[7] – enabling more time to spend on the programme and working alongside NLs, community leaders and groups 11. Integrate EQND training into all CLTS orientation, training and performance management 12. Pay particular attention to the situation of marginalized groups in the trainings (people who might be overlooked or not acknowledged by staff and partners) to ensure their inclusion and that their rights and dignity are respected	1. Don't assume that members of the PCM and senior staff are confident or knowledgeable in EQND – they may also need capacity and confidence building 2. Don't develop monitoring indicators and requirements that are impractical to collect, analyse and use

[7] This is a recommendation from the consultancy team based on the modality currently used by the Nepal programme – however, it is not a modality that has been agreed by the GSF team at the WSSCC Secretariat for a recommendation for use across all country programmes and would need more discussion if a recommendation would be made.

13. At organizational level – provide capacity building on EQND in CLTS for the PCM, CPM, EA, IPs and associated partners <u>Strengthening guidance:</u> 14. Develop practical guidance on EQND in the programme 15. Develop activity checklist tools for – pre-triggering; triggering; and post-triggering stages that remind facilitators to consider the needs of the disadvantaged	

XI.3 Do's and Don'ts – Programme / community level

The 'Applicable to all stages – including 'Do no Harm' section provides general guidance for consideration across all stages. At the end of the tables against the CLTS programme cycle (triggering, pre-triggering and post-triggering follow-up); there is also an additional complementary table which identifies Do's and Don'ts by stakeholder group which should be read in conjunction with the tables by stage of the CLTS process.

Table 9 - Applicable to all stages – including 'Do no Harm'

Do's	Don'ts
1. Collaborate with other local organizations working on EQND e.g. those working on disability, with older people or children. 2. Consider the identification of vulnerability and disadvantage as a process rather than a one-off activity – be aware that sometimes personal biases can lead to inclusions / exclusions – use every contact with the community to consider if some people might be excluded, in what way and what can be done about it 3. Consider ways to include everyone in the process e.g. problem solving, monitoring, as a natural leader or committee member etc. as well as the process leading to the outcome of having and using a toilet 4. Consider the barriers to participation for different individuals and groups (due to cultural norms, prejudices, accessibility, extreme poverty) 5. Respect all members of the community and ensure their dignity, even if you don't agree with a person's lifestyle 6. Use respectful language related to people who may be disadvantaged – consulting with them on the terms they would prefer. Establish acceptable terms in all local languages and provide to facilitators as a starting point. Some words may not translate easily between languages so may need consultation with various people to establish respectful terms 7. Consider different people's perception of privacy and what they think can be done to improve this (such as ensuring 'doors' and 'walls' provide adequate privacy, etc.)	1. Don't assume that community led total sanitation automatically meets the needs of all the community 2. Don't assume that the community will have all of the information necessary – they may feel it is 'normal' some people are not included 3. Don't use stigmatising language 4. Don't assume people who are seen as vulnerable cannot find some way to contribute to the programme or towards building their own latrine 5. Don't ignore indigenous knowledge 6. Don't forget – that people are diverse and do not use stereotypes 7. Don't consider vulnerability as an obstacle – people you might consider vulnerable or disadvantaged might be very resourceful and able 8. Don't interrupt disadvantaged people as they speak – listen carefully to what they have to say 9. Don't prescribe solutions but facilitate discussion and debate about the issues of EQND highlighting harmful or practices that might exclude people 10. Do not assume that sharing a toilet with another family or extended family members (even when living in the same compound) provides adequate privacy and dignity for all family members

8. Advocate with other local sanitation stakeholders for the incorporation of EQND at different stages of all sanitation interventions (including masons, sanitation marketing, loan giving bodies etc.)	11. Don't assume that people will know options for making toilets more accessible for people with disabilities or mobility limitations 12. Never use threats of or actual physical violence to coerce people and help to dissuade others (community leaders, co-facilitators etc.) from using such tactics.
Refer also to the table on Do's and Don'ts by stakeholder group below – which provides complementary information.	

Table 10 - Do's and Don'ts – Pre-triggering

Do's	Don'ts
<u>Identification of partners for the process:</u> 1. Identify support organizations which are based at programme and community level that would be positive to engage in the process e.g. disabled people's organizations, CBO's etc. <u>Identification of people who might be disadvantaged – at pre-triggering stage</u> [noting that more detailed identification will be undertaken after the mass triggering session]: 2. When setting up the planning meeting with the community leaders (Chiefs, WASH Committees, Citizen's Forums, health or teaching staff, youth or women's groups leaders, political leaders etc.), suggest that people representing the different groups in the community should take part in the planning meeting as well as community leaders from various community institutions (including representatives of people with disabilities, older people, male and female youth, minority groups etc). 3. Undertake a preliminary identification with the community leadership and representatives of who might be disadvantaged and struggle to participate in the process or would be less likely to attend the triggering session (for example older people, people with disabilities) – also using your own knowledge about who might be vulnerable and including other expertise where possible e.g. disability or mental health organizations or groups 4. Involve youth leaders in the pre-planning and encourage them to invite all youth, including those who may have difficult behaviours (such as taking drugs or alcohol) 5. Try to understand some of the culture of the community and the different groups within it, particularly any issues that might affect people's engagement in the process, or their willingness to stop OD 6. Identify any people who may not be able to attend the triggering session even with support (such as someone who is bed bound, who are at boarding school or travelling for work) and agree on follow-up activities to ensure that the information from the triggering sessions reach them 7. See **Table 13** – for working with people with mental health conditions <u>Inviting people who may be disadvantaged to the triggering sessions:</u> 8. Encourage and enable those who may be excluded to come to the triggering session: older people, people with disabilities, working men, school children. Where the triggering coincides with school time, the triggering for children may need to be done separately. 9. Ensure people who may be disadvantaged have access to information about the triggering by visiting them at home / encouraging community leaders to visit them at home	1. Do not cut short the pre-triggering meetings – this is a vital stage of the process which should include the identification of support organizations e.g. disabled people's organizations, CBO's etc. 2. Don't assume that people who are invited will all have the confidence to come to the triggering – they may need encouragement and confidence building to feel they can participate

<u>Make the triggering event accessible and easy to handle</u>: 13. Divide large communities into smaller sections and conduct multiple triggering – if possible at the same time/ on the same day 10. Consider the timing of triggering and accessibility (transport, guides, seating etc.) including for remote communities – provide support for transport for those who may not be able to attend on their own (for example people with mobility challenges; people who are blind) 14. Make sure that the triggering event(s) are held in locations that are easily accessible for people within the community, including those who may have mobility problems, and held at a time that people can return home safely at the end (i.e. before it gets dark)	
Refer also to the table on Do's and Don'ts by stakeholder group below – which provides complementary information.	

Table 11 - Do's and Don'ts – Triggering

Do's	Don'ts
<u>Facilitating engagement of people who might be disadvantaged:</u> 1. Ensure that people who might be disadvantaged (vulnerable or marginalized) participate in the triggering exercise (older people, people with disabilities, the poorest, minority groups) and encourage people who are potentially disadvantaged to come to the front of the session to facilitate their participation, but don't force them to if they feel uncomfortable doing this 2. Use the skills of the facilitators to encourage the community to listen to the views of all groups including people who might be considered vulnerable or marginalized – gently encouraging people who might not normally speak out to do so if they would like – try to encouragement from the rest of the community if potentially disadvantaged people voice their views, which aims to build pride and recognise their value 3. If there are people who speak different languages to the majority make sure that there are people present in the triggering who can translate as the process is on-going (for example sometimes older people may only speak their traditional language and not the national language, particularly older women) 4. If there are people who use sign language or other means of communication, make sure that you also have a facilitator who is qualified in sign language to assist, or if this is not possible, make sure that someone in the community who can communicate with that person is available to communicate with them during the process (such as through writing) <u>Considering people who may be disadvantaged and need support:</u> 5. Discuss in the triggering meeting the criteria for who might be considered disadvantaged (vulnerable or marginalized) and who might struggle to build, access and maintain a latrine – and what types of support they may require [for more detailed identification of individual households against this criteria after the triggering] 6. In particular facilitate a discussion on the possible challenges for people with mobility limitations and ideas for solutions and encourage the involvement of adolescent girls in design of household and institutional and public latrines for privacy and safety 7. Encourage the community to identify who can support those who are less able – either people within the community or those working elsewhere – either financially or in-kind (through provision of labour, transport or materials) 8. See **Table 13** – for working with people with mental health conditions <u>Identification of Natural Leaders and development of the community action plan:</u> 9. Pro-actively consider who might be a Natural Leader from people who might be considered disadvantaged	1. Do not automatically exclude women or men as 'natural leaders' or members of a WASH Committee because they have a disability, health condition or are normally excluded 2. Do not assume that it is good practice to highlight those who may be disadvantaged on public community maps as this may further stigmatise individuals 3. Don't force someone to speak who does not feel comfortable to do so 4. Don't support stigmatisation of people including in particular those from minority or excluded groups – the focus should be on the practice of defecating

10. Ensure that community action plan includes suggestions from those who might be disadvantaged and considers their specific needs	in the open as being an inappropriate practice, not putting down or shaming individuals as people
Refer also to the table on Do's and Don'ts by stakeholder group below – which provides complementary information.	

Table 12 - Do's and Don'ts – Post-triggering – follow- up

Do's	Don'ts
1. Use a follow up checklist to ensure that all areas of EQND have been covered <u>Identification of people who may be disadvantaged and need support:</u> 2. Support the community leadership, Natural Leaders and representatives to identify people in the household register – who may be disadvantaged and may need support – use the A, B, C categories to identify a) who should be able to build, access and maintain themselves, b) who has family who can help them or funds to pay someone to build, or c) who has none of these and hence likely to need support from outside of the family/ household 3. Use a household register to identify by household – by age, gender and a number of factors affecting disadvantaged (including the A, B, C categories) – and use this to update the situation during follow up visits – see further guidance in **Section 9.3** and **Annex XIII** 4. Make sure that there is a staged process for identification of who might need support – for example having a checking process by a body such as a Citizen's Forum, community Elders, health professionals or other trusted groups 5. Where possible, enable people who might be considered disadvantaged and need support to put forward their own name if they feel they have been missed but need support [having clear criteria would be useful to have clear arguments as to why someone should or should not be supported] 6. Encourage the community to consider on-going maintenance issues for those who may have problems to rebuild or repair their latrines. 7. See **Table 13** – for working with people with mental health conditions <u>Follow-up:</u> 8. Prioritise visiting people who might be disadvantaged during the follow up – check how they are getting on and whether they need additional support 9. Keep triggering / reminding the community leadership to remember the people who might be disadvantaged and of the need of support 10. Speak directly with people who might be disadvantaged and ask their opinions wherever possible, rather than only speaking with their carer	1. Don't rely solely on government systems for the identification of the people who may be disadvantaged and need support – use them where possible but also involve community representatives to check and consider if anyone has been missed out 2. Don't focus only on the provision of a latrine but enable those who are excluded also to participate in other aspects of the programme 3. Do not promote a one size fits all latrine design (e.g. when training masons) but ensure that consultation and discussion with users can influence designs 4. Don't isolate / set apart people who might be disadvantaged during community activities – although some people may appreciate to have separate support groups such as women or people with disabilities

11. Be vigilant for potential new 'Natural Leaders' who can support the process – particularly from groups that are often excluded – and encourage the community to incorporate them as official Natural Leaders during the on-going processes 12. Agree on 'small doable immediate actions' (SIDAs) that can be done in support of people who are disadvantaged including to make their facilities more user friendly 13. Plan more substantial support where gaps have been established / people have been identified to have 'fallen through the net' – such as support to build a latrine in its entirety or on-going support for access to hand-washing water, soap or ash (where applicable) <u>Training for community leaders, groups, masons, shop-keepers:</u> 14. Include considerations related to disadvantage (vulnerability and marginalized groups) in discussions and training with different community groups and encourage the community to identify practical actions to promote EQND – whenever possible, potentially disadvantaged groups (especially people with disabilities and older people) should be involved in the process for designing actions and options (remember: *"Nothing about us, without us!"*) 15. Encourage the community to consider what advice or support should be given to people who are unable to reach a latrine or are incontinent 16. Include EQND in the training for masons – including how to engage with people who might be disadvantaged and options for improving accessibility at differing levels of cost 17. Consider if there is a need to encourage shop keepers to stock particular products that may assist people who may be disadvantaged or have particular needs (for example with commode chairs; bed pans; re-usable sanitary pads, etc.). <u>Consider the needs, options for support and technical options:</u> 18. Foster community awareness on the existence of people who may be struggling to build, access or maintain a latrine – and encourage community support 19. Actively identify a) emerging adaptations to latrines that can increase accessibility, and b) emerging community engineers/masons that can help adapt latrines for disadvantaged people within, and beyond, their community 20. Consider how the most vulnerable can be supported to climb the sanitation ladder, such as through e.g.: a. The use of solidarity / savings funds b. Low cost loans or subsidised materials c. Income generation activities such as soap making	5. Don't assume people are aware of the adaptations that can be used for making latrines more user-friendly and accessible, particularly for people who have a disability or mobility limitations 6. Don't prescribe latrine models – but sharing ideas for options can be helpful, particularly for modifications that can be helpful to make a latrine more accessible 7. Don't humiliate the children of disadvantaged persons who have not yet been able to build a latrine (for example congratulating other less disadvantaged children on what their parents have been able to achieve in front of them) 8. Don't impose fines on a family who is very vulnerable and has not been able to construct a latrine due to poverty or lack of support to construct one 9. Don't rush the follow up – particularly when visiting people who might be disadvantaged – make time

21. Use sanitation clinics and learning visits to other communities to consider design options and cost implications <u>Sanctions:</u> 22. If sanctions are seen to be necessary consider those that have the least harmful effects e.g. confiscate property temporarily rather than fining those who do not have enough money for food – facilitate community leaders/members to understand the consequences of punitive measures – and wherever possible instead promote positive options such as providing support for behaviour change and sanitation access 23. Wherever possible limit the use of methods that cause shame and embarrassment, such as blowing whistles, putting notices up with lists of people who are still practicing OD	to listen to what they have to say
Refer also to the table on Do's and Don'ts by stakeholder group below – which provides complementary information.	

The following table complements the tables by stage of the CLTS process above and provides additional information on the Do's and Don'ts by stakeholder group. As people with mental health conditions are a particularly vulnerable group, with whom there is limited global experience, recommended Do's and Don'ts have also been elaborated by stage of the CLS process.

Table 13 - Do's and Don'ts – by stakeholder group

	Do's	Don'ts
People with mental health conditions[8]	<u>Enabling environment and organizational:</u> 1. Invite organizations with skills and experience in mental health to support your programme to develop appropriate strategies to respond and how to integrate this good practice into the CLTS training. 2. Provide EQND training or workshops for all facilitators that can trigger participants to confront their own stigmas/assumptions (on mental health/others) 3. Share the learning on mental health and CLTS with other CLTS actors – as this may be a gap in their knowledge.	<u>Enabling environment and organizational:</u> 1. Don't assume that other sector actors or even people with specialism's in disability may be aware of how to work with people with mental health conditions on sanitation programmes
	<u>Pre-triggering:</u> 1. Investigate the nature of marginalization/stigmatization of people with mental health conditions embedded in the community, and if there are any potential negative implications if they attend community functions. 2. Promote the community's role in respecting and protecting the rights and needs of people with mental health conditions – facilitate leadership and the community to see such people as equal members of the community who have rights and a contribution to make to the sanitation programme. Identify and involve organizations or individuals who are skilled/have experience in building a rapport with people with mental health issues. 3. Identify and assess engrained stigmas against vulnerable groups which can potentially put them at risk. 4. Find out how the person's condition impacts on their ability to understand and use a toilet and wash hands.	<u>Pre-triggering:</u> 1. Do not assume that people with mental health conditions are all the same but treat people as individuals and find out as much as possible about how the person's condition impacts on their ability to understand and use a toilet and wash hands.

[8] Cavill et al (2017, publication pending)

People with mental health conditions[9]	<u>Triggering:</u> 1. Facilitators should trigger a positive, supportive community response for including people with mental health conditions – help communities to confront their own stigmas (e.g. via Natural Leaders, sanitation committees), and to trigger a self-realization that it is shameful to leave anyone behind. 2. Work with family members or carers (could be adults or older children) to: a) trigger the person as they often will know how best to convince their relative; b) identify needs and gaps; c) include person in programme; and d) address specific problems and encourage the use of a toilet as a positive thing. 3. Use drawing as an opportunity to explain the good practices. The use of pictures may also be particularly useful for people who find it difficult to communicate in language or to have eye contact with other people, such as people with autism – for example the person or the carer pointing to, or drawing, a picture of a toilet, or a tap with soap to indicate the need to use these items. 4. Encourage people with mental health conditions to become Natural Leaders (could also be effective to change behaviour amongst their peers) or encourage them to have as much self-confidence as possible in the design of their facilities. CLTS should be building pride and self-esteem as a key outcome.	<u>Triggering</u>: 1. Don't allow people with disabilities to be mocked when speaking in public. 2. Don't exclude people further from the process because they are not conforming. 3. Don't misinterpret motor/speech impairment as a mental illness.
	<u>Follow-up:</u> 1. Where there is resistance, identify incentives rather than punishments that might encourage change for that specific individual e.g. recognition, awards, responsibility, training, etc. For instance, consider suggesting Natural Leaders build a toilet specifically for that person, possibly adding features such as colour, plants or mirror etc., which might also build pride in having and using the toilet. 2. Identify when the person may be most receptive to discussions about sanitation e.g. periods of remission or times when they are more lucid/calmer etc. 3. Listen carefully to what each person has to say and their reasons for resistance. It may be they have specific beliefs about excreta disposal that prevent them from complying e.g. they may hear voices telling them not to use a latrine or they may be paranoid about washing their hands – ask them how to overcome the problem.	<u>Follow-up:</u> 1. Do not exclude people with mental health conditions from being Natural Leaders where they have the capacity to do this. They may have a lot to contribute and it may also help their self-esteem and confidence to grow. 2. Don't abuse anyone else's rights when trying to identify potential incentives to stop OD for a person with mental health conditions. Don't force anyone to leave their home (even if temporarily) to ensure there is no OD on the day of verification – they have a

[9] Cavill et al (2017, publication pending)

People with mental health conditions[10]	Sometimes other people with the same condition (for example schizophrenia) understand the experience of hearing voices and can use this knowledge to persuade the person that the voices are not always correct. 4. Encourage the family /carer to take responsibility for sanitation needs of person with mental health issues – if necessary to pick up faeces in the same way as they would a child's to dispose of it in a toilet, if there is no other way to stop the person practicing OD. 5. Be aware that some basic challenges may pose particular issues for people with mental health conditions – for example a lack of water for anal cleansing in a toilet may be particularly stressful for someone with some forms mental health conditions (such as developmental disabilities such as autism or intellectual disabilities such as Down's Syndrome). 6. Pay attention to mental health when monitoring and evaluating programmes. Regular programme monitoring needs to include mental health conditions as part of their tracking of vulnerable groups. This information may be difficult to collect for facilitators, or even for community members if there is extreme stigma. Including changes in mental health as an outcome of the process would be valuable for the overall evaluation of programmes where it feels possible. Make specific efforts to follow up with people who were identified to have mental health conditions to establish the outcome of the process.	right to feel secure in their home. Don't endorse community sanctions that include corporal punishment (beating or flogging) or, in extreme cases, exiling; instead, encourage the community to come up with a positive option. Don't exclude people further from the process because they are not conforming. 3. Don't forget that people with mental health conditions need particular care and protection – some may be at particular risk of physical and sexual abuse because they may not understand when someone does something inappropriate to them – staff, partners and others in the programme must know their safeguarding responsibilities and what are appropriate behaviours 4. Don't assume that there have been no problems faced by people with mental health conditions just because: a) ODF is assumed to mean everyone has access to and is using a latrine; b) you haven't heard about the problems. It is important to pro-actively ask, listen and learn.
The poorest	1. Use government identification systems where available and involve the community as much as possible in identifying if anyone has been excluded 2. Do remember that even if the poorest are physically able to construct a latrine they may devote much of their time to finding enough to survive and may not have adequate time to rebuild their toilet particularly if it collapses easily.	1. Do not assume that the government classification includes all those needing support with sanitation. Safety net lists typically include only a percentage of the poorest and may not include all who need support, for example to improve the accessibility of their latrine.

[10] Cavill et al (2017, publication pending)

	3. Do remember that it is often the poorest families and individuals who will be forced to share and it is important to find out the impact this has on them and how they can be supported to construct their own toilet.	
People with physical disabilities or mobility limitations	1. Identify local organizations and groups working on disability issues and involve them in identifying people with disabilities and how to best support them 2. Involve people with disabilities as natural leaders where possible 3. Enable people with disabilities to define their sanitation needs and suggest sanitation adaptations that might support these 4. Wherever possible identify local solutions for accessibility first and then ask permission for showing what the facilitator has learnt from elsewhere[11]. If accepted then ideas of useful low-cost adaptations e.g. local manual with pictures or demonstration toilets, could be utilized. 5. Provide transport, guides or hold triggering close to the home of person with a disability 6. Encourage people with disabilities to be Natural Leaders 7. Provide written information or use sign language (by someone qualified in sign language) for people who have difficulty hearing and who know how to write or use sign language – and / or involve the family or carer of someone who is unable to speak or hear to communicate	1. Do not assume that people with disabilities cannot make decisions for themselves and have great ideas – they are the experts on how their disability affects them 2. Do not assume that all the household will understand the sanitation difficulties faced by someone with a disability and listen to the views of both the person and their carer (if they have one)
Older people	1. Treat people as individuals with knowledge and experience 2. Find out what each individual can do for themselves and what they might need support with 3. Consider different adaptations that make use of toilets easier (see people with disabilities) 4. Encourage them to be part of the process and take on leadership roles (on WASH Committees, as NL's etc.)	1. Do not treat older people as if they are children 2. Do not assume they are deaf and raise your voice

[11] Refer to the decision-making tree for introducing appropriate technologies in the FUM manual for more information

	5. Speak clearly but without raising your voice	
Babies and children	1. Find out how mothers manage their babies' faeces and discuss opportunities to improve practices 2. Consider adaptations for young children: mini latrine with shallow pit, potties, nappies, smaller drop hole etc. 3. Consider holding additional separate triggering sessions with children – in school and out of school or training older children/youth to hold triggering sessions with younger children	1. Don't involve children in shaming, throwing stones or blowing whistles at people who are practicing OD
Gender	1. Consider the needs of both men and women and how both can be involved in the sanitation programme. It may be necessary to conduct separate triggering sessions / meetings at different times in communities where it is difficult for men and women to meet together and women to speak in front of men 2. Recognise the contribution that men and women of different ages can make to the programme 3. Consider latrine adaptations for pregnant women and families with child-bearing members (e.g. larger door, enough space, raised seat or grab bars etc.) 4. Remember that adolescent girls will have specific sanitation needs and may drop out of school if sanitation provision does not ensure privacy and user-friendly WASH facilities for managing their menstrual hygiene needs (availability of privacy, water, lock, disposal option) 5. Consider the needs of women who are breast feeding but would like to be active as Natural Leaders or community leaders – what could be done to support them?	1. Do not automatically assume that all women are vulnerable but recognise that women will have different needs to men and may not be allowed the same influence in decision making as men 2. Do not assume that it is always women who will not participate – sometimes men may be absent due to work or because they do not feel the issue is as relevant to themselves
Marginalized, minority or excluded groups	1. Ask the question 'does anyone here live apart or separately for any reason – and why?' (this may be because of their group status as minorities; different livelihood practices such as pastoralists; due to behavioural practices such as due to drinking alcohol or sex work; people who live on the streets; people living and working in low paid and dangerous environments, etc.) 2. Discuss how this person/persons can be included in the process	1. Don't assume that everyone will automatically be involved in the process – sometimes there will be people who do not engage so readily with the majority of the community either because they are from a minority group, have had previous negative

	3. Facilitate discussion with the person/persons on their sanitation and hygiene needs	experiences, or have been excluded for some reason
Sexual and gender minorities SGM)	1. Treat people from SGM with dignity and respect as with all members of the community and value their contributions 2. Respect people's right to confidentiality and understand the risk that people can be under to violence and discrimination if their status is known 3. Understand that people who are SGM can be highly discriminated against, may have limited access to education or employment and may live in cramped and difficult conditions 4. Consider the need for gender-neutral public toilet facilities as well as ones separated by male / female – a gender neutral facility that is also accessible can be accessed by someone with disabilities or mobility limitations, parents with small children, people who are SGM or any other member of the public 5. Build links with organizations with specialisations on SGM to gain their experience and knowledge about good practices and in urban areas in particular ask them to identify if there are any SGM communities who may be excluded from the programme processes – and ask them to be the link with this community to establish how much they feel able to engage and to reduce protection risks	1. Do not make assumptions about gender identity and sexual orientation 2. Don't try to identify who might be from a sexual and gender minority – as this can put them in danger of violence, harassment or discrimination 3. Don't highlight their SGM status without their consent
People living with HIV or other long-term illnesses	1. Discuss with the person and their carer to understand issues in relation to sanitation and hygiene 2. Consider if support could be provided by the community where needed for additional challenges (such as incontinence) 3. Be aware that people may often want to keep this issue confidential	1. Where possible don't use abbreviations such as PLWH/A or PLWH except where brevity is required (on graphs etc.) 2. Do not stigmatise person by marking on a community map
People with incontinence	1. Discuss with health professionals and the community the good practices to support people with incontinence (urinary or faecal) and options for referral to the health facility if someone has not already made this contact	1. Don't be embarrassed to talk about incontinence, but always do so in private – managing incontinence can be a big problem for people who suffer it and their

	2. Establish if there is any support that the community could provide to people or families with a person with incontinence (for example provision of a bed pan or mattress protection sheets; provision of additional sanitation or hygiene items; support for a commode chair to have next to the bed; provision of information on re-usable materials that can be purchased to soak up fluids/faeces) 3. Discuss with the person and their carer how they are managing and if there is any support needed	carers – so they may be very appreciative of any useful advice or support that can be provided

Annex XII - Recommendation – Categorisation of factors affecting disadvantage

The following table supports the overview **Fig 10** in **Section 9.3** in the main report with additional notes.

Disclaimer: The suggestions which follow are made by the consultants for discussion and decision by GSF as to what will be taken forward.

Table 14 - Categorisation of clusters and factors that affect the level of disadvantage[12]

Clusters of disadvantage – Modified for CLTS and GSF	Factors which affect level of disadvantage	Additional notes on groups who may be affected
1. Poverty and lack of physical or economic assets	• Small house or rent • Little or no land • Few or no livestock • Limited or no savings • All family members work including children unless they are too young, old or sick • Work is based on low paid daily labour • Majority of income comes from social security payments such as disability or senior citizens allowance • Difficulty to make a living adequate to support family	Difficulty to make a living adequate to support family may be particularly difficult for: • Widows • Older-headed households with no family to support • Orphans and child-headed households with no adults to support • Women-headed households • People living on the streets People working in risky or dangerous income generating activities, such as: • Sex workers • In brick factories • Living and working on refuse dumps
2. Physical or mental health related challenges	• Adults unable to work due to illness or disability (physical or mental health related) • Migration of active adults (leaving less physically able family members) • Adults unable physically construct a latrine • People needing accessibility features or with specific sanitation and hygiene needs	Example of people with additional sanitation and hygiene needs: • People with incontinence including fistula • Older people with mobility limitations or people with disabilities who are unable to use a toilet without inclusion of accessibility features • Pregnant and lactating women girls
3. Limited social capital and challenges from	• People affected by beliefs and practices • Limited skills and knowledge or problematic attitudes	Beliefs and practices which may affect vulnerability include: • Adolescent girls and women (restrictions on daily activities and practices when menstruating including exclusion from the household)

[12] Adapted from Chambers (1983)

beliefs, practices, skills, knowledge and attitudes	• Limited social resources: limited or no networks or connections	• Albinos (vulnerable to violence due to traditional beliefs) • Drug takers or alcohol abusers (behaviour related)
4. Geographical challenges and vulnerability to risks	• Community is remote and may lack access to markets or information • Difficult ground conditions such as high-water tables, rocky soils, sandy soils • Lack of access to natural resources such as timber through deforestation or arid / semi-arid conditions • People living in low-income high density informal settlements • Affected by conflicts or natural disasters such as earthquakes, flooding, landslides • Internally displaced or refugees • Household becomes poorer through having to deal with unforeseen circumstances such as crop failure, accident, sickness, funeral	Examples of informal settlements: • High density poor urban communities with limited services (squatters, people living in slums) • Settlements not formally recognised by government
5. Marginalization & powerlessness	• Weak negotiating position with those in control, ignorant of the law, difficult to obtain employment • Individual factors affecting power within household and society such as gender, age, disability • Marginalized or minority individual or group • People who need to be cared for or under the control of others	People may be marginalized or have less power due to / include: • Race, ethnicity, language, religion, political or other opinion • National or social origin including caste, birth, nationality • Migratory status – economic migrants, displaced persons, refugees • Sexual and gender minorities • Indigenous groups Examples of people being cared or under the control of others: • People living as slaves or in slave like conditions / bonded labour • People living in care – orphans; people with mental health conditions; older people; people in prisons

Annex XIII - Recommendations – Monitoring, evaluation and learning

Disclaimer: The suggestions which follow are made by the consultants for discussion and decision by GSF as to what will be taken forward.

Context of the recommendations for monitoring, evaluation and learning:

1. Whilst a range of factors affect whether a household is disadvantaged and whether this impacts on their ability to participate in the process, construct a latrine, access / use and maintain the latrine; it is clear that physical ability, **access to income and assets** and whether you **have support of family members** has a significant impact on whether you will need support of the community or external to the community to do so. For example, if you are a person with disabilities or an older person heading a household but have a business or a lot of savings you can construct a latrine that you can access and use. Hence, **we have made a distinction between A, B or C groups within the wider categories of 'potentially disadvantaged groups'**. See **Fig 10** in **Section 9** of the main report.
2. **Collecting data from all households is a time-consuming task** – one HSA in Malawi noted that for the areas she covers it takes her a **full week to get around all households** (she also collects other health related data). Hence it should only be recommended on an occasional basis and **if possible some form of support or motivation provided, particularly if the data is wanted for donor purposes.**
3. **Collating data from hand-written records to report upwards is also time-consuming**, but hand-written data is a method that can be managed, owned and used by the community. The team saw in one VDC in Nepal that they were in the process of transferring their data to a computer – but we were not able to see the data as the people we met did not have access. For the use of tablets or mobile phones:
    a. The equipment is expensive, needs replacing at intervals and requires a high level of on-going external support.
    b. The data goes external to the community and hence is analysed and controlled by people outside of the community – taking away ownership and making the data less available for analysis and use within the community.
4. For people with disabilities and mobility limitations:
    a. It is suggested to add on **'People with mobility limitations'** to the term people with disabilities as some older people may not consider they are disabled but still find it difficult to squat
    b. We are not recommending that detailed analysis of the kinds of disability is done (such as using the Washington protocol). Analysing types and degrees of disability is complex even for disability specialists and the information in not particularly relevant to the sanitation programme, except for making a judgement on who may have problems constructing, accessing (assumed to also mean using) or maintaining a latrine.
    c. For monitoring purposes, we are proposing to recommend that **people can self-declare if they have a disability of any kind or level of disability**.
    d. This does mean that the data on people with disabilities supported will include a wide range of types and capacities, including people who have minor impairments; but it will give a general picture and with a clarification of this fact will still be useful information.
    e. It is proposed that **all people with a disability are pro-actively followed up** to check that they have been able to construct, access and maintain a latrine and that they are aware of accessibility features that might be useful to them.

Table 15 - Recommendations on how EQND should be integrated into the different components of MEL

Component of MEL	Recommendations on how EQND should be included in MEL
Community led baseline – of household status	Suggested that the following standard format for baseline data collection by **both the community based actors and the external actors doing the formal baseline data study**, would be useful. This is because: o It would help those leading and following up the process at community level to identify who is likely to need to be supported and to make sure that support is facilitated and follow up particularly targets these groups. o It will also provide baseline data for the programme for the donor purposes against which the outcome data should be compared. o It could also potentially be used to update progress from community level reporting once yearly to enable community based review and also provide progress data to the programme – a once yearly an update on the disadvantaged groups indicator. **Other notes:** a. It is also suggested that once the baseline has been undertaken at household level by the community based actors and judgements made on who might be in the A, B or C categories, that: a. An agreed second party such as a Citizen's Forum or a CBO working in the community supporting particularly disadvantaged groups, or representatives of the Village Committee should undertake a check of the analysis b. If possible, people should be allowed to question the categorisation and suggest if they should be included or otherwise. Hence the importance of being clear on the criteria on which decisions are based. b. It is proposed that this data will be collected alongside the data on whether someone has a latrine and what type and the presence of a hand-washing facility, soap, cover etc. c. The assessment of possible income challenges – needs to be a judgement that is relatively simple – and does not involve a detailed wealth analysis – community members would tend to know who would come into this bracket but some suggestions for simple indicators are included below. **See below for a proposed household register – for use at community level, regular follow up and yearly updates**

Proposed household register for baseline, follow up and yearly update on progress – for adaptation to local context

Fig 1 - Proposed household register for baseline, follow-up and yearly update

Note 1								Note 2	Note 3	Note 4	Note 5	Note 6			Note 7
									Factors within households			Considered the 'disadvantaged households'			
<5		5-18		19-64		>65		Geographic challenges or affected by disaster or conflict	Person with disabilities or mobility problems in household	Household lives in extreme poverty and lacks physical and income generating assets	Household from marginalized group (or has high level of powerlessness)	Judgement on ability to construct, access and maintain a latrine			How many people > 5 years old in the household currently <u>do not always</u> use this household's latrine
F	M	F	M	F	M	F	M					Category A	Category B	Category C	

Notes:

- It is proposed that this data will be collected at baseline and on a yearly basis at community level in addition to the general data on whether they have a latrine, the type, whether they have a cover, hand-washing facility etc.
- It is suggested that there is no need to establish a detailed database that goes down to household level that is kept nationally and feeds in detail to the global level – but that:
    - This level of data should be required at community level – which is in alignment with the existing household registers / lists kept at community level and updated on an on-going basis
    - The IPs should follow up to make sure the registers are kept systematically
    - The IPs should take hard copies / electronic copies of each sheet for the record – every six months or year – for every active community or those where post-ODF follow up is being undertaken
    - A full household check should be done once a year and this data consolidated and fed up to GSF – noting that at the moment GSF is asking for data every quarter, but that it is not clear that this data is accurate from community level

Note 1 – Members of the household by age and gender:

- Suggest that this data is only needed for the:
    - Community and external baselines
    - Yearly updates from community level for donor reporting purposes
- It doesn't tell you much about who is particularly disadvantaged or needs support, although it can indicate when there is no adult male in the family and when there are older people in the family.

Note 2 – Geographic challenges or affected by disaster or conflict:

- It may be that in some communities every household will be indicated as affected by one of the following challenges or risks
- This category would be particularly useful if GSF decides to provide some form of subsidy or associated support to people living in challenging contexts
- Could use a series of codes to indicate which type:
    i. Sandy soils
    ii. High groundwater table
    iii. Rocky soils
    iv. Disaster affected area – earthquake
    v. Disaster affected area – flooding
    vi. Conflict affected area
    vii. Displaced populations
    viii. Very remote
    ix. High density low income urban area
    x. Extreme cold climates

Note 3 – Person with a disability or mobility challenges in the household:

- People should be asked if anyone in the household has a disability – no judgement will be made on the degree or type of their disability, except in relation to the judgement as to whether the household will have a problem constructing and maintaining a latrine that is accessible and easy to use for the household member with disabilities
- Useful to identify for baseline and proactively follow up and involve in the outcome surveys
- Not all of these households will be disadvantaged and need support
- Make sure that both people with physical disabilities, mobility issues and also mental health conditions are included
- Particularly useful for follow up to ensure that the people with disabilities or who have mobility challenges know of the options for making toilets and bathing facilities accessible

Note 4 – Household lives in extreme poverty and lacks physical and income generating assets:

- It is not proposed that a detailed wealth ranking is undertaken – or that all of the following questions need to be asked in each household – but that the person assessing should be from the community and hence will already have some knowledge on the situation of the household, but can also ask some targeted questions which will indicate their situation

- This category may be indicated by:
    i. Small house or rents house
    ii. Little or no land
    iii. Few or no livestock
    iv. Limited or no savings
    v. All family members work including children unless they are too young, old or sick
    vi. Work is based on low paid daily labour
    vii. Majority of income from social security (disability or senior citizens allowance)
    viii. Difficulty to make a living adequate to support family
- The programme may also like to add local indicators that they feel reflect this issue such as:
    i. No TV, no mobile phone
    ii. Or other – known in the particular context

Note 5 – Household from marginalized group (Or has high level of powerlessness):

- This may include groups traditionally marginalized such as Dalits or ethnic minorities in India or Nepal
- Or people from other minority groups known to face some forms of exclusion, marginalization, or high level of discrimination; or more likely to have limited literacy etc.
- It may also include people living in slave like conditions / bonded labour or people living in care
- In some communities, this column may remain blank

Note 6 – A, B, C category of household based on ability to construct, access and maintain a latrine:

- The households that are indicated as Yes in any of these three columns – are considered the 'potentially disadvantaged households' for the purpose of this exercise
- The Category C households are those that are most vulnerable and particular effort will be made in facilitating support for them and following up to check everything is going OK
- The Category B households should be OK on their own but should still be pro-actively followed up in case they are facing any unexpected problems such as family members refusing to support them
- These categories of households should be indicated for any household where a 'Yes' answer has been given in one or more of the three *'Factors within households'* categories:
    - A = Should be able to construct latrine themselves
    - B = May face challenges to construct a latrine themselves, but they can afford to pay someone or have family members who can assist
    - C = Probably not able to construct latrine themselves; no money to pay others to construct; no family members to assist; likely to have to sell limited assets to construct latrine

Note 7 – How many people in the household over 5 years old currently do not always use this household's latrine?

- This question may or may not work
- The intention is to try and investigate if any of the household members are not using the latrine – so that this can be followed up.

- It related to people over 5 years old only as the inclusion of young children would make it less useful (as most h/h may have small children not using the latrine)
- Reasons for adults not using the latrine might be:
    - They have a preference for open defecation
    - Family members frightened to use it at night
    - It is full or smelly or damaged
    - Someone in the household is not mobile enough to use it or cannot squat easily
    - Cultural factors preventing one or more family members sharing the latrine with others
    - Other
- However how easy it will be to get an honest answer for this, particularly if a community has been declared ODF would need further learning

Reporting on community based <u>processes</u>	o It would also be useful to include analysis of the **participation of people who might be considered disadvantaged** in the key community based activities and structures, as well **as participation by gender and age**, for example: o In the triggering event o As members of committees such as a WASH Committee o As Natural Leaders o Village leaders and key personnel (such as teachers, health workers, traditional birth attendants etc.) involved in the campaign o How this data **on programme processes** would be used would have to be further discussed within the GSF-supported programme – perhaps: o Analysed by IP or NL team and fed up to national level for review and discussion on a six monthly or yearly basis? o Not sure how this information would be required by GSF at the WSSCC Secretariat, and at what interval and in what format?
Community led on-going monitoring	o Community led ongoing follow up and monitoring may be ad hoc, focussing on different areas of the programme at a time and depending on the time those undertaking the follow up have to undertake the work. o It would help if standardised forms are utilized. o It might also help if some form of coding is developed in each community to use as reference for households (although this may over-complicate). o A specific summary list could be developed from the community based baseline analysis focussing on the A, B and C households (or just the B and C households) for more regular follow up and to check support is being given where needed. o A once yearly full follow up at community level to monitor and provide progress updates on the progress of all, but particularly the A, B and C groups – should be funded by the programme – to enable adequate time for the NLs, extension workers, or CLTS triggerers etc. to spend on this task.
Baseline study – external supported	o This should cover the same categories as the community level baseline data collection noted above. o But in addition, could establish wealth quintiles.

	o If possible, it would also be useful to establish key assets such as amount of land or house ownership to establish the number of people in the communities who have limited assets. o It should work out statistics and disaggregate by gender, age, disability, marginalized groups and wealth quintiles. o Presuming that the external baseline study does not cover all households in the area? o If it did cover all households in the area then it could also use coding to identify the households which could then be used for comparison with the outcome survey – however this would require a huge database which may be outside the scope of GSF

Outcome survey – externally supported	As above for the baseline study.
	
	<u>But in addition it should:</u>
	o Visit all of the:
	  o B and C category households
	  o And all households with a person with a disability (including physical and mental health conditions) or mobility limitations.
	o Disaggregate answers where possible by:
	  o Whether a respondent is from an A, B, C or other category household
	  o By gender and age of respondent
	  o By whether they have a disability or otherwise
	  o By whether they are from a particularly marginalized group
	
	o Find out:
	  a. How well they have been able to participate in the process:
	  <u>Involvement in triggering:</u>
	  i. Do you recall that your community made a plan to *construct toilets/stop eating shit/become ODF* (select most relevant depending on country programme)?
	  ii. Were you present at the event where this was decided?
	  iii. Did you feel you could give inputs at this event?
	  iv. If you did not attend not why not?
	  v. If you did not go, did you hear about what was discussed?
	  vi. Did anyone come and visit you in your home and discuss directly with you about using a toilet?
	  <u>Decision-making:</u>
	  vii. Did you feel you were included in the community decision to become ODF?

viii. Were you involved in the decision what kind of toilet your household would build?

ix. Were you involved in the decision where the toilet should be located?

<u>Leadership:</u>

x. Were you selected to be a Natural Leader?

xi. Were you selected to be on the WASH Committee?

xii. Were you involved in persuading others to stop OD?

1. If so who?

<u>Awareness of support available:</u>

xiii. Do you know if anyone in your community was supported by people outside of their family to build a latrine?

1. Who?

xiv. Do you know if there were any solidarity funds in your community for supporting people to construct latrines and how it works?

b. **How satisfied are you with the process and results** (presuming some form of scale could be used for these answers)?

i. Is there anyone in the household who cannot use the toilet day and night?

1. If so who?

ii. Do you use the latrine every time you need to go to the toilet (day and night) and you are near or in the house?

1. If not – why not?
2. If not, where do you go?
    a. Share with another family
    b. Use a bucket and someone empties it into the latrine
    c. Go on the floor and someone picks it up and puts it into the latrine
    d. Open defecation on the ground and leave it there?
    e. Dig and bury
    f. Other

iii. Can you use the latrine on your own without help?

1. If not, how do you use it?

iv. Do you feel safe when using the toilet?

v. How safe did you feel when defecating before you built the toilet?

vi. Are you happy with the level of privacy when using the toilet?

1. For women – how easy is it to manage your menstrual period when using the toilet?

vii. Are you happy with the cleanliness of the toilet?

viii. Is the toilet easy and comfortable for you to use?

1. If not why not?

c. How they managed to build a latrine:

i. By themselves

ii. They paid someone to do it

iii. A family member helped them

d. If they were provided with assistance:

i. Was it in the form of:

1. Labour
2. Materials
3. Transport of materials
4. Finance

ii. If they were assisted who helped them?

1. Family
2. Government
3. Neighbours
4. Others

e. The quality of the latrine (affects likelihood of slippage):

i. Is the sub-structure lined?

ii. Does it have a permanent slab?

iii. Etc.

f. If they paid for the latrine to be constructed or for the materials:

i. How did they do that?

1. Use savings
2. Sell assets:
    a. if so what?
3. Take out a loan

ii. If they had a loan:

1. How much was it?
2. Have they paid it back?
    a. If not did they lose their surety?
        i. If so what did they lose?

iii. What have been the impacts of paying for the latrine?

1. Positive?
2. Negative / problems?

g. If the person has a mobility limitation:

i. Has the latrine any adaptations to assist the user?

ii. Is the person actually using the latrine?

iii. Would the user have liked to have had some adaptations?

1. If so what?

	h. **If there is a person in the family with a mental health condition** – ask to speak to the person who has the condition if it is possible or their carer if not: i. How did they or their family manage to build a latrine? ii. Do they like the latrine? iii. Are they able to use the latrine? iv. What are the challenges that have been faced? v. How were they overcome?
Targeted learning exercises for groups B and C	o In addition, the programme could also undertake occasional targeted learning exercises for limited numbers of people in Category B and C as the programme progresses – this information can then be fed back into the process and into the training of new CLTS facilitators, Natural Leaders and others. o Learning exercises could focus on a number of the questions identified above for the outcome surveys above – to try and identify as the programme progresses any gaps or problems – it will be important to disaggregate the learning as noted above o Suggest that some **funding could be provided / incentives to enable leaders at community level to have the time** to engage in this process?
GSF global / quarterly data collection	**Core quantitative indicators reported to global level:** o The current core quantitative indicators are positive but suggesting some modifications and also additional indicators: o *percent of 'households with disadvantaged individuals' changing from open to fixed-place defecation* o *percent of 'households with disadvantaged individuals' changing from open or fixed-place defecation to use of improved sanitation facilities* o But: a. You could consider a focus on '*households with disadvantaged individuals*' rather than individuals – as whether someone is disadvantaged in a way that will affect their ability to construct and maintain a latrine will often depend on the income level and assets of the family / the household. In this case households falling into categories – A, B and C – would be a useful way to establish which households are considered disadvantaged (separated would be useful to know – otherwise combined). b. If focussing on disadvantaged individuals it might be best to focus on *"people with disabilities (physical and mental health conditions) and those with mobility limitations"* (as a single description) which would also potentially include older people but who may not consider themselves having disabilities. But then it's better to focus on ability to use the facility rather than the household having one, as just having a facility does not mean it is usable to someone with a disability or mobility limitations. c. It would also be useful to separate: ▪ Disadvantaged households within communities ▪ Households living in disadvantaged geographical areas or affected by disasters – this may often be between communities – so you could add a separate indicator *"percent disadvantaged people living in challenging*

	geographical or disaster or conflict affected contexts" (or "households living in challenging areas") ▪ Although there will also be some overlap d. Suggest that the community level updates on the disadvantaged indicators could be reported once a year (or every six months) but that the process of data collection for updates by communities themselves should be in some way financed or they should be incentivised as this is a time-consuming task and the data is required for donor purposes e. For disaggregation by gender and age – maybe just include it as a total of people (by gender and age) who live in a house which have stopped OD / with an improved latrine: ▪ Baseline ▪ Annual updates ▪ Outcome **Qualitative indicators:** As it is expected that at a global level, the qualitative learning will mostly be established from the use of the baseline and outcome surveys, it is assumed that GSF can adapt the questions identified above for the baseline and outcome surveys to develop appropriate qualitative indicators, where they are needed. However, examples have been included in the table that follows.

The following table provides an overview of some of the key data that it would be useful to collect, example indicators and suggestions for when and where to use them.

Table 16 - Key data and example indicators related to disadvantage against MEL activity where they may be most usefully used

				1	2	3	4	5	6
	Possible indicators	**Disaggregate by[13]**		**Reporting on community based processes**	**Community register and community-led on-going monitoring**	**Baseline study – externally supported**	**Outcome survey – externally supported**	**Targeted learning exercises for groups B and C**	**GSF global / regular data collection (quarterly)**
		Gender	**Age**						
	Core community data								
1	Number of individuals and households living in challenging areas due to geography or vulnerable to disaster or conflict *(general assessment by the community; agreed by IP)*	X	X		X	X	X		
2	People with disabilities and mobility limitations *(self-reported to the community)*	X	X		X	X	X		
3	Households living in extreme poverty and lacking income, assets and income generating potential *(general assessment by the community)*	Head of household	Head of household		X	X	X		
4	Households from marginalized groups (or has high level of powerlessness) *(general assessment by the community)*				X	X	X		
5	Number of disadvantaged individuals in the community – categorised by A, B, C *(general assessment by the community)*	X	X		X	X	X		
6	Number of public, institutional and workplaces (which require toilets)								
	Outcome indicators								
1	Percent of households with disadvantaged individuals changing from open to fixed-place defecation				X	X	X		X

[13] It will be challenging for the community to produce consolidated disaggregated data from hand-written records even if they have columns indicating the household composition. However, disaggregation has been included here as the information would be useful wherever it may be possible and should be integrate into the more detailed baseline and outcome surveys.

				1	2	3	4	5	6
	Possible indicators	**Disaggregate by[13]**		**Reporting on community based processes**	**Community register and community-led on-going monitoring**	**Baseline study – externally supported**	**Outcome survey – externally supported**	**Targeted learning exercises for groups B and C**	**GSF global / regular data collection (quarterly)**
		Gender	**Age**						
2	Percent of households with disadvantaged individuals changing from open or fixed-place defecation to use of improved sanitation facilities				X	X	X		X
3	Disadvantaged individuals report feeling satisfied that their sanitation needs are being met, they have adequate privacy / or their situation has improved	X	X			X	X	X	
4	People with disabilities or mobility limitations report their sanitation facility is accessible People with disabilities or mobility limitations report that they can go to the toilet and perform hygiene tasks with dignity	X	X			X	X	X	
5	Women and girls' feel that their menstrual hygiene management needs are being met effectively		X			X	X	X	
6	Adolescent girls are happy with the level of privacy and feel safe using the latrine both day and night					X	X	X	
7	The excreta disposal needs of babies and young children are being met effectively					X	X	X	
	Process related indicators								
1	Disadvantaged individuals feel that they have been able to participate in the CLTS process (or particularly the mass triggering event)	X	X	X	X		X	X	
2	Disadvantaged individuals feel that leadership positions in the programme (on WASH Committees, as Natural Leaders etc.) have been open to them	X	X	X			X	X	

				1	2	3	4	5	6
	Possible indicators	**Disaggregate by[13]**		**Reporting on community based processes**	**Community register and community-led on-going monitoring**	**Baseline study – externally supported**	**Outcome survey – externally supported**	**Targeted learning exercises for groups B and C**	**GSF global / regular data collection (quarterly)**
		Gender	**Age**						
3	Both women and men are actively involved in the programme and have the opportunity to take on leadership positions	X	X	X			X	X	
4	People with disabilities and mobility limitations (and / or their carers) have been involved in designing solutions for their sanitation and hygiene needs	X	X	X			X	X	
5	Number of disadvantaged individuals (or families) who have been supported to build or maintain a latrine or hygiene related facility by: a) Their (extended) family b) Community volunteers c) Other (specify)	X	X	X			X	X	
6	Type of support that was provided to individuals who may be disadvantaged to be able to construct a latrine (finance, labour, transport etc)						X	X	
7	Number of people who may be considered disadvantaged who <u>during the programme period</u>: • Had to sell assets to be able to build or upgrade a toilet • Had to take out a loan to be able to build or upgrade a toilet	X	X				X	X	
	Quality of access for people who may be disadvantaged and risk assessment								
1	Percentage of people who may be considered disadvantaged who have been expected to share a	X	X		X	X	X	X	

				1	2	3	4	5	6
	Possible indicators	**Disaggregate by[13]**		**Reporting on community based processes**	**Community register and community-led on-going monitoring**	**Baseline study – externally supported**	**Outcome survey – externally supported**	**Targeted learning exercises for groups B and C**	**GSF global / regular data collection (quarterly)**
		Gender	**Age**						
	latrine with (extended) family members with whom they do not share a cooking pot[14]								
2	Percentage of people who may be considered disadvantaged who have been expected to share a latrine with another household (outside of their extended family)	X	X		X	X	X	X	
3	Percentage of people who have a disability or mobility limitation who have to balance directly on a bucket or sit on the floor (without a commode chair) to go to the toilet at any time of the day or night	X	X		X	X	X	X	
4	Percentage of individuals who may be considered disadvantaged who continue to practice dig and bury at any time of the day or night	X	X		X	X	X	X	
5	The number of people reporting negative consequences from having to sell assets or take out a loan (such as losing surety; losing land; being fined impacting on ability to buy food)						X	X	

[14] This has been included as some older people said that they were expected to share with extended family members but they faced problems with this and were treated as second class citizens or as cleaners. For some families and individuals this arrangement may be acceptable and work well, but for others it may lead to problems.

Annex XIV - Recommendations – from respondents

The following provides a summary of the recommendations that were made by respondents across the six country visits, in response to the question how the programme could be improved to ensure that people who are disadvantaged are better able to benefit from the programme. The question was sometimes interpreted as how the programme could be improved more generally. As some of the general recommendations came up on a regular basis, these have also been noted below, followed by the EQND specific ones.

Recommendations made by participants during the workshops as to specific strategies / approaches to use to respond to EQND throughout the CLTS programme cycle (pre-triggering, triggering, follow-up) have been incorporated separately into the Do's and Don'ts tables in **Annex XI**.

XIV.1 Recommendations – general

Don't stop at ODF: (mentioned by many)

- Continue the programme with total sanitation campaign, integrating an increased focus on other forms of sanitation and not just OD and with attention on behaviours that may be weak in the initial programme (examples given being disposal of child's faeces and hand-washing)
- Bring another programme to the community.
- Need to think more about sustainability and what will happen when the programme pulls out.

Add water as a component of programme (mentioned by many in multiple contexts):

- Give more recognition to the interrelation between sanitation and water availability for the whole community and make funding available to enable the programme to respond to gaps in water supply
- Would be positive as post-ODF action – would add value. One EA team suggested the fund could be relatively minor rather than major water projects.
- Also pay more attention to the water quality issue (particularly where latrines have been constructed near to shallow water points).

Institutional / HR:

- Increase numbers of CLTS facilitators / triggerers
- Increase support for those active in communities – suggestions included to:
    - Support for t-shirts, bags, caps, protective boots – identification of themselves as having a specific role for more respect
    - Support for bicycles for village committee members / natural leaders / CLTS facilitators – to enable to them to reach more people – many communities are spread far apart and it takes up a lot of time moving between households and areas
    - Drinking water or allowances for WASH committee members
    - Bring light snacks and drinks for large meetings – to encourage people to keep coming
- Increase salary / benefits + capacity building for triggerers / mobilisers / community consultants – it's very low [emphasised by a government representatives, and others]
- More payments for follow up to IPs as takes double what is paid for / to increase motivation
- Ensure those employed are carefully chosen (checking for corruption)

Urban areas:

- Focus on faecal sludge management – the problem is emptying pits and lack of sewerage systems

Sources of funding:

- Work closer with the government and the churches [to explore other sources of funding, including that from the Diaspora which is sometimes sent to churches for orphans or during periods of natural disaster].

XIV.2 Recommendations – EQND related

Capacity building and working with EQND experienced organizations:

- We should question our own stereotypes – and don't assume people cannot do things for themselves
- Guidance materials, training and IEC materials are needed on these issues: For trainers; and health extension staff and others engaged on leadership in the CLTS process
- Need database of DPOs who they could engage with / go for advice
- Increase length of training for community level actors such as WASH Committees

Identifying the disadvantaged (also see subsidy below):

- Identifying who is poor or not poor – society to identify; indicators needed to identify which groups should be supported
- Needs deliberate effort to integrate considerations of disadvantaged into process from early stage – during mobilisation, triggering and follow up (need to show them we love/ respect/ value them)
- Need to work out a way as to how to respond to challenges during identification and involving the most disadvantaged, such as: 'self-discrimination', i.e. people not turning up and not sharing views; or the risk if natural leaders were involved in identifying vulnerable they might identify their relatives
- Increase the time allocated for CLTS facilitators to engage with communities in different stages to enable more attention on EQND

Support, subsidy (views varied) and rewards:

- Prizes would be useful for successful villages – would be motivating
- Don't give subsidy:
    - It will be too complex, it causes conflicts, it slows progress
- People without resources to be supported with help to build including:
    - Financial support to be provided or revolving funds for communities /access to finance for the most vulnerable to be able to build latrines that last – particularly for cement.
    - Give subsidy for the ultra-poor / most vulnerable / single females / males
    - If there is some additional fund for subsidy – could be given to government to manage with matching fund from GSF
    - Support materials – although mixed views on this [some said before people didn't use them when they were given and not good if universal distribution; others said if provided now people would use them]
    - Some felt that the programme should provide latrines for people who are disadvantaged – because they can't rely on other community members to construct latrines / provide assistance.

- The provision of toilets for marginalized groups was mentioned or to provide common toilets in public land for the ultra-poor and landless or for the government to provide land for the landless.

Disasters:

- There is a need for a contingency fund for disasters and in disaster prone areas it would be positive to establish a preparedness fund.
- It was also recommended that GSF needs to be flexible in its approaches and funding in these instances and also to respond to changing population movements due to conflict.

Accessibility, designs and upgrading:

- More support should be provided for accessible / disabled-and older people friendly toilet designs / westernised designs: there needs to be an increased awareness of these toilets, models needed as well as a catalogue to show people at community level and for this to be incorporated into trainings
- Participants see the need to better accompany (sensitize, train and orient) disadvantaged persons during the follow up phase, moving beyond the "potty default approach".
- Need range of low cost designs, but also considering sustainability – for example having cement or plastic slab rather than a soil one, which also promotes cleaning.
- There is need for some mechanism to support toilet upgrading.

Public latrines:

- Make sure have public latrines in the market and public spaces (mentioned quite a few times) – support management models, pay-per-use can be viable [this recommendation also has EQND links]

Leadership and employment of people who are potentially disadvantaged:

- Hire more people who are from potentially disadvantaged groups in the programme for decision making.
- Increase opportunities for people with disabilities and others who may be disadvantaged in leadership positions including on WASH Committees.

Research and experience sharing:

- More knowledge of what is happening in other areas – learning visits, capacity building
- Request the WSSCC to carry out more studies and research about the impact on people [recommendation made by a government representative]

Advocacy and institutional triggering:

- Increase the role of GSF in advocating for the incorporation of EQND into national policies and frameworks?
- Explore the possibility of supporting sector advocacy campaigns, featuring sanitation champions voicing the views and needs of disadvantaged groups (e.g. an old disabled politician, a successful female business woman, a disabled artist). [suggestion made by one of the consultants but agreed by representatives in country]

Expand focus of programme:

- Integrating MHM; engage more youth
- Include more support to institutional latrines particularly in schools where the users cannot be charged; also make sure that local government offices have toilets for public use [to be a good role model].

Recommendations from child rights and disabled persons organizations:

- When working on ODF need to also consider:
    - Children and people on the street – there should be a place they can pay a little and access a bath / shower / toilet and they can be safe. On the streets, there can be problems of drugs / violence / crime.
    - Orphanages and drop-in centres. Youth and children with nowhere to go should have the right to use WASH facilities, which they often don't have right now; even in bus stops there are not toilets
    - Workplaces – to ensure that all have WASH facilities including temporary workplaces
    - More public toilets and ways for people to access who cannot afford to pay
- There is a need to mandate that we should include people with disabilities when designing sanitation programmes and facilities:
    - Need to include people with disabilities (link in the national federations of disabled persons organizations) in all stages of the programme: from development to launching, consultations, training and monitoring. Remember: *'Nothing with us, without us'*
    - We should ask how user friendly they are for women and people with disabilities.
- In relation to people who are deaf:
    - Support construction of WASH in schools for the deaf children and awareness raising with people who are deaf; use sign language, working with a qualified interpreter
    - Parents must be told to learn sign language as soon as it is recognised that the child is deaf – they should be encouraged to make contact with an association for the deaf and the children to join a school to learn sign language. But if the child has grown up not knowing sign language then the communication will be difficult. Then the method the parents use to communicate will be needed.
- IEC must be accessible and also include sign language [brail is not commonly used in all countries]
- People with intellectual disabilities / developmental disabilities: use pictures for communication and / or drawing; make sure toilets have required facilities including water (can be stressful without) and work with parents so all understand how to communicate on WASH related issues.

Annex XV - Recommendations – priorities for support on EQND

Table 17 - Priorities for EQND related support – as made by participants of the 6 national workshops

Order		Ethiopia	Nepal	Nigeria	Senegal	Togo	Malawi	AVERAGE
1	Guidance manual	4	3	5.5	2	1.5	1	2.83
2	Special budgets for EQND	1	4	8	6	4.5	Note 1	4.70
3	Review of programme with recommendations	1.5	6	5.5	9	7.5	3	5.42
4	On-the-job training	10	12.5	1	2	1.5	7	5.67
4	Workshop based training	8	11	7	3	1	4	5.67
6	IEC messages tackling these issues	5	12.5	3	4	9.5	Note 1	6.80
7	Minimum standards	1.5	2	12	13	10	6	7.42
7	Linking with other organizations with expertise in this area	13	5	2	11	4.5	9	7.42
9	Access to specialist experts	14	7	4	8	13	2	8.00
10	Checklists	9	1	9.5	15	12.5	5	8.67
11	Research on low cost technologies	6	8	11	11	7.5	Note 1	8.70
12	Learning visits to other countries	11	13	13	3	4	Note 1	8.80
13	Case studies	12	10	9.5	11	11	8	10.25
14	Supporting sanitation entrepreneurs	7	14	14	7	9.5	Note 1	10.30
15	GSF to recruit EQND specialist staff	15	9	15	14	12.5	Note 1	13.10

Others mentioned during workshops:

- Regular M&E
- Adoption of best practices
- Documenting best practice
- Intro. letters for zonal authorities
- Strengthen the capacities of IP supervisors
- Create income generating opportunities for people with disabilities
- Train local artisans to provide adaptations for people with disability
- Training for community members
- Raising awareness
- Advocacy towards decision makers
- Institutional capacity building

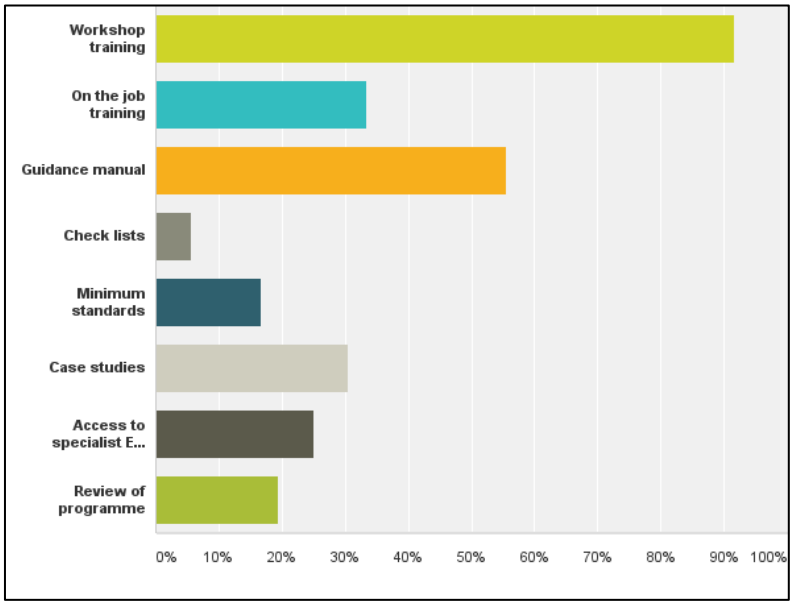
Note 1 – As Malawi was the first country the team visited, a smaller list of options was included in the exercise looking at priorities for support. During the workshop in Malawi additional options for support were proposed and these were added into the subsequent visits.

Online survey respondents references for EQND support:

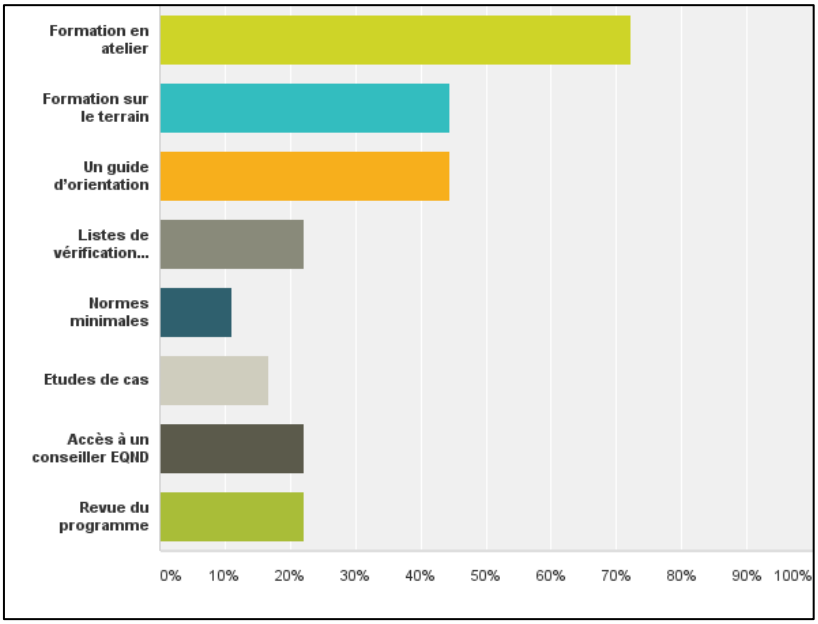
When asked what type of training and support they would like on EQND, 91 percent called for workshop training and only 23 percent for on the job training. This contrasted to the Francophone countries where 72 percent asked for workshop training and 44 percent on the job training.

The second most preferred type of support was a guidance manual with 55 percent of respondents in the English survey and 44 percent of respondents in the French survey asking for this.

Q22: What type of support would you find useful to build your / your colleagues confidence and capacity to be able to respond to EQND issues in your work? (English Survey)



Q22: What type of support would you find useful to build your / your colleagues confidence and capacity to be able to respond to EQND issues in your work? (French Survey)



Annex XVI - Recommendations – Terminology

These definitions are suggested for global use and as a start for countries to adapt as appropriate.

Table 18 - Key terminology and definitions

Terminology	Definition	Notes/source/reference
Accountability	Accountability is the process of 'using power responsibly' and of taking account of and being held accountable by different stakeholders, including primarily those who are affected by the exercise of that power (i.e. those we aim to assist). Being accountable to affected populations helps to make better use of resources, helps to make people safer and helps to ensure that solutions are better suited to people's needs. It involves sharing information transparently, enabling the participation of all sections of the community, seeking feedback, enabling people to complain where necessary and using monitoring and evaluation to improve outcomes.	CHS Alliance, The Sphere Project and Group URD (2015) *Core Humanitarian Standard*; CHS Guidance Notes and Indicators, CHS Alliance, The Sphere Project and Group URD
Disability/Ability	**People with disabilities** include women, men, girls and boys with long-term physical, mental, intellectual or sensory impairments that may hinder their full and effective participation in society on an equal basis with others. **Disability** can be seen as a result of the limitations imposed on people by society. They may face attitudinal, institutional or environmental barriers to their participation. 'Disability' (a social issue) is separate from 'impairment' (a medical or individual issue).	Source: Minimum Standards for Age and Disability Inclusion in Humanitarian Action: Pilot Version Published by the Age and Disability Consortium as part of the ADCAP programme (2016) Adapted from: House et al (2014) Violence, Gender and WASH: A Practitioner's Toolkit
Disadvantaged individuals and groups	Disadvantaged individuals or groups are those who are vulnerable, marginalized, excluded, experiencing inequities, inequalities, or stigma.	Adapted from: Handbook – realizing rights to water and sanitation / UN Special Rapporteur / De Albuquerque (2014)
Discrimination and non-discrimination	**Discrimination** is defined as "any distinction, exclusion or restriction that has the **purpose or effect** of impairing or nullifying the recognition, enjoyment or exercise, **on an equal basis** with others, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." The legal principle of **non-discrimination** prohibits the less favourable *treatment of* individuals or groups, or the detrimental *impact on* such individuals or groups based on their ethnicity, gender, religion, sexuality or other status (see 'prohibited grounds of discrimination' below for more information).	Source: CESCR, General Comment No. 20 on non-discrimination, Para. 7, UN Doc. E/C.12/GC/20, 2009. Source: JMP Working Group on Equity and Non-Discrimination, Final Report, 2012
Diversity	Diversity refers to the visible and invisible differences that exist between people, such as gender, culture, race, ethnic origin, physical and mental ability, sexual orientation, age, economic class, language, religion, nationality, education, and family/marital status. It also refers to diverse ways of thinking and ways of working.	Taken from: Oxfam Australia Human Resources Policy 2007

Equality	**Equality** entails a ***legally binding*** obligation for States to ensure that everyone enjoys equal enjoyment of his or her rights. It is not the same as ***Equity*** (see below). Equality does not mean that everyone should be treated in exactly the same way. Achieving equal access to water and sanitation will require an understanding of people's different needs and requirements. The terms Equality and Equity should not be used interchangeably but achieving equality (in human rights terms) often relies on using equitable approaches that try to address unfairness in society.	Adapted from: Handbook – realizing rights to water and sanitation / UN Special Rapporteur / De Albuquerque (2014) See also: WSSCC (2016) Concepts and definitions for equality and human rights: Towards a common understanding in WSSCC
Equity	**Equity is the principle of fairness –** Equity involves recognising that people are different and need different support and resources to ensure their rights are realized. To ensure fairness, measures must often be taken to compensate for specific discrimination and disadvantages. Equity is not a legally binding term but an approach to achieving equality.	Adapted from: 1. WaterAid (2012) Equity and Inclusion Toolkit. WaterAid, London, UK 2. Handbook – realizing rights to water and sanitation / UN Special Rapporteur / De Albuquerque (2014)
Excluded	People who are denied access to a place, group, privilege or service; also implies a power dynamic where others are doing the excluding.	
Gender	Refers to the socially constructed roles of men and women rather than the biologically determined differences, as well as the relationships between them in a given society at a specific time and place. These roles and relationships are not fixed but can and do change. They are usually unequal in terms of power, freedom, agency [self-confidence in own abilities] and status as well as access to and control over entitlements, resources and assets.	Taken from: WaterAid (2013) Terminology guidelines to support WaterAid's equity and inclusion framework
Inclusive WASH	Inclusive service recognises that users come in all shapes and sizes, and have different needs. It provides a flexible service to try and accommodate as many users as possible, ensuring facilities are accessible and easy for all to use. Inclusive WASH is not just about improving access to services for everyone. It mainstreams a rights-based approach to support people to engage in wider processes and ensure their rights are recognised.	Taken from: WaterAid (2012) Equity and Inclusion Toolkit. WaterAid, London, UK
LGBTIQ [a number of variations of this acronym also exist]	The acronym 'LGBTIQ' encompasses a wide range of people's identities that fall outside of societal norms due to their sexual orientation and/or gender identity. • **Lesbian**: A woman who is attracted to other women • **Gay**: A man who is attracted to other men. The term can be used to describe both gay men and lesbians • **Bisexual**: An individual who is attracted to both men and women	Adapted from: 1. IASC (2015) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action 2. WaterAid (2013) Terminology guidelines to support WaterAid's

	• **Transgender**: People whose gender identity and/or gender expression differs from the sex they were assigned at birth • **Intersex:** Bodily variations including male and female variations at the level of chromosomes, gonads and genitals • **Questioning:** An individual who is unsure about or who is exploring their sexual orientation or gender identity	equity and inclusion framework
Marginalized individuals and groups	Those people (or groups) who are excluded from social, economic, cultural and political life, because of who they are or where they live. This term can refer to a cultural, religious, or ethnic minority, or people suffering from particular stigmatised diseases. In some countries, marginalized individuals and groups can include a significant proportion of the population e.g. women.	Adapted from: Handbook – realizing rights to water and sanitation / UN Special Rapporteur / De Albuquerque (2014)
Minority group	A group numerically inferior to the rest of the population of a State, in a non-dominant position, whose members – being nationals of the State – possess ethnic, religious or linguistic characteristics differing from those of the rest of the population and maintain, if only implicitly, a sense of solidarity, directed towards preserving their culture, traditions, religion or language.	Source: United Nations Human Rights Office of the High Commissioner 2010.
Older people	The concept of older people must be understood in broad terms. In many countries and cultures, being considered old is not necessarily a matter of age, but it is rather linked to circumstances such as being a grandparent, or showing physical signs such as white hair. Where people live in hardship, some of the conditions that can be associated with older age, such as mobility problems or chronic disease, are present at younger ages. While many sources use the age of 60 and above as a definition of old age, a cut-off point of 50 years and over may be more appropriate in many contexts.	Adapted from: Minimum Standards for Age and Disability Inclusion in Humanitarian Action: Pilot Version Published by the Age and Disability Consortium as part of the ADCAP programme (2016)
Prohibited grounds of discrimination	States are prohibited from differentiating among different individuals and groups. They can be grouped into different categories: • **Individual-related inequalities** are based on gender, age and disability, marital and family status, sexual orientation and gender identity, and health status. • **Group-related inequalities** are based on race, colour, ethnicity, language, religion, political or other opinion, national or social origin including caste, birth, nationality, and migratory status. • **Geographic inequalities** are based on the place of residence such as rural-urban and intra-urban disparities between formal and informal settlements. • **Economic inequalities** relate to the ownership of property and people's economic and social situation.	Source: CESCR, General Comment No. 20 on non-discrimination, UN Doc. E/C.12/GC/20, 2009.
(Human) Rights based approach	A human rights-based approach is guided by **human rights standards and principles**. The main human rights principles are:	Adapted from: Concepts and definitions for equality and human rights: Towards a

	• Equality and non-discrimination • Participation • Transparency and access to information • Sustainability • Accountability The human rights to water and sanitation can only be realized through the populations' **active, free and meaningful participation in decision-making processes.**	common understanding in WSSCC'
Sexual and gender based violence **And** **Gender based violence**	**Sexual and gender-based violence (SGBV)** refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It includes physical, emotional or psychological and sexual violence, and denial of resources or access to services. Violence includes threats of violence and coercion. Certain groups in a population may be particularly at risk of SGBV: older persons, persons with disabilities, adolescent girls, children, SGM persons, and female heads of household. Gender based violence is increasingly a more common term being used by those working in the protection sector. It is considered to also include 'sexual' violence although some organizations (such as UNHCR) prefer to keep using SGBV.	Adapted from: Sexual and gender based violence (SGBV) prevention and response UNHCR
Sexual and gender minorities (SGM)	People whose gender identity, sexual orientation or sexual characteristics differ from what is typically expected by a culture or society.	Taken from: Health Policy Project (2015)
Stigma	There is no conceptual clarity about stigma and no agreed definition. But to stigmatise can be understood as 'to label someone and see them as inferior because of an attribute they have'. It is always about a process of 'dehumanising' certain people.	Taken from: WaterAid (2012) Equity and Inclusion Toolkit. WaterAid, London, UK
Ultra-poor	The ultra-poor are considered to be those who live in the lowest earning half of those below the extreme poverty line. Different definitions exist but in general: • They eat below 80 percent of their energy requirements, despite spending 80 percent or more of their income on food • Live below 50 cents per day • Live without access to healthcare, financial services, and basic services • Often lack acceptance in their own communities, lack self-confidence, and have no support systems	Adapted from: BRAC and the original definition for the term, as coined by Michael Lipton of the University of Sussex in 1986
Universality	This is the principle that everyone has equal rights as human beings. In the WASH context, universality requires that services are provided to everyone—including those hardest to reach.	Adapted from: Concepts and definitions for equality and human rights: Towards a common understanding in WSSCC'
Vulnerable individuals and groups	A person (or group) is more vulnerable in a given context when they are less able/ unable to cope with specific problems or hazards that they face and hence are more at risk of harm or ill effects. They are likely to have limited influence and control over decisions or resources. But vulnerability is	Adapted from: House et al (2014) Violence, Gender and WASH: A Practitioner's Toolkit; and the Handbook – realizing rights to water and

	not a fixed concept and can change over time and is specific to each context and people can move in and out of being vulnerable. Nor is it always specific to particular groups. For example, women or people with disabilities will not always be vulnerable.	sanitation / UN Special Rapporteur / De Albuquerque (2014)

Table 19 - Definitions – methods for influence

Terminology	Definition
Persuasion	Is a process in which communicators try to reason with and convince others to change their attitudes or behaviour in the spirit of free choice.
Coercion	Is a technique in which someone in a position of relative power or authority seeks to control and influence the other person by fear through the use of force, threats, manipulation or intimidation. There are various forms of coercion that have different legal, social and ethical implications.
Difference between persuasion and coercion	When people believe that they are free to reject the communicator's position, as a practical matter they are free, and the influence attempt falls under the persuasion umbrella. When individuals perceive that they have no choice but to comply, the influence attempt is better viewed as coercive.
Convince	Cause someone to believe firmly in the truth of something – persuade someone to do something
Manipulate/ manipulation	Control or influence a situation cleverly – often unscrupulously – control something or someone to your advantage – often at another's expense. Manipulation usually involves elements of persuasion and coercion.
Intimidation	To frighten or threaten someone, usually in order to persuade them to do something that you want them to do. To compel or deter, often with the use of threats. Unlawful act of intentional coercion.
Social Justice	Respecting and valuing diversity and difference; challenging oppressive and discriminatory actions and attitudes; addressing power imbalances between individuals, within groups and society; committing to pursue civil and human rights for all; seeking and promoting policy and practices that are just and enhance equality whilst challenging those that are not.

Table 20 - Definitions – Participation ladder

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

Table 21 - Terms that are not considered appropriate or on which differences of opinion exist

	Terminologies
Not appropriate	Cripple; deformity; barren women; dumb; mentally retarded; stutter; backward
Differences of opinion exist	Blind; deaf; differently-abled; disabled person [rather than person with disabilities]; elderly