SANITATION
FOCUSED
PARTICIPATORY
HEALTH AND
HYGIENE EDUCATION

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SANITATION FOCUSED PARTICIPATORY HEALTH & HYGIENE EDUCATION

A TRAINING OF TRAINERS MANUAL

2013

A STEP BY STEP GUIDE ON HOW TO DELIVER SANITATION FOCUSED PHHE
ACKNOWLEDGEMENTS:

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WORKING DEFINITIONS:

Community: refers to a group of people sharing the same geographic area, often using the same resources, identifying with each other and seeking to work together.

Hygiene enabling facility: refers to any structure that enhances positive hygiene practices such as hand washing facilities, pot racks, refuse pits, latrines, tippy-taps and any such other structure.

Open defaecation: refers to the indiscriminate disposal of human excreta.

Open defaecation free: refers to a situation where no one shits in the open, uses an improved latrine and washes hands with soap or ash after using the latrine.

Run to use: refers to the utilization of the waste water from the hand washing process to productive usage e.g. a fruit tree, flower or any such plants.

Sanitation: refers to the principles and practices relating to the safe disposal of human excreta and refuse as they impact on communities and the environment.

Shit: refers to human excreta.

Unhygienic practices: refers to a behaviour that disregards the principles and practices of safe sanitation.
FOREWORD:

Zimbabwe has a long history of championing innovative approaches to safe sanitation improvements. While specific technologies such as the Ventilated Improved Pit Latrine (VIP) rejuvenated access to improved sanitation locally and globally, the use of social marketing strategies, such as the Participatory Health and Hygiene Education (PHHE), provided a strong impetus to positive behaviour change. The National Action Committee (NAC) for rural water supply and sanitation created in the mid-1980s has over the years not only provided leadership in the sub-sector, but also assured co-ordination of efforts, crosscutting learning and become a repository of valuable experiences and lessons.

The Ministry of Health and Child Care as part of its mandate of providing quality health to all Zimbabweans and as Chair of the Sanitation and Hygiene Taskforce will continue to lead in all efforts to ensure sustainable provision of safe sanitation. The Ministry acknowledges the short coming of subsidies based sanitation interventions and therefore has led efforts to have a relook at the national sanitation and hygiene approaches. Experiences to date indicate that access to safe excreta disposal and improving hygiene practices is best achieved by participatory efforts involving communities as key beneficiaries and owners of interventions.

This manual has been written with the Sanitation Focused Participatory Health and Hygiene Education (SaFPHHE) Trainer in mind. It exposes the Trainer to the various participatory approaches available to the WASH Sector. SaFPHHE is a process that aims to promote conditions and practices that help to prevent water and sanitation related diseases. This SaFPHHE guide draws heavily from the main adopted PHHE Guide. Hygiene Education is an important component of water and sanitation programme.

Hygiene education helps to maximize the benefits to the users and secondly it can create an environment that will support the development of management systems for the operation and maintenance of facilities. Integrating hygiene education with the other aspects of water supply and sanitation projects requires skilful planning and management. In order to understand the role of SaFPHHE in development, it is fundamental to take it in the context of community participation. The overriding goal of community participation in development is to help people develop the outlook, the competence, the self confidence and the commitment which will ensure a sustained and responsible community effort towards their overall development, including the control and management of communicable diseases. Change
agents in development particularly Extension workers often come across communities that have fears, suspicion, doubts, lack of self-assurance, traditional beliefs, values and practices that run counter to the proposed change. In such communities, behavioural change is unlikely to take place unless a sufficiently sensitive and facilitative approach is used. A focused participatory approach is usually effective under such circumstances, as it will assist to uncover, examine and address any social constraints, leading to sustainable behaviour change. This book tries to give a step-by-step guide in the use of sanitation focused participatory tools for behaviour change.

The Sanitation Focused PHHE approach, broadly, seeks to facilitate a change in health and hygiene education approaches from a didactic technical model to a much focused and participatory social model, and specifically seeks to eliminate open defaecation and make a significant progress towards the attainment of the sanitation Millennium Development Goals.

Brigadier General (Dr.) G. Gwinji

Permanent Secretary, Ministry of Health and Child Care
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1.0 Overview of the National Water Policy and the Sanitation and Hygiene Strategy:

The National Water Policy launched at the 2013 World Water Day celebrations in Victoria Falls spells out that demand for Water Supply and Sanitation (WSS) services by rural communities will be created through generating a desire by rural communities to address their own basic sanitation needs. On the other hand there is also a National Sanitation and Hygiene Strategy whose objective is to provide a framework for improving and sustaining sanitation and hygiene service delivery for all Zimbabweans, including elimination of open defaecation and making significant progress towards the attainment of the sanitation MDG.

1.1 Background:

- Zimbabwe is off track in meeting the sanitation MDG target - 43% access, 33% practicing open defaecation nationally and 48% in rural areas.

- Over 80% of subsidies for sanitation provision in Zimbabwe have benefited the rich members of community. Subsidies have not reached the most vulnerable and yet the lowest wealth quintile is 10 times less likely to have a latrine than the richest quintile.

- The devastating cholera epidemic of 2008/9 with 98,531 cases and 4,282 deaths gave a wakening call to the sector and government at large to prioritize sanitation amongst many other things. The WASH sector was largely depended on external support.

- The National Water Supply Master Plan (NWSMP) of 1985 clearly defined the level of subsidies for household sanitation and prescribed a standardized VIP Latrine as the technology of choice. To this end, any other types of latrines are not recognized as safe sanitation facilities by the WASH Sector.

- Subsidies are not only unsustainable but cultivate a deep-rooted culture of dependency.

- Zimbabwe’s sanitation coverage continues to drop (<25% in 2004 from >30% in 2001).
1.2 Goal and Objectives of the Sanitation and Hygiene Strategy:

Government of Zimbabwe through the Ministry of Water Resources Development and Management steered a process to develop a National Water Policy which was later approved by government in March 2013. This policy underscores that ‘given that communities will be responsible for recurrent costs of their sanitation facilities; service standards will be reviewed to permit a wide choice among different technologies so as to match the economic capacity of users. Service standards will enable poor communities to improve their levels of service as their economic circumstances improve’, ‘page 31’.

As part of operationalisation of the National Water Policy, there was also a process to develop the National Sanitation and Hygiene Strategy to guide all WASH Sector Policy makers, managers, practitioners and financiers in achieving the shared vision of sustainable access to safe water, sanitation and hygiene and eliminating open defaecation (OD) in Zimbabwe.

The objective of the Sanitation and Hygiene Strategy is to provide a framework for improving and sustaining sanitation and hygiene service delivery for all Zimbabweans, including:

a) Elimination of Open Defaecation (reducing OD from 33% to under 10% by 2015);

b) Making significant progress towards the attainment of the Sanitation Millennium Development Goals by increasing total sanitation coverage (using JMP criteria) to 60% by 2015; and

c) Implementation and sustenance of positive hygiene behaviours in all communities where activities are undertaken to eliminate OD.

The Strategy builds on progress made to-date and lessons learnt through operationalisation of the Participatory Health and Hygiene Education (PHHE) approach. Critically, it adjusts current approaches in the light of recent implementation experiences. The strategy signifies a shift from a supply-driven approach, with a strong emphasis on technologies; to a demand-management approach, with emphasis on behaviour change and services responding to community demand. The priority in rural sanitation finance would be on demand creation, putting the onus on householders to take responsibility for improving their own facilities.
The Sanitation and Hygiene Strategy provides a framework for:

- A sustainable sanitation and hygiene delivery system.
- Amending minimum sanitation and hygiene standards.
- Demand-creation based on behaviour change and community managed approaches for sustained elimination of open defaecation.
- Improving service sustainability through institutional reform, capacity building and rethinking financing priorities.

2.0 Overview of Sanitation and Hygiene Promotion:

At the core of the shift in sanitation programming is a move from donor-determined and supply-driven approaches to community-led and demand-driven approaches. The shared goal of sanitation and hygiene promotion approaches is to help communities become Open Defaecation Free (ODF). They work to generate demand and leadership for improved sanitation and behaviour change within a community; produce sustainable facilities and services through engagement with local markets and artisans; and promote adaptation and replication at scale through local capacity building.

2.1 Sanitation and Hygiene Promotion Approaches:

Various approaches are embraced in this guide and of these, some have approved and adopted whilst others are still under trial e.g. CLTS.

2.1.1 Participatory Community Based Total Hygiene (PCBTH):

- Holistic and aims for a *complete and total hygiene* behaviour change.

- **Total hygiene** includes safe disposal of faeces, hand washing and home treatment of drinking water, but may also include food hygiene and safe disposal of refuse.
- Encourages the participation of individuals in a group process regardless of their age, gender, social class or education background to build self-esteem and a sense of responsibility for one’s decisions.

2.1.2 Participatory Hygiene and Sanitation Transformation (PHAST):

a) Helps communities improve hygiene behaviours, reduce diarrheal diseases and encourage effective community management of WASH services.

PHAST Steps:

- Problem Identification
- Problem analysis
- Planning for solutions
- Selecting options
- Planning for new facilities and behaviour change
- Planning for Monitoring and Evaluation
- Participatory Evaluation

b) Works on the premise that as communities gain awareness of their WASH situation through participatory activities, they are empowered to develop and carry out their own plans to improve their situation.

c) PHAST was piloted by WHO in Zimbabwe, Uganda, Botswana, Kenya and Tanzania.

d) Zimbabwe adopted and adapted the concept and changed it to Participatory Health and Hygiene Education (PHHE) in 1996.

2.1.3 Child Hygiene and Sanitation Training (CHAST):

CHAST is based on the PHAST principles and uses a variety of exercises and educational games to teach children about the direct link between hygiene and good health. (piloted in rural Somalia).
● Premised on that personal hygiene practices are usually acquired during childhood

● Encourages children to actively participate in open discussion and share experiences with their peers.

● Children are encouraged to work independently in pairs or in small groups before reporting to the larger group.

● Use of games, exercises and role playing allows children to discuss and genuinely understand the key issues to personal cleanliness and hygiene, which is extended to the home environment.

2.1.4 WASH in Schools:

● School Sanitation and Hygiene Education (SSHE) focuses on providing children with an effective and healthy learning environment and changing the behaviours

● School Health Clubs (SHCs) are formed to discuss and practice hygiene behaviour related activities.

● The impact of children participation includes:
  ➢ Healthy physical school environment
  ➢ Active and organized children
  ➢ Community and parent participation in WASH in schools
  ➢ Facilities in place at school and community
  ➢ Strong link to both home and community.

● SHCs were piloted in Zambia, Burkina Faso, Colombia, Nepal, Nicaragua and Vietnam by WHO/UNICEF/IRC Netherlands.

2.1.5 Child to Child (CtC) Approach:

● Rights based approach to children’s participation in health promotion and development which enhances personal, physical, social, emotional and intellectual development
CtC based on the UN Convention on the Rights of the Child (rights can be effectively implemented while addressing children’s right to survival, protection, development and participation).

‘A child’s right and responsibility to participate in health and education as well as their right to play’.

CtC recognizes the importance of children to be directly involved in the process of health education and promotion and the nature of their environment.

2.1.6 **Community Hygiene Clubs (CHCs):**

- Voluntary community based organization formed to provide a platform or forum for improving family health through ‘common unity’

- CHC approach has the effect of:
  - Achieving high levels of behaviour change
  - Quantifying change that has taken place
  - Sustaining and replicating
  - Predicting behaviour change

- CHC members are issued with membership cards listing the topics covered and recommended practices to be implemented at home.

**Stages for CHCs:**

a. **Hygiene Promotion Campaign:**

Recruitment of members based on voluntarism.

- Membership card with topics to be covered and recommended practical actions.

- A different practice is targeted each week and the group pressure ensures that behaviour change becomes mandatory within the club.

- Home visits take place between all homes and members offer advice to each other or encourage change.
b. **Implementation:**

- Demand for facilities generated/created.
- Club members actively participate in water service provision and management – supported by CBM Training.
- For sanitation, club members start constructing their own latrines (type and standard depends on affordability in line with the sanitation ladder).

c. **Sustainable Livelihoods:**

- CHCs a vehicle for other development initiatives.
- Nutrition/Herbal gardens
- Handcraft making
- Food drying and packaging
- Soap making etc

d. **Social Development Initiatives:**

- CHCs can transform into a social forum - debating on and taking or recommending action on psychosocial problems such as wife abuse, child abuse, alcohol/drug abuse, care and support for widows, orphans, terminally ill etc.
- Issues of human rights and voter education can also be discussed.

2.1.7 **Community Wide Approaches (CWAs):**

- Aim is to achieve *universal use of toilets and the elimination of Open Defaecation* in targeted communities.
- CWAs focus on the *community rather than the household with emphasis on collective decision making and local problem solving*.
- Main focus is on stopping open defaecation to ensure that every household owns or shares the use of a toilet and that these toilets are effectively used by all.
- *Uses mass social mobilisation* which engages leaders from all levels and sectors of society to focus on ZOD– and DEMAND CREATION.

### 2.1.8 Community Led Total Sanitation (CLTS):

- CLTS aims at ZOD.
- Encourages innovation and commitment within a community, motivating them to build their own sanitation infrastructure
- CLTS uses Participatory Rural Appraisal (PRA) techniques to raise awareness of the risk that OD presents and to reinforce a natural sense of ‘Disgust’ about this practice
- Involves community members in analyzing their own extent of open defecation and the spread of faecal – ORAL contamination that detrimentally affects everyone.

**CLTS Methodology:**

- Focused group discussions.
- Defaecation mapping.
- Transect walks (walk of shame).
- Food oral exercise; plate of food and glass of water.
- “Shit’ calculation – (The total weight of faeces produced and circulating in the community).
- Calculation of medical expenses.
- Simple latrine demonstration.
- Village action plan.
- Formation of Sanitation Action Group (SAG).

The Approach aims to generate a sense of *shame and disgust* amongst the community for behaviour change.
3.0 **Overview of Sanitation Focused Participatory Health and Hygiene Education:**

The Sanitation Focused Participatory Health and Hygiene Education (SaFPHHE) is:

- The Zimbabwean version for behavioral change, demand creation and the elimination of open defaecation based on the sanitation ladder using the Upgradeable BVIP.
- A village centered-community based hygiene promotion approach focusing on demand led and private entrepreneur based systems for Zero Open Defaecation (ZOD).
- An approach that also makes use of Community and School Hygiene Clubs.

3.1 **Essential Elements of SaFPHHE:**

The SaFPHHE essential elements are a framework for action, providing a common foundation in the way programmes are applied and translated locally.

- SaFPHHE aims to achieve 100 per cent ODF communities through affordable, appropriate technology and behaviour change.
- emphasis is on demand creation for sustainable use of sanitation facilities rather supply driven approaches.
- SaFPHHE depends on broad engagement with diverse members of the community, including households, schools, health centres and traditional leadership structures
- Communities lead the change process and use their own capacities to attain their objectives – ie. planning, and implementation.
- SaFPHHE focuses on building local capacities to enable sustainability. This includes the training of community facilitators and local artisans, and the encouragement of local champions for community-led programmes.
- Government participation from the outset – at the local and national levels – ensures the effectiveness of SaFPHHE and the potential for scaling up.
- SaFPHHE is an entry point for social change and a potential catalyst for wider community mobilization.
4.0 Sanitation Focused PHHE Tools and Steps:

NB: Under problem identification a facilitator might need to select just two or three tools for problem identification.

4.1 Stage One, Step One-Problem Identification

4.1.1 Nurse Tanaka

Purpose:

Nurse Tanaka is a tool that allows the community to identify health problems that they feel are relevant to them and indirectly mirror themselves and their community. It also helps to distinguish between diseases that are easily preventable and those that need medical
intervention. In addition this tool helps us to gain a better understanding of the communities’ knowledge of the causes and prevention of certain diseases. It helps the community to identify and prioritize problems in the area. It also helps the community realize that they can do something about their problems.

**Materials:**
A picture of a nurse at the clinic/health centre, figures of males and females of different ages, children and babies. They should not look or appear sick in anyway, just ordinary people. Flexes may also be used but should not be used in isolation.

**Method:**

a. Give the group a full set of pictures.
b. Show them the Nurse Tanaka picture.
c. Ask the participants to place the pictures in a queue in front of Nurse Tanaka.
d. Ask the participants to list down all the various diseases/conditions/problem that come into their minds when they see people in a queue at a health centre/clinic like the one they have created.
e. The participants are then asked which disease/conditions/health problems are preventable and how they can be prevented.
f. From the identified problems, list top five priority health problems in the area.

**Discussion Points:**

a) Do the participants agree on the priority of common diseases/conditions in the area?
b) How easy is it to prevent these diseases/conditions?
c) What can we do to prevent these diseases?
d) Why should we go to the clinic and when?

**4.1.2 Pocket Chart Voting:**

**Purpose:**
To assist individuals and communities to identify and assess their behaviours and practices. It also helps them to prioritize their needs. It stimulates discussion on important issues to communities and can also be used as an investigative tool in carrying out evaluations.

Materials:

i. Picture for hand washing practices.
ii. Pictures for hand washing times or activities before or after which hand washing is done.
iii. Pictures for human excreta disposal practices.
iv. Pictures for water sources (see water ladder pictures).
v. Pictures for water uses.
vi. “Ballot boxes” consisting of a piece of cloth or Manila paper with enough pockets for the options to be voted for.

You can use pots or tins as “ballot boxes.”

Method:

a. Choose the theme of your session and the relevant pictures.
b. Show the participants the pictures and ask them what they see. Ensure that there is agreement on what the pictures depict.
c. Stick the pictures onto the Pocket Chart above corresponding pockets or beside the pot. Give each participant voting disc(s) or pebble(s).
d. Explain to them about voting, what they are voting about and how to “cast” a vote. Assure them that the voting is anonymous and nobody, not even the facilitator shall see how they vote. Stress the need for people to be honest in their voting, as this is a learning exercise where we all want to learn. You as the facilitator should also vote so as to increase people’s confidence in the exercise.
e. Invite one of the participants to come forward and count all the “votes” for each picture and present the results to the group.
f. Use the findings to stimulate a group discussion around the topic/theme.
Discussion Points:
As in all participatory tools the discussion which takes place around the tool is most important. Key issues to be raised under pocket chart are as follows:-

a) What is the most common practice/behaviour (in relation to the theme)?
b) Is this a good or bad practice? Why?
c) Are these practices relevant to your area?
d) What are the priority problems or issues?
e) What can we do on the way forward?

4.1.3 Focused Group Discussion (FGD)

Purpose:
This is an investigative tool, used for:

i. Gathering opinions, beliefs, and attitudes about Water, Sanitation and Hygiene (WASH).

ii. Testing your assumptions about the community including their local understanding of sanitation.

iii. Encouraging discussion about WASH, including Open Defaecation (OD)

iv. Building excitement from spontaneous combination of the community’s comments.

v. Providing an opportunity to learn more about WASH issues.

FGD should focus on key issues of sanitation and hygiene and should avoid diverting attention of community to other issues such as livelihoods, food etc. The introduction should be clear on focus of the approach and the triggering process.

Materials:
Flip charts and maker pens.

Method:

Focus Group Discussions should focus on the following:

a) Agreeing on terms to be used in local language(s) for terms such as ‘faeces’, defaecation and ‘open defaecation’.
b) Discuss acceptability of local terms to be used amongst communities to demystify open defaecation.

c) Discuss other issues like subsidies and how capacity building and sustainability were being done in the community.

d) Discuss paradigm shifts like shifting away from the conventional supply led approach to a sustainable demand driven one.

4.1.4 Community Mapping:

Purpose:

Community mapping is a diagnostic or investigative tool. The tool is meant to get all community members involved in a practical and visual analysis of the community sanitation and hygiene situation.

For it to achieve its intended objectives, administration of the tool should be absolutely focused, fast, pleasurable and exhilarating to all.

Community mapping is carried out inorder to:

a) Afford communities the opportunity to experience diagramming and so understand some of the processes of community map building.

b) Afford communities the opportunity to appreciate issues of scale, symbols, direction and omission in diagramming.

c) Give a picture of the extent of sanitation and hygiene practices including OD in a given community through investigative and analytical processes.
d) Provide communities with an easily accessible visual documentation, which can serve as a record in itself and as a tool for monitoring development in their area.

Materials:

Locally available materials (e.g. sticks, stones, leaves, ash, grass etc), flip chart , coloured cards, marker pens, masking tape/sticky stuff, scissors etc.

Method:

Mapping should first be done on an open ground (with sticks, stones, leaves, ash, grass etc), indicating details relating to health and diarrhoea like the major defaecation areas; households with and without latrines, refuse pits, pot racks, hand washing facilities; water points (protected/unprotected and functional/non-functional); cattle pens; local health centres; schools and so on.

The facilitator will then ask the community to:

i. Visualise their area and draw it indicating the outer boundary of the village, their households (further clarifying which households have latrines, hand washing facilities, refuse pits, pot racks and which ones don’t have); main landmarks like schools, churches, main roads, bushes, forests, water sources, etc.

ii. Show places of open defaecation on the map.

iii. Draw lines to connect defaecation sites with their respective homes. This indicates clearly who goes where for open defaecation. At this point there will be a lot of laughter and fun. Allow the same to happen.

After this when the group thinks it’s done, ask them where they go for emergency defaecation, meaning during rains, in the middle of the night, during times of severe diarrhoea or when sick and so on. Allow them to indicate on the map these spots of emergency defaecation. You will find another round of laughter
After the community has agreed on their map, a few members can then remain behind transferring the map onto a flip chart (where coloured cards, marker pens, masking tape/sticky stuff, scissors etc might be required).

4.2 Stage One, Step Two-Ignition Moment:

4.2.1 Transect Walk:

Purpose:

This is a diagnostic/investigative tool meant to get all community members involved in a practical and visual analysis of the community sanitation situation in view of the already produced community map.

Transect walk is the single most important motivating tool because it triggers sense of pride, shame and disgust when visitors and everybody walks through the community map. The pride and embarrassment experienced during this transect walk can result in an immediate desire to strengthen identified positive practices and ultimately stop open defaecation. Even though everyone sees the faeces every day, they only seem to awaken to the problem when stimulated by outsiders to look at and analyse the situation in detail.

The transect walk should be focused, fast and fun.

Materials:

Map drawn during community mapping, shovels, torch.

Method:

A transect walk involves walking with the community members through the village from one side to the other, observing, asking questions, and listening. During a transect walk locate different types of sanitation and hygiene enabling facilities, water points and areas of open
defaecation. Try to understand with the community what constitutes an unhygienic environment. Flash a torch through the hole of a latrine and ask some people to look inside and say what they see, agree on the implication this has on the health of the community.

During the walk:

- Do not avoid the defaecation areas, but rather spend as much time there as possible with them, asking questions, while people observe and smell their faeces and feel uncomfortable at having brought an outsider there. This will help to trigger the sense of disgust and shame that will make them want to do something to change.

**NB:** A transect walk should not be a faeces hunting exercise.

- Draw attention to the flies on the shit, and the chickens, dogs, pigs etc pecking and eating the shit. Ask how often there are flies on their food, and whether they like to eat this kind of local chicken and pigs.
- Collect a sample of some of the shit you come across to your meeting venue.

- From the Transect Walk, place the shit some few meters away from the meeting venue whilst rounding up the tool. This is meant to avoid compromising delivery of the next tool.

### 4.2.2 Identifying and Blocking the Routes (Faecal-Oral Transmission Route):

**Purpose:**

This is an analytical tool used to assist community members appreciate that poor sanitation and hygiene practices including open defaecation have disgusting consequences and create an
unpleasant environment. It also assists communities to analyze and understand how water and sanitation related diseases are transmitted, controlled and prevented.

Materials:

- Glass of water
- Plate of food (preferably local special menu)
- Shit collected from the transect walk
- Plain cards and markers
- Soap and water
- Tippy tap
- Magnifying glass (optional)

Methods:

A number of methods can be used in identifying and blocking the routes viz:

a) From Open Shit to Open Mouth:

- Ask where all the shit identified during the transect walk goes. As people answer that it is washed away in rain, or enters the soil, provide a picture of somebody defaecating. Put some cards and markers near it. Alternatively, put the cards near the heap of shit collected during the transect walk.
- Ask people to pick up the cards and draw or write the different agents or pathways which bring shit into the home e.g. flies; hands, water, wind; chickens and dogs that eat shit; shit smeared ropes (for example, used for tethering animals etc. Allow the community to come up with as many examples as possible.

NB: Use of the F-Diagramme will assist the facilitator focusing the whole discussion.
BARRIERS TO FAECO-ORAL TRANSMISSION OF DISEASES

Primary Barriers:

1. Pit latrines
2. VIPs, flush toilets, etc
3. Protection of water supplies

Secondary Barriers:

4. Protection of food (e.g. safe waste re-use)
5. Washing of hands after defaecation, after cleaning children’s bottoms, before handling food and before eating
6. Protection of food (e.g. storage)
7. Protection of food (e.g. handling, preparation)
8. Protection of water in the home and in transit
9. Safe eating (e.g. Washing fruits and vegetables before eating them raw).

NB: You should never suggest the pathways of contamination. Let the community discuss and identify the routes.
To conclude this tool, carry out a demonstration on the ‘Shamiso ten steps of hand washing’.

b) The Glass of Water:

- Ask for a glass of drinking water. When the glass of water is brought, offer it to someone and ask them to drink it. If they drink the water, then ask others if they can drink the water until everyone agrees that they could drink the water.
- Next, pull a hair from your head (or from a community member) and ask what is in your hand. Ask if they can see it. Then swipe it on the shit on the ground (collected during the transect walk) so that all can see.
- Now dip the hair in the glass of water and ask if they can see anything in the water.
- Next, offer the glass of water to anyone close to you and ask them to drink it. Immediately they will refuse. Pass the glass on to others and ask if they could drink. No one will want to drink that water. Ask why they refuse it. They will answer that it contains shit.
- Now ask how many legs a fly has. They might tell you the correct answer. If not, inform them it has six legs and they all have tiny hairs. Ask if flies could pick up more or less shit than your hair could. The answer should be ‘more’. Allow the community to discuss faecal oral disease transmission (e.g. open defaecation) in relation to the exercise.
c) **Plate of Food:**

- Similarly, take a plate containing some nicely cooked food which is popular in that community. Offer it to someone and ask if they could eat it. If they say yes, then ask others until everyone agrees that they could eat the food.
- Next, put the plate close to the faecal matter picked up during the transect walk. Immediately, flies hovering around the faecal matter will land on the food.
- Then ask if they can see anything on the food left by the flies.

- Next, offer the plate of food to anyone close to you and ask them to eat it. Immediately they will refuse. Pass the plate on to others and ask if they could eat the food. No one will want to eat the food. Ask why they refuse it. They will answer that it contains shit.
- Now ask them what happens when flies sit on their or their children’s food and plate: what are they bringing with them from places where there are no sanitation and hygiene enabling facilities and open defaecation is practiced.
- Finally ask them what they are eating with their food as they practice OD that you witnessed together with them during transect walk. **When someone says that they are eating one another’s shit, bring them to the front to tell everyone.** The bottom line is: everyone in the village is ingesting each other’s shit. Once one of the community members has said this publicly, you can repeat it from time to time. Do not say it before they do. It has to be what they have said as a result of their analysis, not what you have come to tell them. Be very alert for the ignition moment. It is the moment of collective realization that due to open defaecation all are ingesting each other’s faeces and that this will continue as long as open defaecation goes on.
- Ask them to try and mirror the amount of shit ingested every day. Ask how they feel about ingesting each other’s shit because of open defaecation? Don’t suggest anything
at this point. Just leave the thought with them for now, and remind them of it when you summarize at the end of the community analysis.

4.2.3 Calculation of Shit and Medical Expenses:

Purpose:

Purpose with this tool is to assist communities to view the magnitude of the sanitation problem and compare the costs associated with open defaecation versus the benefits associated with the construction of latrines. This will trigger them to take appropriate action.

Shit calculation

Method:

- Ask the community how much human excreta is being generated by each individual or household per day? Households can use their own methods and local measures for calculating how much they are adding to the problem.
- Ask the community how many households there are in their community. The sum of the households then can be added up to produce a figure for the whole community.
- Multiply the daily figure to know how much shit is produced per week, per month, per year and for 10 years. The quantities can add up to a matter of tonnes which may surprise the community. To aid visualization convert kilograms to number of filled containers familiar to the community, for example scotch carts, lorries, etc.
- Ask them such questions as: Where do all the tonnes of shit go to? What are the possible effects of having so much shit on the ground? These questions will get the
community starting to think for themselves about the possible impact of OD. There is no need for you to tell them.

- Ask the community members if they know of any WASH or OD related diseases. Ask them to calculate the costs that are incurred where a child under the age of 5 years suffers from diarrhoea by month and year. Write the amount of the cost on a flip chart. Include as many costs as possible e.g. transport, phone calls, meals, medical bills etc.

- Ask them to calculate how much the whole community spends in a month, a year, and then over ten years. Put this chart next to the calculation of amounts of shit by month, year and ten years. Tell them they are really well off to be able to spend so much. Ask if any families had to borrow money for emergency treatment of diarrhoea for any family member? If so, what was the amount? From whom and where? Was it easy to borrow money and repay it? Who lends money for emergency treatment and at what rate of interest? Individuals, cooperatives, banks, middle men? Never suggest to stop open defaecation or to construct toilets. You are not supposed to suggest or prescribe.

- The key point in the process of triggering is reached when the community arrives at a collective realization that due to OD and other unhygienic practices, everyone is ingesting each other’s faeces, and that this will continue unless these are stopped. At that moment, thank the community for their participation and conclude.

4.2.4 Cost Benefit Analysis (CBA):

Purpose:
To assist communities to compare the costs associated with open defaecation and unhygienic practices versus the costs associated with the construction of latrines and hygiene enabling facilities.

Method:
- Tell the community that you have now understood how the local community is practicing open defaecation and other unhygienic behaviours and are ingesting each other’s shit knowing well the terrible implication of the faecal-oral transmission routes. At that point some might say they do not want to continue. Ask why? The usual reply is that latrines are too costly to build.
• Ask what a BVIP latrine should cost, and what would be the minimum cost. Common answers are $100 – $250 or more. Tell them about the uBVIP latrines constructed elsewhere, and that one can be constructed for only $12-$50. Most will not believe this.

• Ask them if they are really interested to raise their hands. If they do so, explain with detail on chart paper on a wall. Quickly draw a simple uBVIP latrine and indicate the minimum materials required and how it is constructed. (Do not take a drawing with you, but draw it on the spot).

• Ask how much that would cost and how difficult it would be to construct a similar uBVIP latrine? Let them know that this is another design developed and approved by the government.

• Factor in the cost of constructing other sanitation and hygiene enabling facilities e.g. pot racks, refuse pits, hand washing facilities etc.

• Now compare the cost of this simple uBVIP latrine and other sanitation and hygiene enabling facilities with the medical costs calculated above.

• You can also share experiences of other communities who have taken up total sanitation and have achieved success (if these are available).

4.3 Stage Two, Step Three-Community Planning and Follow Up:

4.3.1 Sanitation Ladder:

Purpose:
This is an analytical, informative and planning tool. The purpose of this exercise is to help communities determine where they are in terms of hygiene behavior in general and sanitation progress in particular.

• It assists communities and health workers to reach a consensus on the directions and steps needed for making progress on sanitation development.

• This exercise is used to show the progression from the undesirable to desirable sanitation practices.
Materials:
Pictures depicting various methods of human excreta disposal including the following:
- Open defaecation close to the house
- Bush defaecation
- Covering faeces with leaves
- Picture of person burying faeces
- Traditional pit latrine
- Picture of uBVIP
- Blair latrine without roof
- Un-plastered Blair latrine
- Blair latrine without hand washing facilities
- Blair latrine with hand washing facilities.

Method:
1. In groups give the community the pictures depicting the various methods of excreta/disposal and ask them to sort them out into “steps” according to improvements in sanitation practices
2. Identify the local behavior
3. Identify improvements in behavioral terms
4. Request the community to sort out the pictures of different behaviors into what they consider to be happening now in the area (place at the bottom of the ladder) and what is the ideal behavior at the top.

Discussion Points:

a) In general at which step is the community?
b) Why have people not moved from one step to the other along the ladder?
c) Why are people not constructing latrines?
d) Is it difficult to construct a latrine?
e) How much is a bag of cement in the local area?
f) Are there any local builders
g) What local materials can be used as superstructures that will provide privacy and dignity
h) What barriers are encountered in constructing latrines?
i) Is it necessary to move directly from bush defaecation to the construction of latrines or are there any other steps we can take to improve sanitation practices?

4.3.2 Developing Community WASH Plans:

Purpose

To assist the community in coming up with a plan detailing how they are going to eliminate open defaecation and other unhygienic practices and also sustain the same by identifying and specifying WHAT will be done, WHO will do it and HOW it will be done.

The process of planning should concentrate on immediate positive actions.

Method

- Ask community members if they are willing to start building their own latrines to stop open defaecation and consequently avoid incurring huge medical expenses.
- Put up a flip chart and encourage early action takers to register their names.
- As they come, give them a big clap and say that they are leaders for a clean future.
- Keep them standing in front of the crowd so as to encourage those who are still seated on the fence to take a decision.
- Also call upon members of the community willing to assist others to come forward.
- Take a photograph of the group as those who are going to transform the community’s environment.
- Ask how long before they will stop OD totally. If the answer is more than 2-3 months, ask if 60-90 days of ingesting each other’s shit is acceptable. The response may be to share toilets and to use the dig and bury method (cat sanitation). Identify 2-4 potential natural leaders from this process – these may suggest immediate actions the community may take! (these would become members of the Community Health Club (CHC) or Sanitation Action Group (SAG) to be constituted later).
- Refer people to other actions by nearby communities and what they are doing. If the community is the first in the area, stress the recognition they will receive, and the chance of a special celebration if they become ODF.
- Allow the people to discuss how they plan to efficiently spearhead the operationalisation of their community action plan. Introduce the idea of a committee (CHC, SAG etc) that would be responsible for the day-to-day mobilisation of their community in implementing the agreed actions and plans.
- Discuss and agree on the roles, responsibilities and qualities of good sanitation action groups and their individual members. Point out that an in-depth training would be availed to the group members in order to build its capacity in doing its work.
- Discuss elements of an action plan with clear objective(s), the activities to be carried out; who will be responsible; what resources and/or skills would be needed and when will the activities be implemented. It is important to emphasize that the community members should be the main actors in preparing their own community action plan regarding elimination of OD.
- Ask the community to identify one member of the community to lead the development of the plan. If they do not finish the plan, suggest that they would need to meet at an agreed place and time to finish it off.

**Planning Matrix- Community Planning for Change**

<table>
<thead>
<tr>
<th>Objective</th>
<th>What to do? ie activities to be carried out</th>
<th>Who will do it?</th>
<th>How to do it? ie resources, skills, etc needed</th>
<th>When to do it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliminate OD and other unhygienic practices.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sustain ODF status and upgrade sanitation facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**4.3.3 Formation of Sanitation Action Groups:**
After the plan has been developed, the community should now elect members of their Sanitation Action Group (SAG) Where Community Health Clubs exist these should be encouraged to takeover functions of the SAG.
Before leaving, ask the SAG to rehearse slogans against OD to be chanted by their fellow Villagers.

**NB:** Do not make commitment of benefits.

4.3.4 Evaluating the Triggering Process:
Before leaving the community, it is advisable for the facilitation team to carry out a mini evaluation in terms of the immediate impact arising from the triggering process. More often than note, responses vary widely as one move from one community to the other. If the evaluation result indicates that nobody is prepared to start any local action there and then (see Damp matchbox below), do not feel that you have somehow failed. You have probably started a process.

Below is a common pattern. However like highlighted above, one should take cognisance of the fact that community responses vary widely. There are actions that one can take to fit into different responses. These can be divided into four categories according to intensity as below.
Triggering Responses:

**NB:** The evaluation result can be used to inform frequency of future interventions and the level and intensity of support required.

### 4.3.5 Post-Triggering Guidelines: Strategies to Achieving and Sustaining ODF and other Key Hygienic Practices

It is important to note that ODF is just one of the first significant steps in addressing key sanitation and hygiene practices. For the purposes of achieving and sustaining this and other key health and hygiene practices, it is recommended that CHCs and SHCs be revived and also formed where they don’t exist to assist in achieving and sustaining ODF.

#### 4.3.5.1 Community and School Health Clubs:

As good health is most peoples’ concern, training in sanitation and hygiene, including the elimination of open defaecation becomes an ideal entry point into a community. A Health Club is a community based organization or grouping made up of voluntary men and women dedicated to improving the health and welfare of their community through common knowledge, common understanding and the practice of safe hygiene in the home leading to a fully functional community which is able to manage its own development. School and Community Health Clubs are very powerful vehicles that can be used not only to achieve and sustain ODF, but also to address other key health and hygiene behaviours in a community.
(i) **Community Health Clubs-Vehicle for Community Development:**

Although the CHCs start as a forum to discuss health and hygiene issues, they soon become a vehicle for all types of community development through enabling and facilitating households to organize their lives as a community. Such activities include, but not limited to home based care, income generation, nutrition gardening and other livelihoods projects. This leads to a fully functional community with positive health, attitudes and practices. The SaFPHHE approach encourages triggered communities to form active School and Community Health Clubs to help achieve and sustain the desired health and hygiene behaviours. As membership to the clubs is voluntary, efforts should be made to encourage ALL members of a community, including children and the most vulnerable members, to become members of the formed clubs where within about 6 months, they will gain a basic understanding of the germ theory, and know the transmission, prevention, and cure of all preventable diseases, which are discussed one topic per week for at least 24 weeks. Every session is also combined with simple, inexpensive and doable changes that people can make to their lives without external assistance.

(ii) **What Community Health Clubs can do?**

Although the CHCs start as a forum to discuss health and hygiene issues, they soon become a vehicle for all types of community development through enabling and facilitating households to organize their lives as a community. Such activities include, but not limited to home based care, income generation, nutrition gardening and other livelihoods projects. This leads to a fully functional community with positive health, attitudes and practices. The SaFPHHE approach encourages triggered communities to form active School and Community Health Clubs to help achieve and sustain the desired health and hygiene behaviours. As membership to the clubs is voluntary, efforts should be made to encourage ALL members of a community, including children and the most vulnerable members, to become members of the formed clubs where within about 6 months, they will gain a basic understanding of the germ theory, and know the transmission, prevention, and cure of all preventable diseases, which are discussed one topic per week for at least 24 weeks. Every session is also combined with simple, inexpensive and doable changes that people can make to their lives without external assistance.

(iii) **Other strategies and activities**

It is also important for other hygiene promotion strategies and activities to be running concurrently as a community will be operationalizing their action plan. Such activities may include, but not limited to:

- hygiene education sessions
- hygiene competitions
- exchange visits and village tours
- production and distribution of IEC materials
- documentation through newsletters and human interest stories
4.3.5 Open Defaecation Free (ODF) Verification and Certification:

Definition of ODF:

ODF means that no one ‘shits in the open’ but everyone uses an improved latrine and also washes hands with soap or ash at all critical times using the run to waste/use method.

The key objective of ODF verification is to ascertain that a community has stopped OD practice and that all households dispose of their faeces safely in a latrine. This therefore requires doing physical inspection of the village, to confirm that all households are using latrines, and that there are no human feces (including children’s faeces) found in the open within the village (behind houses and in nearby bushes).

A community is declared ODF if it meets ALL the key indicators listed below:

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>MEANS OF VERIFICATION (MoV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to an improved latrine(^1) by every household &amp; institution ie 100% sanitation coverage.</td>
<td>-Observation of the presence of facilities at HHs, schools, churches, business centers etc -Discussions with HH &amp; community members NB: sharing of facilities is also permitted.</td>
</tr>
<tr>
<td>2. Evidence of latrine use</td>
<td>Observation of existence of a footpath; fresh faeces in the latrine, presence of anal cleansing material, wet soil around HWF, etc</td>
</tr>
<tr>
<td>3. Absence of faecal matter (including children’s faeces) around the homestead, public places/institutions and previous OD sites</td>
<td>Transect walk around the HH/homestead, public places/institutions, bushy areas &amp; discussions with children to verify information provided by adults. Children tend to be more honest than grown-ups on such matters. Their information usually corroborates what is actually taking place in the village.</td>
</tr>
<tr>
<td>4. Existence of community sanctions, rules or other means to check and prevent OD by anyone.</td>
<td>Interviews with SAG members and community leadership</td>
</tr>
</tbody>
</table>

Other Hygiene Enabling Facilities to be assessed but not affecting ODF Declaration and Certification:

| 5. Presence and use of pot racks | Observation of existence and use of pot rack and checking availability utensils, cutlery and crockery. |
| 6. Presence and use of refuse pits | Observation of existence and use of refuse pits. |

\(^1\) An improved latrine is at least a uBVIP, BVIP and at most a Flush Latrine.
Sometimes when a well-organized team goes to do the verification, word may reach ahead of it in the village, and this may lead to the villagers taking extra precautions by clearing any lingering evidence of open defaecation. This situation can be managed by having an advance team visiting the village. The advance team is usually smaller, and makes a surprise visit to the village, and randomly visits some homesteads to ascertain their status. They also visit previous open defaecation sites. If the advance team is satisfied with their findings, the DWSSC may now proceed and organize a bigger technical team that will do a comprehensive visit and ensure 100% coverage of the homes before ODF status is awarded.

ODF verification results should be discussed with the whole community at a meeting so as to point out areas of improvement or next steps to sustain ODF.

### Step 1: Community Self Verification

- The community, through their WWSSC, EHT, SAG and Local Leadership verify 100% of their households and institutions and if they are satisfied, the self declare themselves to be ODF. Invitation is then extended to the District team i.e. DWSSC.

### Step 2: District Verification

- After a village self declares itself ODF, the DWSSC should meet and constitute a verification team of at least 3 members including the DEHO (within 1 month). The District team should also verify 100% of the HHs, institutions and previous OD sites and should do this together with representatives from the respective community. If the standard verification criterion is met, then the District team declares the Village ODF.

### Step 3: National/Provincial Verification

- A Provincial Team i.e. PWSSC of at least 2 members including the PEHO (which in some cases may include the national team) does quality assurance on the declared Villages.

- This should take place within 3 months after each district declaration. The team should sample at least 10% of the HHs & 50% of the institutions & previous OD sites in each ODF district declared Village.

### Standard ODF Verification Process

- **Step 1** Community Self Verification
- **Step 2** District Verification
- **Step 3** National/Provincial Verification
Discussing and Agreeing on the Verification Tools and Logistics:

It is important that before the verification team goes to the field to carry out the verification exercise, it discusses and comes to a common understanding of the tool to be used. The team may agree to split up in small groups, or conduct the exercise as one group.

Tell-tale Signs of True ODF:

When a village is ODF, you will notice increased confidence amongst the villagers whenever they talk about latrines. For example they would be much more willing to welcome you to their homes and readily show you where their latrines are and take you around their previous OD sites. Where open defaecation is still practiced, some villagers will shy away from talking to the verification team; some may hide, and others may literally run away when they notice the verification team.

When a community reaches maturity of understanding and actioning on their sanitation matters, it is expected that they also adopt other simple hygiene behaviors such as washing their hands at critical times, centralizing waste in an organized manner and be able to manage kitchen utensils in a hygienic manner.

ODF Verification Tool:

This is the tool which the verification team uses to capture data on the household and community key indicators for ODF. The community verification tool serves to triangulate the data obtained during the household verifications. After the data is captured, the team would then analyze the data so as to come to a conclusion on whether the community would have attained ODF or not. It is recommended that the team declares a community to be ODF if 100% of the households attain a score of 1 AND if the community verification confirms that indeed the community is ODF. The tool is as attached in Annex 1.

ODF Certification:

Communities, once verified with the process outlined above, shall receive official certification (sample herein attached as Annex 2). Recognition of certification by signposts,
certificates, a ceremony or any other appropriate means shall be made to praise community members and encourage further sanitation and hygiene improvements. Continuous follow-up visits by the district, provincial and national teams shall be conducted for the certified communities to ensure that the ODF status is maintained, and where need be provide support in re-attaining ODF status if a community reverts to its previous OD practice.
Annex 1

ODF Verification Tool:

***should be completed in triplicates: 1 copy for the community; 1 copy for the DWSSC &
1 copy for PWSSC

<table>
<thead>
<tr>
<th>DATE</th>
<th>PROVINCE</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>WARD</th>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>VILLAGE</th>
<th>No. of HHs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(a). Household ODF Verification Tool

<table>
<thead>
<tr>
<th>Household Name ** list all HHs in the verified community</th>
<th>Access to an improved latrine (uBVIP, BVIP)</th>
<th>Evidence of use</th>
<th>Absence of faeces around the homesteads</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 – no facility/ access</td>
<td>0 – no facility or no evidence of latrine use</td>
<td>0 – faeces present</td>
<td>0 – if HH scores a 0 on at least one indicator</td>
</tr>
<tr>
<td></td>
<td>1– facility present or accessible</td>
<td>1 – latrine being used</td>
<td>1 – faeces absent</td>
<td>1 – if HH scores 3 1s</td>
</tr>
<tr>
<td></td>
<td>** sharing of facilities permissible</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Overall HH verification score:

<table>
<thead>
<tr>
<th>Percentage of HHs scoring a 0</th>
<th>Percentage of HHs scoring a 1</th>
<th>Overall score**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>**0 if less than 100% of the HHs score a 1. 1 if 100% of the HHs score a 1.</td>
</tr>
</tbody>
</table>

Verification of other Hygiene Enabling Facilities:

Mark relevant box with an ‘X’

<table>
<thead>
<tr>
<th>Transect walk around the households confirm presence and use of rubbish pits</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubbish not observed around households.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transect walk around the households confirm presence and use of pot racks</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pot racks observed at the households.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pot racks not observed around households.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(b) Community/Institutional ODF Verification Tool

**Mark relevant box with an ‘X’**

| Transect walk around the community, institutions (schools, clinics, churches, markets, business centers etc) and previous OD sites confirm absence of faeces | Yes faeces not observed during transect walk | No faeces observed during the transect walk |
| Informal discussions with community members (especially children) confirm absence of OD. | Yes community members confirm that OD is no longer being practiced | No community members confirm that OD is still being practiced |
| Observations around the institutions confirm presence and use of latrines | Yes Sanitation facilities observed | No Sanitation facilities not seen |
| Interviews with SAG members and community leadership confirms presence of community sanctions, rules and other means to check and prevent OD by anyone. | Yes Rules/ sanctions exist | No Rules/sanctions do not exist |

**Comments:**
List any other methods used to confirm presence or absence of ODF community.

**Overall community/ institutional verification score**

<table>
<thead>
<tr>
<th>Overall score**</th>
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**0 – if at least one of the means of verifications confirms the presence of OD.**

**1 – if ALL the means of verifications confirms absence of OD**
Village Coverage of other Sanitation and Hygiene Enabling Facilities:

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Refuse Pits</th>
<th>Pot Racks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
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<tr>
<td>Percentage Coverage</td>
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</tbody>
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(c) Final Verification Result

** Community is declared ODF if it scores a 1 for both verification tools

<table>
<thead>
<tr>
<th>ODF Status Granted (circle appropriate box)</th>
<th>YES</th>
<th>NO</th>
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Verification Team

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
<th>CONTACT DETAILS</th>
<th>SIGNATURES</th>
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