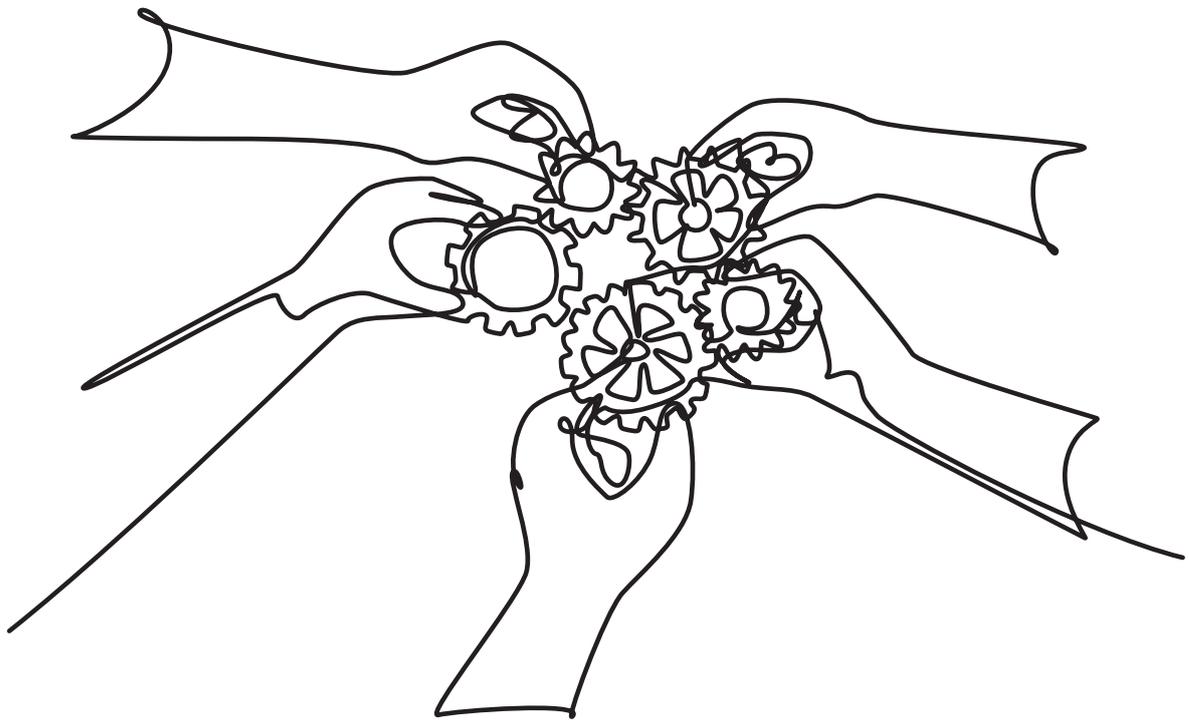


WASH and health working together:

**a 'how-to' guide for
neglected tropical disease
programmes**

Second edition



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Abbreviations

AE	alveolar echinococcosis
BEST	behaviour change, environment, social inclusion, treatment and care
CE	cystic echinococcosis
CHAST	children's hygiene and sanitation training
CHIP	Country Health Information Platform
CLTS	community-led total sanitation
DHS	Demographic Health Surveys
DPO	disabled persons organization
EMIS	education management information system
EPI	Expanded Programme on Immunization
EPIRF	Epidemiological Data Reporting Form
ESPEN	Expanded Special Project for Elimination of NTDs
FBT	foodborne trematodes
FCDO	Foreign, Commonwealth and Development Office (United Kingdom)
FMWR	Federal Ministry of Water Resources (Nigeria)
HAT	<i>human African trypanosomiasis</i>
HCF	health care facility
HMIS	health management information system
IEC	information, education and communication
IMCI	integrated management of childhood illness
IPC	infection prevention and control
IU	implementation unit
JMP	WHO-UNICEF Joint Monitoring Programme for Water and Sanitation
KAP	knowledge, attitudes and practice
LF	lymphatic filariasis
M&E	monitoring and evaluation
MDA	mass drug administration
MICS	Multiple Indicator Cluster Survey
MoV	means of verification
NGO	nongovernmental organization
Norad	Norwegian Agency for Development Cooperation
NTDs	neglected tropical diseases
ODF	open defecation free
PC	preventive chemotherapy
PHAST	participatory hygiene and sanitation transformation
SBC	social and behaviour change
SCH	schistosomiasis
SLTS	school-led total sanitation
STH	soil-transmitted helminthiasis
UHC	universal health coverage
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

I.

What can this toolkit help you achieve?

The equity focus set out by the 2030 Agenda for Sustainable Development demands new ways to extend services to unserved populations. Successful water, sanitation and hygiene (WASH) and neglected tropical disease (NTD) partnerships have the potential to help achieve this ambition. However, working together in new ways requires new ways of thinking.





What can this toolkit help you achieve?

If you are an NTD programme manager or programme partner, this toolkit will help you to work with the WASH community, guiding you through building partnerships, mobilizing resources, and designing, implementing and evaluating interventions. This set of tools is based on real-life programme experience; you can choose and adapt tools according to your needs and local context. The toolkit is designed to help you:

- Build multisectoral partnerships with key stakeholders: ministries, national and local WASH agencies, corporate entities, local health groups, behaviour change and communication experts, etc.
- Shape smart programme structures focused on accountability and shared goals.
- Build an adaptive and flexible approach to programming.
- Ensure sustainability by supporting local capacity at every level.
- Support and complement clinical and public health interventions for NTD control, elimination and eradication.

How to use it?

You can use this toolkit:

- As a step-by-step planning guide.
- As a checklist to ensure that your planning process is on the right path.
- As a reference document to refresh your knowledge on planning and on the links between WASH and NTDs.
- To engage non-NTD partners in planning and delivery.

How was it developed?

The toolkit was developed in collaboration between the NTD NGO Network WASH Working Group and WHO, capitalizing on the experience of member organizations and national NTD programmes. It draws on tools and practices used in the delivery of coordinated and integrated programmes for control, elimination and eradication of NTDs. Following the initial publication of the toolkit in January 2019, this second edition (2022) is based on a review of the application and use of the tools and resources the toolkit contains.

What's inside?

Following this introductory section, Section II gives the context and approach of this guide – how to achieve collaboration between WASH and NTDs to extend services to unserved populations. Section III sets out the steps to delivering successful programmes and interventions. Section IV provides the core tools referred to throughout this guide. Additionally, supplementary tools can be found online and key resources are provided.

- Core tool  and, for Tools 6, 7 and 11, an online Annex 
- Supplementary tool (online) 
- Resource 

Context: collaboration on WASH and NTDs

Core tools

Tool 1: Interventions for NTD control, elimination, eradication and care 

Tool 2: NTD-related behaviours 

Tool 3: Understanding behaviour to develop behaviour change interventions 

Resources

- WHO. Water, sanitation and hygiene for accelerating and sustaining progress on neglected tropical diseases: a global strategy 2015–2020 
- Neglected Tropical Disease NGO Network. The BEST Framework 
- WHO. Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030 
- WHO. Ending the neglect to attain the Sustainable Development Goals: a global strategy on water, sanitation and hygiene to combat neglected tropical diseases 2021–2030 
- WaterAid. Briefing note: Mass behaviour change campaigns. What works and what doesn't 
- Compass. How to conduct a pre-test 
- WHO. Guidelines on sanitation and health 
- Global Handwashing Partnership. The handwashing handbook 
- WHO. Sanitation safety planning (manual) 
- SDG definitions of sanitation service levels (safely managed sanitation, basic, limited, unimproved, open defecation) 
- WHO. Ending the neglect to attain the Sustainable Development Goals: One Health approach for action against neglected tropical diseases 2021–2030 
- WHO. Rabies and One Health OpenWHO course: Rabies & One Health: From basics to cross-sectoral action to stop human rabies deaths 
- UNICEF. Make it count: guidance on disability inclusive WASH programme data collection, monitoring and reporting 

STEP 1. Setting the programme vision

This section of the toolkit should help you analyse your programme context and begin identifying new partners, so you can start planning.

STEP 2. Building partnership

Partnership is crucial for the achievement of NTD control, elimination and eradication targets and for ensuring that the impact of programmes is long-lasting. This section will guide you on how to link NTDs to the objectives of other partners, and help you address challenges you may face as you bring different types of partners into your programme.

Core tools

Tool 4: Messages for engagement 

Tool 5: Initial cross-sectoral meeting for WASH and NTDs: annotated agenda 

STEP 3. Analysing the situation

Being informed and prepared about the national and local context in which you are working can make all the difference to the eventual success of the programme. This section will guide you through the steps to develop a situation analysis, which you can use to identify opportunities and challenges for planning.

Core tool

Tool 6: Situation analysis for WASH and NTD planning: protocol and methods  + Annex (online) 

Supplementary tools (online)

Supplementary tool: WASH-NTD partner form 

Supplementary tool: WASH-NTD situation analysis findings presentation template 

Supplementary tool: Information and examples on data merge 

Supplementary tool: WASH and NTDs decision matrix instructions  and Supplementary tool: WASH Decision Matrix Template 

Supplementary tool: Instructions for using ESPEN Portal data 

Resource

WHO. Country Health Information Platform (CHIP): registration 

STEP 4. Planning and programme design

This section will help you identify where new actions are needed, as well as where it is feasible to link, coordinate or integrate existing programme activities across different sectors and agencies.

Core tools

Tool 7: Planning tool: step-by-step process to developing comprehensive and adaptive NTD programmes 🌀 + Annex (online) 📄

Tool 8: Agenda for joint planning workshop 🌀

Supplementary tools (online)

Supplementary tool: Problem analysis approaches 🗑️

Supplementary tool: Planning for elimination 🗑️

Supplementary tool: Improving coordination in low-resource settings 🗑️

Supplementary tool: Budgeting for joint WASH and NTDs programmes 🗑️

Resources

- WaterAid, Plan International and UNICEF: Guidance on costing of rural sanitation approaches 🔄
- WHO WASH accounts initiative 🔄

STEP 5. Implementing and monitoring

This section will provide useful steps to put in place implementation and monitoring and evaluation (M&E) structures and processes to ensure results, improve accountability and support learning and adaptive planning.

Core tools

Tool 9: Routine supervision of WASH and NTDs programmes: guide and form 🌀

Tool 10: National framework on WASH and NTDs template 🌀

Tool 11: WASH-NTD indicators and logframe 🌀 + Annex (online) 📄

Supplementary tools (online)

Supplementary tool: Programme dashboard template 🗑️

Supplementary tool: National framework checklist 🗑️

Supplementary tool: Programme risk analysis 🗑️

Resources

- Tropical Data. Methodology 🔄
- WHO. Helminth control in school age children: a guide for managers of control programmes, second edition 🔄

II.

Context: collaboration on WASH and NTDs

Collaboration on WASH and NTDs, initiated under the first WASH and NTD strategy in 2015 – (*Water sanitation and hygiene for accelerating and sustaining progress on neglected tropical diseases: a global strategy 2015–2020* ) was given new momentum in 2021, with the release of a new NTD road map (*Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030* ) which includes a pillar on implementation of cross-cutting approaches as well as dedicated targets for achieving universal access to WASH services in endemic areas by 2030. The road map was accompanied by a renewed global strategy and action plan on WASH and NTDs (*Ending the neglect to attain the Sustainable Development Goals: a global strategy on water, sanitation and hygiene to combat neglected tropical diseases 2021–2030* ) which consolidated recent experience on cross-sectoral collaboration and embedded *the BEST Framework*  in the WHO approach.

The BEST Framework, developed by the NTD NGO Network in 2016, supports the strategy by offering a conceptual framework to ensure that all actions needed for NTD control, elimination and eradication, including water and sanitation as well as all other key interventions, are addressed while ensuring sustainability and systems strengthening. The BEST Framework can be used to plan, fund and deliver comprehensive approaches that target the population groups most in need.

II.

Context: collaboration on WASH and NTDs

The BEST Framework for NTDs

Fig. 1. The BEST Framework



Source: NTD NGO Network .

The BEST Framework encompasses:

- **Behaviours** (physical, attitudes, institutional);
- **Environment** (sanitation and waste, infection prevention and control [IPC] in health care, water infrastructure, vector control and veterinary public health);
- **Social inclusion** (empowerment of communities affected by NTDs, addressing stigma and discrimination);
- **Treatment and care** (chemotherapy, surgery, disease management and self-care, rehabilitation and health systems strengthening).

Tool 1 sets out the key interventions under each BEST component for all NTDs, and highlights the necessary WASH conditions and interventions.

See **Tool 1: Interventions for NTD control, elimination, eradication and care** .



WASH in behaviour change

Human behaviour is influenced by the environment, family, society and culture. Behaviour change is influenced by many interrelated factors, such as perception of risk or benefit related to a given behaviour; the skills and belief in the ability to change; access to resources necessary to perform the new behaviour; and norms and values within the family, community and society.

Why address behaviour?

Disease transmission is determined by people's way of life and practices. While they often engage in practices passed down through generations, people can change behaviours to prevent or reduce disease. Communities can normalize new behaviours, while policy-makers can sustain these normalizations, transforming individual behaviours into social norms. The prevention of many NTDs relies in part on WASH behaviours such as improved hygiene and sanitation practices. Behaviour change efforts in NTD programmes should also accommodate timely care-seeking behaviours, uptake of and adherence to treatment to prevent long-term negative consequences such as increased disease severity, and advocacy for change.

See **Tool 2: NTD-related behaviours** .

What can programmes do to promote behaviour change?

Interventions should be developed based on an understanding of behaviours and their determinants in target communities and focused on addressing the factors and mechanisms that influence behaviour. Changing behaviours is complex and requires time. Since change is more likely when supported by a change in social norms, interventions should aim to reach entire groups in the programme area. One possibility is to embed the relevant behaviours in other development programmes, e.g. large-scale campaigns on child health, family health, sanitation/hygiene, nutrition etc. (umbrella campaigns, which address multiple behaviours under a single, aspirational brand may be appropriate). These programmes may already cover NTD-related behaviours, even if they have not been specifically designed for NTD control. Nonetheless, given that NTD transmission can involve highly specific behaviours, it may not always be possible to embed all relevant aspects into broader programmes. In the context of areas with high endemicity and co-endemicity of NTDs, a more targeted behaviour change programme may be appropriate (see WaterAid's briefing note: **Mass behaviour change campaigns. What works and what doesn't** .

Developing a behaviour change programme

Behaviour change programmes have, in the past, been designed based on the assumption that knowledge and awareness primarily drive behaviour – leading to educational interventions using posters, brochures and educational talks as stand-alone interventions. Although these can play a role, they have not proved to be effective at changing and sustaining behaviours when not partnered with interpersonal communication or other supporting mass media. Effective behaviour change programmes therefore require understanding and addressing the underlying drivers of behaviour.

Gather information about relevant behaviours and their causes (formative research)

Formative research, unlike commonly used knowledge, attitudes and practice (KAP) surveys, provides information on what people do, when and why in the specific programme area, and what actions could be taken to change behaviours. While research may sound daunting, this is simply about collecting information to better understand the target population, and to learn about the context of behaviours, including the causes, physical, psychosocial, sociocultural, structural and other influencers and barriers to specific behaviours. Some information may already be available from existing research and situational analyses. Formative research enables the design of a programme approach, activities and tools that are appropriate and relevant to the target group.

See **Tool 3: Understanding behaviour to develop behaviour change interventions** .

Develop a behaviour change intervention

- Translate the insights from the formative research into specific objectives for the programme, including the key aspects the programme needs to address: the practices that need changing, what drives them, and the mechanisms for change.
- Design and pre-test an appealing intervention package involving marketing, branding and creative agencies/individuals, as well as representatives from the target audience and those who will be implementing the intervention can deliver a more effective package and avoids developing stand-alone knowledge-based educational programmes. Cultural appropriateness, accessibility, language and enabling access to inputs (e.g. soap, water containers) should be reflected in the design, and the resulting package should suit the delivery channel (i.e. the specific programme activity through which the behaviour change intervention will be delivered) in terms of use and usefulness. Inclusion of all members of the target group should be part of the design process (e.g. taking into consideration literacy, gender, disability and other aspects). Pre-testing of the materials and revision before a final version is produced is essential (see the **Compass resource for pre-testing tools** .

Implementing and monitoring a behaviour change programme

A successful programme requires a substantive implementation period with sufficient exposure and contact points (making clear the advantages of embedding behaviour change components in routine programmes or undertaking long-term mass media campaigns that are well designed, accessible in various formats, funded and reach many people repeatedly). Monitoring the outcome is essential, as being reached with messages does not guarantee behaviour change. The main focus of monitoring and evaluation (M&E) for behaviour change should be intermediate and long-term behavioural outcomes. Refer to STEP 5 of this toolkit and WHO **Guidelines on sanitation and health: Chapter 5** , which set out the main approaches. The recently published **The handwashing handbook**  offers useful insights for the design, delivery and monitoring of hygiene behaviour change programmes.

Key lessons from behaviour change programmes

- There is no one-size-fits-all behaviour change intervention. A combined multiple, context-specific promotional approach, based on a thorough understanding of behaviours and their determinants, tends to be effective.
- Behaviour change programmes that are culturally salient and locally owned and driven are more likely to be sustained and effective. Community-based approaches and social marketing are effective in reducing open defecation and improving toilet use.
- Long-term behaviour change requires sufficient and dedicated budgets and sufficient implementation time.
- Promotional approaches addressing behavioural determinants and social norms are better at changing and sustaining behaviours than educational approaches.
- Children can be effective behavioural change agents for families and households.
- Government leadership and integrating behaviour change into wider development efforts are critical.



WASH in environment

Although environmental aspects are key to disease control, they are often addressed separately from NTD programmes. When environmental aspects are included in NTD programmes, they rarely address all transmission routes while providing people with adequate water and sanitation services that meet their needs and preferences. A comprehensive approach that delivers sustainable environmental services is needed to achieve and sustain disease control objectives.

Key WASH considerations for NTD programmes

- **Open defecation:** Preventing open defecation by encouraging household toilet construction requires changing social norms around sanitation, especially in rural areas, and providing options for sanitation hardware. Not all households are able to build their own toilets, due to cost, soil conditions, land tenure etc., so solutions must be context relevant. Cultural contexts may require separate toilets for men and women and accessibility for children and adults with disabilities needs to be considered.
- **Pathogen-free environment:** The existence of a toilet does not immediately translate into reduction in exposure to faecal-borne pathogens. For this to occur, toilets should be used by everyone, always, including small children (through safe disposal of faeces), pregnant women, older people, and adults and children with disabilities, offering a pleasant, safe and desirable alternative to open defecation. The main focus on sanitation programmes should be on increasing access to safely managed sanitation services, with toilets provided resulting in safe separation of faeces from humans, animals and vectors. This means that construction should consider the entire sanitation service chain as defined by the WHO **Guidelines on sanitation and health** , including containment, pit/septic tank emptying, safe transportation, disposal/treatment of waste, and protection of water sources from contamination. Additionally, households with toilets are not protected from waste produced by neighbouring households without adequate toilets, and sanitation planning should consider coverage of entire communities with safely managed sanitation services.
- **Beyond the household:** Full community coverage of sanitation includes schools, health care facilities, markets, places of worship and other public buildings and spaces. In health care settings, this must include inclusive and accessible WASH infrastructure, IPC and vector control measures. Some environments, such as nomadic or itinerant communities, as well as areas affected by conflict, present further challenges for water and sanitation provision.
- **Water supply:** Safe, reliable, affordable, universally accessible and sustainable water infrastructure is needed to prevent consumption of contaminated water, reduce contact with surface water and enable personal hygiene practices.
- **Safe storage of water:** Unreliable water supply services have led to large-scale storage of water in overhead tanks, underground tanks, drums and buckets inside and outside the home. These water storage methods should be protected by covering them at all times to prevent continuation, breeding of mosquitoes etc.

Factors beyond the provision of toilets and water supply

- Many upstream and downstream water and sanitation aspects impact NTD control. For example, dam construction to increase availability of water for domestic and productive uses can increase the risk of schistosomiasis, and water bodies for various uses can act as vector breeding sites. Water containers, drainage channels and pit latrines/septic tanks should be constructed and maintained in a way that prevents access by animals and vector breeding, and which doesn't create obstacles or dangers in the environment for persons using wheelchairs or those who are blind or have low vision. Upstream aspects include water production and abstraction, water resource protection, river basin development, and water treatment, transport and distribution; while downstream aspects include wastewater and faecal sludge transport, treatment and safe disposal.
- Solid household waste can encourage breeding of vectors, e.g. flies, mosquitoes and rats; in urban areas it can block and damage drains and create vector breeding sites. Sanitation interventions should therefore include aspects such as appropriate waste management and disposal, as well as overall community cleanliness, and form part of integrated vector management interventions.
- Animals, particularly livestock, are a crucial economic and cultural asset for many households and communities. Proximity to animals influences various disease transmission risks: animal excreta can be both pathogenic and attractive to flies, and animals can act as vectors for human faecal pathogens within the household. Disease control programmes are more likely to succeed if they balance disease control imperatives with social and economic considerations. Veterinary public health services should be linked with disease control efforts, ensuring appropriate livestock keeping and food safety practices and utilizing the available expertise for disease surveillance and control.

Additional resources

- WHO **Guidelines on sanitation and health** .
- **SDG definitions of sanitation service levels** (safely managed sanitation, basic, limited, unimproved, open defecation) .
- WHO **Sanitation safety planning (manual)** .
- **Ending the neglect to attain the Sustainable Development Goals: One Health approach for action against neglected tropical diseases 2021–2030** .
- Rabies and One Health OpenWHO course for further information on rabies specifically: **Rabies & One Health: From basics to cross-sectoral action to stop human rabies deaths** .



WASH in social inclusion

NTDs often affect the poorest and most marginalized groups and are both a cause and consequence of poverty, social inequality and lack of access to basic services.

Targeting inclusive WASH services towards the people most affected by NTDs (people with NTD-related morbidities and disabilities) and at-risk individuals and groups (people living in poverty, vulnerable women and children, or population groups who are systematically marginalized) should therefore be fundamental to NTD control efforts. Programmes and policies should go beyond the practical needs of affected individuals to transformative WASH interventions that can positively impact on power relations within communities and societies. However, the fact that WASH services tend to be harder to deliver in hard-to-reach populations, and that those affected by NTDs are less likely to be able to invest their own limited resources in improving their own access to services, means that interventions are often insufficiently targeted towards those that need them the most.

Voice, participation and leadership

Well-designed programmes that understand and tackle the barriers faced by disadvantaged groups can foster social inclusion. Active and meaningful participation of groups at risk of marginalization is critical for planning, implementation and monitoring of WASH and NTDs programmes and strengthens the likelihood of sustained behaviour change and access to available, accessible, high-quality, affordable and acceptable water and sanitation facilities. Programmes must address institutional, environmental and attitudinal barriers to inclusion, by:

- Ensuring recognition and understanding by service providers of the differential needs of individuals and groups and the root causes of their exclusion, by promoting and ensuring participation of groups and individuals at risk of exclusion and marginalization such as disabled persons organizations (DPOs) and women's group members in WASH and NTD decision-making processes.
- Identifying and implementing appropriate, accessible and sustainable solutions, avoiding one-size-fits-all technology fixes and ensuring that any infrastructure provided is inclusive.
- Ensuring that activities such as hygiene and sanitation promotion are relevant to and inclusive of all groups, for example, by making promotional materials and activities inclusive of people with disabilities, suggesting design modifications to make water points and toilets accessible, and discussing opportunities to access subsidies where financial and material resources for construction may not be available.

Combating stigma and discrimination

Stigma, driven by misconceptions related to disease and visible disfigurement caused by NTDs, and to persons with disability as a group, is linked to social exclusion and can result in reduced education and work opportunities and social capital (e.g. marriage prospects, creating friendship and networks, inclusion in social events). It can also determine the effectiveness of disease control by affecting uptake and participation. Access to WASH is fundamental to dignity and to combating stigma (for example, by improving the capacity for self-care and therefore improved wound management and reduced disfigurement). However, WASH access is also affected by social factors including gender identity, disability, social status, support from family and economic factors. People affected by NTDs may have additional sanitation and hygiene needs to manage the disease compared with those unaffected, while also more likely to face additional barriers to WASH access due to stigma, self-stigma, discrimination and exclusion from communal WASH services.

Behaviour change and norm setting

Groups at risk of marginalization are likely to face multiple barriers to participation in planning and decision-making for WASH and may not have the power or resources to take part in WASH implementation. Promotion activities implemented to change community-wide behaviours and norms for hygiene and sanitation should be conducted in an inclusive way, avoiding stigma, shaming or marginalization by focusing on community, rather than individual, practices. For example, approaches such as community-led total sanitation, which use disgust and shame as drivers for community behaviour change, should not perpetuate stigma or discrimination of people who may be less able to construct toilets or handwashing stations. NTD and WASH actors can combat stigma in their programmes by:

- Avoiding stereotypes, language or images that reinforce gender inequality, disability, stigma or social exclusion, like using negative images of people affected by NTDs or those that have a disability to encourage uptake of mass drug administration (MDA) or WASH behaviour change.
- Using the language and traditions of excluded groups to reinforce change and seeking the input of DPOs and other groups to create locally appropriate non-discriminatory/non-stigmatizing language and materials.
- Improving privacy, safety and dignity through private and secure toilets that are accessible and suited to the physical needs of all household members, including people with disabilities. Shared facilities like community and public toilets should be accessible, well-lit and secure for all users. Cleanliness and management of toilets is important, ensuring that reliance on others for toilet construction (in the case of households unable to construct their own) does not result in poor quality.

Inclusive services

Removing institutional and environmental barriers to inclusion requires provision of high-quality social support services, and creating opportunities for formal and informal work, so that people with disabilities and other key groups can claim their rights to health and WASH services. Groups at risk of marginalization should be targeted specifically while efforts are made to improve the access and inclusivity of services overall. Advocacy and technical support are needed to create public policies that remove barriers to accessing services. NTD stakeholders can facilitate links to support networks and services and strengthen the inclusion focus of interventions. Priority action areas to support this are:

- Facilitating links to wider support mechanisms and initiatives by engaging women's groups, microcredit schemes, DPOs and community-based self-care and rehabilitation schemes. By joining social and financial support programmes, members of these groups can advocate for inclusion in mainstream development programmes and wider society.
- Including equity and inclusion approaches and indicators in plans, proposals, budgets and regular reporting as well as in baseline data collection, outcome surveys and sustainability studies, to ensure progress on reaching the most vulnerable is monitored.

Learning on equity and inclusion should be done regularly, by facilitating regular discussion with partners and communities and feeding back into programme strategies. Some relevant indicators have been included in the indicator menu in **Tool 11: WASH-NTD indicators and logframe** . Further guidance can be found in the United Nations Children's Fund (UNICEF) and Norwegian Agency for Development Cooperation (Norad) publication: ***Make it count: guidance on disability inclusive WASH programme data collection, monitoring and reporting*** .



WASH in treatment and care

WASH plays a crucial role in achieving universal health coverage (UHC), including promotive, preventive, curative and rehabilitative services. It contributes to strong health systems that can deliver comprehensive and inclusive management along the continuum of care beyond prevention or cure.

Ensuring WASH supports treatment and care of NTDs

- Any contact between health care providers and health care service users is an opportunity to raise awareness on disease transmission and key preventive behaviours, through counselling to patients and carers during treatment, and through existing health care outreach programmes and community health volunteer schemes.
- MDA should be implemented alongside other interventions to interrupt transmission and reinfection including water and sanitation infrastructure and is also an important entry point for behaviour change activities including hygiene and sanitation promotion.
- Several NTDs require hospital admission, surgery and other medical interventions. Health care settings require adequate and accessible water and sanitation to ensure infection prevention and control (IPC) as well as dignity for patients and staff. WASH conditions in health care settings also underpin uptake of facility-based services, and health care worker retention and motivation.
- Access to WASH is crucial for disease management and self-care such as for wound management and hygiene practices for some of the most debilitating NTDs with which stigma is frequently associated, to reduce disease severity, prevent suffering and reduce vulnerability to poverty, disability, stigma and exclusion. As certain diseases may result in exclusion from basic services such as water and sanitation, specific efforts are needed to prevent exclusion and address stigma at the patient (self-stigmatization), community and health care levels. Self-help groups can play an important role in empowering individuals to care for themselves and in securing access to water and sanitation services.
- Access to quality, affordable rehabilitation and care services can deliver economic and social benefits, for example, by facilitating recovery from surgery, addressing pain management, maintaining dignity and maximizing independence. Inclusive and comprehensive care has also been shown to improve uptake of other services, such as MDA. This must include provision of accessible and affordable water and sanitation facilities, and provision for maintaining hygiene.

III.

Steps to success

Delivering a comprehensive, multisectoral NTD programme is not only a good idea programmatically but is also more likely to deliver continued results. This section of the toolkit should help you analyse your programme context and begin identifying new partners, so you can start planning.



III.

Steps to success

STEP 1. Setting the programme vision

STEP 2. Building partnership

STEP 3. Analysing the situation

STEP 4. Planning and programme design

STEP 5. Implementing and monitoring

STEP 1

Setting the programme vision

This initial step of the process can be done with a small group, led by you as the programme manager. As you progress through the planning process, your vision will become clearer and more specific.

Establishing the programme vision

Ask yourself and the group, based on the information you have right now and your knowledge of the context:

- 1.** What are you trying to achieve with this process?
For example: sustained control or elimination of a specific disease/set of diseases.
- 2.** What will it take?
For example: funding, efficient cross-ministerial collaboration, a behaviour change programme, etc.
- 3.** How is the problem/vision linked to the broader national agenda?
For example: achieving and sustaining health outcomes, equity, stated government/ministry policy priorities, etc.

Based on this, define your overall vision: *For example: achieving elimination to contribute towards the SDGs through an effective multisectoral programme.*

Ask yourself and the group: Why hasn't it happened yet? What are the initial barriers impeding progress? This can be as simple as not knowing who to contact in other ministries/agencies, not having clearly defined programme solutions, funding restrictions and so on – these challenges are surprisingly common across all countries. This step leads to the next phase – finding your partners and starting a joint planning process.

STEP 2

Building partnership

Partnership is crucial for the achievement of NTD control, elimination and eradication targets and for ensuring that the impact of programmes is long lasting. But partnership between different sectors and government departments is often difficult to establish – different sectors have different objectives, are influenced by different incentives, and at times, speak a very different professional language. The way the government and other agency institutions are organized can also become a barrier to collaboration due to simple reasons such as location in different buildings or conflicting planning and budgeting cycles.

This section will guide you on how to link NTDs to the objectives of other partners, and help you address challenges you may face as you bring different types of partners into your programme.

Fig. 2. The benefits of cross-sector collaboration

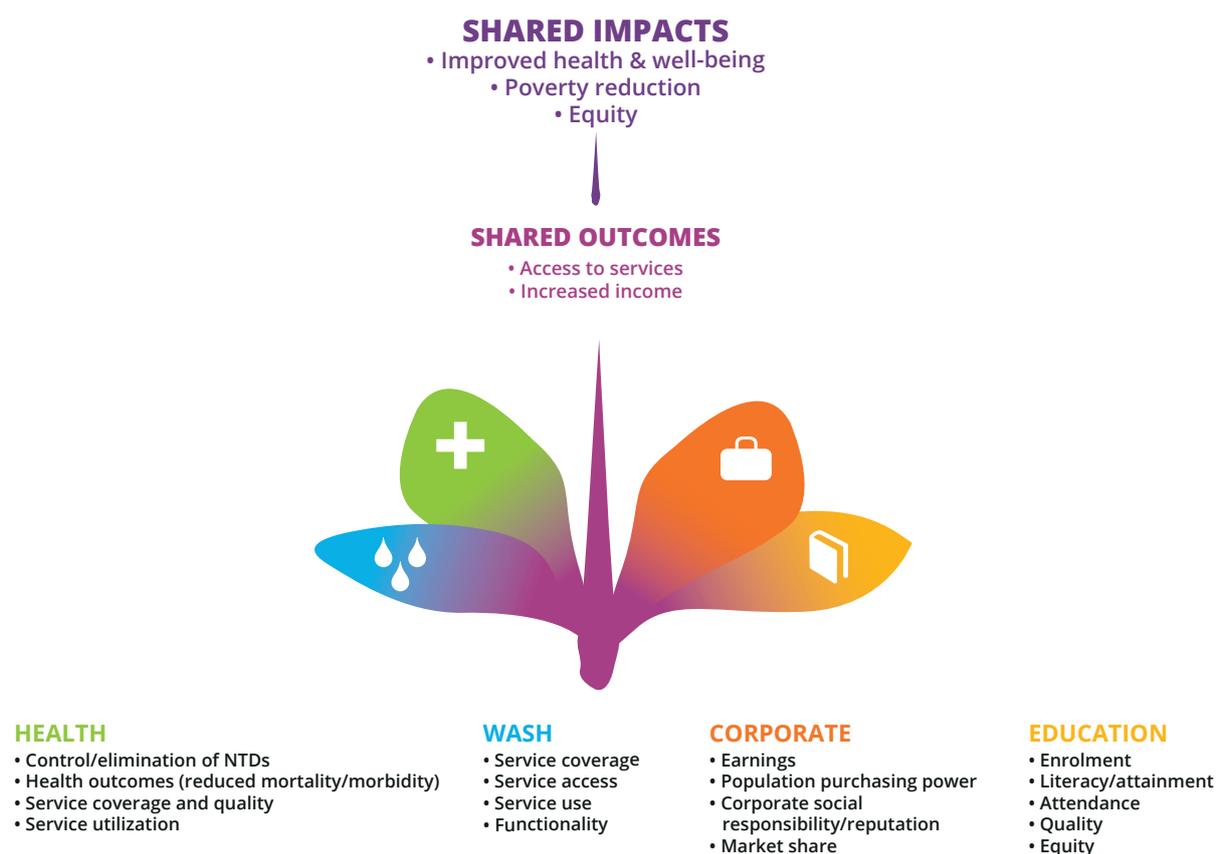


Fig. 2 demonstrates that while different sectors have different goals and objectives, there are multiple outcomes and impacts that are important to all sectors and can be achieved more effectively through collaboration.

See **Tool 4: Messages for engagement** .

Why should we collaborate with partners?

Shared goals

While NTD and WASH stakeholders may have very different objectives, they often have the same ultimate goals – improving people’s health and well-being and contributing to a more equal and happy society. There are also multiple potential shared aims between NTDs and WASH, like service uptake, improving efficiencies, increasing trust in public services, improving information for planning and improving targeting of resources. For-profit service providers may have a slightly different approach, but their aims are generally aligned with efficiency and reach, by wanting cheaper distribution and new markets for their products. The very first step in effective collaboration is defining the shared goals and aims across partners.

Sector-specific goals

Another incentive for collaboration is its potential to help each sector achieve its own specific goals and objectives more quickly and effectively. For example, joint planning with NTD programmes can help WASH partners identify and reach communities with the least access to water and sanitation infrastructure. The WASH sector can embed hygiene promotion and sanitation uptake into NTD outreach programmes or help find resources for such activities through disease control programmes. On the other hand, collaboration with a programme delivering water and sanitation infrastructure can help increase public trust in NTD treatment programmes such as MDA and reduce the likelihood of reinfection among treated populations.

How do we collaborate with partners?

It doesn’t have to be difficult

And you don’t have to start with the most difficult part! Starting a collaboration process with the most difficult problems or trying to address all areas of collaboration from the outset can lead to short-term failures, which can cause people to see collaboration as risky, and to revert to business-as-usual. Instead, collaboration can start where it is simplest, or easy to fund, and be expanded at a later stage as a joint workplan develops and as resources become available. Simple entry points include:

- Inviting other agencies and ministries to NTD meetings (and if relevant, to formally join task forces or working groups).
- Attending meetings and working groups of other sectors and agencies yourself.
- Sharing information on disease prevalence, levels of access to water and sanitation, and existing and planned programmes.
- Identifying potential sources of funding for comprehensive programme delivery.
- Seeking out and engaging with a specific counterpart or ally from the WASH sector with whom you could collaborate closely.
- Adding NTD-related behaviour messages into existing hygiene and sanitation campaigns (shoe wearing, reducing water contact, food hygiene); adding WASH messages into MDA campaigns and other NTD community mobilization activities; or linking both WASH and NTD behaviour messages to other relevant programmes such as agriculture outreach, nutrition, education and veterinary public health.

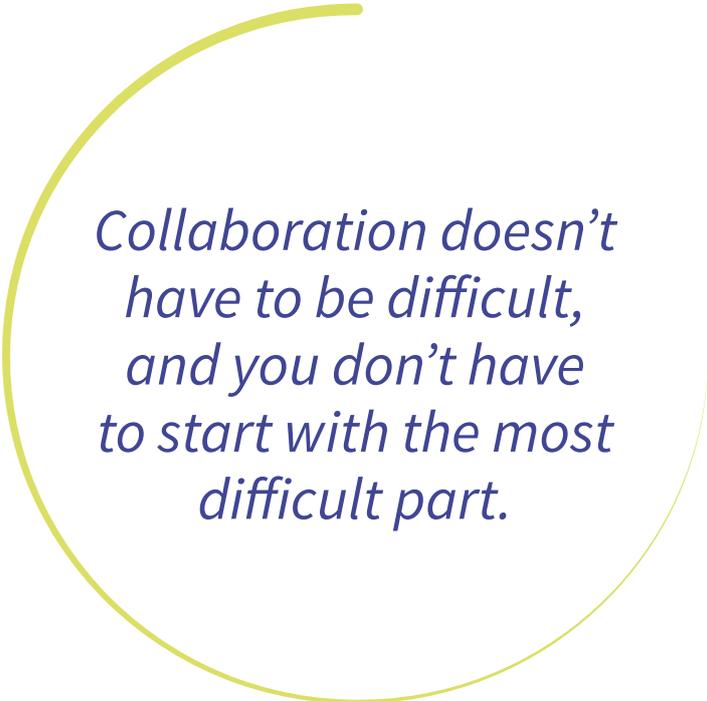
Building a team

Collaboration is not just about setting up a coordination structure such as a committee or working group – it requires a team of people working towards the same goals. Try to build the right team by considering: what common, achievable goal can a team work together on? Who should be involved, what expertise and experience do they bring, and can they commit to being actively engaged over the necessary period?

How to get started on collaborating with partners

First, get everyone together! There are multiple reasons to convene a meeting with other sectors and agencies, including:

- Discussing programmes where implementation challenges are common to everyone (due to conflict, geography, water scarcity, etc.) and agreeing on mutually beneficial approaches.
- Identifying clear opportunities, where there is good overlap and a lot can be achieved quickly.
- Identifying areas where NTDs are endemic and there is a scarcity of WASH partners or implementation is difficult for other reasons.



*Collaboration doesn't
have to be difficult,
and you don't have
to start with the most
difficult part.*

Steps to get collaboration started

1. List who you would like to involve

Make sure all relevant institutions are represented so that they feel included in the process. Be clear about your reasons to engage each potential partner – for example, specific disease control objectives, aspects of the programme that need strengthening, or the need for allies in certain sectors to jointly mobilize resources or prioritize a specific geographic area. Once listed, understand each partner's motivation to collaborate. For instance:

- Integrating NTD-specific messaging or activities into established policies or programmes.
- Fulfilling their own objectives for reaching remote or poor communities.
- Accessing new partnerships and resources.
- Accessing new markets and customers.
- Delivering on corporate social responsibility objectives to increase visibility, credibility and reputation of businesses.

2. Organize a meeting with potential partners

This can be an informal or formal meeting to serve as a starting point for collaboration. Those invited should be the ones who help shape the vision of their organization, understand programme development, and have the authority to make decisions on behalf of their organization. The location can be according to what you've decided about formality as well as convenience for all attendees. Select a location that is accessible to everyone, including persons with disabilities, women from under-represented groups etc. The purpose of the meeting could be to:

- Engage a broader group to access different human, technical and financial resources.
- Bring together participants who already deliver, or could deliver, key components of the programme.
- Enhance ownership by involving everyone at the beginning of the process.

3. Write your invitation

You can use **Tool 4: Messages for engagement**  to make the need for their involvement clear. Share the purpose of this meeting. For example:

- Agreeing a shared vision.
- Learning about partner strengths and potential contributions.
- Establishing or strengthening working groups/task teams.
- Developing and committing to a preliminary scope of work.
- Creating a core team responsible for gathering more information through a situation analysis and a formative assessment of behaviours and practices.

4. Craft your agenda

This cross-sector meeting agenda can help you to structure the meeting.

See **Tool 5: Initial cross-sectoral meeting for WASH and NTDs: annotated agenda** .

STEP 3

Analysing the situation

Being informed and prepared about the national and local context in which you are working can make all the difference to the eventual success of the programme. That means understanding disease prevalence, distribution and impact of programmes, gaps, opportunities and resources. It includes the extent of water and sanitation access, the policy environment, and cultural practices and beliefs. This information should include both quantitative and qualitative data, which accurately represent the local context of the programme target areas.

This section will guide you through the steps to develop a situation analysis, which you can use to identify opportunities and challenges for planning. A useful situation analysis should:

- Include all relevant stakeholders to cultivate collaboration and ownership.
- Obtain up-to-date information in addition to what is already available in official or published documents.
- Provide explanations as to the reasons for the situation.
- Offer possible entry points for addressing the situation.

The use of the information gathered through this step in the planning process is described in detail in STEP 4 and the associated planning tool.

Conducting and using a situation analysis

See **Tool 6: Situation analysis for WASH and NTDs planning: protocol and methods** .

- 1. Identify the analysis team:** This is a recommended core group inside the overall situation analysis team. The team should include members within NTDs (including representation of persons affected by NTDs), WASH, social and behaviour change (SBC) communication, current programme and coordination structures, public health/epidemiology, etc. You may want to use the template terms of reference for the situation analysis team included within **Tool 6: Situation analysis for WASH and NTDs planning: protocol and methods** .
- 2. Identify and formally involve key stakeholders:** This should include identifying potential partner organizations, government agencies, community stakeholders including diverse community groups that can ensure different needs are considered, as well as coordination structures and first steps around joint planning, including both timelines and structures. See **Supplementary tool: WASH-NTD partner form** .

- 3. Collect information:** This should cover disease distribution, services (WASH, health, education), existing programmes, governance and coordination, financial resources, human resources, the policy environment, and other important information.
- 4. Analysis:** Analyse the information gathered to inform the planning and coordination process, identifying challenges and opportunities.
- 5. Recommendations:** Provide clear evidence-supported next steps and actions, including information on who might coordinate and implement the various activities, and how everyone will be engaged in joint planning.
- 6. Report:** Compile all findings in one report, including an executive summary outlining key findings, conclusions and recommendations.

A template situation analysis executive summary is provided within **Tool 6: Situation analysis for WASH and NTDs planning: protocol and methods** . **Supplementary tool: WASH-NTD situation analysis findings presentation template**  is also available.

Data for decision-making

Successful joint planning for WASH and NTDs requires identification of high-priority areas, to enable prioritization and targeting of WASH investment to those in which NTD endemicity is high and access to WASH services is low.

The data for decision-making process will help you identify areas of your country that should be prioritized for joint WASH and NTD implementation. Based on available data and systems in your country, the processes set out below will help bring together information on the burden of NTDs and access to water and sanitation services at the district level, and present it in a way that supports decision-making.

There are three possible options for you to choose from based on your context. In all three options, the output will be a visualization of where the areas of highest priorities are.

What are the approaches?

Option	Basic requirements	Considerations
<p>① Data merge: using an existing WASH or NTD platform or database to add additional information (for instance, adding WASH data to an NTD database or vice versa), for use on an ongoing basis.</p>	<ul style="list-style-type: none"> • An existing, centrally managed database (e.g. DHS2) • Capacity to manage database regularly • Willingness by database “owner” to modify or add parameters 	<ul style="list-style-type: none"> • Technical database expertise needed • Requires regular data collection/updates
<p>② Decision matrix for one-off data collection and analysis, pulling together data from multiple sources onto an Excel-based tool.</p>	<ul style="list-style-type: none"> • Sufficient data for all districts to allow comparison • Agree access thresholds • Excel capacity 	<ul style="list-style-type: none"> • Provides a snapshot at one point in time • Updating the information will require going through the process again
<p>③ Analysis using existing ESPEN NTD Portal WASH and NTD information</p> <p>a. Using the portal analytical file: The data can be filtered down to district level and interactive maps can be built to help with prioritization and decision-making for WASH services in NTD-endemic areas.</p> <p>b. Using the CHIP dashboard: Visualizes the data from the portal in a dashboard with recommended actions.</p>		<ul style="list-style-type: none"> • Uses survey and census data (as collated by the WHO-UNICEF Joint Monitoring Programme for Water and Sanitation [JMP]) that has been modelled down to the district level, and therefore requires validation • Currently only available for countries in sub-Saharan Africa

Note: CHIP – Country Health Information Platform; ESPEN – Expanded Special Project for Elimination of NTDs.

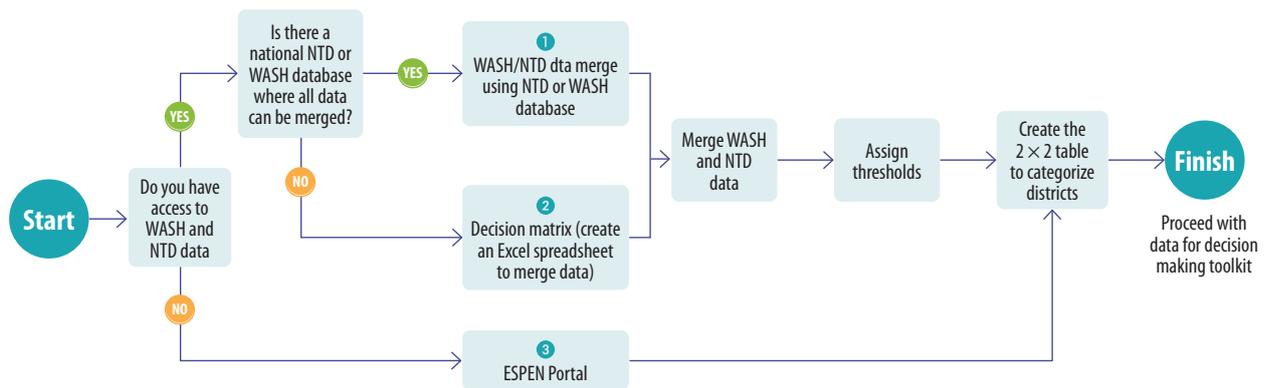
How to choose the approach most suitable for your context

Which scenario applies to your situation?

- There is a database, but it doesn’t include all the information (for example, the NTD database includes district prevalence data, but no data on WASH access) → **Data merge ①**.
- There are district-level data, but they are not held in one or two central locations → **Decision matrix ②**.
- You have no access to district-level WASH and NTD data → **ESPEN NTD Portal ③**.

Note: You can decide to use all options for different purposes. For instance, you could choose to start with the ESPEN NTD Portal data to support initial coordination meetings, or to show in general terms the need for collaboration between the sectors. The matrix can be used as a one-off “proof of concept” for an initial planning meeting, while the longer term process of updating or modifying a database (data merge) gets under way.

Fig. 3. Choosing the approach to obtaining data for decision-making



1 Data merge

- Is there permission/buy-in for adapting the database, for instance by adding new indicators?
- Is there technical capacity to modify and update the database structure?
- Is there a system in place to update the database regularly?
- See **Supplementary tool: Information and examples on data merge**

2 Decision matrix

- Are there WASH and NTD data for all districts?
- Are there agreed thresholds for WASH, i.e. agreement on what constitutes low, moderate or high access to water and sanitation?
- Are there agreed indicators?
- See **Supplementary tool: WASH and NTDs decision matrix instructions** and **Supplementary tool: WASH Decision Matrix Template** .

3 ESPEN NTD Portal

- Is your programme in sub-Saharan Africa?
- Use analytic file and instructions or the **CHIP dashboard** to identify priority district.
- See **Supplementary tool: Instructions for using ESPEN Portal data** or sign up for **CHIP** .

Using the information in joint planning and decision-making

Now that you have identified the most appropriate approach for joint data for decision-making in your country, you will want to ensure the data are used on a regular basis to help inform joint planning and resource allocation. These data can be used to inform the national WASH-NTD framework, guide regular planning, help with resource allocation in technical working group discussions and monitor progress. Once you have the data, you are likely to encounter different scenarios:

- 1. Districts with high NTD burden and low WASH coverage:** These should be the high-priority districts for resource allocation, joint planning and coordination efforts. Also consider using co-endemicity as one of the criteria to encourage more WASH support/financing as there are multiple diseases impacted by investing or working together in a specific district.
- 2. Districts with high NTD burden and average or above average WASH coverage:** These districts also provide an opportunity for improved WASH coordination and joint WASH and NTD interventions (leveraging the WASH access where possible). Since WASH coverage is above average but disease endemicity is high, it may mean that there should be a stronger focus on equity of access at lower administrative levels, quality of WASH infrastructure and behavioural change aspects. It may be useful to consider looking at co-endemicity and opportunities for integration of interventions across different diseases.
- 3. Districts with low NTD endemicity (with variable levels of WASH coverage):** These districts are less likely to be prioritized in the joint planning process. However, they can be used as model districts (where WASH coverage is high), documenting any good practices or lessons learned where applicable. The disease situation in these districts should still be monitored to ensure that disease prevalence stays low, and to ensure a WASH response if it increases.

STEP 4

Planning and programme design

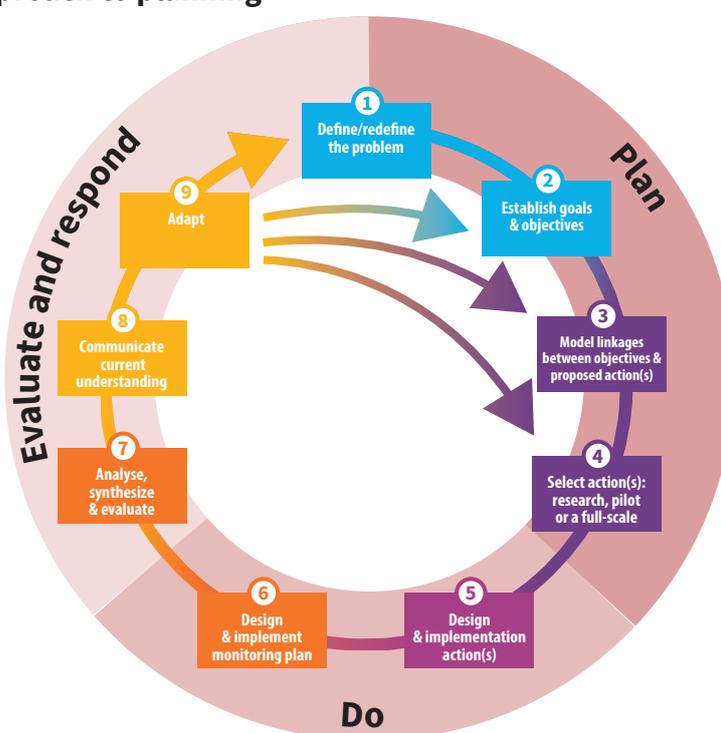
The steps you have taken so far to analyse the situation should have given you a good idea of what you need to do next. Depending on what you found, next steps may be a simple measure such as revitalizing coordination processes, or a more detailed process of developing joint activities.

This section will take you to the next stage – action planning – and will help you identify where new actions are needed, as well as where it is feasible to link, coordinate or integrate existing programme activities across different sectors and agencies. This is particularly important in situations where no substantial specific financial resources are available to develop a new programme of work.

A successful planning process begins with your shared vision and helps you come up with possible pathways that could be taken to get there. This planning is more easily done through incremental steps, which could be defined annually, biannually or any other appropriate period. It is not necessarily about setting out a multi-year programme of work upfront.

Adaptive planning

Fig. 4. Adaptive approach to planning



An adaptive approach to planning emphasizes:

- Formulation of long-term policies and strategies rather than long-term targets.
- Continuously linking planning to implementation, not detailed pre-implementation planning followed by little monitoring.
- Regular participatory M&E to learn from errors on a continuous basis, not periodic external evaluations.
- Continuous dialogue with intended beneficiaries to adjust activities to their needs.

Source: Therkildsen O. *Watering white elephants? Lessons from donor funded planning and implementation of rural water supplies in Tanzania*. Uppsala: Centre for Development Research; 1988:208.

Tips for developing a successful plan

Think beyond a plan as the main objective of the process

In this type of planning process, instead of seeing a written plan as the final output, aim for a process that enables relatively short cycles of planning, implementation, reflection and revision so you can adjust along the way. You don't necessarily need new funding to do this, and this adaptive approach can be built into the programme logical framework just as easily as any other plan.

Be adaptive, which is less risky and more likely to deliver results

Assuming that a specific set of activities will deliver certain results by a defined date can be risky, especially because implementing a multisectoral programme involves changes to established ways of working. Adopting a flexible and adaptive approach helps to reduce risk by not making strict assumptions about what will work, and by allowing changes and adaptations to the design of the programme. This doesn't mean no plan or no accountability, but rather being accountable to delivering a good process, continuing to monitor, using resources well, etc. It helps ensure that what you're doing and spending on is still the right thing to do as the programme progresses.

Start with the problem, not the assumed solution

Although this might seem obvious, many (or even most) programmes are designed with a predetermined approach or solution in mind – which increases the risk of failure. Redefining the approach can be intimidating as it requires thinking outside the box and developing new ideas. First, it is essential that your situational analysis results in a very well-defined problem, which you will return to throughout the design and review process. Second, using a stepped approach that reviews existing knowledge and examples of practice and innovations can help make the process easier.

There's nothing wrong with starting small!

Trying to start a programme around the biggest and most complex challenge, or with many activities, can lead to failure and undermine collaboration. A good alternative is to start with a pilot in a specific area where there is a greater chance of success (this may be due to an enthusiastic partner group, an active and capable programme manager, or some seed funding) and building on successes to gradually increase the scale of the programme.

Get around paralysis

Once the situation analysis has been conducted and initial discussions have begun, it's not unusual for the process to stall – it might look as if the barriers are too systemic or difficult for the programme to change in the short or medium term. You can address this by using **Supplementary tool: Problem analysis approaches**  and by testing various approaches and not giving up if one approach doesn't work. Keep in mind that even though the programme may not change every deeply rooted problem, it can still be delivered successfully.

Practical planning steps

- 1. Gather:** Use the information gathered so far to set out a clear idea of the problems the programme needs to address, and which institutions and individuals to involve in order to develop a successful plan of action.
- 2. Synthesize:** Create a shared understanding of the key problems/issues the joint programme will be designed to address, and how existing programmes and interventions relate (or not) to the problems.
- 3. Align:** Identify what can be done practically, by whom and when, making sure all actions are realistic and achievable, and identify which aspects are not currently being addressed through existing interventions.
- 4. Act:** Jointly prioritize interventions, and take the necessary actions based on the results of the previous step.
- 5. Verify:** Agree the key interventions that will be taken forward, in the form of a 1-year plan.
- 6. Develop or adapt interventions:** Define the parameters for developing new or adapting existing interventions.
- 7. Revisit and realign:** Put in place a process for periodic review of programme implementation to identify challenges and allow necessary adjustments.

See **Tool 7: Planning tool: step-by-step process to developing comprehensive and adaptive NTD programmes**  and **Tool 8: Agenda for joint planning workshop** .

Planning for elimination

Most NTD programmes are set to eliminate or achieve sustained control of a disease; to eventually reduce the need for the programme. This creates certain challenges:

- The smaller the problem is (i.e. the lower the disease prevalence becomes) the more expensive it becomes to address remaining pockets of transmission and the expertise to identify, treat and prevent this disease is also diminished. Sustaining political will and funding at this crucial stage also becomes harder.
- Reduced resources and interest in a disease make it difficult to sustain gains, making resurgence a risk. The smaller the programme, the more reliant it becomes on services and interventions delivered by other agencies and sectors (e.g. for WASH services).
- Once programmes have been in place for some time the incentives attached to them may become strongly embedded, meaning that transferring work into the broader health systems and other sectors can be challenging – especially if programmes close and power and resources are diverted.

NTD programmes should be designed in a manner that prepares them, and their partners, for these inevitable challenges. It is never too early to start planning for the end! **Supplementary tool: Planning for elimination**  sets out the predicted programme phases from morbidity control to post-elimination, and the corresponding intervention areas for each phase.

Financial arrangements for a successful programme

Funding and finance arrangements can have both positive and negative impacts on a programme, so it is essential to ensure that your budget is comprehensive and includes flexibility to deal with fluctuations in work plans and timelines. A multisectoral programme brings with it additional challenges, including different budgeting and planning schedules across different agencies, different financial management and reporting structures, and so on. These should be acknowledged early on, and financial management and processes should be set out before implementation even begins. Note that although it is a common assumption that integrated programmes require additional resources, a lot can be achieved with existing or limited new resources. See **Supplementary tool: Improving coordination in low-resource settings**  for further information.

The budgeting process should begin with reviewing available resources, as well as any resource gaps for which you'll need to develop funding proposals or cover through other funding streams. The budget should:

- Be developed by all stakeholders, including representative organizations of women, persons with disabilities etc., and finance staff, to ensure commitment, realistic costing, and good management practice.
- Consider different costs in different parts of the country – while there may be average unit costs, keep in mind the specifics of different environments. Consider accessibility costs in the budget, including in making information and communication accessible for everyone.
- Be comprehensive, covering the duration of the programme and showing which activities are covered by which funding. This will also help identify financial gaps. The cost categories for sanitation programmes set out by WaterAid, Plan International and UNICEF in a process to develop guidance on rural sanitation: **Guidance on costing of rural sanitation approaches**  is a useful example of programme aspects that should be included: planning, formative research, programme mobilization, capacity development, programme management, community implementation, supply strengthening, sanitation service chain, accessibility and adaptation costs, sanitation finance, M&E, sustainability support, environmental sanitation, enabling environment and knowledge management.
- Be detailed in terms of quantities per unit and total costs, and indirect costs like administration, travel and human resources.
- Include an agreed process for expenditure and reporting that supports the government's financial and management capacity, building on any existing arrangements and processes.
- Acknowledge non-financial contributions. For example, in-kind and time investment might be made by communities, households and other groups.
- Include a contingency line to allow for flexibility and unforeseen activities, and account for inflation (a 3% increase each year is a realistic amount).
- Include a budget for reasonable accommodation and adaptation which will provide for equal opportunities for persons with disabilities and other under-represented groups to participate (supporting accessible facilities and infrastructure).

Supplementary tool: Budgeting for joint WASH and NTDs programmes  provides further detail and advice.

What does funding for WASH mean?

NTD programmes are not expected to assume the responsibility of the WASH sector in terms of full provision of water and sanitation services. Nonetheless, NTD programmes can be expected to co-implement and co-fund certain WASH-related activities. Depending on the specific diseases covered, the costs associated with the following aspects should be considered within NTD programme financial planning, even if funding comes from other sources:

- **Hardware:** Water supply infrastructure (boreholes, protected springs/wells) and systems (piped and rainwater harvesting schemes, tanks and pumps); sanitation infrastructure for households (full latrines or latrine components such as slabs or pit liners, solid waste collection infrastructure) and communities (shared/public toilets and bathing facilities), including accessible facilities and infrastructure).
- **Software:** Handwashing campaigns; promotion of hygiene practices such as safe cooking, bathing and laundry; sanitation promotion including community-led total sanitation; sanitation marketing; menstrual hygiene management promotion; promotion of environmental sanitation (animal pens, solid/liquid waste management), including in accessible formats.
- **Commodities:** Distribution of hygiene products (soap, menstrual pads, handwashing facility components, such as containers), point-of-use water treatment technologies (chlorine, filters) and water storage containers.

These costs should be considered for implementation in households, communities and public places such as schools and clinics, and linked to programmes implemented by government or WASH service providers and agencies

The nature and frequency of WASH costs, especially in relation to operation, maintenance and non-hardware costs, can be underestimated by those unfamiliar with the workings of the WASH sector, and it is important for the NTD community to have a realistic understanding of expected costs during planning. The **WHO WASH accounts initiative** , which defines and tests a globally accepted methodology to track financing for WASH at the national level, classifies WASH costs and expenditures into the following categories:

- **Investment costs:** Initial costs of putting new services in place, including hardware such as pipes, toilets and pumps, and one-off associated software costs, e.g. for design and engineering studies or consultation.
- **Operating and maintenance costs:** Routine maintenance and operation costs to keep services running, including wages, fuel or any other regular purchases.
- **Large capital maintenance costs:** Occasional large maintenance costs for the renewal, replacement and rehabilitation of a system beyond routine repair and replacement costs.
- **Financial costs:** Capital repayments and costs, including interest on loans, and dividends if a return is paid to shareholders.
- **Support or software costs:** Includes charges for direct and indirect support. Direct support includes construction activities at the local level, e.g. training for community or private sector operators or users. Indirect support includes the cost of planning and policy-making at government level, e.g. strengthening the skills and capacities of professionals and technicians.
- **Taxes:** Put in place a process for periodic review of programme implementation to identify challenges and allow necessary adjustments.

Source: WHO WASH Accounts Initiative, WHO, 2016.

STEP 5

Implementing and monitoring

Monitoring and evaluation plays a key part in ensuring good programme results. While M&E is an accountability mechanism to ensure and report that activities are being delivered as planned, it should also be used for learning and adaptive planning. As discussed in STEP 4, ongoing reflection on what is working and what isn't lets you adapt the programme as it progresses.

How to monitor and implement

Obtain and analyse baseline data

Baseline data can serve multiple purposes – identifying community needs, setting programme targets, determining the type of intervention and the level of implementation, and measuring programme performance and impact. Baseline data may have already been collected during the situation analysis phase or as part of formative research, but additional information might be needed at this stage, to inform M&E activities. Much of this information may already exist thanks to routine national and district data collection and should be collated and analysed to arrive at a baseline. This process is also a good opportunity to foster collaboration between different government departments at national and district level. If new information is needed, joint WASH and NTDs surveys can be conducted using the opportunity of disease mapping to collect information on WASH and other determinants (or vice versa). See, for example, the **Tropical data methodology** , which incorporates WASH indicators into disease mapping surveys. Undertaking surveys where possible rather than using routinely collected data can present an opportunity to gather additional information that is usually not captured in routine information systems, such as differences in access to services within households (e.g. for older people, pregnant women, people with disabilities and young children), or the availability, quality and reliability of water supplies for the additional needs of people affected by NTDs (for instance, additional hygiene and self-care needs of people with skin NTDs).

Baseline data can be presented numerically, or in map form by overlaying disease prevalence with relevant data on determinants (for example, soil-transmitted helminthiasis [STH] prevalence and access to sanitation). Maps are powerful tools to visually represent need and progress over time. The following table lists out the type of baseline information you may need for an integrated programme.

Types of baseline information

Survey/observation	Collection method ^b
NTDs	
Disease and/or infection prevalence	Survey (school/community) or routine data collection
Infection intensity	Survey (school/community) or routine data collection
Co-endemicity	Survey (school/community) or routine data collection
WASH^a	
School-level WASH indicators (e.g. % of schools with functional improved sanitation facilities; % of schools with access to improved water supply)	Survey (school); district education office Information can also be collected during disease/infection prevalence surveys for a sample of schools
Health care facility-based indicators (e.g. % of health care facilities with adequate sanitation facilities; % of health care facilities with basic water supply)	Survey (facilities – Service Availability and Readiness Assessments, Service Performance Assessments), health management information system (HMIS)
Household access to basic/safely managed sanitation	District WASH monitoring system/survey
Community coverage of basic/safely managed sanitation	District WASH monitoring system/survey
Household access to basic/safely managed water	District WASH monitoring system/survey
Household presence of handwashing facilities with water and soap	District WASH monitoring system/survey
Sanitation and hygiene practices	Household observations, focus groups, questionnaires
Other determinants	
Housing type	Survey/observation
Presence of animals	Survey/observation
Vector breeding sites	Survey/observation
Governance and coordination	
Coordination structures/committees	District visits/consultation

^a For definitions see **Tool 11: WASH-NTD indicators and logframe**.

^b **Tool 6: Situation analysis for WASH and NTDs planning: protocol and methods**  and **Tool 3: Understanding behaviour to develop behaviour change interventions**  offer methods for obtaining some of the information. Note that setting a baseline on behavioural aspects is likely to require a larger scale survey than formative research.

Routine monitoring and reporting

Routine monitoring shows whether progress is being made against the agreed plan, so you can address challenges as they occur. Information on access to water and sanitation services is often collected at various administrative levels, so rather than collecting new information, you can arrange for this information to be shared. Regular reporting should be accompanied by supervision, either using existing structures or by undertaking joint visits (by WASH and NTD programme managers).

See **Tool 9: Routine supervision of WASH and NTDs programmes: guide and form** .

Keep in mind that for routine supervision to be effective it should have consequences – with good performance being rewarded (for example, through recognition) and underperformance being addressed (for example, through supportive supervision, further training, etc.). The capacity needed for supervision and to analyse routine reports should be included at the planning phase of your programme. See **Supplementary tool: Problem analysis approaches** .

Periodic reflection

Reflection should be part of your M&E plan, so you can regularly respond to questions such as:

- Are there lessons and insights on why progress is or isn't being achieved?
- How can these insights be used to improve implementation or adapt the plan?
- Are there more effective activities that can be done to achieve the objectives, or could activities have been implemented more effectively?
- Are the findings of the original situational analysis still relevant?
- Are there any new risks that need to be mitigated?
- Has anything changed?
- Have all key aspects been addressed?
- What has changed in the environment (politically, administratively, structurally, programmatically etc.) that could be influencing (negatively, positively) expected programme achievements and goals?
- Are there any groups that are not equally benefiting from the programme?

To do this, it may be useful to convene a small group and together go back to the problem analysis conducted during the planning phase (see **Supplementary tool: Problem analysis approaches** ). Once the reflection has taken place, make the necessary changes to your logframe in terms of new resources, activities and outputs.

Evaluation

Unlike routine monitoring, an evaluation takes place at programme milestones and at the end of the programme. An evaluation can help demonstrate impact, how effectively implemented the programme is or was, and the effect it has had on systems and institutions. It is often done by individuals or agencies not involved in programme delivery. The evaluation seeks to answer:

- To what extent did the programme meet its intended goals and objectives?
- What programme activities worked and did not work?

- What are the significant changes and achievements?
- What adaptations were made to the plan, or the implementation structures, to enable this?
- What are the lessons for further changes to the programme or for other programmes?

Keep in mind that disease control programmes tend to focus on epidemiological impact evaluation using impact surveys. It is crucial to go beyond this and include:

- An evaluation of all interventions (such as drugs offered versus uptake of drugs and access versus use of water and sanitation).
- Data quality assessments (e.g. how to improve the data coming from the community to national level).
- A process evaluation to determine how the programme was implemented (this is often overlooked but is very important to evaluate in order to be able to interpret outcomes and impact, and to identify successful processes that can be taken to scale and replicated in similar contexts).
- Some analysis on return on investment, or cost-benefit analysis, by demonstrating the results achieved by the inputs. WHO's *Helminth control in school age children: a guide for managers of control programmes* (second edition)  provides a diagram to illustrate each of these components.

Accountability

Setting up a strong accountability structure at all levels is essential:

- **Community:** The community should not only be aware of the purpose of the programme but should have a say in its design and implementation. This can be done in different ways: circulating information through the media; using social mobilization activities; working through existing community-based administrative and other structures (schools, leadership councils, health clubs/groups, representative organizations of women, persons with disabilities etc.); and outreach functions. This will not only provide insights into programme delivery in different social and cultural settings but can also help make sure that all parts of the community are being reached.
- **Health ministry and other government departments:** Demonstrating good results brings much needed continued resource allocation. It also helps communicate the programme's importance to other ministries (**Supplementary tool: Programme dashboard template**  shows a simple way of presenting such information). For example, by highlighting aspects like value for money, a successful integrated programme provides the health ministry with a valuable business case to bring to the ministry of finance. Results should also be shared in annual health and WASH sector reviews and performance reports, to demonstrate the contribution of the programme to the achievement of sector goals.
- **Funders and partners:** Ideally, the programme should build on a strong existing health management information system put in place by the health authorities. If such a system is not in place, any additional monitoring frameworks that are developed should incorporate standardized indicators and be aligned with government systems to the extent possible in order to reduce the burden of reporting and strengthen the health system.

→ **International community:** All NTD and WASH programmes operate within the overall global development framework (currently enshrined in the SDGs), and in the case of NTDs, ***Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030***  and ***Ending the neglect to attain the Sustainable Development Goals: a global strategy on water, sanitation and hygiene to combat neglected tropical diseases 2021–2030***  programme successes and challenges should therefore be shared in relevant international forums and disease alliances. This will hold the programme to account, help countries learn from one another, and facilitate cross-border collaboration.

Ongoing coordination

Stakeholders and partners need to be constantly engaged. To do this, you can use and reinforce existing structures (task forces, coordination committees and government roles), which will avoid adding more meetings to already busy schedules. This should take place at all administrative levels – national, regional, district, etc. Remember that financial incentives such as per diems may not be the most effective way to keep people involved – the prospect of achieving programme goals may create even stronger motivation. It is worth investing in someone to lead this coordination. It is important not to give up at the first hurdle; if participation falls off after the initial meetings, try to identify and address the reasons for lack of engagement.

Sustaining collaboration through formal guidance: a national framework on WASH and NTDs

Once you have gone through a planning process, it is important to ensure that it is sustained by adopting formal government guidelines.

A useful tool to achieve this is a national framework based on the shared programme objectives and rationale for continued collaboration, that sets out the agreed planning, budgeting and coordination structures. It helps clarify the roles and respectabilities of partners, and ensures that all stakeholders follow the agreed processes.

See **Tool 10: National framework on WASH and NTDs template** .

This tool provides a possible structure for such a document, and incorporates the results of the previous steps of the toolkit. It incorporates the results of **Supplementary tool: WASH and NTDs decision matrix**  referred to in STEP 3: Data for decision-making, to help ensure that high-priority areas are identified, to enable prioritization and targeting of WASH investment to those in which NTD endemicity is high and access to WASH services is low.

Examples of existing national frameworks can be found online on the WASH and NTDs page of the online **infoNTD platform** . See for example the **National Framework for Ethiopia**  and **National Framework for Uganda** .

Getting the M&E framework right

A good logical framework (logframe) is a visual representation of the logic underlying a programme's purpose and activities. It demonstrates the sequence of events through which a programme may contribute to positive changes and helps justify investments and contributes to overall accountability. It is based on the concept of cause and effect, meaning that if certain activities take place under certain conditions, certain results will be delivered.

A logframe summarizes

- What the programme is going to achieve.
- What activities will be carried out.
- What means/resources/inputs (human, technical, infrastructural) are required.
- What potential problems could affect success.
- How progress and achievements will be measured and verified.

Steps to logframe development

1. Define the overall goal to which your programme contributes. That could be poverty reduction, achievement of SDG 3 targets in your country, NTD elimination or sustained control, etc.
2. Define the outcome to be achieved by the programme – the impact the programme will have, or changes to the environment or to behaviours – ideally a single outcome.
3. Define the outputs for achieving that outcome – basically, what the programme will deliver. For example, the number of people who will be trained, number of hardware produced, or number of committees formed.
4. When the programme is multi-year, include milestones – interim outcomes you will achieve by the end of each reporting period.
5. Define the activities for achieving each output – essentially how the programme will be delivered. Provide a brief summary of the activities that must be implemented to accomplish each output, and provide a summary schedule of periodic meetings, monitoring events and evaluations. A Gantt chart is a useful tool for this purpose. A template Gantt chart is provided within **Tool 11: WASH-NTD indicators and logframe** 📄.
6. Build in assumptions – statements about the uncertainty factors that may affect the programme. These should be things that are not activities in the logframe, but that affect whether or not planned activities can take place. Examples include new funding, external investments, availability of specific supplies, etc. Making these assumptions explicit from the beginning will help explain why certain things have or haven't happened. See **Supplementary tool: Problem analysis approaches: Five "whys"/root cause analysis** 📄.
7. Define your indicators: you will need multiple indicators to measure changes and impact, including:
 - a. NTD indicators, such as incidence, prevalence, co-endemicity, intensity.
 - b. WASH coverage, access and use indicators, such as presence and use of household latrines and improved water supply at household level and in schools and health care facilities (disaggregate by age, gender and disability where relevant).

- c. Indicators relating to changes in individual, family and community behaviours and perceptions over time, or proxy measures such as presence of handwashing stations with soap and water.
 - d. Process indicators, such as proportion of district NTD plans that include WASH activities and indicators, proportion of coordination structures with WASH and NTD representation, proportion of accessible WASH facilities and campaigns, etc.
 - e. Programme and data quality indicators, such as number and quality of training sessions, quality of reported treatment data, etc., to ensure the programme is being delivered as planned.
- 8.** To accompany the logframe, prepare a risk analysis and matrix – this will ensure that you are aware of risks and have put in place measures to deal with them. **Supplementary tool: Programme risk analysis**  should help undertake this process.

Tool 11: WASH-NTD indicators and logframe  offers a comprehensive set of indicators for your consideration as well as definitions and a checklist for logframe development to support the development process.

IV.

Core tools



Add internal links
color code the steps and the corresponding tools
feature the core tools icon in the title

IV.

Core tools

- Tool 1:** Interventions for NTD control, elimination, eradication and care
- Tool 2:** NTD-related behaviours
- Tool 3:** Understanding behaviour to develop behaviour change interventions
- Tool 4:** Messages for engagement
- Tool 5:** Initial cross-sectoral meeting for WASH and NTDs: annotated agenda
- Tool 6:** Situation analysis for WASH and NTDs planning: protocol and methods
- Tool 7:** Planning tool: step-by-step process to developing
- Tool 8:** Agenda for joint planning workshop
- Tool 9:** Routine supervision of WASH and NTD programmes: guide and form
- Tool 10:** National framework on WASH and NTDs template
- Tool 11:** WASH-NTD indicators and logframe

TOOL 1

Interventions for NTD control, elimination, eradication and care

WASH-related aspects are highlighted in blue.

Disease • Type • Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Buruli ulcer • Bacterial • Environmental (undetermined)			Addressing stigmatization due to disfigurement, disability and cultural beliefs regarding causes (e.g. witchcraft, curses) Inclusive WASH services for people with disabilities	Hygienic wound management Promotion of early diagnosis and treatment Antibiotic treatment Surgery Physiotherapy and rehabilitation WASH for hygiene and IPC in health care facilities
Chagas disease • Parasitic • Triatomine (kissing) bug	Food hygiene (washing hands, surfaces, utensils and raw food products with clean water and soap; thorough cooking/reheating; safe food storage) Bed net use	Use of improved housing materials such as solid flooring and walls and inorganic roofing materials Insecticide residual spraying		Chemotherapy Medical screening WASH for hygiene and IPC in health care facilities
Dengue and chikungunya • Viral • <i>Aedes aegypti/ albopictus</i> mosquito	Bite prevention (clothing, nets, screens, repellent)	Reliable water supply to avoid need for household water storage Mosquito proofing and cleaning of water containers, tanks, cisterns, reservoirs and drains Safe solid waste management to avoid water accumulation Impoundment management Chemical control: pesticides/larvicides, residual spraying, repellent Biological control: larvivorous fish/predatory copepods to reduce larvae Environmental management by source reduction methods		Symptom management (fever) WASH for hygiene and IPC in health care facilities
Dracunculiasis (Guinea-worm disease) • Parasitic • Water-based	Promotion of safe water practices (including use of safe drinking water and preventing infected individuals from wading into water sources)	Access to safe water to reduce contact with surface water Water treatment and filtration Water for hygiene purposes at households and health care facilities	Addressing disability stigma and cultural beliefs regarding causes (e.g. witchcraft, curses)	Wound management

Disease • Type • Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Echinococcosis (cystic echinococcosis [CE] and alveolar echinococcosis [AE]) • Parasitic, zoonotic • Worm-egg ingestion	Food hygiene (washing hands, surfaces, utensils and raw food products with clean water and soap; thorough cooking/reheating) Handwashing with soap after contact with animals	Deworming of dogs (CE and AE) and cats (AE) Food and slaughter inspection and hygiene; safe disposal of infected carcasses Lamb vaccination and culling of older sheep (CE) Removal of animal faeces from the household environment		Drug therapy Percutaneous treatment Catheterization Watch and wait Surgery WASH for hygiene and IPC in health care facilities
Foodborne trematode (FBT) infections • Parasitic, zoonotic • Foodborne	Addressing cultural food practices (raw foods) Food hygiene (washing hands, surfaces, utensils and raw food products with clean water and soap; safe storage) Avoid defecation in or around water sources	Avoidance of use of unprocessed human/animal faeces as manure/fish feed Good farming practices, including strategic deworming of livestock Deworming of dogs and cats, avoid feeding them with raw fish Control of intermediate hosts (snails) Improved/basic household/community sanitation (toilet construction and use)		Preventive/individual anthelmintic chemotherapy
Human African trypanosomiasis (HAT) (sleeping sickness) • Parasitic • Tsetse fly	Bite avoidance (clothing, avoidance of bushes, repellent, nets/screens)	Water supply to reduce reliance on water fetching from fly-infested sites Treatment of livestock (markets, farms), in rhodesiense-HAT areas Vector control (targeted insecticide spraying, screens, traps, protective fencing, animal spraying/pour-on; use of sterile insect technique in some areas and tiny targets which attract and kill tsetse flies)	Address stigmatization (victim-blaming in some cultural contexts)	Early detection Drug therapy WASH for hygiene and IPC in health care facilities
Leishmaniasis (visceral and cutaneous) • Parasitic • Sandfly	Hygienic self-care	Vector control through improved housing, waste management and drainage Reduce risks increased by major environmental changes Reducing sandfly breeding in animal shelters and improving domestic and peri-domestic sanitary conditions (cleaning, insecticide)	Addressing stigmatization related to ulcers, disfigurement, scarring and disability (cutaneous/mucocutaneous leishmaniasis)	Chemotherapy Topical therapies Wound management WASH for hygiene and IPC in health care facilities

Disease • Type • Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Leprosy • Bacterial • Personal contact	Promotion of early diagnosis and treatment Improved hygiene to reduce severity of disease symptoms, and exclusion due to poor cleanliness and care Personal and household hygiene to improve overall health and reduce susceptibility to infection	Provision of water supply for disease management Improved sanitation and living conditions Inclusive water and sanitation services for people with disabilities	Addressing stigmatization due to cultural/traditional/religious beliefs (witchcraft, curses, immorality, uncleanness): awareness raising in the community and among health and mental health professionals Prevention of stigmatization-based exclusion from services (including water points and toilets) and social/family life by community, family, self Patient support groups with mental health support to address self-stigma and self-care	Multidrug therapy Symptom/wound management
Lymphatic filariasis (LF) • Parasitic • <i>Culex/Anopheles/Aedes</i> mosquito	Hygiene to reduce acute inflammatory episodes (limb washing, skin care, exercise, limb elevation) Wearing adequate footwear Bite avoidance: insecticide-treated nets, indoor residual spraying, personal protection measures	Improved sanitation (including mosquito-proof sludge containment, i.e. septic tanks), wastewater, drainage and water resource management to reduce mosquito breeding sites Water supply to enable hygiene for self-care Safe management of animal waste (especially bovine faeces)	Addressing stigmatization due to misunderstanding of disease cause and fear of contagion: awareness raising in the community and among health and mental health professionals Prevention of stigmatization-based exclusion from services (including water points and toilets) and social/family life by community, family, self Inclusive water and sanitation services for people with disabilities Patient support groups, e.g. "hope clubs" with mental health support to address self-stigma and self-care	Treatment of acute inflammatory episodes (antibiotics, anti-inflammatories, analgesics) Provision of adequate footwear Topical antibacterial, antifungal creams for skin and wound care Hydrocele surgery Chemotherapy treatment Mass chemotherapy WASH for hygiene and IPC in health care facilities for lymphoedema care and hydrocele surgery
Mycetoma, chromoblastomycosis and other deep mycoses • Fungal • Environmental (soil, plants, flowers, wood)	Use of personal protective equipment in occupation groups prone to exposure (farmers, labourers etc.) Regular bathing with clean water and soap Improved nutrition	Increased access to improved water supplies for hygiene	Addressing stigmatization due to disfigurement: awareness raising in the community and among health and mental health professionals Patient support groups and occupational self-help/advisory groups	Early detection and surgical resection Cryotherapy (liquid nitrogen) Heat therapy Laser therapy Oral antifungal medication (not very effective) Topical (Imiquimod cream)
Onchocerciasis (river blindness) • Parasitic • Blackfly	Bite avoidance: personal protection measures (clothing, repellents)	Judicious use of vector control measures including insecticide treatment of larval breeding sites and water flow manipulation	Prevention of stigmatization due to severe itching, skin depigmentation and lichenification, skin nodules Inclusive water and sanitation services for people with disabilities, including visually impaired individuals	Individual/mass treatment with ivermectin Management of visual impairments

Disease • Type • Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Rabies • Viral, zoonotic • Animal bites	Bite prevention and animal bite management through community awareness Reduced contact with wild animals and unknown dogs	Dog vaccination Waste management	Addressing the blaming of the poor (especially in urban contexts) for the spread of dog rabies	Immediate, thorough wound cleansing with soap and water after contact with a suspect rabid animal Pre- or post-exposure prophylaxis, if indicated Pre-exposure immunization
Scabies and other ectoparasitoses • Parasitic • Person-to-person contact	Restriction of skin-to-skin contact			Topical scabicide Oral ivermectin Treatment of secondary infections Treatment of long-term complications of secondary infections Hygiene measures to avoid transmission in health care settings
Schistosomiasis • Parasitic • Water-based	Prevention of open defecation/urination Exclusive use, cleanliness and maintenance of toilets Avoidance of contact with surface water Personal hygiene	Improved sanitation across the entire community and safe management of excreta Protection of freshwater from contact with human and animal excreta Snail control measures Improved water supply to reduce use of surface water for domestic activities	Addressing stigmatization caused by symptom similarity between female genital schistosomiasis and sexually transmissible infections	Individual/mass chemotherapy Treatment of associated morbidities
Snakebite envenoming • Envenoming • Animal bite	Sleeping on raised bed under insecticide-treated bed net Avoidance of firewood collection at night Avoiding contact with potential hiding places Avoid capturing and handling live snakes Avoid killing snakes Careful handling of dead snakes Use of footwear at all times Extra precautions at night and after rains including shoe wearing and light use (also when going to latrines outside the house at night) Avoiding running over snakes with vehicles or bicycles Avoid putting hands in holes or places where one cannot see Open defecation should be avoided, as at these places individuals are at risk of envenoming	Avoidance of factors attracting snakes into homes: livestock, rats, and keep the home clean and tidy (specifically making sure not to leave food waste; ensure safe food storage) Reduction of potential hiding places, clearing solid waste, shortening grass Avoidance of branches touching houses Keeping granaries and ponds/reservoirs away from homes Safe latrines or toilets should be available to reduce the need for open defecation and reduce the risk of snakebite	Avoid ostracization of menstruating women and girls to reduce risk of snakebite envenoming Put in place measures to protect victims from stigmatization and poor mental health outcomes	First aid: Patient safety and immobilization, apply pressure pad, transportation to medical facility Avoidance of rejected/controversial first aid including arterial tourniquet, suction, incision, herbal medicines or black stones etc., and of tampering with bite wound Pain relief (avoiding aspirin and non-steroid anti-inflammatory drugs) Reassure patient to reduce heart rate and put the patient in the recovery position if there is a reduced level of consciousness Clinical management: Rapid clinical assessment and resuscitation Urgent interventions to treat shock, hypotension, cardiovascular and respiratory symptoms, anaphylaxis, bleeding, haemorrhage, renal failure and septicaemia WASH for hygiene and IPC in health care facilities

Disease • Type • Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Soil-transmitted helminthiasis (STH) • Parasitic • Worm-egg ingestion, skin penetration	Exclusive use, cleanliness and maintenance of toilets and safe disposal of child faeces Handwashing with soap before eating Food hygiene (washing, cooking, peeling of vegetables); exclusion of animals from kitchen Shoe-wearing Water treatment	Construction and use of safe household toilets across the entire community to avoid open defecation; safe management of excreta Increased access to improved water supplies for hygiene		Individual/ mass chemotherapy
Taeniasis/ cysticercosis • Parasitic, zoonotic • Foodborne (taeniasis); Worm-egg ingestion (cysticercosis)	Hand and food hygiene Appropriate use of the toilet or latrines with safe disposal of faeces by all family members at all times Avoid eating raw or undercooked pork	Improved household/ community sanitation services to avoid open defecation Improved pig husbandry Pig vaccination plus anthelmintic treatment Improved meat inspection and processing Safe water supply	Prevention of stigmatization (neurocysticercosis may lead to epileptic seizures; some traditional beliefs on epilepsy result in victim-blaming and stigmatization): awareness raising in the community and among health and mental health professionals	Neurocysticercosis: identification and treatment of cases: Anthelmintics Supporting therapy with corticosteroids and/or anti-epileptic drugs Surgery WASH for hygiene and IPC in health care facilities Taeniasis: Individual/mass treatment with praziquantel or niclosamide
Trachoma • Bacterial • Personal contact, flies, fomites	Facial cleanliness Overall personal hygiene (laundry, handwashing) Exclusive use, cleanliness and maintenance of toilets and safe disposal of child faeces	Improved household/ community sanitation services to avoid open defecation Increased access to improved water supplies for hygiene	Inclusive water and sanitation services for people with disabilities, including visually impaired individuals	MDA of antibiotics Trichiasis surgery WASH for hygiene and IPC in trichiasis surgery settings
Yaws (endemic treponematoses) • Bacterial • Personal contact	Regular bathing with clean water and soap	Construction and use of safe household toilets Increased access to improved water supplies for hygiene	Awareness about the disease and effective treatment to reduce stigmatization and discrimination (cultural beliefs preventing care-seeking; teachers dismissing children from school): awareness raising in the community and among health and mental health professionals Patient support groups with mental health support to address self-stigma and self-care	Antibiotic treatment Wound management

TOOL 2

NTD-related behaviours

This resource lists key behaviours at the individual, household and community level related to NTDs, as well as the purpose for reinforcing or changing the behaviour. This can be used as a checklist to ensure all relevant behaviours related to the diseases being tackled have been identified, and can be considered for inclusion in a behaviour change intervention.

	Practice	Purpose	Disease
SANITATION	Always use a toilet for urination and defecation (avoid open defecation)	Prevent urine and faeces from contaminating soil and surface water Keep flies away from faeces Reduce the risk of being bitten by a snake	Cysticercosis, foodborne trematodes (FBT), schistosomiasis, snakebite envenoming, soil-transmitted helminthiasis (STH), trachoma
	Always dispose of faeces (human or animal) in a toilet	Prevent faeces from contaminating soil and surface water Keep flies away from faeces	Cysticercosis, FBT, lymphatic filariasis (LF), schistosomiasis, STH, trachoma
	Never urinate in an open water source such as a pond, river or lake	Prevent schistosomiasis eggs from entering into water sources	Schistosomiasis
	Keep the compound clear of human faeces	Keep flies and mosquitoes away from the immediate living environment Prevent faeces from contaminating living spaces	Cysticercosis, dengue, LF, schistosomiasis, STH, trachoma
	Keep compound clear of animal faeces	Keep flies and mosquitoes away from the immediate living environment	Dengue, echinococcosis, LF, schistosomiasis, STH, trachoma
	Keep toilets, drains and septic tanks covered	Prevent breeding of flies and mosquitoes	Cysticercosis, LF, STH
	Keep toilets well maintained (this includes keeping toilets clean and functional)	Prevent pathogen spread Increase likelihood of toilet use	Cysticercosis, FBT, STH, trachoma
	Adequate provision, maintenance and cleanliness of toilet facilities for patients, staff and care givers (including bedpans); safe disposal of faecal waste	Prevent health care associated infections Prevent disease spread from health care facilities to the surrounding communities Encourage facility-based care seeking by improving quality of care	All diseases requiring health care facility attention, particularly surgical interventions and hospitalization
	Adequate provision, maintenance and cleanliness of sanitation facilities for students and staff in schools	Prevent pathogen spread Reduce the risk of being bitten by a snake Increase likelihood of toilet use Inculcate good sanitation practices among students	Cysticercosis, FBT, snakebite envenoming, STH, trachoma

HYGIENE	Practice	Purpose	Disease
	Personal hygiene		
	Wash hands at critical times	Prevent pathogen spread	Cysticercosis, echinococcosis, schistosomiasis, STH, trachoma
	Wash hands after contact with animals	Prevent ingestion of parasite eggs	Echinococcosis, rabies
	Wash face when dirty	Remove secretions from face Keep flies away from face	Trachoma
	Bathe regularly using clean water and soap (and not in open water sources/surface water)	Prevent skin/fungal infections	Chromoblastomycosis, yaws
	Wash clothes, towels and bedding regularly (not in open water sources/surface water)	Prevent transmission	Trachoma
	Food hygiene		
	Do not serve children food directly on the ground	Prevent pathogen ingestion	STH
	Maintain hygienic food preparation through washing hands, surfaces, utensils and raw food products with clean water and soap	Prevent or remove pathogen contamination of food	Chagas, echinococcosis, FBT
Avoid consumption of raw fish, crustaceans and plants in endemic areas	Prevent FBT infection	FBT	
Avoid consumption of raw or undercooked pork	Prevent transmission of <i>T. solium</i>	Taeniasis	
Thorough cooking and re-heating of food	Kill pathogens through heat inactivation	Chagas, FBT	
Proper storage of food in sealed containers	Prevent re-contamination with pathogens by flies and fomites Avoid attracting snakes/rats	Chagas, FBT, snakebite envenoming	
Keeping animals out of the food preparation and eating area	Avoid pathogen spread in the environment and into food	Echinococcosis	
Cover cleaned dishes	Avoid pathogen ingestion	Chagas	
Discard infected organs and do not use for animal consumption	Avoid parasite transmission	Echinococcosis	

WATER	Practice	Purpose	Disease
	Treat water before drinking	Remove pathogens	Echinococcosis, STH
	In schistosomiasis-endemic areas, if water is collected from open sources, keep water for 48 hours before using it or treating it for drinking	Kill off cercariae	Schistosomiasis
	Filter water from open sources with a fine mesh cloth	Remove infected copepods	Guinea-worm
	Avoid contact with surface water, including for water collection, swimming, bathing and laundry	Prevent contact with parasite or contaminating the water	Guinea-worm, schistosomiasis
	Keep animals away from water sources for human consumption/use	Prevent animal parasites from entering water source	Guinea-worm, schistosomiasis
	Store water in safe containers with tight lid	Prevent mosquito breeding	Dengue
	Regularly empty and clean water containers	Prevent mosquito breeding	Dengue
Obtain water from the closest safe source, both for humans and livestock	To reduce the chances of human-snake conflict	Snakebite envenoming	

TREATMENT AND CARE

Practice	Purpose	Disease
Participate in MDA campaigns	Reduce the burden of disease	Taeniasis, FBT, LF, onchocerciasis, scabies, schistosomiasis, STH, trachoma, yaws
WASH swollen feet and limbs and between the toes with soap and water daily	Prevent bacterial infections and increased severity of disease (acute inflammatory episodes)	Leprosy, LF
Hygienic wound management including washing with clean water and soap, using clean dressings, handwashing with soap before contact	Prevent wound infection	Buruli ulcer, guinea-worm, leishmaniasis, leprosy, scabies (secondary infections), yaws, rabies
Wash hands before and after contact with patient	Prevent infection	All diseases
Seek clinical treatment for chronic morbidity	Reduce severity of disease, reduce likelihood of passing on infection	Cysticercosis, Buruli ulcer, chagas, echinococcosis, leprosy, LF, trachoma, yaws
Seek urgent medical care	Prevent severity of infection and fatal consequences	Dengue, rabies, snakebite envenoming
Attend follow up for treatment/surgery, and surgical aftercare	Prevent severe disease outcomes and further transmission	Buruli ulcer, cysticercosis, echinococcosis, LF, trachoma
Apply IPC measures in health care settings (including cleaning, waste disposal and hand hygiene) by health care staff, patients and visitors	Prevent health care associated infections	All diseases requiring health care facility attention, particularly surgical interventions and hospitalization

OTHER BEHAVIOURS

Practice	Purpose	Disease
Avoid insect bites using clothing, repellent, bed nets, screens	Prevent transmission	Chagas, dengue, human African trypanosomiasis, leishmaniasis, LF
Prevent mosquito breeding: cover and regularly clean water containers, drains and septic tanks, participate in indoor residual spraying programmes or spray home regularly; prevent water accumulation in puddles or solid waste	Reduce vector breeding	Dengue, LF
Reduce sandfly breeding in animal shelters and improve domestic and peri-domestic sanitary conditions (cleaning, insecticide, disposal of household waste (bury/burn organic waste, remove inorganic waste)	Reduce vector breeding	Leishmaniasis
Use of improved housing materials such as solid (concrete, tiled, brick, block) flooring and walls, and inorganic roofing materials	Prevent vector breeding and remove parasite eggs	Chagas, leishmaniasis, STH
Avoidance of snakebite (sleeping on raised bed under insecticide-treated bed net, avoiding firewood collection at night, avoiding contact with potential hiding places, careful handling of dead snakes, extra precautions at night and after rains including shoe wearing and light use, avoiding running over snakes with vehicles or bicycles)	Avoidance of bites	Snakebite envenoming
Avoid contact with wild animals and unknown dogs	Avoidance of bites	Rabies
Apply good animal husbandry practices for livestock and other household animals including deworming and vaccination where relevant	Prevent transmission of pathogens between animals and humans	Echinococcosis, rabies, taeniasis/cysticercosis, FBT
Use of personal protective equipment (gloves, boots/shoes, masks, aprons) for high-risk groups (e.g. sanitation workers, farmers)	Protect occupational health	Chromoblastomycosis, mycetoma, schistosomiasis, STH
Restriction of skin-to-skin contact with infected individuals	Prevent disease transmission	Scabies
Always wear shoes outside	Protect skin	Mycetoma, schistosomiasis, snakebite envenoming, STH

TOOL 3

Understanding behaviour to develop behaviour change interventions

Human behaviour at the individual, household, community and society level underpins the transmission and treatment of NTDs. Promoting healthy behaviours and preventing behaviours that undermine health and associated services is an ongoing challenge of WASH, NTD, education and health programmes. A basic principle for the development of behaviour change initiatives is that changing behaviours requires an understanding of:

- What the target behaviours are.
- Who practises these behaviours.
- Why these behaviours occur.
- What are the effective ways to change them.

The potential behaviours of interest for NTDs are listed in **Tool 2: NTD-related behaviours** . See also WASH in behaviour change (Section II) for further information.

How can information about the behaviours of interest be collected?

The process for answering the above questions is sometimes referred to as **formative research**, a process with the objective of providing detail on specific behaviours in the context in which they happen (through field observation rather than literature review or expert consultation). This type of research generally applies qualitative methods, although some quantitative data may also be gathered. It is designed to provide enough information to understand what drives the target behaviours, and on the specific context in which they take place. The findings are therefore helpful for the design and eventual delivery of the intervention. Given that many NTDs are associated with specific behaviours taking place in specific geographic and cultural settings, formative research can be a powerful tool for designing an effective intervention.

Is research essential?

The term research may be off-putting, as this may seem to imply significant complexity and cost implications. It is possible that relevant information about the specific behaviour and context has already been collected and can be used as a starting point for intervention design. While new information may be needed, it may not be essential to undertake research at a very large scale – having some information to guide intervention design is better than having none. The following steps will guide you in deciding what kind of information you may need and how it may be found. In cases where relevant information is lacking and large-scale behaviour change interventions are being planned, full formative research using an academic team may be an essential and justifiable investment to ensure programme effectiveness.

Process for deciding the purpose and scope of formative research

- 1. Is research needed?** Start off by asking: why is new information needed? What kind of programme is being developed, and where will it be implemented? How will the findings be used to inform programme design? These questions will help you understand whether or not research is needed, the scale and scope, and the potential cost. Remember: formative research is only necessary for the development of behaviour change interventions. If the question you are seeking to answer is about other aspects of the programmes such as improving integration, or improving governance and coordination, the process set out in STEP 3 should be sufficient.
- 2. What information is needed, based on the situation analysis?** What is the behavioural problem you are seeking to address? Several health promotion and behaviour change initiatives are likely to already be taking place in your country. The situation analysis may have brought up a few potential opportunities and entry points relating to these activities. How do you know which one is most useful for addressing the behaviours that are most relevant to your programme?
 - a. Integrating an NTD-specific behaviour into an existing WASH campaign:** Can you assume which behaviour change message will be the most effective, and how it should be delivered? For example, an easy option may be to introduce a message around facial cleanliness for trachoma prevention into a handwashing campaign; however, the motivation for face washing may not be the same as the motivation for handwashing in the particular setting (the former may be driven by social respect, while the latter may be driven by disgust).
 - b. Incorporating behaviour change messages into social mobilization for MDA:** This may be an obvious entry point, but MDA is an infrequent activity (once or twice a year). What might be the most effective message that can deliver impact when communicated at such low frequency?
 - c. Utilizing mass media for behaviour change messages:** The situation analysis may have shown that TV and radio are popular communication channels in your country. However, do they reach endemic communities (who may have less access to these channels)? If they do, are they trusted channels for communicating information on health and well-being?
 - d. Using health outreach programmes:** Outreach programmes have the potential to reach endemic populations and to be a trusted source of information and influence. What is the reach and quality of the health services in endemic areas? If their reach is good, do frontline health workers have the skills, capacity and resources to undertake effective behaviour change activities? Do health workers have a relationship of trust with the target group (especially in situations where NTDs affect particular ethnic, cultural and socioeconomic groups, and in relation to NTDs associated with social stigma and exclusion)? Are the target behaviours already being addressed? Are they being addressed effectively?
 - e. Delivering in schools:** Children are often seen as potential change agents for communities. Consider if there is a school health programme through which behaviour change messages can be delivered effectively? Do teachers have sufficient skills, resources and motivation to deliver messages? Are the target behaviours already being addressed? Are they being addressed effectively?

The information in the situation analysis and your and your team's knowledge may provide you with answers to most of the above questions, and it may be that the behaviour change intervention required is a simple change or adaptation to an existing intervention.

Go through the next two stages to figure out whether you have sufficient information already to deliver the intervention, or whether further investigation is needed.

3. What isn't known about the target behaviour? There may be aspects that are completely unknown about the behaviour, in terms of who practises it, when and why. Alternatively, there may already be some information in the literature or from previous studies about the behaviour, but perhaps not in the specific programme context or location of interest. There may be information about the behaviour (e.g. handwashing with soap after toilet use), but perhaps not in relation to the specific NTD-related risk factors (e.g. handwashing before food preparation or eating, in relation to foodborne diseases or helminth infection). This should be an opportunity to question existing assumptions on what people do or don't do, why, and what may be the entry points for communication that are most influential and effective.

Use the table below to establish what is already known, and where further information is needed.

		Example questions	Example for soil-transmitted helminthiasis (STH) WASH behaviours	More data needed? (Y/N)
Behaviour	Target behaviour	Define the target behaviour (what is the action, who will do it, in the specific location (e.g. district)	Handwashing before eating Exclusive use of toilets for defecation and faeces disposal	Yes <input type="checkbox"/> No <input type="checkbox"/>
Environment	Physical	What things in the physical environment trigger the targets behaviours? What is the physical setting like?	Lack of handwashing stations, water and soap near where people eat Lack of toilets and poor child faeces disposal practices	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Biological	What risk is there from pathogens/faeces? What diseases to people know about or worry about?	We have some data from health care facilities about type and burden of STH infections, and some survey data showing that there is high prevalence. XX% of the population in the district are still assumed to practise open defecation. Access to water is XX%. Child mortality is xxx. We don't know what people are worried about and how they believe diseases are transmitted.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Social	Who are the role models for the target behaviours? How does the social environment (relationships, networks and organizations) affect the target behaviour?	This is a rural setting and most people are farmers. Male household heads are decision-makers, women are the primary carers of children. There are community women's groups and village heads are also influential. In some communities religious leaders are also influential.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Brains	Executive	Do the audience understand the need for the target behaviour and when and how it should be done? Do they make plans related to the target behaviour?	Children are told to wash hands at school and are told about intestinal worms, but it is not clear whether this information is shared at home or in the community. A recent evaluation of the national sanitation programme showed people know the health imperative for stopping open defecation, but the practice persists in this district.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Motivated	Is the target behaviour rewarding? What emotional drivers of behaviours are there?	Literature on handwashing shows that handwashing is often motivated by family culture/parenting, disgust and comfort, and that hands usually get washed if dirty, sticky or smelly. Literature on sanitation shows that privacy, comfort and social aspects (pressure, status) are stronger motives than health for constructing and using latrines.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Reactive	What triggers the target behaviours? Is the behaviour habitual? If the behaviour is skill-based, do the target audience have the necessary skills?	Having a handwashing station where people eat may make handwashing easier to habituate. Having a latrine that is private, safe, near, clean and pleasant to use is likely to increase use.	Yes <input type="checkbox"/> No <input type="checkbox"/>

		Example questions	Example for soil-transmitted helminthiasis (STH) WASH behaviours	More data needed? (Y/N)
Body	Traits, physiology, senses	How do different individuals (older people, young children, people with disabilities) engage with the behaviour? Do they have specific needs compared with other groups?	Small children who play outside are more likely to come into contact with pathogens and also need to be assisted with handwashing. From the literature, we know that pit latrines with large drop holes are scary/unsafe for children to use; and that latrines without pedestals, rails and ramps are difficult for people with disabilities or impairments to use.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Behaviour setting	Stage	Where does the behaviour take place?	Current hygiene promotion initiatives emphasize handwashing station construction outside latrines; we don't know to what extent handwashing facilities exist where people eat. We think that where toilets are built, they are used, but it is not clear if they are used always by everyone (e.g. children). People can also be exposed to pathogens when they are away from the home – public places, fields, schools – where they may not have access to toilets.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Roles	What is the role played by the target audience and how does this relate to the roles played by others?	In this context, women often care for children and we assume children obey their guidance. We don't know what role others, such as broader family and community members, teachers and leaders play in defining behaviours.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Routine and script	How does the daily routine of activities influence the practice of the target behaviour?	Children's hands are checked for dirt at school before meals. Bathing (including handwashing) is likely to happen in the morning. We don't know if there is a routine associated with latrine use although in some countries open defecation has been observed to happen in the early morning or late evening, where it is a group activity.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Norms	What behaviour is the audience expected to carry out? What behaviour would be approved of?	Studies in other countries show people tend to not use soap before eating due to preference, and may only wash hands after eating to remove food. Suspect that although open defecation may be frowned upon, it is still practised routinely by children, and adults under some circumstances (especially if away from the home or if the latrine is inadequate or damaged).	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Props and infrastructure	What objects are needed to perform the target behaviours?	Handwashing stations with water and soap are needed. Uncertain as to the preferred type of handwashing station and handwashing material (bar soap, soapy water, ash). Adobe latrines without slab are the most common type. Uncertain whether lack of washable/concrete slab is a result of cost or availability.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Intervention	Touchpoints	What are the ways in which a programme can reach/communicate with a target audience?	From the situation analysis we know that people listen to the radio and are in frequent contact with health extension workers. Uncertain which communication channels are preferred/most effective for behaviour change messages in terms of trust, reach and relevance.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Context	Programmatic, political, economic, social	What programmes are active in the area/district? What political or historical events/structures need to be considered if delivering a programme in this context?	From the situation analysis, we know that several NGOs promote sanitation and handwashing in this area. The effectiveness of the programmes in terms of improvements in handwashing and latrine use has not been assessed.	Yes <input type="checkbox"/> No <input type="checkbox"/>

Source: Adapted from *Hygiene behaviour change capacity building and technical training manual* (WaterAid and London School of Hygiene & Tropical Medicine, 2016).

4. Identify potential methods: Once you have established what further information is needed, there are several ways in which this information can be best obtained. Each of these has advantages and disadvantages, and the next stage will help you decide which methods would be most appropriate to your needs.

		Example questions	Formative research method
Behaviour	Target behaviour	What is the prevalence of the key risk behaviours? Who carries out the behaviours? When?	Structured observation, participant observation, video observation, self-report when observation is not possible (e.g. anal cleansing)
Environment	Physical	How is water supplied? Are soap, potties etc. materials available in local shops/kiosks? What is the state of toilet provision?	Transect walk, shopkeeper interview
	Biological	Are animals kept in kitchens? Is human and animal faecal material on the ground?	Participant observation, structured observation, video observation
	Social	Do the target communities have active institutions (e.g. leadership, committees, WASH volunteers, trade associations?) Is everyone represented in such communities?	Community map, social network analysis
Brains	Executive	Does the audience understand the need for handwashing? Have they received awareness material and information in a way they can understand?	Questionnaire survey, focus group discussion, worry box, financial life, identity map
	Motivated	What could motivate handwashing, safe faeces disposal?	Motive mapping, superpowers game, forced choice games, attribute ranking, prioritization game
	Reactive	What cues target the behaviour?	Scripting, word association
Body	Traits, physiology, senses	Do elderly, infirm, young, pregnant, persons with disabilities (male and female), less able, etc. have different needs?	Photovoice
Behaviour setting	Stage	Where does the behaviour take place?	Participant observation, video observation
	Roles	What is the role played by the target audience and how does this relate to roles played by others?	Participant observation, video observation
	Routine	What are the daily routines?	Participant observation, video observation
	Script	What is the sequence of behaviours involved in handwashing according to the target audience?	Scripting of normal day, menstruation day
	Norms	What handwashing behaviour is expected and approved of?	Norms questions, "out of 100" people exercise
	Props	Is soap available in the house? What types? What implements are used for handwashing? Are there potties in the house?	Household inventory, behaviour trial
	Infrastructure	Are there toilets? Are toilets accessible to persons with disabilities? What state are they in? Is there a handwashing place? Where is water stored?	Household visits, physical observation
Intervention	Touchpoints	What are the ways in which a programme can contact a target audience?	Social network analysis, touchpoint map, questionnaire
Context	Programmatic, political, economic, social	What programmes are active in region?	Key informant interviews

5. Planning and delivering the research: Now that you have listed all the target behaviours and the potential methods to obtain information, you will need to decide which ones are not only relevant, but also feasible. Ask the following questions:

- a. Do you have sufficient staff to undertake the work (such as experienced data collectors or researchers)? If not, can an appropriate external agency be identified with experience in conducting formative research and/or social investigations?
- b. Is there sufficient expertise within your team to conduct and supervise the work? If not, is training needed and feasible?
- c. What are the likely costs of the work, and is there sufficient budget to undertake it? If not, can additional resources be mobilized, or can costs be reduced by choosing an alternative, appropriate method?
- d. What are the logistics associated with the work, such as timing (consider holidays, seasons, insecurity and other considerations)?
- e. What is the appropriate scale of the investigation in terms of number of people/households/communities you will need to cover? (remember that this is not a baseline study, and therefore you may not need a large sample size in order to draw useful conclusions).
- f. Have you considered accessible communication needs to reach persons with disabilities, sign language interpretation, ensuring accessible venues for community discussions etc.

Once you have decided on the methods, it is advisable to develop a plan that covers the following aspects, with specific timelines:

- Research team composition
- Terms of reference for the research team
- Ethical approval process and forms (as required by the appropriate research council at national level, including additional requirements for any academic institutions involved and process and forms for obtaining informed consent from participants)
- Data storage procedure to maintain confidentiality
- Process for research tool development
- Training schedule and plan for data collectors
- Schedule for data collection and analysis
- Type and framework for analysis
- Data analysis plan: this has to be aligned with the question you are seeking to answer (or the research question for the formative research). When analysing, keep in mind that the point of the analysis is to provide an intervention for intervention design. The way you will analyse the data will depend on the methods chosen.
- Outline for final report
- Detailed budget.

6. Applying the findings for intervention development: Keeping in mind that the investigation/formative research has been done to inform a behaviour change intervention, make sure that the analysis has answered all the necessary questions, and then design a new intervention (or adapt an existing one). Be prepared to question prior assumptions about what drives behaviour and what the intervention should look like; if well-designed and conducted, the process you have gone through will provide you with valuable insights for intervention design, and for convincing others of the validity of the intervention you are proposing. If more information is needed during the process, consider the possibility of finding out more, as well as undertaking small-scale intervention trials and intervention pre-tests. Refer to STEP 4 for more on intervention design.

TOOL 4

Messages for engagement

It is important to form collaborative relationships with a broad set of stakeholders, who may not work specifically on NTDs. Contributions include information sharing, participation in planning, and resource allocation for unfunded areas/aspects. However, although such collaboration is needed, you may find it difficult to initiate a discussion with the necessary stakeholders. Some stakeholders can be nervous about changing existing health/sanitation/hygiene promotion programmes, for fear of diluting messages, overloading field staff, having to share resources with other agencies, etc. This may make them less likely to engage or agree to programme changes or activities. The arguments below have been written to inform the way in which key decision-makers and actors in different sectors can be approached to encourage engagement in NTD planning and activities. Some messages apply across all or many sectors, while others are likely to appeal to the interests and motivations of specific sectors.

Message	Audience									
	Politicians	WASH	Health	Education	Disability inclusion	Veterinary public health	Nutrition	Vector control	Gender equity	Child health and rights
NTDs affect the poorest and most marginalized areas and communities, and can exacerbate poverty disproportionately among women, children and vulnerable groups. Collaborating will help target work towards these areas to reduce poverty and improve development outcomes.	●	●	●	●	●	●	●	●	●	●
NTDs affect populations in remote areas where service delivery/infrastructure can be costly and complex. NTD programmes provide useful, and often highly detailed, information on where the needs are. Joint planning and advocacy can help leverage more resources and make more effective use of existing resources, and improve targeted and equitable service delivery.	●	●	●	●	●	●	●	●	●	●
A collaborative cross-sectoral approach and a coordinated agenda can strengthen health, WASH and education systems and make improvements more sustainable.		●	●	●	●	●	●	●	●	●
COVID-19 recovery efforts should combine climate, economic, health and sociopolitical systems as part of an integrated approach. NTD and WASH integration can offer critical insights for addressing systems-level gaps and is an important barometer for progress in responding to the needs of the most disadvantaged populations and for building resilience to future health and other shocks.	●	●	●	●				●		

Message	Audience									
	Politicians	WASH	Health	Education	Disability inclusion	Veterinary public health	Nutrition	Vector control	Gender equity	Child health and rights
Integrating multisectoral approaches can improve preventive and promotive health services, embed healthy behaviours and embed trust in health and WASH platforms in order to strengthen to community-level pandemic preparedness. Multisectoral working for WASH and NTDs can embed practices and ways of working, such as cross-sectoral coordination, data sharing and joint WASH and health surveillance to strengthen systems for pandemic preparedness.	●	●	●	●				●		
NTDs can disproportionately affect women and girls due to biological and socioeconomic factors. Collaboration and coordination can help ensure a comprehensive response/ approach to improving health outcomes and addressing their determinants. A gender equity focus can increase the uptake of all health care services and promote women's role in decision-making and leadership.	●		●				●	●	●	
Collaboration is crucial to delivering a One Health approach that improves human and animal health as well as protect livelihoods. It can enhance productivity and sustainability by providing new entry points for outreach, increasing reach and uptake of veterinary public health interventions, and improving animal husbandry practices.	●					●		●		
Undernutrition affects the same populations affected by NTDs and poor access to WASH. Collaboration can help address the root causes of undernutrition through prevention of disease and poverty reduction.			●				●			
Coordinated and integrated programmes delivered at school can improve the health outcomes of school-aged children and adolescents. Such programmes can also empower children to take responsibility for their health and hygiene behaviours and influence family behaviours. NTD prevention measures can strengthen the education system by contributing to overall child health, providing educational tools, improving school water and sanitation infrastructure, improving attendance, increasing parental trust, and strengthening teacher motivation and capacity.				●						
Collaboration can improve effectiveness and impact of vector control interventions by enhancing targeting and pooling financial and staff resources across multiple vector-borne disease programmes. More effective delivery and behaviour change communication interventions can increase public uptake of vector control interventions.								●		
A collaborative approach on WASH and NTDs can help ensure a comprehensive and equitable response to the needs and rights of persons affected by NTDs. This can support prevention and (self-) management of disabilities, promotion of mental well-being, reduction of stigma and uptake of other services which promote inclusion.					●					

TOOL 5

Initial cross-sectoral meeting for WASH and NTDs: annotated agenda

This type of meeting is proposed as an initial step for building productive working relationships for implementation of WASH aspects for NTD control, particularly for contexts in which there is limited communication between NTD actors and other health, education, and water and sanitation stakeholders. Such a meeting should ideally take place at both national and subnational levels. The most appropriate subnational level (regional, district or both) in which to hold the meeting will be determined by what is most relevant in the given context. It is crucial to have the key stakeholders understand the importance of this cross-sectoral meeting and why their participation is key. Refer to **Tool 4: Messages for engagement**  for guidance on how to engage with these stakeholders.

The meeting should be set up as a workshop and led by an experienced and impartial facilitator, who can ensure that the discussion leads to clear deliverables. Over-reliance on presentations or panels should be avoided, to ensure optimal engagement by participants as well as ample time for discussion and agreement. It is suggested to identify a WASH champion from within the health ministry or other relevant ministry to co-host the meeting. This will help with engagement and buy-in from key WASH stakeholders and partners.

Pre-meeting activities

1. Obtain data and maps (e.g. of NTD prevalence, water and sanitation access/coverage) and conduct initial analysis for presentation at the meeting.
2. Try to ascertain existing levels of knowledge on the issues to be covered in the meeting (for example, whether non-NTD actors are aware of NTDs and where they are prevalent), and expectations from the meeting.
3. Prepare for the meeting using the provided cross-sector meeting presentation template (see **Supplementary tool: WASH-NTD partner form** , which sets out the key background to and objectives for the meeting, as well as key information on WASH and NTDs. Share the templates with the relevant stakeholders as appropriate.
4. Share relevant documents or meeting concept note with participants in advance of the meeting, in accessible formats, knowing that persons with disabilities may be attending these meetings.
5. Select meeting venues that are accessible to everyone (you can link to accessibility guidelines for organizing meetings, see **AccessibilityGo: a guide to action** . Ask if any meeting participants have accessibility requirements and be ready to provide any necessary support.

Objectives of the meeting

1. Discussion of the current programmes and activities in NTDs and other sectors regarding:
 - geographic and other focus areas for all stakeholders;
 - current WASH, NTDs and education (health education focusing on disease control and health promotion) programmes in terms of location, type of activities and funding sources.
2. Identify areas of converging interests and areas of work, and joint planning opportunities.
3. Identify specific potential joint or coordinated activities (e.g. integrating WASH components into NTD programming, incorporating NTD-related behaviour change promotion into existing or new hygiene promotion activities, etc.).

Preliminary list of potential sectors to consider engaging

When deciding which stakeholders to engage, it is important to think about how each stakeholder will contribute to the objectives above. Keep the meeting to a maximum of 20 participants to ensure an engaged and productive conversation, and ensure a diverse representation of community organizations, women, men, minority groups, persons with disabilities etc.):

- government agencies (education, sanitation [infrastructure and disposal], water, health, nutrition, strategic monitoring);
- agencies working on WASH and NTD-related topics and infrastructure (nongovernmental organizations [NGOs], community-based organizations, United Nations (UN) agencies), including infrastructure, treatment, social inclusion and behaviour change communication;
- communication and behaviour change experts;
- research institutions; and
- corporate businesses involved in WASH provision or corporate social responsibility investments.

MEETING AGENDA: WASH AND NTD STAKEHOLDERS		
Time	Session	Presenter/facilitator
ARRIVAL AND REGISTRATION		
5 minutes	Opening remarks • Objectives • Background	Host
10 minutes	Official opening: NTDs and link with WASH and other sectors	National NTDs coordinator, health ministry/senior WASH partner
45 minutes	Stakeholder presentations on current programming priorities (WASH, Education and Health Promotion)	WHO or UNICEF person if possible Representative from Education and Health Promotion
30 minutes	Group discussion to list opportunities and activities	Facilitator
COFFEE BREAK		
60 minutes	Group discussion to list opportunities and activities (continued)	Facilitator
45 minutes	Key action points and next steps (including future meetings)	Facilitator/host
15 minutes	Closing remarks	NTD coordinator/senior WASH partner
LUNCH/END OF DAY (depending on whether meeting starts in the morning or after lunch)		

AGENDA: DETAILS

Session	Purpose	Delivery
1. Stakeholder introductions and review of meeting objectives	<ul style="list-style-type: none"> • Build a productive working relationship among stakeholders and encourage buy-in • Ensure everyone is aware of the purpose of the meeting, what they can expect, and what is expected of them 	<p>Stakeholders may be coming together for the first time and may not be aware of each other's priorities and work style. They may have also made unsuccessful attempts to work together previously. This could create suspicion or lack of engagement. This initial session should be the first step in developing good working relationships, emphasizing that all stakeholders have something to benefit from increased collaboration.</p>
2. Official opening	<ul style="list-style-type: none"> • Show the prioritization of the issue by government • Signal the importance of collaboration and the benefits to all stakeholders, including link to the national development agenda 	<p>This can be delivered by the national NTD coordinator, or a high-level health ministry or other government official, to lend weight to the meeting and draw participation from all stakeholders.</p>
3. Brief informative presentations on NTDs in the country/district and links with other sectors' programmes and goals	<ul style="list-style-type: none"> • Create a shared basic understanding of NTD issues, and establish the importance of and need for collaboration to achieve shared goals of improved health, equity and growth • Make the case for NTDs: equity and inclusion, economic and development impact; and the case for collaboration – what do actors gain from working together? 	<p>The level at which these presentations are pitched should be based on the level of knowledge established by the pre-meeting preparation. This session would include presenting maps of NTD and WASH priority areas and programme coverage data. It could also include overlaying disease and service coverage data to show areas of high endemicity and low coverage.</p> <p>You will need key statistics on NTDs: endemicity, geographic distribution, key programme information.</p>
4. Brief stakeholder presentations on current programming priorities	<ul style="list-style-type: none"> • Increase understanding by stakeholders of the type of work carried out by others, and considerations that inform this work • Identify areas of programme overlap as well as service/coverage gaps in endemic areas. What do actors bring to the table? What would be needed to work together? • Highlight relevant opportunities and current programmes within education – such as school health and nutrition, and health promotion – focusing on disease prevention (highlight the focus on NTDs if existing) 	<p>This session will help demonstrate the amount of work already being done by various stakeholders and highlight opportunities for collaboration. It should help demonstrate that although collaboration may be rare, much relevant work is already being done by stakeholders. It is also a good opportunity to address misconceptions about how other sectors operate, and to improve mutual understanding of sector-specific priority setting and ways of working.</p> <p>You will need key statistics on WASH (e.g. sanitation access/coverage, open defecation, water access, handwashing stations in households, schools, health care facilities etc.); and key information on current programmes in terms of scale and location.</p> <p>You will also need information on education (school health and nutrition) and health promotion (disease prevention) strategies, current programmes (scale and location) and goals.</p>

AGENDA: DETAILS

Session	Purpose	Delivery
5. Group discussion to list opportunities and activities	<ul style="list-style-type: none"> Identify short-term, achievable actions with clear responsibilities and timeline Discuss and condense proposed activities into a work schedule with clear responsibilities and timeframe 	<p>After presenting the various programmes and activities, brainstorm challenges to stakeholder collaboration, as well as elaborate on potential opportunities and challenges and cross-cutting priorities. Depending on the size of the group, this can be done in plenary or in groups.</p> <p>This session will require careful facilitation to ensure that all proposed activities are agreed and that there is a clear line of responsibility for delivering activities. The facilitator should be prepared to address any disagreements.</p> <p>The discussion should be directed towards a short-term action agenda to encourage buy-in and ownership of the agreed actions. Targeted questions and a format to report back with should be prepared in advance for the group discussion. This could include a table with the following columns: activity, timeframe/completion date, milestones within timeframe, lead agency/person, key stakeholders/delivering agencies, resource requirements (human, technical, financial). The list of activities does not have to be exhaustive or long; the key purpose is to have some clear doable actions that can be delivered as part of a broader effort. Activities that are too ambitious or unlikely to be delivered should be discussed but possibly carried through to more advanced planning stages.</p>
6. Summary and next steps	<ul style="list-style-type: none"> Ensure agreement on activities and assign action points 	<p>This session should wrap up and confirm the agreement in the previous section. There should be agreement on how the action points from the meeting will be communicated to participants and followed up and by whom, and what are the next key important dates/meetings.</p>

TOOL 6

Situation analysis for WASH and NTDs planning: protocol and methods

The situation analysis is composed of several information gathering activities to guide WASH and NTDs joint planning. This is a first step towards developing a joint programme approach to address NTDs at country level, and should be followed by district-focused analyses to understand the partners, resources, and existing WASH, NTDs and other relevant sector activities taking place locally before developing a detailed implementation plan. The national-level assessment will analyse health, water and sanitation, education and other policies, plans and systems at all administrative levels necessary for the effective implementation of WASH interventions for NTD treatment, care, control, elimination and eradication.

Note: Use **Tool 6 Annex**  to capture the required data.

How WASH is defined in this situation analysis: Gathering local knowledge and understanding community needs and preferences are important steps to determine the most suitable type of WASH infrastructure and behaviour change interventions within each setting. In the context of NTDs, WASH activities are defined as:

- Improvement in access to water and sanitation hardware through direct programme investment; or promotion of household/community investment (particularly in latrine construction or maintenance of water points); or advocacy to ensure planned infrastructure is targeted at endemic areas.
- Actions focused on behavioural change and the promotion of healthy behaviours and practices around personal and household hygiene relevant to diseases endemic in the location of interest (e.g. facial cleanliness for trachoma, shoe-wearing, handwashing and food safety for STH, etc.).

1. Preparatory phase

a. Identify analysis team

This is a recommended core group to be included in the overall situation analysis team. The team should include members with experience of NTDs, WASH, social and behaviour change (SBC), current programme and coordination structures, public health/epidemiology, etc.

You can use the following terms of reference for the analysis team.

Terms of Reference for Conducting a WASH NTDs Situation Analysis for [COUNTRY]

[ORGANIZATION OR PERSON RESPONSIBLE FOR CONDUCTING
A WASH AND NTDs SITUATION ANALYSIS]

[DATE]

Overview

[PROVIDE COUNTRY BACKGROUND AND ANY OTHER FULL REVIEWS OR ANALYSES DONE TO DATE]

Key tasks

Present a broad, national perspective on current WASH and behaviour change programming taking place in [COUNTRY] with relevance to NTD care and control:

1. Work with [ORGANIZATION NAME] and [LEAD NATIONAL-LEVEL MINISTRY], to develop a clear timeline for conducting the situation analysis, including a communication plan for keeping all programme stakeholders apprised of progress.
2. Undertake desk review of existing studies, campaigns, white papers, WASH and NTD plans (national, subnational), national health and development strategies as they relate to WASH and NTDs, and analyses of gaps that underpin national WASH and NTD efforts to date.
3. Work with relevant members of established county-, region- and/or district-level NTD task forces and WASH teams to identify and review all relevant WASH strategies currently in place.
4. Meet with representatives of the following entities to discuss their knowledge of, experience with, and any materials they may have in relation to WASH activities undertaken or being undertaken in and around the geographic areas supported by the programme:
 - Implementing partners
 - National-, regional- and/or district-level NTD task force teams
 - National-, regional- and/or district-level formal WASH groups or organizations
 - Organizations/agencies engaging in behaviour change interventions and initiatives.These discussions should also gather input from these representatives regarding what works, what doesn't work and why (in both cases) with regards to WASH and behaviour change initiatives.
5. Summarize and present findings and conclusions to all programme stakeholders.
6. Incorporate programme stakeholder input/feedback into a situation analysis report to be submitted to [AGENCY NAME] and [LEAD NATIONAL-LEVEL MINISTRY].

b. Identify and formally involve key stakeholders

Successful joint planning requires all stakeholders to work together to achieve the common goals of improved public health and equity, as opposed to sector-specific goals such as disease control and WASH access. Reaching agreement and buy-in to a common goal is likely to demand a shared understanding of the goals of all stakeholders and aligning NTD strategies with the national development agenda. Joint planning is likely to be more successful if everyone who should be involved has been involved from the start. It is unrealistic to expect agencies and individuals to buy into an agenda they have not been involved in setting.

Stakeholders can be involved in agenda setting and in gathering further information through a meeting or workshop in which the current situation/landscape of NTDs in the country is discussed with key stakeholders to seek their involvement and advice. Efforts should be made to explicitly link NTDs to the objectives of other stakeholders, in terms of poverty reduction, broader public health benefits, and equity. This could also be the first step for collecting key information or identifying sources of information that should be followed up. This should be done at the national level and in selected endemic regions if possible.

Key types of stakeholders to involve:

- NTD and WASH government programme leads from the health, water and education sectors (including health ministry environmental health department, ministry of education leads for school health and school infrastructure, and any relevant technical or sector working groups).
- NGOs involved in WASH and NTDs implementation and advocacy.
- Bilateral and philanthropic donor and UN agencies involved in WASH and NTDs implementation.
- Organizations involved in developing and implementing behaviour change programmes (government, academic or private).

2. Protocol data tools

Keep background information short.

a. Demographic information

Fill in the table below (provide detailed district-level data – use the **Tool 6 Annex** ). Include information about specific populations of interest, migratory patterns, drought areas, etc. Where possible, include maps.

Table 1. **Demographic information**

Region	Population (% urban, rural, peri-urban)	% of children under 5, total number	% of school age children, total number	Literacy rate (total, male, female)
		11%, 313 196		

b. Disease information

Populate the table below with prevalence of disease for which MDA programmes are being delivered, and treatment coverage, including year in which data were collected. Provide the information by district – use the **Tool 6 Annex** .

Table 2. **Disease programme information** (example)

Region	Disease	Total endemic districts	Implementing partners	Interventions ^a	Districts	Year	Notes
Region I	Lymphatic filariasis	45	Ministry of Health	MDA	12	2011–2018	5 districts not covered for MDA
				Hydrocele surgeries	3	Ongoing	
			Organization X				
			Organization Y				
	Organization Z		17				
	Trachoma						
	Schistosomiasis						

^a Include non-MDA interventions such as community- and facility-based morbidity management, social inclusion and stigma prevention, vector-borne control programmes, veterinary public health interventions for zoonosis control, etc.

c. Data for decision-making context

Where possible, explain the data flow (how are data collected from the field and aggregated) for key programme interventions. At the very least, provide a basic structure for data flow for NTDs and add additional details/disease specific elements where relevant. Use the following questions as a guide. If possible, provide a basic graphic to represent the flow of data. **Please bold the correct answer.** This information can be used to inform the choice of data for decision-making options (see STEP 3: Data for decision-making).

NTD data

1. Is there an NTD database, using database software (Excel or paper files excluded),

- Yes No don't know

If Yes:

a. Specify database software Microsoft Access [CIND or other]

- DHIS2, MySQL/PostgreSQL/MS SQL server other:

b. How is the database accessed? from a specific computer online

- other:

c. How do new data get into the system? data entry data import through integration with cloud service

- d. Does it include epidemiological surveys? (TIS, TAS, other surveys to establish disease prevalence) Yes No
- e. At what level are these data stored in the database?
 community district region national
- f. How are districts and regions coded in the database?
 name code using MFR using HMIS other:
- g. How is the database restricted?
 - i. Districts are reported in the dataset and changes in one year do not affect other years
 Yes No
 - ii. Districts are updated in a central database and both new and historical data need to match that list
 Yes No
 - iii. Other:

- 2. If there is an NTD database (Excel or paper files)
 Yes No don't know (specify what it is

- 3. Does the NTD programme receive any WASH data (include the data received in the Tool 6 Annex).

WASH data

- 1. Is there a WASH sector management information system (WASH MIS)?
 Yes No
- 2. If No, describe what process is used by the government to monitor access to water and sanitation.
- 3. Are other stakeholders collecting WASH?
 - a. If Yes, please list
 - b. Is this additional information available to share?
- 4. Is there a WASH database, using database software (Excel or paper files excluded)?
 Yes No Don't know
 - a. Specify database software Microsoft Access DHIS2
 MySQL/PostgreSQL/MS SQL server other:
 - b. How is the database accessed? from a specific computer online
 other:
 - c. How do new data get into the system? data entry data import
 through integration with cloud service

5. Describe the WASH data being collected routinely by government (check all that apply)

Please provide an example of the data if possible.

- Access to water
 - households
 - schools
 - health care facilities
- Handwashing/face washing stations
 - households
 - schools
 - health care facilities
- Access to toilets
 - households
 - schools
 - health care facilities
- Open defecation free status
 - villages
 - municipalities
 - districts
- Other:

6. How often are these data collected?

- monthly quarterly yearly other

7. At what level of disaggregation are these data available?

- national regional district other:

8. What data are used for admin units (national, regional, district identifiers)?

- Humanitarian Data Exchange GeoConnect Master Facility Registry
 HMIS other

9. How are these data stored?

- online database access database Excel spreadsheet
 other:

10. Are WASH data shared with the health ministry? If so, how, or through which specific units within the health ministry?

- Yes No WASH data are already integrated into the health ministry NTD database

11. Do partners have access to data in the WASH database? Yes No don't know

d. WASH information

Use the WASH data in this tool's annex to write this section. Acceptable information sources include national WASH sector performance reports, Demographic and Health Surveys, Multiple Indicator Surveys, census and other nationally verified assessments. Data should be as up to date as possible, and not older than 2 years. **Available maps should be included.**

Note: This section may not be needed if you are already collating and analysing WASH and NTD data based on the methods described earlier (see STEP 3: Data for decision-making).

1. What are the levels of WASH access at different administrative levels? Detail as follows:

Community/household WASH data: Include a summary of:

- National status of access to water and sanitation services.
- Regions and districts in which household access to water supply is low.
- Regions and districts in which household access to sanitation and community coverage of sanitation is low; and in which there are high levels of open defecation.
- Regions and districts in which household access to handwashing facilities is low.

Highlight the following aspects:

- Large gaps in services by geographic area.
- Information gaps such as missing or outdated data (e.g. data collected more than 5 years ago).
- Areas that have very high coverage of services.

School WASH data: Include a summary of the availability and status of school WASH services at a national, regional and district level.

Highlight the following aspects:

- Large gaps in services by geographic area.
- Information gaps such as missing or outdated data (e.g. data collected more than 5 years ago).
- Areas that have very high coverage of services.

Health facility WASH data: Include a summary of the availability and status of health facility WASH services available at a national, regional and district level.

Highlight the following aspects:

- Large gaps in services by geographic area.
- Information gaps such as missing or outdated data (e.g. data collected more than 5 years ago).
- Areas that have very high coverage of services.

2. What is the current framework used to assess the performance of the WASH sector (e.g. a sector performance monitoring framework)?

- List the components of the framework (e.g. annual reviews, reports, etc., and the key indicators used). *If able, please represent this graphically.*

3. How are the data used for planning purposes? Please be descriptive here (annual planning meetings, etc.). Key points to consider:

- Are there large-scale national programmes in place (e.g. national sanitation campaigns, large WASH initiatives)?
- Is there limited collection of WASH data in accordance with global definitions (e.g. using the access ladders of safely managed, basic and limited services), or are data reported using older definitions of improved/unimproved water and sanitation or nationally specific definitions, no data collected on handwashing, etc.?

e. NTD and WASH coordination information

This section should provide in-depth information on existing coordination structures and strategic entry points for joint planning and implementation (national, district). **Provide organograms where possible.**

NTDs coordination structures

1. Describe the NTD decision-making and coordination structures/team(s) or task forces that support the design and implementation of the NTD master plan at national, district and subdistrict levels.

- Identify any gaps and challenges in the current NTD structure (e.g. coordination structure exists but does not meet).
- Specify whether any behaviour change stakeholders are represented within these structures, and whether behaviour change is included in the roles and responsibilities of the group.
- Specify whether any WASH stakeholders are represented within these structures, and whether WASH is included in the roles and responsibilities of the group.
- Describe the distribution and level of NTD staff (district, subdistrict, village, etc.) (e.g. regional and district health services, technical support units etc.). Outline their roles and responsibilities.

WASH coordination structures

2. Describe the WASH decision-making and coordination structures/teams or task forces at national, district and subdistrict levels.

- Identify any gaps and challenges in the current WASH structure (e.g. coordination structure exists but does not meet).
- Specify whether any behaviour change stakeholders are represented within these structures, and whether behaviour change is included in the roles and responsibilities of the group.
- Specify whether any NTD stakeholders are represented within these structures, and whether NTDs are included in the roles and responsibilities of the group.
- Describe the distribution and level of WASH staff (district, subdistrict, village, etc.) (e.g. district WASH office, technical support units etc.).
- Does the health ministry (or another ministry/agency) have WASH staff/environmental health staff operating at various levels (district, subdistrict, village etc.)? Outline their roles and responsibilities.

Joint coordination structures

3. Provide any information on whether or not the joint WASH and NTD coordination and decision-making structures are implemented in reality.

School and health care coordination structures

4. How do the ministries of education, health and water work together? Are there specific roles and responsibilities within the education sector to respond to health and WASH issues? Are there specific roles and responsibilities within the health ministry focused on education (e.g. school health)? Is there a memorandum of understanding between the three ministries?
5. What other stakeholders that have not been involved in this situation analysis may be able to contribute to NTD programmes? How can they be effectively engaged in NTD programme planning and implementation?

f. Behaviour change initiatives, interventions, tools and approaches

Social behaviour change (SBC) interventions

Include in the table below the existing NTD and/or WASH SBC campaigns or initiatives that are being conducted at the national, district or subdistrict level. Include any of the following:

- School-based programming (e.g. school-led total sanitation [SLTS], children's hygiene and sanitation training [CHAST], school health clubs, early childhood education).
- Community-based programming (e.g. community-led total sanitation [CLTS], participatory hygiene and sanitation transformation [PHAST], house-to-house/health extension or outreach, community health clubs/village health teams etc.).
- Mass media campaigns (TV, radio, mobile phones).
- Social marketing approaches (e.g. sanitation marketing, health commodities marketing).
- Health programmes (e.g. immunization campaigns, integrated management of childhood illness, veterinary health outreach).

Table 3. Social and behaviour change tools, interventions and approaches

Intervention category	Intervention description (examples)	Where (national, region or district – include name if at region or district level)	Partner (NGO or government department)
Select from the bullets above			

Tools and materials

List and describe any tools that currently exist in country for NTDs and WASH behaviour change:

- What materials are available at district/school level for hygiene/sanitation promotion? (include examples).
- Who in the health ministry is responsible for development and distribution of communication materials on NTDs and/or WASH?

- What is the process within the government for approving health and WASH communication strategies and materials?

g. Context for advocacy

Both NTD and WASH stakeholders undertake advocacy to maintain these issues and the sectors that drive them on the national development agenda, and mobilize resources for programme implementation. In order to effectively plan advocacy strategies, it is important to look closely at both the environment in which advocacy activities will happen and the specific issues and barriers that need to be addressed at all levels. The questions listed in this section enable gathering background information for the later development of advocacy strategies.

Policy and finance environment

- Does the NTD strategy or master plan include targets and indicators on WASH?
- Do the main WASH sector strategic plans refer to NTDs? If so, how?
- If the above aspects are reflected at the national level, are they carried out at the subnational (district) level? How?
- Have there been any political commitments/statements to NTDs, WASH or both in the past 18 months (or under the current government)?
- Have any political commitments been made with regards to the implementation of the NTD road map 2021–2030? Do those include WASH?
- Has a joint budget line been established for WASH and NTDs?

Note key documents in an annex to the situation analysis report. In a facilitated workshop setting, divide the group into sectors (e.g. health-NTDs, WASH, education, other) and use the advocacy section questions as a guide to group work.

Influencers

- Are there prominent political or popular figures who have championed WASH and/or NTDs in the past, who are currently engaged or could potentially be engaged further?

Advocacy in action

- How is advocacy currently carried out by WASH and NTDs stakeholders?
- Is there any joint advocacy, for example presenting a shared need for investment to government decision-makers or donors?
- Have there been any notable successes?
- What are the main challenges?
- What other initiatives compete for funding and political influence (e.g. president is a big support of the malaria programme)?
- Is there potential for the NTD and WASH agenda to be linked to these initiatives?

Advocacy priorities

- Based on results from the questions above, what should be the top three priorities for WASH/NTDs advocacy work?

3. Analysis

The information gathered must be usefully and critically analysed to inform the planning and coordination process. It is important to discuss findings in a group to ensure that information and data gathered from all sources including interviews are verified, contextualized and objectively presented. The analysis should include:

Key issues underpinning disease prevalence and programming in the country – BEST Framework

For this section refer to **Tool 1: Interventions for NTD control, elimination, eradication and care**  and **Tool 2: NTD-related behaviours** . These two resources provide a comprehensive list of interventions for NTDs as well as WASH-related behaviours associated with each NTD. In this section it is important to review carefully the highlighted NTDs in the country context as well as what activities or interventions have been undertaken based on the gathered data. This section should synthesize the **key issues** that are relevant for the country context. This section should **not** simply repeat the information provided in the toolkit but rather highlight the **priority issues** in the country based on ongoing interventions or lack thereof to address specific behaviours that take place within this specific country context. This will provide a starting place to coordinate planning meetings and policy recommendations. See Table 4 for a way to format the key priority issues.

Table 4. **Key challenges for NTDs (BEST)**

Theme	NTDs Note some NTDs may share key problems or challenges. List all endemic NTDs in this table.	Key problem/challenge to address Refer to Tool 1 and Tool 2 to fill in this column. Information provided in this column should be specific to the country context. The more specific here the better in terms of planning and identifying gaps and opportunities.
Behaviour	<i>Soil-transmitted helminths, trachoma</i>	<i>(e.g. poor hygiene practices – lack of handwashing with soap, lack of face washing, lack of shoe wearing)</i>
	<i>Schistosomiasis</i>	<i>(e.g. bathing, swimming and laundry in surface water)</i>
	<i>Lymphatic filariasis</i>	
Environment	<i>Trachoma, schistosomiasis, soil-transmitted helminths, trachoma</i>	<i>(e.g. lack of access to and use of toilets; poor maintenance of sanitation facilities)</i>
	<i>Dengue, lymphatic filariasis</i>	<i>vector breeding near/in poorly managed water sources or uncovered storage containers</i>
Social inclusion		<i>(e.g. stigma-related exclusion from water sources – e.g. for people affected by certain NTDs)</i>
Treatment and care		<i>(e.g. lack of reliable water supply in health care facilities providing surgical interventions; lack of water for self-care)</i>

Critical actors: primary and key stakeholders/actors to implement joint WASH and NTD interventions

- **Primary:** Who needs to be involved in a joint planning process? They will need to have a specific reason to be engaged because they will need to deliver the programme or are a key gatekeeper to delivery (e.g. by having a regulatory or financial role). These institutions/individuals will be involved in the next stage of the process, and therefore the list must be focused and justified.
- **Key:** Who needs to be consulted about the process and contacted for data and input, but not necessarily be involved in the detailed planning process?
- **Secondary:** Who needs to be informed about the planning process, and endorse it?

For this section refer to Table 2 along with the data included in this tool's annex relating to key stakeholders and partners currently implementing interventions or with specific expertise.

Key points to consider:

- Based on the available mapping exercises, where are the priority intervention areas? (use data from this tool's annex to provide this analysis).
- If relevant, include in this analysis a breakdown of stakeholders with specific intervention expertise (e.g. rural/urban water supply, rural/urban sanitation, SBC, NTD specific).

Coordination: overlaps, synergies and gaps

For this section refer to the graphics and data collected in the previous section (2. Protocol data tools: e. NTD and WASH coordination information) and provide a synthesis of the identified overlaps/synergies, barriers and gaps that need to be addressed through the planning process in terms of:

- Financial and human resources.
- Availability of approaches/tools, refer to previous section (2. Protocol data tools: f. Behaviour change initiatives, interventions, tools and approaches).
- Governance and coordination structures, refer to previous section (2. Protocol data tools: e. NTD and WASH coordination information).
- Challenges specific to particular endemic areas (e.g. geography, culture, population density and movement, political instability etc.). (Use data from this tool's annex as well as general demographic information).

Key points to consider:

- **Identified gaps:** Are there aspects on which information/formative research is still required?
- **Opportunities (synergies/overlaps):** Provide clear set of the existing entry points and gaps, and their implications for programme design to inform the recommendations.

4. Recommendations

Provide clear recommendations including next steps, actions, timelines and responsible individuals. Recommendations should be as specific as possible to be actionable. For example, vague recommendations such as increase financial resources or undertake capacity building should be accompanied by specific information on the level, type and purpose of resources needed, and the specific skills and cadres needed. Recommendations should be grouped under useful headings to enable effective planning. Policy change recommendations should be detailed as per Table 5.

Table 5. Policy change recommendations

Recommended policy change (including the level of change: national, subnational)	Who needs to be engaged on this (name, role and institution)?	What can they change on this issue (budget/ planning/ political will)?	What are their priorities?	What level of influence do they have over this change (rate from 1 “little to no influence” to 5 “high degree of influence”)

5. Report

All findings should be compiled in one report, including an executive summary outlining key findings, conclusions and recommendations, to enable use of the information for planning purposes. You may find the situation analysis executive summary template in section 6 below and **Supplementary tool: WASH-NTD situation analysis findings presentation template**  useful, as both can be used effectively in the next phase of the joint planning process.

6. Situation analysis executive summary template

Purpose

- Outline the purpose/objectives for the situation analysis (e.g. to support the development of an integrated/coordinated disease control programme).

Methods

- Describe the methods used for the analysis, such as document reviews, consultation workshops, interviews and field visits.
- Outline the constituencies of stakeholders involved in the analysis (government, NGO, specific sectors etc.).
- Outline the key areas and topics of investigation.
- Set out how the findings will be used.

Key findings

- Data: demographic, disease and WASH information
- Current challenges for WASH-NTDs integration and collaboration: Who are the primary and key implementation actors? What are the key coordination overlaps, synergies and gaps? Based on the available mapping exercises, where are the priority intervention areas?
- Behaviour change tools and approaches, media channels, advocacy.
- Are there aspects on which information/formative research is still required?
- Key issues underpinning disease prevalence and programming in the country (see Table 6).

Table 6. **Key issues to address**

Theme	Key problem/challenge to address
Behaviour	<i>(e.g. poor hygiene practices – lack of handwashing with soap, lack of face washing, lack of shoe wearing)</i>
	<i>(e.g. bathing, swimming and laundry in surface water)</i>
Environment	<i>(e.g. lack of access to and use of toilets; vector breeding near/in poorly managed water sources; poor maintenance of sanitation facilities)</i>
Social inclusion	<i>(e.g. stigma-related exclusion from water sources (e.g. for people affected by certain NTDs))</i>
Treatment and care	<i>(e.g. lack of reliable water supply in health care facilities providing surgical interventions; lack of water for self-care)</i>

Key opportunities

- Technical/programmatic (e.g. features of existing or planned programmes that enable integration/coordination; opportunities for new approaches and innovation).
- Financial (opportunities to increase domestic or external funding, improve financial management, any health or WASH system strengthening initiatives for improving absorptive capacity and spending).
- Coordination (forthcoming policy or strategy reviews, new coordination initiatives, existing coordination structures that can be further strengthened or utilized).

Recommendations

- 1.
- 2.
- 3.
- 4.
- 5.

TOOL 7

Planning tool: step-by-step process to developing comprehensive and adaptive NTD programmes

The purpose of this tool is to help you move from building initial willingness among the partners you have engaged so far to do something, to deciding what you will *actually* do together. It will help you:

- Use the information and evidence you have assembled so far to **define the problem** you are trying to solve and develop a clear set of *realistic* and *effective* actions and possible solutions; and
- Systematically review, **revise, develop and adapt** current interventions, approaches and materials to reach your shared vision.

Note: Use **Tool 7 Annex**  (Excel-based **table templates**) during the planning process.

An important **ground rule:** Anyone involved in this process (including you!) must be prepared to move away from their own priorities and focus on a shared agenda. This is crucial for bringing together a diverse set of actors. This might mean excluding from the process anything that is not relevant to the joint agenda, for example, surgical activities, regular MDAs (unless you are looking at integrating WASH aspects), etc.

Phase 1: Before a planning workshop is organized

1. Gather

The purpose of this step is to use the information gathered so far to set out a clear idea of the problems the programme needs to address, and which institutions and individuals to involve to develop a successful plan of action.

What do you need in order to start a planning process?

- Conduct a situation analysis, as set out in STEP 3. The products of this process – report, executive summary, presentation – will serve as the starting point for the planning process.
- Look at the recommendations of the situation analysis to decide what the planning tool can be used for; having collected all the information, you need to focus on what needs to be achieved. Are you:
 - Developing or building on a coordination structure?
 - Producing a joint annual plan for service delivery?
 - › Identifying the aspects/activities that need to be integrated into an existing programme?
 - Working on a behaviour change programme?

Knowing what the result of the process should be will affect how you conduct the planning process.

Assemble a small team of people to lead the process: You may have already formed this group before commissioning the situation analysis, and at this point, you may want to consider whether the composition of the group should be revised. Be sure to include people who have in-depth knowledge of NTDs and WASH programmes operating at the national and community levels as well as health promotion and behaviour change experts – this will make it more likely that the action plan will be properly owned and implemented. This includes relevant government and nongovernmental partners.

Set up the planning workshop and assign a facilitator: Good facilitation is crucial for a successful planning workshop. The facilitator can be someone from the existing group of stakeholders, or an external facilitator. Ensuring the facilitator is well briefed and understands the content may require separate meetings in advance. Some key considerations are:

- It may be advisable to appoint a facilitator who is known and respected, but is not closely associated with either WASH or NTDs, to avoid the impression that the programme priorities will be skewed towards the priorities of one sector over the other.
- The facilitator must have in-depth knowledge of the situational analysis and context, and familiarity with public health and with the country's development sector, in order to keep the meeting on track and to help participants stay focused on the task.
- The facilitator should be highly experienced in leading planning processes.

Convene the small team together with a limited number of additional individuals you consider crucial for developing the planning process in advance of the planning workshop, to agree the process for the meeting. The planning meeting facilitator should be part of this discussion.

Review the situation analysis findings:

- Review STEP 3 and pull out key information for presentation at the planning meeting. Focus on the key points that are most relevant:
 - What are the key coordination overlaps, synergies and gaps?
 - Who are the primary and key implementation actors?
 - Based on the available mapping exercises, where are the priority intervention areas? Use STEP 3: Data for decision-making as needed.
 - Key issues underpinning disease prevalence and programming in the country.
 - What are the key opportunities identified in the situation analysis?
- Identify as many existing and relevant interventions, tools and entry points described in the situation analysis, and pre-populate **Table 2** (see Phase 2. Synthesize).

Facilitation note: *This is a crucial step to ensure that the information from the situation analysis is used to inform the planning discussion, and that all activities decided later are based on sufficient information, and less likely to be diverted to other priorities or opinions.*

Agree the agenda: Review **Tool 8: Agenda for joint planning workshop**  and insert/modify relevant content for discussion based on the situation analysis findings. Adapt the agenda according to the purpose of the meeting. If the meeting is focused on intervention planning, review the tables in this tool's annex and make sure you allocate sufficient time for each part of the discussion, considering breakout groups, presentations and the process for completing the tables.

Agree meeting participants: Identify a full list of potential participants for the planning process. Focus on specific individuals who are **sufficiently** well informed, and have the necessary **authority**, to be able to contribute to the discussion and take actions forward. This means leaving plenty of lead time to ensure participants are available. Ensure all the relevant constituencies are represented and that no crucial participants are left out. Keep in mind that the complexity of the landscape for an integrated programme increases with the number of topics and sectors involved (e.g. health, agriculture and education) and the extent of decentralization in those sectors (e.g. operating at national, regional, district and/or village levels).

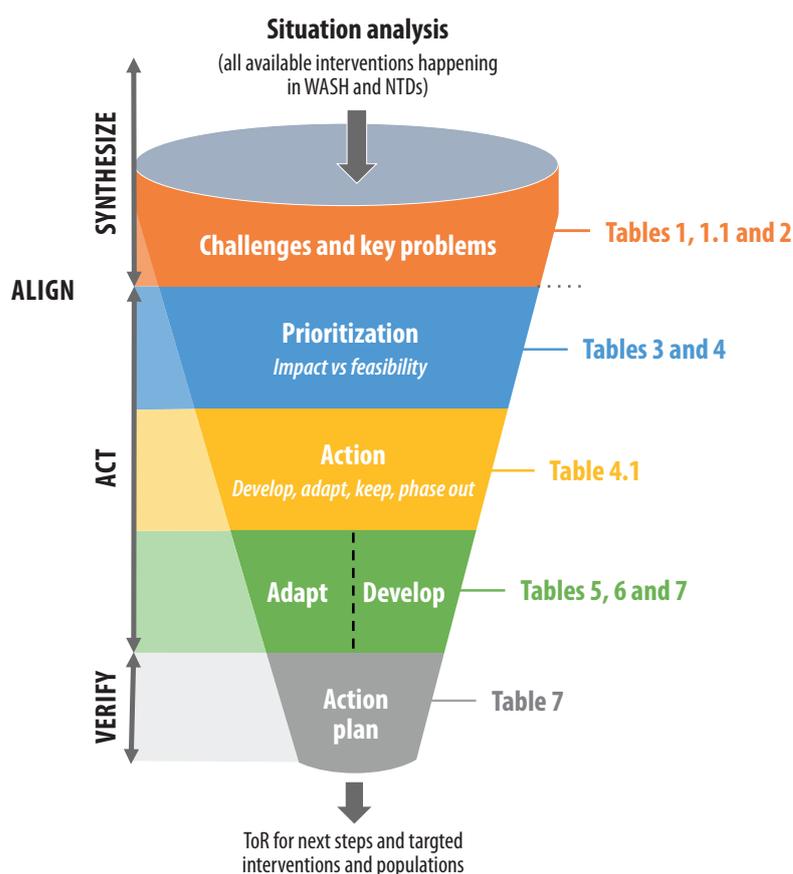
Facilitation note: *It may be useful to contact as many stakeholders as possible ahead of the meeting and ask key questions to understand the stakeholders involved and to set the level of information to be shared:*

- *goals and objectives of institution/organization;*
- *key intervention/activity areas;*
- *level of understanding of NTDs; and*
- *stakeholders' key performance indicators.*

Phase 2: In the planning workshop

Fig. 1 shows the full planning process, from the end of the situation analysis phase through to the joint action plan. The funnel shape suggests a gradual consolidation and prioritization of joint actions. The relevant tables are also signposted.

Fig. 1. Full planning process



2. Synthesize

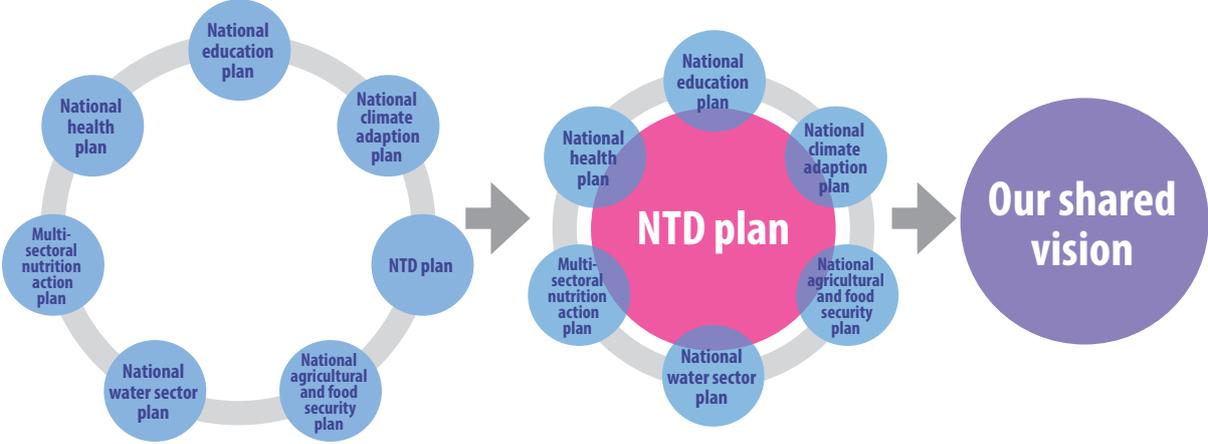
This phase focuses on creating a shared understanding of the key problems/issues the joint programme will be designed to address, and how existing programmes and interventions relate (or not) to the problems.

Present findings from the situation analysis: You may wish to use **Supplementary tool: WASH-NTD situation analysis findings presentation template** . Ensure sufficient time is allocated to providing the key conclusions and recommendations, and the problems identified in the analysis. These will form the basis for intervention selection and action planning.

Agree shared programme vision: Start with agreeing the vision set out in STEP 1. This initial programme vision needs to be validated by the group, followed by a discussion on how other programmes relate to this vision (as shown in Fig. 2). This helps to clearly show how the NTD programme vision contributes to other visions, and vice versa. The shared vision (on the right of Fig. 2) defines what all stakeholders aim to achieve together.

Facilitation note: Ensure the key definitions are shared and understood. For example, integration, access etc., even if they have been mentioned earlier in the workshop. This may take some time and you will need to come to a consensus before moving forward.

Fig. 2. Shared vision



Example of a shared vision:

Achieving sustained control, elimination and eradication of WASH-related NTDs to contribute towards the SDGs (3 & 6) through an effective multisectoral programme.

Agree a shared programme mission: In order to achieve the goals outlined in the agreed shared vision it is helpful to also determine a programme’s shared mission or missions. A shared mission is the mechanism by which a programme will operationalize the common vision through behaviour change while targeting existing resources platforms, and synergies on three levels:

- Institutional support for coordination, capacity, M&E.
- Communities and schools: encourage maintenance and utilization of WASH services.
- Individuals: encourage healthy hygiene behaviours.

A shared mission seeks to **achieve** sustained elimination of trachoma and other WASH-related NTDs **through** interventions targeting hygiene and sanitation practices and coordination of WASH services.

It is important to be specific in the shared mission. If there is dedicated funding for a specific NTD or geographic region this would be outlined in the shared mission.

Identify specific programme priorities: Based on the situation analysis, the key problems should be summarized in **Table 1. Key issues underpinning disease prevalence and programming in the country (Tool 7 Annex)** 📄. When identifying these problems, you should consider which NTDs are prevalent, who is affected and why; these become the intervention themes in the action plan. The themes in the table are defined according to the BEST Framework (see Context: collaboration on WASH and NTDs).

Facilitation note: Depending on the participants' knowledge and prior engagement on NTDs, you may wish to provide a quick overview of the BEST Framework, to ensure a common understanding of what each theme represents. When defining the problems, take time to go through this and validate each problem, making any wording adjustments or crucial changes before moving on. This is essential to ensure everyone is on the same page.

Now that you have set out the key issues, you can identify which of the key problems relate to the joint programme vision and mission you developed, to ensure you are staying focused on the scope of the programme. You can use **Table 1.1 Key issues underpinning disease prevalence and programming in the country** (stoplight scoping activity) (**Tool 7 Annex**)  to do this.

Identify existing interventions: From the situation analysis, identify a master list of relevant existing interventions, tools and entry points (inventory). Using **Table 2. Intervention inventory (Tool 7 Annex)** , list relevant interventions that are happening, or that will be happening in the near future. The small team should populate as much of the table as possible prior to the workshop on an Excel sheet that can be updated during the workshop, to modify and add interventions. Only include interventions that are directly related to the purpose of the meeting.

Facilitation note: Refer back to the BEST Framework to ensure that you are covering all relevant intervention areas (behaviour, environment, social inclusion and treatment and care). This is important as some types of interventions tend to be forgotten within disease control discussions. List all interventions, even if you are not sure they are relevant or not; the following steps in this tool will help you reduce and focus the list. If interventions that are being implemented are not related to the purpose of the meeting, acknowledge them but exclude them from the table. This is important to ensure the meeting stays focused.

3. Align (with the defined priorities)

The purpose of this step is to identify what can be done practically, by whom and when, making sure all actions are realistic and achievable, and to identify which aspects are not currently being addressed through existing interventions. The purpose of this exercise is not to criticize existing activities but to make strategic choices on what will work best to achieve the shared vision and mission. Participants may feel defensive if they feel their work is being criticized. They should be encouraged to reflect on lessons from implementation and be willing to adapt interventions to benefit the goal – as it may just be the case that the interventions are either not relevant to the NTD programme, or that they should be adapted in a way that improves their impact for the joint programme.

Facilitation note: Having a common understanding is important here. There will likely be interventions that can fit into multiple themes. Ensuring at least a common definition and criteria for aligning the interventions with specific themes will help move the process forward.

Setting the programme boundaries: Before you carry on, review the BEST Framework, **Tool 1: Interventions for NTD control, elimination, eradication and care** , the programme vision and the intervention inventory (**Table 2**), to agree the boundaries of the programme (i.e. are there any aspects that are explicitly outside of the boundaries of this planning process?). There should be a good reason – i.e. these aspects are being actively and sufficiently covered by another programme. However, they should still be linked with and coordinated with these programmes (e.g. we *don't* do water body spraying for integrated vector control and management, but we *do* make sure that WASH activities do not undermine vector control activities). The purpose of this process is to ensure that only identified priority interventions that are most relevant to your context's disease profile and existing interventions, are carried forward into your action plan.

Aligning the interventions with the defined problems: This is the basis for the action plan, ensuring it is strategic, i.e. that it responds to the problems defined by the situation analysis. This should also help highlight gaps in delivery. You could add a column to count the number of interventions currently being delivered under each area.

Facilitation note: A good process to do this is to essentially put Tables 1 and 2 together using **Table 3. Current interventions and how they respond to the problems (Tool 7 Annex)** , through the following steps:

- Put each intervention from the inventory on a sticky note.
- Assign areas for B, E, S and T on different wall sections.
- List agreed problems (**Table 1**) under each theme.
- Take each intervention and discuss where to place it (under which letter and under which problem) (use the BEST Framework to help you categorize).
- Any interventions that do not fit under BEST and do not respond to the stated problems, should be set aside as they are not relevant for the current programme. Make sure to keep the full list of interventions as a valuable source of information on key interventions happening that may be linked with later on.

Fig. 3. **Funnel – prioritization**

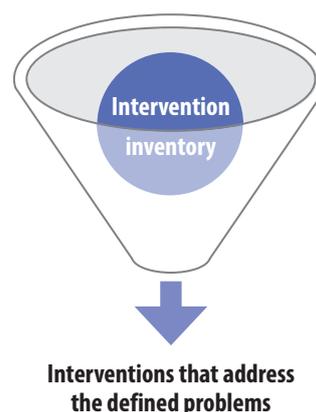
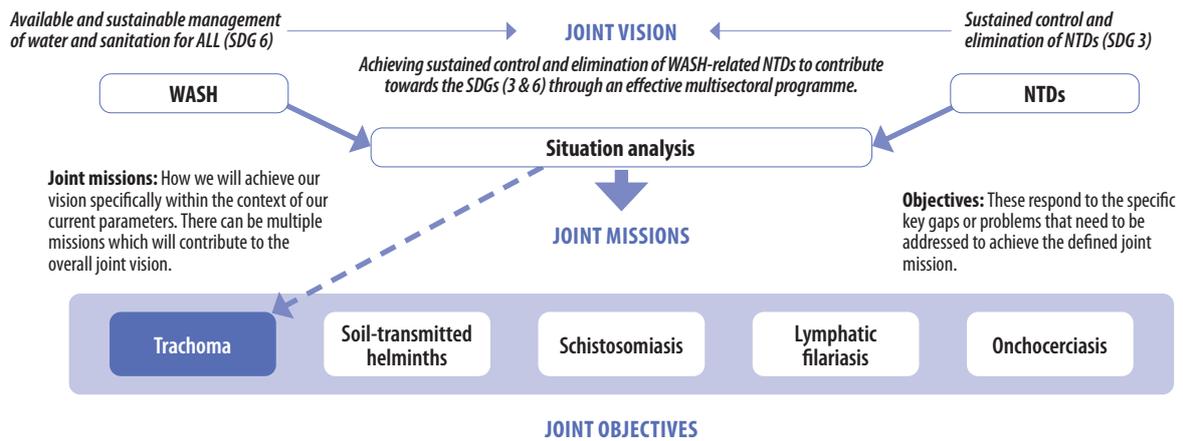


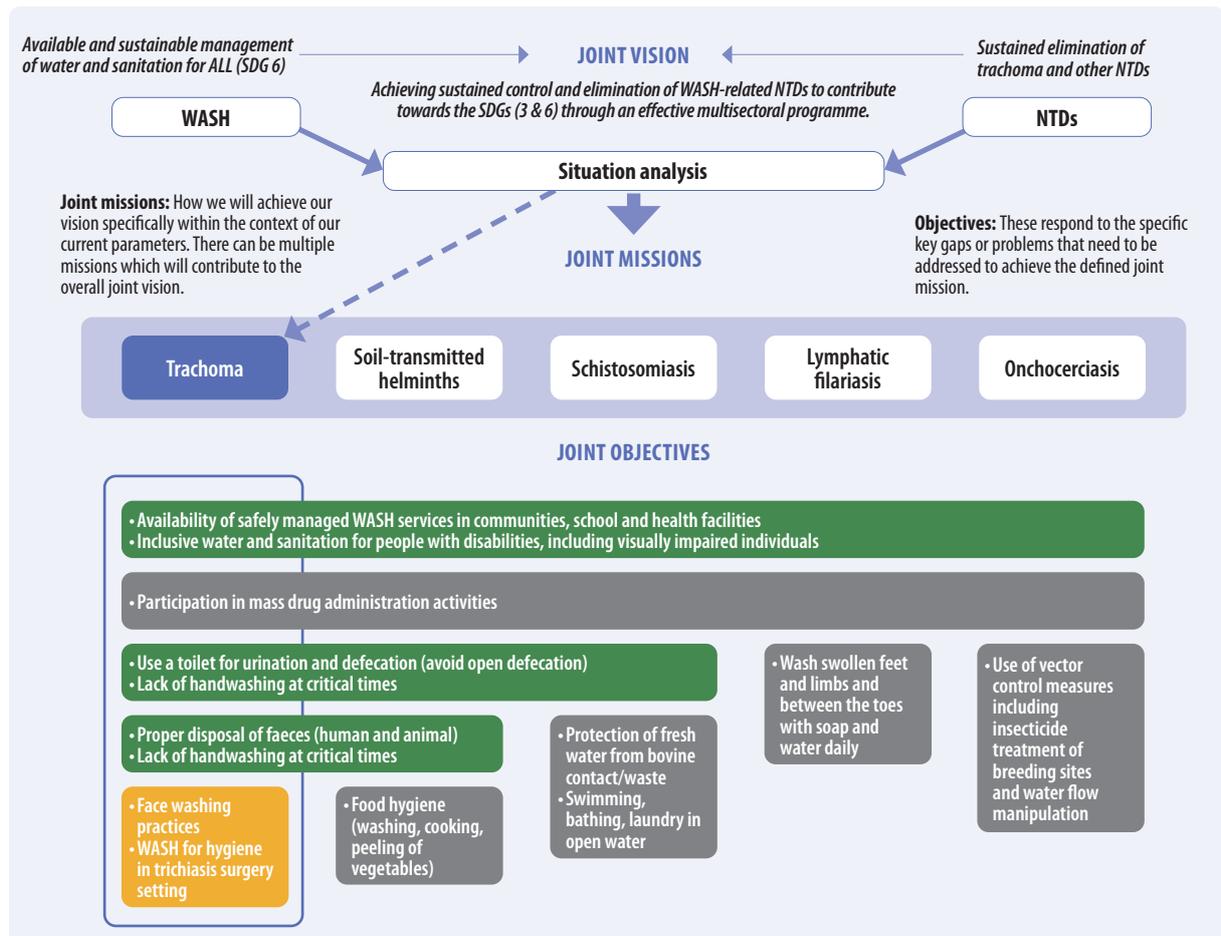
Fig. 4 sets out how using the joint vision and mission can help consolidate the problems and activities that will be addressed by the programme, and that will be taken forward in the next stage (4. Act). This example shows the problems marked in green (non-negotiable problems that must be addressed related to trachoma and other NTDs/programme vision) and yellow (key problems with regard to the scope/programme mission) are those being taken forward in the next stage as part of the joint programme mission. Those marked in grey (key problems outside of scope), although they continue to be addressed by other programmes, are outside of the scope of the joint WASH and NTDs programme.

Fig. 4. Consolidating problems and activities to be addressed by the programme



Sorting BEST – within the scope of a joint programme

- ① Non-negotiable (problems that MUST be addressed related to trachoma and other NTDs/programme vision)
- ② Key problems (with regard to the scope/programme mission)
- ③ Key problems (outside of scope/programme mission)



TOOL
7

4. Act

In this step, you will jointly prioritize interventions, and take the necessary actions based on the results of the previous step.

Facilitation note: Ensure once more that the key definitions are shared and understood. For example, integration, access etc., even if this has been mentioned earlier in the workshop.

Deciding what action is needed on each intervention: Table 4. Actions (Tool 7 Annex)  lists all relevant interventions, with an additional righthand column to denote the action needed on each:

- **Develop:** Based on the table, you should be able to clearly see any problems that are not being addressed currently – intervention gaps. New interventions will need to be developed to address these gaps (see Phase 3: After the workshop).
- **Keep:** This action should be assigned to existing interventions that are structured adequately to address the stated problem.
- **Adapt:** This action denotes interventions that require change in order to adequately address the problem – for example, changes to the content or delivery method of the intervention (see Phase 3: After the workshop).
- **Phase out:** These interventions may be relevant in terms of the problem they have been designed to address, but are perhaps ineffective at resolving the problem. These interventions should be phased out, i.e. not stopped immediately, but also not renewed (e.g. not printing another batch of posters or leaflets that are not effective).
- **Implemented through other programmes:** These interventions, although relevant, fall outside the programme boundaries (see 3. Align). List out which programmes are delivering these interventions and note whether any explicit link or coordination actions should be included in the final action plan to ensure that the interventions are implemented effectively.

Rationalize the list of interventions: From **Table 4**, you should now have a shorter list of interventions – only those marked as Develop, Keep and Adapt. Even so, you may still have a long list of activities, and it may not be feasible to implement all of them. If this is the case, you may want to use the following exercise to reflect on each intervention and ensure it should be included in the action plan. You may want to do this exercise in small groups (one for each BEST theme).

- For each intervention, discuss where it falls within the feasibility matrix. You can do this physically using the sticky notes you prepared in 2. Synthesize. Try to be as objective and realistic as possible.

Fig. 5. **Feasibility matrix**

HI/HF High impact, High feasibility	HI/LF High impact, Low feasibility	<p>Impact: Does the intervention work to resolve the stated problem?</p> <p>Feasibility: Is it possible to implement the intervention? In terms of: funding, timeframe, governance, leadership (including personalities), human resources/skills, existing programme entry points, precedent for engagement, tools (data collection and monitoring), security, etc.</p>
LI/HF Low impact, High feasibility	LI/LF Low impact, Low feasibility	

- Based on this discussion, fill out **Table 4.1. Actions based on feasibility (Tool 7 Annex)** . Interventions that fall into the HI/HF quadrant should be prioritized. Interventions that fall into the LI/LF quadrant should be excluded. You will need to agree as a group how to view the interventions that fall into the other two quadrants: the HI/LF interventions may be prohibitively difficult; and going for the low-hanging fruit of low impact high/feasibility could help generate momentum for the programme even if they don't have a significant impact, because they will be relatively easy to implement. There are no right or wrong answers, as long as there is agreement.

Facilitation note: *This process helps avoid any tensions around excluding certain interventions that participants are attached to, by being participatory and transparent. You can also use this process to revisit any previously excluded Phase out activities, if there is any remaining disagreement.*

5. Verify

This crucial step involves agreeing the key interventions that will be taken forward, in the form of a 1-year plan.

Populate the plan: Using **Table 5. Action plan (Tool 7 Annex)** , list out the interventions identified as they relate to each of the themes, the delivery channel/mechanism (who will deliver and through which entry point), next steps (what needs to be done immediately, and any intermediate steps including involving other individuals/institutions or developing terms of reference for new activities), who is responsible for the delivery, and what the anticipated achievement will be within the 1 year (for example, at 3-month intervals) and by the end of the year (medium-term milestones).

Facilitation note: *Make sure the meeting ends having agreed a clear and realistic activity plan and next steps – with clear accountability of who will be progress chasing, sending notes, setting up the next meeting. It may be useful to set out some immediate milestones (presenting the plan at a meeting taking place soon (such as a sector working group meeting), getting the activities into the next sector plan, etc.) to create some urgency for finalizing the plan.*

Identify specific points at which you will reconvene (and who will reconvene) and review (see 7. Revisit and realign). This also serves as another reality check as to what may or may not be feasible, if anything has been missed, and if anyone else needs to be involved.

Ensure that roles and responsibilities are assigned for any development or adaptation of interventions after the planning workshop (see 6. Develop or adapt interventions).

Phase 3: After the workshop

6. Develop or adapt interventions

This stage can be started during the workshop if time allows, using **Table 6. Intervention development (Tool 7 Annex)** . However, the purpose of this exercise is not to develop a full intervention within the workshop but to define its parameters for development and design later on. The action plan should task a smaller group or task team to actually design the intervention, which can be brought back to the entire group or coordinating group for approval. Once this process is complete, all the new interventions should be reviewed by the group in plenary to verify that all these interventions should be developed as new.

Facilitation note: Ask the group if any existing interventions could be adapted to achieve the same outcome? If so, remove these interventions from the table and discuss (see 4. Act: Adapt). This is important to do because developing new interventions can add time and cost to the programme, and should only be done if a new intervention is justified. Adaptation of existing activities also has the added benefit of strengthening existing programmes.

Developing new interventions: Work through the following:

- State the desired outcome (the opposite of the problem).
- Describe the intervention.
- Define the target.
- Define the delivery channel/mechanism.

Facilitation note: For information on designing behavioural interventions, refer to Context: collaboration on WASH and NTDs (WASH in behaviour change) and **Tool 3: Understanding behaviour to develop behaviour change interventions** .

Adapting interventions: Fill out **Table 7. Intervention adaptation (Tool 7 Annex)** , to identify what adaptation may be needed. Adaptation means investing some resources and making changes to existing interventions. This can be operational (how an intervention is delivered or managed), design and/or content (such as behaviour change promotion materials). Adaptation is justified if it will improve the effectiveness of the existing intervention in addressing the stated problem. **Go back to the situation analysis report, for detailed information on the nature, delivery and quality of current interventions.** Avoid a full adaptation of the intervention at this point, focusing on full revision later on. Check: Do you have the owners of the intervention in the room – those whom you expect to make adaptations to interventions they are currently implementing? If not, you may need to engage them at a later stage. This needs to be reflected in the action plan.

7. Revisit and realign

This step is an important aspect of adaptive planning, as set out in STEP 4, as it allows to review progress within a relatively short timeframe during implementation to identify challenges and make necessary adjustments to the plan.

Review progress: This can be done in the same small coordinating group set up to lead the planning process, involving other key stakeholders as needed. This process may be helped by speaking to individual stakeholders and having informal discussions before coming together for the review. Refer back to STEP 4: Tips for developing a successful plan. In this process, all planned activities should be reviewed along the following questions:

- Are the activities happening? If not, why not?
- Are the activities still relevant for addressing the problems and outcomes stated in the plan?
- Should any of the activities be stopped or changed? What are the alternatives?
- Has there been any change to the impact or feasibility of the activities? These may have changed due to external circumstances (e.g. political, institutional, epidemiological) since the plan was developed.
- Is there a new opportunity that could potentially support the plan that has come up since the plan was developed (e.g. new champions, funding)?
- Are there any threats that need to be mitigated (e.g. changes in management, funding etc.)?
- Are all necessary actions captured in the annual planning and budgeting cycle? See STEP 4: Financial arrangements for a successful programme.
- Are the individuals responsible for each activity still in place? Are they the appropriate and willing leads? If not, who should take on the role of leading the activity?

Report: The group should document and explain each decision, and report back to the larger stakeholder group (meeting participants and others).

TOOL 8

Agenda for joint planning workshop

This agenda template accompanies Tool 7 and assumes a 3-day workshop, based on the need to build a shared understanding of the planning process among stakeholders who may not be accustomed to working together, and on the need for sufficient time for discussion and detail. If the workshop is held to develop a plan for a specific grant, therefore requiring a higher level of detail as the final output, a 5-day workshop is advisable.

DAY 1 (DATE)			
Time	Activity	Presenter/facilitator	Facilitation notes
9:00–9:30	Welcome/Introduction and objectives Key terms for discussion		Review and agree key terms Integration, cooperation, coordination, impact, feasibility, behaviour change, hygiene promotion etc. (include any other terms relevant to your context). The following ice breaker may be helpful to support a shared understanding of key terms as well as serve as an energizer for the group. Match the jargon game (20 minutes): <ol style="list-style-type: none"> In advance, prepare two sets of terms: concepts that are referred to differently by each sector. For example (there may be other relevant terms): <ul style="list-style-type: none"> Health education (NTDs) vs Hygiene promotion (WASH); Latrines (NTDs) vs Sanitation (WASH); Infection prevention and control (IPC) in health care settings (NTDs/Health) vs WASH in health care settings (WASH). Divide the group into two. In each group, work to match the NTD/health terminology with the terminology used in the WASH sector. The winning team is the one that matches all terms correctly first.
SYNTHESIZE			
9:30–10:15	Findings from the situation analysis	All	See Supplementary tool: WASH-NTD situation analysis findings presentation template  Emphasize the following aspects: <ul style="list-style-type: none"> What are the key coordination overlaps, synergies and gaps? Who are the primary and key implementation actors? Based on the available mapping exercises, where are the priority intervention areas? Are there aspects on which information/formative research is still required? Key issues underpinning disease prevalence and programming in the country. What are the key opportunities identified in the situation analysis?

DAY 1 (DATE)

Time	Activity	Presenter/facilitator	Facilitation notes
10:15–10:45	<i>Break</i>		
10:45–11:15	Defining the shared programme vision		Based on validation of the programme vision previously defined (see STEP 1. Setting the programme vision). Ensure a shared understanding of the key terms being used. It may be helpful to have the definitions written on flipchart paper on the wall during this session.
11:15–13:00	Programme priorities The BEST Framework Key aspects (problems) the programme should address		Provide a quick overview of the BEST Framework to ensure a common understanding of what each theme represents. Ensure there is consensus and understanding on each theme. Complete Tool 7: Annex ^{1A} Tables 1 and 1.1 (either on four flipchart pages, one for each BEST component, or on a Word or Excel document on the screen). Ensure agreement on each problem before moving on.
13:00–14:00	<i>Lunch</i>		
14:00–15:30	Intervention inventory		Use the (pre-populated) Tool 7: Annex ^{1A} Table 2 and add any interventions not captured in the situation analysis. Refer to the BEST Framework and the links with WASH to ensure all programme aspects are covered, even if those implementing certain interventions are not represented in the meeting (see Context: collaboration on WASH and NTDs). With a large group of participants, it may be best to split into four groups, with each group covering a different aspect of BEST, before validating the list in plenary.
15:30–16:00	<i>Break</i>		
16:00–16:30	Intervention inventory (continued)		
ALIGN			
16:30–17:00	Programme boundaries		Extract any activities falling outside the programme boundaries. These should be noted separately as they will need to be considered at the action planning stage for purposes of linking and coordination.

DAY 2 (DATE)

Time	Activity	Presenter/facilitator	Facilitation notes
9:00–9:15	Recap Day 1		Present the intervention inventory.
ALIGN			
9:15–10:45	Aligning interventions to programme priorities		<p>Aligning the interventions with the problems (using Tool 7: Annex ^{TA} Tables 1 and 2 to populate Table 3):</p> <ol style="list-style-type: none"> 1. Put each intervention from the inventory on a sticky note. 2. Assign areas for B, E, S and T on different wall sections. 3. List agreed problems (Tool 7: Annex ^{TA} Table 1) under each theme. 4. Take each intervention and discuss where to place it (under which letter and under which problem). <p>Interventions that do not fit under BEST and do not respond to the stated problems, should be set aside as they are not relevant for the current programme. Make sure to keep the full list of interventions as a valuable source of information on key interventions that are happening and may be linked with later on.</p>
10:45–11:15	<i>Break</i>		
ACT			
11:15–13:00	Actioning interventions		Populate Tool 7: Annex ^{TA} Table 4 (using all interventions from Table 3 and denoting the action needed for each: Develop, Keep, Adapt, Phase out, Implemented through other programmes). Ensure each of these concepts are clear to the participants.
13:00–14:00	<i>Lunch</i>		
14:00–15:00	Actioning interventions (continued)		
15:00–15:30	<i>Break</i>		
15:30–17:00	Rationalizing interventions		<p>Taking forward interventions marked Develop, Keep and Adapt, use the feasibility matrix to prioritize interventions in Tool 7: Annex ^{TA} Table 4.1, ensuring the definitions of Impact and Feasibility are understood by participants. This process helps avoid any tensions around excluding certain interventions that participants are attached to, by being participatory and transparent. You can also use this process to revisit any previously excluded Phase out activities, if there is any remaining disagreement.</p> <p>If time permits, begin work on Tool 7: Annex ^{TA} Table 6. Intervention development and Tool 7: Annex ^{TA} Table 7. Intervention adaptation.</p>

DAY3 (DATE)

Time	Activity	Presenter/facilitator	Facilitation notes
9:00–9:45	Recap of Day 2		Review the process undertaken to agree the set of interventions that will be taken forward by the programme, linking those to the agreed problems and programme vision. This is essential to remind participants of the rationale for selection. Take this opportunity to clarify any remaining questions or tensions around intervention selection.
VERIFY			
9:45–10:45	Action plan development		<p>Populate Tool 7: Annex  Table 5. Action plan. You may want to speed up this process by pre-populating the <i>intervention</i> and the <i>delivery channel</i> columns after Day 2, leaving ample time to agree the practical aspects regarding next steps, leads and milestones. The <i>accountability</i> row can be discussed after the break or after lunch.</p> <p>Make sure you carry forward the actions needed to complete stage 6: Develop or adapt interventions. This may mean setting up a small group specifically tasked to work on this.</p> <p>Make sure the meeting ends having agreed a clear and realistic activity plan and next steps – with clear accountability of who will be progress chasing, sending notes, setting up the next meeting.</p>
10:45–11:15	Break		
11:15–13:00	Action plan development (continued)		
13:00–14:00	Lunch		
14:00–15:30	Action plan development (continued)		
15:30–16:00	Break		

TOOL 9

Routine supervision of WASH and NTD programmes: guide and form

Guide: routine supervision

Supervision plays an important role in programme management, offering opportunities to:

- Ensure that the programme is being delivered as planned.
- Provide an opportunity to identify and address challenges early in the implementation process while reinforcing good practices.
- Motivate and support implementers, by being present, providing advice, raising local needs with higher levels of decision-making, and identifying opportunities for performance management and rewards for good performance.
- Gather information on what works well, for learning and programme development.
- Encourage collaboration across teams (through joint supervision).
- Increase community trust in the programme by showing that health care and WASH authorities care about programme quality.

This tool has been developed for NTD programme managers wishing to supervise joint WASH and NTD programmes implemented at district level. It can be used while conducting supervision visits – by national- or regional-level staff, or at district level by district health, NTD, WASH and education officers. Supervision should not add to a heavy bureaucratic burden but should be used in the way that is most helpful to ensure the programme achieves its objectives.

Before you start

- **Budget:** Ensure funds are available to conduct routine supervision, ideally on a monthly basis. This should include travel costs as well as individual costs such as per diems and accommodation. Consider adding joint WASH-NTDs supervision to existing routine visits and supervision plans, as appropriate to the national context, such as routine WASH visits or reviews, meetings with district- and community-based committees, and routine health sector supervision activities.
- **Contextualize:** Your programme may already have a standard supervision structure and format, as part of existing government or grant requirements. Use this tool to reflect on existing processes and consider any needed adjustments to facilitate joint supervision and include all relevant WASH-NTDs aspects. You can adjust the tool by adding or removing components and questions based on your programme elements and needs.
- **Clarify:** Ensure that all processes for supervision are clear, including the supervision schedule, roles and responsibilities, process for submission (computerized or paper-based, and timeframe for submission once the visit has been conducted), process and responsibility for analysing the data from the supervision forms, where records are kept and by whom, and how data will be managed in a secure and confidential way.
- **Prepare:** Once supervision is in place, it is important to ensure that any issues raised in previous visits have been addressed or followed up. Before visiting or returning to a site, prepare by reviewing previous supervision reports or other relevant sources of information.

Use

You may wish to aggregate the information into a simplified Excel database, with a tab for each location visited. The full information gathered using the supervision form can be used to supplement monthly or quarterly meetings at central/regional level, as well as to supplement programme reports

Form: routine supervision of WASH and NTD programmes

Note: A Word version of the form is available online to download and edit .

This form provides an example of the method for and nature of supervision for integrated or coordinated WASH and NTDs programmes. The specific topics and outputs covered by the form should be adapted in line with the specific programme context and content. If used as part of a paper-based system, edit form to ensure sufficient space for handwriting.

Visit

Date of supervision [dd/mm yy]

Visit location

Conducted by: Role NTDs Name

Role WASH Name

Role [other] Name

Date of submission [dd/mm yy]

Submitted to: Role Name

1. Routine activity supervision

Method: Questions to programme implementers (e.g. frontline health and WASH staff, school teachers/administrators, NGO implementing partners).

Note to supervisor: Ensure that any challenges are carried over to section 5.

Community health/hygiene promotion

Questions

1. Do health/hygiene promotion sessions take place?

Responses

Supervisory notes/follow-up

2. If yes, in what frequency?

Responses

Supervisory notes/follow-up

3. Are NTD-related promotion sessions/activities delivered as a stand-alone intervention, or as part of:

- a. Health extension/outreach programme.
- b. Primary health care activities (e.g. immunization, nutrition, maternal newborn and child health, etc.).
- c. WASH programmes.
- d. Agricultural extension/farming associations.

Responses

Supervisory notes/follow-up

4. What topics are covered in the sessions? Do these include WASH behaviours related to the prevention and/or care of NTDs? Do they include vector control and safe animal husbandry practices?

Responses

Supervisory notes/follow-up

5. Who delivers the sessions? Have promoters received training with regard to WASH/NTDs promotion?

Responses

Supervisory notes/follow-up

6. What materials are used in the sessions (e.g. flipcharts)? Are they available and useable? *[check supply in section 2]*

Responses

Supervisory notes/follow-up

7. Do you keep a log of sessions and participants? *[check log is up to date]*

Responses

Supervisory notes/follow-up

8. How many community members participate on average? Are the numbers consistent over time or has there been any drop-off?

Responses

Supervisory notes/follow-up

9. Do you attend the sessions (always, sometimes)? In your view, are they effective?

Responses

Supervisory notes/follow-up

10. Can the sessions be improved? How?

Responses

Supervisory notes/follow-up

School health/hygiene education

Questions

1. If relevant activities included in the school curriculum as standard, are health education activities conducted as stipulated by the national curriculum?

Responses

Supervisory notes/follow-up

2. If relevant activities are not included in the school curriculum as standard, do health/hygiene education activities take place in schools? What topics related to WASH and NTDs do they cover?

Responses

Supervisory notes/follow-up

3. Do activities take place in all schools or only some? Please specify.

Responses

Supervisory notes/follow-up

4. Have teachers/teaching assistants been trained to deliver the relevant educational activities? Do they receive refresher training? How regularly? Do schools receive regular support for health/hygiene education delivery?

Responses

Supervisory notes/follow-up

5. Do schools keep logbooks of health/hygiene education activities? Are they up to date? Who checks the logbooks?

Responses

Supervisory notes/follow-up

6. What materials are used for the activities? Is the supply and quality sufficient? *[check materials supply in section 2]*

.....

.....

7. Do schools have school health clubs or a similar structure? What activities do they undertake? Are these functional in all or only some schools? Please specify.

Responses

Supervisory notes/follow-up

8. Are the parent-teacher associations involved in health/hygiene education activities? Please specify.

Responses

Supervisory notes/follow-up

9. In your view, can school-based health/hygiene education activities be improved? In what way?

Responses

Supervisory notes/follow-up

Health care facility activities

Questions

1. Do health/hygiene promotion activities related to NTD prevention and care take place in health care facilities or as part of facility-based health care programmes (e.g. health talks to patients and carers, individual counselling)?

Responses

Supervisory notes/follow-up

2. Are health/hygiene promotion activities integrated into morbidity management and disability inclusion activities (such as in patient counselling on self-care for lymphatic filariasis, leprosy or other diseases, and in activities for stigma prevention)?

Responses

Supervisory notes/follow-up

3. Are there under/unutilized facility-based opportunities for health/hygiene promotion related to NTD prevention and care?

Responses

Supervisory notes/follow-up

Infrastructure

Questions

1. If the programme includes provision of water and sanitation infrastructure, are infrastructure targets on track? Please specify:

- a. Community/household: number of water points/systems installed and estimated number of users; number of handwashing facilities; number of toilets (or slabs) (specify whether toilets were provided by the programme or constructed by households).
- b. Institutional:
 - Schools: number of water points/systems constructed; number of school toilet cubicles (for girls/boys/teachers) in relation to standards.
 - Health care facilities: number of facility water points/systems constructed in relation to standards; number of health care facility toilet cubicles constructed (for patients/staff) in relation to standards.
- c. Public: number and location of public water points (protected spring, protected well, hand pump, water kiosk) constructed; number and location of public toilets constructed and number of cubicles.

Responses

Supervisory notes/follow-up

2. If the programme does not include provision of water and sanitation infrastructure:

- a. Have any water and sanitation service provision activities taken place in NTD endemic areas?
- b. Have activities been directed to NTD-endemic areas as a result of the programme?
- c. Are there any current water and sanitation service gaps? Are there plans for addressing them? Please specify.

Responses

Supervisory notes/follow-up

Community engagement

Questions

1. Are meetings held with community leaders and members to engage communities in programme activities? How frequently? What has been the result of the meetings?

Responses

.....

Supervisory notes/follow-up

.....

2. What other social mobilization activities have been conducted? Have these been successful?

Responses

.....

Supervisory notes/follow-up

.....

3. Have any training activities been conducted for community leaders/groups? When? What has been the outcome? Are there plans for further training activities?

Responses

.....

Supervisory notes/follow-up

.....

4. Are there ongoing challenges relating to community participation? How may they be addressed?

Responses

.....

Supervisory notes/follow-up

.....

Coordination

Questions

1. Are there regular (monthly or at least quarterly) meetings between the district WASH, NTDs, education and health teams? Is there a formal mechanism in place for coordination? Who participates? How frequently do meetings take place?
 - a. What is discussed in the meetings?
 - b. What challenges have been raised and have they been resolved?
 - c. Do issues discussed include vector control and veterinary public health aspects?
 - d. Are meetings supporting effective coordination of activities?
 - e. Has coordination resulted in improved targeting of resources and/or timely implementation?

Responses

.....

Supervisory notes/follow-up

.....

2. Are other sector-specific coordination structures used for ensuring NTD aspects are addressed (e.g. district WASH, health or education committees)?

Responses

.....

Supervisory notes/follow-up

.....

3. Are there any ongoing coordination challenges? What potential measures can be taken to address these challenges?

Responses

Supervisory notes/follow-up

Mass drug administration

(Supervision of MDA programmes should be done in line with existing WHO and health ministry guidance. The questions included here illustrate aspects likely to be covered)

Questions

1. Are the relevant drugs available at the district level for timely implementation of the MDA campaign?

Responses

Supervisory notes/follow-up

2. Are drugs effectively distributed to community drug distributors, school teachers and community members? Are clear records maintained?

Responses

Supervisory notes/follow-up

3. Does treatment take place as directed by the national programme?

Responses

Supervisory notes/follow-up

4. Are community members, teachers and leaders effectively involved and informed about MDA to ensure that benefits are understood, and commitment is made?

Responses

Supervisory notes/follow-up

5. Is treatment co-implemented with other interventions, such as other child health and/or WASH campaigns? Are any promotional activities related to prevention of NTDs conducted during MDAs? Please specify.

Responses

Supervisory notes/follow-up

2. Materials

Method: Physical observation of materials and stocks available at the district health office, district WASH office, schools, etc. Insert additional materials based on specific programme.

Drugs

(List any drugs for MDA and treatment stored at the district level and for distribution to health care facilities for individual case management)

.....

.....

.....

Medical supplies and other aides

(List any supplies stipulated by the NTD programme stored at district level and for distribution to health care facilities for medical, case management and disability inclusion purposes)

.....

.....

.....

Vector-proof containers and lids

(List any supplies stipulated by the NTD programme stored at district level and for distribution to health care facilities or other public settings)

.....

.....

.....

Chemicals for vector control

(List any supplies stipulated by the NTD programme stored at district level such as larvicide, insecticide and molluscicide)

.....

.....

.....

Promotional materials

(Include any posters, flipcharts, handbooks, cards and other materials. Note any aspects such as relevance, condition, use, and whether materials are up to date)

.....

.....

.....

Patient/user records

(Include patient/user records and logbooks; check latest logbook entry to ensure timely records are maintained)

.....

.....

.....

Guidelines

(Ensure all relevant guidelines for programme delivery are available upon request at district and subdistrict levels)

.....

.....

.....

3. Observations

Method: Observations should be rapid and non-representative, with the main purpose to identify any obvious challenges to ongoing programme implementation. They can be conducted as part of a brief walk through the community, health care facility or school. The below questions should not be used as a guide for conducting baseline surveys, sanitary supervision or research.

Note: For health care facilities observations, *Water and sanitation for health facility improvement (WASH FIT): a practical guide for improving quality of care through water, sanitation and hygiene in health care facilities* (WHO, UNICEF, 2018)  may be useful.

Environmental observation

WASH: community

1. Have you observed a public water point? Was water available at the time of the visit? Was the tap/pump being used at the time of the visit? Was there a long queue?

Comments

2. Do households store water? Is water safely stored in clean containers with tight fitting lids?

Comments

3. Do households have outdoor toilets? If you observed a toilet, did it appear to be in regular use? Was it clean? Were there visible faeces present on any surfaces? Were there flies or unpleasant smells? Were there fly- and mosquito-proofing measures? Was there a handwashing facility in or near the toilet? Was soap and water available?

Comments

4. Were there any signs of open defecation, such as visible human faeces, or absence of toilets? (*Note whether the community has been declared as open defecation free [ODF]*)

Comments

5. What is the overall state of cleanliness in the community, in terms of solid waste, stagnant water, animal presence in/near houses, animal faeces, flies?

Comments

6. Are there visible environmental measures, such as vector-proof water storage tanks, safe solid waste disposal points, cemented ditches and irrigation drainage canals, identification and signalling of safe/snail-infested water recreation areas, protection barriers?

Comments

WASH: school

1. Does the school have a water source? Was it functioning at the time of the visit?

Comments

2. Are there toilet blocks (separate for girls/boys, and for staff)? Are the toilets accessible to pupils/staff with disabilities? Were the toilets clean? Were there visible faeces present on any surfaces? Were there flies or unpleasant smells? Was there a handwashing facility in or near the toilet? Was soap and water available?

Comments

3. What is the overall state of cleanliness in the school in the classrooms, break areas etc., in terms of solid waste, animal presence, faeces (human/animal), flies?

Comments

4. Are there vector control measures in place such as window screens, spraying and waste management?

Comments

WASH: health care facility

1. Does the facility have a piped water supply? Was water available from the taps at the time of the visit? If no piped supply available, was there an alternative supply at the time of the visit? Was water being stored in buckets?

Comments

2. Was there a functioning handwashing station with soap and water in any treatment areas visited?

Comments

3. Are there toilets for patients and staff? Are the toilets accessible to patients/staff with disabilities? Were the toilets clean? Were there visible faeces present on any surfaces? Were there flies or unpleasant smells? Was there a handwashing facility in or near the toilet? Was soap and water available?

Comments

4. What was the overall state of cleanliness in the facility, in terms of visible dirt, blood or fluids on floors, beds and other surfaces, and medical, sharp or other waste? Are animals present in the facility grounds? If observed, was the waste pit or incinerator protected from animal and/or human contact?

Comments

5. Are there vector control measures in place such as window screens, bed nets, spraying and waste management?

Comments

Activity observation

If any programme activities, such as health/hygiene promotion sessions, school education activities MDAs etc., were observed during the supervision visit, use the space below to record your observations.

Activity #1

Observations

Activity #2

Observations

Activity #3

Observations

Activity #4

Observations

4. Additional feedback/observations

Record below any additional issues generated through open and unstructured discussion with field staff, service users and others, or through structured discussions through focus groups or meetings.

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TOOL 10

National framework on WASH and NTDs template

Note for the user: This template is accompanied by **Supplementary tool: National framework checklist** 📄 to support the process of developing the framework content, including sources of information, workshop discussions, etc.

Title:

The type of document should be relevant to the national context and the existing policy framework. This could be a framework, guidelines, policy etc.

1. Purpose of the framework

a. Purpose of the document (this may include some or all of the following):

- Setting out programme quality standards for any collaborative action on WASH and NTDs by any stakeholders operating within the country, including government and nongovernment actors.
- Setting out structures for joint planning coordination at national and subnational levels.
- Setting out specific areas for integrated programming; ensuring sustainability of impact of non-WASH NTD interventions such as MDA.

b. Expectations for how the framework will be applied by all stakeholders, including requirements from all non-state actors to submit a programme/project document for approval by the NTD programme. Programme or project documents should set out how these projects will contribute to achieving disease control, health system strengthening and WASH sector goals and targets.

2. Background

a. NTD statistics: Overview of the state of NTDs in the country including key statistics and maps if available.

b. WASH statistics: Overview of the state of access to water supply, sanitation and hygiene in the country including key statistics and maps if available.

c. Importance of WASH for NTDs: General overview of the role of WASH in the control, treatment and care of NTDs (see Context: collaboration on WASH and NTDs).

d. Policy context: Reference to key global and national documents (e.g. the WHO NTD Roadmap, the WHO Global Strategy on WASH and NTDs, national NTD master plan, national WASH strategy, national health strategy and any other relevant documents).

e. A summary of action taken so far to enhance collaboration on WASH and NTDs.

f. Link between WASH and NTDs collaboration and the achievement of other national health and development priorities, strategies and goals.

3. Location and targeting of programme activities

This section should outline the need for **improved targeting of WASH and NTDs investment to areas where WASH access is low, and the burden of disease is highest**. This should be a core outcome of national WASH and NTDs coordination. A robust assessment of the distribution of disease and the WASH conditions relevant to disease control and care can help maximize resources, prevent programme resource duplication and achieve the equity goals of the national NTD programme and national WASH efforts. A process for using WASH and NTD data for decision-making and producing data visualization is provided in STEP 3: Data for decision-making and accompanying tools. It is suggested that proposals for new programmes or for the expansion of existing programmes into new geographic areas should be approved by the health ministry in negotiation with other sectors prior to implementation in line with the areas of high need.

You may wish to include the following data for decision-making outputs in the national framework to enable decision-making:

- a. A **prioritized (preferably colour-coded) table** showing all districts with data on NTD endemicity and co-endemicity, as well as access to WASH services.
- b. A **district-level map of the country**, showing the result of the district prioritization.
- c. An **alternative district map**, incorporating the need with information on programme delivery – for instance, highlighting districts in which there are few or no WASH implementing partners. You may wish to use **Supplementary tool: WASH-NTD partner form**  to identify this information.

4. Coordination

This section should set out the **purpose of WASH and NTDs coordination, and the structures for coordination at each level of government** (central, state/regional, district, subdistrict). Coordination may take place through a dedicated WASH-NTDs coordination mechanism, or through established sector-specific mechanisms, as appropriate to the national context. It should include:

- a. **Key principles** that all actors involved should adhere to (agreed through stakeholder consultation).
- b. **Key actions** to be undertaken by all actors (these may include: appointing a focal person for coordination; share plans and data for decision-making; align plans with the relevant national NTD and WASH plans; undertake coordination with the relevant WASH and NTDs leads in the relevant regions/districts; attend coordination and planning meetings at the relevant levels; work with appropriate subnational administrative structures).
- c. Description of **WASH and NTDs sector-specific management structures** (including any tables or organograms) at the central and subnational level.
- d. Description of the **WASH-NTDs coordination structure** (including any tables or organograms) if this exists or will be established; this may take the form of a task force, a working group etc., including the terms of reference of this coordination structure and any relevant financial arrangements. If a dedicated coordination structure does not exist and will not be established, a description of the process for coordination between sectors, including frequency and purpose of meetings, should be included. A table or diagram describing the link mechanism between the existing WASH and NTD sector structures may be useful.
- e. Description of any **specific WASH-NTDs coordination posts** at national and subnational level, and roles and responsibilities.

5. Joint planning

This section should include detailed description/tables of the **planning schedule**, including:

- a. Timing of and process for **annual planning** in both sectors, at each administrative level.
- b. Timing of and process for **joint** annual planning and budgeting, agreed by all stakeholders in the process of developing the framework. This may need to take place prior to the sector-specific planning processes, in order to ensure that joint or integrated activities are included in the sector plans and budgets. It is recommended that a data gathering period is factored into this process to allow for collection and analysis of disaggregated sector-specific data, WASH and NTD matrix or database analysis, and selection of priority districts for interventions. A planning Gantt chart or diagram may be useful to ensure that the timeframe is clear.

6. Integration

This section should **detail whether and how any integrated interventions should be delivered**. In line with the definition of integration provided in your definitions section (see 9. Annexes below), this should refer to interventions designed to meet WASH and NTDs objectives and delivered through a single entry point. For example, delivery of hygiene promotion messages during social mobilization for MDA. This section should provide specific detail on the following aspects:

- a. Any **programme guidelines** that must be adhered to (e.g. community health outreach manuals, school health and nutrition programme guidelines, health promotion and education guidelines, MDA protocols, etc.).
- b. **Guidance on remuneration of activities**, such as government set per diem rules.
- c. **Minimum aspects that must be included in all programmes** (e.g. communication of key behaviour change messages).
- d. **Key health, education and community structures** that should be informed or involved in the delivery of the intervention, to ensure strengthening of existing structures.
- e. Explicit **equity measures**, such as disability inclusion.
- f. A **comprehensive list** (table) of specific key NTD interventions, the WASH intervention that should be integrated with these, the mechanism for integration (such as tool or messaging development, and the delivery mechanism such as teachers, health workers etc.), monitoring mechanism, and the roles and responsibilities of both the WASH and NTDs implementers.

Priority NTDs/or NTDs interventions	WASH interventions/ activities to be integrated	Mechanism for integration	Means of verification (ensuring implementation)	Role of NTDs intervention implementer	Role of WASH intervention implementer
Mass drug administration (MDA)					
Integrated disease management					
NTD promotion through the community health programme					
Other health programmes (IMCI, EPI, nutrition)					
School health and nutrition programmes					
Identification and management of vector breeding sites					

7. Technical programme quality

This section should set out the **quality standards to be adhered to by all stakeholders when implementing WASH and NTDs interventions**. It should make explicit reference to:

- a. WASH infrastructure:** Alignment with national targets and indicators for service provision as well as the human rights to water and sanitation; national water quality standards; construction standards for water and sanitation supply (households and institutional settings); measures for disability-inclusive infrastructure; standards and regulations for user fees; requirements for service delivery through accredited service providers; and requirements for operation and maintenance of infrastructure including community-based water supply and water resource management mechanisms.
- b. Behaviour change:** Alignment with any existing nationally agreed behaviour change strategies on WASH and/or NTDs; use of evidence (such as from formative or other social research) relevant to the context in which the intervention will be delivered, in the design of behaviour change interventions/materials; use of extensive consultation and sign off or relevant bodies and the WASH-NTDs coordination mechanism in the design and finalization of behaviour change materials; any other country-specific stipulations based on previous programme experience, and desired links with other existing behaviour change campaigns/programmes.
- c. NTDs:** Alignment with relevant NTD programme quality standards.

8. Monitoring, evaluation and reporting

This section should set out the **monitoring, evaluation and reporting processes** that should ensure that the objectives of WASH and NTDs collaboration are met. To the extent possible, such processes should improve or strengthen existing systems, and avoid added complexity, cost and duplication where possible. Although the specific processes are highly country specific, the following aspects may need to be included:

- a.** Inclusion of data on WASH access, use and functionality in NTD programme baseline, routine monitoring and evaluation surveys; in some contexts, it may also be possible to collect information on behavioural outcomes and process indicators, see **Tool 11: WASH-NTD indicators and logframe** .
- b.** Data sharing:
 - Engaging with and utilizing information from WASH and NTDs mapping initiatives, and other available endemicity data, to identify and address areas with poor WASH coverage and high disease endemicity.
 - Data sources and information systems to be used, and the level and frequency of data provided through these sources.
 - Sharing information through existing coordination structures and in line with the annual reporting schedule to enable the use of data for enhanced planning and budgeting processes.
- c.** Conducting routine joint monitoring and supervision of programmes as subnational level, see **Tool 9: Routine supervision of WASH and NTDs programmes: guide and form** .
- d.** Tracking and reporting financial investment on WASH and NTDs services to endemic populations through established ministerial databases, against the budgets agreed during the planning phase. Where the financial system allows, dedicated budget codes should be used to enable investment monitoring

- e. Production of high-quality programme documentation detailing challenges, lessons and successful practices as tools for improving programme quality across the country, enhancing accountability, and mobilizing resources.

9. Annexes

These may include:

- a. Links to key policy documents.
- b. Lists of key indicators (including any process indicators for WASH-NTDs coordination).
- c. Additional statistics.
- d. Case studies/lessons from past/existing coordinated or integrated programmes.
- e. Definitions and glossary: Include any key definitions needed to ensure that all stakeholders have a shared understanding of the content of the document. This is particularly important for terms that are used or understood differently in different sectors/ministries. The below definitions may be useful, but others may need to be added depending on the national context.
 - **Coordination:** Collaboration to achieve joint goal while maintaining separate structures, including coordinating committees, financial coordination of components, staff/facility sharing, use of similar M&E indicators.
 - **Integration:** Complete merging of some or all components of different programmes; including single management body, joint financing arrangements, multidisciplinary teams under the same management, single M&E system. In NTD programmes, the term *integration* often refers to coordination of drug distribution programmes to address multiple diseases, or the integration of NTD aspects within the primary health care system. In this framework, *integration* refers to joint planning, implementation, and evaluation of activities across sectors and programmes to achieve common goals. The degree of integration needed depends on the context and nature of the diseases being addressed, and it is possible to integrate selected programme components.
 - **Linked programme:** Informal link through ad hoc meetings, delivery of services in the same location, separate reporting systems.

TOOL 11

WASH-NTD indicators and logframe

WASH-NTD indicators

This tool will help you to demonstrate that your programme has contributed to positive changes; it will help you to justify investments to your programme and contribute to overall accountability. It is based on the concept of cause and effect, meaning that if certain activities take place under certain conditions, certain results will be delivered. It includes a menu of potential Impact, Output and Outcome objectives and indicators which are relevant for WASH-NTD programming.

Some of the indicators should be considered investigational, requiring further research to confirm their programmatic relevance, repeatability, utility and/or safety. These indicators are marked with an asterisk (*).

A checklist for logframe development is provided at the end of the tool.

Note: Use **Tool 11 Annex**  for the Excel-based logframe, activities and Gantt templates, as well as milestones and means of verification for the indicator menu.

Definitions	
Goal(s)	Define the overall goal/higher order objective/impact/long-term result to which your programme contributes. That could be poverty reduction, achievement of SDG 3 targets in your country, NTD elimination or sustained control, etc.
Outcomes	Define the outcomes to be achieved by the programme – in other words, the impact the programme will achieve, or changes to the environment or to behaviours (can be short term or medium term). Outcomes should be related to the goal(s).
Outputs	Define the outputs for achieving that outcome – basically, what the programme will deliver. For example, number of people who will be trained, number of hardware produced, or number of committees formed. Outputs are also referred to as expected results, expected change, immediate change and short-term results. Outputs must have a direct relationship with the outcomes.
Basic drinking water (households)	Drinking water from an improved* source, provided collection time is not more than 30 minutes for a roundtrip including queuing.
Basic drinking water (schools)	Drinking water from an improved* source is available [at the time of survey/questionnaire] at the school.
Basic drinking water (health care facilities [HCF])	Water is available [at the time of survey/questionnaire] from an improved* source on-premises.
<i>*Improved drinking water sources are those that have the potential to deliver safe water by nature of their design and construction, and include: piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater, and packaged or delivered water.</i>	

Basic sanitation (households)	Use of improved** facilities which are not shared with other households.
Basic sanitation (schools)	Improved** facilities, which are single sex and usable [at the time of survey/questionnaire] at the school. [<i>“Usable” refers to toilets or latrines that are accessible to students (doors are unlocked or a key is available at all times), functional (the toilet is not broken, the toilet hole is not blocked, and water is available for flush/pour-flush toilets), and private (there are closable doors that lock from the inside and no large gaps in the structure)</i>]
Basic sanitation (HCF)	Improved** sanitation facilities are usable [at the time of survey/questionnaire] with at least one toilet dedicated for staff, at least one sex-separated toilet with menstrual hygiene facilities, and at least one toilet accessible for people with limited mobility. [<i>“Usable” refers to toilets or latrines that are accessible to patients and staff (doors are unlocked or a key is available at all times), functional (the toilet is not broken, the toilet hole is not blocked, and water is available for flush/pour-flush toilets), and private (there are closable doors that lock from the inside and no large gaps in the structure)</i>]
**Improved sanitation facilities are those designed to hygienically separate excreta from human contact, and include: flush/pour flush to piped sewer system, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.	
Basic handwashing (households)	Availability of a handwashing facility*** on premises with soap and water 
Basic handwashing (schools)	Handwashing facilities***, which have water and soap available [at the time of survey/questionnaire].
Basic handwashing (HCF)	Functional hand hygiene facilities (with water and soap and/or alcohol-based hand rub) are available at points of care, and within 5 m of toilets.
***Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents.	
Baseline	The status of services and outcome-related measures such as knowledge, attitudes, norms, behaviours and conditions before an intervention, against which progress can be assessed or comparisons made.
Endline	The endline survey measures how much has changed since the first time (baseline) outcome related measures (knowledge, attitudes, norms, behaviours) were gathered.
Incidence	The number of new cases of a disease that occur in a specified population during a specified time period.
Prevalence	The total number of persons living with a specific disease or condition at a given time.

Objectives	Indicators
Goal (impact)	
Soil-transmitted helminths	% change in
Trachoma	% change in
Schistosomiasis	% change in
Disease (morbidity) progression	% change in
Process outcomes	
Outcome P1	
NTD National and district master plans include WASH activities, targets and indicators	Presence of an NTD master plans with WASH referenced and operationalized throughout (targets, activities and monitoring)
	% of district NTD plans with WASH referenced and operationalized throughout (targets, activities and monitoring)
Output p1.1	
Increased number of WASH sector individuals at NTD planning meetings	# of WASH sector individuals at NTD planning meetings
Output p1.2	
Increased number of district NTD plans that include WASH activities	# of district NTD plans that include WASH activities
Outcome P2	
Mutual representation of WASH and NTDs on national and district-level NTD task forces and WASH sector coordination groups	Presence of WASH sector representation on a national NTD task forces
	% of district-level NTD task forces with WASH sector representation
	Presence of NTD representation in a national WASH sector coordination group
Output p2.1	
Increased number of functioning WASH-NTD coordination structures at national level	# functioning WASH-NTD coordination structures at national level
Output p2.2	
Increased number of districts with functioning WASH-NTD coordination structures	# districts with functioning coordination structures
Community outcomes [water]	
Outcome W1	
Increased access and use of (at least) basic water source	% households using water from (at least) basic water source
Output w1.1	
Provision of (at least) basic water source to communities	# households using accessible (at least) basic water source

Objectives	Indicators
Outcome W2	
Consistent availability of (at least) basic water in sufficient quantities for all domestic uses	% of households with sufficient quantities of (at least) basic water for all domestic uses (personal hygiene/self-care, cleaning, food preparation and drinking)
Output w2.1	
Promotion of (at least) basic water source for all domestic uses	# of households using (at least) basic water sources for all domestic uses such as laundry, washing and cooking
Outcome W3	
Reduced exposure to schistosome contaminated surface water sources	% of households where no member is exposed to surface water sources
Output w3.1	
Increased number of households who are not exposed to surface water sources through occupation	% households who are not exposed to surface water sources through occupation
Output w3.2	
Promotion of (at least) basic water source for all domestic uses	# of households using (at least) basic water sources for all domestic uses such as laundry, washing and cooking
Output w3.3	
Increased number of households who are not exposed to surface water sources through domestic activities	% households who are not exposed to surface water sources through domestic activities
Output w3.4	
Increased number of households with children who do not bathe, swim, and/ or play in surface water sources	% households with children who do not bathe, swim, and/ or play in surface water sources*
School outcomes [water]	
Outcome W4	
Increase in (at least) basic water sources located on site and available for all children at school throughout the year	% of schools with (at least) basic water sources on the premises % (at least) basic water sources accessible to all users (pupils and staff) during school hours
Output w4.1	
Provision of (at least) basic water sources in schools	# of schools with (at least) basic water source that are accessible for children with disabilities
Health care facility outcomes [water]	
Outcome W5	
Increased access to (at least) basic water source in health care facilities (HCFs).	% of HCFs with water from (at least) basic source available for drinking for patients, staff and carers % of HCFs with water from (at least) basic source available for cleaning and for patient needs
Output w5.1	
Provision of (at least) basic water source in targeted HCFs	# of HCFs using accessible (at least) basic water source

Objectives	Indicators
Community outcomes [sanitation]	
Outcome S1	
Consistent use of (at least) basic sanitation by all households (HH) in the community	% of HH with access to functioning (at least) basic sanitation
Output s1.1	
Increased household coverage of (at least) basic sanitation	% households with (at least) basic sanitation
Output s1.2	
Consistent use of (at least basic) sanitation by all household members	% households in which all members access and use (at least) basic sanitation at all times of day and night
Output s1.3	
Increased household access to (at least) basic sanitation for people with disability (limited mobility or vision)	% households with people with disabilities that have access to (at least basic) accessible sanitation at all times
Outcome S2	
Young children not exposed to faecally contaminated soil in household compound	% households with no evidence of human faeces in the compound
Output s2.1	
Increased number of compounds and play spaces free from human faecal waste	# households with no evidence of human faeces in the compound # households with no evidence of human faeces in play spaces
Outcome S3	
Increased hygienic disposal of child faeces	% of households where child faeces is safely disposed of
Output s3.1	
Increased household coverage of (at least) basic sanitation	% households with (at least) basic sanitation
Output s3.2	
Consistent use of (at least basic) sanitation by all household members	% households in which all members access and use (at least) basic sanitation at all times of day and night
Outcome S4	
Enhanced safe sanitation practices in communities	% communities/villages declared open defecation free (ODF)
Output s4.1	
Increase in improved sanitation practices in communities	# of communities triggered (using an adapted community-led total sanitation (CLTS) hygiene focused approach with NTD prevention messaging) # of community champions or promoters trained (community members rather than health staff)
School outcomes [sanitation]	
Outcome S5	
Consistent use of (at least) basic sanitation by all school staff and students	% of schools with access to functioning (at least) basic sanitation [disaggregated by staff, students and sex]
Output s5.1	
Increased school coverage of (at least) basic sanitation	% students using (at least) basic sanitation [disaggregated by age, sex] % staff using (at least) basic sanitation [disaggregated by sex]

Objectives	Indicators
Output s5.2 Increased access to single-sex (at least) basic sanitation in a school	# of (at least) basic sanitation for girls # of (at least) basic sanitation for boys # of (at least) basic sanitation for female staff # of (at least) basic sanitation for male staff
Output s5.3 Increased access to (at least) basic inclusive school sanitation	% of schools with (at least) basic sanitation that is accessible to people with disabilities
Outcome S6 School is faeces free	% schools with no evidence of human faeces in compound
Output s6.1 Increased number of school compounds free from human faecal waste	# schools with no evidence of human faeces in compound % students using (at least) basic sanitation last time they defecated [disaggregated by age, sex, disability] % staff using (at least) basic sanitation last time they defecated [disaggregated by sex, disability]
Health care facility outcomes [sanitation]	
Outcome S7 Increase in access to basic sanitation in HCF	% of HCFs with basic sanitation
Output s7.1 Provision of basic sanitation in targeted HCFs	# of HCFs with (at least) basic sanitation
Community outcomes [hygiene]	
Outcome H1 Basic handwashing following faecal contact (toilet use, child faeces disposal, returning from agricultural activities) by all household members	% of households with basic handwashing facilities
Output h1.1 Increased basic handwashing facility available on premises	# of basic handwashing facilities for household use
Output h1.2 Increased household access to a basic handwashing facility for members with disabilities	% households with people with disabilities that have access to basic handwashing facility
Outcome H2 Use of water, soap and other means for management of NTD-related wounds, infections and other effects caused by disease	% households with people with water, soap and other means for management of NTD-related wounds, infections and other effects caused by disease
Output h2.1 Increased household use of water, soap and other means for management of NTD-related wounds, infections and other effects caused by disease	% households with people with disabilities that have access to a private washing facility

Objectives	Indicators
Outcome H3	
Improved safe household food hygiene practices (preparation, storage, cooking and feeding/eating)	% of household with basic handwashing facility in food preparation area % of household with basic handwashing facility in eating area
Output h3.1	
Increased basic handwashing facility in household food preparation area	# basic handwashing facility in household food preparation area
Output h3.2	
Increased basic handwashing facility in household eating area	# basic handwashing facility in household eating area
Outcome H4	
Enhanced healthy hygiene behaviours in communities	% of household practising hand, face, body washing at critical times* % of households in which all members wear shoes for hookworm prevention [disaggregated, where possible, by children/adults and sex] % of households avoiding contact with surface water for schistosomiasis prevention
Output h4.1	
Increased training of health workers/volunteers on NTD and WASH related topics	# of health workers/volunteers receiving training on NTD and WASH related topics
Output h4.2	
Increased training of organizations (government or NGO) on NTD and WASH related topics	# of organizations (government or NGO) receiving training on NTD and WASH related topics
Output h4.3	
Increased number of household members who have basic knowledge of hygiene practices	# of household members who have basic knowledge of hygiene practices [broken down by relevant NTD specific indicators]
Output h4.4	
Increased number of household members who recall key messages about NTD prevention and treatment	# of household members in target population who recall key messages about NTD prevention and treatment [broken down by relevant NTD specific indicators]
Outcome H5	
Children have clean faces (free of dirt and/or nasal and ocular discharge)	% of household children with clean faces (free of dirt and/or nasal and ocular discharge) among all children*
Output h5.1	
Increased number of children in household with clean faces (free of dirt and/or nasal and ocular discharge)	# of children in household with clean faces (free of dirt and/or nasal and ocular discharge)*
Outcome H6	
Absence of vector breeding sites in household compound	% household where compound is free from solid waste and animal waste*
Output h6.1	
Increased number of HH free from human faecal waste	# household with no evidence of human faeces in the compound*

Objectives	Indicators
School outcomes [hygiene]	
Outcome H7	
Basic handwashing following faecal contact by all students	% of schools with basic handwashing facilities in or near sanitation facility
Output h7.1	
Increased basic handwashing facility available on premises	# of basic handwashing facilities on the premises
Output h7.2	
Increased access to a basic handwashing facilities for students with disabilities	# of schools with handwashing facilities available and accessible to students with disabilities
Outcome H8	
Improved safe school food hygiene practices (preparation, storage, cooking and feeding/eating)	% of schools with basic handwashing facilities in food preparation area
	% of schools with basic handwashing facilities in eating area
Output h8.1	
Increased availability of basic handwashing facilities in school food preparation area	# basic handwashing facilities in school food preparation area
Output h8.2	
Increased availability of basic handwashing facilities in school eating area	# basic handwashing facilities in school eating area
Outcome H9	
Children have clean faces	% of children at school with clean faces (free of dirt and/or nasal and ocular discharge) among all children*
Output h9.1	
Increased number of children at school with clean faces (free of dirt and/or nasal and ocular discharge)	# of children at school with clean faces (free of dirt and/or nasal and ocular discharge)*
Outcome H10	
Enhanced healthy hygiene behaviours in schools	% of students practicing hand, face, body washing at critical times*
	% of students with awareness of critical times to wash (hands, face, body)*
	% of students wearing shoes for hookworm prevention
	% of students avoiding contact with surface water for schistosomiasis prevention*
Output h10.1	
Increased number of schools where NTD-WASH related behaviour change promotion activities held	# of schools where NTD-WASH related behaviour change promotion activities held
Output h10.2	
Increased number of schools where NTD-WASH behaviour change is included in the curriculum	# of schools where NTD-WASH behaviour change is included in the curriculum
Output h10.3	
Increased number of pupils who received WASH-NTD related training (by sex)	# of pupils who received WASH-NTD related training (by sex)
Output h10.4	
Increased number of teachers/parent-teacher association (PTA)/school management committee (SMC) members trained on WASH-NTD activities	# of teachers/PTA/SMC members trained on WASH-NTD activities

Objectives	Indicators
Outcome H11	
Absence of vector breeding sites in school compound	% schools where compound is well swept and free from solid waste and animal waste
Output h11.1	
Increased number of schools free from human faecal waste	# schools with no evidence of human faeces in the compound
Health care facility outcomes [hygiene]	
Outcome H12	
Improved hygiene and infection prevention and control (IPC) in HCF	% of HCFs using hygienic equipment during surgical procedures and post-surgical wound care
Output h12.1	
Use of hygienic equipment during surgical procedures and post-surgical wound care at HCF	# of HCFs using hygienic equipment during surgical procedures and post-surgical wound care
Output h12.2	
HCFs with basic handwashing facilities present at critical points of care and within 5 m of sanitation facilities	% of HCFs with basic handwashing facilities present at critical points of care and within 5 m of sanitation facilities
Outcome H13	
Improved hygiene behaviours by health care staff in HCF	% of health care staff who practise key hygiene behaviours
Output h13.1	
Increased health care staff capacity on WASH-NTD related practices (hygiene, safe waste disposal, water quality, sanitation)	% of health care staff who receive IPC training that includes WASH-NTD related practices (hygiene, safe waste disposal, water quality, sanitation)
Output h13.2	
Increased number of HCF staff that received refresher training on IPC, which includes WASH-NTD practices, at facility or district/national level training	# of HCF staff that received refresher training on IPC, which includes WASH-NTD practices, at facility or district/national level training

Logframe checklist

- The programme has a stated goal in line with the broader national and international development agenda. The goal should be beyond the management responsibility of the programme team.
- The programme has clearly stated outcomes to be achieved as a result of programme activities.
- Outputs are clearly set out as results, and all are necessary for accomplishing the outcomes.
- Realistic milestones are included (if relevant), which can be achieved at the end of each programme reporting period.
- The activities define the action strategy for accomplishing each output.
- The relationship between the action and result is logical and does not miss important steps:
 - The outputs plus assumptions produce the necessary and sufficient conditions for achieving the outcomes.
 - The outcome plus assumptions describe the critical conditions for achieving the goal.
- There is a realistic relationship between:
 - the inputs/resources and the activities;
 - the activities and outputs;
 - the outputs and the outcome.
- The vertical logic among activities, outputs, outcomes and goal is realistic.
- The outcome indicators measure the project impact to be sustained.
- The indicators at the outcome level are not just a summary of outputs but a measure of the outcome.
- The goal and outcome indicators have quantity, quality and time measures, and are objectively verifiable.
- The inputs described at the activity level define the resources and costs required for accomplishing the purpose.
- Sources are clearly identified, i.e. where the information for verifying each indicator will be found. The actions required for gathering sources, i.e. household surveys, are identified and included in the activities.
- An evaluation plan, i.e. when, where, who and how the programme will be evaluated has been defined.

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