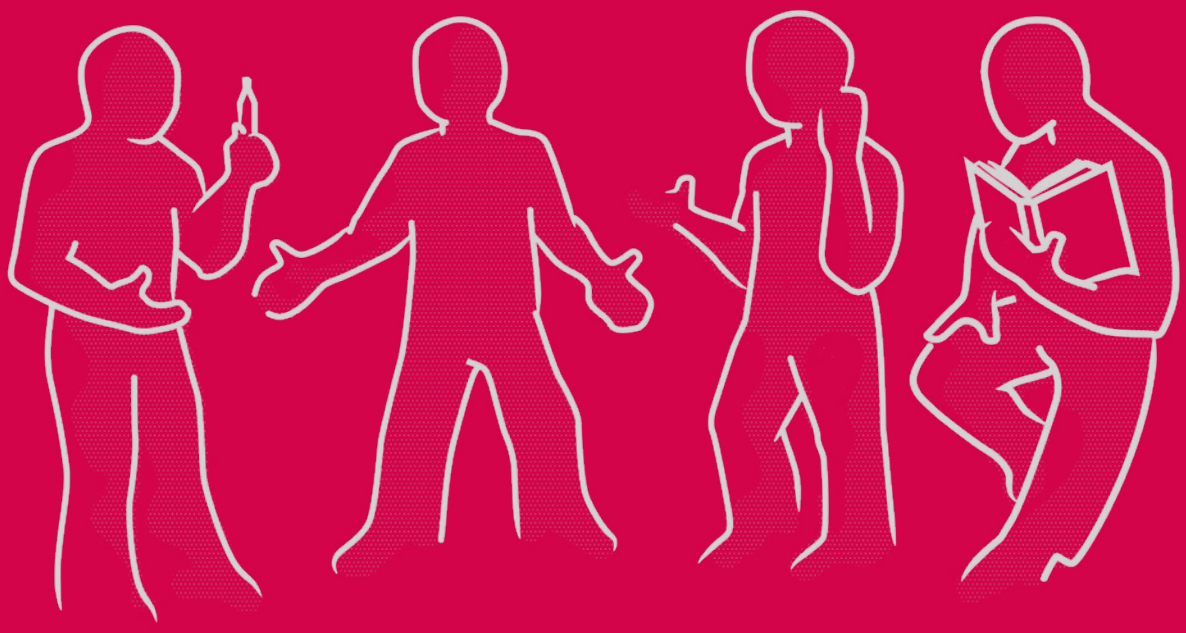
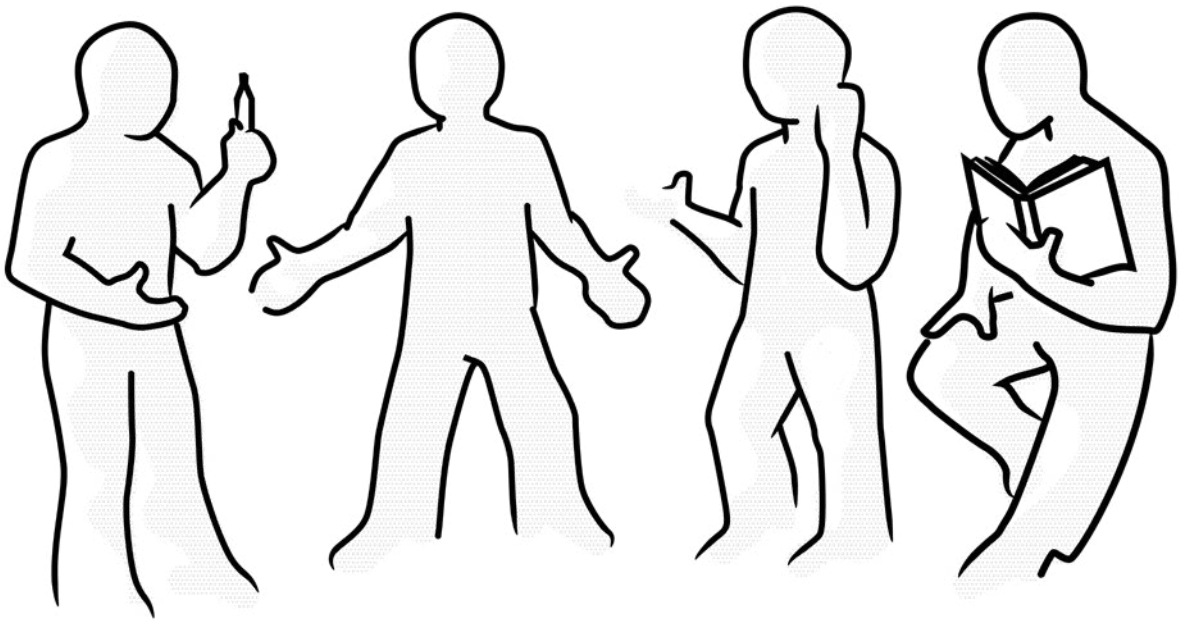


WASH and Health working together

A 'HOW-TO' GUIDE FOR NEGLECTED TROPICAL DISEASE PROGRAMMES

NEGLECTED TROPICAL DISEASE NGO NETWORK

World Health Organization



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WASH and Health working together: a ‘how-to’ guide for neglected tropical disease programmes

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I. What can this toolkit help you achieve?

The equity focus set out by the 2030 Agenda for Sustainable Development demands new ways to deliberately 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. But working together in new ways requires new ways of thinking.

→ What can this toolkit help you achieve?
→ How to use it?
→ How was it developed?
→ Acknowledgements
→ What's inside?

I. What can this toolkit help you achieve?

This toolkit will help you – whether you are a NTD programme manager or programme partner – to work with the WASH community, guiding you through building those partnerships, mobilising resources, and designing, implementing and evaluating interventions. Rather than a 'best practice' guide, it's a set of tools based on real-life programme experience; you can choose and adapt tools according to your needs and local context. The toolkit will help you:

- Build multisectoral partnerships with key stakeholders: ministries, national and local WASH agencies, corporates, 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 building local capacity at every level.
- Support and complement clinical and public health interventions for NTD control.

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 WASH and NTDs.
- → To engage non-NTD partners in planning and delivery.

How was it developed?

The toolkit was developed in collaboration between the NTDs NGO Network WASH Working Group and the World Health Organization, drawing on the experience of member organizations and country NTD programmes. It draws on tools and practices used in the delivery of coordinated and integrated programmes for control and elimination of neglected tropical diseases.

Acknowledgements

The concept and contents of this resource were developed by past and present members of the WASH working group of the NTDs NGO Network and staff from the Water, Sanitation, Hygiene and Health Unit, Department of Public Health, Environmental and Social Determinants of Health and the Department for Control of Neglected Tropical Diseases at the World Health Organization.

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The toolkit draws on some programming and technical resources developed by the London School of Hygiene and Tropical Medicine, and WaterAid. Certain tools were developed based on experience from implementing the ENVISION and Sightsavers "IEC and Social Mobilization NTD Tool Kit" and the International Coalition for Trachoma Control "All You Need for F and E: A practical guide to partnering and planning".

WHO gratefully acknowledges the financial support provided by the UK Department for International Development for their wider support to its work on WASH and Neglected Tropical Diseases.

What's inside?

SECTION	DESCRIPTION	TOOLS
Setting the scene	Background to the toolkit – the need and context for WASH and NTDs collaboration	• Interventions for NTD control and care • NTD-related behaviours • Guide on understanding behaviours for developing behaviour change interventions
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.	
2. Building partnership	Partnership is crucial for the achievement of NTD control and elimination 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.	• Messages for engagement • Cross sector meeting annotated agenda • Cross sector meeting PowerPoint presentation template
3. Analysing the situation	Being informed and prepared about the national and local context in which you're 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.	• Situation analysis protocol • Situation analysis executive summary template • Situation analysis presentation template • WASH NTDs partner form
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.	• Planning tool • Agenda for planning workshop • Problem analysis approaches • Planning for Elimination: getting NTD programmes across the finish line • Budget items and checklist • Improving coordination in low-resource settings
5.Implementing and monitoring	This section will provide useful steps to put in place implementation and monitoring and evaluation structures and processes to ensure results, improve accountability and support learning and adaptive planning.	• Routine supervision guide and form • Problem analysis tool • Programme dashboard template • Gantt chart template • Programme risk analysis template • Template logframe & indicator menu • Definitions & checklist for logframe development

II. Context

In 2015, WHO issued a **Global Strategy and action plan (http://www.who.int/water_sanitation_health/publications/wash-and-ntd-strategy/en/)** on WASH and NTDs encouraging new ways to partner and invest across programmes in support of the goals of the WHO 2012 NTD roadmap. The BEST Framework, developed by the NTDs NGDO Network in 2016, supports the strategy by offering a helpful conceptual framework to ensure that all actions needed for control and elimination, including water and sanitation as well as all other key interventions for NTD control and elimination, are addressed while ensuring sustainability and systems strengthening. BEST can be used to help plan, fund and deliver comprehensive approaches that target the population groups most in need.

→ The BEST framework for NTDs
→ WASH in Behaviour Change
→ WASH in Environment
→ WASH in Social Inclusion
→ WASH in Treatment and care

The BEST framework for NTDs

The BEST framework encompasses

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

Source: NTDs NGDO Network http://www.ntd-ngdonetwork.org/best-framework

RESOURCE
#1 Interventions for NTD control and care
Explore NTD-related interventions under the BEST framework

The **Interventions for NTD control and care** resource sets out the key interventions under each BEST component for all NTDs, as well as highlighting the necessary WASH conditions and interventions.

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 that make the behaviour acceptable.

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, individuals, communities and institutions can change behaviours to prevent or reduce disease. Communities can normalise new behaviours, while policy makers can sustain these normalisations, transforming individual behaviours into social norms. Prevention of many NTDs relies in part on WASH behaviours such as improved hygiene and sanitation practices at the individual, household, community and institutional levels. Behaviour change in NTD programmes should also accommodate prompt care-seeking behaviours, uptake of and adherence to treatment to prevent long-term negative consequences such as increased disease severity, and advocacy for change.

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 should be focused on addressing the factors and mechanisms that influence behaviour (regardless of whether or not the target group understands the link between the behaviour and the disease). Changing behaviours is complex and requires time. Since change is more likely when it is supported by a change in social norms, behaviour change interventions should aim to reach entire groups in the programme area. One possibility is to embed the relevant behaviours in other development programmes, for example any large-scale campaigns on child health,

RESOURCE
#2 NTD-related behaviours
Identify target WASH, treatment and other behaviours

family health, sanitation/hygiene, nutrition etc ('umbrella' campaigns, that address multiple behaviours under a single, aspirational 'brand' may be an appropriate method. **WaterAid briefing note on BCC campaigns (https://washmatters.wateraid.org/publications/mass-behaviour-change-campaigns-briefing-note).** These programmes may already cover NTD-related behaviours (e.g. hygiene), even if they have not been specifically designed for NTD control. Nonetheless, given that NTDs transmission can involve highly specific behaviours, it may not always be possible to embed all relevant aspects into broader programmes. This might be particularly relevant in areas with high endemicity and co-endemicity of NTDs. In these contexts, a more targeted behaviour change programme may be appropriate.

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 standalone interventions. Although these play a role in addressing behaviours, standard knowledge/awareness programmes have not shown to be very 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 can 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, socio-cultural, structural, and other influencers and barriers to specific behaviours. Some information may already be available from existing research and situational analyses.

Formative research enables designing a program approach, activities, materials and tools that are appropriate and relevant to the target group, and address cultural beliefs and the main facilitators and barriers to behaviour change. **Understanding behaviour to develop behaviour change interventions**

RESOURCE
#3 Understanding behaviour to develop behaviour change interventions
Develop behaviour change interventions for NTD control

Develop a Behaviour Change intervention

- Translate the insights from the formative research into specific objectives for the program, including the key aspects the programme needs to address: the practices that need changing, what drives them, and the mechanisms for change (messages, products, activities).
- 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 standalone knowledge-based educational programmes. Cultural appropriateness, 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 targets group should be part of the design process (e.g. taking into consideration literacy, gender and other aspects). Pre-testing of the materials and revision before a final version is produced is essential. See, for example:
  Resource for pre-testing tools (http://www.thehealthcompass.org/how-to-guides/how-conduct-pretest)

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 and funded and reach many people repeatedly).

Monitoring the outcome of the programme is essential, as being "reached" with messages, does not guarantee behaviour change. The main focus of monitoring and evaluation for behaviour change should be intermediate and long-term behavioural outcomes (people have changed their attitudes and practice of behaviours). Refer to step 5 of this toolkit and WHO Guidelines on Sanitation and Health, Chapter 5, which sets out the main frameworks :

https://www.who.int/water_sanitation_health/publications/en/

Key lessons from behaviour change programmes

- There is no 'one size fits all' behavior change intervention. A combination of multiple, context-specific promotional approaches, 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 appear particularly effective in reducing open defecation and improving toilet use.
- Long term behavior change requires sufficient and dedicated budgets as well as sufficient implementation time.
- Promotional approaches addressing behavioral determinants and social norms perform better at changing and sustaining behaviours than educational approaches aiming to increase knowledge of disease risks.
- Children can be effective BC agents for families and households.
- Government leadership and integrating behavior 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 in order 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.

- **Pathogen-free environment:** The existence of a toilet does not immediately translate into reduction in exposure to disease. For this to occur, toilets should be used by everyone, always, including small children (through safe disposal of child faeces), pregnant women, older people, and people with disabilities, offering a pleasant, safe and desirable alternative to open defecation. Toilets should result in safe separation of faeces from humans, animals and vectors. This means that construction should consider the entire sanitation 'chain', 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 entire communities.

- **Beyond the household:** Full community coverage of sanitation includes schools, healthcare facilities, markets, places of worship and other public buildings and spaces. In healthcare settings, this must include water, sanitation and hygiene infrastructure, Infection Prevention and Control, 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.

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. '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 utilising the available expertise for disease surveillance and control.

Additional resources:

WHO Guidelines on Sanitation and Health (https://www.who.int/water_sanitation_health/publications/guidelines-on-sanitation-and-health/en/)

WHO Sanitation Safety Planning Manual (http://www.who.int/water_sanitation_health/publications/ssp-manual/en/)

WASH in Social Inclusion

NTDs often affect the poorest and most marginalised 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 most affected and at-risk individuals and groups should therefore be fundamental to NTD control efforts, and 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 resources in improving their own access to services, means that interventions are often insufficiently targeted towards those that need them the most.

→ WASH WITHIN BEST

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 marginalisation 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 marginalisation such as Disabled Persons Organisations (DPOs) and women's group members in WASH and NTDs decision-making processes.
- Identifying and implementing appropriate and sustainable solutions, avoiding one-size-fits-all technology fixes and ensuring that any infrastructure provided is inclusive and accessible.
- Ensuring that activities such as hygiene and sanitation promotion are relevant to all groups, for example by suggesting design modifications to make 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 disfigurement caused by NTDs is linked to social exclusion and can result in reduced education and work opportunities and social capital (e.g. marriage prospects). 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 and social status, support from family and economic factors. People affected by NTDs may have additional sanitation and hygiene needs to manage the disease to those unaffected, while also more likely to face additional barriers to WASH access due to stigma, discrimination and exclusion from communal WASH services.

Behaviour change and norm setting

Groups at risk of marginalisation 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 marginalisation 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 and social exclusion, like using negative images of people affected by NTDs to encourage uptake of mass drug administration 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-stigmatising 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. Shared facilities like community and public toilets should be well-lit and secure for female users. Cleanliness and management of the toilet 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 marginalisation should be targeted specifically whilst 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 inclusion focus of interventions. Priority action areas to support this are:

- Facilitating links to wider networks by engaging women's groups, microcredit schemes, DPOs and community-based 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.

WASH in Treatment and care

WASH plays a crucial role in achieving Universal Health Coverage, 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 healthcare providers and healthcare 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 healthcare outreach programmes and community health volunteer schemes.
- Mass drug administration 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. Healthcare settings require adequate water and sanitation to ensure infection prevention and control as well as dignity for patients and staff. WASH conditions in healthcare settings also underpin uptake of facility-based services, and healthcare 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-stigmatisation), community and healthcare levels. Self-help groups can play an important role in empowering individuals to care for themselves and 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 maximising 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 provisions for maintaining hygiene.

III. STEPS TO SUCCESS

01 Setting the programme vision

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.

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.

01 Setting 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.

Write your notes

III. STEPS TO SUCCESS

02 Building partnership

Partnership is crucial for the achievement of NTD control and elimination 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 government and other agency institutions are organised can also become a barrier to collaboration due to simple reasons such as location in different buildings or conflicting planning and budgeting cycles.

- → Why should we collaborate with partners?
- → How do we collaborate with partners?
- → How to get started?

02 Building partnership

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.

SHARED IMPACTS

- Improved health & well being
- Poverty reduction
- Equity

SHARED OUTCOMES

- Access to services
- Increased income

HEALTH

- Control/elimination of NTDs
- Health outcomes (reduced mortality/morbidity)
- Service coverage and quality
- Service utilization

WASH

- Service coverage
- Service access
- Service use
- Functionality

CORPORATE

- Earnings
- Population purchasing power
- Corporate social responsibility/reputation
- Market share

EDUCATION

- Enrolment
- Literacy/Attainment
- Attendance
- Quality
- Equity

→ **The benefits of cross sector collaboration:** the figure 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.

Why should we collaborate with partners?

Messages for engagement resource

Shared goals

While NTDs and WASH stakeholders may have very different objectives, they often have the same ultimate goals – improving people's health and wellbeing 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 attractive 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 mass drug administration (MDA) and reduce the likelihood of re-infection among treated populations.

RESOURCE
#4 Messages for engagement
Engage multiple sectors in NTD collaboration

How should 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 start 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 can 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 mobilisation 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 goal. 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?

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

Whatever the reason most relevant to you, these steps could help you get 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 mobilise resources or prioritise a specific geographic area. Once listed, understand each partner's motivation to partner. 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. Organise 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 to shape the vision of their organisation, understand programme development, and have authority to make decisions on behalf of their organisation. The location can be according to what you've decided about formality as well as convenience for all attendees. 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 the **Message for engagement resource** 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 behaviors and practices.

4. Craft your agenda.

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

Cross sector meeting agenda tool

TOOL
#5 Cross sector meeting agenda
Initiate WASH-NTDs collaboration

Write your notes

III. STEPS TO SUCCESS

03 Analysing the situation

Being informed and prepared about the national and local context in which you're 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 that accurately represents the local context of the programme target areas.

→ Conducting and using a situation analysis

03 Analysing the situation

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.

Conducting and using a situation analysis

TOOL
#6 Situation analysis protocol
Gather essential data for joint planning

Situation analysis protocol

1. Identify the analysis team

This is a recommended core group inside the overall situation analysis team. The team should include members within NTDs, WASH, social and behavior change 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 the situation analysis
protocol tool.

2. Identify and formally involve key stakeholders

This should include identifying potential partner organisations, government agencies and community stakeholders, as well as coordination structures and first steps around joint planning, including both timelines
and structures.

TOOL
#7 WASH/NTDs partner form
Gather partner data for programme delivery

WASH/NTDs 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.

The **Situation analysis executive summary template** and **Situation analysis presentation template** can be used to present the findings.

TOOL
#8 Situation analysis executive summary template
Synthesise data from the situation analysis report

TOOL
#9 Situation analysis presentation template
Present data from the situation analysis report

Write your notes

III. STEPS TO SUCCESS

04 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 revitalising coordination processes, or a more detailed process of developing joint activities.

- → Tips for success
- → Practical planning steps
- → Financial arrangements for a successful programme

04 Planning and programme design

This section will take you to the next step – 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 additional substantial financial resources are available to develop a whole 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 management

An adaptive approach to planning emphasises

- → 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 monitoring and evaluation to learn from errors on a continuous basis, not periodic external evaluations;
- → Continuous dialogue with intended beneficiaries to adjust activities to their needs.

(see Therkildsen 1988: 208)

Tips for success

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's 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 are greater chances of success (this may be due to a vibrant 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 the **Problem analysis approaches tool**, 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-routed problem, it can itself still be delivered successfully.

TOOL
#10 Problem analysis approaches
Understand challenges and develop solutions

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. Synthesise

> 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 prioritise 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 one-year plan

6. Revisit and realign

> Put in place a process for periodic review of programme implementation to identify challenges and allow necessary adjustments.

The **Planning tool** and **Agenda for joint planning workshop tool** will guide you through this process.

TOOL
#11 Planning tool
Develop a robust joint planning process

TOOL
#12 Agenda for joint planning workshop tool
Conduct a successful a three-day joint planning workshop

RESOURCE
#13 Planning for elimination
Explore key considerations for disease elimination programmes

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 prevalence of a disease 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 is, the more reliant it becomes on services and interventions delivered by other agencies and sectors (for example for water, sanitation and hygiene 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 threatening – 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! The **Planning for elimination** resource 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's 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's a common assumption that integrated programmes require additional resources, a lot can be achieved with existing or limited new resources. See the **Improving coordination in low-resource settings** resource for more.

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, 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.
- 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 recently set out by WaterAid, Plan and UNICEF in a process to develop guidance on rural sanitation (**https://washmatters.wateraid.org/publications/rethinking-rural-sanitation)** are a useful example of programme aspects that should be included: planning, formative research, programme mobilisation, capacity development, programme management, community implementation, supply strengthening, sanitation service chain, sanitation finance, monitoring & evaluation, sustainability support, and environmental sanitation.

RESOURCE
#14 Improving coordination in low-resource settings
Find out what you can do with little or no extra funding

- 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).

TOOL
#15 Budgeting for joint WASH and NTDs programmes
Plan your detailed programme budget

The **Budgeting for joint WASH and NTDs programmes tool** 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)

- **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)
- **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, is at times underestimated by those not familiar 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/UN Water TrackFin Initiative **(http://www.who.int/water_sanitation_health/monitoring/investments/trackfin/en/)**, 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:

1. Investment costs

> Initial costs of putting new services in place, including hardware such as pipes, toilets, and pumps, and one-off associated software costs, like for design and engineering studies or consultation.

2. Operating and maintenance costs

> Routine maintenance and operation costs to keep services running, including wages, fuel, or any other regular purchases.

3. Large capital maintenance costs

> Occasional large maintenance costs for the renewal, replacement and rehabilitation of a system beyond routine repair and replacement costs.

4. Financial costs

> Capital repayments and costs - including interest on loans, and dividends if a return is paid to shareholders.

5. Support or software costs

> Includes charges for direct and indirect support. Direct support includes construction activities at the local level, like training for community or private sector operators or users. Indirect support includes the cost of planning and policy-making at government level, like strengthening the skills and capacities of professionals and technicians.

6. Taxes

> Put in place a process for periodic review of programme implementation to identify challenges and allow necessary adjustments.

(Source: UN-Water, WHO 2016. TrackFin Guidance)

Write your notes

III. STEPS TO SUCCESS

05 Implementing and monitoring

Monitoring and evaluation plays a key part in ensuring good programme results. While monitoring and evaluation 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 do this?

→ Getting the M&E framework right

05 Implementing and monitoring

How to do this?

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 situational 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 (http://tropicaldata.knowledgeowl.com/help),** which incorporates WASH indicators into disease mapping surveys. Baseline data can be presented numerically, or in map form by overlaying disease prevalence with relevant data on determinants (for example, STH prevalence and access to sanitation). Maps are powerful tools to visually represent need *and* progress over time. The table below lists out the type of baseline information you may need for an integrated programme.

Survey/ observation	COLLECTION METHOD*
NTDs	
Disease and/or infection prevalence	Survey (school/ community)
Infection intensity	Survey (school/ community)
Co-endemicity	Survey (school/ community)
WASH	
School-level WASH indicators (e.g. % of schools with functional improved sanitation facilities; % of schools with access to improved water supply).	Survey (school/ community); district Education Office. Information can also be collected during disease/infection prevalence surveys for a sample of schools.
Healthcare facility-based indicators (e.g. % of healthcare facilities with adequate sanitation facilities; % of healthcare facilities with improved water supply).	Survey (facilities – Service Availability and Readiness Assessments, Service Performance Assessments), HMIS.
Household access to improved/safely managed sanitation.	District WASH monitoring system/ survey
Community coverage of improved/safely managed sanitation	District WASH monitoring system/ survey
Household access to improved/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

** The **#6 situation analysis protocol** and **#3 Understanding behaviour to develop behaviour change interventions** offer methods for obtaining some of the below information. Note that setting a baseline on behavioural aspects is likely to require a larger scale survey than formative research.*

TOOL
#16 Routine supervision guide and form
Ensure the programme is being delivered successfully

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).

You may find the **Routine supervision guide and form** a useful tool for this purpose. 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.

Periodic reflection

Reflection should be part of your monitoring and evaluation 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?

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 **Problem analysis approaches tool**. Once the reflection has taken place, make the necessary changes to your logframe in terms of new resources, activities and outputs.

TOOL
#10 Problem analysis approaches
Understand challenges and develop solutions

Evaluation

Unlike routine monitoring, an evaluation takes place at programme milestones and at the end of the programme to assess it. 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 (like 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 through to national levels;
- 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. The **WHO: Helminth control in school age children: a guide for managers of control programmes, Second edition (http://www.who.int/neglected_diseases/resources/9789241548267/en/)** provides a diagram to illustrate each of these components.

Accountability

Setting up a strong accountability structure will be essential, and accountability should be addressed at multiple levels:

- ***To the 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, like circulating information through the media, using social mobilisation activities, or working through existing community-based administrative and other structures (schools, leadership councils, health clubs/groups) 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.

- ***Within the Ministry of Health and other government departments:*** Demonstrating good results brings much needed continued resource allocation. It also helps communicate the programme's importance to other ministries (see the **Programme Dashboard template** for a simple way of presenting such information). For example, by highlighting aspects like value for money, a successful integrated programme provides the Ministry of Health 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.

- ***To 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 as system is not in place, any additional monitoring frameworks put in place should incorporate standardised indicators and be aligned with governments systems to the extent possible in order to reduce the burden of reporting and strengthen the health system.

TOOL
#17 Programme Dashboard template
Showcase programme progress in an engaging way

- ***The international community:*** all NTD and WASH programmes operate within the overall global development framework (currently enshrined in the Sustainable Development Goals), and in the case of NTDs, the WHO 2020 Roadmap and the WHO Global Strategy on WASH and NTDs. 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's 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.

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 log-frame summarises

- 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 – in other words the impact the programme will have, or changes to the environment or to behaviours. This should ideally be 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.

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 of this are new funding, external investments, availability of specific supplies, etc. Making these assumptions explicit from the beginning will

TOOL
#18 Gantt chart format
Plan your implementation schedule

help explain why certain things have or haven't happened (for example when using the 'five whys' approach to **Problem 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 healthcare facilities

   c. Indicators relating to changes in individual, family and community behaviours and perceptions over time, or proxy measures such as presence of hand-washing 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, 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.
   The **Programme risk analysis template** should help undertake this process.

The **WASH and NTDs indicators and logframe tool** offers a comprehensive set of indicators for your consideration. Use the **Definitions and checklist for logframe development** to help the development process.

TOOL
#10 Problem analysis approaches
Understand challenges and develop solutions

TOOL
#19 Programme risk analysis template
Plan for and mitigate risk in programme delivery

TOOL
#20 WASH and NTDs indicators and logframe
Develop a useful programme monitoring, evaluation and reporting process

TOOL
#21 Definitions and checklist for logframe development
Develop a clear and useful logical framework

Write
your notes

IV. Tools and resources

Interventions for NTD control and care

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Buruli ulcer ▸ Bacterial ▸ Environmental (undertermined)			▸ Addressing stigma 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 & treatment ▸ Antibiotic treatment ▸ Surgery ▸ Physiotherapy and rehabilitation ▸ WASH for hygiene and infection prevention and control in healthcare 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 infection prevention and control in healthcare facilities
Chromoblastomy-cosis ▸ 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 stigma due to disfigurement	▸ Early detection and surgical resection ▸ Cryotherapy (liquid nitrogen) ▸ Heat therapy ▸ Laser therapy ▸ Oral antifungal medication (not very effective) ▸ Topical (Imiquimod cream)

WASH-related aspects highlighted in blue

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Dengue ▸ Viral ▸ Aedes aegypti/ albopictus Mosquito	▸ Bite prevention (clothing, nets, repellent)	▸ Environmental management: water supply, water container management , screens, solid waste disposal to avoid water pooling ▸ Chemical control: pesticides, residual spraying, repellent ▸ Biological control: larvivorous fish/ predatory copepods to reduce larvae		▸ Symptom management (fever) ▸ WASH for hygiene and infection prevention and control in healthcare facilities
Dracunculiasis (Guinea worm disease) ▸ Parasitic ▸ Water-based	▸ Promotion of safe water practices	▸ Access to safe water to reduce contact with surface water ▸ Water treatment & filtration ▸ Water for hygiene purposes at households and healthcare facilities		▸ Wound management
Echinococcosis/ hydatidosis ▸ 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, cats and sheep ▸ Food and slaughter inspection and hygiene; safe disposal of infected carcasses ▸ Lamb vaccination and culling of older sheep ▸ Removal of animal faeces from the household environment		▸ Drug therapy ▸ Surgery ▸ WASH for hygiene and infection prevention and control in healthcare facilities

WASH-related aspects highlighted in blue

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Endemic treponematoses (Yaws) ▸ 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 stigma and discrimination (cultural beliefs preventing care-seeking; teachers dismissing children from school)	▸ Antibiotic treatment ▸ Wound management
Foodborne trematode 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)	▸ Avoidance of use of unprocessed human/animal faeces as manure/ fish feed ▸ Improved/ basic household/ community sanitation (toilet construction and use)		▸ Preventive/ individual anthelmintic chemotherapy
Human African trypanosomiasis (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)	▸ Address stigma (victim-blaming in some cultural contexts)	▸ Early detection ▸ Drug therapy ▸ WASH for hygiene and infection prevention and control in healthcare facilities

WASH-related aspects highlighted in blue

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Leishmaniasis (Visceral/ cutaneous) ▸ Parasitic ▸ Sandfly	▸ Hygienic self-care	▸ Vector control through improved housing, waste management & 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 stigma related to ulcers, disfigurement, scarring & disability (cutaneous/ mucocutaneous leishmaniasis)	▸ Chemotherapy ▸ Wound management ▸ WASH for hygiene and infection prevention and control in healthcare facilities
Leprosy ▸ Bacterial ▸ Personal contact	▸ Promotion of early diagnosis & 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	▸ Addressing stigma due to cultural/ traditional/ religious beliefs (witchcraft, curses, immorality, uncleanliness) ▸ Prevention of stigma-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	▸ Multidrug therapy ▸ Symptom/ wound management

WASH-related aspects highlighted in blue

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Lymphatic filariasis ▸ Parasitic ▸ Culex/ Anopheles/ Aedes mosquito	▸ Hygiene to reduce acute inflammatory episodes (limb washing, skin care, exercise, limb elevation) ▸ Bite avoidance: insecticide-treated nets, indoor residual spraying, personal protection measures ▸ Wearing adequate footwear	▸ Improved sanitation, draining and water resource management to reduce mosquito breeding sites ▸ Water supply to enable hygiene for self-care	▸ Addressing stigma due to misunderstanding of disease cause and fear of contagion ▸ Prevention of stigma-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	▸ Treatment of acute inflammatory episodes (antibiotics, anti-inflammatories, analgesics) ▸ Provision of adequate footwear ▸ Hydrocele surgery ▸ Chemotherapy treatment ▸ Mass chemotherapy ▸ WASH for hygiene and infection prevention and control in healthcare facilities for lymphoedema care and hydrocele surgery
Onchocerciasis (River blindness) ▸ Parasitic ▸ Blackfly		▸ Judicious use of vector control measures including insecticide treatment of larval breeding sites and water flow manipulation	▸ Prevention of stigma 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
Rabies ▸ Viral, zoonotic ▸ Animal bites	▸ Bite prevention through community promotion ▸ Reduced contact with wild animals	▸ Dog vaccination		▸ Immediate, thorough wound cleansing with soap and water after contact with a suspect rabid animal ▸ Post-exposure prophylaxis ▸ Pre-exposure immunisation

WASH-related aspects highlighted in blue

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Scabies ▸ 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 healthcare 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 bovine contact/ waste ▸ Snail control measures ▸ Improved water supply to reduce use of surface water for domestic activities	▸ Addressing stigma caused by symptom similarity between female genital schistosomiasis and sexually transmissible infections	▸ Individual/ mass chemotherapy

WASH-related aspects highlighted in blue

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
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 ▸ 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 factors attracting snakes into homes: livestock, rats (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		First aid: ▸ Patient safety and immobilisation, transportation to medical facility ▸ Avoidance of rejected/ controversial first aid including arterial tourniquet, suction, cauterisation, cryotherapy, prophylactic amputation etc, and of washing/ tampering with bite wound ▸ Pain relief (avoiding aspirin and non-steroid anti-inflammatory drugs) 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 infection prevention and control in healthcare facilities

WASH-related aspects highlighted in blue

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Soil-transmitted helminthiases ▸ 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 (cycticercosis)	▸ Hand and food hygiene ▸ Exclusive use, cleanliness and maintenance of toilets and safe disposal of child faeces	▸ Safe water supply ▸ Improved household/ community sanitation services to avoid open defecation ▸ Improved pig husbandry and management of pig faeces ▸ Pig anthelmintic treatment ▸ Pig vaccination ▸ Improved meat inspection & processing (Taeniasis)	▸ Stigma prevention (Neurocycticercosis may lead to epileptic seizures; some traditional beliefs on epilepsy result in victim-blaming and stigma)	▸ Chemotherapy ▸ Supporting therapy with corticosteroids and/or anti-epileptic drugs (neurocysticercosis) ▸ Identification & treatment of cases ▸ Surgery (neurocysticercosis) ▸ WASH for hygiene and infection prevention and control in healthcare facilities

WASH-related aspects highlighted in blue

Disease ▸Type ▸Transmission	Behaviour	Environment	Social inclusion	Treatment and care
Trachoma	▸ 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	▸ Mass administration of antibiotics ▸ Trichiasis surgery ▸ WASH for hygiene and infection prevention and control in trichiasis surgery settings

WASH-related aspects highlighted in blue

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 Prevent diseases Keep flies away from faeces	Cysticercosis, Foodborne trematodes, Schistosomiasis, Soil-transmitted helminthiasis (STH), Trachoma, Yaws,
	Always dispose of faeces (human or animal) in a toilet	Prevent faeces from contaminating soil Break cycle of spreading diseases Keep flies away from faeces	Cysticercosis, STH, Trachoma
	Never urinate in an open water source such as a pond, river or dam	Prevent schistosomiasis eggs from getting back into water sources	Schistosomiasis
	Keep the compound clear of human feces.	To prevent disease To keep flies away from the immediate living environment	Cysticercosis, Dengue, Schistosomiasis, STH, Trachoma, Yaws
	Keep compound clear of animal faeces	To prevent disease To keep flies away from the immediate living environment	Cysticercosis, Dengue, Echinococcosis, Schistosomiasis, STH, Trachoma
	Keep toilets, drains and septic tanks covered	To keep flies and mosquitos away from faeces	Lymphatic Filariasis (LF), STH
	Keep toilets well maintained (This includes keeping toilets clean and functional)	To prevent pathogen spread To increase likelihood of toilet use	Cysticercosis, STH, Trachoma
	Adequate provision, maintenance and cleanliness of toilet facilities for patients, staff and care givers (including bedpans); safe disposal of faecal waste	Prevent healthcare associated infections Prevent disease spread from healthcare facilities to the surrounding communities Encourage facility-based care seeking	All diseases requiring healthcare facility attention, particularly surgical interventions and hospitalisation
	Adequate provision, maintenance and cleanliness of sanitation facilities for students and staff in schools	Prevent disease spread Inculcate good sanitation practices among students	Cysticercosis, STH, Trachoma

	Practice	Purpose	Disease
HYGIENE	**Personal hygiene**		
	Wash hands at critical times	To prevent disease transmission	Echinococcosis, Schistosomiasis, STH, Trachoma
	Wash hands after contact with animals	To prevent hand to mouth ingestion of parasite eggs	Echinococcosis
	Wash face when dirty	To remove secretions from face	Trachoma
		To keep flies away from face	
	Bathe regularly using clean water and soap (and not in open water sources/ surface water)	Prevent skin/fungal infections	Chromoblastomicosis, Yaws
	Wash regularly cloths, towels and bedding (not in open water sources/surface water)	To prevent transmission through fomites	Trachoma
	Food hygiene		
	Do not serve children food directly on the ground	To prevent disease transmission	STH
	Maintain hygienic food preparation through washing hands, surfaces, utensils and raw food products with clean water and soap	To prevent pathogen contamination of food	Chagas, Echinococcosis, Foodborne trematodes
	Avoid consumption of raw fish, crustaceans and plants in endemic areas	To prevent foodborne trematode infection	Foodborne trematodes
	Thorough cooking and re-heating of food	To kill pathogens through heat inactivation	Chagas, Echinococcosis, Foodborne trematodes
	Proper storage of food in sealed containers	To prevent re-contamination with pathogens by flies and fomites	Chagas, Foodborne trematodes, Snakebite envenoming
		To avoid attracting snakes/ rats	
	Keeping animals out of the food preparation and eating area	To avoid pathogen spread in the environment and into food	Echinococcosis
	Cover cleaned dishes	To avoid pathogen ingestion	Chagas

	Practice	Purpose	Disease
WATER	Treat water before drinking	To kill 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	To kill schistosomes	Schistosomiasis
	Filter water from open sources with a fine mesh cloth	To strain out infected copepods	Guinea worm
	Avoid contact with surface water	Prevent contact with parasite	Guinea worm, Schistosomiasis
	Keep animals away from water sources for human consumption/ use	Prevent animal parasites from entering water source	Guinea worm, Schistosomiasis
	Never swim or bathe in open water sources	To protect skin from schistosomes	Guinea worm, Schistosomiasis
	Never wash laundry in open water sources	To protect skin from schistosomes	Schistosomiasis, Guinea worm

	Practice	Purpose	Disease
TREATMENT AND CARE	Participate in mass drug administration campaigns	To reduce the burden of parasites already in the body that infect the population	LF, Onchocerciasis, Schistosomiasis, STH, Trachoma
	WASH swollen feet and limbs and between the toes with soap and water daily	To 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	To prevent wound infection	Buruli ulcer, Guinea worm, Leishmaniasis, Leprosy, Scabies (to avoid secondary infections), Yaws
	Wash hands before and after contact with patient	To prevent disease transmission	All diseases
	Seek clinical treatment for chronic morbidity	Reduce severity of disease, reduce likelihood of passing on infection	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 infection prevention and control measures in healthcare settings (including cleaning, waste disposal and hand hygiene) – by healthcare staff, patients and visitors	Prevent healthcare-associated infections	All diseases requiring healthcare facility attention, particularly surgical interventions and hospitalisation

	Practice	Purpose	Disease
OTHER BEHAVIOURS	Avoid insect bites using clothing, repellent, bed nets, screens	Prevent transmission	Chagas, Dengue, Human African trypanosomiasis, Leishmaniasis, LF
	Prevent mosquito breeding: cover water containers, drains and septic tanks, participate in Indoor Residual Spraying programmes or spray your home regularly; prevent water pooling in puddles or solid waste	Reduce vector breeding	Dengue, LF
	Reducing sandfly breeding in animal shelters and improving 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 solid flooring in households	To prevent vector breeding and helminth maturation	Chagas, STH
	Use of improved housing materials such as solid (concrete, tiled, brick, block) flooring and walls, and inorganic roofing materials	To prevent vector breeding	Chagas, Leishmaniasis
	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 feral dogs	Avoidance of bites	Rabies
	Apply good animal husbandry practices for livestock and other household animals including deworming and vaccination where relevant	To prevent transmission of pathogens between animals and humans	Echinococcosis, Rabies, Taeniasis/ cysticercosis
	Use of personal protective equipment (gloves, boots/shoes, masks, aprons) for high-risk groups (e.g. sanitation workers, farmers)	To protect occupational health	Chromoblastomicosis, STH
	Restriction of skin to skin contact	To prevent disease transmission	Scabies
	Always wear shoes outside	To protect skin from schistosomes (adult larvae) and hookworm	Schistosomiasis, STH
	Always wear boots when working in rice fields	To protect skin from schistosomes (adult larvae) and hookworm	Schistosomiasis, STH

Understanding behaviour to develop behaviour change interventions

Understanding behaviour to develop behaviour change interventions

Human behaviour at the individual, household, community and society level underpin 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 and understanding of

- What the target behaviours are
- Who practices these behaviours
- Why these behaviours occur, and
- What are the effective ways to change them

The potential behaviours of interest for NTDs are listed in the **NTD-related behavours (#2)** resource. See also the **WASH in Behaviour** section of the toolkit 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 very 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 the **Situation analysis protocol (#6)** 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 a 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 handwasing 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 mobilisation for mass drug administration (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. **Utilising 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 wellbeing?

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 trusting relationship with the target group (especially in situations where NTDs affect particular ethnic, cultural and socio-economic 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: is there 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 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 steps 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 practices 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 (for example, handwashing with soap after toilet use), but perhaps not in relation to the specific NTD-related risk factors (for example, 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 (adapted from: Hygiene Behaviour Change Capacity Building and Technical Training Manual. WaterAid and London School of Hygiene and Tropical Medicine, 2016) to establish what is already known, and where further information is needed.

		Example Questions	Example for soil transmitted helminths soil transmitted helminths (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	
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 feces disposal practices	
	Biological	What risk is there from pathogens/ feces? What diseases to people know about or worry about?	We have some data from healthcare 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 practice 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.	
	Social	Who are the role models for the target behaviours? How does the social environment (relationships, networks and organisations) 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.	

		Example Questions	Example for soil transmitted helminths soil transmitted helminths (STH) WASH behaviours	More data needed? (Y/N)
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.	
	Motivated	Is the target behaviour rewarding? What emotional drivers of behaviours are there?	▸ Literature on handwashing shows that handwashing is often motivated by nurture, disgust and comfort, and that hands usually get washed if dirty, sticky or smelly. ▸ literature of sanitation show that privacy, comfort and social aspects (pressure, status) are stronger motives than health for constructing and using latrines.	
	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.	

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 step will help you decide which methods would be most appropriate to your needs.

		Example Questions	FR 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)

		Example Questions	FR Method
Environment	Physical	How is water supplied? Are soap, potties etc. 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?)	Community map, Social network analysis
Brains	Executive	Does the audience understand the need for handwashing?	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, Prioritisation game
	Reactive	What cues target the behaviour?	Scripting, Word association
Body	Traits, Physiology, Senses	Do elderly, infirm, young, pregnant, 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? 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? (should be covered in Assess step)	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 mobilised, 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)

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 of the toolkit** for more on intervention design.

Messages for Engagement

It is important to form collaborative relationships with a broad set of stakeholders that may not work specifically on Neglected Tropical Diseases. 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 stakeholders can be approached to encourage engagement in NTD planning and activities.

Audience	What are their interests/ objectives	Problem/barrier
Senior decision makers/politicians at national and district level	Profile and success Cost effectiveness and value for money Response to urgency National development/SDG targets	NTDs not seen as an urgent development issue, making it difficult to engage non-NTD stakeholders in joint planning and delivery
General: Health, WASH and education program managers and implementers (e.g. managers of existing health extension programs)		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.
General: All sector specific stakeholders		NTD actors may not see NTDs as an opportunity that adds value to their own objectives, compared with other opportunities.

What's in it for them	Message	Notes
Being part of disease elimination success Reaching hard-to-reach populations for achieving universal access/coverage Being part of a proven effective programme Positive externalities for other development areas (health systems strengthening, WASH etc)	NTDs affect the poorest and most marginalised areas and communities, and can exacerbate poverty disproportionately among women, children and vulnerable groups. Collaborating will help us target our work towards these areas to reduce poverty and improve development outcomes.	This message can be refined by referring to a specific national goal/ target on poverty reduction, addressing inequalities, gender empowerment, economic growth, educational attainment, etc. You could also target specific known interests of individuals.
	Existing health/ sanitation/ hygiene/ education activities can be strengthened by creating a coordinated health promotion agenda that includes NTDs.	Explain that: NTD contents and expertise can help make existing packages better (by, for example, addressing the determinants of behaviours, creating new innovative tools, etc.); and It is better to have a comprehensive and strong health promotion programme than separate programmes; additionally, the capacity of health promotion staff can be strengthened by the training and learning opportunities offered by the NTD programme.
	The NTD programme can provide an opportunity for new partnerships, influence and potentially, resources.	All sectors need resources, and experience the same challenges of finding new sources of funding or good partners to work with. All sectors want to be able to have influence over the agendas of other sectors. Emphasise the NTD initiative as a platform for new partnerships and a way of increasing inter-sectoral dialogue (for example, WASH NGOs are increasingly seeking opportunities to work with the health and education sectors).

Audience	What are their interests/ objectives	Problem/barrier
WASH service delivery agencies (decision-makers)	Service coverage/access/use (in accordance with national targets); Water safety/quality Sustainability Functionality Progressingf up the WASH 'ladder' - from unimproved-limited-basic-safely managed Increased budget allocation (in many countries, the proportion of the national budget allocated to WASH is frequently lower than 5%)	WASH agencies are not held to account for improving disease outcomes, and may not prioritise working towards a specific disease (and if so, other issues such as diarrhoeal diseases or outbreaks may be seen as more urgent and more immediately linked with inadequate WASH). Institutional responsibility for sanitation and hygiene promotion is often unclear or fragmented, making these issues underprioritised and underresourced. This means that establishing joint action can be difficult. WASH agencies are often resourced by technical specialists/engineers, making dialogue on shared objectives challenging.
WASH service delivery agencies (decision-makers)	Viable effective approaches to behaviour change - to achieve handwashing with soap Funding for behaviour change programme components and access to expertise	There is little expertise in the WASH sector, especially at national level, in design of effective behaviour change programmes There is little funding available Responsibility for delivery for behaviour change interventions is not clear
WASH service providers (District level managers)	Reaching coverage targets Service functionality Effective spending of district WASH resources Improved targeting of services to avoid political pressure	Insufficient resources (financing, staff) affecting capacity to absorb funding Prohibitive costs in hard to reach areas (drilling, parts, roads) Poor functionality of existing services and lack of live functionality data Political pressure at local level to a. serve hard to reach areas or conversly b. direct services according to the wishes of politicians rather than need

What's in it for them	Message	Notes
More resources Reaching hard to reach areas and communities Improved information for planning and delivery Increasing the value of WASH programmes (particularly sanitation and hygiene) in the eyes of communities and politicians Providing a platform for WASH-health integration that can be replicated in other health/nutrition programmes	NTDs affect populations in hard to-reach areas that are complex or expensive in terms of service delivery/infrastructure. NTD programmes provide useful information on where the needs are. Joint planning and advocacy can help leverage more resources and make more effective use of existing resources.	Explain that programming can help target 'expensive' areas more effectively. Use maps to show distribution of NTDs relative to water and sanitation access in endemic areas, to highlight areas of need. Be sensitive about using data that contradicts official coverage figures. Explain that this can also demonstrate multiple outcomes and benefits of WASH and NTDs programmes to politicians. A coherent message to communities also helps demonstrate that programmes are responsive to their needs. When this is achieved, it shows that this type of collaboration demonstrates mutual gaines, and offers an approach for collaboration with other health sub-sectors.
Access to innovative approaches to behaviour change and shared learning Improved behaviour change can lead to more use and sustainability of WASH services Community level entry points such as health outreach, mass drug administration and school-based programmes Producing programme evidence that behaviour change can contribute to achieving elimination Showing that embedding behaviour change in health programmes is possible	NTD programmes provide entry points at community level for health promotion activities that can improve behaviours and use, and enhance sustainability. The emphasis on elimination and the access to private sector collaboration means that NTD programmes are well-positioned and motivated to access expertise and to embed behaviour change in programme delivery	
Being able to state clearly where services should be targeted More effective management processes through the programme	NTD programmes produce information that helps identify and target areas in need, to meet equitable service delivery targets. The reach of the programme can provide 'live' information on service functionality.	

Audience	What are their interests/ objectives	Problem/barrier
Health sector decision makers	Universal health coverage Financing healthcare Health worker training and retention Burden of disease Emerging threats Meeting the objectives of vertical programmes (immunisation, HIV)	The health sector has many urgent priorities and targets; NTDs are one issue among many, and have a low sector profile. It is not immediately obvious that NTDs programmes can contribute to the broader system. The health sector is also trying to reconcile the need for achieving health systems strengthening while delivering vertical programmes with multiple funders
Healthcare service implementers- District Health Officers and District Medical Officers	Responding to health needs of s ervice users Meeting vertical targets (e.g. vaccine coverage) Reliable supply of drugs and health care commodities Staff retention Access to reliable data for interventions Coodinated service delivery Ensuring service quality	NTDs viewed as an additional vertical programme Both WASH and NTDs programmes are delivered by separate institutions and delivery mechanisms NTD continuum of care bteween mass drug administration and care and treatment is fragmented and WASH services are delivered by different institutions
Veterinary public health	Programme coverage, immunisation coverage Improved yield: Livestock survival and growth Disease control Reliable supply of commodities	Animal focus More linked with agricultural extension programmes than healthcare services Professional barriers- different lanuguage/jargon WASH not a priority in veterinary public health programmes Unclear case for impact of WASH interventions on animal health

What's in it for them	Message	Notes
Reducing burden on frontline health workers and volunteers by rationalising their job descriptions around a coherent package of interventions and health promotion components Capitalising on emerging behaviour change approaches to respond to multiple health needs Improving cross-sectoral collaboration for increased efficiency and sustained health outcomes Reaching elimination goal = political capital Enhancing healthcare services in hard-to-reach areas Useful platform for other programmes	WASH interventions do not just respond to NTDs needs; they have a role in improving other health outcomes related to diarrhea, pneumonia and nutrition. NTD programmes offer an effective platform to bring multiple programmes and interventions together to achieve equitable health outcomes and stronger health systems.	
Health needs of the population are being responded to without adding burden onto exisiting resources. Increased coverage of a broader package of services targeted more equitably. More and better data available on health outcomes and interventions District Health Office has oversight of the quality of interventions being delivered throughout the district. Oppprtunity to deliver other interventions through the NTDs platform, such as Vitamin A supplementation	Integrated WASH and NTDs programmes provide platforms for delivering an extensive, equitably-taregted package of preventive and treatment services - allowing more effective use of resources and improved capacity to reach health sector targets.	
Raising political attention to veterinary public health by linking it more closely with human health Increased reach and uptake of veterinary public health services Cost efficiencies Improved animal husbandry practices	Collaboration on WASH and NTDs is crucial to delivering a One Health approach Collaboration on WASH and NTDs offers new opportunities to improve both human and animal health as well as protect livelihoods Collaboration can improve reach and uptake of veterinary public health interventions Collaboration on behaviour change can improve animal husbandry practices	

Audience	What are their interests/ objectives	Problem/barrier
Nutrition	Reaching global targets: childhood overweight, wasting, Stunting, anaemia in women of repductive age, low birthweight, exclusive breastfeeding Universal improvement in nutritional outcomes - everyone, everywhere Delivery of top 10 priority nutrition interventions Delivery of nutrition sensitive programmes	The nutrition sector acts as a sub-sector, and is ofen populated with institutions different to those of the health sector Traditionally poorly-coordinated with the WASH sector Does not have disease-focused objectives Complex multiple determinants and low relative impact of each individual intervention
Education (national level decision makers)	Increase school attendance Improve educational attainment outcomes Closing the gap between girls and boys on both of the above Recruitment and retention of teachers Universal access to free quality primary and secondary education Access to quality early childhood development, care and pre-primary education	Not immediately obvious how NTD programmes can strengthen education, and WASH often seen as a separate infrastructure issue to quality education Education sector not held to account against health outcomes and therefore these are not measured or funded Overburdening of teachers/schools as entry points for multiple and uncoordinated health and gender programme objectives

What's in it for them	Message	Notes
Particular relevance of WASH and NTDs to stunting and anaemia, and additionally wasting and low birthweight Another entry point for promoting healthy behaviours including exclusive breastfeeding and safe feeding Both communtiy and school-based platforms (school health and nutrition programmes an easy entry point for WASH and NTDs behaviour change communication) Dealing with the non-food targets (stunting) Delivering nutrition-sensitive interventions - cordination for achieving interventions that are not the explicit responsibility of the nutrition programme but that help meet nutrition objectives Innovative behaviour change approaches that go beyond nutrition education Stronger link to district programmes (health, WASH, NTDs)	Undernutrition affects the same populations that are affected by NTDs and poor access to WASH. Collaboration can help break the cycle of poor nutrition and target populations and areas with the highest burden. Such collaboration also helps respond to the multiple determinants of undernutrition in a way that makes better use of resources and helps meet population needs.	
Coherent and well-coordinated school health and nutrition programmes (that reduce burden on teachers and provide skills and tools) Alignment of various school modalities (school health clubs, school WASH clubs, disease-specific clubs, parent-teacher association activities) Better health outcomes and related attendance for children Improved reach of out-of-school children Opportunities for effective and innovative behaviour change promotion Funding for school health and behaviour change activities Increasing children's potential for educational attainment	Coordinated and integrated WASH and NTDs programmes delivered at school can improve the health outomes of students and out-of-school children. 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 and strengthening teacher capacity	

Audience	What are their interests/ objectives	Problem/barrier
Education (district level managers)	Enrolement and retention of students School performance ratings of students and teachers Teacher availability and retention Funding for commodities/materials School infrastructure	Limited resources Overburdening of teachers and multiple non-education (health, WASH, nutrition) programme priorities to be delivered by teachers without adequate skills and tools Fragmented school system - district education authorities may not control all schools in their catchment area
Vector control	Disease control by reducing vector breeding Public compliance/ behaviour change at scale Reduce need for insecticide spraying (cost, sustainability/resistance)	Vector control is often joint with malaria control programmes rather than other NTDs, and malaria dominates the political and funding agenda Lack of clarity of the remits of the vector control programme in terms of NTDs Public mistrust in vector control programmes Not valued as much as treatment programmes
Gender equity programmes and initiatives	Women's involvement in planning and decision making of programmes Enabling meaningful participation of women in programme development and implementation Improved access to health services for and by women	NTD programmes viewed as seeing women as a useful entry point rather than genuine stakeholders Other health interventions that have more obvious links to women's health, more immediate need and stronger mechanisms for women's engagement are prioritised
Disability organisations	Development programming that is disability-inclusive Accessible services Meaningful participation by people with disabilties in programme development and implementation	NTD programmes are seen as highly medicalised - not aligned with the social model of disability and a rights-based approach

What's in it for them	Message	Notes
Improvement to inclusive school WASH infrastructure New sources of funding New educational skills and tools New platforms provide a way of advocating for more resources to education Improved school attendance and health of children (and potentially educational outcomes)	Coordination with WASH and NTDs can improve school access to infrastructure and teacher training, by highlighting areas of need. This increase in resource and teaching skills can improve teacher retention, enhance parent trust in the education system, and improve student retention and attainment	
Linking vector control strategies to housing and sanitation Demonstrating additional benefits of vector control for improvement in WASH Improving public compliance with vector control measures Additional entry points for community engagement	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.	
Participation of women in programmes that affect their health Opportunity to educate the NTD sector on gender tranformative programming Improved health outcomes for women	NTDs can disproportionately affect women and girls due to biological and socioeconomic factors. Collaboration and coordination can help ensure a comprehensive response to health outcomes and their determinants. Gender equity focus can increase the uptake of all healthcare services	
Increased access to NTD and WASH services by people with disabilities. Participation in decision making on community programmes. Opportunities to address stigma and exclusion related to NTDs	A collaborative approach on WASH and NTDs can help ensure a comprehensive and equitable response to the needs of persons affected by NTDs	

Initial cross-sectoral meeting for WASH and NTDs: Annotated Agenda

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 NTDs actors and other health, education, and water and sanitation stakeholders. Such a meeting should ideally take place at both national and sub-national levels. The most appropriate sub-national 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 the **Messages for engagement resource (#4)** for guidance on how to engage with these stakeholders

The meeting should be set up as a workshop, and led by an excellent 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 Ministry of Health 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 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 (#5a)
   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.

Objectives of the meeting

1. Discussion of the current programmes and activities in NTDs and other sectors
    - Understanding of the geographic and other focus areas for all stakeholders
    - Understanding of current WASH, NTDs and education* 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 (for example integrating WASH components into NTD programming, incorporating NTD-related behaviour change promotion into existing or new hygiene promotion activities, etc).

*For the education sector, focus on the areas (i.e. health education) that focus on disease control and health promotion within the sector

Preliminary list of potential sectors to consider engaging*:

- → Government agencies (education, sanitation (infrastructure and disposal), water, health, nutrition, strategic monitoring)
- → Agencies working on WASH and NTDs related topics and infrastructure (NGOs, community-based organisations, UN agencies), including infrastructure, treatment, social inclusion and behaviour change communication
- → Communication and behavior change experts
- → Research institutions
- → Corporate businesses involved in WASH provision or corporate social responsibility investments

*When deciding what stakeholders to engage, it is important to think about how each stakeholder will contribute to the objectives above. It is suggested to keep the meeting to no more than 20 participants to ensure an engaged and productive conversation.

WASH and NTD Stakeholders Meeting Agenda

Date

Time	Session	Presenter/Facilitator
ARRIVAL & REGISTRATION		
5 minutes	**Opening Remarks** a. Objectives b. Background	Host
10 minutes	**Official Opening: NTDs and link with WASH and other sectors**	National NTDs Coordinator, MoH/ 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	Continued **Group discussion to list opportunities and activities**	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	▸ 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.	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, emphasising that all stakeholders have something to benefit from increased collaboration.
2. Official opening	▸ Show the prioritisation of the issue by Government ▸ Signal the importance of collaboration and the benefits to all stakeholders, including link to the national development agenda	This can be delivered by the national NTD coordinator, or a high level Ministry of Health or other government official, to lend weight to the meeting and draw participation from all stakeholders
3. Brief informative presentations on NTDs in the country/district and links with other sectors' programmes and goals	▸ 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?	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. **You will need** key statistics on NTDs: endemicity, geographic distribution, key programme information.
4. Brief stakeholder presentations on current programming priorities	▸ 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)	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. **You will need** key statistics on WASH (e.g. sanitation access/ coverage, open defecation, water access, handwashing stations in households, schools, healthcare facilities etc; and key information on current programmes in terms of scale and location. You will also need information on education (school health and nutrition) and health promotion (disease prevention) strategies, current programmes (scale and location) and goals.

Session	Purpose	Delivery
5. Group discussion to list opportunities and activities	▸ Identify short-term, achievable actions with clear responsibilities and timeline. ▸ Discuss and condense proposed activities into a work schedule with clear responsibilities and timeframe	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. 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. 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.
6. Summary and next Steps	▸ Ensure agreement on activities and assign action points.	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.

Cross sector meeting presentation template

This template provides a set of slides to be used in the initial cross-sectoral meeting on NTDs (see **Tool 5 - Cross sector meeting agenda**), with an emphasis on collaboration with WASH stakeholders. The template can be used flexibly, adding or removing slides as needed, and inserting country or local information and images as needed.

To download this tool in PowerPoint format, go to the web version of the toolkit.

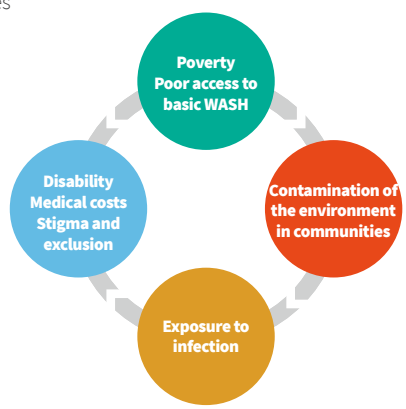
Meeting objectives

- Understand the current programmes and activities in NTDs and other key sectors
- Identify areas of converging interests and areas of work and joint planning opportunities
- Identify specific joint or coordinated activities

Insert additional specific objectives as relevant to your programme. It is important to set out the objectives clearly so that the discussion can focus on the purpose of collaboration and lead to identification of joint action.

What are the NTDs

- Neglected Tropical Diseases (NTDs) are a group of ~20 parasitic, viral, protozoan and bacterial infections that cause substantial illness for more than one billion people in 149 countries
- Affect the world's poorest people
- Cause physical and cognitive impairments, pain and suffering
- contribute to mother and child illness and death
- make it difficult to lead a productive life - vicious cycle of poverty and disease



Source: WHO, 2015

Purpose: Establish the importance of and need for collaboration to achieve shared goals of improved health, equity and growth. NTDs trap the poor in a cycle of poverty and disease, as seen in this diagram:
• Poor people lack access to basic WASH infrastructure
• This contaminates the environment by open defecation, and over use of limited water resources
• Because of the contaminated environment they are exposed to infection
• Infection leads to disability, medical costs, and further deepening of poverty

The WHO list of NTDs

- Buruli ulcer
- Chagas disease
- Chromoblastomycosis
- Cutaneous Leishmaniasis
- Dengue
- Dracunculiasis
- Echinococcosis/ hydatidosis
- Endemic treponematoses (Yaws)
- Foodborne trematode infections
- Human African trypanosomiasis (Sleeping sickness)
- Visceral Leishmaniasis
- Leprosy
- Lymphatic filariasis
- Onchocerciasis (river blindness)
- Rabies
- Scabies
- Schistosomiasis
- Snakebite envenoming
- Soil transmitted helminthiases
- Taeniasis/ cysticercosis
- Trachoma

Neglected Tropical Diseases in [country]

- <<insert: map, table, graphs with endemicity data>>
- Insert NTD master plan/ other related health strategies
- Relevant indicators in the Health Management Information System MIS

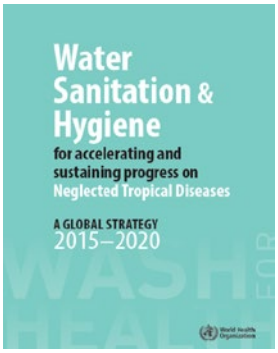
Priority NTDs in [country]

How are they transmitted? What do they cause?

- Slide for each disease with an image, areas of the country where it is endemic, the main control strategy
- NTD programme priorities

Depending on the level of knowledge and the time allocated for the meeting, you may want to include details on the disease/s being discussed to ensure that the problem that requires addressing is clear. It is also important to take the opportunity to clarify any misunderstandings about the way in which the disease is transmitted, and emphasise any additional aspects for which WASH is important (such as stigma reduction, self-care, WASH in healthcare settings and so on).

Global strategies and policies



Source: WHO, 2015

The World Health Organization defined a global roadmap for NTD control and elimination in 2012, with specific targets to be achieved by 2020. In 2015, WHO published a global strategy on WASH and NTDs, to support the delivery of WASH as one of five key strategies to combat NTDs.
This global policy framework acknowledges the crucial role of WASH in fighting NTDs and provides the mandate for close collaboration.

Rationale for WASH-NTD coordination

Source: WHO, 2015

Make the case for NTDs: equity and inclusion, economic and development impact; and the case for collaboration – what do actors gain from working together?
The WASH and NTDs sectors share clear common goals. Both sectors aim to sustainably improve the health and prosperity of people living in poverty, as outlined in the Sustainable Development Goals. Success for both sectors relies heavily on creating access to water and sanitation, and ensuring sustainable usage for hygiene and disease prevention.

Double link between WASH & NTDs

→ Prevention:

- Access & use of sanitation
- Safe water supply (drinking & hygiene)
- Water source, wastewater & solid waste management
- Hygiene practices

→ Treatment & care:

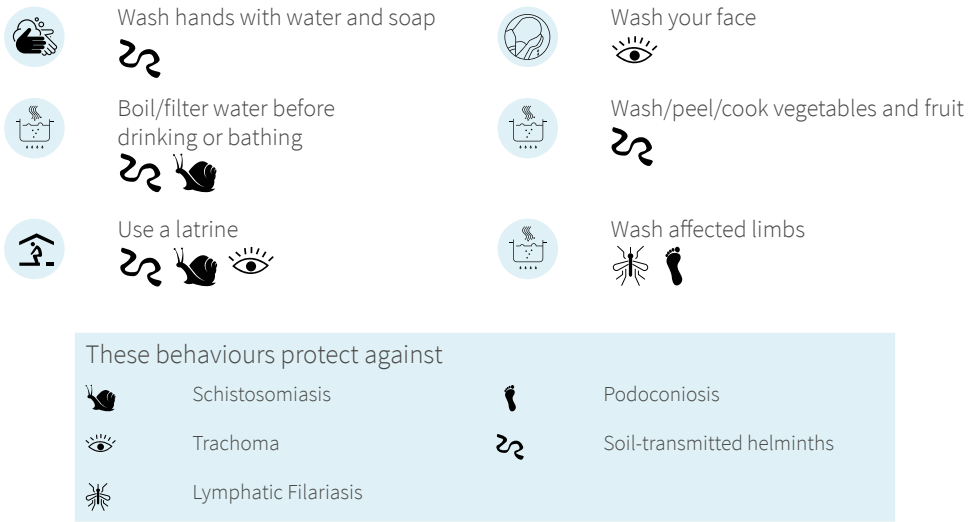
- Water for facility-based & self care
- Hygienic conditions for surgery
- Accessibility of WASH services for people with impairments/ carers
- Prevention of stigma-based exclusion

Priority NTDs in [country] and their link with WASH

Disease	WASH for transmission control	WASH for treatment & care
Yaws	✓	✓
Leprosy		✓
Lymphatic filariasis	✓	✓
Schistosomiasis	✓	
Soil-transmitted helminths	✓	
Trachoma	✓	✓

<<Insert simplified table depending on your country's disease profile>>

WASH Behaviors to prevent NTDs



Some of the key WASH related behaviors that prevent neglected tropical diseases are washing hands and faces with water and soap. These, as well as use of latrines, are key behaviors for preventing the two most prevalent diseases- Soil transmitted helminths and Trachoma. Other behavioral change elements including boiling or filtering water for drinking or bathing, safely handling fruit and vegetables, and washing affected limbs.

Access to safe water supply in [country]

- <<insert relevant statistics, maps and graphs detailing access to safely managed, basic (improved) and unimproved drinking water in the country>>
- <<If possible, include trends in access over time, and information on disparities between different parts of the country and/or rural and urban areas>>.
- <<Highlight any areas where low access to water supplies and disease prevalence coincide>>

Purpose: Increase understanding by stakeholders of the type of work carried out by others, and considerations that inform this work.
Identify areas of programming overlap as well as service/coverage gaps in endemic areas. What do actors bring to the table? What would be needed to work together?

WHO-UNICEF Joint Monitoring Programme definitions for water services under SDG6

Service level	Definition
Safely managed	Drinking water from an improved water source that is located on premises, available when needed and free from faecal and priority chemical contamination
Basic	Drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing
Limited	Drinking water from an improved source for which collection time exceeds 30 minutes for a round trip, including queuing
Unimproved	Drinking water from an unprotected dug well or unprotected spring
Surface water	Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal

This slide provides definitions on water service levels to inform the discussion. It may not be required for the presentation during the meeting.

Access to sanitation in [country]

- <<insert relevant statistics, maps and graphs detailing access to safely managed, basic (improved) and unimproved sanitation, and open defecation, in the country>>
- <<If possible, include trends in access over time, and information on disparities between different parts of the country and/or rural and urban areas>>.
- <<Highlight any areas where low access to basic (improved) or safely managed supplies and disease prevalence coincide>>

WHO-UNICEF Joint Monitoring Programme definitions for sanitation services under SDG6

Service level	Definition
Safely managed	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite
Basic	Use of improved facilities that are not shared with other households
Limited	Use of improved facilities shared between two or more households
Unimproved	Use of pit latrines without a slab or platform, hanging latrines or bucket latrines
Surface water	Disposal of human faeces in fields, forests, bushes, open bodies of water, beaches or other open spaces, or with solid waste

This slide provides definitions on sanitation service levels to inform the discussion. It may not be required for the presentation during the meeting.

Access to handwashing facilities

<<Insert data if available (some countries monitor proxy indicators for handwashing with soap, such as presence of a handwashing facility with soap and water in or near the latrine, in household surveys)>>

WHO-UNICEF Joint Monitoring Programme definitions for hygiene services under SDG6

Service level	Definition
Basic	Availability of a handwashing facility on premises with soap and water
Limited	Availability of a handwashing facility on premises without soap and water
No facility	No handwashing facility on premises

Note: *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.*

Access to water and sanitation services in institutions

<<If available and relevant to the NTD programme, include information on access to water and sanitation facilities in schools and healthcare settings>>

Key WASH programme priorities and strategies

<<Outline:

Any national WASH goals and targets

Relevant national strategies and plans

The main government-led and/or donor supported WASH programmes in the country – scale, location and priorities>>

Other Sector Involvement

Education- School Health and Health Promotion- Disease Prevention

Key education programme priorities and strategies

<<<Outline:

Any school health targets and goals

Relevant national strategies focusing on school health (in particular health education) and plans

The main government-led and/or donor supported school health programmes in the country – scale, location and priorities>>

Key health promotion programme priorities and strategies

<<Outline:

Any health promotion (disease prevention) targets and goals

Relevant national strategies focusing on health promotion (in particular disease prevention -highlight NTDs if existing) and plans

The main government-led and/or donor supported health promotion programmes in the country – scale, location and priorities>>

Group work or plenary discussion

- Discuss and agree cross cutting priorities
- Discuss and agree challenges to collaboration that should be addressed
- brainstorm opportunities for stakeholder collaboration
  - Coordination structures that can be enhanced
  - Forthcoming policy review or planning processes
  - Existing programme activities that can be used as entry points
  - New grant opportunities
- Brainstorm 3-5 short-term potential activities

Purpose: Identify short-term, achievable actions with clear responsibilities and timeline.
Discuss and condense proposed activities into a work schedule with clear responsibilities and timeframe.

Activity plan

Specific acivities	Responsible for implementation	By when	Support from MoH	Potential barriers for implementing the activity	Ways to overcome the barriers	Outcome

This activity plan should focus on short-term, doable actions, with the purpose of creating positive momentum for collaboration. Activities that are too ambitious or unlikely to be delivered should be discussed but possibly carried through to more advanced planning stages.

Next Steps

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.

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 programming and activities. This is a first step to developing a joint programme approach to address NTDs at country level, and will need to be followed by district-focused analyses to understand the partners, resources, and existing WASH, NTDs and other relevant activities taking place locally before developing a detailed implementation plan that involves all key stakeholders. The national level assessment will analyse national 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 care, control and elimination.

Situation Analysis for WASH and NTDs planning: protocol and methods

How WASH is defined in this situation analysis.

Investment in sustainable water and sanitation infrastructure is critical to development and equity. Tapping into local knowledge from the government and understanding community needs and preferences are important steps to determine the most suitable type of infrastructure and behaviour change WASH 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)

This can be achieved through various mechanisms and interventions including:

- Developing social norms on cleanliness and hygiene practices/habits driven by community dialogue.
- Capacity building and infrastructure development around water and sanitation (ie: construction, use, sustainability, and management)
- Development of tailored hygiene programmes that serve to integrate and/or coordinate with existing NTD and other relevant health or WASH programmes.

→ Key steps

1. Identify analysis team
2. Identify and formally involve key stakeholders
3. Collect information
    I. Demographic Information
    II. Disease information
    III. WASH information
    IV. NTDs and WASH Coordination Information
    V. Behavior Change Tools and Approaches
    VI. Advocacy
4. Analyse
5. Recommend
6. Report

1. Identify analysis team

This is a recommended core group to be included in the overall situation analysis team. The team should include members with NTDs, WASH, Social and Behavior Change Communication (SBCC), and public health/epidemiology expertise, representatives from current programme and coordination structures, etc.

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 County background and any other full reviews or analyses done to date:]

Key tasks:

- Present a broad, national perspective on current WASH and behavior 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, sub-national), gap analyses 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;
   - Other national, regional and/or district level formal WASH groups or organizations; and
   - Organisations/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 Program stakeholder input/feedback into a Situation Analysis Report to be submitted to [AGENCY NAME] and [lead national-level Ministry].

2. 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 of NTDs in the country is discussed with key stakeholders to seek their involvement and advice. Effort 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.

See **Messages for engagement (#4)** for details

Key types of stakeholders to involve:

- NTD and WASH government programme leads from the health, water and education sectors (including Ministry of Health 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
- Organisations involved in developing and implementing behaviour change programmes (government, academic or private)

3. Collect information

A robust Situation Analysis requires information on disease distribution, services (WASH, health, education), existing programmes, governance and coordination, financial resources, human resources, the policy environment, and all other relevant aspects that influence the design and implementation of the programme. This section provides detailed questions for collecting this information as a basis; however, the Analysis Team should be aware of any additional context-specific aspects for which additional detail is required, and should adapt this protocol to capture all relevant information.

Useful information sources:

- Aqueduct Atlas- Water Risk. http://www.wri.org/our-work/project/aqueduct/aqueduct-atlas
- CIA World Factbook. www.cia.gov/library/publications/the-world-factbook/
- Global Atlas of Helminth Infection. www.thiswormyworld.org
- NTD Mapping Tool. http://www.ntdmap.org
- Trachoma Atlas. www.Trachomaatlas.org
- USAID, Measure Demographic Health Survey Report (DHS). www.measuredhs.com/. (WASH information usually found on Chapter 2 – Household Environment)
- WHO, World Health Statistics. www.who.int/healthinfo/EN_WHS2012_Part3.pdf
- WHO/UNICEF Joint Monitoring Program (JMP) for Water Supply and Sanitation. https://washdata.org/
- WHO Preventive Chemotherapy Databank: historical data on mass drug administration. http://www.who.int/neglected_diseases/preventive_chemotherapy/databank/en/

I. Demographic Information

1. How many districts (or equivalent) in your country are considered 'endemic' for NTDs? What is the total population of these districts? Attach a table or map of endemic districts showing the population of each, and percentage of the population defined as rural, peri-urban and urban (include the national definitions of rural, peri-urban and urban populations).
2. Provide additional demographic information for endemic districts or regions:

- number of children under 5
- number of school-age children
- percent of boys, girls, and all school-age attending school

3. What is the adult literacy rate? If possible, by district or region.
   - Total _____ Male _____ Female _____

II. Disease information

1. Populate the table below with prevalence of disease for which mass drug administration programmes are being delivered, treatment coverage, including year in which data were collected.

District	Diseases	MDA (%)
District X	LF	
	Onchocerciasis	
	Schistosomiasis	
	STH	
	Trachoma (TF)	

2. Provide prevalence and programme information on endemic NTDs, including
   a. Community- and facility-based morbidity management
   b. Social inclusion and stigma prevention
   c. Vector-borne control programmes
   d. Veterinary public health interventions for zoonoses control
   e. Non-MDA interventions for diseases mentioned in QII.1*

Disease [delete as necessary]	Endemic districts [include suspected]	Prevalence/ incidence/ cases	Programme & coverage
Buruli ulcer			
Chagas disease			
Chromoblastomycosis			
Dengue			
Dracunculiasis (Guinea worm)			
Echinococcosis/ hydatidosis			
Endemic treponematoses (Yaws)			
Foodborne trematode infections			
Human African trypanosomiasis (Sleeping sickness)			
Leishmaniasis (Visceral/ cutaneous)			
Leprosy			
Lymphatic filariasis			[* disease management, inclusion, vector control]
Onchocerciasis (River blindness)			[* Vector control, inclusion, addressing impairment]
Rabies			
Scabies			
Schistosomiasis			[* WASH, snail control]
Snakebite			
Soil-transmitted helminthiases			[*WASH]
Taeniasis/ Cysticercosis			
Trachoma			[*Surgery, WASH]

III. WASH information

1. Detail the proportion of the population in each endemic district that has access to improved drinking water sources and sanitation facilities, and handwashing facilities (with water and soap present at the time of assessment). Include nationally-agreed definitions of "improved water" and "improved sanitation" and state information source and date[1] (if multiple access assessments have been done, include figures from all these assessments). Available maps should be included as an annex.

    a. Community/household WASH data

District	% Access to improved water*	% Access to improved sanitation**	% Population practising open defecation	% households with handwashing facilities (of which % with soap and water)

Definitions (WHO/UNICEF Joint Monitoring Programme on Water and Sanitation):
* Improved water sources include: 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. An improved source should be accessible on premises, water should be available when needed, and the water supplied should be free from contamination.
** 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.

1 Acceptable information sources include national WASH sector performance reports, Demographic and Health Surveys, Multi-cluster Indicator Surveys, census, and other nationally-verified assessments. Data should be as up to date as possible, and not older than two years.

b. Institutional WASH data: Include any available information at district level on:

iii. Type/level of healthcare facilities (health post, primary health centre, district hospital) and WASH services within those facilities as relevant (type and reliability of water supply, handwashing facilities, adequate toilets for staff and patients, or any other nationally-set criteria)

iv. Level of schools (primary, secondary) and WASH services within those schools (type and reliability of water supply, handwashing facilities, separate and adequate toilets for boys, girls and teachers).

2. Provide additional information on the local context useful for planning purposes, such as population densities around water sources, drought risk and frequency, population mobility (e.g. nomadic/pastoralist populations, cross border movement, seasonal migration, areas experiencing waterborne disease outbreaks in recent years, specific farming practices that raise transmission risk, etc).

3. What is the current framework used to assess the performance of the WASH sector (for example, a Sector Performance Monitoring Framework?) What are the indicators used for this purpose? What are the components of the framework (e.g. annual reviews, reports, etc)?

4. Include information from formative research[2] on sanitation and hygiene behaviour (such as hand washing and latrine use) conducted in the past five years in the country/endemic districts. List all available online research reports, or obtain and review unpublished materials. Include any information on knowledge, attitudes or practices captured in existing WASH Sector Performance Monitoring Frameworks and reports.

IV. NTDs 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).

1. Describe the NTD Coordination Team(s) or Task Forces that support the design and implementation of the NTD Master Plan at national, district, and sub-district levels – including Terms of Reference, leadership, membership, meeting frequency, planning schedules and

2 Formative research is research undertaken prior to the design of programme materials to describe existing practices and their context, as well as the motives and perceptions that underlie these practices.

funding sources. Identify any gaps and challenges in the current structure. Include any relevant organizational diagram showing the coordination structure. Specify whether any WASH and behaviour change stakeholders are represented within these structures, and whether WASH and behaviour change are included in the roles and responsibilities of the group.

2. Describe the WASH coordination structures from national to community level, including sector and technical working groups, and their leadership, membership, meeting frequency, planning schedules and funding sources. Identify any gaps and challenges in the current structure. Include any relevant organizational diagram showing the coordination structure. Specify whether any NTD stakeholders are represented within these structures, and whether NTDs are included in the roles and responsibilities of the group. Specify whether the group/s include any stakeholders working specifically on behaviour change, and whether behaviour change forms part of the group's responsibilities.

3. If available, include a country-level map or document that describes what WASH, hygiene or sanitation interventions are taking place in each region of the country.

   Use the **WASH NTDs partner form (#7).**

4. Describe the distribution and level of WASH staff (district, sub- district, village, etc.), e.g. District WASH Office, technical support units etc. Does the Ministry of Health (or another ministry/ agency) have WASH staff/environmental health staff support at various levels (district, sub-district, village etc.)? Outline their roles and responsibilities.

5. What is the structure of the national education system from Ministry of Education to primary schools?

6. Is hygiene education included in the national primary school curriculum and does it include any personal hygiene aspects? Are teachers trained to deliver this content and is it currently being implemented? Do schools regularly form school health clubs or similar initiatives? When is the primary school curriculum scheduled to be revised?

7. Are there any other stakeholders that have not been involved in the situation analysis and that may be able to contribute to and implement NTD programmes? How can they be brought into NTD programme planning and implementation?

V. Behavior Change Initiatives, Tools and Approaches

1. Are there any ongoing WASH-related Social and Behavior Change Communication campaigns or initiatives that are being conducted at the national, district or sub-national level with which NTD-related messages could potentially be linked? Include any of the following:

    a. School-based programming

    b. Community-based programming

    c. Mass media approaches

    d. Social marketing approaches

    e. Community Led Total Sanitation

    f. Use of health outreach programmes

    g. Behaviour change materials used during NTD MDA campaigns

Intervention and Description	Target/ Audience	Who delivers it

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

    a. What materials are available at district/school level for hygiene/sanitation promotion?

    b. Are these materials available to key stakeholders that implement NTD programmes?

    c. Who in the Ministry of Health is responsible for development and distribution of communication materials on NTDs and/or WASH?

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

3. Provide a description of the quality and effectiveness of existing tools. *NB: Quality of tools and messages should be assessed by a trained health communication specialist to determine whether they have been developed in-line with social and behaviour change communication standards that include (but are not limited to) measures of a) technical accuracy, b) presentation of actionable information, c) literacy and cultural considerations, d) a specified call to action, e) encouraging social dialog, f) dispelling myths/rumours, g) ensuring that messages are consistent throughout materials (and with communication strategy, if available), h) that graphical elements are consistent among materials, and i) that it is clear which target audiences the tools or messages are intended for.*

4. What are the main media channels in the country and endemic districts? This may be presented in a table by region/district and nationally:

    a. Radio stations that broadcast in each trachoma endemic district/region or nationally.

    b. Percent of people listening to the radio at least once a week by sex, age, district/region

    c. TV stations that broadcast in each endemic district/region or nationally.

    d. Percent of people viewing TV at least once a week by sex, age, district/region

    e. Percent of people who read at newspaper at least once a week by district/region.

    f. Percent of people who own mobile phones by age and sex and district, if possible

    g. Provide a mobile phone network coverage map, showing the major mobile phone providers coverage by district

    h. What other local media is used in the districts (eg. town criers or “walking radios”, film/video halls, drama groups, etc.)?

VI. Advocacy

Both NTD and WASH stakeholders undertake advocacy to maintain these sectors on the national development agenda and mobilise the necessary 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. This section enables gathering background information for the later development of advocacy strategies.

1. Describe the level of priority given to NTDs and WASH within
    a. The national development agenda
    b. Domestic resource allocation
    c. National health strategy and plan
    d. External funding
2. What other initiatives compete for funding and political influence? Please describe those you see in action at the a) household, b) community, c) district/state, and d) national levels. Can these initiatives serve as potential allies?
3. 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?
4. Do current NTD and WASH plans have advocacy objectives, and how are these being monitored?
5. 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?
6. Who are the primary decision makers influencing WASH at the national regional and community levels?
    a. Have these decision makers been approached to collaborate with NTD efforts? Have these efforts resulted in successful engagement? If not, what are the reasons?
    b. Are these decision makers currently involved in NTD initiatives?
7. What are some potential joint advocacy objectives for an integrated WASH/NTDs initiative?

4. Analyse

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 gathered from interviews is verified, contextualised and objectively presented. The analysis should include:

1. Key issues underpinning disease prevalence and programming in the country:

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

2. Who are the primary and key implementation actors? Based on the available mapping exercises where are the priority intervention areas?
3. What are the key coordination overlaps, synergies and gaps? Identify the barriers and gaps that need to be addressed through the planning process in terms of financial and human resources, availability of approaches/tools, governance and coordination structures, as well as challenges specific to particular endemic areas (e.g. geography, culture, population density and movement, political instability etc.).
4. Are there aspects on which information/formative research is still required?

5. Opportunities: Provide clear set of the existing entry points and gaps, and their implications for programme design to inform the recommendations.

5. Recommend

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.

6. 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 (#8)** and **Situation Analysis presentation template (#9)** useful, as both can be used effectively in the next phase of the joint planning process.

WASH NTDs partner form

Instructions

For ease of use, please download the Microsoft Excel version of this tool from the web version of this toolkit.

Type of Information	What does this spread sheet include?	Notes
Adminstrative	Region	Be consistent with spelling of regions
Adminstrative	District	Be consistent with spelling of districts
NTD	Disease	Include all NTDs that are endemic in that district (one disease per row)
NTD	Endemicty	The level of prevalence of the NTD- be consisent (i.e. if for
NTD	NTD Partner	The name of the NTD partner working on the specific disease in that district (there can be multiple NTD partners per district as it depends on the disease)
WASH	WASH Partner Name	The name of any WASH partners (N/A if no WASH partner present)
WASH	WASH Activity	For each WASH parnter entered, select (broadly) which type of activity they are doing. Options include Community Intiatives (women's groups , sanitation/health clubs, micro finance, etc), education (school programming), infrastructure, behaviour change, social marketing, mass media, water managment and other. If they are doing multiple activities - include all separated by a comma.
WASH	% Access to improved water*	This should be at district level. If your country does not collect this indicator then please update the field and define the indicator.
WASH	% Access to improved sanitation**	This should be at district level. If your country does not collect this indicator then please update the field and define the indicator.
WASH	% Population practising open defecation	This should be at district level. If your country does not collect this indicator then please update the field and define the indicator.
WASH	% households with handwashing facilities (of which % with soap and water)	This should be at district level. If you country does not collect this indicator then please update the field and define the indicator.

Definitions (WHO/UNICEF Joint Monitoring Programme on Water and Sanitation)

* Improved water sources include: 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. An improved source should be accessible on premises, water should be available when needed, and the water supplied should be free from contamination.

** 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.

Region	District	NTD	Prevalence	NTD Partner	WASH Partner Name	WASH Activity (1. Community Iniatives, 2. Education, 3. Infrastructure 4.Behaviour Change, Social Marketing, Mass Media, 5. Water Management, 6. Other)	% Access to improved water	% Access to improved sanitation	% Population practicing open defecation	% households with handwashing facilities (of which % with soap and water)

Situation analysis executive summary template

Situation analysis executive summary template

*NB: include all relevant tables, graphs and maps where appropriate

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:

Theme	Key problem/challenge to address
Behaviour	▸ (e.g. poor hygiene practices – lack of handwashing with soap, lack of face washing, lack of shoe wearing) ▸ (e.g. bathing, swimming and laundry in surface water)

Theme	Key problem/challenge to address
Environment	▸ (e.g. Lack of access to and use of toilets; Vector breeding near/in poorly managed water sources; Poor maintenance of sanitation facilities)
Social inclusion	▸ (e.g. Stigma-related exclusion from water sources (e.g. for people affected by certain NTDs))
Treatment and care	▸ (e.g. lack of reliable water supply in healthcare facilities providing surgical interventions; lack of water for self-care)

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 utilised)

Recommendations

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2. .....

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Situation analysis presentation template

This presentation uses data from Ethiopia by way of illustration. For a PowerPoint version of this template, please go to the web version of the toolkit.

Purpose

What are the objectives of the analysis?

What process is it linked to and how will the findings be used?

Analysis team and methods

Workshops

Document review

Interviews

Field visits

Constituencies of stakeholders involved in the analysis (government, NGO, specific sectors etc)

Key areas and topics of investigation

Key findings

Demographic information

Population data:

- → Tables or maps of endemic districts and populations
- → Table/map of urban/peri urban/rural populations

Demographic information:

- → number of children
- → school attendance
- → literacy rates

Neglected Tropical Diseases

Maps/tables/graphs with endemicity data

District	Diseases	MDA (%)
District X	LF	
	Onchocerciasis	
	Schistosomiasis	
	STH	
	Trachoma (TF)	

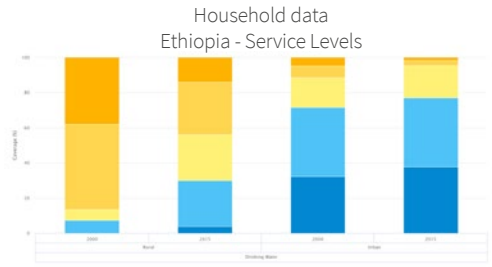
Diseases	Endemic districts	Prevalence/ incidence/ cases	Programme & coverage

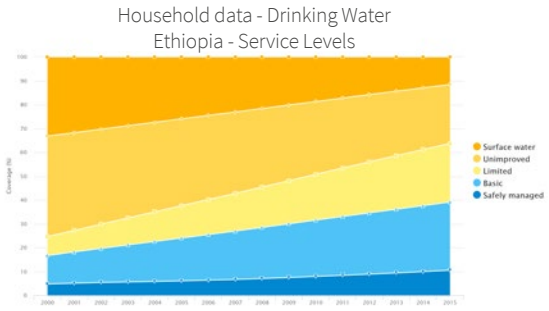
Ethiopia has one of the highest burden of Neglected Tropical Diseases (NTDs) in Africa. For instance 30% of the global trachoma burden lies within Ethiopia.

NTDs have been included in the country's Health Sector Transformation Plan, and a five year NTDs Master Plan has been developed by the FMoH to tackle this problem. There are regular drug administration campaigns, but for sustainable prevention of the disease, the root causes of those diseases need to be addressed, by allowing access to adequate water sanitation and hygiene, and by creating awareness for behavioral change and disease prevention activities. Therefore, the 2016-2020 master plan calls for a holistic approach and integration with other relevant sectors.

Access to safe water supply

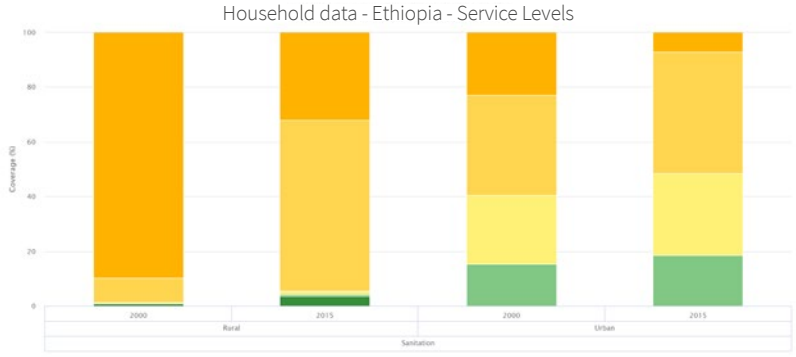
Insert JMP ladders





Access to sanitation in [country]

JMP ladder



Hygiene practices

JMP ladder if available

Plus any information from previous formative research

District	% Access to improved water*	% Access to improved sanitation	% Population practicing open defeacation	% households with handwashing facilities

WASH in healthcare facilities

If data available. Use JMP example.

WASH in schools

If data available. Use JMP example.

Key risk factors and populations of interest

Coordination

NTDs coordination structure [include organogram]

WASH coordination structure [include organogram]

Joint WASH NTDs initiatives so far if any

How WASH/NTDs currently included in education programme, health programme

Partner mapping

Include map, or findings in terms of gap areas – where is there need but investment is lacking? Frame as 'opportunity for engagement'

Behaviour change tools and approaches

Table summarizing current initiatives and approaches (include summary only)

Key media channels

Gaps and issues with current approaches in relation to WASH and NTDs

Advocacy

Challenges for WASH and NTDs collaboration/integration

Barriers and gaps:

- Financial resources
- Human resources
- Availability of approaches/tools
- Governance and coordination
- Challenges specific to particular endemic areas (e.g. geography, culture, population density and movement, political instability etc.).

Key issues underpinning disease prevalence and programming in the country

Theme	Key problem/challenge to address
Behaviour	
Environment	
Social inclusion	
Treatment and care	

Opportunities

Technical (e.g. features of existing or planned progress 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 utilised)

Recommendations

Next Steps

Open the floor for discussion here the bureau deputy head on how this coordination and collaboration can be endorsed and promoted by the RB.

Problem analysis approaches

There are many simple approaches developed to help planners analyse problems in a way that identifies root causes and provides the starting point for solutions. This tool provides a basic overview of three of these approaches.

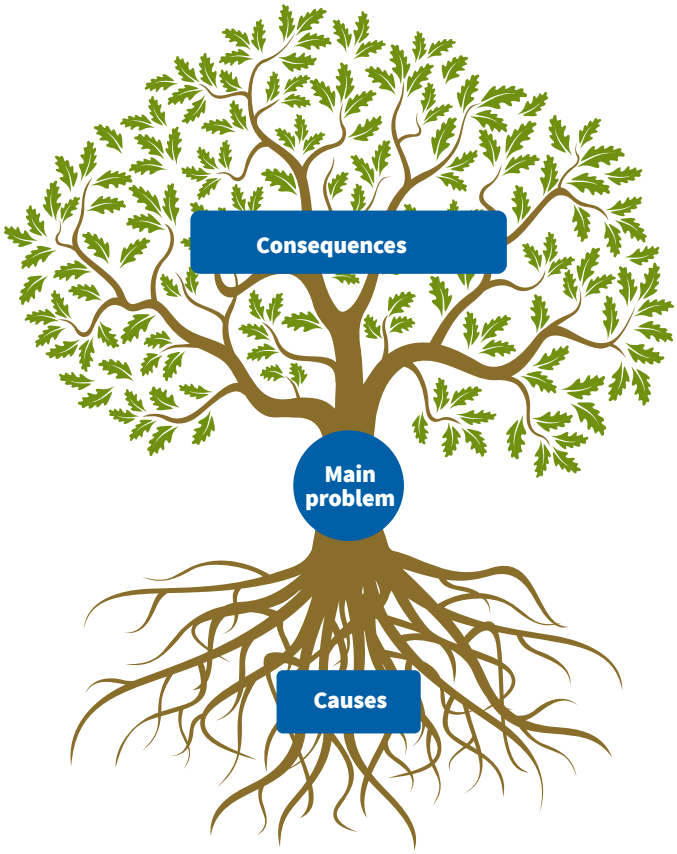
Tips:

- → all these approaches work best in a small group setting (six to eight people), and with good facilitation to ensure consensus on the root causes
- → make sure participants have the necessary basic knowledge required to understand the problem and its context
- → avoid over-simplifying the problems at hand; problems may have complex and interrelated causes, which these approaches should help you explore
- → when using the 'problem tree' and 'fishbone diagram', make sure you have a large space/paper on which to capture all the potential root causes

Problem-analysis approaches

1. The Problem Tree

The problem tree is a visual method of analysing a problem. The tree maps the links between the main issue and its resulting problems, as well as its root causes, helping to find a solution in a structured way. In this way, the process helps to question assumptions, break down the problem into manageable pieces, improve the understanding of the problem for developing solutions, and prioritise consequences and actions. It also helps to build shared understanding, purpose and action, which are crucial for planning processes involving multiple agencies and sectors.



Key steps:

- **Step 1:** discuss and agree the main problem/concern and write it in the centre of a large flip chart (trunk).
- **Step 2:** Add the causes of the main problem onto the chart below the main problem, with arrows leading to the problem (primary roots).
- **Step 3:** For each of the causes, write the factors that lead to them, again using arrows to show how each one contributes (secondary roots).
- **Step 4:** Draw arrows leading upwards from the main problem to the various effects/ consequences of the main problem (branches).
- **Step 5:** For each of these effects, add any further effects/consequences (leaves).

(*Make sure to list all solutions, concerns and decisions on separate paper, to inform the rest of the planning process).

Resource: ODI planning tool: Problem Tree Analysis. https:// www.odi.org/publications/5258-problem-tree-analysis

Tip

Rephrase the problem/s into positive desirable outcomes to convert root causes and consequences into root solutions and establish actions and entry points.

2. Five 'whys'/ Root Cause Analysis

Initially developed by the Toyota Corporation to optimise its manufacturing process, this method relies on interrogating a problem or an event to identify cause and effect. It is a simple method that involves asking 'why' or 'what caused this problem' repeatedly to arrive at further causes, with each 'why' prompting another. The method assumes that 'why?' needs to be asked around five times to arrive at the root cause. The root cause should point toward a process or behaviour that are failing or missing, and that can be changed through action (i.e. it cannot be a factor beyond the control of the programme, such as the climate or the political regime). Aside from helping to identify and address the root causes, this approach also helps identify interim opportunities, at each 'why' level, to intervene and address problems, especially if the root cause is difficult to address in the short term.

Key steps:

- → Agree and clearly state the specific problem
  - e.g: WASH activities were not included in the NTDs annual plan
- → Discuss: why did the problem happen? Record the response.
  - e.g. government WASH stakeholders did not participate in the last NTD planning process.
- → To determine if the response is the root cause of the problem, ask: "If this response were corrected, is it likely the problem would recur?" If the answer is yes, it is likely this is a contributing factor, not a root cause.
  - e.g. even if the WASH department/ministry participated in the planning process, activities would not have been included in the plan – i.e. the lack of participation is a contributing factor but not a root cause.
- → If the answer provided is a contributing factor to the problem, the team keeps asking "Why?" until there is agreement from the team that the root cause has been identified.
  - why did the WASH stakeholders not participate in the meeting?
    Response: the meeting was not in the planning schedule of the department.
  - why is it not part of the planning schedule?
    Response: because the department is not accountable to contributing to NTD goals.
  - why is the department not accountable to contributing to NTD goals?
    Response: because NTD progress indicators are not part of the accountability framework of the WASH sector.

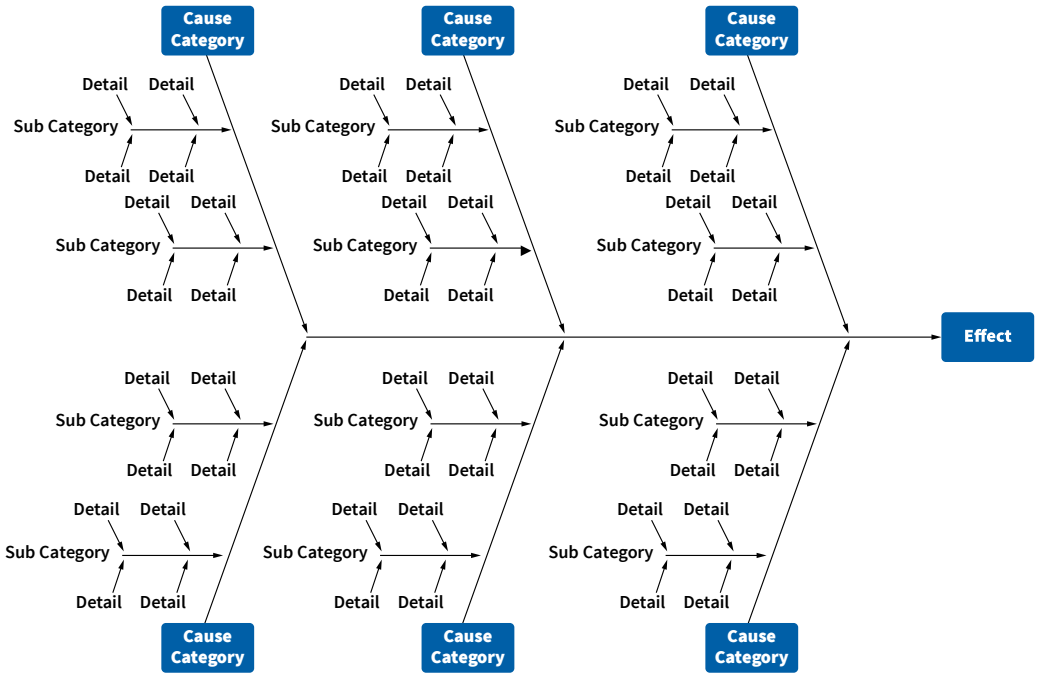
It can take three to five 'whys' to get to the root cases, but it can take even more depending on the complexity of the issue. The team should keep going until it agrees the root cause has been identified. In the above example, the root cause identified by the team is the lack of shared indicators, resulting in lack of incentives for the government WASH departments to get involved in NTD planning. If the NTD department tried to address the problem by sending information on the planning meeting to the WASH department, the root cause would not be identified or solved.

3. The Fishbone analysis

The fishbone analysis, or diagram, can also be used in a group setting to identify the root causes of a specific problem, and builds on the 'five whys' method to help organise multiple root causes under specific themes or problem areas to illustrate and/or communicate the relationships among several potential (or actual) causes of a problem.

Key steps:

- Agree the "head": The diagram can be used in two ways:
  - Negative consequence: With a problem as the "head" of the fish
  - Positive: With the goal or target of the process as the "head" of the fish
- Using a long sheet of paper, draw a line horizontally along the page (the "spine" of the fish). At one end of the line, add the problem or goal as the "head" of the fish.
- Draw lines coming out of the spine at an angle – the "bones" of the fish. At the end of each line, write a category of causes that lead to the problem (negative consequence) or the target (positive consequence). These could include: processes (coordination, planning), human resources, inputs (e.g. financial resources), policies, procedures, etc.



credit: http://www.change-management-consultant.com/fishbone-diagram.html

- Brainstorm: Discuss each category of causes: how does each one impact the effect? For example, how do human resources affect the achievement of the effect, or undermine it? Use the 'five whys' method described above to describe the problem and root causes under each category, creating sub-categories as needed.
- Discuss the details of each sub-category: for example, under human resources, you may list training, skills, recruitment and retention issues. Note: problems that come up frequently at this stage, or that have a major impact, may need to be turned into a specific category and therefore have their own separate "bone".
- List all points under each sub-category. When doing this, consider which issues have the biggest possible impact on the final result. Looking at the diagram together, circle anything that seems to be a root cause. Prioritise the root causes.
- Use the priorities to inform the rest of the planning process, turning them into actions to include in the activity plan.

Planning tool: developing comprehensive and adaptive NTD programmes

Planning tool: developing comprehensive and adaptive NTD programmes

Purpose: This tool is designed 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 to reach your shared vision.

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.

Step-by-step planning process

BEFORE A PLANNING WORKSHOP IS ORGANISED

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 in order 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 of the toolkit.** The 'products' of this process – the report, executive summary and the presentation, will serve as the starting point for 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 behavior 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.

Setting up the planning process:

- **Assign a meeting facilitator:** good facilitation is crucial for a successful planning meeting. 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 should have a general grasp of the main issues discussed – at least a familiarity with public health and with the country's development sector.

- The facilitator should have a firm grasp of the content of the situation analysis and the objectives of the meeting, 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 the analysis chapter and pull out key information for presentation at the planning meeting:

a. What are the key coordination overlaps, synergies and gaps?

b. Who are the primary and key implementation actors?

c. Based on the available mapping exercises, where are the priority intervention areas? Use the **WASH/NTDs partner form (#7)** to collect sufficient detail.

d. Are there aspects on which information/formative research is still required?

e. Key issues underpinning disease prevalence and programming in the country.

f. what are the key opportunities identified in the Situation Analysis?

- Identify as many existing interventions, tools and entry points described in the situation analysis, and pre-populate Table 2 (see Step 2, “Synthesise”).

→ **Agree the agenda:** Review the **Agenda for joint planning workshop (#12)** and insert/modify relevant content for discussion based on the situation analysis findings.

→ **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, the number of sectors involved (e.g., health, agriculture and education) and the extent of decentralisation in those sectors (e.g., operating at national, regional, district and/or village levels).

Facilitator 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.

It may be useful to contact as many stakeholders as possible and ask key questions to understand the stakeholders involved and in order to set the level of information to be shared during the meeting: a. Goals and objectives of institution/organisation b. Key Intervention/activity areas; c. their level of understanding of NTDs; and d. What are their key performance indicators?

IN THE PLANNING WORKSHOP

2. **Synthesise:**
   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.

   I. **Present findings from the Situation Analysis:** (you may wish to use the **Situation Analysis presentation template (#9).** 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.

   II. **Agree shared programme vision:** Start with agreeing the vision set out in Step 1 of the toolkit **Setting the programme vision.** 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 the diagram below). This helps to clearly show how the NTD programme vision contributes to other visions, and vice versa. The shared vision (on the right of the diagram) defines what all stakeholders aim to achieve together.

   III. **Identify specific programme priorities:** based on the situation analysis, the key problems should be summarised in the table below. 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, as set out in the **Context** section of the toolkit.

Facilitator 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.

Facilitator 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.

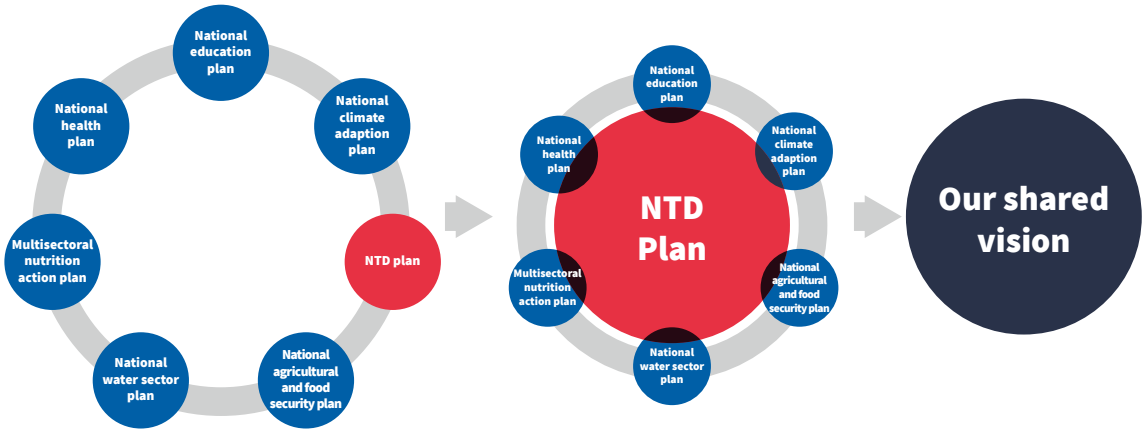


Table 1: Key issues underpinning disease prevalence and programming in the country (from Situation Analysis, section 4)

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

Facilitator note

Refer back to the **BEST factsheets** at the start of the toolkit 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.

IV. **Identify existing interventions:** From the **Situation analysis.** identify a master list of relevant existing interventions, tools and entry points ('inventory') under each of the above themes (see 'interventions' table in Section 3.V.1). List relevant interventions that are happening, or that will be happening in the near future. The small team should populate as much of the below table as possible prior to the workshop on an Excel sheet that can be updated during the workshop, to modify and add interventions.

Table 2: Intervention inventory table

Intervention and Description	Target/ Audience	Who delivers it

Facilitator 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.

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

criticise existing activities but to make strategic choices on what will work best to achieve the shared vision. Participants may feel defensive if they feel their work is being criticised. 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.

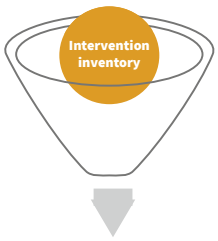
I. **Setting the programme boundaries:** Before you carry on: Relook at the **BEST factsheets.** the **Interventions for NTD control and care (#1).** the programme vision and the inventory, to agree the boundaries of the programme (i.e. are there any aspects that are explicitly outside of the boundaries of this planning process? There should be a good reason – i.e. these aspects are being actively and sufficiently covered by another programme. Note – 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.

II. **Aligning the interventions with the defined problems** as the basis for the action plan. This helps make sure that it's strategic – 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.

Facilitator note

A good process to do this is to essentially put Tables 1 and 2 together 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 section
- 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 factsheets to help you categorise]
- 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.



Interventions that address the defined problems

Table 3: Current interventions and how they respond to the problems (based on Tables 1 and 2)

Theme	Key problem/challenge to address (pre-populate from Situation Analysis)	Relevant interventions from the inventory in Step 2 (if you have a lot of interventions, use the column/row reference from the Excel version of the inventory)
Behaviour	Problem 1 (e.g. poor hygiene practices – lack of handwashing with soap, lack of face washing, lack of shoe wearing; bathing, swimming and laundry in surface water)	Intervention x Intervention y Intervention z
	Problem 2...	Intervention x Intervention y
	Problem 3...	Intervention x Intervention y
Environment	(e.g. Lack of access to and use of toilets; Vector breeding near/in poorly managed water sources; Poor maintenance of sanitation facilities)	
	Problem 2...	
	Problem 3...	
Social inclusion	(e.g. Stigma-related exclusion from water sources (e.g. for people affected by certain NTDs))	
Treatment and care	(e.g. lack of reliable water supply in healthcare facilities providing surgical interventions; lack of water for self-care)	

4. **Act:**

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

I. **Deciding what action is needed on each intervention:** The table below lists all relevant interventions, with an additional column on the right 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 'Act' below).
- 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 'Act' below).
- 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 (for example, not printing another batch of posters or leaflets that are not effective).
- Implemented through other programmes: These interventions, although relevant, fall outside

Facilitator 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.

the programme boundaries (see 3.I above). 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.

Table 4: actions

Theme	Intervention	Action Develop (new intervention) Keep (implement as is) Adapt (make changes) Phase out Implemented through other programmes
Behaviour Problem 1… Problem 2…		
Environment Problem 1… Problem 2…		
Social inclusion Problem 1… Problem 2…		
Treatment and care Problem 1… Problem 2…		

II. **Rationalise 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 below feasibility matrix. You can do this physically using the sticky notes you prepared in the 'synthesise' step. Try to be as objective and realistic as possible.

HI/HF High impact, high feasibility	**HI/LF** High impact, low feasibility
LI/HF Low impact, High feasibility	**LI/LF** Low impact, low feasibility

Impact: Does the intervention work to resolve the stated problem?

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.

- Based on this discussion: Interventions that fall into the HI/HF quadrant should be prioritised. 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 it doesn't have a significant impact, because it will be relatively easy to implement. There are no right or wrong answers, as long as there is agreement.

Facilitator 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.

Facilitator note

For information on designing behavioural interventions, refer to the **B issue sheet** and the **Understanding behaviour to develop behaviour change interventions (#3)** resource.

III. **Developing New interventions:**

a. State the desired outcome (the opposite of the problem)

b. Describe the intervention

c. Define the target

d. Define the delivery channel/mechanism

NB: the purpose of this exercise is not to develop a full intervention but to define its parameters for development and design later on. Instead, consider the option of the full stakeholder group tasking 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.

Facilitator note

Ask the group - could any existing interventions be adapted to achieve the same outcome? If so, remove these interventions from the table and discuss them under 4.IV ('Adapting interventions'). 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.

Table 5: intervention development

Theme	Outcome	Intervention	Target	Delivery channel/ mechanism
Behaviour Problem 1… Problem 2…				
Environment Problem 1… Problem 2…				
Social inclusion Problem 1… Problem 2…				
Treatment and care Problem 1… Problem 2…				

IV. Adapting interventions: 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 of a specific material (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 (Section 3.V), for detailed information on the nature, delivery and quality of current interventions.

NB: avoid a full adaptation of the intervention at this point, focusing on for full revision later on. Check: Do you have the 'owners' of the intervention in the room – those you expect to make adaptations to interventions they are currently implementing? If not, you may need to reach engage them at a later stage. This needs to be reflected in the action plan.

Table 6: Intervention adaptation

Theme	Outcome	Intervention	Adaptation needed
Behaviour Problem 1… Problem 2…			
Environment Problem 1… Problem 2…			
Social inclusion Problem 1… Problem 2…			
Treatment and care Problem 1… Problem 2…			

5. **Verify:**

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

   I. Populate the plan: 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

Facilitator 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 finalising the plan.

for new activities), who is responsible for the delivery, and what the anticipated achievement will be within the one year (for example, at three-month intervals) and by the end of the year (medium term milestones).

II. Identify specific points at which you will reconvene (and who will reconvene) and review (see "Revisit and realign" below). 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.

Table 7: Action plan

Theme	Intervention	Delivery channel/ mechanism	Next steps/ interim measures What needs to happen and by when	Responsible This should be a named individual rather than institution	Medium-term milestones
Behaviour					
Environment					
Social inclusion					
Treatment and care					
Accountability	<<insert activities for regular monitoring and progress chase for the plan>>				

AFTER THE WORKSHOP

6. **Revisit and realign**

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

I. **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 **section 4 of the toolkit - Important tips for adaptive action planning.** In this process, all planned activities should be reviewed along the following questions:

a. Are the activities happening? If not, why not?

b. Are the activities still relevant for addressing the problems and outcomes stated in the plan?

c. Should any of the activities be stopped or changed? What are the alternatives?

d. 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).

e. 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)

f. Are there any threats that need to be mitigated (e.g. changes in management, funding etc).

g. Are all necessary actions captured in the annual planning and budgeting cycle?
(see **section 4, Financial arrangements for a successful intersectoral programme**).

h. 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?

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

Agenda for joint planning meeting

This is a companion tool to tool 11: **Planning tool**

This agenda template assumes a three-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 to have 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 five-day workshop is advisable.

Time	Activity	Presenter/ facilitator	Facilitation notes
DAY 1 <date>>			
9:00-9:30	**Welcome/ Introduction and objctives** **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): 1. In advance, prepare two sets of terms: concepts that are referred to differently by each sector. For example (there may be other relevant terms): Health education (NTDs) vs. Hygiene promotion (WASH); Latrines (NTDs) vs Sanitation (WASH); Infection prevention and control (IPC) in healthcare settings (NTDs/Health), vs WASH in healthcare settings (WASH). 2. Divide the group into two. In each group, work to match the NTD/health terminology with the terminology used in the WASH sector 3. The winning team is the one that matches all terms correctly first
SYNTHESISE			
9:30-10:15	**Findings of the situation analysis**	All	See **Situation Analysis presentation template (#9)** Emphasise the following aspects: a. What are the key coordination overlaps, synergies and gaps? b. Who are the primary and key implementation actors? c. Based on the available mapping exercises, where are the priority intervention areas? d. Are there aspects on which information/formative research is still required? e. Key issues underpinning disease prevalence and programming in the country f. What are the key opportunities identified in the Situation Analysis?

Time	Activity	Presenter/ facilitator	Facilitation notes
10:15 – 10:45	**Break**		
10:45– 11:15	**Defining the shared programme vision**		Based on validation of the programme vision previously defined See **Step 1 of the Toolkit** 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 Table 1 (either on four flipchart pages, one for each BEST component, or on a Word document on the screen). Ensure agreement on each problem before moving on.
13:00-14:00	**Lunch**		
14:00-15:30	**Intervention inventory**		Use the (pre-populated) Table 2 and add any interventions not captured in the situation analysis. Refer to the **Context** section of the toolkit for detailed information on 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. 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	**Break**		
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.

Time	Activity	Presenter/ facilitator	Facilitation notes
DAY 2 <date>>			
9:00-9:15	**Recap Day 1**		Present the intervention inventory
ALIGN			
9:15-10:45	**Aligning interventions to programme priorities**		Aligning the interventions with the problems (using Tables 1 and 2 to populate Table 3 in the **Planning tool**): ▸ 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) 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.
10:45 – 11:15	**Break**		
ACT			
11:15-13:00	**Actioning interventions**		Populate Table 4 (using all interventions from Table 3 and denoting the action needed for each: Develop, keep, adapt, phase out, implement through other programmes). Ensure each of these concepts are clear to the participants.
13:00-14:00	**Lunch**		
14:00-15:00	**Rationalising interventions**		Taking forward interventions marked Develop, Keep and Adapt: use the feasibility matrix to prioritise interventions, 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.
15:00-15:30	**Break**		

Time	Activity	Presenter/ facilitator	Facilitation notes
15:30-16:15	**Developing new interventions**		Populate Table 5, defining parameters for new interventions. In the discussion, ascertain if any existing interventions could be adapted to achieve the same outcome? If so, remove these from the table and discuss next ('adapting existing interventions'). ▸ Appoint any needed task teams to take forward intervention development
16:15-17:00	**Adapting existing interventions**		Populate Table 6 with the necessary adaptation for each intervention. ▸ Appoint any needed task teams to take forward intervention adaptation, and discuss actions for involving the intervention 'owners' if they are not represented at the meeting.

Time	Activity	Presenter/ facilitator	Facilitation notes
DAY 3 <date>>			
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 particpants 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**		Populate Table 7. You may want to speed up this process by pre-populating the 'intervention' and the 'delivery channel' columns after Day 2, leaving ample time to agree the practical aspects regarding next steps, leads and milestones. The 'accountability' row can be discussed after the break or after lunch. 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.
10:45– 11:15	**Break**		
11:15-13:00	**Plan development (continued)**		
13:00-14:00	**Lunch**		
14:00-15:30	**Plan development (continued)**		
15:30-16:00	**Break**		
16:00-16:30	**Wrap up and next steps**		The meeting should be closed by the individual/s who convened the meeting, summarising the agreed next steps and timeline, with specific dates for circulating a meeting report and setting up future meetings and activities.

Planning for Elimination: getting NTD programmes across the finish line

Planning for Elimination: getting NTD programmes across the finish line

Background

In line with the WHO 2020 NTD Roadmap, the majority of NTD programmes have been set up with the eventual goal of either elimination or at the very least sustained control of disease. Alongside these targets, and the 2030 Sustainable Development agenda, programmes are also expected to contribute to poverty reduction and equity. In other words, NTD programmes should ideally be designed to "work themselves" into inexistence as vertical disease control programmes, by eliminating the disease from the national context, and embedding any other functions, such as management of existing cases, into routine healthcare services. This presents a set of unique problems already encountered in certain countries and by some disease programmes. These problems are to a large extent inevitable, and can be expected as a country's disease profile changes.

- **Reduced priority:** As disease prevalence diminishes in the later stages of the control programme, low prevalence drives the disease lower down the order of priority compared to other health issues that are seemingly more urgent or affect larger parts of the population. This lower priority can reduce resourcing and political will for the programme, just as it becomes more expensive to implement due to the need to target smaller and more remote pockets of transmission. This reduction in prioritisation and resources is likely to cause delays in meeting elimination targets. For example, once prevalence drops below the defined thresholds and mass drug administration (MDA) is no longer carried out, lack of resources and prioritisation undermines delivery of activities needed to sustain the gains achieved through MDA, risking continued transmission and possible resurgence.

- **Resistance to change:** Once programmes have been in place for some time, the incentives attached to them are likely to become strongly embedded – including specific jobs, budgets, resources such as vehicles and other programme supplies, as well as less tangible aspects such as prestige and work relationships. This means that integration, and incorporating programme functions into the broader health systems and other sectors can be threatening – especially if

it leads to programmes being closed, and power and resources are diverted away from people who have held them for a long time. This can make changes difficult even if they make sense from a disease-control, cost effectiveness and health systems strengthening perspective.

- **Diminished expertise and support:** The specialised nature of many disease programmes also makes them highly dependent on specific skills and resources. As the disease becomes rarer, so do the expertise to identify, treat and prevent it, and the desire of medical professionals to gain these skills. Additionally, many NTD programmes rely on drugs donated by pharmaceutical companies, and are therefore subject to the continued availability of the drugs and the willingness of the companies to donate them – both of which may not be indefinite.

The purpose of this resource is to assist NTD programmes to plan from the outset for elimination, and pre-empt and possibly avoid the problems described above. It describes the stages likely to be experienced by programmes as they progress though the control-to-elimination continuum, and the measures and activities that should be implemented at each stage to sustain the gains made in disease control, poverty and inequity in the long run. It uses the intervention area of water, sanitation and hygiene to illustrate the way interventions and activities change as a programme moves from its initial phase towards elimination.

The table below (based on criteria described by Xiao-Nong Zhou on Schistosomiasis elimination in China) sets out the phases that disease control programmes are predicted to follow towards elimination, from the starting point of ongoing transmission and high prevalence (morbidity control), through to lower prevalence with transmission in specific locations (infection control), to low prevalence (transmission control), to very low prevalence (transmission interruption) to elimination. The post-elimination (or post validation of elimination) phase is also included here, acknowledging the need for continued activities to retain low levels of prevalence. As programmes progress through these phases, the interventions implemented change from specific interventions designed to treat the disease or reduce prevalence, to activities that sustain the impact of the initial direct interventions. Intervention areas include preventive chemotherapy (PCT); vector ecology and management (VEM); innovative and intensified disease management (IIDM); water, sanitation and hygiene (WASH); and measures to address neglected zoonotic diseases through veterinary public health (VPH) interventions. At the same time that the interventions themselves change, programmes should endeavour to shift away from vertical delivery of all components through the specific disease control programme, to embedding key interventions into existing health systems (for example, diagnostic and surgical capacity) and programmes delivered by other sectors (for example, water and sanitation interventions).

THRESHOLD		Morbidity control	Infection control	Transmission control	Transmission interruption	ELIMINATION	Post-elimination (post validation)
PREVALENCE THRESHOLD (threshold levels for schistosomiasis control used for illustration)		**>10%**	**5-10%**	**1%-5%**	**0%-1%**		**(0%)**
DESCRIPTION		Transmission/ High prevalence	Continued transmission in specific geographic areas	Under control	**Pre-elimination**		Continued action to ensure sustained low prevalence
INTERVENTIONS	Baseline mapping	All interventions (WASH, MDA, VEM, VPH, IIDM)	▸ Selective chemotherapy ▸ WASH ▸ VEM ▸ IIDM	▸ Surveillance ▸ Individual chemotherapy treatment ▸ IIDM ▸ WASH ▸ VEM	▸ Individual chemotherapy treatment ▸ IIDM ▸ WASH ▸ VEM ▸ Surveillance-response		▸ Monitoring environmental factors ▸ Case finding ▸ IIDM

As programmes progress from the initial (morbidity control) phase, the nature of the interventions as well as those delivering them are likely to require change, to respond to the changing epidemiology of the disease, levels of awareness of the affected population, resourcing levels, partnerships, and so on. The following section illustrates this point through the WASH intervention area.

Key WASH considerations for elimination planning

Although the role of WASH interventions in prevention and care of many NTDs is acknowledged in most control strategies, the specific actions that should be implemented by NTD programmes are often undefined. Planning for elimination should consider how, and by whom, WASH interventions will be implemented throughout the programme lifecycle, and once the programme ends (where relevant). Given the nature of WASH interventions and the fact that the overall responsibility for delivering WASH services often lies with agencies other than the disease control programme or the health authorities, the transition towards elimination should be planned for from the outset of the programme by involving key WASH, education and health stakeholders in programme design and implementation, identifying intervention delivery avenues including both the WASH sector and health outreach programmes (for infrastructure development and promotional activities respectively), and making lesson-based adjustments to these programmes to ensure they include actions necessary

for sustaining low levels of NTD prevalence. This "planning for elimination" process should consider:

- **The optimal delivery avenue for different WASH interventions:** Although the NTD programme may not be responsible for delivering WASH interventions (although some do include specific WASH interventions), it plays an important role in highlighting where the need is by identifying endemic populations . To the extent possible, infrastructure development should be led by the national water and sanitation programme in accordance with agreed standards and targets. Infrastructure interventions implemented by the NTD programme itself should be justified on the basis of coverage gaps or specific disease control measures and delivered in close coordination with the WASH sector. The 'lifetime costs' of WASH interventions should be considered (including maintenance, rehabilitation, replacement, hydrological changes) beyond the programme ending and in line with global NTD and development targets.
  See the **section on Financial arrangements for a successful programme in Step 4 of the toolkit**
- **Best practice in behaviour change communication:** Addressing behaviours that lead to disease transmission, increased disease severity or discrimination against people affected by disease is a crucial part of any disease control programme, and should be included in programme design from the outset. As the disease becomes rarer, the motives of individuals and communities for changing their behaviours may shift away from the need to avoid infection, as the risk of disease and its implications becomes less obvious. In other words, people are less likely to fear an infection they have never witnessed. This means that behaviour change activities should be planned in advance around, or shifted towards, broader and more positive motives around overall well-being, convenience, social respect and so on – and explicitly away from focusing on the need to prevent a specific disease. The shift in the nature of the behaviour change objectives should be accompanied by embedding behaviour change activities within WASH programmes and other health promotion initiatives and services.
  See **Understanding behaviour to develop behaviour change interventions (#3)** and **NTD-related behaviours (#2)**

- **System strengthening for sustaining elimination:** WASH interventions should be implemented in a way that strengthens the capacity of the WASH sector to implement and manage services, by utilising and enhancing existing decision making and coordination structures. This may include national level working groups and technical support units, as well as environmental

health departments within ministries of health, and district level WASH offices and WASH coordination committees. Collaboration with WASH sector professionals from the design phase of the disease control programme is important to ensure that infrastructure is optimised for disease control purposes (for example, to ensure that construction of basic toilets meets quality standards that ensure safe separation of excreta from humans and the environment), and to ensure that infrastructure is inclusive (for example, accessible to people with disease-related disabilities).

- **Link with other disease control efforts:** complementarities with other disease control programmes, e.g. for other NTDs or WASH-related diseases, should be explored as the basis for integration of activities. The more integrated the disease control programme, the simpler it will be to coordinate with the WASH sector, and to gain broader health benefits from WASH interventions. Broadening the scope of the programme also makes it easier for WASH and other health programmes to see the benefits of collaboration, when it is obvious that this will help these programmes achieve their own objectives.

Basic steps for elimination-planning

Establish a clear vision, by defining

- The nature of the programme towards and after elimination, i.e., changing from a vertical disease control programme focused on MDA to significantly reduce prevalence, to a comprehensive, multisectoral programme embedded in respective sectors designed to keep prevalence low. In China, for example, the schistosomiasis control strategy changed from MDA-based morbidity control to an integrated scheme including livestock management, snail control, improved sanitation, and intensive behaviour change promotion to further reduce the disease burden and interrupt transmission.

- The prevailing conditions in previously-endemic areas once the programme goals have been achieved, such as level of access to and quality of WASH services, key practices and behaviours.

Identify key partners and relevant programmes for collaboration and eventual integration in the WASH, health, education and other sectors

See **Planning tool (#11)**

- Use **WASH/NTDs partner form (#7)** to understand where partners operate and where the gaps are as you plan.

- Identify health system components to link with the programme for eventual integration of routine activities (case detection, individual treatment, passive surveillance through routine health reporting systems, health promotion) into existing health system structures including environmental health (e.g., for behaviour change, vector control, food chain inspection, water quality monitoring) and community outreach programmes.
  See in the **Situation analysis protocol (#6)** for further detail on how this can be done.

- Identify entry points for delivery of key functions in non-health sectors, e.g., use of disease prevalence data for targeting WASH services, identifying areas at risk of resurgence due to poor WASH conditions, use of agricultural outreach for zoonosis surveillance, promotion of animal husbandry practices, immunization, food chain inspection and standards enforcement.
  See the **Situation analysis protocol (#6)** for further detail on how this can be done.
- Take a phased approach to integration – identify which components can be easily integrated from the outset, and which will require a transition process. For example, enhancing behaviour change programmes to include additional messaging would be relatively simple, while programme elements such as diagnosis or surgery may take longer to embed in the healthcare system.

  See www.trachomacoalition.org/resources/transition for detailed examples from trachoma elimination transition planning.

Be prepared for the risk of reduced programme funding as you near elimination, and the disease becomes less urgent and de-prioritised.

- Establish a clear business case for full funding until elimination has been achieved, articulating the benefits of the disease programme in terms of health systems strengthening, broader health impact and achieving equity and poverty reduction goals in line with the sustainable development agenda.
  See the text and accompanying tools in **Step 4: Financial arrangements for a successful programme** and **Improving coordination in low-resource settings (#14)**

- Be conscious of the incentives and power dynamics that accompany reductions in programme income, and develop measures to address these as the programme transitions towards later phases. For example, identify opportunities for professional development and job progression for programme staff.

Define the monitoring approach for implementation at late programme stages
See **Step 5 of the toolkit – Planning and Monitoring.**

Improving coordination in low-resource settings: what can be done with little or no extra funding?

Improving coordination in low-resource settings: what can be done with little or no extra funding?

Since you are reading this toolkit, you may have already identified a need to improve collaboration between WASH and NTDs stakeholders in your setting. However, you may be concerned about the financial implications of doing so. While you may not have access at this time to new funding for developing an entirely new comprehensive WASH and NTDs initiative, lack of new funding should not mean that nothing can be done. This resource provides some ideas for action in low-resource settings, which can be used based on the circumstances in your own settings.

What are you trying to achieve?

It's important to be clear on what improvements you think are needed to the current way in which your programme is being implemented. In the short term, you may want to:

- **Improve coordination**
- **Create opportunities to exchange and learn from experience on technical programming aspects**
- **Identify opportunities for mobilising new funding** (from domestic or external resources)

These steps should help you move towards medium- to long-term objectives, once a level of collaboration has been established, such as developing a national framework to guide intersectoral NTDs initiatives, or implementing a new large-scale, comprehensive programme.

What activities are needed in the short term?

When starting a process of collaboration building, the activities needed may be very basic, with the aim of establishing a collaborative working relationship and a shared understanding of objectives and implementation across NTDs and WASH stakeholders. Consider the following basic steps:

- Be clear on where both WASH and NTDs sit in the current government agenda and what the key priorities are. Use the **Messages for engagement (#4)** resource to identify the mutual benefits of WASH and NTDs collaboration, and the importance of both areas to the national development agenda.

- Gain an understanding of which agencies are working where, and what their key focus is, by contacting key WASH government departments or NGOs. The **WASH NTDs partner form (#7)** may help you capture this information. Find out: are there plans for WASH infrastructure investment in a specific district or region in which the NTD programme is operating? Are there opportunities to influence which areas and communities will receive infrastructure investment?

- Identify existing coordination structures – are there any WASH sector working groups, other technical working groups or annual review forums? When and how often do they meet? Try to join these groups and attend their meetings, even if as an observer initially. This requires establishing a relationship with the lead agency or person in charge of the meetings. This will help you get to know relevant individuals, and understand the key priorities and ways of working in the group/sector. It will also help you identify potential individual champions for integration, who may become important allies in future collaborative initiatives as advocates within their own organisations and sectors. At the same time, make sure you invite these allies into other relevant groups, such as the NTDs Task Force or annual review. Collaboration often starts between individuals rather than organisations, and a good working relationship can help you convince your respective organisations to work together. You may need to be patient and be prepared for some resistance within your own (and your allies') organisations to changing established ways of working until the benefits of collaboration become clear.

- Once you have identified key individuals with whom collaboration is useful, you may want to start meeting informally to exchange ideas or discuss specific technical issues – for example, what are the successful approaches for behaviour change currently being implemented, and are there aspects that can be introduced to your programme? What are the ways in which other programmes are currently being implemented – and do they include potential entry points for NTD control? Are there useful lessons for working in specific geographic or cultural settings? These informal meetings can form the basis for future technical working groups or learning initiatives, and do not have cost implications as they can simply involve visiting the offices of an ally organisation.

- The informal discussions should help you identify relatively simple programming changes and ideas for integration. For example, you may
  - find ways of engaging an NGO experienced in WASH and behaviour change programme delivery to help develop health and hygiene promotion materials for your programme, or to deliver behaviour change activities during annual MDA campaigns;
  - adapt your M&E framework to include information on access to WASH services, using data from existing WASH sector government monitoring systems, to inform your own plans and programming approach; the indicators included in the **WASH NTD indicators and logframe (#20)** may be useful for this purpose
  - identify the schedules and timeframe for planning processes at various levels, and ways to influence them so that disease burden is considered when allocating resources for WASH service delivery. **Situation analysis protocol (#6).**

Taking collaboration to the next level

Once a relationship has been built, you may jointly identify new actions that require increased human and financial resources. Consider:

- Are there resources in your existing programme or budget that can be used to support these activities? For example, can an existing member of staff be appointed as a focal point for collaboration with the WASH sector? Can any funds in your current budget be used differently, for example to support regular coordination meetings, or to engage a larger set of stakeholders in current plans? If most or all of your funds are tied to specific activities, look for areas of underspend, or for where an integrated approach can improve the implementation likelihood, quality and sustainability of the activity, so that the (re)allocation of resources can be justified in your regular reports.
- Can any of the potential activities you have identified be included in plans and budgets for the forthcoming financial year? Look carefully at the budgeting and planning schedule and include realistic amounts when submitting your plans.
- Are there any partners with an interest in integration who can provide 'seed' funding, for example for an initial stakeholder workshop (see below)? Consider what sort of information

they may need based on their priorities in order to support the workshop, and meet with them to discuss your ideas. You may find the **Messages for engagement (#4)** tool helpful for this purpose.

→ Are there any potential opportunities for which grants may become available for integrated programme implementation (for example, from a donor agency)? Work with your allies and potential implementing partners to develop and submit a proposal (proposal development may also be the purpose or output of a planning workshop).

Summary of possible actions for various funding scenarios

No financial implications	Using existing resources differently	Low-cost [limited new resources]
▸ Map WASH partners and activities ▸ Attend existing WASH sector meetings ▸ Invite WASH sector stakeholders to NTD meetings ▸ Undertake joint advocacy on the need to link WASH and NTDs ▸ Learn/exchange on technical programme aspects through informal discussion ▸ Influence WASH planning processes to improve targeting of endemic districts/communities	▸ Adapt an existing programme role to be focal person for coordination ▸ Build integrated activities and coordination needs into forthcoming plans and budgets ▸ Adapt M&E framework to gather useful information (e.g. access to WASH)	▸ Conduct coordination/planning/ resource mobilisation workshop ▸ Involve WASH stakeholders in developing promotion materials and implementing behaviour change activities in MDA campaigns ▸ Embed NTD-related WASH behaviours in WASH behaviour change initiatives (e.g. Global Handwashing Day celebrations or other campaigns) ▸ Form technical working groups to resolve specific issues

Conducting a coordination workshop within low-resource setting

To be used in conjunction with **Cross sector meeting agenda (#5)**

Workshops are often organised when a new grant or initiative are being planned; when there is no new funding on the table, workshops can help increase momentum and formalise the willingness of WASH and NTDs agencies and specific individuals to work together. Here are helpful tips on organising such a workshop:

- → Be clear about the **purpose** of the workshop – improving coordination, developing new programming approaches, attracting new funding, etc. – and ensure that this understanding is shared between the organisers, sponsors and participants as well (be careful not to set expectations regarding new funding opportunities – since if these do not materialise, stakeholders may disengage from the process).
- → Set out clear **deliverables**, to keep all stakeholders engaged in the process, e.g.
  - ▸ A time-bound action plan focused on improvement of existing interventions and coordination

- Terms of reference for undertaking research, or seeking new funding – for example developing a proposal and identifying who to approach

→ **Invite the right people**:

- keep the number of participants manageable (30 people max)
- Ensure the timing does not conflict with other major meetings or workshops in the other sectors
- share as much information as possible in advance on the meeting purpose so that the right individuals are assigned to attend and are well-prepared.
- ensure balanced representation of WASH and NTDs partners to give a sense of a shared agenda; invite sub-national NTD programme leads as well as their WASH counterparts, for their engagement and to avoid the workshop resulting in unrealistic demands. Ideally, the meeting should be co-led by both WASH and NTDs representatives.
- include sufficiently senior staff, who are able to make decisions on behalf of their organisation and lend credibility to the process. Senior officials from WASH and NTDs-related government departments should, at the very least, open the meeting.

→ **When developing the agenda**:

- Know your participants: what knowledge do they have of technical aspects, institutional and programme structures, and the process undertaken so far? What information will they need to participate effectively? Avoid oversimplification for very informed audiences, but include all relevant information such as disease distribution, WASH-related risk factors, and WASH conditions in endemic areas. This will help avoid disengagement, as well as tie in with all participants' priorities and motivations.
- Conduct the workshop in the local language (if external facilitators are used, take into account time for simultaneous translation)
- Use clear terminology and ensure all participants have a shared understanding of key concepts and acronyms; do not assume that what is common knowledge to you is understood by others

- Appoint good facilitators, familiar with the local context and current programmes and structures, who are able to draw on real life examples that participants can relate to
- Allocate sufficient time for work and discussion, keeping presentations and speeches to a minimum.

→ Conduct **preparatory and follow up meetings** with a small group to clarify responsibilities and next steps. Use the opportunity to brief senior officials, to help ensure they understand the purpose of the meeting. Appoint someone responsible for following up all the agreed actions.

→ Ensure all relevant **data** (disease burden, WASH access) is collected in advance, properly analysed and well-presented to avoid disputes and enable moving quickly into discussion and decision-making. The **Situation analysis protocol (#6)** and **WASH NTDs partner form (#7)** are helpful tools for gathering and analysing this information.

→ **During the workshop**, guide participants away from coming up with blueprint approaches such as setting up new coordination structures (as this requires new funding, and can also undermine existing structures), or making unrealistic demands from other sectors and programmes.

- Consider relevant government visions and plans – how does improved collaboration on WASH and NTDs help achieve national targets on poverty, health, education and economic growth?
- Map existing activities and how they can be enhanced for achieving better WASH and NTDs outcomes. Focus on 'easy wins' and on potential impact, using commonly agreed definitions so that all participants are using the same criteria when making choices.
- Map existing coordination structures that need to be reinforced.
- If a need for new activities arises, discuss these carefully, identify opportunities for new funding, and develop an action plan or terms of reference to deliver these. This should help avoid including unrealistic or unnecessary activities in your action plan. Ensure the outcomes and suggestions from the workshop are well-documented, and shared with all participants.

Budgeting for joint WASH and NTDs programmes

Budgeting for Joint WASH and NTDs Programmes

Key budget components/ Line items:

Line item	Description
Direct costs: costs that are clearly and directly incurred as a result of the programme:	
Salaries and incentives (full or proportion of)	Of programme staff, NGO implementers, community promoters, extension workers, government officials (for example, those involved in coordination and supervision activities)
M&E	▸ Baseline surveys (consider outsourcing costs if relevant) ▸ Routine monitoring and supervision: staff, travel, reporting costs ▸ Evaluation and impact surveys (consider outsourcing costs if relevant)
Coordination	Meetings, including venue, audiovisual (AV) equipment, facilitation costs (if needed), food, travel and per diems at defined rates per government norms – at central and sub-national administrative levels
Communications	Mobile phone calls/texts, internet
Programme equipment and materials	Medical equipment, laboratory and testing equipment, vehicles, computers/ tablets, phones, GPS devices, cameras, training and delivery manuals, banners, AV equipment
Capacity development	Training, facilitation, venues, materials, subsistence
Behaviour change	▸ Formative research (outsourcing costs) ▸ Creative process for package design (incl. outsourcing to creative agency or convening individual consultants) ▸ Manufacturing and delivery costs of programme materials (posters, flip charts, videos) ▸ Training costs
Transportation	▸ Including standing vehicle costs, drivers, petrol and insurance (costs may be included in other lines or as a separate line)
Indirect costs: These costs are incurred for the overall operation of the programme and the department/s responsible for it, but do not relate specifically to one project.	
Salaries	Of support staff e.g. finance, administration, management
Finance & administration	Additional non-salary finance and administration costs
Governance	Compliance, registration, ethical approvals, permits, legal fees
Facilities	Buildings, IT, rent, utilities (water, electricity)

Budget checklist

- Is the budget consistent with the overall funding envelope? If not, have resource gaps been highlighted and addressed?
- Are the amounts mentioned in the narrative consistent with the budget?
- Is it clear how costs are allocated to different funders, donors or different agencies/government departments (ie are they contributing a proportion of the total or is their contribution allocated to specific lines)?
- If there are no specific requirements, is the ratio of 'support costs' to 'project costs' reasonable? (i.e. fine if <10%, check if between 10% and 20%, and question if >20%)
- Are unit costs shown (if required)? Are they consistent (if not, is this explained, e.g. different geographic locations of boreholes)?
- Has sufficient provision been made for all activities included in the narrative?
- Is it clear how all costs are related to the activities described in the logframe?
- Have all integrated activities in the logframe been accommodated in the budget? Is it clear which budgets and agencies cover the costs of integrated activities (e.g. does the budget ensure that there is no double-billing of activities, with the same activities being charged to different departments)?
- If required, have costs been split by result? Or by programmatic area/theme?
- If relevant, have donor requirements been respected when allocating their contribution (e.g. if there are exclusions on using donor funds for vehicle purchase)?
- Have costs for start-up and follow up workshops/visits been included?
- Is there sufficient allocation for ongoing coordination and supervision?
- If required, is there budget for final audit/evaluation?

- Have sufficient costs for staff relating to the project been included (in terms of time as well as salary and benefits)? Have potential salary increments been factored in (e.g. based on cost of living adjustments or salary scale progression)? Is there sufficient and clearly defined allocation for NGO and government staff, including non-staff per diems?
- Has inflation been taken into consideration on multi-year projects?
- Have promotion opportunities for raising the profile of the programme (e.g. media coverage, launch event) been included?

Routine supervision guide and form

Routine supervision guide and form

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 healthcare 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 the 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 contribute 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.

- **Contextualise:** 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 (computerised 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 for joint supervision of WASH and NTD programmes

[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].

Date of supervision	___ / ___ / 20___		**Visit Location**			
Conducted by:	Role [NTDs]	Name	Role [WASH]	Name	Role [other]	Name
Date of submission	___ / ___ / 20___		**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]

Questions	responses	Supervisor notes/ follow up
Community health/hygiene promotion		
1. Do health/hygiene promotion sessions take place? **2.** If 'yes', in what frequency? **3.** Are NTD-related promotion sessions/activities delivered as a standalone intervention, or as part of a. The health extension/outreach programme b. Primary healthcare activities (e.g. immunisation, nutrition, maternal newborn and child health, etc) c. WASH programmes **4.** What topics are covered in the sessions? Do these include WASH behaviours related to the prevention and/or care of NTDs? **5.** Who delivers the sessions? Have promoters received training with regards to WASH/NTDs promotion? **6.** What materials are used in the sessions (e.g. flip charts)? Are they available and useable? [check supply in section 2] **7.** Do you keep a log of sessions and participants? [check log is up to date] **8.** How many community members participate on average? Are the numbers consistent over time or has there been any drop-off? **9.** Do you attend the sessions (always, sometimes)? In your view, are they effective? **10.** Can the sessions be improved? How?		

School health/hygiene education		
1. [If relevant activities included in the school curriculum as standard] Are health education activities conducted as stipulated by the national curriculum? **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? **3.** Do activities take place in all schools or only some? Please specify **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? **5.** Do schools keep log books of health/hygiene education activities? Are they up to date? Who checks the logbooks? **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. **8.** Are the Parent-Teacher Associations involved in health/hygiene education activities? Please specify. **9.** In your view, can school-based health/hygiene education activities be improved? In what way?		
Healthcare facility activities		
1. Do health/hygiene promotion activities related to NTD prevention and care take place in healthcare facilities or as part of facility-based healthcare programmes? (e.g. health talks to patients and carers, individual counselling) **2.** Are health/hygiene promotion activities integrated into morbidity management and disability inclusion activities (such as in patient counselling on self-care for LF, leprosy or other diseases, and in activities for stigma prevention)? **3.** Are there under/unutilised facility-based opportunities for health/hygiene promotion related to NTD prevention and care?		

Infrastructure		
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: number of school water points/systems constructed; number of school toilet cubicles (for girls/boys/teachers) in relation to standards; number of healthcare facility water points/systems constructed in relation to standards; number of healthcare 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. **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.		
Community engagement		
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? **2.** What other social mobilisation activities have been conducted? Have these been successful? **3.** Have any training activities been conducted for community leaders/ groups? When? What has been the outcome? Are there plans for further training activities? **4.** Are there ongoing challenges relating to community participation? How may they be addressed?		
Coordination		
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. Are meetings supporting effective coordination of activities? d. Has coordination resulted in improved targeting of resources and/or timely implementation? **2.** Are other sector-specific coordination structures used for ensuring NTD aspects are addressed? (e.g. District WASH, health or education committees) **3.** Are there any ongoing coordination challenges? What potential measures can be taken to address these challenges?		

Mass drug administration*		
1. Are the relevant drugs available at the district level for timely implementation of the MDA campaign? 2. Are drugs effectively distributed to community drug distributors, school teachers and community members? Are clear records maintained? 3. Does treatment take place as directed by the national programme? 4. Are community members, teachers and leaders effectively involved and informed about MDA to ensure that benefits are understood and commitment is made? 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.		

** Supervision of MDA programmes should be done in line with existing WHO and Ministry of Health guidance. The questions included here are included to illustrate aspects likely to be covered.*

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

Materials	Detail	Gaps/problems	Follow up measures
Drugs	*[List any drugs for MDA and treatment stored at the district level and for distribution to healthcare 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 healthcare facilities for medical, case management and disability inclusion purposes]*		
Promotional materials	*[nclude 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 cards 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 sub-district 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, healthcare facility or school. The below questions should not be used as a guide for conducting baseline surveys, sanitary supervision or research.

Refer to: Water and sanitation for health facility improvement tool (WASH FIT): A practical guide for improving quality of care through water, sanitation and hygiene in health care facilities. http://www.who.int/water_sanitation_health/publications/ water-and-sanitation-for-health-facility-improvement-tool/en/.

Observation area	Guiding questions for supervisor	Comments
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?	
	2. 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? Was there a handwashing facility in or near the toilet? Was soap and water available?	
	3. Were there any signs of open defecation, such as visible human faeces, or absence of toilets? [note whether the community has been declared as ODF (Open Defecation Free)]	
	4. What is the overall state of cleanliness in the community, in terms of solid waste, animal presence in/near houses, animal faeces, flies?	
WASH – School	1. Does the school have a water source? Was it functioning at the time of the visit?	
	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?	
	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?	

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

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	
Activity #2	
Activity #3	
Activity #4	

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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5. Gaps/challenges and remedial measures

Types of gaps or challenges may include aspects related to implementation effectiveness, partnership issues, financial resources, staffing and capacity constraints, and so on. These should be discussed with the relevant supervisees and actions agreed in writing. Ensure that this part of the supervision process is used not only for performance management but also to identify opportunities for staff professional development.

Problem/constraint	Assumed cause	Action (by whom, by when)

Programme dashboard template

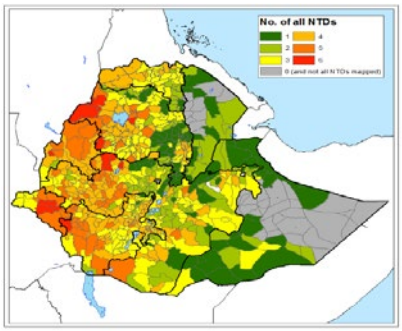
The purpose of the dashboard it to provide at-a-glance information on the need for and successes of the programme to decision makers who may not be regularly involved in the programme. This can be used as an advocacy tool to communicate the need for the programme, and to seek further political and financial support.

COUNTRY: .....

NTDs context

[Insert key information on NTDs in your country. If available, insert maps showing disease prevalence and/or co-endemicity as in the example below from Ethiopia]

Disease	# endemic districts/ % prevalence	Population at risk
STH		
Schistosomiasis		
LF		
…		
…		
…		
…		



Map credit: Ethiopia Federal Ministry of Health – Neglected Tropical Diseases Section, and Hygiene and Environmental Health Section.

Other figures:

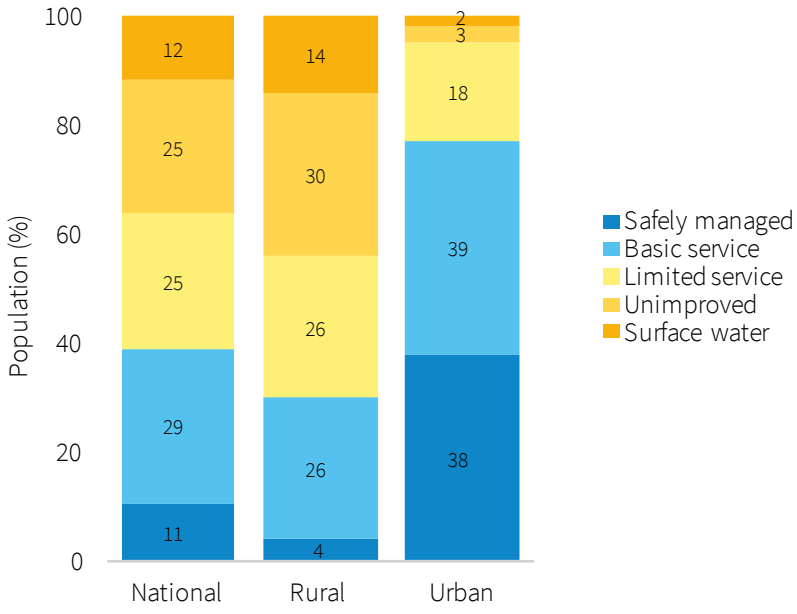
NTD-related disability

Number of cases of other NTDs of interest

Transmission/ implementation context

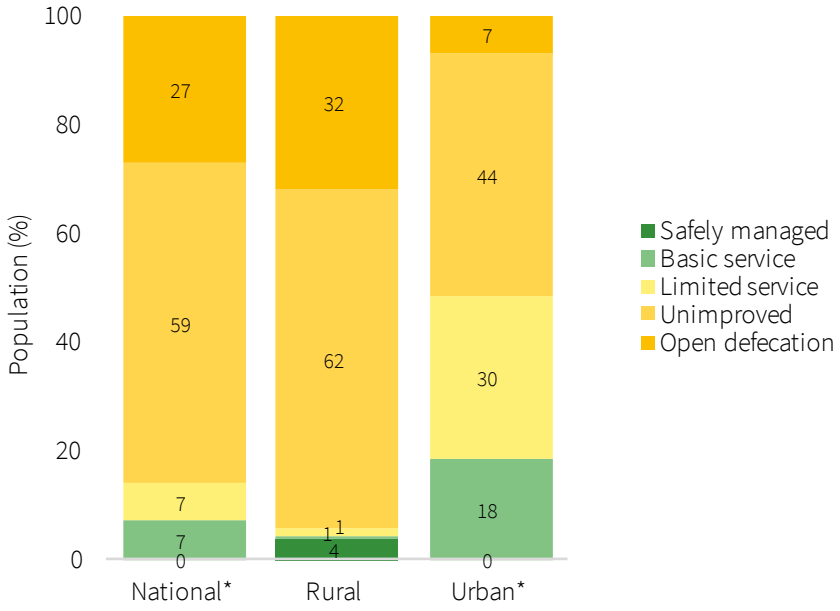
[Insert key information on determinants and broader impact of NTDs, such as access to water and sanitation services or trends in access, undernutrition trends, poverty indices etc]

Access to drinking water



Source: WHO/UNICEF JMP

Access to sanitation



Source: WHO/UNICEF JMP

(Annual/ interim) Results
[Insert key figures showing progress against the programme success indicators, such as numbers of beneficiaries reached, process indicators, etc]

- #/% districts with functioning coordination structures
- Trends in NTD prevalence
- Beneficiaries reached with programme interventions
  - Mass drug administration
  - Water supply
  - Sanitation and hygiene promotion
  - Surgery

GANTT CHART FORMAT

GANTT chart format

	<YEAR>											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Outcome PX												
OUTPUT px.1												
ACTIVITY px.1	xxxx											
ACTIVITY px.2	xxxx											
ACTIVITY px.3	xxxx											
Outcome WX												
OUTPUT wx.1												
ACTIVITY wx.1	xxxx											
ACTIVITY wx.2	xxxx											
ACTIVITY wx.3	xxxx											
Outcome SX												
OUTPUT sx.1												
ACTIVITY sx.1	xxxx											
ACTIVITY sx.2	xxxx											
ACTIVITY sx.3	xxxx											
Outcome HX												
OUTPUT hx.1												
ACTIVITY hx.1	xxxx											
ACTIVITY hx.2	xxxx											
ACTIVITY hx.3	xxxx											

Programme risk analysis

This simple matrix lists potential risks under different categories, the probability of a risk happening, the level of impact on the programme if it happens, and the mitigation plan for minimising the impact. The example below lists out potential risks for an integrated WASH-NTDs programme.

	Key risk parameters	Likelihood	Impact	Mitigation strategy
Political risks	Change in government may slow down project implementation. The success of the project is contingent on political peace and neutrality	**Low:** The current trend of political stability is likely to continue and no political hiccup is expected	**High:** Local government leaders will be subject to high political influence without being able to produce output	Continued neutrality of the programme, and clear links to existing national and international development commitments and policies
	Reduction in funding available to WASH and/or NTD programmes within the national budget	**Low:** Commitment is well-framed in various policy documents and political manifesto	**High:** reduced incentives for joint action; reduced donor commitment	Continued advocacy on the 'business case' for intersectoral programmes; sharing successes of the programme in national forums
	Newly elected local government leaders not supportive of programme activities	**Medium:** A significant number of new members were elected in the last election	**Medium:** This will require effort to reorient local leaders	Continued involvement of local leaders in WASH-NTD coordination and programme mobilisation activities; conducting learning visits in established programme areas
Strategic risks	Stigma and/or lack of awareness may result in low programme buy-in from local stakeholders	**Medium:** NTDs can be a 'silent' issue due to perceived lack of severity compared to more acute/ severe health conditions	**High:** lack of buy-in can hinder participation in essential programme activities and uptake of preventive and care-seeking behaviours	Carefully-considered promotion and mobilisation activities, based on context and responsive/linked with community needs
	Economic difficulties leading to increased poverty and hunger	**Low:** current rate of economic growth is stable	**Medium:** Economic difficulties can delay household and community investment in WASH improvements	Ensuring the programme results in improved access to basic services and productive opportunities
Implementation	Programme not delivered to high standards (infrastructure, promotion)	**Low:** implementing partners have capacity to deliver, have been trained and are being supervised by the programme	**High:** low quality implementation can undermine the reputation of the programme and therefore uptake of services and overall impact	Continued supervision of programme activities; regular reflection on lessons to adapt programme implementation
	Construction of low-quality toilets in a densely populated community with limited space can worsen disease transmission	**Medium:** conditions in high-endemicity areas can be challenging for construction of safely-managed sanitation; poor households may not be able to afford improved toilets	**Medium:** poor quality sanitation can result in reduced uptake and use of sanitation, with ultimate impact on disease transmission	Robust sanitation promotion activities focused on dignity, consumer preferences and quality, accompanied by routine supervision of promotion and construction standards

WASH NTD indicators and logframe

Overview

Tool purpose : This logical framework (logframe) 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.

For ease of use, please download this tool in Microsoft Excel from the web version of the toolkit.
Tool use : There are four sheets in this document:

1. WASH-NTD_Indicators_menu is a menu of potential Impact, Output and Oucome objectives which are relevant for WASH-NTD programming (column A). Impact, Outcome and Output indicators are detailed in column B. In columns C - F is where you will estimate baseline values (from existing evidence) for each of the indicators and set milestones (interim outcomes) you will achieve by the end of each reporting period. Please add more columns for milestones if required for your programme. 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 asterix.
   Below milestones (columns C - F) is where the sources of data for recording the milestones to meaure progress over time is recorded and examples have been provided from existing global monitoring frameworks for WASH and for NTDs. These can be changed depending on the context of your joint planning and programming.
   Column G is for the means of verification which determines where these data will be reported, verified and dissseminated. Finally, assumptions should be entered to state the uncertainty factors that may affect the programme and be specific against the objectives set out in planning.

2. WASH-NTD_LogF_template is the template logframe for you to develop your own programme specific WASH-NTD Logframe. To begin, you can review the 1. WASH-NTD_Indicators_menu and copy and paste the relevant Impact, Outcome and Output indicators, sources and means of verifcation in to your template. The next step would be to alter and populate the remaining cells in your WASH-NTD Logframe with information relevant to your context.

3. WASH-NTDs_Activities_Log_template allows you to determine the specific activities and sub-activities for achieving each Output in your WASH-NTD Logframe - essentially how the programme will be delivered to reach each of the milestones you have planned. You can also summarise any risks from your risk analysis matrix within this WASH-NTDs Activities Log.

See below for more detailed definitions of many of the terms used in this document.

Definitions	
Goal (Impact)	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.
Outcome	Define the outcome to be achieved by the programme – in other words, the impact the programme will have, or changes to the environment or to behaviours. This should ideally be a single outcome.
Output	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.
Milestone	When the programme is multi-year, include milestones – interim outcomes you will achieve by the end of each reporting period.
Indicators	Define your indicators: you will need multiple indicators to measure changes and impact, including: NTD indicators (prevalence, intensity, etc); WASH coverage and access; changes in behaviours; process indicators; programme and data quality indicators.

Sources	These are the routine monitoring activities and surveys which will be implemented as part of the programme and will be the direct data source of the milestones.
Means of Verification (MoV)	The MoV are the tangible reports and databases against which you will be able to verify the completion of your milestones and are usually used for dissemination of achivements to programme partners.
Activities	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 through a Gantt chart.
Assumptions	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 of this are 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 (for example when using the 'five whys' approach to problem analysis).
Risks	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. Summarise these risks within your Activities Log
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	Water is available [at the time of survey/questionnaire] from an improved* source on-premises.
	**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*
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
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.
	***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 meters 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.
Qualitative data	Data collected using qualitative methods, such as interviews, focus groups, observation, and key informant interviews. Qualitative data can provide an understanding of social situations and interaction, as well as people's values, perceptions, motivations, and reactions. Qualitative data are generally expressed in narrative form, pictures or objects (i.e., not numerically). Note: The aim of a qualitative study is to provide a complete, detailed description.
Quantitative data	Data collected using quantitative methods, such as surveys. Quantitative data are measured on a numerical scale, can be analysed using statistical methods, and can be displayed using tables, charts, histograms and graphs.
Existing surveys	
Demographic Health Survey (DHS)	DHS country reports can be downloaded here: http://dhsprogram.com/publications/index.cfm
	DHS are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition.
Joint Monitoring Program (JMP)	JMP country files can be downloaded here: https://washdata.org/
	The JMP is a trusted source of global, regional and national data on sustainable access to safe drinking-water and basic sanitation, for use by governments, donors, international organizations and civil society. JMP data are drawn from national data sources including: Nationally representative household surveys; Population and housing censuses; Administrative data (such as regulatory agencies); Service provider data *For household and school-based surveys that are implemented as part of NTD monitoring frameworks, the JMP core questions can be used for determining outputs and milestones.*
Multiple Indicator Cluster Surveys (MICS)	MICS country reports can be downloaded here: http://mics.unicef.org/surveys
	MICS has become the largest source of statistically sound and internationally comparable data on women and children worldwide. Trained fieldwork teams conduct face-to-face interviews with household members on a variety of topics – focusing mainly on those issues that directly affect the lives of children and women. MICS was a major source of data on the MDG indicators and will continue to be a major data for the SDGs

WASH-NTD toolkit logframe - indicator menu

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Goal (Impact)							
Soil Transmitted Helminths	% change in					WHO EPIRF and National Survey Reports	
Trachoma	% change in					WHO EPIRF and National Survey Reports	
Schistosomiasis	% change in					WHO EPIRF and National Survey Reports	
Disease (morbidity) progression	% change in					WHO EPIRF and National Survey Reports	
		Sources: Collected during planned programmatic school and community-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance) and routine programme supervision					
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 operationalised throughout (targets, activities and monitoring) % of District NTD plans with WASH referenced and operationalised throughout (targets, activities and monitoring)					NTD National and District Master Plans; Minutes and list of participants for NTD planning meetings	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
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						
		Sources: Collected through desk-based review of NTD National and District Master Plans; Agendas and list of invitees for NTD planning meetings					
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 taskforces					National NTD taskforce meeting minutes and attendance records	
	% of District-level NTD taskforces with WASH sector representation						
	Presence of NTD representation in a national WASH Sector coordination group						

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
	% of District-level WASH sector coordination groups with NTD representation						
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						
		Sources: Collected through desk-based review of agendas and list of invitees for National and District-level NTD Task Forces and WASH sector Coordination Groups					
COMMUNITY OUTCOMES [WATER]							
Outcome W1							
Increased access and use of (at least) basic water source	% households (HH) using water from (at least) basic water source					WASH sector management information system and reports; household survey reports; routine programme supervision reports	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Output w1.1							
Provision of (at least) basic water source to communities	# HH using accessible (at least) basic water source						
		Sources: Collected in any planned program household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance) and routine programme supervision					
Outcome W2							
Consistent availability of (at least) basic water in sufficient quantities for all domestic uses	% of HH with sufficient quantities of (at least) basic water for all domestic uses (personal hygiene/self-care, cleaning, food preparation and drinking)					Household survey reports and some WASH sector MIS and reports (e.g. infrastructure functionality reports)	
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						
		Sources: Collected in any planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance) and routine programme supervision					
Outcome W3							
Reduced exposure to schistosome contaminated surface water sources	% of HH where no member is exposed to surface water sources					Household survey reports	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Output w3.1							
Increased number of HH who are not exposed to surface water sources through occupation	% HH 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 HH using (at least) basic water sources for all domestic uses such as laundry, washing and cooking						
Output w3.3							
Increased number of HH who are not exposed to surface water sources through domestic activities	% HH who are not exposed to surface water sources through domestic activities						
Output w3.4							
Increased number of HH with children who do not bathe, swim, and/ or play in surface water sources	% HH with children who do not bathe, swim, and/ or play in surface water sources*						
		Sources : Collected in any planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance)					

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
SCHOOL OUTCOMES [WATER]							
Outcome W4							
Increase in (at least) basic water sources located on site and available for all children at school through-out 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					WASH sector MIS and reports; institutional survey reports; programme routine supervision reports; programme survey and evaluation reports; Education Management Information System (EMIS)	
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	**Sources:** Collected during planned institutional surveys, programme school-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance), routine education reporting (MIS) and routine programme supervision					
HEALTHCARE FACILITY OUTCOMES [WATER]							
Outcome W5							
Increased access to (at least) basic water source in healthcare 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					WASH sector MIS and reports; institutional surveys; programme routine supervision; programme evaluation; Health MIS, Service Availability and Readiness Assessments	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Output w5.1							
Provision of (at least) basic water source in targeted HCFs	# of HCFs using accessible (at least) basic water source	**Sources:** Service availability and readiness assessment protocol, WASHFIT protocol and JMP core questions and indicators for monitoring WASH in HCF					
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					WASH sector MIS and reports; household survey reports; programme routine supervision reports; programme evaluation reports	
Output s1.1							
Increased HH coverage to (at least) basic sanitation	% HH with (at least) basic sanitation						
Output s1.2							
Consistent use of (at least basic) sanitation by all HH members	% HH in which all members with access and use (at least) basic sanitation at all times of day and night						
Output s1.3							
Increased HH access to (at least) basic sanitation for people with disability (limited mobility or vision)	% HH with people with disabilities that have access to (at least basic) accessible sanitation at all times						

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
		Source : Collected during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance) and routine programme supervision					
Outcome S2							
Young children not exposed to faecally-contaminated contaminated soil in household compound	% HH with no evidence of human faeces in the compound					Household survey reports	
Output s2.1							
Increased number of compounds and play spaces free from human faecally-contaminated waste	# HH with no evidence of human faeces in the compound # HH with no evidence of human faeces in play spaces	**Sources:** Collected during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance)					
Outcome S3							
Increased hygenic disposal of child faeces	% of HH where child faeces is safely disposed of					WASH sector MIS and reports; household survey reports; programme routine supervision reports; programme evaluation reports	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Output s3.1							
Increased HH coverage of (at least) basic sanitation	% HH with (at least) basic sanitation						
Output s3.2							
Consistent use of (at least basic) sanitation by all HH members	% HH in which all members access and use (at least) basic sanitation at all times of day and night						
		Sources: Collected during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance) and routine programme supervision					
Outcome S4							
Enhanced safe sanitation practices in communities	% communities/villages declared open defecation free (ODF)					National report/database on districts/communities/ villages declared as 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)						
		Sources: Collected through routine programme supervision					

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
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]					WASH sector MIS and reports; institutional surveys; programme routine supervision; programme evaluation; EMIS	
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]						
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						
		Sources: Collected in any planned institutional surveys, programme school-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance), routine education reporting (MIS) and routine programme supervision					

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Outcome S6							
School is faeces free	% schools with no evidence of human faeces in the compound					School-based survey reports	
Output s6.1							
Increased number of school compounds free from human faecal waste	# schools with no evidence of human faeces in the 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]						
		Source : Collected in any planned programme school-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance)					
HEALTHCARE FACILITY OUTCOMES [SANITATION]							
Outcome S7							
Increase in access to basic sanitation in HCF	% of HCFs with basic sanitation					WASH sector MIS and reports; institutional surveys; programme routine supervision; programme evaluation; Health MIS, Service Availability and Readiness Assessments	
Output s7.1							
Provision of basic sanitation in targeted HCFs	# of HCFs with (at least) basic sanitation						
		Sources: Service availability and readiness assessment protocol, WASHFIT protocol and JMP core questions and indicators for monitoring WASH in HCF					

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
COMMUNITY OUTCOMES [HYGIENE]							
Outcome H1							
Basic handwashing following faecal contact (toilet use, child faeces disposal, returning from agricultural activities) by all HH members	% of HH with basic handwashing facilities					Household survey reports	
Output h1.1							
Increased basic handwashing facility available on premises	# of basic handwashing facilities for HH use						
Output h1.2							
Increased HH access to a basic handwashing facility for members with disabilities	% HH with people with disabilities that have access to basic handwashing facility						
		Sources: Collected during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance)					

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Outcome H2							
Use of water, soap and other means for management of NTD-related wounds, infections and other effects caused by disease	% HH with people with water, soap and other means for management of NTD-related wounds, infections and other effects caused by disease					Household survey reports including observed private washing space in the household	
Output h2.1							
Increased HH use of water, soap and other means for management of NTD-related wounds, infections and other effects caused by disease	% HH with people with disabilities that have access to a private washing facility						
		Sources: Collected during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance) - including observation of private washing space in the household					
Outcome H3							
Improved safe household food hygiene practices (preparation, storage, cooking and feeding/ eating)	% of HH with basic handwashing facility in food preparation area					Household survey reports	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
	% of HH with basic handwashing facility in eating area						
Output h3.1							
Increased basic handwashing facility in HH food preparation area	# basic handwashing facility in HH food preparation area						
Output h3.2							
Increased basic handwashing facility in HH eating area	# basic handwashing facility in HH eating area						
		Sources: Collected during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance)					
Outcome H4							
Enhanced healthy hygiene behaviours in communities	% of HH practicing hand, face, body washing at critical times* % of HH in which all members wear shoes for hookworm prevention [disaggregated, where possible, by children/ adults and sex] % of HH avoiding contact with surface water for schistosomiasis prevention					Household survey reports including; observed (or proxy measures) hand, face, body washing practice at critical times; observed shoe wearing; direct answers about surface water contact	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
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 HH members who have basic knowledge of hygiene practices	# of HH members who have basic knowledge of hygiene practices [broken down by relevant NTD specific indicators]						
Output h4.4							
Increased number of HH members who recall key messages about NTD prevention and treatment	# of HH members in target population who recall key messages about NTD prevention and treatment [broken down by relevant NTD specific indicators]						
		Sources: Collected during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance) - including structured observation or proxy measures of practicing hand, face, body washing at critical times; observation of shoe wearing; direct questions about suface water contact					

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Outcome H5							
Children have clean faces (free of dirt and/or nasal and ocular discharge)	% of HH children with clean faces (free of dirt and/or nasal and ocular discharge) among all children*					Household survey reports including; spot check reports on clean faces in HH children	
Output h5.1							
Increased number of children in HH with clean faces (free of dirt and/or nasal and ocular discharge)	# of children in HH with clean faces (free of dirt and/or nasal and ocular discharge)*						
		Sources: Spot checks during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance) - including spot checks on clean faces in HH children					
Outcome H6							
Absence of vector breeding sites in household compound	% HH where compound is free from solid waste and animal waste*					Household survey reports including observed presence of solid, animal and human waste	
Output h6.1							
Increased number of HH free from human faecal waste	# HH with no evidence of human faeces in the compound*						
		Sources: Collected during planned programme household surveys (including but not limited to baseline and endline surveys, coverage surveys, impact evaluations, and surveillance) - including structured observation on presence of solid, animal and human waste					

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
SCHOOL OUTCOMES [HYGIENE]							
Outcome H7							
Basic handwashing following faecal contact by all students	% of schools with basic handwashing facilities in or near sanitation facility					School-based survey reports; EMIS	
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						
		Sources: Collected during planned programme school-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance), routine education reporting (EMIS) and routine programme supervision					
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					School-based survey reports including; spot check reports on presence of basic handwashing facilities in food preparation and eating areas	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
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						
		Sources: Spot checks during planned programme school-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance) - including spot checks on presence of basic handwashing facilities in food preparation and eating areas					
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*					School-based survey reports including; spot check reports on clean faces in children at school	
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)*						
		Sources: Spot checks during planned programme school-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance) - including spot checks on on clean faces in children at school					

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
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*					School-based survey reports including; observed (or proxy measures) hand, face, body washing practice at critical times; observed shoe wearing; direct answers about surface water contact	
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						

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
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						
		Sources: Collected during planned programme school-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance) - including observations (or proxy measures) for hand, face, body washing practice at critical times; observed shoe wearing in students; direct answers about surface water contact					
Outcome H11							
Absence of vector breeding sites in school compound	% schools where compound is well swept and free from solid waste and animal waste					School-based survey reports including; spot check reports on observed presence of solid, animal and human waste in the school compound	

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Output h11.1							
Increased number of schols free from human faecal waste	# schools with no evidence of human faeces in the compound						
		Sources: Collected during planned programme school-based surveys (including but not limited to baseline and endline surveys, impact evaluations, and surveillance) - including structured observation on presence of solid, animal and human waste in the school compound					
Healthcare Facility Outcomes [Hygiene]							
Outcome H12							
Improved hygeine and infection prevention and control (IPC) in HCF	% of HCF using hygienic equipment during surgical procedures and post surgical wound care					WASH sector MIS and reports; institutional surveys; programme routine supervision; programme evaluation; Health MIS, Service Availability and Readiness Assessments	
Output h12.1							
Use of hygienic equipment during surgical procedures and post surgical wound care at HCF	# of HCF using hygienic equipment during surgical procedures and post surgical wound care						

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Output h12.2							
HCFs with basic handwashing facilities present at critical points of care and within 5 metres of sanitation facilities	% of HCFs with basic handwashing facilities present at critical points of care and within 5 metres of sanitation facilities						
		Sources: Service Availability and Readiness Assessment protocol, WASHFIT protocol and JMP core questions and indicators for monitoring WASH in HCF					
Outcome H13							
Improved hygiene behaviours by healthcare staff in HCF	% of health care staff who practice key hygiene behaviours					WASH sector MIS and reports; institutional surveys; programme routine supervision; programme evaluation; Health MIS, Service Availability and Readiness Assessments and/or reports including observed practice of key hygiene behaviours in HCF staff	
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)						

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
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						
		Sources: Service Availability and Readiness Assessment protocol, WASHFIT protocol and JMP core questions and indicators for monitoring WASH in HCF - including sructured observations on HCF staff practicing key hygiene behaviours					

WASH NTD Logframe template

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
GOAL (IMPACT)							
		Sources					
Process outcomes							
Outcome PX							
Output px.1							
Output px.2							
		Sources					
Community Outcomes [Water]							
Outcome WX							
Output wx.1							
Output wx.2							
		Sources					
School Outcomes [Water]							
Outcome WX							
Output wx.1							
Output wx.2							
		Sources					
Healthcare Facility Outcomes [Water]							
Outcome WX							
Output wx.1							
Output wx.2							
		Sources					
Community Outcomes [Sanitation]							
Outcome SX							
Output sx.1							
Output sx.2							
		Sources					
School Outcomes [Sanitation]							
Outcome SX							
Output sx.1							
Output sx.2							
		Sources					
Healthcare Facility Outcomes [Sanitation]							
Outcome SX							

OBJECTIVES	INDICATORS	MILESTONES				MEANS OF VERIFICATION	ASSUMPTIONS
		Baseline	Milestone 1	Milestone 2	Endline		
Output sx.1							
Output sx.2							
		Sources					
Community Outcomes [Hygiene]							
Outcome HX							
Output hx.1							
Output hx.2							
		Sources					
School Outcomes [Hygiene]							
Outcome HX							
Output hx.1							
Output hx.2							
		Sources					
Healthcare Facility Outcomes [Hygiene]							
Outcome HX							
Output hx.1							
Output hx.2							

WASH NTDs Activities logframe template

Outcome PX								
OUTPUT px.1	ACTIVITY px.1	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	Risks
	ACTIVITY px.2	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	
	ACTIVITY px.3	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	
Outcome WX								
OUTPUT wx.1	ACTIVITY wx.1	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	
	ACTIVITY wx.2	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	
	ACTIVITY wx.3	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	
Outcome SX								
OUTPUT sx.1	ACTIVITY sx.1	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	Risks
	ACTIVITY sx.2	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	
	ACTIVITY sx.3	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	
Outcome HX								
OUTPUT hx.1	ACTIVITY hx.1	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	Risks
	ACTIVITY hx.2	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	
	ACTIVITY hx.3	Sub-Activities	Baseline	Milestone 1	Milestone 2	Milestone 3	Endline	

Definitions and checklist for programme monitoring logical framework development

Definitions and checklist for programme monitoring logical framework development

Definitions:

- Goal: the higher order objective that you are seeking to achieve through this project, often in combination with others. also referred to as overall objective, impact, long-term result.
- Outcome: the primary results the programme will achieve, such as short-term and medium term changes, as a result of the programme. Also referred to as specific objective, purpose, mid-term result. Outcomes must relate to the Goal.
- Output: what the programme will deliver. Also referred to as expected results, results, expected change, immediate change, short-term result. Outputs must have a direct relationship with the Outcomes.
- Activities: how the programme will be delivered. Also referred to as interventions, inputs, organised actions.
- Indicator: set to help monitor progress and evaluate performance on the objectives set at the beginning of the programme and whether outcomes and outputs are being achieved.
- Means of verification: The source of information to inform the indicators (e.g. surveys).
- Assumption: An important event, condition or decision outside the control of the programme, identified at the start of the process. Assumptions are important to clarify the extent to which programme objectives depend on external factors.

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 if/then relationship 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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