Single Form WASH Indicators guidance

PRELIMINARY REMARK:

Most of the reported guidance are extracted from the following references:

The SPHERE Standards: https://www.spherestandards.org/

John Adams, Jamie Bartram, Yves Chartier, Jackie Sims, Water, Sanitation and Hygiene Standards for Schools in Low-cost Settings (2009): https://iris.who.int/bitstream/handle/10665/44159/9789241547796_eng.pdf

[JMP] Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals (2018) https://iris.who.int/bitstream/handle/10665/275783/9789241514545-eng.pdf?sequence=1

WHO, Guidelines for drinking-water quality, 4th edition, 2017: https://iris.who.int/bitstream/handle/10665/254637/9789241549950-eng.pdf?sequence=1.

WHO, Guideline for drinking water quality, small water supplies (2024): https://iris.who.int/bitstream/handle/10665/375822/9789240088740-eng.pdf?sequence=1.

WHO, John Adams, Jamie Bartram, Yves Chartier, Essential environmental health standards in health care (2012): https://iris.who.int/bitstream/handle/10665/43767/9789241547239_eng.pdf?sequence=1

WHO, John Adams, Yves Chartier, Ben Harvey and Dominique Maison, Water, Sanitation and Hygiene (WASH) in healthcare facilities in emergencies (2011): https://unicefeapronutritionwashtoolkit.com/wp-content/uploads/2017/09/wash_in_health_facilities_in_emergencies_who.pdf.

WHO, Adams J. Bartram J. Chartier Y. & Sims J., Water Sanitation & Hygiene standards for school in Low-cost settings (2009): https://iris.who.int/bitstream/handle/10665/44159/9789241547796_eng.pdf?sequence=1

WHO & UNEP Guidelines for the safe use of wastewater, excreta and Greywater, vol 1 Policy and regulatory aspects (2006): https://iris.who.int/bitstream/handle/10665/78265/9241546824_eng.pdf?sequence=1.

Handicap international, Accessibility for all in emergency context (2009). https://www.humanitarianlibrary.org/sites/default/files/2014/02/Guidelines-for-Accessibility-in-Emergencies-HI.pdf.

UNICEF; Water, Sanitation and Hygiene (WASH) in Schools, A companion to the Child Friendly Schools Manual (2012): https://inee.org/sites/default/files/resources/CFS_WASH_E_web.pdf.

WASH Cluster, Sanitation Quality Standards for Emergencies (2021): https://sanihub.info/wp-content/uploads/2022/11/FSM-TWiG-Sanitation-Quality-Standards-2021.pdf.

UNICEF, Scaling up Group Handwashing in Schools, Compendium of group washing facilities across the globe (2016): http://www.fitforschool.international/wp-content/ezdocs/giz_unicef_Catalogue_WashingFacilities_FINAL_WEB_new.pdf.

WEDC, Peter Harvey, Sohrab Baghir & Bob Reed, Emergency Sanitation, Assessment and programme design (2002): https://wedc-knowledge.lboro.ac.uk/resources/books/Emergency_Sanitation_-_Complete.pdf

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Water Supply

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1 **Compulsory Indicator:** Number of beneficiaries having access to sufficient and safe water for domestic use

Definition:

Access:

1) Maximum distance to water point 500m, queuing time less than 30min, filling time maximum 3 min/20 litres or as locally agreed.
2) During the whole duration of the action as soon as water services are delivered.

Sufficient: 7.5-15 l/p/d or as locally agreed.

Safe:

1) Protected water point and no faecal coliforms detectable in any 100-ml sample.
2) 0.5 mg/l of free residual chlorine, turbidity below 5 NTU, pH below 7.5 measured at point of use level for all transported (network, trucking) and stored waters.
3) Free residual chlorine minimum requirement raised to 1 mg/l in cholera prone season in hotspots areas or during ongoing

epidemic.

4) Drinking water physical, chemical contents & radiological or levels remain below WHO or locally agreed standards.

Domestic use: drinking, cooking and personal hygiene (incl. laundry).

Perceived safety and security hazards: refer to §**Error! Reference source not found.** (% of beneficiaries satisfied with water supply service).

Reported safety and security hazards: refer to Shelter & Settlements standard indicator.

- ***Sources of verification:***

Dividing the quantity of delivered water by the population served does not reflect the discrepancies of performance among the different points of water collection.

Focus Group discussions are not recommended as those are indirect report of the performance of the service. Households' interviews must be completed with households' premises observations (status of the water storage recipient, capacity, number).

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Refer to related used sampling protocols & calculations.

The frequency of sampling for water quality measurement is monthly at point of collection for piped water system serving less than 5,000p. The table below details the required frequency according to the water network coverage:

Minimum sampling frequency for large piped water supplies	
Population served	Minimum sampling frequency
Less than 5,000	1 sample monthly
5,000-100,000	1 sample per 5,000 population monthly
Over 100,000	20 samples monthly plus one sample per 10,0000 population monthly

[WHO]

Absence of faecal contamination (E. Coli) can be confirmed with the measurement of residual chlorine, turbidity and pH.

At point of use level, the frequency of sampling for bacteriological analysis purposes can vary from twice a year up to once a month if results show higher likeliness of bacteriological contamination.

Physical/chemical sampling & Analysis can be measured once to twice yearly. For parameters of concerns (near the WHO threshold) a more frequent monitoring is required (monthly at the beginning to document the parameters content' stability).

1.1 Standard indicator: Number of patients having access to sufficient and safe water in Health Facilities

- ***Definition***

Quantities required:

- Pending on case management: 5 litres per outpatient and 40–60 litres per in-patient per day.
- For mobile Clinic: 1 -5l/patient/day pending on the centre visit frequency (the lower the frequency, the highest the need).
- Per disease:
  - Cholera
    - Treatment Centres:
      - 60 litres per patient per day.
      - 15 litres per carer per day.
    - Oral rehydration points (ORPs): 10 litres per patient per day.
  - Viral Haemorrhagic Fever Centres: 300–400 litres per patient per day.
  - Therapeutic feeding centres:
    - 30 litres per in-patient per day
    - 15 litres per carer per day.
- Per intervention: 100 litres per surgical intervention and delivery
- Per toilet: 20–40p/d/user for conventional sewer-connected flushing toilets, 3–5 l/d/user for pour-flush toilets, 1-2l/p/d for Anal washing.
- Additional quantities may be needed for laundry equipment.
- Needs of the health staff must also be considered pending on whether they stay in the structure at night or not (15l/d or 5l/d respectively).

All the water dedicated to drinking purposes that is stored in a tank or a reservoir, or that is distributed from an internal water supply network, must have at least a 0.5 mg/l of free residual chlorine, turbidity below 5 NTU and pH below 7.5. measured at point of use level.

Storage capacities must be adapted according to the frequentation of the health facilities (average, maximum, etc; number of outpatient & in-patient per day) and the foreseen number of interventions.

In case of hot water network, piped water should be maintained at 50°C to reduce bacteria proliferation (legionella, or pseudomonas).

The operation and maintenance of water supply service must:

- Be done by a qualified technician able to ensure basic repairs (leak fixing, pipe replacement) water treatment and quality control (turbidity, pH and free residual chlorine measurements). Health facilities management should know whom to contact in case of major equipment repairs or replacement.
- Medical staff should not do such operations.
- Dedicated resources (staff, equipment and consumables costs) must be included in the running cost of the health facility's budget.

- ***Sources of verification:***

All health facilities supported by the action must be monitored. Dedicated register reporting water quality measurements, water supply events and intervention done by the technician should serve as a basis for water supply performance's documentation. It should nevertheless be completed by random visit (once a month) aiming at measuring if the water quality & quantities available are compliant with the expected standards. Measurements & observations should be completed by users' interviews (medical staff & patients).

1.2 Standard indicator: Number of learners having access to sufficient and safe water in learning facilities.

- ***Definition***

Quantities required:

- Day school: 3-5 l/d per learner and per staff for drinking and hand washing purposes (use for toilets not included).
- Boarding schools: 20 l/d per learner and per overnight staff for drinking and personal hygiene purposes (use for toilets not included).
- Per toilet: 20–40p/d/user for conventional sewer-connected flushing toilets, 3–5 l/d/user for pour-flush toilets, 1-2l/p/d for Anal washing.

All the water dedicated to drinking purposes that is stored in a tank or a reservoir, or that is distributed from an internal water supply network, must have at least a 0.5 mg/l of free residual chlorine, turbidity below 5 NTU and pH below 7.5. measured at point of use level.

Storage capacities must be adapted according to the frequentation of the learning facility (number of student and school staff).

The operation and maintenance of water supply service must:

- Be done by a qualified technician able to ensure basic repairs (leak fixing, pipe replacement) water treatment and quality control (turbidity, pH and free residual chlorine measurements). Learning facilities management should know whom to contact to process major equipment repairs or replacement.
- Neither learner nor teacher should do such operations.
- Dedicated resources (staff, equipment and consumables costs) must be included in the running cost of the school's budget.

- ***Sources of verification:***

All learning facilities supported by the action must be monitored. Dedicated register reporting water quality measurements, water supply events and intervention done by the technician should serve as a basis for water supply performance documentation. It should nevertheless be completed by random visit (once a month) aiming at measuring if the water quality & quantities available are compliant with the expected standards. Measurements & observations should be completed by users' interviews (teachers & learners).

1.3 Standard indicator: Number of beneficiaries with a reliable water supply service

- ***Definition***

In case of infrastructure breakdown, continuity of service must be ensured by:

Designs:

- Interconnections of water supply and distribution lines that can back up defaulting sections of the network.
- Water storage facilities have a cumulated storage capacity equivalent to a one-day water consumption demand (public and humanitarian support services' included).
- Each water storage infrastructure can be bypassed.

Capacities:

- Main equipment (submersible pumps, solar panels, etc) have replacement unit or can be compensated by the functioning ones (interoperability of equipment).
- Spare part buffer stock covers their replenishment delays.
- Organization in charge of O&M have technicians onsite able to reorient water distribution and process basic repairs such as spare part replacement, pipe fixing, masonry, water tanks patching.

Contingencies: There is an alternative water supply scheme that secures service delivery in case of major breakdown.

Sources of verification

Systematic register of water supply disruption delay including disruption description, repair &/or replacement proceeded, and cost involved. Name, location and contact information of suppliers (equipment & spare parts). Equipment & spare part stock registers with reported minimum buffer quantities required. Water network schemes and characteristics (pipes & infrastructure).

1.4 Standard indicator: Number of beneficiaries whose water resources are monitored, and resource-related water shortage mitigated

Definition

Monitoring:

1) Underground water: Aquifer water levels are being monitored at least on a weekly to monthly basis if the dynamic level of the aquifer is located 10 m higher (or as per locally agreed) than the water extraction level. Daily to weekly if dynamic level is less than 10m higher.
2) Surface water: River water levels are being monitored at least on a weekly to monthly basis if the river water level is located 1,50 m higher (or as per locally agreed) than the water extraction level. Daily to weekly if river water level is less than 1.5m higher

Mitigation: Alternative water resources are identified, accessible, available and equipped to comply to water supply compulsory indicator requirements (§**Error! Reference source not found.**).

Sources of verification

Systematic register of all water resources level at the same spot and same time of the day. Groundwater levels should not be monitored in borehole also used for water production. When impossible, water levels should be measured in the morning prior to water extraction. Data collection frequency depends on the aquifer's depth (see indicator definition).

1.5 Standard indicator: % of beneficiaries that are satisfied with water supply service

Definition

Six indicators should be monitored, and the reported value should the lowest. Those indicators are the % of users satisfied with:

1) Water availability (quantities).
2) Water accessibility (time required to access it).
3) The safety of the service (access & in situ).
4) Water quality as perceived (taste, odour).
5) Household's storage capacity (volume).
6) Households' transportation capacity (containers size, material & number).

Sources of verification

Interview of key informants and focus Group discussions can replace 5% statistically accurate households' interviews to capture the satisfaction of the users provided the audience is endorsed by the users to represent them. Complain mechanisms could also complement the reliability of the information collected.

5% statistically households' interviews does not mean a sample of 5% of the beneficiaries' population. Please refer to related used sampling protocols & calculations.

Sanitation

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2 **Compulsory Indicator:** Number of beneficiaries with access to dignified, safe, clean and functional excreta disposal facilities

Definition

Access:

1) Unlocked doors: No lock should prevent user from accessing the latrine (external access). Locks should be systematically placed inside to ensure privacy (inner safety).
2) Ratio (user/facility) of 1 toilet for a maximum of 20 people or as locally agreed.
3) Distance: < 50 metres from dwellings or as locally agreed.
4) One access ramp with a ≤10% slope & ≥ 90 cm width for people with disabilities.

Clean: absence of faeces & urine inside and around the toilet cabins.

Dignified:

1) Use of toilets respect cultural preference and is arranged by household(s) and/or segregated by sex.
2) For collective latrines, Hygiene promotion materials can be displayed on the structure to strengthen the link between practice and health benefit.

Safe:

1) Stable (lined) pits with no risk of collapse, isolated from the environment
2) Minimum 30m distant from any drinking water sources and pit base located at least 1.5m higher than the aquifer level all year long.
3) Hazard free located (floods) and designed (earthquake or weather related).
4) Properly sited facilities which preserve women and girls from attacks, especially at night.

Functional:

1) Service: Fully constructed and in working order, with adequate quantity of water (1-2l/p/d for anal cleansing, 20-40l/p/d for conventional flushing connected to sewers, 3-5l/p/d for poor-flush toilet).
2) Hand washing facilities (water & soap or other disinfecting consumable such as hydroalcoholic solutions) should be provided within 5m of the latrine. They should include an adequate drainage if needs be.
3) Menstrual Hygiene Management: Female-shared facilities should include a discrete disposal mechanism (container with a lid) and a supply, collection and disposal system.
4) Other Equipment such adequate lighting, accessibility for people with disabilities, and anal cleansing material should be included in the facility's design.
5) The expected public health benefit provided by latrines is granted only if the response secures absence or limited open defecation within the targeted community. It implies that 75% to 80% of the community hosting the beneficiaries are also using safe latrines. In acute emergencies, it can usually be achieved in a timely manner with the following options:
    - Provision of collective emergency latrine in settlement.
    - Provision of households' latrines with conditional cash for scattered populations (self-built latrines).
    - Inclusion of small shovels in the WASH kit (self-disposed excreta).

    If the strategy does not aim at achieving 75% to 80% community coverage, it cannot be considered as seeking to achieve a public health benefit and is, therefore, not a WASH related activity. It can nevertheless follow a protection related rationale aiming at improving the feeling of safety of vulnerable population. Being the case; related activity should be reported in a Protection related intervention. In that case, the upper technical requirements still apply.

- ***Sources of verification***

Dividing the number of beneficiaries by the number of excreta disposal facilities is not an accurate proxy that can reflect the discrepancies of the access to the service among them. What should be reported is the number of users that have access to facilities that are compliant with the above guidance.

For structural related indicators (distance; access ways), all infrastructures should at least be monitored once unless context evolves (new influxes of people in need, security situation worsen, services collapse, etc.).

For all usage related issue (number of users, cleanness, inner locks, lighting, etc), all infrastructures should be monitored monthly. Frequency can be adjusted in accordance with the number of users (the higher the number, the higher the frequency) and public health related risks (epidemic prone areas require more frequent monitoring). Inspections should be completed by interviews of users' perception of safety and functionality (medical staff & patients).

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Refer to related used sampling protocols & calculations.

2.1 Standard indicator: Number of patients with access to dignified, safe, clean and functional excreta disposal facilities in Health Facilities

- ***Definition***

Access:

1) Unlocked doors: No lock should prevent user from accessing the latrine (external access). Locks should be systematically placed inside to ensure privacy (inner safety).
2) Ratio (user/facility) of 1 toilet for a max. 20 outpatient and for every 10 beds. Dedicated latrines for staff. Number of latrines should be calculated according to the frequentation of the health facility.
3) Distance: within the facility premises with exclusive facilities for services requiring specific infection prevention and control protocols such as cholera or haemorrhagic fevers treatment wards.
4) One access ramp with a ≤10% slope & ≥ 90 cm width for people with disabilities.

Clean: absence of faeces & urine inside and around the toilet cabins.

Dignified:

1) Segregated by sex and user (staff, patients).
2) Hygiene promotion materials can be displayed on the structure and within the health centres premises to strengthen the link between practice and health benefit.

Safe and functional toilets:

1) Special toilets adapted to children should be provided for paediatric wards.
2) Toilets should be cleaned at least twice per day with detergent and water, using brushes and disinfectant (0.2% chlorine) to remove soiling. In specific contexts (cholera), half a cup of 2% active chlorine solution is used to disinfect patient's excreta.
3) Refer to the definition of Excreta management compulsory indicator in §**Error! Reference source not found.** for further guidance.

- ***Sources of verification***

All health facilities supported by the action must be monitored with programmed (once a month) and random visits aiming at measuring the accessibility of the premises, the availability of water, soap, MHM consumables, the cleanness of the premises, etc. are compliant with the expected standards. Frequency of monitoring must be adjusted in accordance with public health related hazards specific to the area covered by the health facility (cholera hot spot for instance) and its frequentation. Inspections should be completed by interviews of users' perception of safety and functionality (medical staff & patients).

2.2 Standard indicator: Number of patients benefiting from health facility with safe wastewater management system

- ***Definition***

1) Health facilities drainage and wastewater system can treat and evacuate:
   - Field hospital: 55 litres/person/day.
   - Cholera treatment centre: 100 litres/person/day.
   - Feeding centre: 25 litres/person/day.
   - Out-patients clinic: 100 litres/day (total).
2) All water consuming services (such as bathing areas, laundry places, kitchens, handwashing facilities) are equipped with appropriate wastewater evacuation system.
3) Infiltration systems are sited to avoid contaminating groundwater (1.5 m above the groundwater table the whole year long and >30 m from any groundwater source).
4) Drainage designs include wastewater from services, roofs and runoffs.

- ***Sources of verification***

Direct observation of all health facilities on a monthly basis as a routine. Frequency of monitoring must be adjusted in accordance with public health related hazards specific to the area covered by the health facility (cholera hot spot for instance) and its frequentation. During epidemic prone season or effective outbreak, frequency of monitoring can be weekly to daily as per locally agreed.

2.3 Standard indicator: Number of learners with access to dignified, safe, clean and functional excreta disposal facilities in learning facilities

- ***Definition***

Access:

1) Unlocked doors: No lock should prevent user from accessing the latrine (external access). Locks should be systematically placed inside to ensure privacy (inner safety).
2) Ratio (user/facility) of 1 toilet for a max. 20 learners with separated latrines for staff.
3) Distance: within the facility premises with dedicated infrastructures for infirmary and dormitories (when those are included in the learning facilities premises).
4) One access ramp with a ≤10% slope & ≥ 90 cm width for people with disabilities.

Clean: absence of faeces & urine inside and around the toilet cabins.

Dignified:

1) Separate toilet facilities for younger and older children; for girls and boys, particularly adolescents; and for female and male teachers.
2) Hygiene promotion materials linking the benefit of using latrine with health are displayed.
3) Hygiene promotion is included in the curricula of the teachers of the learning facilities.

Safe and functional:

1) Toilets and hand washing devices are adapted to the children' size.
2) Refer to the definition of Excreta management compulsory indicator in §**Error! Reference source not found.** for further

guidance.

- ***Sources of verification***

All learning facilities supported by the action must be regularly monitored (once a month) and completed with random visits aiming at measuring that accessibility of the premises, availability of water, soap and MHM consumables, cleanness of the premises, etc. are compliant with the expected standards. Frequency of monitoring must be adjusted in accordance with the learner's population, in cholera hotspot and in case of ongoing epidemic in the catchment area of the learning facility. Inspections should be completed by interviews of users' perception of safety and functionality (staff & learners).

2.4 Standard indicator: Number of beneficiaries having a reliable excreta management service

- ***Definition***

Management:

1) Excreta level in pit remain 1m below its top (or as per locally agreed).
2) Excreta collection (pit emptying), transport and final disposal operations are isolated from the environment (absence of nuisance - smell, spillovers-).
3) Staff in charge of excreta management are equipped with personal protective equipment (gloves, safety glasses and shoes, overalls, or as per locally agreed) and vaccinated against infection linked to excreta exposure (Tetanus, Polio, Typhoid fever, Hepatitis A and B or as per locally agreed)
4) Consumable & cleaning tools buffer stock covers their replenishment delays.

Reliable:

1) Disruption of service linked to failure of basic equipment (excreta spillage) is addressed within 24 hours following its occurrence.
2) Organization in charge of O&M have access to equipment & consumable supply chains and appropriate technician's network within 24h or a delay that does not lead affected populations to adopt negative coping mechanism with regards to excreta disposal.

- ***Sources of verification***

Latrine pit filling levels are monitored on a quarterly basis as a routine and on a monthly when they are about to be filled. Latrines that required an intervention (repair, emptying) should be identified in registers, with the type of intervention processed, delays & costs. Name, location and contact information of suppliers (equipment & spare parts) should be recorded. Equipment & spare part stock with reported minimum buffer quantities required as well. Latrines' design and location (GPS coordinates) should also be recorded.

2.5 Standard indicator: Number of beneficiaries using environment friendly latrine (contamination monitoring)

- ***Definition***

Monitored:

1) The extend of the effluent plume in the soil should not be closer to 1.5m of any aquifer limit.
2) Faecal sludge parameters before release should be pH ≤9, Temperature ≤30°C, Nitrate ≤50 mg/l, Phosphate ≤15mg/l, BOD ≤30 mg/l, COD ≤125mg/l, Oil & grease ≤10 mg/l, Total Coliform ≤1,000 units/100 ml, Conductivity ≤1000µS/cm, TSS ≤100mg/l, or as locally agreed.

Contamination

1) Faecal Sludge contamination source is decommissioned when the effluent plume is less than 1.5m distant from any aquifer limit or as per locally agreed.
2) Faecal sludge management alternative sites of similar treatment capacity are identified, accessible and available in case of failure of the existing one.

Recycling:

1) Storage treatment of dry excreta and faecal sludge before household or municipal use should be at least one year (when storage ambient temperature is >20–35°C) to 2 years (when 2-20°C) ensuring that pH is above 9 for at least a six-month duration.
2) Helminth eggs content in treated faeces and faecal sludge grey water should not exceed 1g/l for irrigation (restricted or not) while E. Coli units count is:
   - $<10^3$ per gramme of treated faeces and faecal sludge.
   - $<10^5$ per 100ml for greywater use in restricted irrigation ($<10^3$ for unrestricted irrigation).

- ***Sources of verification***

Quarterly monitoring of all effluent plume extent & composition is recommended as a basis that can be modified according to contamination risks previous monitoring may highlight. Geophysics and physiochemical methods can be used to document plume extent around latrines. Groundwater levels monitoring, geology, location of drinking water points latrine and latrines, their

characteristics (borehole logs, type of latrine), site inspection and bacteriological analysis of surrounding water points can be used as proxies when direct measurement methods are not available.

2.6 Standard indicator: % of beneficiaries satisfied with excreta disposal service

- ***Definition***

Four indicators should be monitored, and the reported value should the lowest. Those indicators are the % of users satisfied with:

1) The latrines access (distance and availability).
2) The safety of the service (path and location).
3) The appropriateness of the latrines (robustness, equipment).
4) The security of the latrines (locks, lightings).

- ***Sources of verification***

Users' perception of the service can be captured twice a year either through households' interviews (with a 5% statistically accurate sample size) or interview of key informants and focus Group discussions provided the audience is endorsed by the users to represent them.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Please refer to related used sampling protocols & calculations.

Hygiene

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3 **Compulsory Indicator:** Number of beneficiaries having regular and appropriate access to soap to meet hygienic needs

- ***Definition***

Quantities distributed must ensure access to 250g soap/person/month for personal hygiene and 200g soap/person/month for the entire duration of the acute phase of the crisis.

Additional provision of soap must be envisaged for:

- Menstrual hygiene (250g/woman/month)
- Incontinence (500g/p/m for bathing and 500g/p/m for laundry).

Local practice and expectations should be privileged when they provide the same benefit as soap in terms of public health.

Distribution of soap should be complemented with onsite hygiene promotion sessions about the five handwashing key moments. Provision of IEC leaflet to beneficiaries is also recommended during distribution.

In-kind modality should be privileged when access to soap is challenging either in terms of physical access (road destruction), security or supply chain disruption. When privileged, the use of Multipurpose Cash Transfer should be:

- Preceded by a preliminary assessment of proper access to marketplaces in terms of distance, safety, security and supply chain capacity.
- Concluded by a post distribution monitoring analysing the difference between the cost of the foreseen quantities of soap in the minimum basket expenditure with the effective spending on soap and the related quantities it provided.

Items such as hairbrush, shampoo, toothpaste, toothbrush are not lifesaving per say and can only be envisaged if minimum needs in terms of soap or essential items (refer to §**Error! Reference source not found.**) are covered.

- ***Sources of verification***

Presence of soap at household level should be monitored during post-distribution monitoring household survey which verifies with 5% statistically accurate representative sample. Interview of key informants and focus Group discussions can be envisaged if access to beneficiaries' households is not possible. It should not be privileged, though, as it may not guaranty a reliable evaluation of the duration of the support provided.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Refer to related used sampling protocols & calculations.

3.1 Standard indicator: Number of patients having regular and appropriate access to soap to meet hygienic needs in Health Facilities

- ***Definition***

Soap is the most frequent consumable to secure personal hygiene in health facilities. Access to soap implicitly include access to water.

It is also considered here as a generic term that can also include hydroalcoholic gels, 0.05% chlorinated solution, or other locally agreed practises that provide the same public health benefit.

Access to soap and handwashing devices includes:

1) Needs of outpatients, inpatients and staff for healthcare delivery services (wards, consulting rooms, delivery rooms, operating theatres, etc.) and service areas (kitchen, laundry, showers, toilets, sterilization, laboratory, waste zone and mortuary).
2) Handwashing devices located inside or aside the service (less than 5 metre distant).
3) Handwashing devices can be operated by patients with disabilities.
4) At least two handwashing stations per wards with more than 20 beds.

Functional implies:

1) Information of outpatient and inpatient of the hygiene practises that apply in the health facility upon arrival (within 30 minutes): All patients should be encouraged to wash their hands with soap and water:
   - Directly before handling food, water, or medication.
   - Directly after using the toilet.
   - Directly after handling infectious materials (e.g. soiled clothing / bedding).
   - When entering and leaving high-risk areas such as isolation areas.

   Posters and other visual containing practical and realistic advice and information should be adapted and used to promote infection control measures among staff, patients and carers.
2) Continuous availability of:
   - Soap, water and proper drainage at handwashing station level
   - Hydroalcoholic gel or chlorinated water stored under shade the whole day.

About showers & laundry stations:

1) Shower ratio is one shower per 40 users (patients, staff and carers) for inpatients services. For outpatient facilities, four showers can be recommended (gender separated structure for staff and outpatient). All showers should be properly drained.
2) Laundry facilities, with soap or detergent, hot water (if appropriate) and a disinfectant (such as chlorine solution), are available for inpatient settings. Laundry Stations:
   - Should be close to users to facilitate laundry washing as often as required.
   - Provide sufficient privacy (drying of underwear, menstrual hygiene materials, etc.).
   - Potentially infectious wastewater should be disposed of in a safe soak pit that does not contaminate groundwater or the public environment.
   - Should be exclusive in infectious wards. Materials should be provided so that soiled bedding or clothing and bedding can be soaked in 0.2% chlorine solution before being rinsed, washed and dried.

- ***Sources of verification***

All health facilities supported by the action must be monitored on a regular basis (monthly) to ascertain the functionality of the hand washing device (availability of soap, water, proper drainage) or other disinfecting device (dispensers with chlorinated water or hydroalcoholic gel stored in the shade). Regular visit should be completed with random site inspections and users' interviews (medical staff & patients).

3.2 Standard indicator: Number of learners having regular and appropriate access to soap to meet hygienic needs in learning facilities

- ***Definition***

Recommended techniques are hand washing with soap but hydroalcoholic gels or 0.05% chlorinated solution can be envisaged as a temporary solution.

Access:

1) Handwashing stations usually accommodate ten children (number depending on school size and available space).
2) Handwashing stations serves are not only located aside toilets but should also be located nearby services that requires regular handwashing such as waste management areas, or refectories.
3) All hand washing devices are located inside or aside the service (less than 5 metre distant).
4) Handwashing devices can be operated by learners with disabilities

Functional implies:

1) All hand washing devices dedicated to children's use are adapted to their size.
2) All handwashing facilities using water have a drainage system.
3) Signboards presenting the five key moments for handwashing with soap are displayed in classrooms and latrines (or as per locally agreed).

4) Hygiene awareness (handwashing with soap) is integrated in the school curricula. It should include menstrual hygiene management awareness session for girls in age.
   Continuous availability of either:
   - Soap, water and proper drainage at handwashing station level
   - Hydroalcoholic gel or chlorinated water stored under shade the whole day.

- ***Sources of verification***

All learning facilities supported by the action must be monitored on a regular basis (monthly) to ascertain the functionality of the hand washing device (availability of soap, water, proper drainage) or other disinfecting device (dispensers with chlorinated water or hydroalcoholic gel stored in the shade). Regular visit should be completed with random site inspections and users' interviews (staff & learners).

3.3 Standard indicator: Number of beneficiaries with access to appropriate hygienic practises awareness.

- ***Definition***

Awareness focuses on the key handwashing moments: After latrine, before eating, before cooking, before breastfeeding and after disposing baby's faeces.

The monitoring of the awareness should be completed with the monitoring of:

1) The availability of soap (§3) to document the capacity of the beneficiaries to implement hygiene recommendations (Attitude).
2) The presence of soap in areas prone to handwashing (latrines, dining areas) as a proxy to assess the practise of the hygiene recommendations.

Hygiene promotion activities should be:

1) Preceded by an assessment of the targeted communities' knowledge to document the need for sensitization and finetune the sensitization methodology in accordance with the context of the intervention (acute, post-acute, protracted), the timeframe of the action and the foreseen duration of the support.
2) Documented in terms of communication channels:
   - Recurrence (number of time targeted people participate to a hygiene sensitization session).
   - Audience (number of people per session and total number of people reached per communication channel).
3) Followed by an analysis of the most effective channel of communication when several ones are implemented.

Access:

1) One hygiene promoter per 500 people when targeted in communities, camp or settlement.
2) Beneficiaries receives related message at least once every quarterly or as per locally agreed.

Signboards presenting the five key moments for handwashing should be displayed in every public building (reception centres, learning facilities, health centres, etc.) & sites (markets, food & NFI distribution points) of the settlement or camp. Signboard includes pictures & local language messages as per locally agreed.

- ***Sources of verification***

Target direct household survey with 5% statistically accurate representative sample twice a year (at the beginning and at the end of the action) or during post distribution monitoring. Focus group discussion and key informer interviews should be avoided as much as possible when access to households is not restricted for security reason or time constraints.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Please refer to related used sampling protocols & calculations.

3.4 Standard indicator: Number of beneficiaries having timely and continuous access to appropriate WASH-related items

- ***Definition***

Timeliness of the provision of WASH related kits implies that the response is:

1) Coordinated with other WASH interventions completing the response (for instance water supply complementing distribution of household water treatment tabs).
2) Optimized with other sectors response (delivery of WASH kits merged with shelter kits, food or cash distribution for instance).

Continuity implies a repeated supply of consumables if the quantities initially provided do not cover the duration of the acute crisis beneficiaries are confronted to.

Access:

1) Distributed quantities should be based on households' size and composition (number of elderly, women -incl. teenagers-, etc.). If kits with predefined quantities are distributed, the number of kits distributed per household must take into consideration its size and composition to secure the coverage of their basic needs over the foreseen duration.
2) Refer to the definition in §**Error! Reference source not found.** for guidance on distribution modality (in-kind, cash, voucher).

Appropriate: Pending on the gaps identified per subsectors, the following items should be privileged:

1) Water supply:
   - Water containers:
     - Distinction should be made between transportation device (jerrycan type) and storage devices (bucket with taps & lids).
     - Volume of containers should allow a 24-hours needs coverage to cope with any service disruption and limit water chores.
     - They should be long lasting, made of UV resistant material and prone to recycling/repurposable (single coloured item made of food grade PP or other recyclable plastic material).
   - Household water treatment
     - The type of household water treatment provided must be consistent with the turbidity of the water collected:
       - 5 NTU or less, Chlorination tablets (NaDCC type) is to be privileged.
       - More than 5 NTU, Flocculation + Chlorination tablets is required. If it is the case, WASH kit should include an additional water container and a cotton cloth of 60*70 cm² size 210g/m² thread).

     Use of commercial water filter is not recommended unless:

     - Its use was already widespread among beneficiaries before the intervention.
     - Spare part network is accessible and affordable to the beneficiaries.
     - It demonstrates a clear added value in terms of cost effectiveness, operation and maintenance and versality compared to the provision of water disinfection tablets.
     - It implies limited use of plastic materials likely to generate non-recyclable waste (either because of the material itself or because of the absence of recycling opportunities).
2) Sanitation:
   - Garden Trowel Hand Shovel to bury excreta (refer to definition §**Error! Reference source not found.**).
   - Bin with lid for solid waste ≥ 30-40l volume (or as per locally agreed) if not addressed by other interventions.
3) Hygiene:
   - Soap: Refer to compulsory standard §3.
4) Menstrual Hygiene Management and incontinence are not WASH specific per say. The are cross sectoral per nature and should be mainstreamed in any distribution activity including women and girls or elderly populations: Beside soap (refer to compulsory standard §3), they should include:
   - Menstrual Hygiene Management:
     - Dedicated container with lid.
     - Rope and pegs.
     - Either (according to women and girls preference):
       - Absorbent cotton material (4m²/year).
       - Disposable pads (15 units/month).
       - Reusable sanitary pads (6 units/ year).
   - Incontinence:
     - Dedicated container with lid.
     - Rope and pegs.
     - Either:
       - Absorbent soft cotton material (8m²/year).
       - Disposable incontinence pads (150 units/month).
       - Reusable incontinence underwear (12 units/year).
       - Underwear (12 units /year).
       - 2 washable leak-proof mattress protectors.
       - Additional water containers.
       - 3 litres of non-diluted domestic bleach (3-6% chlorine)/year or similar disinfectant cleaning product.
       - Bed pan and urinal bottles (male and female).
       - Toilet commode chair (as appropriate).

Items are considering local practice and expectations that are compliant with expected public health benefits and cost effectiveness expectations (lifespan of the kit, number of beneficiaries). The provisions of items that are not lifesaving such as hairbrush, shampoo, toothpaste, toothbrush, comb, can be envisaged as long as upper mentioned items are supply with the recommended quantities.

- ***Sources of verification***

Refer to §**Error! Reference source not found.** Source of verification guidance.

3.5 Standard indicator: % of beneficiaries satisfied with hygiene promotion service.

Definition

Five indicators should be monitored, and the reported value should the lowest. Those indicators are the % of users satisfied with the hygiene promotion:

1) Frequency of sessions.
2) Accessibility to sessions (distance to session, audience size).
3) Safety of sessions (exposure on route to and during session, hygiene promoter behaviours).
4) Tools and methodologies used (in groups, per household, etc.).
5) Content of the sessions (relevancy & language used).

Sources of verification

Users' perception of the service can be captured twice a year (at the beginning and at the end of the action) or during post distribution monitoring either through households' interviews (with a 5% statistically accurate sample size) or interview of key informants and focus Group discussions provided the audience is endorsed by the users to represent them.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Please refer to related used sampling protocols & calculations.

Waste and Environment

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4 **Compulsory Indicator:** Number of beneficiaries living in settlements with an accessible, safe and functional solid waste management system

Definition

Accessible:

1) Pit should be fenced.
2) Distance from household should be 15-30m for family pits and 100 to 150m for communal pits.
3) In marketplace, there is one 100 litres bins for every to 20 market stalls.
4) In feeding centres one 100 litres bins for every 200 users.

Safe:

1) Communal pit dumping area should be equipped with safeguard at waste dumping point.
2) Solid waste landfills are located minimum 750 to 1,000m from any inhabitation.
3) Staff in charge of waste management should be equipped with personal protective equipment (gloves, boots and protective masks or as per local recommendations) and vaccinated against tetanus and hepatitis B.

Functional:

1) Absence of solid waste scattered in the premises of all the households and in the public areas of the settlements.
2) Coherent solid waste storage collection, transport and disposal of 1–3 l/p/d (200 to 400kg/m^3 solid waste density) or as per existing solid waste production/p/d.
3) Disposal facilities (containers, etc) should be emptied at least weekly and every day at markets and feeding centres.
4) No spillage of solid waste occurs during their collection, transport and final disposal.
5) Family and communal pits should be covered with layers of ground or any suitable material at the end of every day.
6) Minimal communal pit volume should be 6 12m^3/100p.
7) Solid Waste landfills waste layers are less than 2m high, its surface is covered with a 15-25cm thick soil layer at the end of each day.
8) Appropriate drainage systems are in place to avoid the flooding of pits and landfill areas.
9) The bases of communal pits, general land-filling sites and medical waste pits should be at least 1.5m above the water table all year long.

Sources of verification

Quantities and type of solid waste collected, transported and treated should be reported in register distinguishing their frequency of collection, the different types of transportations used, and treatments processed (recycling, landfilling, etc.).

All public places included in the solid waste management system must be monitored on a regular basis (quarterly) to ascertain its functionality (absence of solid waste and proper treatment at landfill site). Regular visit should be completed with 5% statistically accurate households assessment and random sites inspections.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Refer to related used sampling protocols & calculations.

4.1 Standard indicator: Number of patients with an accessible, safe and functional solid waste management system at health facilities

- ***Definition***

Accessible

1) Waste containers for infectious waste location is within easy arm's reach everywhere these wastes are generated.
2) Non-sharp non-infectious waste container are in every room.
3) There is at least one set of waste containers per 20 to 40 beds/ward.

Functional:

1) Absence of waste scattered in the health facilities perimeters and within the building.
2) Coherent solid waste storage collection, transport and disposal of 1 to 1.5l of waste/bed or as per local recommendations.
3) The bases of medical waste pits should be at least 1.5m above underground water table all year long.
4) Incinerators are:
   - Designed to burn 10kg of waste/day for every 10,000 people included in the catchment area of the health facility.
   - Designed to reach at least a 1,000°C temperature.
   - Made of refractory brick.
   - At least 4 metre high (to the top of the chimney) and with its metallic components made of stainless steel or cast iron.

Safe:

1) Waste segregation is done at point of production
2) It distinguishes sharps infectious waste and non-sharps infectious waste, non-sharps non-infectious waste and hazardous waste that are stored into different collection containers.
3) Waste containers are colour-coded with pictograms according to their content.
   - Sharps infectious wastes are placed immediately in puncture-proof and covered safe yellow containers.
   - Non-sharps infectious wastes are placed immediately in capacity yellow or red waste bags or 15–40-litre containers with lids. Containers should be collected, emptied, cleaned, disinfected and replaced after each intervention (e.g. in an operating or maternity unit) or twice daily.
   - Non-sharps non-infectious waste are placed in containers (20–60 litre capacity) with a lid (ideally operated with a foot pedal), lined with black sacks, collected daily. Containers are cleaned daily.
4) Poster explaining the colour and symbols of the containers are displayed, explained to and understood by staff and patients.
5) Medical wastes are disinfected before disposal and containers are sealed and leak-proof.
6) Transportation of waste should be done by trolleys or handcarts.
7) Any leakages or spills should be cleared with a 2% chlorinated water solution.
8) Wastes should be disposed as follows
   - Sharps in a dedicated sharps pit (concrete lined pit or buried drums).
   - Non-sharps infectious waste buried in a pit equipped with a sealed cover and ventilation pipe, high temperature incinerated, or steam sterilized.
   - Infectious waste (plastic syringes, laboratory tests) are steam sterilized before disposal.
   - Non-sharps non-infectious waste should be recycled, buried in a pit, or incinerated if space is limited.
9) The Waste-disposal zone
   - Is fenced, protected from flood and water runoffs.
   - Is at least >100m located from any buildings or public areas, >30m from groundwater sources and pits bottom at least >1.5m above the groundwater table all year long.
10) Incinerators
   - Have low or zero visible emissions when operating.
   - Are >300m located from horticulture or leaf crops activity in the direction of the prevailing winds.
   - Distant from regular public passage within its immediate proximity.
11) Personnel assigned to waste management are trained, vaccinated against tetanus and hepatitis B (with semestrial health check-up), equipped with personal protective equipment (thick armoured gloves, thick soled boots, work overalls, aprons, masks, eye protection) and have access to cleaning equipment (brushes, shovels, mops, buckets, wheelbarrows, waste carts etc.), supplies (detergents, disinfectants), functional showers and soap.
12) In Landfills, medical wastes are never mixed with domestic and communal waste.

- ***Sources of verification***

All health facilities supported by the action must be monitored on a regular basis (quarterly or more often in case of epidemic) to

ascertain the functionality of the solid waste management system (absence of waste in the services and common services, proper treatment of medical waste). Regular visit should be completed with random site inspections and users' interviews (medical staff & patients).

4.2 Standard indicator: Number of leaners with an accessible, safe and functional solid waste management system in learning facilities

- ***Definition***

Accessible:

1) Segregated (one for biodegradable and another for non-biodegradable waste) & labelled trash bins present in each building - including toilets- and playgrounds.
2) One trash bin with lid for menstrual hygiene waste in each female latrine cabin in learning facilities hosting girls in age.

Safe:

1) Daily waste collection is not assigned to teachers or learners but to staff recruited to do so. They are provided with appropriate protective equipment and/or clothing (facial mask, hand gloves, wrist covers or long sleeve shirts, rubber boots and apron).
2) Easy to clean trash bins, made of durable, non-porous material; and protection from vermin (lid).
3) Outside and inside areas are free of sharp objects and other physical hazards.
4) In the absence of externalized solid waste collection services, the learning facility is equipped with:
   - One fenced refuse pit, equipped with warning signs, ≥30 m from groundwater source, ≥ 1 m deep.
   - One fenced incinerator ≥30m distant from nearest habitable building with low or zero visible emissions when operating.
   - One compost facility for biodegradable and repurposed waste.

Functional:

1) Absence of waste scattered in the school perimeters and within the buildings
2) Classrooms and other teaching areas are regularly cleaned to minimize dust and moulds.
3) Garbage collection is done at least every day to once a week.
4) Garbage segregation & recycling included in the school curricula.
5) In secondary school, menstrual hygiene waste should be either safely collected and disposed of or incinerated on the school premises once each day.

- ***Sources of verification***

All learning facilities supported by the action must be monitored on a regular basis (quarterly) to ascertain the functionality of the solid waste management system (absence of waste inside the classes, in the courtyard, proper functioning of the waste treatment zone). Regular visit should be completed with random site inspections and users' interviews (staff & learners).

4.3 Standard indicator: % of relief related waste mitigated; segregated, recycled or repurposed

- ***Definition***

All relief deliverables minimize CO_2 gas emission and waste production:

CO_2 gas emission minimizing can be achieved through the provision of equipment or selection of non-food items:

1) That have the greatest lifespan/durability.
2) That have limited volume and weight.
3) That are locally produced.
4) Whose fabrication requires limited industrial processes.
5) Whose components generate no or limited non-recyclable waste.
6) Whose use generates limited or no CO_2 emissions.
7) For which there is a recycling branch where they are delivered.
8) Whose spare parts are also compliant with the upper criteria.

All relief related wastes (including packaging) are collected, segregated according to their own treatment processes:

1) Organic wastes are composted.
2) Plastic (PET, PVC, PPP, HDPE & LDPE); glass & metallic related wastes are recycled.
3) Wastes that cannot be recycled or repurposed are reduced and disposed in a dedicated landfill approved by the authorities.

Staff in charge of waste treatment should be equipped with personal protective equipment (gloves, boots and protective masks or as per local recommendations) and vaccinated against tetanus and hepatitis B.

- ***Sources of verification***

Schemes, technical specification, bills of quantities of all designs, equipment and consumable included in the action. Landfills and waste treatment sites must be monitored on a regular basis (quarterly) to ascertain the effectiveness of the process set in place (proper

segregation, controlled treatment and landfilling, existing commercial outlets for recycled/repurposed waste). Regular visit should be completed with random site inspections and staff interviews.

4.4 Standard indicator: % of beneficiaries satisfied with solid waste management services

- ***Definition***

Five indicators should be monitored, and the reported value should the lowest. Those indicators are the % of users satisfied with the solid waste management system:

1) Access to waste collection device (distance).
2) Design (robustness and user-friendliness).
3) Safety (storage and transport).
4) Collection frequency and capacity.
5) Treatment (processes efficiency and nuisance).

- ***Sources of verification***

Users' perception of the service can be captured twice a year (at the beginning and at the end of the action) through households' interviews (with a 5% statistically accurate sample size) or interview of key informants and focus Group discussions provided the audience is endorsed by the users to represent them.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Please refer to related used sampling protocols & calculations.

Vector Control

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5 **Compulsory Indicator:** Number of beneficiaries benefiting from absence of vector breeding sites in household, public service facilities and places

- ***Definition***

Functional drainage network:

1) No substantial presence of stagnant water in and around the settlement, whether as a large body of standing water (such as a pond) or a high density of small areas (such as water standing in ruts). Small quantities must be considered if contaminated by wastewater but small puddles of rainwater that dry up after a day or so should not be considered a substantial presence.
2) Absence of device or debris likely to serve as an opportunistic vector-breeding water storage (used tyre, broken jars, etc.).
3) Drainage channels:
   - are designed with a [1%;3%] slope.
   - not obstructed by waste, sediments or debris.

Adequate Site:

1) Standing water is ≥ 30m distant from the perimeter of the settlement.
2) Gradient site is:
   - ≥ 1% to provide for adequate drainage.
   - ≤ 6%, unless extensive drainage and erosion control measures are taken.
3) Lowest point of the site is ≥3 metres above underground water table all year long.

Adequate design:

1) Safety: Drainage networks are completed with the required guardrail, piping and bridge at crossovers and highly frequented areas.
2) Water storage devices are covered with lid/free of larvae (in particular rainwater harvesting devices).
3) Water related devices (water points, hand washing stations, laundry & bathing areas, etc.) are equipped with functional drainage channel and soak away pit (absence of stagnant water after use).

- ***Sources of verification***

All public places and services must be monitored on a regular basis (quarterly and more often during the rainy season) to ascertain the absence of obstructing element or presence of stagnant water in drainage networks, and the absence of waste or unused items likely to store water such as tyres, broken recipient, etc. It should be completed with a 5% statistically accurate households' compounds inspection.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Refer to related used

sampling protocols & calculations.

5.1 Standard indicator: % of beneficiaries satisfied with vector control activities

- ***Definition***

Three indicators should be monitored, and the reported value should the lowest. Those indicators are the % of users satisfied with the:

1) Functionality of the drainage system (absence of stagnant water, limited vector presence).
2) The drainage design (footprint).
3) The safety of the drainage network (crossovers and fall hazards).

- ***Sources of verification***

Users' perception of the service can be captured twice a year or at key moments (rainy and or vector prone season) through households' interviews (with a 5% statistically accurate sample size) or interview of key informants and focus Group discussions provided the audience is endorsed by the users to represent them.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Please refer to related used sampling protocols & calculations.

Cholera epidemic

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6 **Compulsory Indicator:** Number of cholera-affected populations covered by a Case Area Targeted Intervention (CATI)

- ***Définition***

Case detection and deployment imply:

1) A coordinated surveillance system with health service allowing immediate alert of cholera cases suspicion upon its detection.
2) A Deployment in affected areas within less than 48 hours following detection.
3) Targeted areas include:
   - The suspected cases compound.
   - The neighbourhood located in a 100-150m radius around the suspected cases compound.
   - WASH facilities, public service and events such as market, place of worship, stations, schools, prisons, funerals and pilgrimage.
   - Specific attention is paid to cholera suspected case funeral monitoring, taking into account local belief and local mourning practises adaptation to infection prevention and control requirements.

Main interventions consist in:

1) Disinfection using different types of chlorinated solutions:
   - 2% for suspected soiled items (latrines, areas soiled with vomit or excreta, mostly at affected households' level).
   - 0,2% for all surface & equipment (floors, beds, latrines, laundry, utensils) that could potentially be hosting the vibrion (at affected household but also in public service).
1) Prevention:
   - 0.05% chlorinated hand washing facilities to be placed at least at the entrance and exit of all public places that are likely to contribute to the dissemination of the disease.
   - Distribution of hygiene kits to cholera affected households and close neighbourhood) to secure the access to safe water and hygiene during the duration of the epidemic. It includes:
     - 450g/soap/p/m.
     - two 20 litres jerrycans or bucket with lids and taps per household of 5 people.
     - Water treatment capacity (disinfection or disinfection-flocculation tabs according to the turbidity of the water the household has access to).
2) Information: Mass media communication about the existence of an ongoing cholera epidemic, the means to identify & avoid contamination and about the management of suspected cases. It includes:
   - At local level: Signboards, public shouters, community-based radios, community relay such as churches, youth, brotherhood and business leaders, community & local authorities.
   - At regional or national level: Mobile phone messaging, radio & television channels, social media platforms.
   - Communication requiring gathering of people are avoided.
   - Specific attention is paid to disease-related local belief and stigma mitigation.

3) Documenting the CATI performance including:
   - Its reactivity: date of first symptoms of suspected case, date of its detection by health service, of the CATI responders alert and of their deployments at affected household & neighbourhood.
   - Its capacity: Maximum number of CATI deployments done per day or week, its geographic coverage, the targeted public and private facilities (latrines, water points, markets, station, etc.).
   - Epidemic dynamic: Georeferencing of affected households, the targeted public places, their catchment areas, the main axis of circulation of people & goods in affected areas.

Sources de verification

For epidemiological figures and CATI documentation: Records of all cholera suspected cases, those who benefited from a CATI and those who did not. Georeferencing and dates of interventions (households and public places) should be carefully recorded to be able to record both the epidemic dynamic and the reactivity of the CATI.

For Disinfection, Prevention & Mass media communication: conduct PDM and KAP surveys of populations exposed to the disease a with 5% statistically accurate representative sample.

5% statistically accurate representative sample does not mean a sample of 5% of the beneficiaries' population. Please refer to related used sampling protocols & calculations.

COORDINATION

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7 Compulsory Indicator: % of affected populations benefiting from an effective WASH coordination mechanism

Definition

Coordination:

1) Comprehensiveness is granted if the all the WASH actors contributing to the support of the affected populations report to the WASH cluster. It documents the coverage of WASH response encompassed by the WASH sector coordination.
2) Consistency is granted when information reported by all WASH actors to the cluster has the same content.
3) Coherency is granted when the information reported by all WASH actors to the cluster is collected the same way (same frequency, sample size; collection methodology).
4) Timeliness is granted when all WASH actors report to the cluster before agreed deadline.
5) Reliability is granted when the information provided by all WASH actors has been verified on site by the WASH cluster team or by a third-party on its behalf. The verification process must be defined and agreed by the WASH sector coordination.

Equity is granted when the access to the WASH services is the same across WASH actors with a similar compliance to access, safety, security and functionality standards among them. The existence of minimum standards and designs in each WASH subsectors working groups combined with onsite WASH cluster team (or third party) inspections will document this indicator.

Sources of verification

Comprehensiveness, consistency, coherency, timeliness and reliability can be assessed with the proportion of WASH actors compliant to the criteria among all the WASH actors involved in the support to affected population. When beneficiaries' figures per WASH actor are available, it is preferable to use them when calculating the ratio (instead of using the number of WASH actors).

Source of information are mostly the register of WASH actors recorded in institutions (at local and/or national level/ministries), WASH actors reports sent to coordination, sector cluster progress updates on response standardization (technical working group workplan achievement, proportion of guidance issued among those needed) and WASH cluster team (or third party) onsite visit report. The information should be aggregated and analysed at least on a yearly basis. The result should serve as a basis to define the following year's cluster performance objectives.

Cholera epidemic KOI

Compulsory Indicator: %-affected populations covered by a Case Area Targeted Intervention (CATI)

Definition

Timely, consistent and comprehensive CATI: Refer to Cholera Epidemic key result indicator definition in the guidelines.

Sources of verification

Records of all cholera suspected cases using consolidated data from the health system in charge of the surveillance of this epidemic. Record of CATI related deployments from all WASH actors involved in the containment of this epidemic. Refer to Cholera Epidemic key result indicator sources of verification in the guidelines.