MODULAR ANALYTICAL FRAMEWORK FOR QUALITY AND ACCOUNTABILITY

WASH Cluster
Water Sanitation Hygiene

ACKNOWLEDGEMENTS

AUDIENCE

This document is designed to be used by National Humanitarian WASH Coordination Platforms (NHWCPs), including Humanitarian WASH Cluster / cluster coordination unit (includes Cluster Coordinator, Information Management Officers, Assessment Specialists, Sub-Cluster Coordinators), in addition to WASH Partner Organisations, Strategic Advisory Group (SAG) members and Technical Working Groups (TWGs). The guidance may also be useful to support WASH partners to develop and apply QAAS within their own programmes or organisations.

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Water Sanitation Hygiene

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CONTENTS

ACRONYMS

QAAP	Quality Assurance and Accountability Project
QAAS	Quality Assurance and Accountability System
AAP	Accountability to Affected Populations
SAG	Strategic Advisory Group
TWG	Technical Working Group
GWC	Global WASH Cluster
SOF	Strategic Operational Framework
ToR	Terms of Reference
HPC	Humanitarian Programme Cycle
DMAIC	Define - Measure - Analyse - Improve - Control
M&E	Monitoring & Evaluation

INTRODUCTION

This document, and each of the modules, should be read alongside the Quality Assurance and Accountability Systems (QAAS) Guidance Note. This framework provides additional guidance on the specific standards, indicators and approaches to be used to monitor the quality and accountability of WASH responses. To support WASH Clusters to apply the broad range of principles and standards of quality to a wide range of contexts, the framework has been created as a set of modules that can be chosen depending on the context, phase and strategic objectives of the sector.

FRAMEWORK STATUS AND DEVELOPMENT
Modules for Public Health Risk, WASH Service provision, People-centred programming have been developed. Additional modules will be added to the framework throughout 2020. The modular analytical framework will continue to be developed with input from stakeholders and technical specialists at national and global levels.

The framework can be used as a basic starting point for measuring quality in humanitarian WASH responses, which can be further developed and adapted to each context over time. The focus areas, outcomes, indicators and questions have been developed by distilling and adapting a range of humanitarian quality standards into a format that can be used as the basis for developing a context-specific quality assurance system. The framework should be made contextually appropriate by defining key standards or expectations as noted in the key terms. The focus of quality monitoring should evolve over time to adapt to the changing context through joint review and endorsement of the Strategic Operational Framework (SOF).

MODULE STRUCTURE

The framework proposes metrics that apply broadly to WASH responses, and that are in line with global humanitarian standards such as Sphere and the CHS as well as with the GWC Needs Assessment Indicators & Question Bank and guidance on Response Monitoring Plans. These indicators do not aim to capture every factor that could be considered part of quality programming but are designed to be broadly applicable to a range of responses whilst illustrating key trends and changes over time. This information should be compared with and understood against other sources of information such as participatory approaches, thematic studies, safety audits, assessments, feedback and complaints.

Each module is focussed on a dimension of quality that is based on globally accepted standards and includes the following information:

Standards:
Each module includes references to globally recognised standards which link the indicators back to fundamental humanitarian principles. The standards are universal statements that apply to humanitarian response in any context,

whereas indicators and benchmarks may need to be contextualised.

Key Quality Indicators (KQI):
KQIs are measurable values that can be used to illustrate a component of quality linked to a standard. KQIs are relative values that must be disaggregated to make comparisons over time, between locations and between different affected groups (See Data Disaggregation). KQIs are calculated and presented in a regularly updated Quality Snapshot in order to inform the analysis of quality gaps and trigger corrective action. KQIs are written in a general form and should be contextualised by specifically defining key terms and providing benchmarks appropriate to the context(s).

Benchmark guidance:
Benchmarks are points of reference that define how the KQIs should be measured. For example: *% of affected population using a sufficient quantity of water for drinking, cooking, cleaning and personal hygiene*. The quantity of water that is considered 'sufficient' will differ from one context to another and so must be agreed jointly by the sector based on consultation with communities and set out in the SOF. Different benchmarks may be needed for the different contexts within a response – e.g. for camp vs. urban, acute vs. stable contexts, secure vs. hard to reach etc. Guidance is provided to support setting benchmarks.

Monitoring approaches:
Each indicator may be measured in different ways depending on the information available. Whilst during sudden onset or rapid escalation of crisis, the availability and granularity of information may not be sufficient to provide quantitative measures of the KQIs, rapid data collection methods such as Key Informant Interviews (KII) and observations can provide indications on the presence and severity of gaps. Suggestions are provided for both rapid and in-depth approaches to data collection, as well as for sources of information that can be used for triangulation.

CONSIDERATIONS FOR SUDDEN ONSET / RAPID ESCALATION

QAAS should be put in place as soon as possible. In sudden onset or rapid escalation contexts, the wording of KQIs may be adapted to reflect the limited availability and reliability of data. For example, it may not be worthwhile to attempt to estimate % of the affected population disposing of faeces safely every time they defecate when information is being collected through ad-hoc observations and KIIs. In this case a simple score on a 0-5 scale can be used to illustrate the likely severity of gap in a particular location or population group for each indicator. In a rapidly evolving context, a traffic-light or risk-level system can effectively present the information that is available in an operationally relevant way.
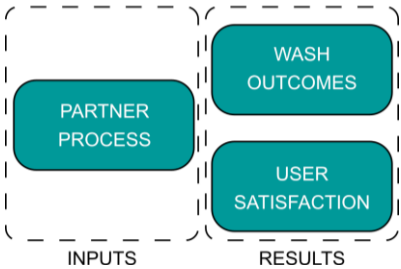
PERSPECTIVES ON QUALITY

Figure 1: Monitoring perspectives

The framework includes indicators that measure quality and accountability from three perspectives:

1. What *processes* do WASH partners have in place to ensure that they are able to provide high quality services? Are they collecting the right information about needs, priorities and abilities from different groups of people? Are they routinely engaging with and encouraging participation? Are they providing appropriate mechanisms for people to provide feedback?

2. How effectively are WASH partners achieving desired *outcomes*? Are they reducing public health risks, providing equitable and safe access to WASH services for communities? Are they providing safe access to WASH services in institutions? Are they supporting health, nutrition or livelihoods outcomes?...

3. How *satisfied* are WASH service users/non-users about the way their priority needs are being met? Are people happy about the level of involvement they have in the process? Have specific needs been overlooked? Do different groups feel safe using services?

WASH SERVICES

This framework uses the concept of WASH Services when considering the activities and outputs that make up a WASH response. This re-arranges how WASH activities are considered, putting the 'user' at the centre and considering all the activities that are required in order to provide an outcome for that user. For example, a 'water supply service' includes the tap stand, the water supply network, communications materials, distributions of water containers and jerrycan cleaning events, hygiene sessions on safe water chain, distribution of water treatment systems etc. Services include both 'user interfaces', communications channels and the back-end systems that support them.

GENERAL MONITORING CONSIDERATIONS

The indicators included in this framework are designed to be measured through routine data collection, either by WASH partners or third parties. Approaches to data collection should be adapted to context and should fit with existing data collection efforts wherever possible. Monitoring should focus on collecting a small but consistent set of measurements regularly at different

times across the response to understand how the situation changes over time and place. Collect basic and harmonised data on sex, age and disability to enable results to be disaggregated to show differences between different affected groups. Data collection methods appropriate to each indicator are included in the framework.

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MANAGING REPORTING BURDEN

Monitoring too many aspects of the response is counter-productive, creating unmanageable quantities of data that are unactionable and diverting resources from service delivery.

Manage partner reporting burden by minimising the quantity and frequency of data requested from partners and focus on collecting information that can be used to trigger action or improve response analysis.

Where there is significant difference in monitoring and reporting capacity between national and international partners, consider how best to utilise the contextual knowledge from national organisations in the analysis of data. Promote the use of harmonised indicators and monitoring approaches across partners where possible to support comparison across the response.

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Process monitoring:
Monitoring how partners are working to meet their commitments to safety, participation, inclusion and feedback can be achieved by requesting that partners self-report through a short digital survey. Partners are requested to score themselves based on how well their internal processes comply with the expectations set out in the SOF for each of the four indicators. Depending on context, the survey can either be completed at national or sub-national level.

Outcome monitoring:
Outcome monitoring should be integrated into existing partner monitoring processes. For each outcome indicator the WASH cluster should collectively agree standard questions sets or observations carried out across the response in a harmonised way. These harmonised question sets should also be used as the basis for third party monitoring. Refer to the GWC Needs Assessment Indicators & Question Bank and Guidance on Response Monitoring Plans for guidance.

Perception monitoring:
Collecting information on how the response is perceived by people affected by crisis involves systematically asking a wide range of people to share their opinions. As with any community engagement, the approach taken must be appropriate to the context and this depends on trust and respect between field staff and affected people. Perception surveys may be carried out in person, or through other channels such as phone calls or instant messenger chats. Prioritise collecting the perceptions of individuals rather than groups and make sure to specifically include people of different ages, genders and disabilities in the sample. Global WASH Cluster Partners have committed to "Give priority to girls (particularly adolescents) and women's participation in the consultation process" as part of the Five Minimum Commitments for the Safety and Dignity of Affected Populations.

WASH quality monitoring should collect data that is disaggregated by Age, Sex[1] and Disability, especially when investigating the accessibility and acceptability of WASH services. Analysis should also routinely consider differences in the key indicators across sex, age and disability cohorts as a first step in identifying groups who may be excluded and understanding how this exclusion happens.

Use the short set of Washington Group[2] questions (or the Washington Group/UNICEF child functioning question set[3] for children aged 2-17) to classify disability for data disaggregation purposes. To disaggregate age data, use the same age cohorts as in national data systems and major multi-sectoral assessments.

DATA COLLECTION APPROACHES

Group and Key Informant Interviews:
Group interviews and key informant interviews are commonly used in humanitarian response to collect data from individuals, households or small groups of respondents. They can be used to collect a combination of qualitative and quantitative information through dialogue between the interviewer and respondents. The age, gender, ethnicity, apparent status of the interviewer will have some impact on the responses provided, as will the context in which the interview is held. It may only be appropriate to ask about sensitive topics in safe settings, with interviewers of the same gender as respondents so enumerator recruitment should aim for at least gender equity. Interview based approaches may be structured, semi-structured or unstructured and usually not intended to be generalised to a wider population. However, they can be effective in allowing specific issues to be understood in depth.

AVOID PUTTING PEOPLE AT RISK

In some contexts, interviewing people may put them at risk. Do not conduct interviews in such circumstances unless the interviewees are fully aware of the risks and accepts them. While the interview may put them at risk, they also have the right to have their voices heard.[4]

Focus groups:
Use a structured interview approach with open ended questions with a group of between 6-8 participants who have characteristics in common (gender, age, disability, social status, etc.). They are good for consulting a particular group on 3-5 discussion topics to produce qualitative information through open-ended discussion. Data saturation for a particular group can be expected after three groups. Controlling the size and composition of the group to ensure that everyone can contribute requires skilled facilitation, with separate note taker in a comfortable and controlled space. Focus group sessions can be expected to take roughly 2 hours.

[1] Inter-Agency Standing Committee (2017). Gender Handbook for Humanitarian Action. http://bit.ly/2keX9o2
[2] Washington Group on Disability Statistics 2016). The Washington Group Short Set of Questions on Disability. http://bit.ly/2daMyJb
[3] UNICEF & Washington Group on Disability Statistics (2016). Child Functioning Question Sets. http://bit.ly/2hDVZOR
[4] Cosgrave J., Buchanan-Smith M. and Warner, A. (2016). Evaluation of Humanitarian Action Guide. ALNAP
(https://www.alnap.org/help-library/evaluation-of-humanitarian-action-guide)

Surveys:
Use a questionnaire or 'survey instrument' that is administered to a sample that is often designed to be random and large enough to allow findings to be generalised to a wider population. Depending on the survey and sample design, it may be possible to generalise at different levels – so that information can be compared between different locations, or between males and females for example. More granular information requires larger sample sizes, which can have a large impact on the cost and time required to complete the survey. Because random sampling of households may exclude the perspectives of marginalised individuals, sampling and data collection approaches must be carefully designed to gain insights about how different people experience the crisis and response.

DIGITAL DATA COLLECTION

Digital data collection techniques can reduce the work required to enter, clean and carry out initial analysis on the data. Qualitative information about perceptions can be collected in digital survey forms using the Likert scale to quantify how positive or negative the respondent feels about a question. Likert scales should have 5-7 possible responses ranging from very negative to very positive, including a neutral value.

Open-ended questions should be avoided in surveys as the coding and analysis of responses can become very demanding.

Observations:
Structured or unstructured observational approaches can provide quick and low-cost insights into key characteristics of the crisis and response. As with interviews, the information collected through observations can rarely be generalised to the overall situation, however they are useful in illustrating particular cases and investigating causes and effects. Structured observations can be used to assess behaviour, use of WASH services, quality of design and construction of facilities, treatment of service users by response staff. They require standard observation forms, such as a checklist, and minimal training. Checklists of minimum requirements for different types of WASH facilities can also be used to structure observations during infrastructure mapping.

DATA COLLECTION FROM HARD TO REACH AREAS

When access constraints limit the use of direct data collection approaches for some or **all** the affected population, alternative way**s** to identify and understand quality gaps should be found. Coordinating with other sectors to prevent the duplication of data collection is especially important in hard to reach areas where data collection opportunities and key informants may be limited. The following approaches may be useful to understand the situation in hard to reach areas, but caution must be taken to ensure that the safety of both key informants and interviewers:

• Use of local key informants who can carry out interviews with the affected population
• Carry out surveys online, by phone, through social media or instant-messaging[5]

Conduct interviews with people, such as returnees, who have travelled out of hard to reach areas and who have recent knowledge of the situation there.

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[5] For example, see the UNICEF's U-Report tool (https://www.unicef.org/innovation/U-Report) or Oxfam's Your Word Counts initiative (https://views-voices.oxfam.org.uk/2019/09/the-future-is-bright-for-digital-accountability/)

MODULE: PUBLIC HEALTH RISK

WASH programmes are commonly concerned with public health risks related to faecal-oral transmission of disease. The F-diagram(Figure 2) illustrates the various pathways for faecal oral transmission, as well as the barriers that are effective in preventing transmission. Using health data to track the effectiveness of WASH programmes is often difficult due to the availability of data and the many factors that potentially confound results. Monitoring the presence of four key barriers can be used as a proxy for estimating the level of public health risk due to WASH-related disease.
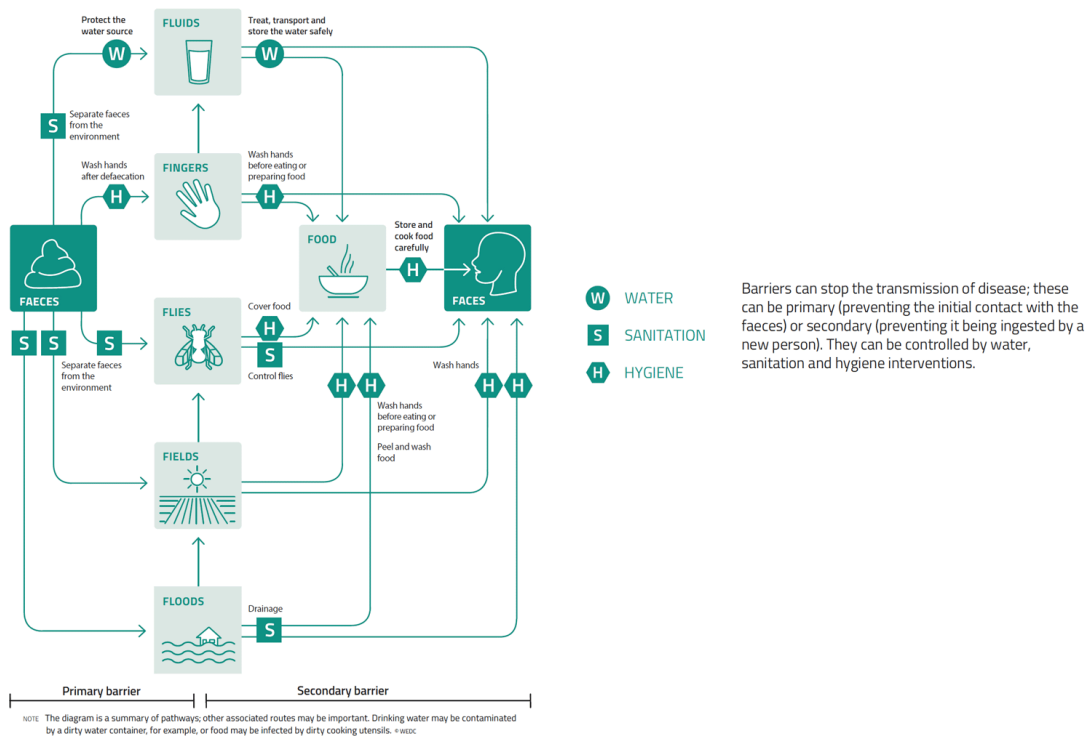

Figure 2: F-Diagram (From The Sphere Handbook 2018)

The four KQIs in this module are designed to provide an overview of the relative risk of faecal oral transmission between different settings, locations and population groups. Whilst it cannot be used to understand risk in absolute terms, use of the framework can contribute to understanding and prioritising where corrective action is required to improve effectiveness.

PUBLIC HEALTH RISK			
WATER QUANTITY:	**WATER QUALITY:**	**EXCRETA DISPOSAL:**	**HANDWASHING:**
Providing sufficient quantity of water enables people to keep themselves and their environment clean	Providing clean water prevents transmission through the ingestion of pathogens in drinking water	Separating faeces from the living environment limits the risk of pathogens being spread through many routes	Handwashing after defecation, before eating or preparing food is an important barrier at many points

Table 1: Key barriers to faecal-oral transmission

WATER QUANTITY

Definition

The threshold for sufficient quantity should be decided based on consultation with the affected population as well as an assessment of the availability and sustainability of water resources. The minimum quantity should be documented in the SOF along with any seasonal or geographical variations and consideration for the needs of different age, gender or ability groups.

Some communities may have different priorities for water use than drinking, cooking, personal hygiene and domestic cleaning. Livelihoods related water use (water for agriculture, livestock, brick making, selling etc.) may significantly increase water demand and impact perceptions of what is a sufficient quantity of water. The SOF should clearly document which water uses are considered priorities for the threshold calculation.

Measurement

The measurement of water use should be made at the household level rather than solely through the use of flowmeters, pumping hours calculations or water trucking records. These point of delivery measures are useful but will not capture the variation in water use across different locations or user groups and cannot account for factors limiting water use between the point of delivery and the point of use.

Water pressure and flowrate affects the availability of water, and these factors change across a water network. Ensure sampling includes locations at the start and end of network branches, as well as at different distances from water points. Ensure if possible that questions about water collection are asked of women, or those responsible for collecting water in the household. Water collection and storage is likely to be carried out at the household level so disaggregate data by age, sex and disability status of the head of household.

Measurement approaches should be appropriate to the context and water supply mechanism(s) in place. Quantifying daily water consumption is often difficult and can be inaccurate, so begin by asking "Does your household currently have enough water for: (Drinking, Cooking, Personal hygiene, Cleaning)". Qualitative data from community engagement sessions, focus groups, feedback and complaints mechanisms should complement quantitative survey data and be used to highlight any particular challenges faced.

WATER QUALITY

Definition

The requirements for acceptable quality should be decided based on water sources and treatment methods in use, as well as the available resources and technical capacity for water quality testing.

The minimum water quality standards, testing requirements and where they

are applicable (e.g. centralised treatment, untreated water points, household treatment and safe storage etc.) should be documented in the SOF.

Measurement

Safe drinking water is defined by WHO as water that does not represent any significant risk to health over a lifetime of consumption. In a humanitarian context, faecal contamination of drinking water is likely to be the most important water-related health risk. The definition of 'acceptable quality' should be decided based upon an analysis of both public health risk factors and through consultation with affected people.

Where water supplies are not being treated, or where household level water testing is not practical, asking household about their primary and other water sources for drinking water and assessing the likely water quality at these sources may be a useful proxy for drinking water quality.

Free chlorine residual testing at household level – where water supplies are being treated through chlorination (either by centralised treatment, at distribution points or through distributions of household water treatment chemicals) bacteriological water quality may be obtained through measurement of free residual chlorine at household level.

Detecting an FRC level of 0.2mg/l or higher in stored drinking water suggests that the water is bacteriologically safe and confirms that households are collecting water from treated sources, or effectively treating it at the household level.

Water sources may be assessed through a combination of water testing and visual inspection (sanitary inspection[6]). In contexts where drinking water is being collected from many dispersed, untreated sources (such as handpumps, wells) and where household water testing is not possible, a risk-based approach based on sanitary inspections of the water points in use may be an effective alternative.

Bacteriological testing of water sources may be carried out to understand the water quality at different sources, but significant contamination is likely to occur between collection and consumption in unchlorinated supplies. In many contexts it may be appropriate to assume all unprotected / unimproved sources are contaminated.

EXCRETA DISPOSAL

Definition

What is considered 'safe' excreta disposal should be agreed based on an understanding of human and environmental factors and documented in the SOF.

Consider user preferences and the barriers that may make it difficult for

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[6] See WHO Sanitary Inspection Packages for drinking water: https://www.who.int/water_sanitation_health/water-quality/safety-planning/sanitary-inspection-packages-for-drinking-water/en/

people to use toilets (protection risks, limited mobility, fears, cultural factors etc.) and ensure that the definition is inclusive of these varying needs. Different and targeted approaches to sanitation systems may be required to meet the excreta disposal needs of all affected people. (E.g. container-based toilets or adapted facilities for those with limited mobility, household or shared household facilities for those at risk)

Consider also how environmental factors such as the depth of water table and flood risk, soil permeability and the source and treatment of drinking water affects the level of risk and the definition of what is considered safe.

Measurement

In terms of public health risk, safe disposal of faeces requires that excreta are effectively separated from both the user and the environment to prevent both direct and indirect contamination. Acceptable toilet facilities may include the many different types of latrine, toilets connected to municipal sewer systems or container-based toilets. In all cases appropriate management of faecal sludge is required to prevent environmental contamination beyond the facility itself.

Similar to measuring handwashing behaviour, estimating the % of people regularly using toilets is challenging. Self-reporting may over-estimate the real figure due to perceived social desirability of using a toilet, but structured observations of behaviour are intrusive and time intensive.

Self-reporting may be the most appropriate measurement approach, backed up with observations of open defecation in the living environment. Asking about the behaviours of neighbours, or the community may increase the accuracy of estimates.

Different groups may face different challenges in using toilets and defecation practices may very between men, women, children, babies, the elderly and those living with disability. During household surveys it is important to ask whether all members of the household use toilet facilities how baby's excreta is disposed, and how any container-based solutions are managed. Disaggregating data by age, sex and disability will help to inform the design of safe and inclusive sanitation services.

HANDWASHING

Definition

The requirements for hand washing methods should be agreed based on an understanding of preferences, practices and health risks. Take into account the approach to sanitation – toilet types, locations and whether communal, shared between households or for each household. Also consider practices around meal preparation (communal or household kitchens), food stalls in markets and other livelihoods activities which may require provision for hand hygiene.

Handwashing behaviours should be monitored at the point where

handwashing is being supported and/or promoted by the response – for example handwashing stands at communal toilets and other public facilities as well as within the household.

Key times for handwashing should include before touching food (eating, preparing food or feeding a child) and after contact with excreta (after using the toilet or cleaning a child's bottom).

Effective cleansing agents include solid or liquid soap, detergent, chlorinated water or ash, the choice of appropriate method should be made based on local context and acceptability.

Measurement

Handwashing behaviour can be challenging to measure. Self-reporting may over-estimate compliance, whilst other observational methods can be intrusive and require too many resources. Self-reporting may be validated by enumerators asking to see where respondents wash their hands and observing whether soap and water are present at these locations[7]. The presence of soap and water, and the functionality of handwashing stations placed outside toilets may also be measured during facility monitoring.

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[7] Ram (2013) Practical Guidance for Measuring Handwashing Behaviour: 2013 Update. World Bank

STANDARDS, INDICATORS AND BENCHMARKS

MODULE	PUBLIC HEALTH RISK			
	Reduce public health risks by creating barriers to faecal-oral transmission along the pathways described in the F-diagram			
COMPONENT	WATER QUANTITY	WATER QUALITY	EXCRETA DISPOSAL	HANDWASHING
STANDARD	**SPHERE 2018** **Water supply standard 2.1: Access and water quantity** *People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking and domestic needs.*	**SPHERE 2018** **Water supply standard 2.2: Water quality** *Water is palatable and of sufficient quality for drinking and cooking, and for personal and domestic hygiene, without causing a risk to health.*	**SPHERE 2018** **Excreta management standard 3.1: Environment free from human excreta** *All excreta is safely contained on-site to avoid contamination of the natural, living, learning, working and communal environments.*	**SPHERE 2018** **Hygiene promotion standard 1.1: Hygiene promotion** *People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them.*
KEY QUALITY INDICATOR	**Outcome:** % of affected population using a sufficient quantity of water for drinking, cooking, cleaning and personal hygiene	**Outcome:** % of affected population using water for drinking and cooking that is acceptable quality	**Outcome:** % of affected population disposing of their faeces safely every time they defecate	**Outcome:** % of affected population washing their hands with soap at key times
BENCHMARK GUIDANCE	Quantity (l/p/d) agreed by WASH cluster partners through consultation with different affected groups or by reference to national standards	Quality agreed by WASH cluster partners through consultation with different affected groups, an understanding of treatment methods and an analysis of waterborne risks in the context	Safe disposal means that faeces is disposed of in a way that effectively prevents contact with people, the environment and other potential vectors. Minimum requirements and approaches to be agreed by the WASH cluster partners	Soap: Effective cleansing agents include solid or liquid soap, detergent, chlorinated water or ash, the choice of appropriate method should be made based on local context and acceptability Key times: As defined by cluster partners, but generally before touching food (eating, preparing food or feeding a child) and after contact with excreta (after using the toilet or cleaning a child's bottom)

MONITORING APPROACHES

COMPONENT	WATER QUANTITY	WATER QUALITY	EXCRETA DISPOSAL	HANDWASHING
RAPID	• Key Informant Interview • Observation	• Water quality testing at water point	• Key Informant Interview • Observation	• Observation of communal handwashing facilities with water and soap outside toilets
IN-DEPTH	• Water user survey	• Water quality testing at household storage	• Household survey (self-reporting)	• Household survey (self-reporting) • Observation of place to wash hands in the home with water and soap available (during household survey)
TRIANGULATION	• Water pumping / Delivery records • Water point mapping • Qualitative information from group discussions or participatory approaches	• Sanitary survey of waterpoints • Bulk water treatment process records • Qualitative information from group discussions or participatory approaches	• Safety perception survey • Toilet facility mapping • Qualitative information from group discussions or participatory approaches	• Qualitative information from group discussions or participatory approaches

INFORMATION ANALYSIS

	WATER QUANTITY	WATER QUALITY	EXCRETA DISPOSAL	HANDWASHING
ANALYSIS QUESTIONS	• Is there sufficient water available at the household level to allow all affected people to drink, cook, and keep themselves and their environment clean? • Who faces particular challenges accessing a sufficient quality of water? • Who might need different quantities of water? • How much water is being used on a daily basis? • Does water use change due to seasonality or functionality (because of changing demand, or changing supply)?	• How many people are at risk of disease through the consumption of contaminated water? • Who is most likely to be at risk? What are the factors that increase risks? • Where along the water chain is water being contaminated? • How does water quality change over time? • Where in the safe water chain is contamination most likely to be occurring?	• Who faces particular challenges using toilets? • What is the level of risk of faecal-oral disease transmission through direct or indirect contact with faeces? • What practices or preferences around the use of toilets affect the risk of faecal-oral transmission? • What are the determinants and barriers to toilet use? • When people can't access toilets safely, how do they dispose of faeces? • How are children's faeces managed?	• What proportion of the affected population regularly wash their hands at the appropriate times? • Who is not washing their hands at key times? • What barriers and enablers are the most important determinants of good hygiene practices? • Where do people wash their hands? Are facilities located to enable handwashing at key times? • For communal facilities how are these managed? • What preferences do people have about soap or other cleansing agents?

MODULE: WASH SERVICE PROVISION

This module provides key quality indicators for monitoring Water, Sanitation and Hygiene services provided to the affected population as part of humanitarian WASH responses. Understanding the level of services is critical to understanding the quality of WASH responses. Comparing the level of services being provided to different groups may highlight inequalities in assistance provided and identify the population groups most at risk of being left behind.

Strengthening existing WASH systems:

Wherever possible, emergency WASH response should use, support or strengthen existing systems for service provision, rather than bypassing them. Existing WASH supply systems may include government agencies, utilities, community service organisations and market systems.

Awareness of the different ways affected populations access WASH goods and services before the crisis, as well as how the crisis has impacted these systems should inform the decision to use, support or strengthen these systems for emergency response, recovery and resilience, as well as provide justification for direct in-kind distributions when necessary.

In line with the Global WASH Cluster Needs Assessment Indicators & Question Bank, this module is based on the Joint Monitoring Programme (JMP) service ladders as a basis of categorising service levels for water supply, sanitation and hygiene. Aligning with this framework enables humanitarian actors to compare results to existing pre-crisis baseline data. If appropriate, additional 'rungs' may be added to service ladders to understand context-specific criteria of service whilst maintaining comparability.

In contrast to the Public Health Risk module, the level of service module measures what is being provided, rather than behaviour or risk factors. This allows data from the two modules to be compared over time to understand how the level of service provided influences the severity of public health risks.

WATER SUPPLY

Definition

Domestic water supply services must provide adequate quantities of safe water for drinking, cooking, personal hygiene and other domestic uses. This indicator uses the JMP definitions to categorise level of drinking water services based on the likely water quality, the accessibility of the water point, and availability of water. The service levels are:

SURFACE WATER	Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal
UNIMPROVED	Drinking water from an unprotected dug well or unprotected spring
LIMITED	Drinking water from an improved source for which collection time exceeds 30 minutes for a roundtrip including queuing
BASIC	Drinking water from an improved source, provided collection time is not more than 30 minutes for a roundtrip including queuing
SAFELY MANAGED	Drinking water from an improved water source which is located on premises, available when needed and free from faecal and priority chemical contamination

Since these definitions are adapted to long term development programmes, additional criteria may be proposed.

SANITATION

Definition

Sanitation services aim to provide safe, private and dignified toilet facilities that immediately contain excreta. They are the barrier between people and the waste, thus reducing direct and indirect routes of disease transmission. The components of sanitation services include the toilet or 'user interface', collection, storage and transport, the various stages of waste treatment and final use or disposal. Maintenance, cleaning, desludging and decommissioning activities may also be required to maintain service levels.

This indicator uses JMP definitions to categorise level of sanitation services based on whether excreta is effectively contained, treated and disposed, whether toilets are shared with other households and where they are located. The service levels are:

OPEN DEFECATION	Disposal of human faeces in fields, forests, bushes, open bodies of water, beaches and other open spaces or with solid waste
UNIMPROVED	Use of pit latrines without a slab or platform, hanging latrines or bucket latrines
LIMITED	Use of improved facilities shared between two or more households
BASIC	Use of improved facilities which are not shared with other households
SAFELY MANAGED	Use of improved facilities which are not shared with other households and where excreta are safely disposed in situ or transported and treated off-site

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.

HYGIENE

Definition

The content and approach to providing hygiene items should be agreed based on consultation with affected people to assess actual need; an analysis of local WASH systems to identify local availability of hygiene items locally;[8], [2]and an understanding of relevant hygiene behaviours including a willingness to use or perception of value of the hygiene item to the household.

This indicator uses the JMP definitions to categorise level of hygiene service by the presence of a handwashing facility at the household level with both soap and water available. The service levels are:

NO FACILITY	No handwashing facility on premises
LIMITED	Availability of a handwashing facility on premises without soap and water
BASIC	Availability of a handwashing facility on premises with soap and water

Handwashing facilities include both fixed (e.g. sink with tap) and mobile (e.g. basin, jug or bucket). Soap can include bar, powder or liquid soaps/detergents and soapy water. Additional 'rungs' may be added to this basic ladder to ensure that it is appropriate to the context, whilst maintaining compatibility with the JMP approach.

Minimum hygiene item requirements, frequency of use and duration of intervention modality to support provision of these items, as well as standard approaches to post-action monitoring should be agreed and documented in the SOF.

MENSTRUAL HYGIENE

Definition

Menstrual hygiene services aim to support women and girls of menstruating age to manage their periods in safety and with dignity. Services may include menstrual hygiene awareness initiatives, provision of materials and adapted facilities to safely and privately wash, dry or dispose of these materials.

Contextually appropriate approaches to menstrual hygiene should be agreed based on consultation with affected women and girls and should be documented in the SOF. Service levels for menstrual hygiene services have not been set globally. WASH cluster partners should identify the minimum criteria for menstrual hygiene and use this as the basis for calculating the KQI.

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[8] See CaLP. (2018). Minimum Standards for Market Analysis (MISMA)
[2] See MERS (2017). Assessment and Analysis Standards

STANDARDS, INDICATORS AND BENCHMARKS

MODULE	WASH SERVICE PROVISION Provide access to WASH services that support life with dignity, considering local WASH systems, service providers and the needs of targeted groups.			
COMPONENT	WATER SUPPLY	SANITATION	HYGIENE	MENSTRUAL HYGIENE
STANDARDS	**SPHERE 2018** **Water supply standard 2.1: Access and water quantity** People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking and domestic needs.	**SPHERE 2018** **Excreta management standard 3.2: Access to and use of toilets** People have adequate, appropriate and acceptable toilets to allow rapid, safe and secure access at all times.	**SPHERE 2018** **Hygiene promotion standard 1.2: Identification, access to and use of hygiene items** Appropriate items to support hygiene, health, dignity and well-being are available and used by the affected people.	**SPHERE 2018** **Hygiene promotion standard 1.3: Menstrual hygiene management and incontinence** Women and girls of menstruating age, and males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being.
KEY QUALITY INDICATOR	% of affected population with access to drinking water services, by <u>level of service</u>	% of affected population with access to sanitation services, by <u>level of service</u>	% of affected population with access to handwashing facilities, <u>by level of service</u>	% of affected women/girls of menstruating age with access to <u>menstrual hygiene services</u>
BENCHMARK GUIDANCE	<u>Level of service:</u> See JMP service level ladder. Additional service levels may be added to monitor e.g. water source type, design, borehole depth or other contextually relevant criteria.	<u>Level of service:</u> See JMP service level ladder. Additional service levels may be added to monitor e.g. sex segregation, privacy or other contextually relevant criteria.	<u>Level of service:</u> See JMP service level ladder. Additional service levels may be added to monitor e.g. access to basic hygiene items	<u>Menstrual hygiene services:</u> Includes provision of menstrual hygiene materials, facilities for cleaning or disposing of materials and appropriate information, education and communication provision. Minimum requirements to be agreed by WASH cluster partners in consultation with women and girls.

MONITORING APPROACHES

COMPONENT	WATER SUPPLY	SANITATION	HYGIENE	MENSTRUAL HYGIENE
RAPID	Key informant interview Observations Rapid assessment for markets (RAM)[9] Multi Sector Market Assessment (MSMA)[10]	Key informant interview Observations Rapid assessment for markets (RAM)[3] Multi Sector Market Assessment (MSMA)	Key informant interview Observations Rapid assessment for markets (RAM)[3] Multi Sector Market Assessment (MSMA)	Key informant interview Observations Rapid assessment for markets (RAM)[3] Multi Sector Market Assessment (MSMA)
IN-DEPTH	Water point mapping Household survey Supplier survey Market system map System service level functionality assessment (e.g., EMMA, PCMA) [3]	Toilet facility mapping Household survey Supplier survey Market system map System service level functionality assessment (e.g., EMMA, PCMA) [3]	Household survey (self-reporting) Supplier survey Market system map System service level functionality assessment (e.g., EMMA, PCMA) [3]	Household survey (self-reporting) Supplier survey Market system map System service level functionality assessment (e.g., EMMA, PCMA) [3]
TRIANGULATION	Post action monitoring Service provider / supplier monitoring	Post action monitoring Service provider / supplier monitoring	Post action monitoring Service provider / supplier monitoring	Post action monitoring Service provider / supplier monitoring

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[9] SEE MERS Annex: Market linked Tools and Frameworks for Assessments, p. 157
[10] https://www.calpnetwork.org/publication/multi-sector-market-assessment-companion-guide-and-toolkit/

INFORMATION ANALYSIS

	WATER SUPPLY	SANITATION	HYGIENE	MENSTRUAL HYGIENE
ANALYSIS QUESTIONS	• How does water quality change between different sources in use? • Who is responsible for collecting water? How much time do they spend collecting water? What other activities are they unable to do because of this burden? • What proportion of the affected population have adequate items to allow for water collection and safe storage? • Who in the household has makes decisions about buying water? • Who faces particular challenges collecting and storing sufficient quantities of safe water? What are the factors that increase or exacerbate these challenges? • Are there safety fears around collecting water? How does this impact the quality or quantity of water used? • How are local water service providers being supported to continue to operate? • Do households have to pay for water? What proportion of household income is spent on water? • How many hours per day is water available? • How often does the water system break down? How quickly is it repaired? Who is responsible for maintenance and repair?	• What proportion of the affected population have access to sanitation facilities that are safe to use, private and dignified? • What proportion of constructed toilets are unusable at any given time due to being full, damaged poorly constructed, poorly culturally adapted, not gender-, age- or disability-appropriate? • How often do toilets fill up? Once full, how quickly can they be desludged? • When toilets are damaged or broken, how long does it take to make repairs? • Who are the local sanitation service providers and how can they be supported to provide safe, sustainable, high quality services?	• What proportion of the affected population have regular access to the hygiene items needed? • What is the cost of hygiene items and how does this compare to HH income? • Who has been consulted about the selection of hygiene items? • Are there local providers that are able to continue to deliver hygiene goods and services? • How have the different needs of men, women, children, the elderly and people living with disabilities been addressed? • Are NFIs being re-sold by recipients? • Are distributions mechanisms designed to be safe and accessible to all? • Would blanket or targeted approaches be more effective in meeting needs? • How is feedback collected and shared with WASH partners?	• What proportion of affected women and girls of reproductive age have access to education, facilities and materials that address their menstrual hygiene needs? • What is the cost of menstrual hygiene items and how does this compare to HH income? • What practices, beliefs and preferences do women and girls have around menstrual hygiene? • Are materials available in local markets? Are these markets safely accessible for women and girls? • Outside of local markets, how are menstrual hygiene items distributed? • Have women and girls been involved in the selection of menstrual hygiene items? • Do women and girls have different preferences about materials and facilities? • Where do women and girls change, wash and dispose of menstrual hygiene materials? • What considerations need to be made in the design of other WASH facilities? • Are women and girls able to make decisions to prioritise their menstrual hygiene needs?

MODULE: PEOPLE-CENTRED PROGRAMMING

Accountability to Affected Populations (AAP) requires that people are central to the assessment planning, implementation and monitoring of WASH responses. The foundations for AAP are set out in the Humanitarian Charter[11] and the Core Humanitarian Standard (CHS) and these principles underpin all humanitarian action.

This module supports collective monitoring of inclusion, safety, participation and feedback, by assessing whether partners are fulfilling their commitments to AAP in the way they work. The module also provides a framework for integrating the views of the affected population into quality monitoring. The opinions and perspectives of people affected by crisis hold crucial information about how quality and accountability are experienced by the people we aim to support[12]. Understanding the response through the different perspectives of those affected by crisis is a critical step towards achieving quality and accountability in any context.

WASH 5 MINIMUM COMMITMENTS

The Global WASH cluster partners have agreed on 5 minimum commitments to be upheld in all humanitarian WASH programmes to ensure that the distinct assistance and protection needs of the affected population are met. The respect of these minimum commitments all along the humanitarian programme cycle reinforces the accountability of the WASH partners to the affected population. These commitments are as follows:

- Consult separately girls, boys, women, and men, including older people and those with disabilities, to ensure that WASH programs are designed to provide equitable access and reduce incidences of violence
- Ensure that girls, boys, women, and men, including older people and those with disabilities have access to appropriate and safe WASH services
- Ensure that girls, boys, women, and men, including older people and those with disabilities, have access to feedback & complaint mechanisms so that corrective actions can address their specific protection and assistance needs
- Monitor and evaluate safe and equitable access and use of WASH services in WASH projects
- Give priority to girls (particularly adolescents) and women's participation in the consultation process

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SATISFACTION

Monitoring the general level of satisfaction amongst different groups provides a high-level overview of the quality of response. Satisfaction is highly subjective and sensitive to the respondent's personal situation and expectations. Because of this, it is not appropriate to set an absolute target

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[11] Sphere (2018). The Sphere Handbook. https://handbook.spherestandards.org/en/sphere/#ch003
[12] For examples of how perception information can be used to monitor humanitarian action, see:
https://groundtruthsolutions.org/our-work/strengthening-the-humanitarian-response-in-chad

for satisfaction levels and difficult to make comparisons between different contexts. Instead, focus on how satisfaction responds to changes in WASH services over time and how satisfaction differs between different groups. Changes in levels of satisfaction may be a good indicator of emerging quality issues that require further engagement, analysis and action. To support initial analysis, it may be useful to collect both quantitative data on satisfaction scores with qualitative information on key issues or priorities.

INCLUSION

Expectations regarding how WASH partners address inclusion of WASH services and ensure equitable access to all should be collectively agreed and documented in the SOF. Inclusion should be addressed throughout the project cycle, with specific consideration for inclusive and participatory assessment, implementation and monitoring activities[13].

Asking the affected population whether they feel that WASH services are accessible for all in need may provide useful insight into accessibility barriers that are less obvious from the outside, such as financial, bureaucratic, social or information barriers. Focus groups can be held with groups of individuals who may have reduced access to services as a second step in understanding barriers and possible ways to overcome them.

SAFETY

Feeling unsafe can be an important barrier that prevents people from accessing WASH services. Discussing specific safety threats or incidents requires careful consideration to avoid putting people at increased risk or doing harm. It is the responsibility of all humanitarian actors to work within a protection framework and understand the safety and security risks that women, girls, men and boys face. Therefore, it is extremely important that assessment and monitoring of general safety issues be an ongoing feature of assistance. This includes exploring—through a variety of entry points and participatory processes—when, why and how GBV-related safety issues might arise, particularly as the result of delivery or use of humanitarian services[14].The WASH cluster should work with protection and GBV specialists to identify appropriate mechanisms for collecting information about feelings of safety, and to ensure that field staff are ready to make referrals to protection and GBV teams if necessary. Information on protection risks and safety perceptions may also be available from protection and GBV colleagues so inter-cluster coordination is key.

Expectations regarding how WASH partners address the safety of affected people should be collectively agreed and documented in the SOF. Women and adolescent girls are often at particular risk of harm. Safe WASH programming begins by partners identifying risks faced by people of different

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[13] For more information see: Age and Disability Consortium. (2018). Humanitarian inclusion standards for older people and people with disabilities.
[14] IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, 2015. Water, Sanitation and Hygiene, Thematic Area Guide

ages, genders, abilities and backgrounds and understanding who is most vulnerable to these risks. Specific actions to address the safety of WASH services should be taken and safety should be appropriately monitored in collaboration with protection and GBV colleagues.

PARTICIPATION

Questions about participation should seek to understand how well people understand their rights, what they are entitled to as well as how well informed they feel about the WASH response and how much influence they have over the way assistance is provided. Consult separately girls, boys, women, and men, including older people and those with disabilities, to ensure that WASH programs are designed so as to provide equitable access and reduce incidences of violence. Specific focus group discussions are organized for women and girls during the needs assessment phase and across the response[15].

Participation in design of assessments, programmes, evaluations etc, means that a selected segment(s) of the affected population have a direct influence on decision making. Measures should be taken to ensure the participation of members of all groups of affected people – young and old, men and women. Special efforts should be made to include people who are not well represented, are marginalised (e.g. by ethnicity or religion) or otherwise 'invisible' (e.g. housebound or in an institution).[16]

Expectations regarding how WASH partners ensure the active and meaningful participation of affected people in the assessment, design, implementation and monitoring of the WASH response should be collectively agreed and documented in the SOF.

Participation involves not only the provision of information, but also involves providing opportunities to all affected people to play a part in influencing decisions that affect them. This involves engaging with a diverse range of affected people and acting on the insights gained from these consultations to improve the response.

FEEDBACK

Effect, affected people need to be aware of complaints response and feedback mechanisms, feel confident that they could use them and that if they do, action would be taken, and they would receive a response. This indicator measures both the awareness of, and trust in, the mechanisms that organisations have set up to monitor complaints and feedback. Where multi-sector complaints and response mechanisms are set up, the WASH cluster should agree how best to monitor perceptions of WASH-specific complaints response.

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[15] For more information on the WASH 5 Commitments, see:
https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/wash_gender_minimum_commitments_.pdf

The minimum requirements and approaches for complaints feedback and response mechanisms (CFRM) should be collectively agreed and documented in the SOF. Where inter-agency or inter-sectoral CFRM are in place, WASH partners should ensure that they are able to receive and respond to WASH-related referrals in a timely way.

STANDARDS, INDICATORS AND BENCHMARKS

MODULE	PEOPLE-CENTRED PROGRAMMING Ensure the response upholds commitments to humanitarian principles and enhances the safety, dignity and rights of those affected by crisis				
COMPONENT	SATISFACTION	INCLUSION	SAFETY	PARTICIPATION	FEEDBACK
STANDARDS	CORE HUMANITARIAN STANDARD Commitment 2: *Communities and people affected by crisis have access to the humanitarian assistance they need at the right time.*	CORE HUMANITARIAN STANDARD Commitment 1: *Communities and people affected by crisis receive assistance appropriate and relevant to their needs.*	CORE HUMANITARIAN STANDARD Commitment 3: *Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.*	CORE HUMANITARIAN STANDARD Commitment 4: *Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.*	CORE HUMANITARIAN STANDARD Commitment 5: *Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.*
KEY QUALITY INDICATOR	**PERCEPTION** % of affected population who are satisfied that WASH services meet their priority needs in an appropriate and timely way	**PERCEPTION** % of affected population who feel that WASH services are accessible to all those in need **PROCESS** % of partners who design, implement and monitor WASH services to be accessible for people of all genders, ages, abilities and backgrounds	**PERCEPTION** % of affected population who report feeling safe using WASH services at night and during the day, by service **PROCESS** % of partners who design, implement and monitor WASH services based on an analysis of the specific safety risks faced by people of all ages, genders, abilities and backgrounds	**PERCEPTION** % of affected population who feel that they are able to influence the way that assistance is designed, implemented and monitored **PROCESS** % of partners who design, implement and monitor WASH services based on the participation of people of all ages, genders, abilities and backgrounds	**PERCEPTION** % of affected population who feel that they have a safe, accessible and responsive channel for providing feedback to WASH partners **PROCESS** % of partners who ensure that people of all ages, genders, abilities and backgrounds can safely provide feedback & complaints that trigger corrective actions
BENCHMARK GUIDANCE	**PERCEPTIONS** Perceptions are subjective measures. Ask respondents to score how they feel about satisfaction, inclusion, safety, participation and feedback on a 5 point Likert scale[17] and compare answers over time and between gender, age and disability groups to identify disparities and trends that should be investigated further. **PROCESS** Minimum process requirements for assessment, design, implementation and monitoring should be agreed by the WASH Custer to ensure that the 5 Minimum Commitments are upheld				

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[17] Likert scale: a 5-point linear scale used to measure how a respondent feels about a particular statement. E.g. 1: Strongly agree; 2: Agree; 3: Neutral; 4: Disagree; 5: Strongly disagree. The scale can be used to measure frequency, importance, satisfaction and other similar variations of attitude.

MONITORING APPROACHES

	SATISFACTION	INCLUSION	SAFETY	PARTICIPATION	FEEDBACK
RAPID	Group discussion Key informant interview Partner survey (e.g. WASH 5 Minimum Commitments Organisation Survey)	Group discussion Key informant interview Partner survey (e.g. WASH 5 Minimum Commitments Organisation Survey)	Group discussion Key informant interview Partner survey (e.g. WASH 5 Minimum Commitments Organisation Survey)	Group interview Key informant interview Partner survey (e.g. WASH 5 Minimum Commitments Organisation Survey)	Group interview Key informant interview Partner survey (e.g. WASH 5 Minimum Commitments Organisation Survey)
IN-DEPTH	Perception survey	Perception survey	Perception survey	Perception survey	Perception survey
TRIANGULATION	Qualitative information from participatory methods	Qualitative information from participatory methods	Qualitative information from participatory methods Safety Audit	Qualitative information from participatory methods	Qualitative information from participatory methods

INFORMATION ANALYSIS

ANALYSIS QUESTIONS					
	• Is the WASH response addressing the issues that matter most to them? • What are people's top priorities? How are they coping on their own or as a community and where do they need external support? • How does age, gender and disability affect people's priorities and whether they feel these are being addressed? • Do people feel that timing of assistance is adequate to address priority needs in an adequate timeline? • How does the perception of the response change in under-served or hard-to-reach areas? • Do people feel that the assistance provided has	• How have the needs, capacities and vulnerabilities of different groups been identified and categorised? • How is assessment and monitoring data being disaggregated? • Have women and girls been specifically included in discussions about WASH assistance? • Have older people and people with disabilities been identified and specifically included in discussions about WASH assistance? • Are there groups of people whose needs are 'invisible' because they have not been actively identified? • How do temporary changes (injury, sickness, pregnancy) affect a person's access to assistance?	• What proportion of the affected population are at risk from violence, exploitation, harassment or abuse, connected to their use of WASH services? • Who faces particular risks? What are the factors that increase or reduce risks? • Who has power? How is this power used? What are the potential negative effects? • What proportion of the affected population avoid using available WASH services, or change their behaviours in different ways due to the fear of harm? • What strategies do different people use to cope with the risks of harm?	• Do people feel they were able to participate in the assessment, design, monitoring and of WASH services? • Do people feel they were able to influence decisions about the response that affect them? • Who face particular challenges participating in decisions or having their voices heard? What are the challenges and barriers to participation? • Do people feel informed about the process of assessment, design, implementation and monitoring? • Do people feel informed about the aid providers, services and feedback channels? • Do all groups feel that they are listened to and that they are able to influence the way	• Was the complaints and feedback mechanism developed with the participation of different affected groups to understand preferred methods of communication? • Are all groups within the affected community aware of how to give feedback or raise complaints about the response? • Do affected people feel safe using the feedback channels? • How quickly and reliably are concerns addressed? • Who faces particular challenges to provide feedback? What are the key barriers for providing feedback? • Are older people and people with disabilities able to provide feedback about the WASH response? What considerations need to be made to ensure information

	been targeted to those who are most in need? • Do people feel that the WASH services are being delivered in an appropriate way that takes into account their culture, preferences and priorities? • What are the potential obstacles and opportunities regarding the possibility for communities and people to express their degree of satisfaction?	• How have WASH facilities and services been designed to enable the most inclusive access? • Who may need specific, targeted assistance in order to enjoy the same level of access to WASH services? • How do social or institutional attitudes, beliefs or practices affect equitable inclusion? Are people excluded on the basis of ethnicity, health, social-economic status, religion, place of origin or other factors?		WASH services are delivered?	and communication channels are accessible? • Do affected people trust that humanitarian agencies will respond to complaints and feedback? • What are the preferred channels for providing feedback and complaints? • Are particular considerations required for sensitive complaints (e.g. reporting misconduct, aid diversion or PSEA)?