Ministry of Health

REPUBLIC OF KENYA

KENYA RURAL SANITATION & HYGIENE PROTOCOL

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KENYA RURAL SANITATION & HYGIENE PROTOCOL

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Acronyms

ASAL	Arid and Semi-Arid Lands
CBO	Community-Based Organisation
CHEW	Community Health Extension Worker
CHV	Community Health Volunteer
CLTS	Community-Led Total Sanitation
DHIS	District Health Information System
G1	Grade 1 Open Defecation Free environment
G2	Grade 2 Safe & Sustainable environment
G3	Grade 3 Clean & Healthy environment
HH	Household
JMP	Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
KESHP	Kenya Environmental Sanitation and Hygiene Policy
MoH	Ministry of Health
MoWSI	Ministry of Water, Sanitation and Irrigation
NGO	Non-Governmental Organisation
ODF	Open Defecation Free
PHO	Public Health Officer
RTMIS	Real-Time Monitoring Information System
RuSH	Rural Sanitation and Hygiene
SDG	Sustainable Development Goal
STH	Soil-Transmitted Helminths
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Foreword

Recognizing the importance of environmental sanitation and hygiene, the Government of Kenya has set ambitious targets through the Kenya Vision 2030. These objectives include achieving universal access to improved sanitation, eliminating open defecation, and ensuring that everyone lives in clean and healthy environments by 2030. The 2016-2030 Kenya Environmental Sanitation and Hygiene Policy and the 2019-2030 Kenya Menstrual Hygiene Management Policy further emphasize the need for safe and hygienic practices.

Despite efforts over the past decade, progress in eliminating open defecation at the community level has been slower than anticipated. The 2019 Kenya Population and Housing Census revealed the pressing need for improvement, with some rural households lacking access to quality sanitation facilities and resorting to open defecation. By mid-2021, only 25% of rural communities had been certified as Open Defecation Free (ODF), with ASAL counties facing particular challenges. To address these issues and achieve the sanitation and hygiene goals, the Ministry of Health and its partners recognized the need to update the existing Community Led Total Sanitation (CLTS) protocol for rural sanitation and hygiene (RUSH) protocol.

The Rural Sanitation and Hygiene Protocol presented here outlines a phased approach to guide the achievement of the government's strategic objectives. It is intended for use by public health officials, community health teams, and key local stakeholders at various administrative levels. This protocol forms part of a comprehensive guidance package that includes Implementation Guidelines and a Monitoring Framework, providing practical advice and tools to accelerate and enhance rural sanitation and hygiene services across Kenya.

The protocol emphasizes six building blocks: the construction and proper use of clean latrines, safe treatment and disposal of faecal sludge, sustained handwashing practices, food hygiene, safe water handling, and maintenance of a clean home environment. Furthermore, it aligns with the Sustainable Development Goal sanitation target and addresses the specific requirements of menstrual hygiene management.

Over the next eight years, county governments and sub-county administrations will play a crucial role in planning, implementing, and monitoring interventions to achieve the sanitation and hygiene outcomes set out in this protocol. By working collaboratively with communities, development partners, and other relevant stakeholders, we can make significant strides towards a future where all rural communities in Kenya have eliminated open defecation, achieving universal access to improved sanitation, and live in clean and healthy environments.

This protocol marks a pivotal step forward in our collective journey to transform rural sanitation and hygiene. It provides a roadmap for action, offering guidance on the progressive grading system that encompasses Open Defecation Free (G1), Safe and Sustainable (G2), and Clean and Healthy (G3) environments. Focusing on behaviour change, safe management practices, and sustainability, will ensure there is a long-term impact of the efforts made.

Dr. Patrick Amoth, EBS
Ag. DIRECTOR GENERAL FOR HEALTH

Rationale

The development of the Rural Sanitation and Hygiene Protocol is rooted in the urgent need to address the persistent challenges of rural sanitation and hygiene in Kenya. The 2019 Kenya Population and Housing Census highlighted the continued struggle to provide adequate sanitation access in rural areas, with low-quality toilets and open defecation practices posing risks to public health and the environment. It is imperative to take proactive measures to improve sanitation infrastructure, eliminate open defecation, and create clean and healthy environments for all rural communities.

Recognizing the need for accelerated progress and context-specific strategies, the Ministry of Health and its partners have developed the Rural Sanitation and Hygiene Protocol. This protocol provides a comprehensive framework to guide the achievement of the government's strategic objectives. It builds upon the Community-Led Total Sanitation (CLTS) approach and incorporates additional outcome targets and sustainability indicators to address the diverse challenges faced by different rural communities.

The phased approach outlined in the protocol aims to break down the implementation and sustainability challenges of rural sanitation and hygiene into manageable phases. It sets specific outcomes for each phase, requiring verification of additional milestones to achieve higher service levels for toilets and handwashing. The three renamed grades - Open Defecation Free (ODF), Safe and Sustainable, and Clean and Healthy - provide a roadmap for communities to progress towards improved sanitation and hygiene practices.

The Rural Sanitation and Hygiene Protocol is designed to be implemented at various administrative levels, from villages to counties, involving public health officials, community health teams, and other key stakeholders. By following this protocol, these stakeholders can work collaboratively to address the construction and utilization of clean latrines, safe treatment and disposal of waste, sustained handwashing practices, food hygiene, safe water handling, and maintaining clean home environments.

The protocol is part of a comprehensive guidance package that includes Implementation Guidelines and a Monitoring Framework. These additional documents provide practical guidance for county governments and local administrations and establish a monitoring system to track progress and certify outcome grades defined by the protocol.

Overall, the Rural Sanitation and Hygiene Protocol aims to accelerate progress towards improved sanitation and hygiene outcomes in rural communities in Kenya. It underscores the importance of a coordinated, context-specific approach and the involvement of multiple stakeholders to achieve the shared vision of universal access to improved sanitation and hygiene and clean and healthy environments for all Kenyans by 2030.

Dr. Maureen Kamene
Ag. HEAD, DIRECTORATE OF PUBLIC HEALTH

Acknowledgement

The Ministry of Health is grateful for the collaborative efforts that have gone into developing this Rural Sanitation and Hygiene Protocol in Kenya. This endeavour has brought together the expertise, dedication, and contributions of numerous individuals and organizations. The Ministry extends its appreciation to all those who have played a part in shaping a comprehensive protocol to address the sanitation and hygiene challenges in our country led by Adam Mohammed, Janet Mule, Ibrahim Basweti, Doyle Leonard and Emmah Mwende from the WASH Division, Ministry of Health. The Ministry is grateful to UNICEF-Kenya for providing financial and technical support towards this process led by Hodaka Kosugi and Jimmy Eric Kariuki. We also want to express our appreciation to our line Ministry of Water Sanitation and Irrigation (Eng. Kimanthi Kyengo and Maureen Kirwa), development partners and international organizations for their invaluable support and collaboration throughout this process. We are grateful to the numerous civil society organizations, research institutions, and community-based organizations that actively participated in consultations, shared their insights, and provided valuable inputs into the protocols. The document was developed by Andy Robinson, Nancy Balfour, Gerishom Gimaiyo and Chamia Mutuku (consultants) following consultations with numerous individuals, sector organisations and county governments. We would particularly like to thank the Public Health teams from the following counties for their significant contributions to the development of this document: Garissa, Homa Bay, Kilifi, Kitui, Kwale, Marsabit, Migori, Nakuru, Narok, Siaya, Turkana, Wajir. Acknowledgement should also be given to Africa AHEAD for the development of the Household Inventory Monitoring Tool used by the Rwanda Ministry of Health, which inspired some of the outcome indicators and service level scales used in this protocol.

Insights and feedback from the teams provided critical perspectives that shaped the protocol's priorities and actions. To everyone who has contributed to this roadmap, directly or indirectly, we offer our appreciation. Your collective efforts have laid the foundation for a comprehensive and transformative protocol that will drive positive change in Kenya's sanitation and hygiene landscape. We are excited to embark on this journey.

Anthony Wainaina
HEAD, DIVISION OF ENVIRONMENTAL HEALTH

Preface

Rural sanitation and hygiene are vital elements in safeguarding public health and promoting sustainable development. However, the 2019 Kenya Population and Housing Census revealed persistent challenges in ensuring adequate sanitation access in rural areas. The availability of low-quality toilets and the prevalence of open defecation pose significant risks to the health and well-being of individuals and communities.

Recognizing the urgency of the situation, the Government of Kenya has established targets aligned with national and international commitments, including the Kenya Vision 2030 and the Sustainable Development Goals. These targets emphasize the importance of universal access to improved sanitation, the elimination of open defecation, and the creation of clean and healthy environments by 2030.

To effectively address these challenges and accelerate progress, the Ministry of Health, in collaboration with partners and stakeholders, has developed the Rural Sanitation and Hygiene Protocol. This protocol serves as a comprehensive guide for public health officials, community health teams, and other key stakeholders involved in rural sanitation and hygiene interventions. It provides a phased approach to achieving the strategic objectives set by the government, taking into account the diverse challenges faced by different rural communities.

The Rural Sanitation and Hygiene Protocol is part of a broader guidance package that includes Implementation Guidelines and a Monitoring Framework. These documents work in tandem to provide practical guidance, inform decision-making, and ensure the effective implementation and monitoring of sanitation and hygiene interventions in rural areas.

By implementing the Rural Sanitation and Hygiene Protocol, we can foster behavioural change, improve the construction and utilization of clean latrines, promote safe treatment and disposal of waste, encourage sustained handwashing practices, ensure food hygiene, promote safe water handling, and maintain clean home environments. These collective efforts will contribute to the realization of the Kenya Vision 2030, the Sustainable Development Goals, and ultimately, the well-being and prosperity of all rural communities in Kenya.

Definitions

Animal management
Safe household management of animals includes: safe disposal of animal excreta, penning and isolation of animals, and safe handling and management of animal products.

Certification (outcomes)
An official process to confirm and certify the rural sanitation and hygiene outcomes previously verified for a particular grade of the Rural Sanitation & Hygiene Protocol.

Child excreta (safe disposal)
The urine and faeces of infants and young children, which should be safely disposed of into improved toilets or covered disposal pits.

Clean homes
Houses that have clean and swept floors, clothes and other items are well stored, with beds or mattresses.

Clean & Healthy environment
All households in the community (or administrative unit) meet the criteria for a G3 Clean & Healthy environment.

Communal areas
Areas within the settlement that are not part of household compounds, and which are accessible to all.

Community
A group of households in a single settlement, or a single neighbourhood. Usually either a village, a sub-village or a neighbourhood in a larger urban or peri-urban settlement.

Critical times (handwashing)
The times for handwashing with soap that are considered most critical to preventing faecal-oral contamination.

Diapers (safe disposal)
The washable cloths or disposable material worn by infants to absorb and retain urine and faeces.

Durable toilets
Toilets with durable slabs and pits that allow sustained use without the need for frequent repair and replacement.

Faecal sludge
Solid and liquid contents of pit latrines or septic tanks (or other excreta containment systems).

Flyproof and clean toilets
Toilets with slabs and superstructures that are free of visible excreta, and prevent flies from entering the excreta containment system.

Food hygiene (safe)
Food, utensils, storage areas, and food preparation and eating areas are kept clean and safe before, during and after eating.

Good nutrition
People receive the macronutrients (carbohydrates, proteins and fats) and micronutrients (minerals and vitamins) required for good health.

Household
Single or polygamous household structure, in which there is a joint provision of food or other essentials. More complex household structures should be recognised in polygamous families.

Household compound
The area around the household residence that is used and managed by the household (either fenced or unfenced)

Handwashing with soap
Act of cleaning one's hands with soap and water to remove any harmful or unwanted substances.

Liquid waste management (safe)
Safe management of the spent or used water from homes and other sources.

Hygiene
Set of practices associated with the preservation of good health and healthy living, including handwashing with soap, safe disposal of children's faeces, and keeping oneself and one's home and surroundings clean.

Malaria-safe
Prevention of malaria through vector control and protection from mosquito bites, including the use of insecticide-treated nets and screens.

Menstrual health
State of complete physical, mental and social well-being in all matters relating to the menstrual process.

Menstrual materials
Menstrual products, including disposable and reusable sanitary pads, tampons and menstrual cups, and clean pieces of cotton cloth or cotton wool, that are safe and hygienic for collection and absorption of blood during menstrual periods.

Open Defecation Free (ODF)
Free from indiscriminate defecation or discharge of excreta into open spaces, water bodies or other places.

Open Defecation Free environment
All households in the community (or administrative unit) meet the criteria for a G1 ODF environment.

Personal hygiene
Act of keeping the body clean to remove any harmful or unwanted substances and prevent disease.

Resilient toilets
Sanitation facilities (and related sanitation services) designed using local materials to resist the main local sustainability challenges.

Safe & Sustainable environment
All households in the community (or administrative unit) meet the criteria for a G2 Safe & Sustainable environment.

Safely managed sanitation services
Use of improved sanitation services, with excreta either safely disposed of on-site, or transported and treated off-site.

Sanitation
Maintenance of hygienic conditions and healthy environments through safe management of human excreta, and safe management of solid and liquid wastes.

Solid waste management (safe)
Management of household and other solid wastes, including their safe collection, transfer, treatment, recycling, resource recovery and disposal.

Vector control
Control of insects or other organisms (e.g. mosquitoes, flies or bilharzia-infected snails) that carry disease from animals to humans or other insects or organisms.

Verification (outcomes)
A local administration process to inspect, assess and verify the rural sanitation and hygiene outcomes agreed for each grade of the Rural Sanitation & Hygiene Protocol.

Water management (safe)
Management of domestic water to prevent contamination through all of the stages from the water source to consumption in the home, including protection, collection, handling, transport, storage, treatment and use.

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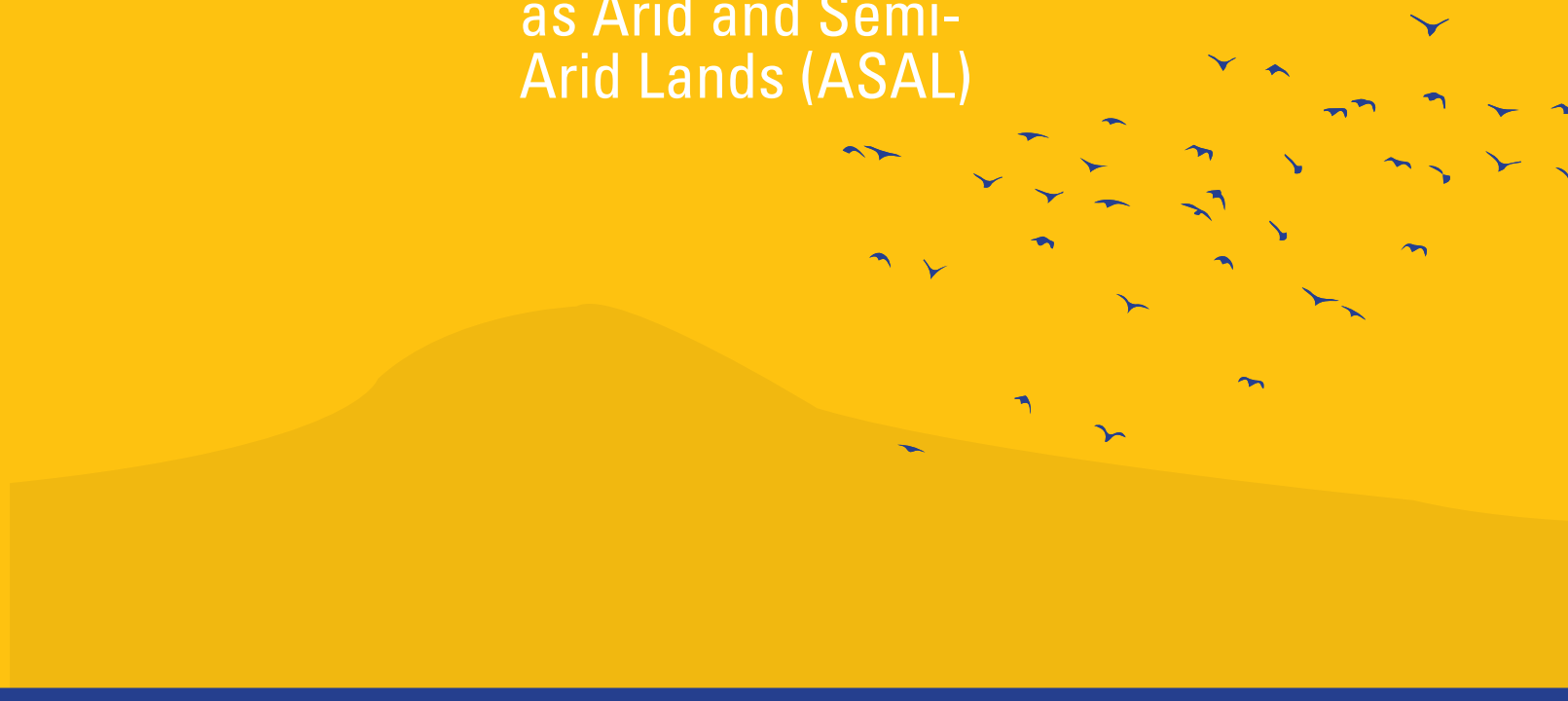
83%

of the population that practices open defecation lives in 15 counties classed as Arid and Semi-Arid Lands (ASAL)



1 Introduction

The *2019 Kenya Population and Housing Census* confirmed that rural sanitation remains a significant challenge in Kenya. While sanitation access was found to be above 75% in around two-thirds of Kenya's counties, some of these household toilets are reported to be of low quality and have limited sustainability. Similarly, the census found that the practice of open defecation is generally low in rural Kenya, with around 10% of the rural population reported to defecate in the open, and less than 2.5% open defecation reported in 21 of the 47 counties. However, even in counties with lower rates of open defecation, children's faeces are often not contained, and some adults who own household toilets are reported to defecate in the open at night or during the rainy season[1].

10%
of rural population defecate in the open

1 Ministry of Health (2016) *Kenya Environmental Sanitation and Hygiene Policy 2016-2030* Nairobi: Republic of Kenya, Ministry of Health.

Sanitation access is also highly variable across Kenya: 83% of the population that practices open defecation lives in 15 counties classed as Arid and Semi-Arid Lands (ASAL), where sanitation access is generally below 60% and the proportion of unimproved toilets is often higher than in other counties. Progress in the elimination of open defecation at the community level has been slower than expected – despite significant efforts over the last ten years, and the target of an ODF Kenya by 2020, only 25% of rural communities have been certified as Open Defecation Free (ODF) by mid-2021. ODF progress has been significantly slower in the ASAL counties that have high open defecation rates, with most ASAL counties reporting that less than 12% of rural communities have achieved ODF status by mid-2021. However, a few ASAL counties have made good progress (Garissa, Turkana and West Pokot), and adapted implementation approaches are beginning to be developed for ASAL communities.

The *2016-2030 Kenya Environmental Sanitation and Hygiene Policy* (2016-2030 KESHP) states that, as per the Kenya Vision 2030 and the global 2030 Sustainable Development Agenda[2], Kenyans should have universal access to improved sanitation, open defecation should be eliminated, and **everyone should live in clean and healthy environments by 2030**. The 2016-2030 KESHP also states that promotion of environmental sanitation and hygiene should be based on six building blocks:

- Construction and proper use of clean latrines
- Safe treatment and disposal of faecal sludge
- Sustained handwashing practices
- Food hygiene
- Safe water handling and proper use
- Maintenance of a clean home environment

The *2019-2030 Kenya Menstrual Hygiene Management Policy* states that women and girls should have access to safe and hygienic menstrual products, services and facilities; and all **Kenyans should live in a clean and healthy environment** through appropriate technology choices for menstrual waste management and pollution control. It is also well-aligned with the requirements of the Sustainable Development Goal sanitation target (6.2), including the safe management of faecal sludge as part of the use of safely managed sanitation services.

Given the broader environmental sanitation and hygiene objectives and the higher service levels to be achieved by 2030, as well as the ongoing challenges to sanitation and hygiene development in the ASAL areas, the Ministry of Health and partners recognised the need to update the existing protocol for rural sanitation and hygiene.

2 Sustainable Development Goal (SDG) target 6.2 Sanitation and Hygiene: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.

1.1 CLTS protocol

The Rural Sanitation and Hygiene Protocol builds on and replaces the 2014 CLTS Protocol. The 2014 CLTS Protocol[3] promoted the use of the Community-Led Total Sanitation (CLTS) approach for the achievement of ODF outcomes among the rural population of Kenya. CLTS was adopted as the main approach for rural sanitation development by all governments and partners and was the foundation for the recently expired (2016-2020) national ODF roadmap.

The 2014 CLTS Protocol included three phases: ODF; Post ODF; and Total Sanitation environment. Most stakeholders in Kenya are familiar with the ODF criteria:

- no exposed human excreta
- all households have access to a toilet (with covered squathole, floor free of faeces and urine, and superstructure that provides privacy)
- all households have a handwashing facility near the toilet with soap/ash and water
- continued use of the toilet by the household

The Post ODF and Total Sanitation phases have not been operationalised. The CLTS protocol listed the additional outcome criteria for each of the subsequent phases, which included: use and maintenance of institutional WASH facilities, safe storage and handling of food, safe storage and handling of drinking water, personal hygiene, clean villages with no visible solid waste or stagnant water, and the presence of a community monitoring system for open defecation. However, under the CLTS Protocol, implementation and monitoring activities focused heavily on ODF achievement, with the other criteria for the Post ODF and Total Sanitation phases not well used, not monitored or reported by most stakeholders, and few of these indicators were included in the national monitoring information system (MIS).

The CLTS approach has been instrumental in the elimination of open defecation from several counties, but it has proved less effective in some contexts and communities. For instance, adaptations to the original CLTS approach are required in ASAL contexts, where conventional CLTS has proved insufficient for widespread behaviour change. While CLTS can be adapted for many purposes, the process typically focuses on the elimination of open defecation rather than on other environmental sanitation and hygiene outcomes, such as food hygiene and animal management, and is rarely designed to address the development of new services, such as solid and liquid waste management, or faecal sludge management.

Furthermore, other sanitation approaches, such as market-based sanitation, are required to improve sanitation services in areas where open defecation is already low and most people use some form of toilet.

3 Ministry of Health (2014) *Protocol for implementing CLTS in Kenya* Nairobi: Republic of Kenya, Ministry of Health, Protocol.

Sustained use of durable toilets, will be harder to achieve in **ASAL** communities

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In 2016, the Kenya Environmental Sanitation and Hygiene Policy (KESHP) introduced additional 2030 outcome targets for rural communities, including several new environmental sanitation and hygiene outcomes that were not included in the CLTS protocol. As a result, the protocol required updating – both to reflect the broader outcomes and universal targets of the 2016 KESHP, and to recognise that effective rural sanitation and hygiene development across the wide range of rural contexts in Kenya requires the use of a range of implementation approaches, including but not limited to CLTS.

1.2 Sustainability

Several studies of CLTS interventions have highlighted the sustainability risks associated with simple pit latrines built using local materials. The collapse of simple latrine slabs and unlined latrine pits is a common problem in many parts of the country. A 2015 UNICEF Kenya study[4] found that latrine collapse was an important factor in household reversion to the practice of open defecation; and that environmental factors, such as flooding of the latrine pit, reduced motivation to repair and replace damaged facilities.

The *2018 World Health Organization (WHO) Sanitation and Health Guidelines* recognise the risk that toilets that are not well constructed, or that are made from non-durable materials, may be difficult to clean and may not allow sustained use. Therefore, the WHO guidelines state that toilet slabs should be constructed from durable materials that can be easily cleaned. As a result, in 2019, the WHO-UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) updated its global monitoring definitions[5] so that a "pit latrine with slab" will only be counted as an improved sanitation facility[6] if the slab is constructed from materials that are durable and easy to clean.

Several countries (notably the Philippines, Nepal and Zambia) have used a phased approach to sanitation development to encourage sustained outcomes, and outcomes beyond ODF status, by requiring that verification of each higher level of collective sanitation and hygiene outcomes includes re-verification of previously verified outcomes. This approach ensures that communities cannot progress until behaviour changes have solidified, and services are sustained. The *2019 Guidelines on the Implementation of the Philippine Approach to Sustainable Sanitation* (PhATSS) also require verification of sustainability indicators, such as the existence of local ordinances and monitoring systems to sustain ODF status, and the presence of an approved action plan and funding allocations for progress to the next outcome phase.

4 Singh S and Balfour N (2015) *Sustainability of ODF practices in Kenya* Nairobi: UNICEF Eastern and Southern Africa Regional Office, WASH Field Note.

5 JMP (2018) *Core questions on water, sanitation and hygiene for household surveys: 2018 update* New York: World Health Organization (WHO) and United Nations Children's Fund (UNICEF) Joint Monitoring Programme for Water Supply, Sanitation and Hygiene.

6 The JMP define use of a basic sanitation service as: use of an improved sanitation facility that is not shared with other households.

The Rural Sanitation and Hygiene Protocol in Kenya seeks to strengthen and institutionalise the phased approach initiated by the 2014 CLTS protocol, including sustainability checks and the use of sustainability indicators.

1.3 ASAL contexts

The challenges to sanitation development in ASAL areas are significant, making it hard for some ASAL communities to follow the same development trajectory as communities from other areas. Furthermore, the greater proximity and contact with animals found in pastoralist communities suggests that faecal exposure and disease transmission from unsafe management of animal wastes are likely to be far higher risks in pastoralist ASAL communities than in other rural communities in Kenya.

In 2020-2021, USAID conducted research[7] that confirmed the challenges of sanitation marketing in remote pastoralist communities, and suggested that ASAL communities offer low potential for market-based sanitation. As a result, some of the sanitation outcomes that could be targeted in other rural communities, such as sustained use of durable toilets, will be harder to achieve in ASAL communities without additional support.

The different challenges and contexts found in ASAL communities suggest that adapted approaches will be required in these areas, and that sanitation development is likely to be harder and take longer in these communities. In particular, it will take time to improve the traditional management of animals and animal wastes; and greater efforts (and more time) will be required to extend market-based sanitation services and goods to these communities. Nonetheless, ASAL communities should be supported to achieve the same sanitation and hygiene outcomes as other rural communities in Kenya, with appropriate allowances made in planning, budgeting and programming to allow for the more challenging contexts.

1.4 Other contexts

The development of sanitation and hygiene in ASAL areas is one of the main challenges faced by the rural sanitation and hygiene subsector, but there are also other contexts in which implementation approaches other than CLTS are required. For instance, areas that are already ODF, or have low levels of open defecation, need to focus on upgrading existing toilets to more durable and safely managed facilities.

Other areas face particular context-related challenges, such as climate-related events (flooding, heavy rain, drought, sea level rises, landslides), physical challenges (collapsible soils, rocky soils, water scarcity) and socio-cultural challenges (barriers to toilet use and hygiene) that require more targeted and specific implementation approaches. The range of contexts and populations found in each county means that counties should develop implementation strategies that identify the range of approaches, and the capacity and resources needed, to achieve results across all of these different contexts and populations.

7 FSG (2021) *Sanitation market assessment in Western Kenya and Marsabit: Preliminary findings* USAID Water Sanitation and Hygiene Partnerships for Learning (WASHPaLS) research activity.

2 Objectives

All rural communities in Kenya will have to eliminate open defecation, achieve universal access to improved sanitation, and work towards clean and healthy environments by 2030. Over the next eight years, county governments and sub-county administrations will have to plan and implement interventions, monitor progress, and certify sanitation and hygiene outcomes, in every rural community in every area of the country.

The Rural Sanitation and Hygiene Protocol is intended to facilitate this process, by providing a phased approach for the achievement of the strategic objectives set by the Government of Kenya. The main users of the protocol will be the public health officials and community health teams at county, sub-county, ward and community levels. These health officials and health workers will work with other key local stakeholders, such as development partners, officials from other departments, communities and community leaders to achieve the outcomes set out by the protocol.

achieve universal access to improved sanitation by **2030**

This Rural Sanitation and Hygiene Protocol forms part of a three-document guidance package developed by the Ministry of Health, with support from UNICEF, to accelerate and improve rural sanitation and hygiene services in Kenya, including:

1. ***Rural Sanitation and Hygiene Protocol*** (RuSH Protocol)
2. ***Implementation Guidelines for Rural Sanitation and Hygiene*** (Implementation Guidelines)
3. ***Monitoring Framework for Rural Sanitation and Hygiene*** (Monitoring Framework)

The **RuSH Protocol** sets out the sanitation and hygiene outcomes that the Government of Kenya would like rural communities, local administrations and county governments to achieve by 2030, based on national policies, strategies and plans, and on international commitments like the 2030 sanitation and hygiene target (6.2) included in the Sustainable Development Goals.

The **Implementation Guidelines** inform county governments and local administrations how to achieve the rural sanitation and hygiene outcomes required by the RuSH Protocol, given local contexts and constraints.

The **Monitoring Framework** details how the sanitation and hygiene outcomes required by the RuSH Protocol should be monitored over time, and how the national and county governments will certify the overall outcome grades defined by the RuSH Protocol (G1 Open Defecation Free; G2 Safe and Sustainable; and G3 Clean and Healthy).

Other ongoing sanitation and hygiene initiatives

The Rural Sanitation and Hygiene Protocol has been developed in parallel with the National Sanitation Management Policy (NSMP). Both documents were developed during the same period, with close collaboration between the Ministry of Health (MoH), Ministry of Water, Sanitation and Irrigation (MoWSI) and other key sanitation stakeholders.

The national monitoring information system (MIS) for rural sanitation and hygiene will be updated to reflect the new outcomes and monitoring indicators required by the RuSH Protocol. The MoH, supported by UNICEF, is leading the MIS development process.

The Rural Sanitation & Hygiene Protocol will also inform the development of a new roadmap for rural sanitation and hygiene. The previous ODF roadmap expired in 2020, with a new roadmap now under development to reflect the wider environmental sanitation and hygiene objectives in the 2016 Kenya Environmental Sanitation and Hygiene Policy, and the outcomes required by the revised Rural Sanitation and Hygiene Protocol.

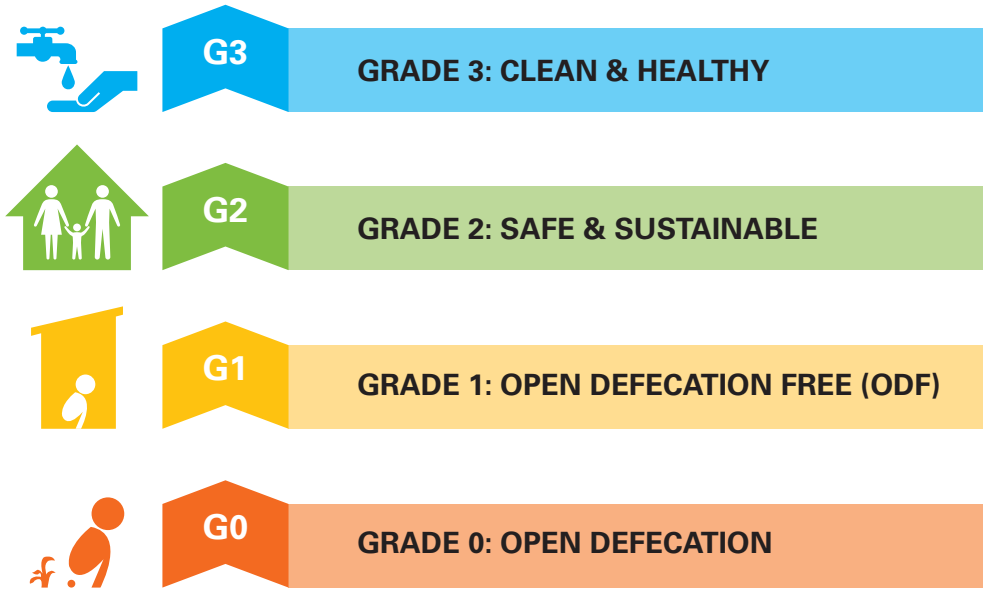
3 Rural Sanitation and Hygiene Protocol

The Rural Sanitation and Hygiene Protocol (RuSH Protocol) sets out the sanitation and hygiene outcomes that rural communities should achieve by 2030, as required by the Kenya 2030 Vision and the international SDGs.

The lowest level of the administrative structure is the village. However, some villages comprise multiple separate sub-villages (e.g. hamlets), and some rural communities are neighbourhoods of larger settlements (e.g. peri-urban areas). All of these different types of rural community have to achieve the sanitation and hygiene outcomes set out in the RuSH Protocol, with the aim that the higher levels of the administrative structure (wards, subcounties and counties) gradually achieve universal improvements in outcomes.

The RuSH Protocol is designed to operationalise and strengthen the phased approach promoted by the 2014 CLTS Protocol, through the inclusion of additional outcome targets and sustainability indicators. The protocol also reflects the ongoing transition from CLTS-only implementation towards more context-specific implementation strategies that utilise a mix of implementation approaches (e.g. adapted CLTS, market-based sanitation, behaviour change communication, system strengthening) to address the particular contextual and technical challenges faced by different communities in rural areas.

Figure 1: Rural Sanitation and Hygiene Protocol: Grading system



The RuSH Protocol sets out a phased approach including three renamed grades:

G1

Open Defecation Free environment

G2

Safe and Sustainable environment

G3

Clean and Healthy environment

The phased approach intends to break down the implementation and sustainability challenges of rural sanitation and hygiene into several more focused and more easily achieved phases, with verification of additional outcomes, or higher service levels for toilets and handwashing, required to achieve each subsequent grade.

Each of the three grades has a slightly different focus:

- **G1 Open Defecation Free (ODF)** is focused on behaviour change and the elimination of the unsafe return of excreta to the open (e.g. unsafe excreta return through open defecation or unsafe disposal of child excreta and diapers).
- **G2 Safe & Sustainable** is focused on the safe management of toilets, hands, food, water and animal wastes to block the primary routes of faecal exposure and faecal-oral contamination; and on more sustainable services.
- **G3 Clean & Healthy** is focused on more permanent and safely managed services and on other critical aspects of environmental sanitation and hygiene, to create a "clean and healthy environment" for rural Kenyans as required by the *2016-2030 Kenya Environmental Sanitation and Hygiene Policy*[8].

All rural communities should be certified as living in G2 Safe & Sustainable environments by 2030. G2 status includes critical safe sanitation and hygiene practices and requires durable toilets for sustainability, thus is the minimum standard that all rural communities should aim to achieve. G1 ODF status is an intermediate phase that confirms sanitation and hygiene behaviour change, and encourages progress towards G2 status. Finally, G3 Clean and Healthy status is the ultimate aim, which should be achieved by well-managed and well-supported rural communities before 2030, with communities in more challenging rural contexts expected to take longer to work towards and achieve G3 status.

8 Section 4.2.3 of the Ministry of Health 2016-2030 Kenya Environmental Sanitation and Hygiene Policy states that *"The policy goal is to ensure universal access to improved sanitation, [and a] clean and healthy environment by 2030."*

Figure 2: Summary of Rural Sanitation and Hygiene Protocol

GRADE 0: OPEN DEFECATION	GRADE 1: OPEN DEFECATION FREE (ODF)	GRADE 2: SAFE & SUSTAINABLE	GRADE 3: CLEAN & HEALTHY
Exposed human and animal excreta People not using toilets Lack of handwashing practice	G1-1 Use of fly-proof and clean toilets G1-2 Presence of handwashing facilities with water & soap G1-3 No exposed human excreta G1-4 Safe management of child excreta & diapers	G2-1 Individual use of durable toilets with safe containment G2-2 Handwashing with soap at critical times G2-3 Safe food hygiene G2-4 Safe water management G2-5 Safe management of animals and animal wastes	G3-1 Safely managed sanitation services G3-2 Permananent handwashing stations G3-3 Safe waste management G3-4 Personal hygiene G3-5 Good nutrition G3-6 Safely managed institutional sanitation Endemic areas: G3-E1 Malaria-safe homes G3-E2 Dewormed homes
	Sustainability Criteria » Monitoring of OD & toilet use » Identification of shared & high-risk households » Action plan for G2 achievement	**Sustainability Criteria** » Re-verification of G1 ODF status » Checks on new & high-risk households » Monitoring of Safe & Sustatinable status » Action plan for G3 achievement	**Sustainability Criteria** » Re-verification of G1 & G2 status » Checks on high-risk & new households » Monitoring of Clean & Healthy status

3.1 Grade 1: ODF status

Figure 3: Outcome indicators for G1 ODF environment

G1: OPEN DEFECATION FREE (ODF)	**G1-1** Use of flyproof and clean toilets
	G1-2 Presence of handwashing facility with water & soap
	G1-3 No exposed human excreta
	G1-4 Safe management of child excreta and diapers
G1: Sustainability indicators	**G1-S1** Monitoring system for OD and toilet use
	G1-S2 Disaggregated monitoring of at-risk households
	G1-S3 Action plan for G2 achievement

Grade 1 (G1) Open Defecation Free (ODF) status has similar requirements to the current ODF status (as certified under the CLTS Protocol). Previously, the ODF criteria required that no exposed human excreta (including child excreta) should be visible in the community. The high risk associated with unsafe child excreta (and diaper) disposal close to the home, and the different caregiver practices related to child excreta and diaper management, recommend that – in all future ODF interventions – safe disposal of child excreta and safe management of diapers should be promoted, and these outcomes should be separately monitored and certified.

Previously certified ODF communities will be considered as G1 ODF communities. However, communities have to re-verify the sustained achievement of the G1 outcomes to achieve Grade 2 Safe and Sustainable status. Additional promotion of the safe disposal of child excreta and safe diaper management may be required in these ODF communities to ensure that all of the G1 outcomes can be re-verified as part of the G2 certification process.

G1-1 Use of flyproof and clean toilets

Indicator criteria	Notes
G1-1.1 Presence of functional household toilet with privacy	**Assessment:** observation of household toilet
	Functional: working as intended; can be used
	Privacy: superstructure meets local criteria for privacy; animals are prevented from entering the toilet.
	Toilet: facility for containment of human excreta (or for transport into a sewer)
G1-1.2 Toilet use by all household members	**Assessment:** observation & household interview to confirm that everyone uses the toilet, and check shared use
	Sharing threshold: 10-15 people
G1-1.3 Flyproof toilet	**Assessment:** observation of household toilet
	Flyproof: flies prevented from reaching excreta in the pit
G1-1.4 Clean toilet	**Assessment:** by observation of slab and toilet interior
	Clean: no visible faeces, urine or soiled cleaning materials in or around the toilet

For G1 status, all households should use flyproof and clean toilets, with confirmation that all members of the household either use the toilet, or are assisted to use the toilet (e.g. disabled or older people, or young children that need assistance). Where children are too young to use the toilet, see indicator **G1-3 for safe disposal of child excreta and safe management of diapers**.

Shared use of a toilet is acceptable providing that the total number of toilet users is less than 10-15 people (adults and children). Households who own shared toilets, and households who do not own a toilet but share use of another toilet, should be identified and monitored in separate categories to recognise the higher risk of sustainability problems when people use shared toilets.

Functional toilet: when observed, the household toilet should be functioning as intended, and able to be used (i.e. not blocked, abandoned or collapsed).

Privacy: the toilet superstructure should meet local criteria for privacy, as agreed by the County Public Health Office. In most cases, toilet superstructures will include walls and a door, which allow use of the toilet without external observation. The superstructure should also prevent animals from entering, to limit contact between animals and human excreta.

Toilet use: the interior of the toilet should have no signs of disuse (e.g. spider webs in the pan or squat hole, dry water seal, objects blocking the squat hole or pan). A household respondent should also confirm whether all members of the household use the toilet, and whether the household shares the toilet with other households.

Shared toilet use: shared use of a toilet is acceptable, providing that no more than 10-15 people use the toilet. The County Public Health Office should agree on the sharing threshold based on local practices and evidence of hygienic outcomes in shared toilets.

Flyproof toilet: design prevents flies from reaching the excreta in the pit (or other containment system). Examples of flyproof toilets include:

1. Pour-flush pit latrine with a functional water seal pan.
2. VIP latrine with a screened vent pipe.
3. Dry pit latrine with a tight-fitting squat hole cover.

Clean toilet: interior of the toilet should appear clean, with no visible faeces, urine or used cleaning materials (e.g. toilet paper, other paper, leaves or other anal cleansing materials) in or around the toilet.

G1-2 Presence of handwashing facility with water and soap

Indicator criteria	Notes
G1-2.1 Presence of household handwashing facility	**Assessment:** observation of handwashing facility
	Handwashing facility: confirm the number of handwashing facilities, and location of handwashing facilities
G1-2.2 Water available at handwashing facility	**Assessment:** observation of handwashing facility
	Water: confirm whether water is available at the main facility
G1-2.3 Soap available at handwashing facility	**Assessment:** observation of handwashing facility
	Soap: confirm whether soap is available at the main facility

For G1 status, all households should have a handwashing facility with water and soap available, either at the toilet, or in the house or kitchen (if the toilet is nearby).

Presence of handwashing facility: a household respondent should be asked where members of the household usually wash their hands. This facility should be observed for the presence of water and soap.

Location of handwashing facility: ask and observe whether there is only one handwashing facility, or whether facilities are available in more than one place (e.g. by the toilet and in the kitchen).

Presence of water at the handwashing facility: water should be observed at the handwashing facility. Where an empty water container is observed, the presence of wet ground (or wet materials) under the handwashing facility can be accepted as proof of the recent presence of water at the handwashing facility.

Presence of soap at the handwashing facility: soap should be observed at the handwashing facility. Soap can be in the form of solid soap, liquid soap (e.g. soapy water) or soap powder. The presence of ash (or other cleaning agents such as sand, soil or plants) should be recorded as a lower level of service (not meeting the G1 requirements).

G1-3 No exposed human excreta

Indicator criteria	Notes
G1-3.1 No exposed human excreta in household compound	**Assessment:** observation of household compound
	No exposed human excreta: no visible human faeces in the household compound (or in the house, toilet or any other buildings or facilities in the compound)
G1-3C No exposed human excreta in communal areas	**Assessment:** observation of communal areas
	No exposed human excreta: no visible human faeces in communal areas (including previous OD sites)

For G1 status, open defecation has to be eliminated from the community. All households should confirm that they are using toilets, and there should be no exposed human excreta.

No exposed human excreta: by observation of household compounds and communal areas for visible human (adult or child) faeces.

Open defecation in water bodies: where groups or communities (e.g. people living near beaches, lakes or rivers) practice open defecation in nearby water bodies, human excreta may not be visible in and around household compounds and communal areas. In these cases, household interviews should be used to assess whether people practice open defecation or use a toilet, in combination with observation of the presence of functional toilets (to verify claims of toilet use).

G1-4 Safe management of child excreta and diapers

Indicator criteria	Notes
G1-4.1 Safe management of child excreta in household compound	**Assessment:** household interview (main caregiver)
	Child excreta disposal: child faeces are safely managed and disposed of, and implements are cleaned in a safe place
G1-4.2 Safe management of diapers in household compound	**Assessment:** observation & household interview
	No used diapers: no used diapers visible within the household compound
	Diaper management: washable cloths and diapers are cleaned in a safe place; used disposable diapers are safely disposed off
G1-4C Safe management of diapers in communal areas	**Assessment:** observation of communal areas
	No used diapers: no used diapers visible in communal areas

For G1 status, all households should practice **safe management of child excreta and diapers.**

Child excreta: faeces and urine of children who are too young to use a toilet.

Safe management of child excreta: child excreta are safely managed and safely disposed of (e.g. put or rinsed into the toilet, or buried).

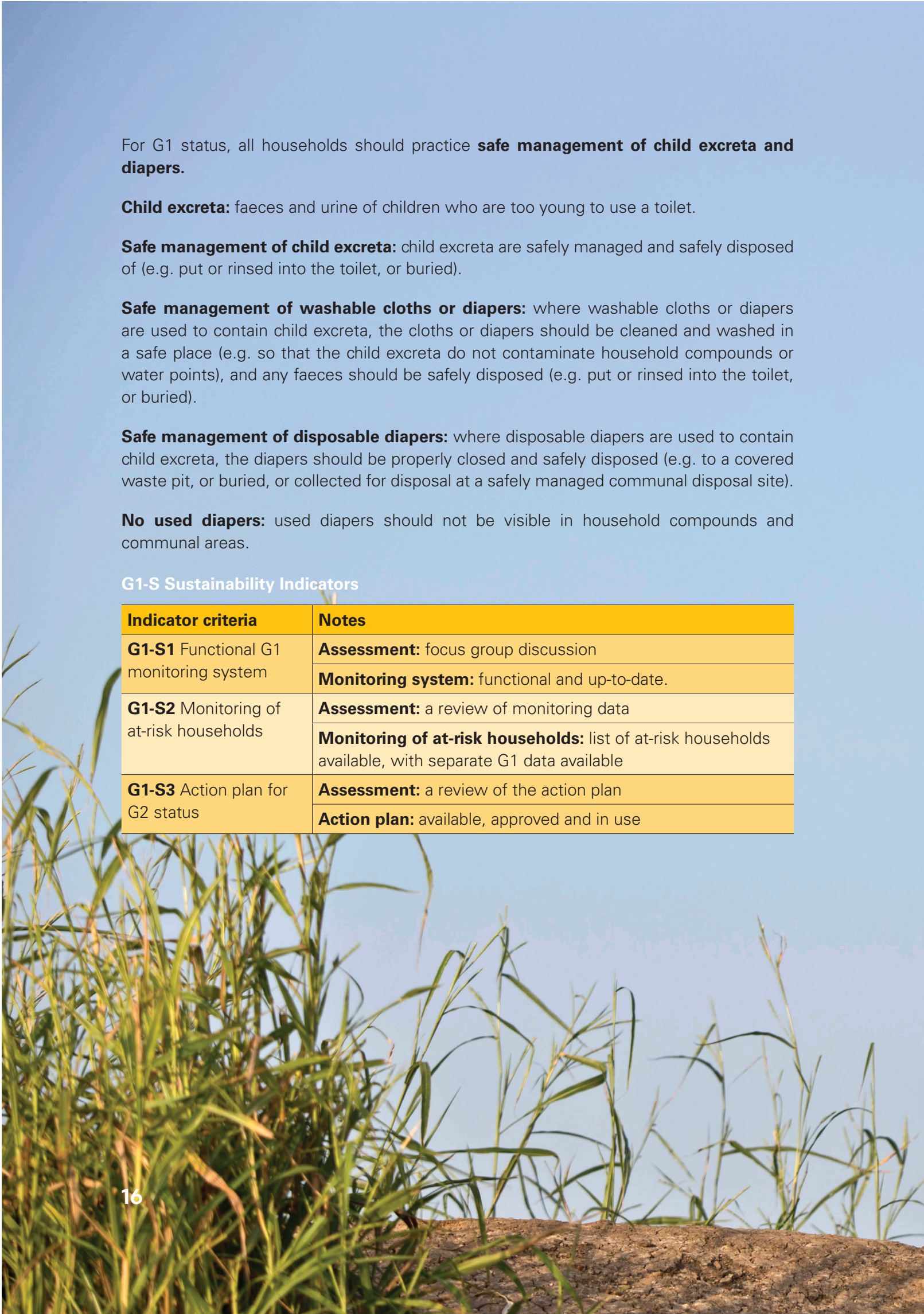
Safe management of washable cloths or diapers: where washable cloths or diapers are used to contain child excreta, the cloths or diapers should be cleaned and washed in a safe place (e.g. so that the child excreta do not contaminate household compounds or water points), and any faeces should be safely disposed (e.g. put or rinsed into the toilet, or buried).

Safe management of disposable diapers: where disposable diapers are used to contain child excreta, the diapers should be properly closed and safely disposed (e.g. to a covered waste pit, or buried, or collected for disposal at a safely managed communal disposal site).

No used diapers: used diapers should not be visible in household compounds and communal areas.

G1-S Sustainability Indicators

Indicator criteria	Notes
G1-S1 Functional G1 monitoring system	**Assessment:** focus group discussion
	Monitoring system: functional and up-to-date.
G1-S2 Monitoring of at-risk households	**Assessment:** a review of monitoring data
	Monitoring of at-risk households: list of at-risk households available, with separate G1 data available
G1-S3 Action plan for G2 status	**Assessment:** a review of the action plan
	Action plan: available, approved and in use



For G1 status, the community should also have achieved the three sustainability indicators.

Monitoring system: the community (or local administration) has established a sustainability monitoring system for open defecation and toilet use, which is functional and provides up-to-date information.

Monitoring of at-risk households: households using shared toilets, new households, and other households at higher risk of unhygienic, unsafe or unsustainable sanitation practices, have been identified and their sanitation and hygiene outcomes are monitored and reported separately (i.e. disaggregated from other household data).

Action plan: the community (or local administration) has developed, approved and is using an action plan for the achievement of a **G2 Safe & Sustainable environment**.

3.2 G2 Safe & Sustainable status

Figure 4: Outcome indicators for G2 Safe & Sustainable environment

G2: SAFE & SUSTAINABLE	**G2-1** Individual use of durable toilets with safe containment
	G2-2 Handwashing with soap at critical times
	G2-3 Safe food hygiene
	G2-4 Safe water management
	G2-5 Safe management of animals and animal wastes
G2: Sustainability indicators	**G2-S1** Monitoring system for G2 outcomes
	G2-S2 Disaggregated monitoring of at-risk households
	G2-S3 Action plan for G3 achievement
	G2-S4 Re-verification of G1 outcomes

G1 ODF communities should aim to progress to Grade 2 Safe & Sustainable status as quickly as possible. The aim is that all rural communities achieve G2 status by 2030. Communities with supportive conditions can progress directly to G2 status, providing that the G1 outcomes are checked and certified at the same time as the G2 outcomes.

G2-1 Individual use of durable toilets with safe containment

Indicator criteria	Notes
G2-1.1 Individual use of toilet	**Assessment:** by household interview
	Individual use: all household members are individually confirmed (by name) to use the toilet, or be assisted to use the toilet
G2-1.2 Durable toilet slab	**Assessment:** by observation
	Durable toilet slab: made from durable materials, or approved resilient local materials
G2-1.3 Durable toilet pit	**Assessment:** by observation & household interview
	Durable toilet pit: made from durable or resilient local materials (unstable soils), or unlined (stable soils)
G2-1.4 Safe containment	**Assessment:** by observation & household interview
	Safe containment: excreta are safely contained in the pit with no evidence of surface outflows or unsafe emptying
G2-1C Low risk of groundwater contamination	**Assessment:** community-level assessment (using online SFD tool, or other)
	Low risk of groundwater contamination: on-site sanitation has a low risk of faecal contamination of drinking water obtained from groundwater sources

For G2 status, **all individuals in all households should use durable toilets with safe containment**, with individual confirmation (by name) that all members of the household either use the toilet, or are assisted to use the toilet (e.g. disabled or older people, or young children that need assistance). Where children are too young to use the toilet, see indicator **G1-3 for safe disposal of child excreta and safe management of diapers**.

Individual use: a household interview should be used to assess whether all members of the household use the toilet (or have another safe sanitation practice). Each household member should be assessed individually, either through a question to that person (if available, and old enough to respond reliably), or through questions to a household respondent. Where household members cannot use the toilet unassisted (e.g. young children, older or disabled people), the assessment should confirm whether they are assisted to use the toilet, how their excreta are collected and whether they are safely disposed of.

Durable toilet slab: the toilet slab should be made of durable materials. The range of materials that are considered durable will depend on local contexts. The County Public Health Office should approve the use of resilient local materials that will not degrade rapidly under local conditions, and which provide similar lifespans, functionality and cleanliness to toilet slabs made from conventional durable materials (e.g. concrete, structural plastic).

Durable toilet pit:

- *in unstable soils*, the toilet pit should either be lined with durable materials (e.g. from blocks, bricks and mortar, or concrete rings), or lined with resilient local materials that will not degrade rapidly under local conditions, and which provide similar lifespans and support to pit linings made from durable materials.
- *in stable soils*, unlined pits may be assessed as durable, providing the unlined pits are stable and long-lasting.

Safe containment:

- excreta are safely contained in a pit or tank
- no surface outflows or deliberate discharges[9]
- no emptying (or other leaks) of fresh faecal sludge; and
- separation and storage of faecal sludge for at least two years before emptying (e.g. in alternating twin pit latrine systems, or where faecal sludge is used in agriculture)

Firstly, safe containment should be assessed by observation of the pit (or other type of excreta containment system). Where evidence of outflows is observed (e.g. continuous flows from overflow pipes, holes or leaks; or significantly increased vegetation growth around the pit), the toilet should be classed as having unsafe containment.

Secondly, a household respondent should be asked whether the pit (or other type of excreta containment system) has ever been emptied either partially or fully (e.g. emptying of faecal sludge or supernatant liquid), and whether there have been any surface outflows from the pit (or other containment). Where any (occasional, regular or continuous) surface

9 Alternating twin pit latrines must provide storage in a closed pit for at least two years before emptying, with no surface outflows, to be certified as toilets with safe containment.

outflows have been observed from the pit (or other containment system), the toilet should be classed as having unsafe containment.

If faecal sludge is emptied from the pit (or other containment system), the off-site sanitation services have to meet the **G3-1 criteria for the use of safely managed household sanitation** services (e.g. safe emptying, safe handling, safe transport and safe disposal) before G2 status is achieved. Where there is emptying of faecal sludge from some household toilets, and the faecal sludge is not safely disposed of, G2 status is not achieved (because the excreta are neither safely contained on-site, nor safely disposed of off-site).

Low risk of groundwater contamination: assessment of the soil type, groundwater depth, water supply source, and sanitation facility locations suggests that there is a low risk of groundwater contamination from on-site sanitation services. That is, where faecal pathogens are transported into the soil by leaching (e.g. flow of contaminated wastewater into the soil), the assessment suggests that:

a) natural processes in the soil, combined with the time and distance travelled, are sufficient to retain or inactivate any faecal pathogens before they reach the groundwater supply point, or;

b) drinking water is not obtained from (untreated) groundwater sources.

A community-level check should be made on the risk of groundwater contamination in each rural community, using a simple tool such as the Groundwater Pollution Risk Estimation tool on the Shit Flow Diagram (SFD) website: https://sfd.susana.org/risk-groundwater

G2-2 Handwashing with soap at critical times

Indicator criteria	Notes
G2-2.1 Handwashing with soap at critical toilet times	**Assessment:** by household interview
	Handwashing with soap: with water and soap
	Critical toilet times: after toilet use; after anal cleansing
G2-2.2 Handwashing with soap at critical food times	**Assessment:** by household interview (main caregiver)
	Handwashing with soap: with water and soap
	Critical food times: before eating, before preparing food, and before feeding children
G2-2.3 Handwashing with soap at critical infant care times	**Assessment:** by household interview (main caregiver)
	Handwashing with soap: with water and soap
	Critical infant care times: after cleaning an infant of excreta, after handling child faeces, or after washing or disposal of a used diaper
G2-2.4 Handwashing with soap at critical animal times	**Assessment:** by household interview
	Handwashing with soap: with water and soap
	Critical animal times: after contact with animals, animal products or animal wastes (before and after milking)

For G2 status, all members of the household should practice **handwashing with soap at critical times** (in addition to the G1 requirement for the presence of a household handwashing facility with water and soap available). Household interviews should be used to confirm that members of the household usually use water and soap to wash their hands, and to check when members of the household usually wash their hands.

Handwashing with soap: use of water and soap to wash hands.

Critical toilet times: individual members of the household should wash their hands with water and soap after toilet use and after anal cleansing.

Critical food times: members of the household who handle, prepare, cook or serve food should wash their hands with water and soap before food preparation or cooking; caregivers should wash their hands with water and soap before feeding infants or young children, and all members of the household should wash their hands with water and soap before eating.

Critical infant care times: caregivers should wash their hands with water and soap after cleaning an infant of excreta, after handling child faeces, or after washing or disposing of a used diaper.

Critical animal times: members of the household who have contact with animals should wash their hands with water and soap after contact with animals, animal products or animal wastes (e.g. manure or other materials containing fresh animal excreta), and before and after milking (in households that milk animals).

Animal products: includes meat, milk, eggs, blood, other animal tissues (e.g. organs and offal), animal skins, and other animal parts (e.g. feathers, bones etc).

Animal wastes: comprise animal excreta mixed with a wide variety of other materials, including bedding (e.g. straw and other materials), washing water, spilled feed and water, animal parts, blood, skin, feathers, and other contaminated wastes and residues.

G2-3 Safe food hygiene

Indicator criteria	Notes
G2-3.1 Clean and safely stored food	**Assessment:** by observation
	Clean food: washed (no visible dirt or contamination)
	Safely stored food: off ground, in covered storage
G2-3.2 Clean and safely stored kitchen utensils	**Assessment:** by observation
	Clean utensils: washed (no visible dirt or contamination)
	Safely stored utensils: off ground, in covered storage
G2-3.3 Clean and safely stored milk containers (in households that collect milk from livestock)	**Assessment:** by observation
	Clean containers: washed (no visible dirt or contamination)
	Safely stored containers: off ground, covered storage

For G2 status, households should practice safe food hygiene (in addition to handwashing with soap at critical food times) including reduction in the potential faecal contamination of food, kitchen utensils and milk containers by thorough washing and storage off the ground, inside the house, in covered stores.

Clean food: wash raw food (e.g. fruit and vegetables) to remove dirt or other contamination before preparing, cooking or storing

Safely stored food: safe storage of raw food, other produce, and cooked food (leftovers). Food storage should be off the ground, inside the house (or kitchen), and protected from animal contact in covered or raised storage (e.g. cupboards, shelves, boxes, containers).

Clean kitchen utensils: wash used or dirty kitchen utensils (e.g. pots, pans, plates, cutlery, cups, glasses, and any cutting, stirring or serving utensils) before storage or re-use.

Safely stored kitchen utensils: safe storage of clean kitchen utensils. Utensil storage should be off the ground, inside the house (or kitchen), and protected from animal contact in covered or raised storage (e.g. cupboards, shelves, boxes or containers).

Clean milk containers: the containers used to collect and store milk should be thoroughly washed before each milking, so that they are free of dirt or other contamination.

Safely stored milk containers: when empty, the containers used to collect and store milk should be safely stored off the ground, inside the house (or kitchen), and protected from animal contact in covered or raised storage (e.g. cupboards, shelves, boxes or containers).

G2-4 Safe water management

Indicator criteria	Notes
G2-4.1 Safe management of household drinking water	**Assessment:** by observation and household interview
	Household drinking water: water used by the household for drinking and cooking
	Safe management: drinking water is collected in clean containers; adequate quality; safely stored, and safely used
G2-4.2 Safe management of household water sources	**Assessment:** by observation
	Household water sources: water sources within or nearby the household compound
	Safe management: water sources are clean, protected and well-drained
G2-4C Safe management of communal water sources	**Assessment:** by observation
	Communal water sources: water sources located in communal areas, or used by larger groups
	Safe management: water sources are clean, protected and well-drained

For G2 status, all households should practice **safe water management** including the safe management of household drinking water, and safe management of drinking water sources.

Safe management of household drinking water

Four main criteria (assessed by observation and household interview):

1. Drinking water is collected in clean, covered containers (free of visible contamination)
2. Drinking water is of adequate quality:
   - drinking water is already adequate quality at the collection point (e.g. groundwater or treated surface water, such as water treated by use of chlorine dispensers); or
   - drinking water is treated by the household (e.g. settled, filtered, boiled or chemically treated, for example with chlorine solution or tablets)
3. Drinking water is safely stored (in clean, covered containers; separate from the water used for other purposes; and away from animals)
4. Drinking water is safely used (from containers with spigots and taps, or from narrow-mouthed containers, or using a dedicated clean utensil)

Safe management of household and communal water sources

Three main criteria (assessed by observation):

1. Water sources are clean: free from debris, solid waste, human or animal faeces, and any other potential sources of contamination)
2. Water sources are protected:
   - surface water sources (e.g. pans, dams, lakes, rivers) are fenced to prevent animal access
   - water supply source catchments are protected from wastes and pollutants, including human excreta and animal wastes (e.g. by the exclusion of animals and the prohibition of unsafe activities, such as the use of manure or chemical fertilisers, in areas around water supply sources)
   - separate water troughs provided for animal watering
   - groundwater sources (e.g. springs, wells, handpumps, boreholes) are protected from contamination, wastes and pollutants (e.g. by the construction of a spring box, raised parapet wall and cover, wellhead protection and a sealed borehole casing)
3. Water sources are well-drained: no standing water visible at or around the water source (drainage and soakpits may be required in low permeability soils)

G2-5 Safe management of animals and animal wastes

Indicator criteria	Notes
G2-5.1 No animal wastes in or around the house	**Assessment:** by observation
	Animal wastes: include animal faeces, urine, bedding, washing water, spilled feed and water, animal parts, blood, skin, feathers, and other wastes and residues.
	In or around the house: no animal wastes inside the house, or around the house in the household compound (other than in sites where manure is stored).
G2-5.2 Safe management of animal wastes in the household compound	**Assessment:** by observation
	Animal wastes: include animal faeces, urine, bedding, washing water, spilled feed and water, animal parts, blood, skin, feathers, and other wastes and residues.
	Safe management: animal wastes are collected, stored and managed in an appropriate facility, located away from the house.
G2-5.3 Safe separation of animals from under-5 children	**Assessment:** by observation.
	Safe separation: penning and confinement of animals in the household compound away from the house.

For G2 status, households should practice **safe management of animals and animal wastes**, including safe management of animal wastes in the household compound, and safe separation of animals from under-5 children.

Animals: include ruminant livestock (cattle, buffalo, goats and sheep), monogastric livestock (pigs and poultry), domestic animals (dogs and cats) and rodents (rats, mice). The majority of the animal wastes that need to be managed in rural households come from livestock.

Animal wastes: include animal faeces and urine, animal bedding, spilled feed and water, contaminated washing water and other wastewater, and animal parts and products (e.g. blood, skins, feathers, animal parts). These wastes may be combined, or separate, depending on local practices.

Manure: animal faeces mixed with other substances like urine, water or bedding materials, and used in agriculture or aquaculture (after appropriate collection, treatment and storage).

No animal wastes in or around the house: the house and household compound should be free of animal wastes, except in areas where manure is properly stored and managed. Regular collection of animal wastes (e.g. daily collection of animal faeces and other wastes) should be evident from observation of the house and household compound.

Safe management of animal wastes in the household compound: through regular collection, storage and management in an appropriate facility that is located away from the house, and away from child play areas. The animal waste facility should prevent animal and child access to the wastes, and limit the leaking or discharge of solid or liquid animal wastes into the area around the animal waste storage facility.

Safe separation of animals from under-five children: penning and confinement of animals in the household compound, in a location away from the house and from child play areas (i.e. as far away from the house as possible in small compounds).

G2-S Sustainability Indicators

Indicator criteria	Notes
G2-S1 Functional G2 monitoring system	**Assessment:** focus group discussion
	Monitoring system: functional and up-to-date.
G2-S2 Monitoring of at-risk households	**Assessment:** review of monitoring data
	Monitoring of at-risk households: list of at-risk households available, with separate G2 data available
G2-S3 Action plan for G3 status	**Assessment:** review of action plan
	Action plan: available, approved and in use
G2-S4 Re-verification of G1 status	**Assessment:** verification process
	G1 status: all G1 outcome indicators are re-verified

For G2 status, the community should also have achieved the four sustainability indicators.

Monitoring system: the community (or local administration) has established a monitoring system for the G2 safe and sustainable outcomes (toilet, handwashing, food, water and animal waste management), which is functional and provides up-to-date information.

Monitoring of at-risk households: households using shared toilets, new households, and other households at higher risk of unhygienic, unsafe or unsustainable practices, have been identified and their sanitation and hygiene outcomes are monitored and reported separately (i.e. disaggregated from other household data).

Action plan: the community (or local administration) has developed, approved and is using an action plan for the achievement of a G3 Clean & Healthy environment.

Re-verification of G1 status: all households have sustained the G1 ODF outcomes, as confirmed by a G1 verification process.

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3.3 G3 Clean & Healthy status

Figure 5: Outcome indicators for G3 Clean & Healthy environment

G3: CLEAN & HEALTHY	**G3-1** Use of safely managed household sanitation services
	G3-2 Permanent handwashing services
	G3-3 Safe waste management
	G3-4 Good personal hygiene
	G3-5 Good nutrition
	G3-6C Safely managed institutional sanitation services
	Endemic counties: malaria-safe and worm-free homes
G3: Sustainability indicators	**G3-S1** Monitoring system for G3 outcomes
	G3-S2 Disaggregated monitoring of at-risk households
	G3-S3 Re-verification of G1 & G2 outcomes

G2 Safe and Sustainable communities should aim to progress to Grade 3 Clean & Health status wherever possible. By 2030, progressive rural communities in each county should have demonstrated how to achieve the G3 outcomes, including re-verification of the G2 and G1 outcomes to ensure sustainability.

G3-1 Use of safely managed household sanitation services

Indicator criteria	Notes
G3-1.1 Safe management of household faecal sludge	**Assessment:** by household interview & by local authority and service provider interviews (where required)
	Safe management: all on-site or off-site sanitation services related to faecal sludge from household toilets (including emptying, transport, treatment, disposal or use) are safely managed
G3-1C Safe management of faecal sludge in communal areas	**Assessment:** by observation & by household, local authority and service provider interviews
	Safe management: services for the transport, treatment, disposal and use of faecal sludge are safely managed in communal areas (e.g. at communal disposal sites)

For G3 status, **all households should use safely managed sanitation services**. The JMP defines safely managed sanitation services[10] as: *the use of improved sanitation services, with excreta either safely disposed on-site, or transported and treated off-site*. **Where rural latrine pits are covered and replaced when full (without emptying), and safe containment is certified, the sanitation services should be classed as safely managed**.

The G2 criterion for household toilets with safe containment addresses the requirement for safe on-site disposal of excreta, but does not address what happens if faecal sludge is removed from the containment system, or discharged into communal systems. In these cases, where faecal sludge or wastewater leaves the containment system, further checks are required to verify whether emptying and related sanitation services are safely managed, including surveys of households, service providers and local authorities (where appropriate).

Safe management of household faecal sludge

There are five main options for safe management of household faecal sludge:

1. Safe excreta containment with no emptying: faecal sludge remains in the pit, and the full pit is closed and replaced with a new pit
2. Safe on-site management with burial: faecal sludge is emptied into a covered pit in the household compound
3. Safe on-site management with alternating pits: only one pit is in use at any time; when this pit is full, the other pit is connected, and the faecal sludge is stored in the full pit for more than 2 years before being emptied for use on fields or in the garden
4. Safe off-site disposal: faecal sludge is safely emptied and transported to a safe disposal site
5. Safe off-site treatment: faecal sludge is safely emptied and transported to a safe treatment site.

Safely emptied: faecal sludge is emptied from the containment system without spillage or contamination of the local environment. Any spilled faecal sludge is contained and cleaned up, and the faecal sludge is either immediately buried in a nearby pit, or transported off-site. All containers and equipment used to empty the faecal sludge are thoroughly cleaned in a location that avoids contamination of the local environment (including the household compound, areas around water points or water bodies, and other communal areas).

Safely transported: faecal sludge is transported in a vehicle or storage container that does not leak or spill faecal sludge during transportation off-site. Any spilled faecal sludge is contained and cleaned up. All vehicles, containers and equipment used to transport the faecal sludge are thoroughly cleaned in a location that avoids contamination of the local environment (including the household compound, areas around water points or water bodies, and other communal areas).

10 JMP (2017) Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines Geneva: World Health Organization (WHO) and United Nations Children's Fund (UNICEF) Joint Monitoring Programme for Water supply, Sanitation and Hygiene.

Safe disposal site: faecal sludge disposal sites (e.g. disposal pits or trenches) should be located away from settlements and other facilities that might be affected by the burial of faecal sludge, in areas with a low risk of groundwater contamination. Where the disposal sites are in communal areas of the community (or a nearby community), the local administration should supervise, monitor and regulate faecal sludge disposal practices.

Safe treatment site: treatment sites should be appropriate for the treatment of the faecal sludge from local sanitation facilities, and the products and effluents from the treatment processes should meet national standards for waste management.

G3-2 Permanent handwashing services

Indicator criteria	Notes
G3-2.1 Permanent handwashing station	**Assessment:** by observation
	Permanent facility: durable handwashing facility with piped water or water storage, in a fixed and appropriate location
G3-2.2 Hands-free operation of handwashing station	**Assessment:** by observation
	Hands-free operation: water is available with minimal handling or hands-free operation of the handwashing facility
G3-2.3 Drainage of wastewater from handwashing station	**Assessment:** by observation
	Drainage: water is collected and drained from the handwashing facility into a safe disposal point

For G3 status, households should use **permanent handwashing stations** (in addition to the G1 and G2 handwashing criteria) such as:

- **Piped water supply:** tap with continuous water supply, wash basin and drainage
- **Other permanent facility:** Manufactured handwashing station with closed water storage, tap or handsfree water drawing system (e.g. foot pedal), and drainage

Permanent station: the handwashing facility should be made of durable materials, with a piped water connection or adequate water storage, and located in a fixed place that is appropriate for handwashing at critical times (see G2-2).

Hands-free operation: the operation of the handwashing station should be by tap, or other hands-free mechanism that minimises contact with the handwashing facility (e.g. foot pedal).

Drainage: the dirty washing water from handwashing should be collected (e.g. in a basin or other container) and directed to an appropriate disposal point (e.g. soakpit). No standing water should be observed beside or underneath the handwashing station.

G3-3 Safe waste management

Indicator criteria	Notes
G3-3.1 Safe management of liquid wastes and stormwater in the household compound	**Assessment:** by observation
	Liquid wastes: used, polluted or other waste water from homes, kitchens, and gardens
	Stormwater: run-off water or flooding from rain storms
	Safe management: adequate soakpits and drainage, with no visible erosion or liquid wastes in the household compound
G3-3.2 Safe management of solid wastes in the household compound	**Assessment:** by observation
	Solid wastes: litter, food wastes, and all other solid wastes generated by households
	Safe management: clean compound with well-managed solid waste facility
G3-3.3 Good vector control in the household compound	**Assessment:** by observation
	Vector control: no standing water or untreated larval breeding sites are visible in the household compound
G3-3.C1 Safe management of liquid wastes and stormwater in communal areas	**Assessment:** by observation
	Liquid wastes: used, polluted or waste water from households, farms, businesses and communities
	Stormwater: run-off water or flooding from rain storms
	Safe management: no building erosion or visible liquid wastes in communal areas
G3-3.C2 Safe management of solid wastes in communal areas	**Assessment:** by observation
	Solid wastes: litter, food wastes, and all other solid wastes generated by households, farms, businesses and communities
	Safe management: clean communal areas with well-managed solid waste services
G3-3.C3 Good vector control in communal areas	**Assessment:** by observation
	Vector control: no standing water or untreated larval breeding sites are visible in communal areas

For G3 status, household compounds and communal areas should have **safe waste management** including:

- No visible liquid wastes
- No visible erosion of buildings
- Clean areas (free of solid waste)
- No standing water or untreated larval breeding sites

Safe management of liquid wastes and stormwater: no visible erosion of buildings or facilities; no visible liquid wastes in household compounds or communal areas; and use of adequate soakpits and drainage (where required).

Safe management of solid wastes: clean compounds and communal areas (free of solid waste), with well-managed household facilities and communal services for solid waste collection, management and disposal. Solid waste management options include: dedicated household pits (covered), central disposal sites, or other waste collection services.

Good vector control: no standing water or untreated larval breeding sites visible in household compounds or communal areas. Where water bodies are close to households and settlements, treatment and vector control activities should be used to limit mosquito breeding.

G3-4 Good personal hygiene

Indicator criteria	Notes
G3-4.1 Clean face & hands	**Assessment:** by observation of all under-5 children and main caregiver
	Clean face: no visible dirt on face
	Clean hands: no visible dirt on hands
G3-4.2 Good menstrual health	**Assessment:** by observation & interviews with adult female members of the household
	Menstrual health: availability of adequate menstrual hygiene materials, a private washing place, and a safe disposal point

For G3 status, households should have **good personal hygiene** including:

- Clean face and hands
- Good menstrual health

The clean face and hands indicator should be assessed by observation of the faces and hands of all of the under-5 children in the household, and the main caregiver. If one of the under-5 children or the caregiver does not have a clean face and hands, the outcome is not achieved.

Clean face: no visible dirt on the face.

Clean hands: no visible dirt on hands.

Menstrual health should be assessed in households with female members. **Good menstrual health** requires:

- Private and clean place available for washing and menstrual hygiene
- Adequate menstrual hygiene materials and products
- A safe disposal site for used menstrual hygiene materials

G3-5 Good nutrition

Indicator criteria	Notes
G3-5.1 Fully Immunized Children	**Assessment:** by observation of vaccination records
	Children: Under-5 years old
	Fully immunized: all under-5 children have received the relevant vaccinations
G3-5.2 Vitamin A supplements	**Assessment:** by observation of supplement records
	Vitamin A supplements: all under-5 children have received a Vitamin A supplement in the last 6 months.
G3-5.3 Exclusive breastfeeding	**Assessment:** by an interview with the mother
	Exclusive breastfeeding: all infants are exclusively breastfed until 6 months old
G3-5.4 Nutritious diet	**Assessment:** by observation and household interview
	Nutritious diet: all under-2 children receive foods from 5 or more food groups

For G3 status, the children in all households should have good nutrition, including:

- Protection: Fully immunized children (all under-5 children)
- Protection: Vitamin A supplements (all under-5 children have received a supplement in the last 6 months)
- Nutrient intake: Exclusively breastfed (for first 6 months)
- Nutrient intake: Nutritious diet (eating from 5 or more food groups for first two years)

Fully vaccinated: all under-5 children are fully vaccinated under the immunization programme (as per national and county government health requirements). Vaccination records should be checked for each under-5 child.

Vitamin A supplements: all under-5 children should receive Vitamin A supplements every 6 months, with mothers receiving Vitamin A supplements within 6 weeks of delivery to pass the vitamin on to the newborn child through breast milk. Assessment should confirm that all under-5 children in the household have received a Vitamin A supplement in the last 6 months.

Exclusive breastfeeding: all infants are exclusively breastfed until 6 months old. No other food or water should be given to the infant during the first 6-month period, because of the risk that this food or water may be contaminated and cause illness. Assessment is by an interview with the mother to determine whether other foods and water have been given to the baby during its first 6 months.

Nutritious diet: all under-2 children received foods from 5 or more food groups during the previous day. Assessment is by household interview, supported by observation of the foods available in the house to confirm the reported diet of the under-2 children.

Food groups: for minimum dietary diversity (five or more foods from the following eight food groups)[11]:

1. Breast milk
2. Grains, white roots and tubers, and plantains
3. Legumes and nuts
4. Dairy
5. Flesh foods (meat, fish, poultry and liver & organ meats)
6. Eggs
7. Vitamin-A rich fruits and vegetables (e.g. sweet potato, kale, carrot, red pepper, mango, pink grapefruit, watermelon)
8. Other fruits and vegetables

G3-6 Safely managed institutional sanitation services: Community outcome

Indicator criteria	Notes
G3-6.C1 Safely managed and usable institutional toilets	**Assessment:** by observation
	Institutional toilets: in schools, health care facilities, public and private institutions, and in public places
	Safely managed: flyproof, clean and durable toilets with safe containment and safe faecal sludge management
	Usable: facilities are available, functional and provide privacy
G3-6.C2 Permanent institutional handwashing services	**Assessment:** by observation
	Institutional services: in schools, health care facilities, public and private institutions, and in public places
	Permanent handwashing: durable handwashing facility with piped water or water storage, in a fixed and appropriate location, with hands-free operation, adequate drainage, and presence of water and soap.

For G3 status, all schools, health care facilities and institutions should have safely managed and usable toilets and permanent handwashing facilities.

School toilets: all schools (primary, secondary and other) in the community shall provide safely managed and usable toilets for students, with separate toilets for girls and boys, and at least one toilet for every 25 girls enrolled, and one toilet for every 35 boys enrolled. All schools should provide at least one toilet unit for girls and one for boys that are designed for access and use by children with disabilities. Separate disability-friendly toilets should be provided for male and female teachers. All school toilets should be designed to consider the security, privacy and hygiene needs of girls, female teachers and female workers, and enable them to manage their hygiene needs during menstruation.

11 Ministry of Health (2018) *Kenya Nutrition Monitoring and Evaluation Framework 2018 to 2022* Nairobi: Republic of Kenya, Ministry of Health.

Health care facility toilets: all health care facilities (including health posts and dispensaries) in the community shall provide safely managed and usable toilets for health staff, patients, other workers and other visitors. Separate toilets should be provided for males and females, and all toilets should be disability-friendly, with female toilets designed to consider the security, privacy and hygiene needs of women and girls, including during menstruation.

Other institutional toilets: all public and private institutions (hotels, restaurants, guest houses, garages, centres of worship, factories, nursing homes, camps, office premises, prisons and other centres of learning) in the community shall provide an appropriate number of safely managed and usable toilets.

Public toilets: all markets, fairs, recreational areas (playgrounds, beaches, halls), transport centres (train stations, bus stations), fishing camps, mining camps, burial places, warehouses, and fuel stations shall provide an appropriate number of safely managed and usable public toilets.

Safely managed toilets

All institutional toilets shall meet the following criteria:

- Flyproof and clean (see G1-1 outcome for detailed criteria)
- Durable slabs and pits (see G2-1 outcome for detailed criteria)
- Safe containment (see G2-1 outcome for detailed criteria)
- Safe faecal sludge management (see G3-1 outcome for detailed criteria)

Usable toilets: all institutional toilets should be available, functional and private. These toilets should have doors that can be locked from the inside, but should not be locked from the outside (unless the key is readily and immediately available from the institution). Institutional toilets that are locked, with the key unavailable to people who want to use the toilets, do not meet the G3 criteria.

Permanent handwashing services: all schools, health care facilities, institutions and public places should provide permanent handwashing facilities beside the institutional toilets. The handwashing facilities should be durable with piped water or adequate water storage, in a fixed and appropriate location nearby the toilet, with hands-free operation and adequate drainage. All institutional handwashing facilities should have water and soap available.

G3-E Endemic outcomes

Indicator criteria	Notes
G3-E1 Malaria-endemic counties: malaria-safe homes	**Assessment:** by observation
	Malaria-safe homes: use of insecticide-treated bed nets on all beds, or insect screens on all doors, windows and other openings into the house.
G3-E2 Soil-transmitted helminth endemic counties: dewormed homes	**Assessment:** by checking deworming records
	Dewormed homes: all children and all at-risk adults have received deworming treatment in the last 12 months

In Malaria-endemic counties, G3 status also requires that all households have a **malaria-safe home** including:

- Protection: Insecticide-treated bed nets, and closed or screened openings

In Soil-Transmitted Helminth (STH) endemic counties, G3-status also requires that all households have **dewormed homes** in which all children and at-risk adults have received deworming treatment in the last 12 months.

Malaria risk in different zones[12]:

- **Endemic counties:** Lake endemic zone (27% average prevalence in Kisumu, Siaya, Migori, Homa Bay, Kakamega, Busia, Bungoma and Vihiga) and Coast endemic zone (8% prevalence in Kilifi, Kwale, Lamu and Taita-Taveta)
- **Malaria epidemic areas:** western highlands face seasonal transmission, with considerable year to year variation and epidemics when climatic conditions support larval breeding (3% prevalence)
- **Seasonal malaria transmission:** arid and semi-arid areas on northern and south-eastern Kenya, with short periods of intense malaria transmission during the rainy season (less than 1% prevalence)
- **Low-risk malaria areas:** central highlands (including Nairobi), where temperatures are usually too low for the malaria parasite. However, climate change may increase the areas suitable for mosquito breeding, leading to malaria transmission in new areas (less than 1% prevalence)

Malaria-safe homes: in endemic counties, where insecticide-treated bed nets are distributed to rural communities, all members of all households should either sleep under insecticide-treated bed nets, or live in homes with insect screens on all doors, windows and other openings (e.g. gaps around roof eaves of house).

Counties covered by National School-Based Deworming Programme:

- **Lake region STH-endemic counties** (Bungoma, Busia, Homa Bay, Kakamega, Kisii, Kisumu, Migori, Nyamira, Siaya, Vihiga)
- **Coastal STH-endemic counties** (Kilifi, Kwale, Lamu, Mombasa, Taita Taveta, Tana River)
- **Rift Valley counties** (Bomet, Kericho, Nandi, Narok, Trans Nzoia)
- **Central counties** (Kirinyaga)

12 Ministry of Health (2019) *Kenya Malaria Strategy 2019-2023: Towards a malaria-free Kenya* Nairobi: Republic of Kenya, Ministry of Health, National Malaria Control Programme.

The Ministry of Health *National Breaking Transmission Strategy for Neglected Tropical Diseases (STH, SCH, LF and Trachoma)* 2019-2023[13] signalled a major shift in the elimination and control approaches for soil-transmitted helminths (STHs). Previously, schools were the platform for mass drug administration (MDA), whereas in the new strategy a community-based approach will be utilised for MDA through households, schools, training institutions, market places, health facilities and other venues.

Dewormed homes: all children and all at-risk adults have received deworming treatment in the last 12 months.

Children: all pre-school age and school-age children.

At-risk adults: groups with occupations that result in contact with infested media (e.g. soil, water or excreta) including farmers, fishermen, irrigation workers, sanitation workers, women of child-bearing age, and entire communities (all people) in highly endemic areas.

G3-S Sustainability Indicators

Indicator criteria	Notes
G3-S1 Functional G3 monitoring system	**Assessment:** focus group discussion
	Monitoring system: functional and up-to-date.
G3-S2 Monitoring of at-risk households	**Assessment:** review of monitoring data
	Monitoring of at-risk households: list of at-risk households available, with separate G3 data available
G3-S3 Re-verification of G1 & G2 status	**Assessment:** verification process
	G1 status: all G1 outcome indicators are re-verified
	G2 status: all G2 outcome indicators are re-verified

For G3 status, the community should also have achieved the three sustainability indicators.

Monitoring system: the community (or local administration) has established a monitoring system for the G3 Clean and Healthy outcomes (toilet, handwashing, waste management, personal hygiene, nutrition), which is functional and provides up-to-date information.

Monitoring of at-risk households: households using shared toilets, new households, and other households at higher risk of unhygienic, unsafe or unsustainable practices, have been identified and their sanitation and hygiene outcomes are monitored and reported separately (i.e. disaggregated from other household data).

Re-verification of G1 and G2 status: all households have sustained the G1 ODF outcomes and G2 Safe & Sustainable outcomes, as confirmed by G1 and G2 verification processes.

13 Ministry of Health (2019) *National Breaking Transmission Strategy for Soil-transmitted Helminthiasis, Schistosomiasis, Lymphatic Filariasis and Trachoma* Nairobi: Republic of Kenya, Ministry of Health.

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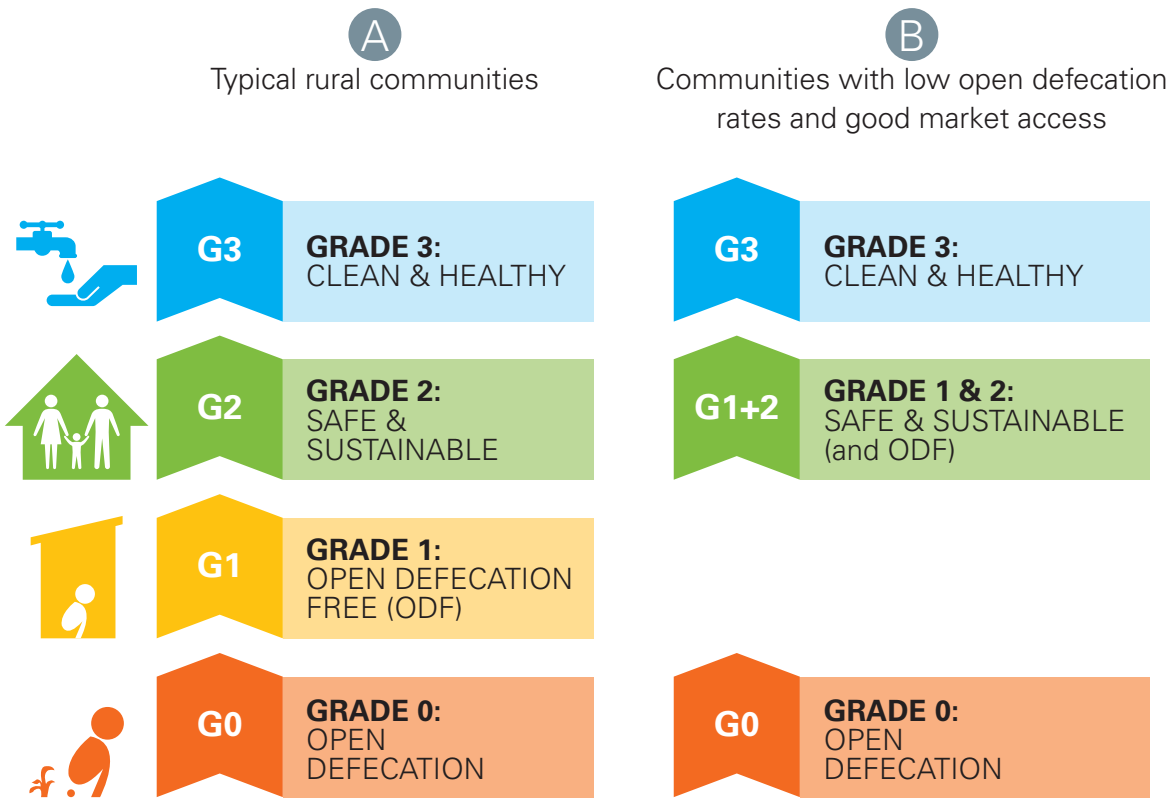
3.4 Routes to G3 Clean & Healthy status

There are several different routes that rural communities, or local administrations, can take to achieve G2 and G3 status.

Figure 6: Different routes to G2 and G3 status



Rural communities should progress through the grades one by one, aiming to achieve either G2 Safe & Sustainable status or G3 Clean & Healthy status by 2030. However, in some rural communities, where open defecation rates are already low and access to sanitation goods and services is good, households may be able to progress directly to G2 status and have both G1 and G2 status verified at the same time.

In all cases, previous grades have to be re-verified before achievement of the next grade: G2 status also requires that the G1 ODF criteria have been checked and re-verified, and G3 status requires that both the G1 and G2 criteria have been checked and re-verified. The re-verification requirement provides a sustainability check on previous achievements and encourages all stakeholders to continue monitoring and supporting the outcomes and services from earlier phases of sanitation and hygiene development.

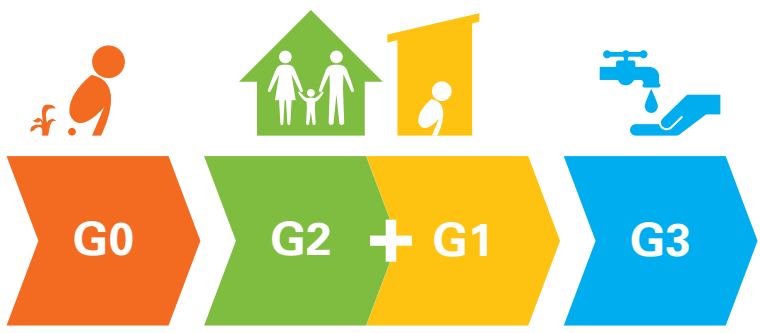
4 Implementation Strategy

The RuSH Protocol defines the sanitation and hygiene outcomes that rural communities should achieve by 2030, with different paths shown towards G2 and G3 outcomes depending on the context and type of rural community.

The three main routes to G3 status are:

Typical rural communities

High capacity communities



Communities that have been certified as ODF under the previous CLTS Protocol will retain their ODF status. However, before being certified as having achieved G2 Safe & Sustainable status under the RuSH Protocol, all communities (including previously ODF communities) will have to meet both the criteria for G1 ODF status (including safe disposal of child excreta and diapers), and the criteria for G2 Safe & Sustainable status.

The RuSH Protocol details the outcomes to be achieved, but does not guide implementers or other stakeholders how to achieve these outcomes. The **Implementation Guidelines for Rural Sanitation and Hygiene**[14] provide guidance on implementation of rural sanitation and hygiene in different contexts, including the development of an appropriate implementation strategy for the achievement of the outcomes required by the appropriate protocol. The implementation guidelines explain the main requirements of the different components of the implementation strategy. However, each implementation strategy will be different, based on the sanitation situation and context, thus each local administration and its partners will find different parts of the implementation guidelines relevant and useful.

Sanitation finance and other forms of support can play important roles in the achievement of higher outcome grades. Local administration support should aim to reward good sanitation behaviour – that is, communities that achieve G1 status should be supported to achieve G2 status and communities that achieve G2 status should be supported to achieve G3 status. Support may also be required to link communities with sanitation markets, suppliers and service providers, and to develop any communal services that are required e.g. for safe transport and disposal of faecal sludge, stormwater drainage, or solid waste management in larger communities.

In this way, other rural communities will observe that local efforts to change sanitation and hygiene behaviours (through the achievement of G1 status) are rewarded with ongoing support for higher-level and more permanent sanitation and hygiene services. These higher level and more sustainable outcomes (G2 and G3) are often attractive to both communities and local administrations, thus any support provided to these G1 communities is likely to generate incentives for other communities to become ODF and accelerate the process of sanitation development.

Different forms of support and incentives may be required in different contexts. In ASAL settings, where access to market goods and services is often limited and transport costs are high, local administrations should consider support to develop and extend appropriate market services, as well as support to make these goods and services more affordable in poor and remote communities. Without appropriate support, some ASAL communities may struggle to build durable toilets and achieve sustainable and safely managed services.

14 The *2023 Implementation Guidelines for Rural Sanitation and Hygiene* is a related Ministry of Health document that should be read in conjunction with the Rural Sanitation & Hygiene Protocol.

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5 Outcome Monitoring and Certification

The **Monitoring Framework for Rural Sanitation and Hygiene**[15] (Monitoring Framework) provides details on the criteria, processes and tools for monitoring progress and for the certification of the outcome grades in the Rural Sanitation & Hygiene Protocol.

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15 The *2023 Monitoring Framework for Rural Sanitation and Hygiene* is a related Ministry of Health document that should be read in conjunction with the Rural Sanitation & Hygiene Protocol.

5.1 Progress monitoring

Progress and grade status will be monitored against service level indicators. A service level ladder will be provided for each outcome criterion to assist the monitor to assess whether the required service level has been achieved (at each different grade: G1, G2 and G3).

The RuSH Protocol will require the following indicators to be monitored:

- G1 ODF: 4 outcome indicators + 3 sustainability indicators
- G2 Safe & Sustainable: 5 outcome indicators + 3 sustainability indicators
- G3 Clean & Healthy: 6 outcome indicators + 3 sustainability indicators

Progress monitoring should include, at a minimum, **an annual update of the monitoring data on sanitation and hygiene for each rural community in the county**. Where no interventions have taken place, the annual monitoring process will provide a baseline for future interventions. Where either G1, G2 or G3 status has already been achieved, the annual monitoring process will provide a sustainability check.

5.2 Grade Certification and Declaration

Four levels of monitoring and evaluation will be required to assess grade achievement:

1. **Grade Claim**
2. **Grade Certification**
3. **Quality Control of Grade Certification**
4. **Grade Declaration in Wards, Sub-Counties and Counties**

Further details on these processes are included in the **Monitoring Framework for Rural Sanitation and Hygiene**.

5.3 Celebration of outcome achievements

The celebration of grade achievements, such as G1 ODF, is an important part of the process. A variety of different celebrations and incentives should be utilised, in recognition of the different budgets and resources available to different local administrations and their development partners.

For villages, celebrations can be conducted once the grade achievement has been certified by the county government. For administrative units (wards, subcounties and counties), celebrations should be conducted once quality control of the grade certification process has taken place, and the formal declaration of the area grade achievement is confirmed.

5.4 Monitoring systems

The Real-Time Monitoring Information System (RTMIS) will be significantly revised and updated to reflect the new grading system and monitoring indicators in the RuSH Protocol. The revised RTMIS will be designed to accept inputs from both a smartphone monitoring application (to be developed) and from manual input of data collected on paper forms into the online database.

6 Roles and Responsibilities

The 2016-2030 Kenya Environmental Sanitation and Hygiene Policy defines the institutional framework for rural sanitation and hygiene, and states the roles and responsibilities of key stakeholders within the devolved and decentralised administration system.

6.1 National Government

The national government has several sanitation related functions and powers, including responsibility for the protection of the environment, sanitation policy, sanitation statistics and data, capacity building and technical assistance to counties.

Related to the RusH Protocol, these roles and responsibilities include:

- Development of national policies, strategies, plans, protocols, monitoring frameworks and guidelines
- Development of training materials to support policies, programmes and approaches
- Support to capacity development in county governments and local administrations
- Development of standard monitoring tools
- Development, management and capacity building for the national Monitoring Information System (MIS) for rural sanitation and hygiene (tracking progress towards targets)
- Advocacy and support for resource mobilisation by county governments
- Technical support and supervision
- Strengthening of national systems and support to strengthen county systems
- Sharing, learning and innovation (including national learning forums and dialogues)
- Quality control (checks on county implementation and results, including grade certification process)
- Coordination of implementation of the RuSH Protocol with other national policies, laws, regulations, guidelines and standards.

6.2 County Government

The county governments have the mandate for sanitation and hygiene services, including sanitation planning and financing, development of implementation strategies, and achievement of 100% ODF and access to improved sanitation by 2030.

Related to the RuSH Protocol, these roles and responsibilities include:

- Development of a county implementation strategy and roadmap
- Identification of at-risk groups that require separate monitoring and reporting

- Resource, budget and capacity mobilisation for implementation, support to service development and the sustainability of services, and monitoring and evaluation
- Training (including refresher training) of implementation and monitoring teams
- Certification of G1, G2 and G3 results
- Quality control of certification process
- Reporting on county progress towards national and county targets for rural sanitation and hygiene
- Technical support and supervision to the Sub-county levels
- Coordination of implementation of the RuSH Protocol with other county policies, laws, regulations, guidelines and standards.
- Coordination with national MoH teams, county health management teams, and among sub-county and community stakeholders in all environmental sanitation and hygiene issues within the county
- Inclusion of sanitation-related activities into the County Integrated Development Plans, annual work plans etc.
- Establishment of county coordination mechanisms for rural sanitation and hygiene
- Data quality audits and checks.

6.3 Sub-county Administration

The sub-county public health officer is responsible for involving the sub-county health management team, deputy county commissioner and sub-county administrator in the promotion of access to environmental sanitation and hygiene services within the sub-county, including the preparation of proposals and plans for environmental sanitation and hygiene projects within the sub-county, and the facilitation of stakeholder participation in planning, budgeting, implementation and monitoring of environmental sanitation and hygiene projects, activities and service delivery within the sub-county.

Related to the RuSH Protocol, these roles and responsibilities include:

- Implementation of sanitation and hygiene interventions designed to progress towards universal sanitation and hygiene access by 2030
- Supervision of implementation and monitoring teams
- Data collection and data entry into the MIS where mobile monitoring is not used
- Data quality checks where mobile monitoring is used
- Planning and supervision of outcome verification processes
- Support to the sustainability of sanitation services and systems managed by communities.

6.4 Ward Administration

The ward public health assistant and the ward administrator are responsible for community mobilisation, facilitation and coordination of participation in the development of ward level sanitation plans and delivery of services, and involvement of the ward representative and assistant county commissioner in the promotion of sustainable access to sanitation and hygiene programmes, services and facilities.

6.5 Location and sub-location

Chiefs in locations, and assistant chiefs in sub-locations, along with the Community Health Assistants (CHAs) have the responsibility of promoting sanitation and hygiene and enforcing environmental sanitation and hygiene regulations in their areas in close collaboration with the sub-county and ward administrators, and public health and community health personnel.

6.6 Community and village

At the community and village level, community health units through Community Health Assistants (CHAs), Community Health Extension Workers (CHEWs), Community Health Volunteers (CHVs) and community health committees should collaborate with village administrators, village councils, location chiefs and assistant chiefs, and other sanitation and hygiene stakeholders including non-governmental organisations (NGOs) and community-based organisations (CBOs), to:

- Establish community environmental sanitation norms in line with national and county sanitation policies and protocols (including food safety and hygiene, water safety, personal hygiene, excreta and solid waste disposal, vector control, wastewater disposal, public sanitation, school WASH, and healthcare waste management)
- Initiate environmental sanitation and hygiene interventions and actively participate in planning, implementation, monitoring, evaluation and support of the projects and services (including food safety and hygiene, water safety, personal hygiene, excreta and solid waste disposal, vector control, wastewater disposal, public sanitation, school WASH, and healthcare waste management)
- Maintain a clean, safe and pleasant physical environment in their settlement
- Prevent soil, water and air pollution
- Develop appropriate environmental sanitation infrastructure such as domestic and public toilets, and waste disposal sites.
- Support the monitoring of sanitation and hygiene outcomes in the community
- Support the certification process for sanitation and hygiene outcomes.

6.7 Households

Through the household head, households are responsible for:

- Promotion and observation of good household sanitation and hygiene practices
- Mobilisation and investment of household resources for environmental sanitation and hygiene
- Developing appropriate sanitation facilities for the disposal of human excreta
- Cleaning of household and compound environments, including disposal of wastes
- Disease vector control within the household and immediate area
- Participation of all household members in community environmental sanitation and hygiene activities.


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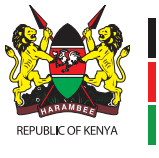

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