MODULAR ANALYTICAL FRAMEWORK FOR QUALITY AND ACCOUNTABILITY

08

**Fall**

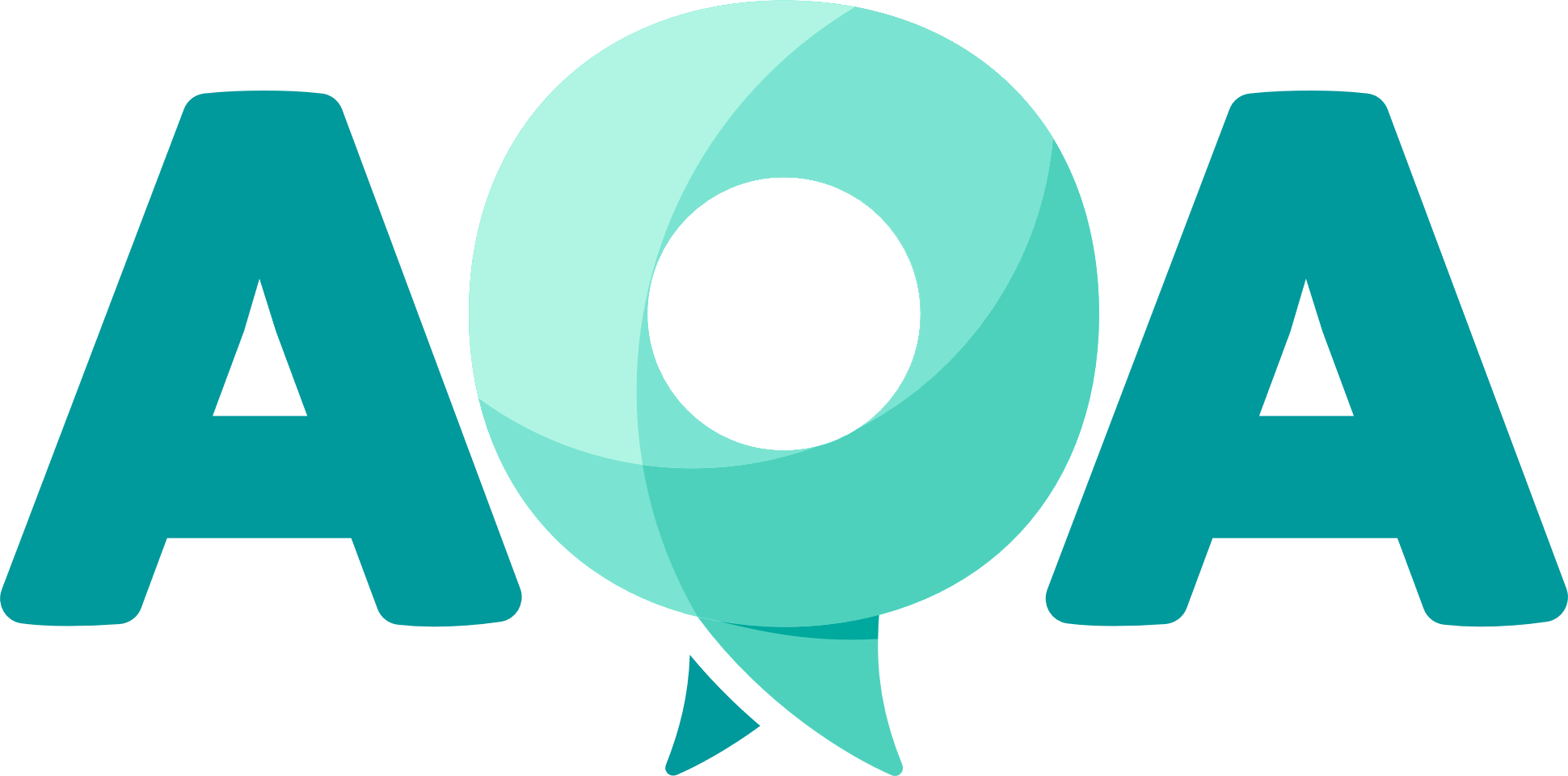
MEASURING WHAT MATTERS

First published: June 2020

Revised: February 2021

Authors: Lise Lacan (Solidarités International) and James Brown (Oxfam)

Editing and design: Ibex Ideas Ltd



**WHO IS THIS FOR?**

The AQA tools are designed to be used routinely and collectively at the national coordination level, with a focus on small, achievable actions.

THE ROLE OF NATIONAL COORDINATION PLATFORMS:

While partners are responsible for delivering their own programmes and should have adequate systems in place for ensuring quality and accountability, national coordination platforms play an important role in enabling a collective approach to humanitarian assistance.

Different stakeholders play specific roles, but effective quality assurance and accountability is the joint responsibility of all partners.

|  |
| --- |
| ACKNOWLEDGEMENTS |
| This document has been developed on behalf of the WASH sector as part of the Accountability and Quality Assurance (AQA) Initiative, led by [Oxfam](https://www.oxfamwash.org/) and [Solidarités International](https://www.solidarites.org/en/) in partnership with the [Global WASH Cluster](https://washcluster.net/). The AQA Initiative is funded by [UNICEF](https://www.unicef.org/) and is supported by the [Global WASH Cluster](https://washcluster.net/)'s [Technical Working Group on Quality Assurance](http://washcluster.net/twigs/quality_assurance) as a priority initiative of the WASH Sector’s Road Map 2020-2025. |

[CONTENTS 2](#_Toc63761487)

[INTRODUCTION 4](#_Toc63761488)

[MODULE STRUCTURE 4](#_Toc63761489)

[PERSPECTIVES ON QUALITY 6](#_Toc63761490)

[GENERAL MONITORING CONSIDERATIONS 6](#_Toc63761491)

[DATA COLLECTION APPROACHES 8](#_Toc63761492)

[MODULE: PUBLIC HEALTH RISK 12](#_Toc63761493)

[WATER QUANTITY 13](#_Toc63761494)

[WATER QUALITY 13](#_Toc63761495)

[EXCRETA DISPOSAL 14](#_Toc63761496)

[HANDWASHING 15](#_Toc63761497)

[MODULE: WASH SERVICE PROVISION 19](#_Toc63761498)

[WATER SUPPLY 19](#_Toc63761499)

[SANITATION 20](#_Toc63761500)

[HYGIENE 21](#_Toc63761501)

[MENSTRUAL HYGIENE 21](#_Toc63761502)

[MODULE: PEOPLE-CENTRED PROGRAMMING 25](#_Toc63761503)

[SATISFACTION 25](#_Toc63761504)

[INCLUSION 26](#_Toc63761505)

[SAFETY 26](#_Toc63761506)

[PARTICIPATION 27](#_Toc63761507)

[FEEDBACK 27](#_Toc63761508)

[MODULE: WASH IN HEALTH CARE FACILITIES 32](#_Toc63761509)

[WATER 33](#_Toc63761510)

[SANITATION 33](#_Toc63761511)

[HYGIENE 34](#_Toc63761512)

[HEALTH CARE WASTE MANAGEMENT 34](#_Toc63761513)

[ENVIRONMENTAL CLEANING 35](#_Toc63761514)

[OTHER COMPONENTS OF QUALITY 36](#_Toc63761515)

[DISINFECTION 40](#_Toc63761516)

[WASTEWATER DISPOSAL 40](#_Toc63761517)

[WASTE MANAGEMENT 40](#_Toc63761518)

[PPE 40](#_Toc63761519)

[IPC IN CTC 40](#_Toc63761520)

ACRONYMS

|  |  |
| --- | --- |
| AAP | Accountability to Affected Populations |
| AQA | Accountability & Quality Assurance |
| IMO | Information Management Officer |
| GWC | Global WASH Cluster |
| HNO | Humanitarian Needs Overview |
| HPC | Humanitarian Programme Cycle |
| HRP | Humanitarian Response Plan |
| KII | Key Informant Interview |
| KQI | Key Quality Indicator |
| MEAL | Monitoring, Evaluation, Accountability & Learning |
| SAG | Strategic Advisory Group |
| SOF | Strategic Operational Framework |
| ToR | Terms of Reference |
| TWG | Technical Working Group |
| WASH | Water, Sanitation and Hygiene |

***Fundo preto com letras brancas

Descrição gerada automaticamente***

**INTRODUCTION**

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

|  |
| --- |
| **FRAMEWORK STATUS AND DEVELOPMENT** |
| Modules for Public Health Risk, WASH Service provision, People-Centred Programming, WASH in Health Care Facilities and Market Based Programming have been developed. Additional modules will be added to the framework throughout 2021. The Modular Analytical Framework will continue to be developed with input from stakeholders and technical specialists at national and global levels. |

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

## MODULE STRUCTURE

The framework proposes metrics that apply broadly to WASH responses, in alignment with global humanitarian standards such as Sphere and the CHS, as well as with the GWC [Needs Assessment Indicators & Question Bank](https://washcluster.atlassian.net/wiki/spaces/CTK/pages/10782065/Core+indicators). The KQIs do not aim to capture every factor that could be considered part of quality programming, but rather to illustrate key trends and changes over time so that quality gaps can be identified and addressed.

Each module focuses on a different WASH intervention and includes the following information:

Standards:

Each module includes references to globally recognised standards which link the indicators back to fundamental humanitarian principles. The standards are universal statements that apply to humanitarian response in any context, whereas indicators and benchmarks may need to be contextualised.

Key Quality Indicators:

KQIs are measurable values that can be used to illustrate whether a standard is being met. KQIs are relative values that must be disaggregated by age, disability and gender and compared over time, between locations and between different affected groups. KQIs are calculated and presented in a regularly updated Quality Snapshot to inform the analysis of quality gaps and trigger corrective action. KQIs should be contextualised by specifically defining key terms.

Benchmarks:

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

Monitoring approaches:

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

Data collection:

Specific questions for KIIs and surveys are provided as well as observation points for field visits. Refer to the GWC [Needs Assessment Indicators & Question Bank](https://washcluster.atlassian.net/wiki/spaces/CTK/pages/10782065/Core+indicators) for guidance on question sets.

|  |
| --- |
| **CONSIDERATIONS FOR SUDDEN ONSET / RAPID ESCALATION** |
| The AQA process should be put in place as soon as possible. In sudden onset or rapid escalation contexts, the wording of KQIs may be adapted to reflect the limited availability and reliability of data. For example, it may not be worthwhile to attempt to estimate % of the affected population disposing of faeces safely every time they defecate when information is being collected through ad-hoc observations and KIIs. In this case a simple scoring system can be used to illustrate the likely severity of gap in a location or population group for each indicator. In a rapidly evolving context, a traffic-light or risk-level system can effectively present the information that is available in an operationally relevant way. |

## PERSPECTIVES ON QUALITY

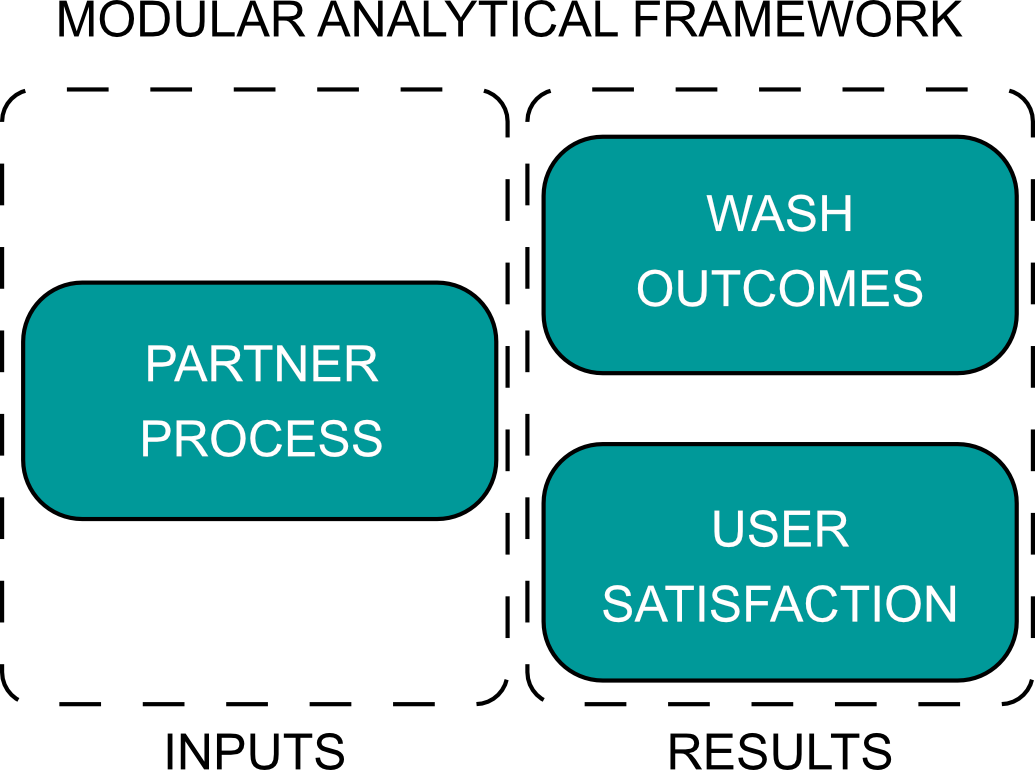


Figure 1: Monitoring perspectives

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

* 1. What processes do WASH partners have in place to ensure that they are able to provide high quality services? Are they collecting the right information about needs, priorities and abilities from different groups of people? Are they routinely engaging with and encouraging participation? Are they providing appropriate mechanisms for people to provide feedback?
  2. How effectively are WASH partners achieving desired outcomes? Are they reducing public health risks, providing equitable and safe access to WASH services for communities? Are they providing equitable and safe access to WASH services in institutions? Are they supporting health, nutrition or livelihoods outcomes?...
  3. How satisfied are WASH service users/non-users about the way their priority needs are being met? Are people happy about the level of involvement they have in the process? Have specific needs been overlooked? Do different groups feel safe using services?

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

## GENERAL MONITORING CONSIDERATIONS

The indicators included in this framework are designed to be measured through routine data collection, either by WASH partners or third parties. Approaches to data collection should be adapted to context and should fit with existing data collection efforts wherever possible. Monitoring should focus on collecting a small but consistent set of measurements regularly at different times across the response to understand how the situation changes over time and place. Collect basic and harmonised data on sex, age and disability to enable results to be disaggregated to show differences between different affected groups. Data collection methods appropriate to each indicator are included in the framework.

|  |
| --- |
| **MANAGING REPORTING BURDEN** |
| Monitoring too many aspects of the response is counter-productive, creating unmanageable quantities of data that are unactionable and diverting resources from service delivery.  Manage partner reporting burden by minimising the quantity and frequency of data requested from partners and focus on collecting information that can be used to trigger action or improve response analysis.  Where there is significant difference in monitoring and reporting capacity between national and international partners, consider how best to utilise the contextual knowledge from national organisations in the analysis of data. Promote the use of harmonised indicators and monitoring approaches across partners where possible to support comparison across the response. |

Process monitoring:

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

Outcome monitoring:

Outcome monitoring should be integrated into existing partner monitoring processes. For each outcome indicator the WASH cluster should collectively agree standard questions sets or observations carried out across the response in a harmonised way. These harmonised question sets should also be used as the basis for third party monitoring. Refer to the GWC [Needs Assessment Indicators & Question Bank](http://washcluster.net/resources/ctk) and [Guidance on Response Monitoring Plans](https://washcluster.atlassian.net/wiki/spaces/CTK/pages/10790459/Monitoring+Plan) for guidance.

Perception monitoring:

Collecting information on how the response is perceived by people affected by crisis involves systematically asking a wide range of people to share their opinions, including the most marginalised. As with any community engagement, the approach taken must be appropriate to the context and this depends on trust and respect between field staff and affected people. Perception surveys may be carried out in person, or through other channels such as phone calls or instant messenger chats. Consider the accessibility of the selected platform to ensure the inclusion of different groups, such as people with disabilities. In addition, adopt your information for specific groups (e.g. easy reading/simple format when communicating with a person with a learning disability). Prioritise collecting the perceptions of individuals rather than groups and make sure to specifically include people of different ages, genders and disabilities in the sample. Global WASH Cluster Partners have committed to “Give priority to girls (particularly adolescents) and women’s participation in the consultation process” as part of the [Five Minimum Commitments for the Safety and Dignity of Affected Populations](https://washcluster.atlassian.net/wiki/spaces/CTK/pages/10782123/Accountability+Protection).

|  |
| --- |
| **DATA DISAGGREGATION** |
| WASH quality monitoring should collect data that is disaggregated by Age, Sex and Disability, especially when investigating the accessibility and acceptability of WASH services. Analysis should also routinely consider differences in the key indicators across sex, age and disability cohorts as a first step in identifying groups who may be excluded and understanding how this exclusion happens.  Use the short set of Washington Group questions (or the Washington Group/UNICEF child functioning question set for children aged 2-17) to classify disability for data disaggregation purposes. To disaggregate age data, use the same age cohorts as in national data systems and major multi-sectoral assessments. |

## DATA COLLECTION APPROACHES

Group and Key Informant Interviews:

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

|  |
| --- |
| **AVOID PUTTING PEOPLE AT RISK** |
| In some contexts, interviewing people may put them at risk. Do not conduct interviews in such circumstances unless the interviewees are fully aware of the risks and accepts them. While the interview may put them at risk, they also have the right to have their voices heard. [[1]](#footnote-1) |

Focus groups:

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

Surveys:

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

|  |
| --- |
| **DIGITAL DATA COLLECTION** |
| Digital data collection techniques can reduce the work required to enter, clean and carry out initial analysis on the data. Qualitative information about perceptions can be collected in digital survey forms using the Likert scale to quantify how positive or negative the respondent feels about a question. Likert scales should have 5-7 possible responses ranging from very negative to very positive, including a neutral value.  Open-ended questions should be avoided in surveys as the coding and analysis of responses can become very demanding. |

Observations:

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

|  |
| --- |
| **DATA COLLECTION FROM HARD TO REACH AREAS** |
| When access constraints limit the use of direct data collection approaches for some or all the affected population, alternative ways to identify and understand quality gaps should be found. Coordinating with other sectors to prevent the duplication of data collection is especially important in hard to reach areas where data collection opportunities and key informants may be limited. The following approaches may be useful to understand the situation in hard to reach areas, but caution must be taken to ensure that the safety of both key informants and interviewers:   * Use of local key informants who can carry out interviews with the affected population. * Local actors such as community organisations, faith-based networks, women's or youth groups are probably the only ones in hard-to-reach areas. It is important to invest in building their capacity for data collection. * Carry out surveys online, by phone, through social media or instant-messaging[[2]](#footnote-2) * Take into account the accessibility of the platform and ensure that information is shared in at least two formats (e.g. visual and audio). * Conduct interviews with people, such as returnees, who have travelled out of hard to reach areas and who have recent knowledge of the situation there. |

Fundo preto com letras brancas

Descrição gerada automaticamente

**MODULE:**

**PUBLIC HEALTH RISK**

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

A screenshot of a cell phone screen with text

Description automatically generated

A screenshot of a cell phone screen with text

Description automatically generatedFigure 2: F-Diagram (From The Sphere Handbook 2018)

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

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

Table 1: Key barriers to faecal-oral transmission

## WATER QUANTITY

Definition

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

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

Measurement

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

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

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

## WATER QUALITY

Definition

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

The minimum water quality standards, testing requirements and where they are applicable (e.g. centralised treatment, untreated water points, household treatment and safe storage etc.) should be documented in the SOF.

Measurement

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

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

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

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

Water sources may be assessed through a combination of water testing and visual inspection (sanitary inspection[[3]](#footnote-3)). In contexts where drinking water is being collected from many dispersed, untreated sources (such as handpumps, wells) and where household water testing is not possible, a risk-based approach based on sanitary inspections of the water points in use may be an effective alternative.

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

## EXCRETA DISPOSAL

Definition

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

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

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

Measurement

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

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

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

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

## HANDWASHING

Definition

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

Handwashing behaviours should be monitored at the point where handwashing is being supported and/or promoted by the response – for example handwashing stands at communal toilets and other public facilities as well as within the household.

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

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

Measurement

Handwashing behaviour can be challenging to measure. Self-reporting may over-estimate compliance, whilst other observational methods can be intrusive and require too many resources. Self-reporting may be validated by enumerators asking to see where respondents wash their hands and observing whether soap and water are present at these locations[[4]](#footnote-4). The presence of soap and water, and the functionality of handwashing stations placed outside toilets may also be measured during facility monitoring.

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

**MONITORING APPROACHES**

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

**INFORMATION ANALYSIS**

**ANALYSIS QUESTIONS:**

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

# Fundo preto com letras brancas Descrição gerada automaticamente

**MODULE:**

**WASH SERVICE PROVISION**

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

|  |
| --- |
| **STRENGTHENING EXISTING WASH SYSTEMS:** |
| Wherever possible, emergency WASH response should use, support or strengthen existing systems for service provision, rather than bypassing them. Existing WASH supply systems may include government agencies, utilities, community service organisations and market systems.    Awareness of the different ways affected populations access WASH goods and services before the crisis, as well as how the crisis has impacted these systems should inform the decision to use, support or strengthen these systems for emergency response, recovery and resilience, as well as provide justification for direct in-kind distributions when necessary. |

In line with the [Global WASH Cluster Needs Assessment Indicators & Question Bank,](https://washcluster.atlassian.net/wiki/spaces/CTK/pages/10782065/Core+indicators) this module is based on the [Joint Monitoring Programme (JMP)](https://washdata.org/) service ladders as a basis of categorising service levels for water supply, sanitation and hygiene. Aligning with this framework enables humanitarian actors to compare results to existing pre-crisis baseline data. If appropriate, additional ‘rungs’ may be added to service ladders to understand context-specific criteria of service whilst maintaining comparability.

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

## WATER SUPPLY

Definition

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

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

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

## SANITATION

Definition

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

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

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

Improved sanitation facilities are those designed to hygienically separate excreta from human contact and include: flush/pour flush to piped sewer system, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.

## HYGIENE

Definition

The content and approach to providing hygiene items should be agreed based on consultation with affected people to assess actual need; an analysis of local WASH systems to identify local availability of hygiene items locally;[[5]](#footnote-5), 2 and an understanding of relevant hygiene behaviours including a willingness to use or perception of value of the hygiene item to the household.

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

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

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

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

## MENSTRUAL HYGIENE

Definition

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

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

**STANDARDS, INDICATORS AND BENCHMARKS**

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

**MONITORING APPROACHES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **COMPONENT** | **WATER SUPPLY** | **SANITATION** | **HYGIENE** | **MENSTRUAL HYGIENE** |
| **RAPID** | Key informant interview  Observations  Rapid assessment for markets (RAM)[[6]](#footnote-6)  Multi Sector Market Assessment (MSMA)[[7]](#footnote-7) | Key informant interview  Observations  Rapid assessment for markets (RAM)3  Multi Sector Market Assessment (MSMA) | Key informant interview  Observations  Rapid assessment for markets (RAM)3  Multi Sector Market Assessment (MSMA) | Key informant interview  Observations  Rapid assessment for markets (RAM)3  Multi Sector Market Assessment (MSMA) |
| **IN-DEPTH** | Water point mapping  Household survey  Supplier survey  Market system map  System service level functionality assessment (e.g., EMMA, PCMA) 3 | Toilet facility mapping  Household survey  Supplier survey  Market system map  System service level functionality assessment (e.g., EMMA, PCMA) 3 | Household survey (self-reporting)  Supplier survey  Market system map  System service level functionality assessment (e.g., EMMA, PCMA) 3 | Household survey (self-reporting)  Supplier survey  Market system map  System service level functionality assessment (e.g., EMMA, PCMA) 3 |
| **TRIANGULATION** | Post action monitoring  Service provider / supplier monitoring | Post action monitoring  Service provider / supplier monitoring | Post action monitoring  Service provider / supplier monitoring | Post action monitoring  Service provider / supplier monitoring |

**INFORMATION ANALYSIS**

**ANALYSIS QUESTIONS:**

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

Fundo preto com letras brancas

Descrição gerada automaticamente

**MODULE:**

**PEOPLE-CENTRED**

**PROGRAMMING**

*Accountability to Affected Populations (AAP) requires that people are central to the assessment planning, implementation, and monitoring of WASH responses. The foundations for AAP are set out in the Humanitarian Charter[[8]](#footnote-8) and the Core Humanitarian Standard (CHS) and these principles underpin all humanitarian action.*

*This module supports collective monitoring of inclusion, safety, participation and feedback, by assessing whether partners are fulfilling their commitments to AAP in the way they work. The module also provides a framework for integrating the views of the affected population into quality monitoring. The opinions and perspectives of people affected by crisis hold crucial information about how quality and accountability are experienced by the people we aim to support[[9]](#footnote-9). Understanding the response through the different perspectives of those affected by crisis is a critical step towards achieving quality and accountability in any context.*

|  |
| --- |
| **WASH 5 MINIMUM COMMITMENTS** |
| The Global WASH cluster partners have agreed on 5 minimum commitments to be upheld in all humanitarian WASH programmes to ensure that the distinct assistance and protection needs of the affected population are met. The respect of these minimum commitments all along the humanitarian programme cycle reinforces the accountability of the WASH partners to the affected population. These commitments are as follows:  • Consult separately girls, boys, women, and men, including older people and those with disabilities, to ensure that WASH programs are designed to provide equitable access and reduce incidences of violence.  • Ensure that girls, boys, women, and men, including older people and those with disabilities have access to appropriate and safe WASH services.  • Ensure that girls, boys, women, and men, including older people and those with disabilities, have access to feedback & complaint mechanisms so that corrective actions can address their specific protection and assistance needs.  • Monitor and evaluate safe and equitable access and use of WASH services in WASH projects.  • Give priority to girls (particularly adolescents) and women’s participation in the consultation process |

## SATISFACTION

Monitoring the general level of satisfaction amongst different groups provides a high-level overview of the quality of response. Satisfaction is highly subjective and sensitive to the respondent’s personal situation and expectations. Because of this, it is not appropriate to set an absolute target for satisfaction levels and difficult to make comparisons between different contexts. Instead, focus on how satisfaction responds to changes in WASH services over time and how satisfaction differs between different groups. Changes in levels of satisfaction may be a good indicator of emerging quality issues that require further engagement, analysis and action. To support initial analysis, it may be useful to collect both quantitative data on satisfaction scores with qualitative information on key issues or priorities.

## INCLUSION

Expectations regarding how WASH partners address inclusion of WASH services and ensure equitable access to all should be collectively agreed and documented in the SOF. Inclusion should be addressed throughout the project cycle, with specific consideration for inclusive and participatory assessment, implementation and monitoring activities[[10]](#footnote-10).

Asking the affected population whether they feel that WASH services are accessible for all in need may provide useful insight into accessibility barriers that are less obvious from the outside, such as financial, bureaucratic, social or information barriers. Focus groups can be held with groups of individuals who may have reduced access to services as a second step in understanding barriers and possible ways to overcome them. It is important to work with organisations that represent marginalised groups, such as organisations of people with disabilities, to ensure that the right questions are asked and that information is provided in an accessible format.

## SAFETY

Feeling unsafe can be an important barrier that prevents people from accessing WASH services. Discussing specific safety threats or incidents requires careful consideration to avoid putting people at increased risk or doing harm. It is the responsibility of all humanitarian actors to work within a protection framework and understand the safety and security risks that women, girls, men and boys face. Therefore, it is extremely important that assessment and monitoring of general safety issues be an ongoing feature of assistance. This includes exploring—through a variety of entry points and participatory processes—when, why and how GBV-related safety issues might arise, particularly as the result of delivery or use of humanitarian services[[11]](#footnote-11).The WASH cluster should work with protection and GBV specialists to identify appropriate mechanisms for collecting information about feelings of safety, and to ensure that field staff are ready to make referrals to protection and GBV teams if necessary. Information on protection risks and safety perceptions may also be available from protection and GBV colleagues so inter-cluster coordination is key.

Expectations regarding how WASH partners address the safety of affected people should be collectively agreed and documented in the SOF. Women and adolescent girls are often at particular risk of harm. Safe WASH programming begins by partners identifying risks faced by people of different ages, genders, abilities and backgrounds and understanding who is most vulnerable to these risks. Specific actions to address the safety of WASH services should be taken and safety should be appropriately monitored in collaboration with protection and GBV colleagues.

## PARTICIPATION

Questions about participation should seek to understand how well people understand their rights, what they are entitled to as well as how well informed they feel about the WASH response and how much influence they have over the way assistance is provided. Consult separately girls, boys, women, and men, including older people and those with disabilities, to ensure that WASH programs are designed so as to provide equitable access and reduce incidences of violence. Specific focus group discussions are organized for women and girls during the needs assessment phase and across the response[[12]](#footnote-12).

Participation in design of assessments, programmes, evaluations etc, means that a selected segment(s) of the affected population have a direct influence on decision making. Measures should be taken to ensure the participation of members of all groups of affected people – young and old, men and women. Special efforts should be made to include people who are not well represented, are marginalised (e.g. by ethnicity or religion) or otherwise ‘invisible’ (e.g. housebound or in an institution).[[13]](#footnote-13)

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

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

## FEEDBACK

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

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

**STANDARDS, INDICATORS AND BENCHMARKS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MODULE** | **PEOPLE-CENTRED PROGRAMMING**  Ensure the response upholds commitments to humanitarian principles and enhances the safety, dignity and rights of those affected by crisis | | | | | |
| **COMPONENT** | **SATISFACTION** | **INCLUSION** | **SAFETY** | **PARTICIPATION** | **FEEDBACK** |
| **STANDARDS** | **CORE HUMANITARIAN STANDARD**  **Commitment 2:**  Communities and people affected by crisis have access to the humanitarian assistance they need at the right time. | **CORE HUMANITARIAN STANDARD**  **Commitment 1:**  Communities and people affected by crisis receive assistance appropriate and relevant to their needs. | **CORE HUMANITARIAN STANDARD**  **Commitment 3:**  Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action. | **CORE HUMANITARIAN STANDARD**  **Commitment 4:**  Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them. | **CORE HUMANITARIAN STANDARD**  **Commitment 5:**  Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints. |
| **KEY QUALITY INDICATOR** | **PERCEPTION**  % of affected population who are satisfied that WASH services meet their priority needs in an appropriate and timely way | **PERCEPTION**  % of affected population who feel that WASH services are accessible to all those in need  **PROCESS**  % of partners who design, implement and monitor WASH services to be accessible for people of all genders, ages, abilities and backgrounds | **PERCEPTION**  % of affected population who report feeling safe using WASH services at night and during the day, by service  **PROCESS**  % of partners who design, implement and monitor WASH services based on an analysis of the specific safety risks faced by people of all ages, genders, abilities and backgrounds | **PERCEPTION**  % of affected population who feel that they are able to influence the way that assistance is designed, implemented and monitored  **PROCESS**  % of partners who design, implement and monitor WASH services based on the participation of people of all ages, genders, abilities and backgrounds | **PERCEPTION**  % of affected population who feel that they have a safe, accessible and responsive channel for providing feedback to WASH partners  **PROCESS**  % of partners who ensure that people of all ages, genders, abilities and backgrounds can safely provide feedback & complaints that trigger corrective actions |
| **BENCHMARK GUIDANCE** | **PERCEPTIONS**  Perceptions are subjective measures. Ask respondents to score how they feel about satisfaction, inclusion, safety, participation and feedback on a 5 point Likert scale[[14]](#footnote-14) and compare answers over time and between gender, age and disability groups to identify disparities and trends that should be investigated further.  **PROCESS**  Minimum process requirements for assessment, design, implementation and monitoring should be agreed by the WASH Custer to ensure that the 5 Minimum Commitments are upheld | | | | | |

**MONITORING APPROACHES**

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

**INFORMATION ANALYSIS**

**ANALYSIS QUESTIONS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SATISFACTION** |  | **INCLUSION** |  | **FEEDBACK** |
| * Is the WASH response addressing the issues that matter most to them? * What are people’s top priorities? How are they coping on their own or as a community and where do they need external support? * How does age, gender and disability affect people’s priorities and whether they feel these are being addressed? * Do people feel that timing of assistance is adequate to address priority needs in an adequate timeline? * How does the perception of the response change in under-served or hard-to-reach areas? * Do people feel that the assistance provided has been targeted to those who are most in need? * Do people feel that the WASH services are being delivered in an appropriate way that takes into account their culture, preferences and priorities? * What are the potential obstacles and opportunities regarding the possibility for communities and people to express their degree of satisfaction? |  | * How have the needs, capacities and vulnerabilities of different groups been identified and categorised? * How is assessment and monitoring data being disaggregated? * Have women and girls been specifically included in discussions about WASH assistance? * Have older people and people with disabilities been identified and specifically included in discussions about WASH assistance? * Are there groups of people whose needs are ‘invisible’ because they have not been actively identified? * How do temporary changes (injury, sickness, pregnancy) affect a person’s access to assistance? * How have WASH facilities and services been designed to enable the most inclusive access? * Who may need specific, targeted assistance in order to enjoy the same level of access to WASH services? * How do social or institutional attitudes, beliefs or practices affect equitable inclusion? Are people excluded on the basis of ethnicity, health, social-economic status, religion, place of origin or other factors? |  | * Was the complaints and feedback mechanism developed with the participation of different affected groups to understand preferred methods of communication? * Are all groups within the affected community aware of how to give feedback or raise complaints about the response? * Do affected people feel safe using the feedback channels? * How quickly and reliably are concerns addressed? * Who faces particular challenges to provide feedback? What are the key barriers for providing feedback? * Are older people and people with disabilities able to provide feedback about the WASH response? What considerations need to be made to ensure information and communication channels are accessible? * Do affected people trust that humanitarian agencies will respond to complaints and feedback? * What are the preferred channels for providing feedback and complaints? * Are particular considerations required for sensitive complaints (e.g. reporting misconduct, aid diversion or PSEA)? |
|  |  |  |  |  |
| **PARTICIPATION** |  | **SAFETY** |  |  |
| * Do people feel they were able to participate in the assessment, design, monitoring and of WASH services? * Do people feel they were able to influence decisions about the response that affect them? * Who face particular challenges participating in decisions or having their voices heard? What are the challenges and barriers to participation? * Do people feel informed about the process of assessment, design, implementation and monitoring? * Do people feel informed about the aid providers, services and feedback channels? * Do all groups feel that they are listened to and that they are able to influence the way WASH services are delivered? |  | * What proportion of the affected population are at risk from violence, exploitation, harassment or abuse, connected to their use of WASH services? * Who faces particular risks? What are the factors that increase or reduce risks? * Who has power? How is this power used? What are the potential negative effects? * What proportion of the affected population avoid using available WASH services, or change their behaviours in different ways due to the fear of harm? * What strategies do different people use to cope with the risks of harm? |  |  |

Fundo preto com letras brancas

Descrição gerada automaticamente

**MODULE:**

**WASH IN HEALTH CARE FACILITIES**

This module provides basic key quality indicators to support national WASH clusters to monitor standards of WASH and related Infection Prevention and Control (IPC) services in health care facilities (HCFs). Appropriate WASH and IPC in health care settings can contribute to the prevention of healthcare-associated infections and reduce infection risk to surrounding communities. Adequate WASH services also contribute to the safety and welfare of staff, patients, and visitors. Effective IPC may reduce hospital-acquired infections by at least 30% (WHO, 2016).

The module may be applied in general humanitarian WASH response or adapted to specific outbreak settings with additional criteria relevant to the context.

|  |
| --- |
| **COORDINATION WITH HEALTH ACTORS** |
| The indicators proposed here must be adapted to align with national standards and additional protocols to respond to specific disease outbreaks. Coordination with Government Health Authorities and the National Health Cluster is essential for ensuring standards, roles, and responsibilities of WASH and health actors are clear. |

This module is adapted from the Joint Monitoring Programme (JMP) service ladders for water, sanitation, hand hygiene, health care waste management, and environmental cleaning services in health care facilities. It applies to existing primary health care facilities as well as temporary health care or isolation facilities set up in response to a health outbreak. The requirements for WASH services in health care facilities may need to be adapted depending on the type of facility and specific health risks present.

WASH is a critical part of the implementation of Standard Precautions (those that apply to all healthcare settings) and Transmission Based Precautions (those that apply under specific circumstances). Where specific standards for WASH in health care facilities have been developed and agreed upon nationally, these standards should be included in the ‘contextual’ service level. Examples of how additional criteria can be applied in Cholera, Ebola, and COVID-19 outbreaks, see the resources listed in the annex.

|  |
| --- |
| **CONTEXTUALISATION** |
| The indicators in this module are designed to be broadly applicable measurable across a range of different contexts. This means that additional criteria are required to monitor compliance with national standards in some contexts. National WASH Clusters are encouraged to incorporate more detailed and context-specific indicators where these have been agreed.  Examples of additional considerations that may be incorporated include:  • Water quality, treatment, and quality monitoring protocols for different water uses (consumption, cleaning, disinfection for medical use).  • Availability of water, minimum storage capacity, and contingency supplies.  • Sanitary facilities (latrines, showers, laundry), drainage and wastewater management systems.  • Waste management (collection, segregation, transport, and safe disposal).  • Vector control, (availability and use of Long-Lasting Insecticide-treated Nets, protocols for indoor residual spraying. |

Providing high-quality WASH services in health care facilities is a critical foundation for universal health coverage and quality of care, infection prevention and control, patient safety, and child and maternal health. Additionally, adequate WASH services can contribute to feelings of dignity and respect, staff morale, performance, and safety.

## WATER

**Definition**

Health care facilities (HCF) must have a primary water source that is an improved source, located on-premises from which safe water is available as required. The water quantity required for HCFs will depend on factors such as the facility's size, the number and type of procedures being carried out, the number of patients, and the particular IPC protocols in place. Standards for WASH in HCF must align with those of the Ministry of Health, or the WHO as required by the context and based on consultations with health care providers.

This indicator uses the JMP definitions to categorize water services levels based on the likely water quality, water quantity, and water availability (see table below). A further, contextual, service level has been added to include specific criteria related to the crisis, country, or response context. For example, additional criteria required for outbreak settings can be added as agreed with health actors and in line with MoH or WHO standards.

**Service levels:**

|  |  |
| --- | --- |
| CONTEXTUAL | Specific additional criteria related to the crisis, country, or response context. |
| BASIC | Water is available from an improved source on the premises. |
| LIMITED | An improved water source is available within 500 metres of the premises, but not all basic service requirements are met. |
| NO FACILITY | Water is taken from unprotected dug wells, springs, or surface water sources; an improved source is available more than 500 metres from the facility, the facility has no water source. |

## SANITATION

**Definition**

This indicator is based on JMP definitions that categorize sanitation services levels based on whether toilets are available and accessible to all users, and whether excreta is effectively contained to prevent contamination.

HCFs must have improved and usable[[15]](#footnote-15) sanitation facilities, with at least: one toilet dedicated for staff, one gender-segregated toilet with menstrual hygiene facilities, and one toilet accessible for users with limited mobility[[16]](#footnote-16). Facilities that meet this requirement are categorised as having “basic service”. In contexts where more advanced criteria have been set, these may be included in the ‘contextual’ service level. Additional requirements for sanitation facilities may include stipulations around treatment of effluent, cleaning and maintenance, lighting or patient to toilet ratios for example.

**Service levels**

|  |  |
| --- | --- |
| **CONTEXTUAL** | Specific additional criteria related to the crisis, country, or response context. |
| **BASIC** | Improved sanitation facilities are usable with at least: one toilet dedicated for staff, one sex-separated toilet with menstrual hygiene facilities, and one toilet accessible for people with limited mobility. |
| **LIMITED** | At least one improved sanitation facility, but not all requirements for basic service are met. |
| **NO FACILITY** | Toilet facilities are unimproved (pit latrines without a slab or platform, hanging latrines and bucket latrines), or there are no toilets or latrines at the facility. |

## HYGIENE

**Definition**

Functional hand hygiene facilities should be available at the point of care, within 5 metres of toilets, in entrances and waiting areas. Handwashing facilities include both fixed (e.g., sink with tap) and mobile (e.g., basin, jug, or bucket). Soap can include a bar, powder, or liquid soaps/detergents and soapy water. This indicator uses the JMP definitions to categorise levels of hygiene service.

Two main essential criteria define " Basic” hand hygiene in HCFs either alcohol hand-rub or a basin with running water and soap are available at points of care, and handwashing facilities with running water and soap are available in toilets. Points of care are defined here as any location in the outpatient setting where care or treatment is delivered (i.e., consultation/exam rooms).

HCFs with hand hygiene materials at either point of care or toilets, but not both, are considered to have “limited service, while HCF with no hand hygiene stations or with no cleansing materials are classified as having “no service.”

|  |  |
| --- | --- |
| **ACTION** | **OTHER IMPORTANT TIMES** |
| Before touching a patient | Upon entering and exiting patient areas  After using a latrine (or handling a child’s faeces)  After handling dead bodies  Before food preparation and handling |
| Before performing clean or aseptic procedures |
| After body fluid exposure or risk (e.g. after handling any potentially contaminated equipment or material such as laundry, waste, dishes, vomit and stool buckets, etc.) |
| After touching a patient |
| After touching patient’s surroundings |

Hygiene promotion sessions should be used to promote effective hand hygiene among personnel, patients, and caregivers. Hand hygiene sessions can further inform the locations of handwashing facilities. Handwashing stations should be available for personnel, patients, and caregivers. Waterless antiseptic or alcohol gel should also be available in consultation areas.

**Service levels:**

|  |  |
| --- | --- |
| CONTEXTUAL | Specific additional criteria related to the crisis, country, or response context |
| BASIC | Functional hand hygiene facilities (with running water and soap and/or alcohol-based hand rub) are available at points of care and within 5 metres of toilets. |
| LIMITED | Functional hand hygiene facilities are available at either point of care or toilets, but not both. |
| NO FACILITY | No functional hand hygiene facilities are available at either point of care or toilets. |

## HEALTH CARE WASTE MANAGEMENT

**Definition**

Health care waste management must deal with different categories of waste requiring specific treatment and disposal to limit the risks of injury or infection. Waste streams from health care facilities may include sharps, infectious or contaminated materials, hazardous chemicals or pharmaceuticals and organic waste, all of which must be separated and made safe prior to disposal[[17]](#footnote-17). General, non-health care waste from staff, patients and visitors must also be managed effectively. All staff with waste management responsibilities must receive training on cleaning and disinfecting procedures as well as on waste management and be provided with Personal Protective Equipment (PPE) appropriate to the specific tasks they carry out.

This indicator uses the JMP definitions to categorise levels of service for health care waste management.

HCFs, where waste is safely segregated into at least three receptacles (sharp, infectious, and non-infectious) in all consultation and treat and dispose of sharp and infectious waste, are classified as having “basic service.” Facilities that do not effectively segregate waste or waste but do not treat and dispose of it safely are considered to have “limited service.” If waste is not segregated or safely treated and disposed of, the facility is classified as having “no service.”

**Service levels**

|  |  |
| --- | --- |
| CONTEXTUAL | Specific additional criteria related to the crisis, country, or response context |
| BASIC | Waste is safely segregated into at least three bins, and sharp and infectious waste is treated and disposed of safely. |
| LIMITED | There is limited separation and/or treatment and disposal of sharp and infectious waste, but not basic service requirements are met. |
| NO FACILITY | There are no separate bins for sharps or infectious waste, and sharp and/or infectious waste are not treated/disposed of safely. |

## ENVIRONMENTAL CLEANING

**Definition**

Health care facilities must have protocols for cleaning staff with cleaning responsibilities and must receive training on cleaning procedures and must be provided with adequate and appropriate Personal Protective Equipment (PPE) tailored to the level of risk associated and specific tasks. This indicator uses the JMP definitions to categorise levels of environmental cleaning service. HCFs with basic protocols for cleaning and providing all staff with cleaning responsibilities, appropriate training are classified as providing a “basic service.” Facilities with cleaning protocols where only part of the staff with cleaning responsibilities is provided with appropriate training have “limited service.” If there are no cleaning protocols available, and no staff member received training, the facility is considered “no service.”

**Service levels**

|  |  |  |
| --- | --- | --- |
| CONTEXTUAL | Specific additional criteria related to the crisis, country, or response context |  |
| BASIC | Basic cleaning protocols are available, and all staff with cleaning responsibilities have received training. |  |
| LIMITED | There are cleaning protocols, and at least some members of the staff have received training on cleaning. |  |
| NO FACILITY | No cleaning protocols are available, and the staff hasn’t received training on cleaning. |  |

## 

## OTHER COMPONENTS OF QUALITY

Depending on the crisis context, and the agreed roles of WASH actors in providing support to health care facilities, other considerations for quality may be relevant for quality monitoring purposes. Examples are provided below, specific indicators for monitoring should be determined based on context and in coordination with health partners.

For further guidance on in-depth assessments of WASH in Health Care Facilities, refer to the WHO the Water and Sanitation for Health Facility Improvement Tool (WASH FIT).

**Infection Prevention and Control**

Infection prevention and control (IPC) includes a combination of approaches designed to prevent infection to patients, caregivers and health workers in health care settings. WASH services are an essential component of IPC and must be designed to enable health care facility users to comply with IPC protocols. This might include the design and location of hand hygiene stations, provision of high strength chlorine solution for disinfection or the availability of appropriate personal protective equipment.

**Disinfection**

Disinfection is essential to maintain a hygienic and safe environment within a health structure, particularly during outbreaks of infectious diseases such as cholera, Ebola, and COVID. Guidance from healthcare or IPC specialists should be sought to ensure that standard disinfection protocols can be ensured.

**Personal Protective Equipment PPE**

Personal protective equipment (PPE) is mandatory for compliance with IPC protocols and ensures that patients, families, and staff are not put at further risk. Guidance from healthcare or IPC specialists should be sought to ensure that standard protocols can be ensured.

**Vector control**

The control of insects and rodents in health care facilities is important because of the presence of potentially infectious materials and the susceptibility of patients. Basic vector control measures include the protection of water systems and surface water management to prevent stagnant water, environmental cleaning and solid waste management and the use of insecticide treated nets.

**Wastewater management**

Wastewater in the vicinity of the health care facility presents risks linked to transmission of water-borne pathogens, presence of mosquito breeding areas or the environmental contamination of infectious or chemical agents. Specific wastewater management approaches must be used in health care settings to address high-risk contaminants such as chemical, pharmaceutical or infectious agents. Refer to the guidance in the annex for wastewater removal, pre-treatment and disposal requirements for routine and outbreak contexts.

**Dead body management**

While the management of dead bodies must be carried out by trained and authorized personnel, the routine, or outbreak-specific procedures in place must be supported by adequate water, sanitation and hygiene provision.

**STANDARDS, INDICATORS AND BENCHMARKS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MODULE** | **WASH IN HEALTH CARE FACILITIES**  **Ensure that health care facilities are equipped with adequate WASH and IPC services that are sufficient to protect the health, safety, and dignity of staff, patients, and visitors, including disease outbreaks.** | | | | | |
| **COMPONENT** | **WATER** | **SANITATION** | **HYGIENE** | **HEATH CARE WASTE MANAGEMENT** | **ENVIRONMENTAL CLEANING** |
| **STANDARD** | **SPHERE 2018**  **WASH in Healthcare Settings Standard 6:**  All healthcare settings maintain minimum WASH infection prevention and control standards, including disease outbreaks. | | | | | |
| **KEY QUALITY INDICATOR** | % of health care facilities where the primary source of water is an improvedsource, located on-premises, from which water is available at all times**.** | % of health care facilities equipped with improvedand usablesanitation facilities, with at least one toilet dedicated for staff, at least one sex-separated toiletwith menstrual hygiene facilities, and at least one toilet accessible for users with limited mobility. | % of health care facilities with functional hand hygiene facilitiesavailable at one or more points of careand within 5 metres of toilets | % of health care facilities where waste is safely segregatedin consultation areas and sharps and infectious wastes are treated and disposed of safely | % of healthcare facilities with cleaning and staff protocols with cleaning responsibilities have all received training on cleaning procedures and the use and disposal of appropriate personal protective equipment. |
| **BENCHMARK**  **GUIDANCE** | Level of service: See JMP service level ladder. Additional service levels may be added to monitor, e.g., water source type, design, borehole depth, or other contextually relevant criteria. | Level of service: See JMP service level ladder. Additional service levels may be added to monitor, e.g., sex segregation, privacy, or other contextually relevant criteria. | Level of service: See JMP service level ladder. Additional service levels may be added to monitor, e.g., access to basic hygiene items | Level of service: See JMP service level ladder. Additional service levels may be added to monitor, e.g., treatment and disposal of wastes or protective equipment used by the HCF staff during transportation, treatment, and disposal | Level of service: See JMP service level ladder. Additional service levels may be added to monitor, e.g., access to cleaning materials, personal protective equipment. |

**MONITORING APPROACHES**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WATER** | **SANITATION** | **HYGIENE** | **HEALTH CARE WASTE MANAGEMENT** | **ENVIRONMENTAL CLEANING** |
| **RAPID** | Key informant interview  Observations  Water quality testing at the water point  IPC Scorecard | Key informant interview  Observations  IPC Scorecard | Key informant interview  Observations  IPC Scorecard | Key informant interview  Observations  IPC Scorecard | Key informant interview  Observations  IPC Scorecard |
| **IN-DEPTH**  (compliance with national protocols and norms regarding HCF operation) | Waterpoint mapping  Bulk water treatment process records  Water pumping / Delivery records  Sanitary survey of water points  WASH FIT (<https://washfit.org/#/>) | Toilet facility mapping  WASH FIT (<https://washfit.org/#/>) | Observation of place to wash hands in the HCF with water and soap available  WASH FIT (<https://washfit.org/#/>) | Waste management area mapping  WASH FIT (<https://washfit.org/#/>) | WASH FIT (<https://washfit.org/#/>) |
| **TRIANGULATION** | Qualitative information from group discussions or participatory approaches | Qualitative information from group discussions or participatory approaches | Qualitative information from group discussions or participatory approaches | Qualitative information from group discussions or participatory approaches | Qualitative information from group discussions or participatory approaches |

**INFORMATION ANALYSIS**

**ANALYSIS QUESTIONS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **WATER** |  | **SANITATION** |  | **HYGIENE** |
| * What is the main water supply for the facility? * Where is the main water supply for the facility located? * Is water available from the main water supply at the time of the survey? * How much water is being used daily? * Is there a storage capacity to cover at least the needs for 48h? * Are there drinking water dispenser/ points available in all consultation rooms? * Is the water facility correctly managed? |  | * What type of toilets/latrines are at the facility for patients? * Is at least one toilet usable (available, functional, private)? * Are there toilets that: * Are dedicated to staff? * Are in sex-separated or gender-neutral rooms? * Have menstrual hygiene facilities? * Are they accessible for people with limited mobility? * Providing privacy? * Are the sanitation facilities correctly managed? |  | * Is there a functional hand hygiene facility (either alcohol hand-rub or a basin with water and soap are available at points of care) at points of care on the day of the survey? * Is there a functional handwashing facility at one or more toilets on the day of the survey? * What barriers and enablers are the most important determinants of acceptable hygiene practices? * Are the hygiene facilities correctly managed? |
|  |  |  |  |  |
| **HEALTH CARE WASTE MANAGEMENT** |  | **ENVIRONMENTAL CLEANING** |  |  |
| * Is waste correctly segregated into at least three labelled bins in the consultation area? * How does this facility usually treat/ dispose of infectious waste? * How does this facility usually treat/ dispose of sharps waste? * Is there a waste management area fenced off? * Is there an incinerator? Are there different pits according to the type of waste? * Are the incinerator and waste pits correctly managed? |  | * Are cleaning protocols available? * Have all staff responsible for cleaning received training? * Have all staff responsible for cleaning received training on the use and disposal of PPE? |  |  |

**ANNEX: ADDITIONAL GUIDANCE ON WASH IN HCF**

## DISINFECTION

Details on the use of chlorine solution per concentration can be found in these documents:

<https://medicalguidelines.msf.org/viewport/phe/files/english/30544471/30544477/1/1527598394568/public_health_en.pdf>

<https://www.who.int/publications/i/item/cleaning-and-disinfection-of-environmental-surfaces-inthe-context-of-covid-19>

## WASTEWATER DISPOSAL

Details on removal pre-treatment and disposal can be found in this document:

<https://medicalguidelines.msf.org/viewport/phe/files/english/30544471/30544477/1/1527598394568/public_health_en.pdf>

## WASTE MANAGEMENT

Details on removal pre-treatment and disposal can be found in this document:

<https://www.who.int/water_sanitation_health/facilities/waste/en/>

## PPE

**Standard Precautions**

<https://medicalguidelines.msf.org/viewport/phe/files/english/30544471/30544477/1/1527598394568/public_health_en.pdf>

**Ebola**

<https://www.who.int/csr/resources/publications/ebola/ppe-guideline/en/>

**COVID**

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance-publications?publicationtypes=d198f134-5eed-400d-922e-1ac06462e676>

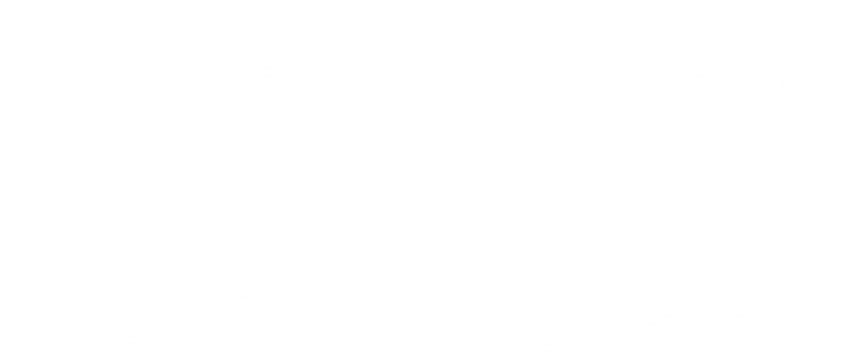
## IPC IN CTC

<https://www.gtfcc.org/wp-content/uploads/2019/10/gtfcc-technical-note-on-water-sanitation-and-hygiene-and-infection-prevention-and-control-in-cholera-treatment-structures.pdf>

***Fundo preto com letras brancas

Descrição gerada automaticamente***Fundo preto com letras brancas

Descrição gerada automaticamente



1. Cosgrave J., Buchanan-Smith M. and Warner, A. (2016). Evaluation of Humanitarian Action Guide. ALNAP (<https://www.alnap.org/help-library/evaluation-of-humanitarian-action-guide>) [↑](#footnote-ref-1)
2. For example, see the UNICEF’s U-Report tool (<https://www.unicef.org/innovation/U-Report>) or Oxfam’s Your Word Counts initiative (<https://views-voices.oxfam.org.uk/2019/09/the-future-is-bright-for-digital-accountability/>) [↑](#footnote-ref-2)
3. See WHO Sanitary Inspection Packages for drinking water: <https://www.who.int/water_sanitation_health/water-quality/safety-planning/sanitary-inspection-packages-for-drinking-water/en/> [↑](#footnote-ref-3)
4. [Ram (2013) Practical Guidance for Measuring Handwashing Behaviour: 2013 Update. World Bank](https://www.wsp.org/sites/wsp.org/files/publications/WSP-Practical-Guidance-Measuring-Handwashing-Behavior-2013-Update.pdf) [↑](#footnote-ref-4)
5. See [CaLP. (2018). Minimum Standards for Market Analysis (MISMA)](http://www.cashlearning.org/resources/library/1263-minimum-standard-for-market-analysis-misma)

   2 See [MERS](http://www.mershandbook.org) (2017). Assessment and Analysis Standards [↑](#footnote-ref-5)
6. SEE [MERS Annex: Market linked Tools and Frameworks for Assessments](http://www.mershandbook.org), p. 157 [↑](#footnote-ref-6)
7. <https://www.calpnetwork.org/publication/multi-sector-market-assessment-companion-guide-and-toolkit/> [↑](#footnote-ref-7)
8. Sphere (2018). The Sphere Handbook. <https://handbook.spherestandards.org/en/sphere/#ch003> [↑](#footnote-ref-8)
9. For examples of how perception information can be used to monitor humanitarian action, see: <https://groundtruthsolutions.org/our-work/strengthening-the-humanitarian-response-in-chad> [↑](#footnote-ref-9)
10. For more information see: [Age and Disability Consortium. (2018). Humanitarian inclusion standards for older people and people with disabilities.](https://d3n8a8pro7vhmx.cloudfront.net/handicapinternational/pages/3859/attachments/original/1527777024/Humanitarian_inclusion_standards_for_older_people_and_people_with_disabilities.pdf) [↑](#footnote-ref-10)
11. IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, 2015. Water, Sanitation and Hygiene, Thematic Area Guide [↑](#footnote-ref-11)
12. For more information on the WASH 5 Commitments, see: <https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/wash_gender_minimum_commitments_.pdf> [↑](#footnote-ref-12)
13. [↑](#footnote-ref-13)
14. Likert scale: a 5-point linear scale used to measure how a respondent feels about a particular statement. E.g. 1: Strongly agree; 2: Agree; 3: Neutral; 4: Disagree; 5: Strongly disagree. The scale can be used to measure frequency, importance, satisfaction and other similar variations of attitude. [↑](#footnote-ref-14)
15. The term usable here refers to toilets or latrines accessible to patients and staff and private. [↑](#footnote-ref-15)
16. Point of care sanitation such as bedpans or commodes should also be available for those unable to use toilet facilities. [↑](#footnote-ref-16)
17. For detailed guidance on health care waste management, see resources in the annex [↑](#footnote-ref-17)