World Health Organization

REGIONAL OFFICE FOR South-East Asia

Toolkit on mainstreaming of gender equality, disability and social inclusion (GEDSI) in WASH in health-care facilities

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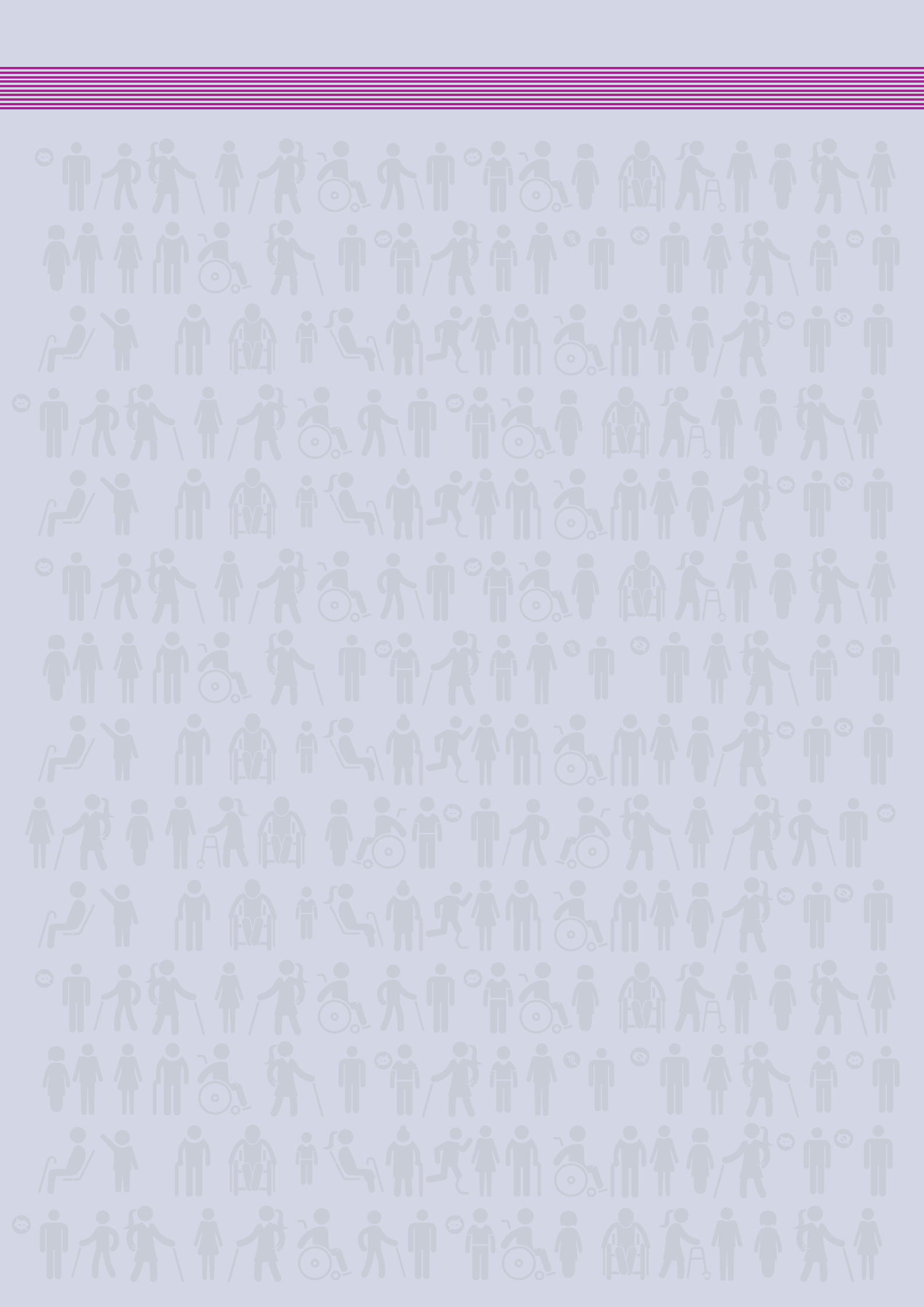


Foreword

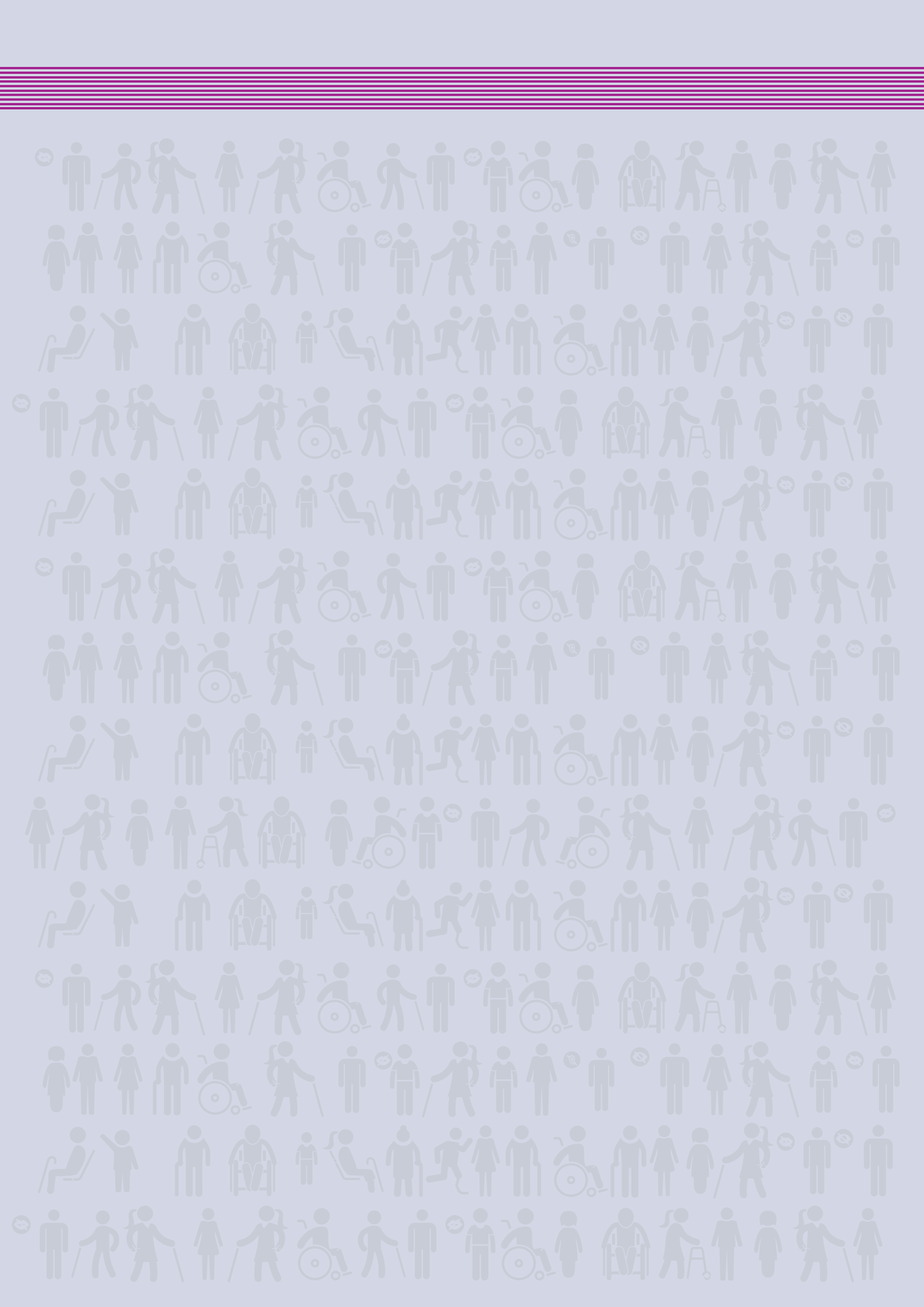
The WHO South-East Asia Region has in recent years achieved significant improvements in access to safe water, sanitation and hygiene (WASH) services in health-care facilities, in alignment with the 2018 Global Call to Action by the Secretary-General of the United Nations. At both national and regional levels, WHO has enhanced health worker capacity to implement safe WASH practices and formulated an array of policies, standards and quality enhancement tools that can be adapted and implemented based on country and facility needs.

However, to unlock the full benefits of WASH in health-care facilities, people who work in or rely on these services must be engaged and empowered, particularly women and girls, those with disabilities and other marginalized groups. To that end, this WHO-developed *"Toolkit on mainstreaming of gender equality, disability and social inclusion in WASH in health-care facilities"* aims to support policy-makers, programme managers and facility administrators to create health-care facilities that are inclusive, accessible and respectful of every person's rights and dignity.

The Toolkit is aligned with the eight practical steps outlined in *"WASH in health care facilities: Practical steps to achieve universal access to quality care"*, as well as key components of the *"Water and Sanitation for Health Facility Improvement Tool (WASH FIT)"*, which countries across the Region continue to implement. The Toolkit includes several tools, resources and case studies from countries that WASH practitioners may find helpful when designing and implementing facility-level programmes.

I urge all stakeholders to appropriately implement the Toolkit, accelerating our onward journey to ensure that every health facility meets the needs of every community. For this, I reiterate WHO's ongoing and unmitigated support, for healthier lives, improved quality of care, and a more equitable and sustainable South-East Asia Region for all.

Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia



Acknowledgments

This Toolkit on mainstreaming of gender equality, disability and social inclusion (GEDSI) in WASH in health-care facilities draws on the eight practical steps outlined in *WASH in health care facilities: Practical steps to achieve universal access to quality care* (2019) and key components of the *WASH FIT: A practical guide for improving quality of care through water, sanitation and hygiene in health-care facilities, Second edition (2022)*, developed by the World Health Organization and UNICEF.

This Toolkit includes contributions from several experts within and outside the World Health Organization and are duly acknowledged. Ms Faustina Gomez and Mr Hussain Rasheed from the Water Sanitation and Climate Change Unit at the WHO Regional Office provided technical guidance.

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Abbreviations

AAAQ	availability, accessibility, acceptability and quality care
ASEAN	Association of Southeast Asian Nations
CSO	civil society organization
DPO	disabled people's organization
FGD	focus group discussion
GEDSI	gender equality, disability and social inclusion
HMIS	Health Management Information System
IPC	infection prevention and control
JMP	Joint Monitoring Programme
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, intersex, asexual and others
M&E	monitoring and evaluation
MHM	menstrual hygiene management
MoH	Ministry of Health
MoHS	Ministry of Health and Sports
NGO	nongovernmental organization

PHC	primary health care
PLHIV	people living with HIV
PPE	personal protective equipment
QA	quality assurance
QI	quality improvement
SDGs	Sustainable Development Goals
TB	tuberculosis
UHC	universal health coverage
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WASH FIT	Water and Sanitation for Health Facility Improvement Tool
WEDC	Water, Engineering and Development Centre
WHA	World Health Assembly
WHO	World Health Organization

Executive summary

At the World Health Assembly in 2019, 194 countries agreed to work towards a global target of 100% of health-care facilities having basic water, sanitation and hygiene (WASH) services by 2030. WASH in health-care facilities is fundamental to infection prevention and control (IPC) and the delivery of high-quality care. It improves staff ability to provide safe care, increases uptake of services, and saves maternal and newborn lives.

To realize the full benefits of WASH in health-care facilities, people must be at the centre of WASH improvement efforts. Engaging health-care workers, clients and community members gives voice to local needs and prioritizes and supports continued use of WASH. However, some people and groups are at risk of being left behind. Women and girls, persons with disabilities, and other marginalized groups face unique barriers in the use of WASH services, and often lack opportunities to influence improvement efforts. These inequalities in health and WASH will be further exacerbated by a number of factors e.g. climate change. It is therefore urgently required to integrate gender equality, disability, and social inclusion (GEDSI) in planning and improvement of WASH in health-care facilities at all levels.

A “GEDSI” approach is an explicit effort to leave no one behind in WASH in health facilities. It ensures that the WASH services that are available at the health facility are also accessible to all users, acceptable in terms of their privacy, dignity, safety and cultural values, and equitably used by health facility staff to improve quality of care for all patients, regardless of their personal characteristics. A GEDSI approach actively engages marginalized groups in planning, implementing and monitoring WASH at the health facility and reduces social inequalities.

Intended for national health and WASH sector stakeholders spearheading WASH augmentation, along with units advocating GEDSI integration this “Toolkit on mainstreaming of gender equality, disability and social inclusion (GEDSI) in WASH in health-care facilities” serves as a comprehensive compass, guiding nations in the seamless integration of GEDSI into strategies and actions fortifying WASH in health-care facilities. Drawing from the WHO’s South-East Asia Region and fortified by tools and case studies rooted in GEDSI and WASH amalgamation, this document aligns with the eight practical steps outlined in “WASH in health care facilities: practical steps to achieve universal access to quality care”. It harmoniously dovetails with the Water and Sanitation for Health Facility Improvement Tool (WASH FIT), reinforcing GEDSI priorities. WASH practitioners and health facility managers and staff, community leaders and representatives, and organizations that represent excluded and marginalized groups will also find this toolkit useful in ensuring that WASH at their health facility meets the needs of all the community members.

While GEDSI integration will strengthen WASH, improve the working environment in health-care facilities, and contribute to better health outcomes, the approach will also strengthen gender equality and women’s empowerment and reduce social inequalities, helping countries achieve the Sustainable Development Goals (SDGs).

Integrating GEDSI into the eight practical steps to improve WASH in health-care facilities calls attention to inclusion in each practical step and the toolkit outlines how this can be achieved. This is done through eight chapters that describe the means for inclusion in each of the eight practical steps.

The chapter on integrating GEDSI in Step 1 situation analysis and assessment calls for a comprehensive examination of existing disparities and obstacles that hinder equitable access to WASH services. It emphasizes the integration of GEDSI considerations in policies and strategies. The engagement of key stakeholders in this process is explored to pave the way for inclusive service delivery.

In the next chapter on setting targets and defining the roadmap as per Step 2, the GEDSI focus is on establishment of an intersectoral inclusive task force. Further, this chapter advocates for GEDSI integration in the roadmap for WASH in health-care facilities through the definition of relevant goals, targets and activities, budgets, and implementation and monitoring mechanisms. Ensuring the inclusivity of the task force is envisioned as a catalyst for driving GEDSI perspectives within WASH in health-care facility initiatives.

While establishing mechanisms for national standards and accountability in Step 3, the chapter focuses on how GEDSI calls for these standards to measure the availability, accessibility and acceptability of WASH services in health facilities. It emphasizes their use for equitable service delivery, and the engagement of marginalized groups in facility WASH committees and developing accountability at the facility level.

While discussing how to improve and maintain infrastructure as described in Step 4, the chapter focuses on the congruence between infrastructure enhancements with national GEDSI–WASH standards and how it is critical to address the unique requirements of marginalized users. It stresses on the use of tools such as WASH FIT that facilitate engagement of marginalized groups in the assessment and development of plans for improvement. The outcome is a transformative approach to infrastructure development that embodies inclusivity.

The next chapter shows how inclusion in monitoring and review of data in Step 5 can be framed around participatory methodologies, with an emphasis on developing relevant indicators, data collection processes, and mechanisms for interpretation. Marginalized groups play a central role in these activities, facilitating a comprehensive understanding of WASH access and utilization.

Preparing the health-care staff with a proficient understanding of GEDSI–WASH dynamics is key while developing the health workforce as part of Step 6. The chapter focuses on how empathy towards marginalized groups can be cultivated and provides practical tools for effective engagement to support inclusion further.

The chapter on Step 7 of engaging communities focuses on community-driven transformation, and advocates for the integration of GEDSI principles within local WASH planning, improvement and oversight processes. Representation of marginalized groups within national and local teams is emphasized, fostering genuine community participation and leadership.

Finally, the chapter focusing on Step 8 of operational research and sharing learning helps support GEDSI by identifying effective strategies and proven approaches for facilitating inclusion for scale up.

Introduction

The importance of WASH in health-care facilities

The term "WASH in health-care facilities" refers to the provision of water, sanitation, health-care waste management, hygiene and environmental cleaning infrastructure and services across all parts of a health facility. WASH services are fundamental to providing quality care, including infection prevention and control (IPC) within the health facility. WASH has a critical impact on safe childbirth and postpartum care. Health-care workers require clean water for hand washing, cleaning medical instruments and equipment, the environment, and for maternal and newborn care.[1] Without WASH, health goals will not be met, especially those for reducing maternal and neonatal deaths, stopping the spread of antimicrobial resistance, and preventing and containing disease outbreaks.[2]

Building upon the 2018 Global Call to Action on WASH in health-care facilities issued by the UN Secretary General, in the 2019 World Health Assembly, 194 WHO Member States unanimously passed a resolution to develop national roadmaps, monitor progress, and invest in WASH in health-care facilities. Since then, countries have intensified efforts to achieve the global target of 100% of health facilities having basic WASH services by 2030. This will improve quality of care, contribute to increased demand for health services, and save lives.

> *"Globally, 1 in 10 patients get an infection while receiving care, resulting in increased illness and death."*
>
> World Health Organization[3]

> *"Inadequate WASH increases risk of disease: infections associated with unclean births account for 26% of neonatal deaths and 11% of maternal mortality; together these account for more than 1 million deaths each year."*
>
> World Health Organization[4]

> *"A 2019 survey of the top maternal and reproductive health service demands of over 1 million women and girls in 114 countries found that WASH services and facilities were a key priority, second only to respectful and dignified maternity care."*
>
> What Women Want – global survey[5]

[1] Global progress report on water, sanitation and hygiene in health care facilities: fundamentals first. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337604, accessed 18 September 2023).

[2] World Health Organization, United Nations Children's Fund (UNICEF). Global SDG baseline for WASH in health care facilities: practical steps to achieve universal WASH in health care facilities. Questions and answers. Geneva: WHO and UNICEF (*https://cdn.who.int/media/docs/default-source/wash-documents/wash-in-hcf-q-a-2april.pdf?sfvrsn=69d0d54a_6*, accessed 25 August 2023).

[3] Infection prevention and control. Geneva: World Health Organization; 2021 (*https://www.who.int/teams/integrated-health-services/infection-prevention-control*, accessed 23 August 2023).

[4] Global progress report on water, sanitation and hygiene in health care facilities: fundamentals first. Geneva: World Health Organization; 2020 (*https://apps.who.int/iris/handle/10665/337604*, accessed 18 September 2023).

[5] What Women Want survey: Demands for quality health care for women and girls. Washington DC: White Ribbon Alliance; 2019.

Ensuring WASH for all health facility users

To maximize the full benefits of WASH in health-care facilities, it is essential to put people at the centre. Health-care workers, clients and community members must be engaged in planning and improvement to understand local WASH needs and priorities and to ensure continued use of WASH infrastructure and services. However, some people and groups are often left behind in WASH improvement. They may face unique physical challenges in accessing WASH facilities or be prevented from using them by negative social attitudes or discrimination. If excluded from health facility committees, they are unable to voice their needs and influence WASH improvements. Subgroups that are often left behind in WASH improvements in health-care facilities include: persons with disabilities; women and girls; children and older adults; people from lower-income or education groups; ethnic, racial, religious and linguistic minorities; people from lower castes; and lesbian, gay, bisexual, transgender, queer, intersex, asexual and others (LGBTQIA+).

Resource 1 outlines some population groups who are marginalized, and lists barriers linked to WASH that they face. Note that the resource is not exhaustive and nor are all categories exclusive of each other. Many of these individuals may face multiple forms of disadvantages. The identity of marginalized groups will vary from one country and community to the next, and will require planned assessment. **Resource 2** describes how the barriers, identified in **Resource 1**, are likely to be increased as the world experiences climate change.

> *"We feel that our dignity is stripped each day when we need to depend on others to use the toilet."*
>
> A woman interviewed at a health-care facility in Nepal[6]

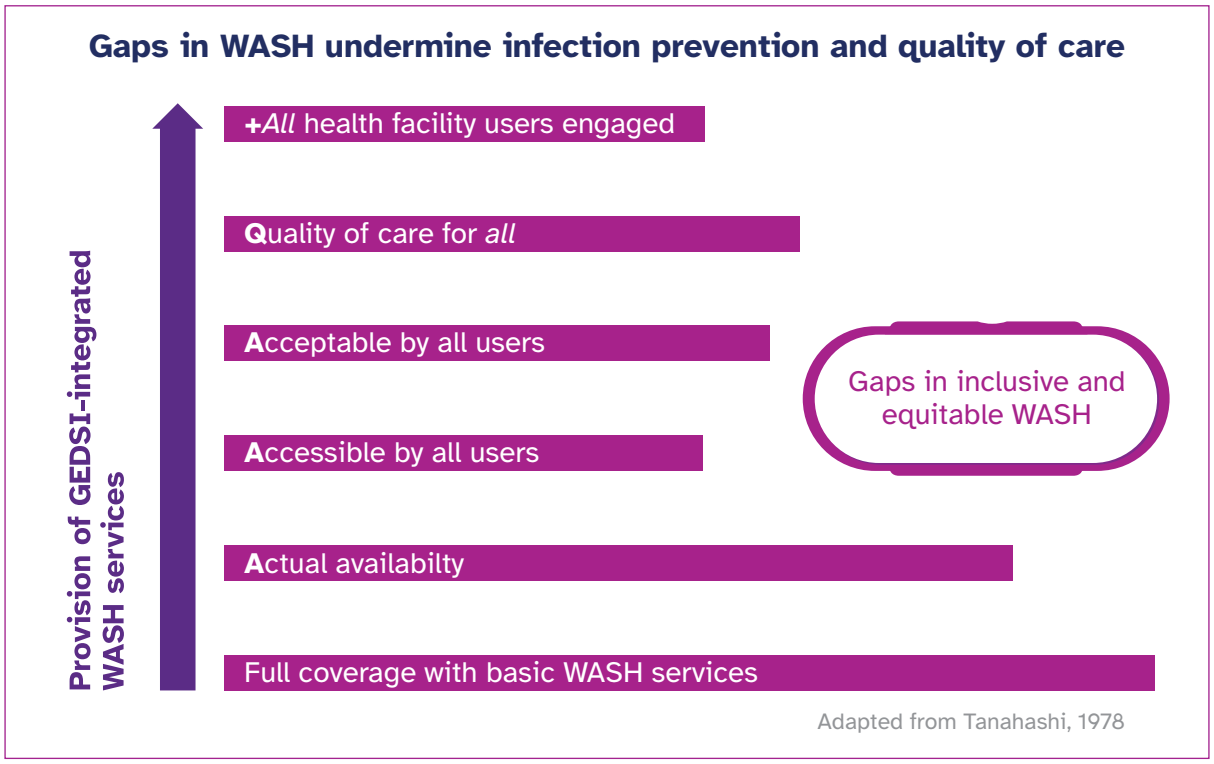
A **"GEDSI" approach** to WASH in health-care facilities entails making an explicit effort to be equitable and inclusive, leaving no one behind. GEDSI prevents and addresses discrimination on the basis of gender, age, ethnicity and other factors, and supports equal treatment of all. It promotes the rights of women and girls, persons with disabilities, and other health facility users to make their voices heard in discussions about WASH in health-care facilities and to use WASH at the facility to improve their health and well-being.

Integrating a GEDSI approach contributes to the commitment to *"Leave no one behind"* made by United Nations (UN) Member States to eradicate poverty, reduce inequalities and end discrimination. It prioritizes the most vulnerable and marginalized members of society, and is at the heart of the Sustainable Development Goals (SDGs). The importance of GEDSI and WASH in health-care facilities is reflected in numerous global commitments, as summarized in **Resource 3.**

Achieving the full benefits of WASH in health-care facilities requires increasing the **A**vailability of WASH infrastructure and services in the facility, while also improving **A**ccess, **A**cceptability, and equitable use for **Q**uality of care for all, plus **(+)** engaging

[6] Towards inclusive WASH: sharing evidence and experience from the field. London: WaterAid; 2012 (*https://www.ircwash.org/sites/default/files/Wateraid-2012-Towards.pdf*, accessed 25 August 2023).

marginalized groups in planning and improvement to ensure no one is left behind **(AAAQ+)**.



Availability: Ensuring that the health facility has sufficient quantities of clean water; sanitation facilities that separate human excreta from human contact; functional hand hygiene facilities with soap and/or alcohol-based hand rub; segregation, treatment and disposal of wastes; and protocols and trained staff for environmental cleaning.

Continued availability requires that WASH programming – including operation and maintenance of infrastructure and behaviour change to support its use – is included in health facility and health system plans, budgets and monitoring systems.

Accessibility: Using universal and accessible design to support use of WASH facilities by all, including those with disabilities, users who are pregnant, children and older adults, sexual and gender minorities including LGBTQIA+, and users unable to access hygiene information due to language barriers or inability to read.

Acceptability: Respecting the privacy, dignity and safety of the users, and being culturally appropriate and sensitive to the users' needs and priorities, which are influenced in part by social beliefs and expectations. This includes, for example, appropriate menstrual hygiene management (MHM) and products for urinary incontinence after childbirth.

Equitable use to improve Quality of care for all: Ensuring that health facility staff address the WASH-related needs and priorities of all patients and their caregivers, regardless of the patient's personal situation or characteristics. Quality of care also includes a sustainable and safe service delivery environment, free from health care-associated infections, maintained by health facility staff who have the WASH facilities

they need, and who promote hygienic behaviours in a way that all patients and caregivers understand.

+: Engaging marginalized health facility users in planning, practice and monitoring of WASH in health-care facilities. Marginalized facility users are those who have experienced discrimination and exclusion because of unequal social status and power relationships. Their exclusion from improved WASH mirrors their broader exclusion in society where they often experience fewer opportunities and discrimination.

> *"People hush me up. I speak my mind and they dislike it. But unless I speak up, how else will the crisis here get solved?"*
>
> A midwife in India

Progress on equitable, inclusive WASH in the WHO South-East Asia Region

The WHO South-East Asia Region[7] performs better than the global average on WASH in health-care facilities, particularly in the area of improved sanitation.[8] However, progress towards improved WASH that is also accessible, acceptable, and supports quality of care has been slow. For example, while the majority of health-care facilities in the WHO South-East Asia Region have improved sanitation facilities, **only four countries monitor whether they are responsive to diverse user needs.**[9] Data also highlight disparities in basic sanitation meeting diverse user needs in countries that monitor progress. As efforts towards improved WASH continue, it is time to lay more stress on meeting the needs of *all* health facility users.

Availability of basic sanitation in Member States of the South-East Asia Region responsive to diverse user needs (2022)[10]

Country	Any sanitation facility	Improved sanitation facility	Improved and usable sanitation facility	Improved and dedicated for staff	Improved and gender-separated	Improved and providing menstrual hygiene facilities	Improved and accessible to those with limited mobility	Basic sanitation services
Bangladesh	97	94	36	98	93	31	38	31
Bhutan	100	99	84	73	31	16	31	16
Maldives	100	100	99	80	15	30	44	15
Thailand	-	-	96	92	-	81	97	61

[7] The WHO South-East Asia Region has 11 Member States – Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. Data was not available for all countries in 2019.

[8] World Health Organization, United Nations Children's Fund (UNICEF). Global progress report on water, sanitation and hygiene in health care facilities: fundamentals first. Geneva: WHO; 2020 (https://apps.who.int/iris/handle/10665/337604, accessed 25 August 2023).

[9] Progress on WASH in health care facilities 2000–2021: special focus on WASH and infection prevention and control (IPC). Geneva: World Health Organization (WHO) and the United Nations Children's Fund (UNICEF); 2022 (*https://www.who.int/publications/i/item/9789240058699*, accessed 25 August 2023).

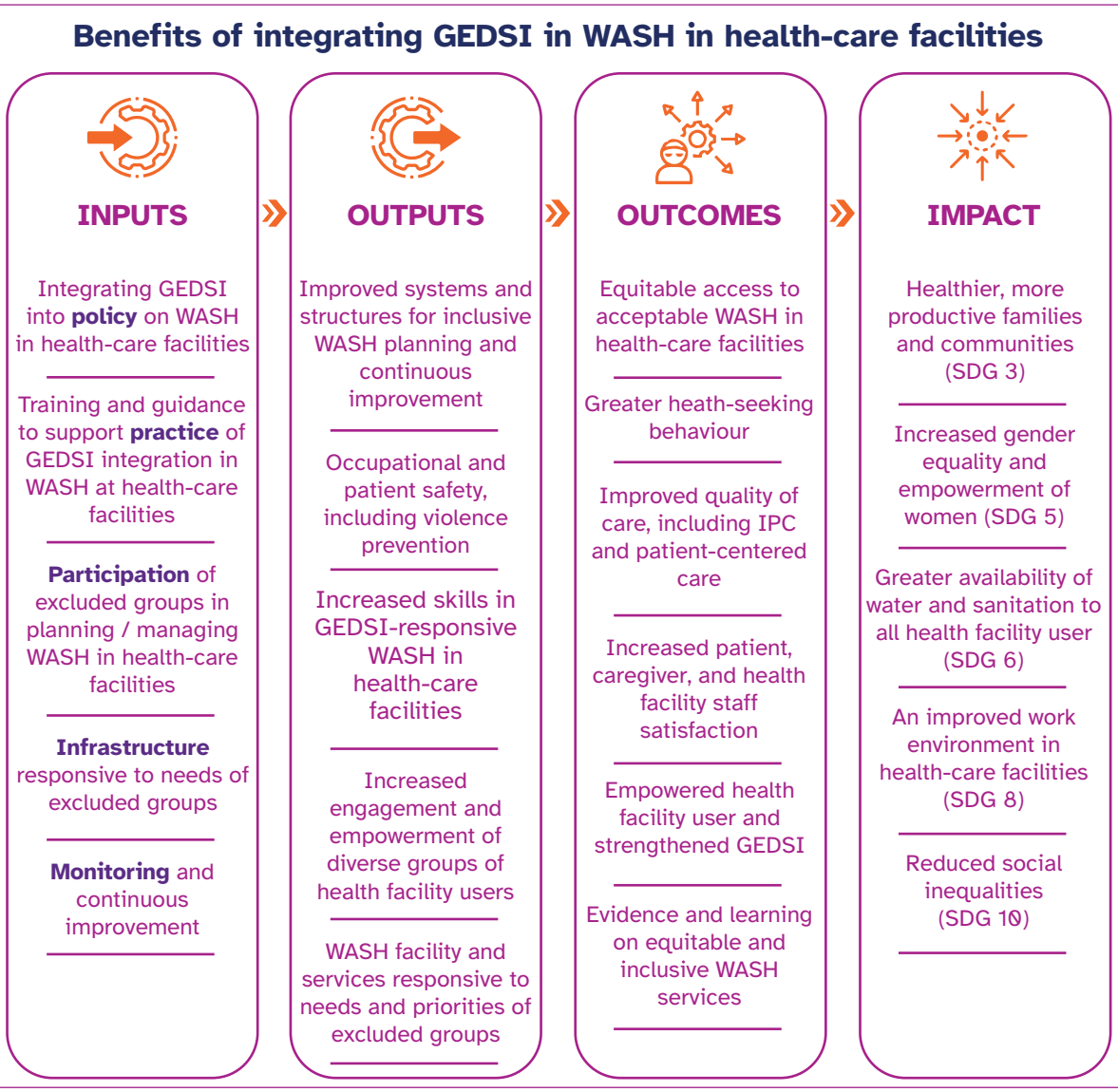
[10] Progress on WASH in health care facilities 2020–2021 – Special focus on WASH and infection prevention and control (IPC); August 2022.

Integrating a GEDSI approach into policies, plans and activities to improve WASH in health-care facilities can be challenging and **will require conscious effort and persistent advocacy.** GEDSI initiatives are often a low priority in resource allocations, and WASH or health data management systems are generally not equipped to support monitoring of GEDSI indicators. Deep-rooted social norms and unequal power structures may seek to maintain exclusion of some population groups.

Benefits of equitable, inclusive WASH

Using a GEDSI approach to WASH in health-care facilities brings benefits in many areas. It helps ensure that diverse WASH needs and priorities are recognized and addressed at the health-care facility, helping achieve SDG 6 on water and sanitation and SDG 3 on improved health outcomes. A GEDSI approach also contributes to increased gender equality and women's empowerment (SDG 5), reduces social inequalities (SDG 10), and improves the working environment in health-care facilities (SDG 8). **Resource 3** provides an overview of different global commitments linked to GEDSI.

Benefits of integrating GEDSI in WASH in health-care facilities



Purpose of the toolkit

This Toolkit on mainstreaming of GEDSI in WASH in health-care facilities provides step-by-step guidance on how countries can integrate GEDSI into their strategies and activities for strengthening WASH in health-care facilities. It is framed by the eight steps as outlined in the *WASH in health care facilities: practical steps to achieve universal access to quality care*. It also includes case studies from the WHO South-East Asia Region and tools to support GEDSI integration, drawn or adapted from existing materials and initiatives that integrate GEDSI and WASH.

Integrating GEDSI across the eight practical steps for WASH in health-care facilities

1. Conduct situation analysis and assessment to understand:

- who is being left behind and the barriers they face in terms of availability, accessibility, and acceptability of WASH services, the use of WASH in equitable service delivery, and engagement in decision-making;
- what is the status of GEDSI in health and WASH policies and programmes; and
- who are the influential stakeholders that can champion GEDSI.

2. Set targets and define a roadmap that supports GEDSI by engaging marginalized groups in an intersectoral, inclusive task force that champions GEDSI in WASH in health-care facilities.

Advocate for GEDSI integration in all areas of WASH in health-care facilities roadmap development, from definition of relevant goals, targets and activities, budgets, and implementation and monitoring mechanisms.

3. Establish national standards and accountability mechanisms that measure the availability, accessibility, and acceptability of WASH services in health facilities, their use for equitable service delivery, and the engagement of marginalized groups in facility WASH committees.

Ensure that the standards are reflected in health facility assessments and used to hold facilities accountable.

4. Improve and maintain infrastructure to meet national GEDSI in WASH standards and the needs and priorities of marginalized health facility users by using quality improvement tools such as WASH FIT. Engage marginalized groups in planning, implementing and monitoring improvements.

5. Monitor and review data on availability, accessibility, and acceptability of WASH for marginalized groups, and its use for equitable service delivery.

Engage marginalized groups in identifying or developing indicators, collecting data, and interpretating findings to ensure that they are relevant and useful.

6. Develop the health workforce to apply GEDSI at the health facility by increasing knowledge of GEDSI in WASH, improving attitudes towards marginalized groups, and providing staff with skills to engage marginalized groups through WASH.

7. Engage communities in planning, improving and monitoring GEDSI integration in WASH in health-care facilities. This includes involving marginalized groups on national and local teams working to improve WASH in health-care facilities; activating community groups and civil society platforms; and embedding community representation in monitoring activities.

8. Conduct operational research and share learning to identify and scale-up innovative approaches to integrate GEDSI in WASH in health facilities.

Target audience

The toolkit has been designed for practitioners, industry experts and other stakeholders working towards inclusive and equitable WASH in health-care facilities. This includes:

- National health and WASH sector actors who are leading the planning, development and implementation of activities to strengthen WASH in health-care facilities, as well as units that want to ensure that GEDSI issues become an integrated component of WASH in health facilities.
- WASH practitioners and health facility managers and staff who are taking steps to improve WASH in their health facilities, as well as staff working with GEDSI issues who recognize a need to improve GEDSI as part of WASH at the health-care facility.
- Community leaders and representatives who want to ensure that the WASH infrastructure and services at their health facility meet the needs of all the community members across the life course.
- Organizations that represent excluded and marginalized groups and are advocating for increased responsiveness of health facilities to the needs of their communities.

How was the toolkit developed?

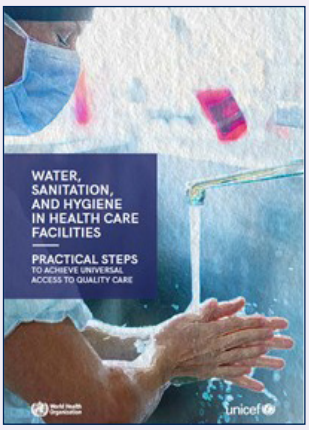
The framework for the toolkit is provided by the *WASH in health care facilities: practical steps to achieve universal access to quality care* (2019) developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) (See box). This document outlines eight practical steps that countries should take in order to sustain WASH services and practices in a range of health-care settings, from primary to tertiary facilities. Practical Steps 1–3 involve priority actions that can be taken at the national level for creating an enabling environment for WASH in health-care facilities. Practical Steps 4, 6 and 7 focus on actions that can be taken at the health facility level to improve WASH and health service delivery. Steps 5 and 8 involve actions that need to be taken to guide, support and sustain WASH improvements after they have been implemented. While the eight practical steps are presented in a linear fashion, the actions can occur in any order and/or simultaneously.[11]

WASH in health-care facilities: practical steps to achieve universal access to quality care

In 2018, the United Nations (UN) Secretary-General issued a Global Call to Action to elevate the importance of and prioritize action on WASH in all health-care facilities. The call recognizes the important role WASH plays in preventing infections and saving lives. WHO and UNICEF have established a set of global targets for achieving universal access to WASH in health-care facilities, and, for the first time through the WHO/UNICEF Joint Monitoring Programme (JMP), a global reporting and monitoring mechanism for WASH in health-care facilities. The targets are that at least 60% of all health-care facilities globally and in each SDG region should have basic WASH services by 2022, and 80% by 2025, with the ultimate aim of 100% by 2030.

Alongside the resolution, WHO and UNICEF published a set of eight practical steps that can be taken up by Member States, at the national and subnational levels, to improve and sustain WASH services and practices in health-care facilities:

1. Conduct a situation analysis and assessment
2. Set targets and define a national roadmap
3. Establish national standards and accountability mechanisms
4. Improve and maintain infrastructure
5. Monitor progress and review data
6. Develop the health workforce
7. Engage communities
8. Conduct operational research and share learning.



[11] Key WASH FIT resources – WASH FIT portal | WASH in Health Care Facilities (washinhcf.org)

These steps are further described and illustrated with country examples. Country priorities and contexts are important and will influence how steps are implemented and whether additional steps are also pursued.

UN agencies, Member States and partners are now mobilizing resources to invest more in this fundamental element for providing universal, quality care.

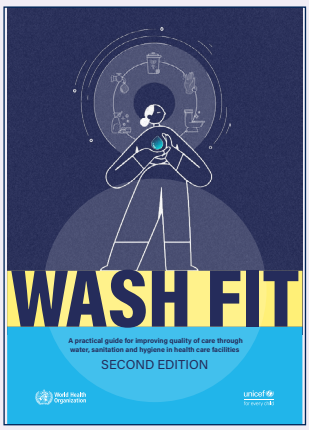
The toolkit also reinforces integration of GEDSI priorities in the *Water and Sanitation for Health Facility Improvement Tool (WASH FIT)*, which contributes to Step 4 of the eight practical steps.

Water and Sanitation for Health Facility Improvement Tool (WASH FIT): a practical guide for improving quality of care through WASH in health care facilities, second edition (2022)

WASH FIT is a risk-based, quality improvement tool for strengthening WASH services in health-care facilities, covering key aspects of WASH services: water; sanitation; hand hygiene; environmental cleaning; health-care waste management; and selected aspects of energy, building and facility management.

WASH FIT:

- provides a framework to develop, monitor and continuously implement an improvement plan and prioritize specific WASH actions that are climate-resilient, equitable and inclusive;
- guides planning and implementation of WASH improvements as part of wider quality improvement efforts, and to meet local, national and global standards;
- supports the implementation of infection prevention and control (IPC) standards and transmission-based precautions according to national guidelines and standard operating procedures; and
- facilitates multisectoral actions by bringing together all those who share responsibility for providing WASH services.



The second edition of WASH FIT published in 2022 responds to member state and user requests for more guidance and information on incorporating gender and equity and climate and environment considerations throughout each of the WASH FIT steps as well as a greater focus on sustainable, implementation and engagement with health actors. The Second Edition also includes a set of fact sheets, check lists, training manual and a set of training slides, updated assessments and examples of national adoption and use of WASH FIT.

As of early 2022, WASH FIT has been used in more than 40 countries, primarily in small, primary care health facilities in low-resource settings.

Resources and Tools

Resource 1: WASH barriers faced by marginalized groups

Examples of groups who are often marginalized in decision-making at health-care facilities and in relation to WASH

Resource 2: The impact of climate change on GEDSI and WASH in health-care facilities

An overview of how climate change will impact WASH in health-care facilities and the need to integrate GEDSI

Resource 3: Summary of global commitments

An overview of the different international commitments linked to GEDSI

Resource 1:

WASH barriers faced by marginalized groups

This resource examines the challenges faced by population groups that are marginalized and lists barriers linked to WASH that they face. When reviewing this list, it is important to remember that each of these groups can have multiple identities that interact and intersect with each other, compounding impact and leading to unique experiences of marginalization. For example, the challenges faced by an older woman with disability are influenced by – the challenges linked to gender, age and disability.

Marginalized group	Barriers specific to WASH
Women and girls 	**Accessibility** • Lack of access to income and decision-making on WASH • Lack of an adequate number of gender-segregated toilets • Lack of hygiene facilities and products for menstrual hygiene management (MHM) and postpartum care • Limited physical mobility during pregnancy (in some cases) and linked barriers in WASH in health care • Privacy concerns from ability to lock toilets and bathing units from inside • Limited access to safe drinking water for women in drought-prone areas or those with contaminated sources of water **Acceptability** • Social and cultural expectations around privacy, maintaining 'dignity' and 'modesty' and taboos around menstruation and post-birth bleeding • Security concerns including risk of harassment and sexual abuse while accessing water or toilets due to poor lighting, distant location, lack of a mechanism to lock the toilet door from inside, etc • Stigma around incontinence • MHM facilities that are inconvenient; products that do not meet user needs • Discrimination based on specific patient attributes **Utilization and quality of care** • Caregiving responsibilities for children, sick or older relatives, and persons with disabilities constrain own WASH use

Marginalized group	Barriers specific to WASH
	• Dependency on health facility staff and family members for WASH and infection prevention and control (IPC) during childbirth and inpatient care **Engagement** • Limited decision-making authority restricts opportunities to voice opinion on WASH in health facilities • Family responsibilities limit time for engaging in committees for WASH in health-care facilities
Persons with disabilities 	**Accessibility** • Physical barriers such as narrow doorways, internal steps or distance to WASH facilities • Challenges to access other infrastructure in the health-care facilities, such as drinking water • WASH-related signages that are difficult to read • Announcements are inaudible to persons with hearing impairments • Health worker counselling on WASH that is difficult to hear or understand • Risk of stigma and discrimination from health facility staff and users who refuse to make adjustment to infrastructure and services for WASH to accommodate the disability or prevent the person from accessing WASH facilities **Acceptability** • Indignity of using WASH facilities and products that do not meet physical needs, or that are substandard. • Attitudinal challenges in the form of stigma and discrimination from health facility staff **Utilization and quality of care** • Dependency on health facility staff and family members for WASH and IPC during visits to the health facility **Engagement** • Discrimination that prevents persons with disabilities from voicing their opinions or participating in WASH committees

Marginalized group	Barriers specific to WASH
Older adults 	**Accessibility** • Physical barriers such as steps, distance to WASH facilities, or toilets and handwashing facilities that are difficult to reach • WASH-related signages that are difficult to read • Unmet needs related to incontinence • Health worker (potentially erroneous) assumption that older adults' WASH needs will be supported by their caregiver • Health worker counselling on WASH that is inaudible or incomprehensible **Acceptability** • Negative or condescending attitudes of other health facility users who are impatient with or disdainful of WASH needs of older adults • Indignity of using WASH facilities and products (e.g. for incontinence) that do not meet needs **Utilization and quality of care** • Dependency on health facility staff and family members for WASH and IPC during visits to the health facility **Engagement** • Discrimination restricting participation of older adults in WASH committees or disregarding their inputs
Indigenous people, ethnic minorities 	**Accessibility** • WASH-related signages and provider counselling do not meet the language needs of diverse user groups • Negative attitudes and stigmatizing behaviour from health facility staff and users that prevent individuals from indigenous or ethnic groups from using WASH facilities or services **Acceptability** • Lack of culturally appropriate WASH facilities and services **Utilization and quality of care** • Discrimination resulting in substandard care, e.g. denying WASH during service delivery or poor IPC **Engagement** • Discrimination against people from different ethnic, racial and linguistic backgrounds • Language barriers to participation

Marginalized group	Barriers specific to WASH
Lesbian, gay, bisexual, transgender, queer, inter-sex, asexual and others (LGBTQIA+) 	**Accessibility** • Risk of verbal, physical and sexual abuse or assault, denial of access, arrest and expulsion. In Malaysia, for example, a survey of transgender individuals found that almost half (41%) had experienced discrimination when using a public toilet[12] • Lack of access to gender-neutral toilets for non-binary and other gender or sexually diverse individuals **Acceptability** • Toilet stalls used by transmen lack MHM facilities and products **Utilization and quality of care** • Discrimination and risk of violence restrict use of WASH facilities, increasing health risks such as urinary tract infections **Engagement** • Exclusion from community and WASH committees and activities
Frontline health-care workers 	**Accessibility** • Unavailability of separate WASH facilities from patients/ caregivers • Lack of facilities and products for MHM • Lack of toilets on site • Lack of showers for use during/after a long shift **Acceptability** • Social and gender norms linked to WASH • MHM products that do not meet user needs • Lack of personal protection in sizes suitable for both women and men **Utilization and quality of care** • Lack of training on IPC and WASH • Fatigue and time constraints to perform proper hand hygiene or use WASH facilities, reducing compliance with WASH practices • Poor working conditions lead to psychological stress and low motivation to integrate WASH and IPC services

[12] Gender identity and the human rights to water and sanitation: a compilation by the special rapporteur on the human rights water and sanitation, Léo Heller. Geneva: Office of the United Nations High Commissioner for Human Rights; 2020 (*https://www.ohchr.org/Documents/Issues/Water/10anniversary/GenderIdentity.pdf*, accessed 25 August 2023).

Marginalized group	Barriers specific to WASH
	Engagement • Exclusion from planning and decision-making related to WASH at the health-care facility despite being significant users of WASH • Time and resource constraints to participate in WASH committee meetings, activities, etc.; often these constraints are linked to gender roles
Maintenance, cleaning, and waste management staff 	**Accessibility** • Unavailability of non-toxic environmental cleaning supplies and personal protection **Acceptability** • Lack of personal protective equipment (PPE) in sizes suitable for women and men **Utilization and quality of care** • Low motivation to comply with environmental standards due to poor working conditions **Engagement** • Often excluded from WASH and IPC planning and decision-making • Inadequate training on WASH and IPC-linked practices • Reluctant to voice their opinion or offer solutions due to stigma or fear of losing employment

Resource 2:

The impact of climate change on GEDSI and WASH in health-care facilities

How climate change will impact WASH in health-care facilities

As the climate changes, people are finding it increasingly difficult to stay healthy. Severe weather events such as heat waves, droughts and heavy storms result in trauma and injury. Shifting weather patterns increase or change the spread of infectious diseases. Impacts on our food resources lead to food and water insecurity and undernutrition. Between 2030 and 2050, climate change is expected to cause approximately 250,000 additional deaths per year from malnutrition, malaria, diarrhoea and heat stress alone.[13]

Climate change can also impact services provided by health-care facilities. Severe weather events may destroy health infrastructure, disrupt water and sanitation systems, and damage roads and other transportation systems, preventing health-care workers and supplies from reaching the facility. The lack of preventive and curative services further increases the risk of poor health and death for individuals and communities.

The brunt of the impact will be borne by marginalized groups

Marginalized groups are more vulnerable to the impacts of climate change. Many are already living in areas that are more vulnerable to natural hazards, polluted, and have inferior roads, health-care facilities, water and sanitation systems, and other resources. With less financial resources, marginalized groups are less able to make changes such as building a cooler home, procuring seeds for more resilient crops, or moving to a safe area. Mental stress and competition for resources increases discrimination and risk of violence against marginalized groups, including gender-based violence. Pregnant women, older adults, children, and people with chronic conditions are more vulnerable to heat and infections, but have less access to health services.

> *"If you are invisible in everyday life, your needs will not be thought of, let alone addressed, in a crisis situation."*
>
> Matcha Phorn-In, human-rights defender, Thailand[14]

Climate change can exacerbate existing health and WASH-related inequalities and discrimination in health-care facilities. Increased rainfall or heat may make it even

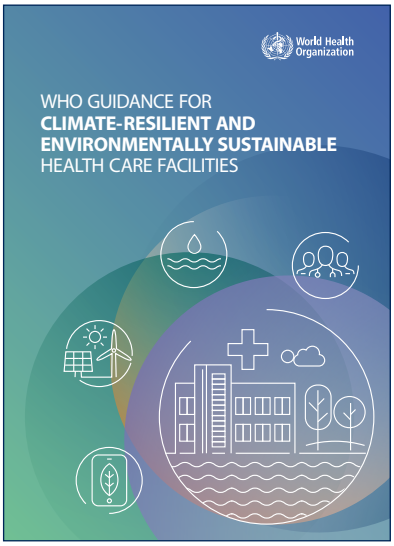
[13] Climate change [website]. Geneva: WHO; 2020 (*https://www.who.int/health-topics/climate-change#tab=tab_1*, accessed 25 August 2023).

[14] Take Five: "If you are invisible in everyday life, your needs will not be thought of, let alone addressed, in a crisis situation". UN Women; 2018 (*https://www.unwomen.org/en/news/stories/2018/7/take-five-matcha-phorn-in*, accessed 25 August 2023).

more difficult for persons with disabilities to reach WASH facilities. Hazards related to climate change exacerbate the vulnerabilities of persons with disabilities. During climate-driven disasters, persons with disabilities may be less able to escape from hazards, lose essential medications or assistive products such as spectacles or prostheses, be left behind when a community is forced to evacuate, or experience greater difficulty accessing basic needs and health service.[15] Water shortages due to drought can come in the way of hygiene and environmental cleaning practices, and can impede access to WASH to women during labour and delivery, reducing quality of care and worsening maternal and neonatal outcomes. Floods may cause sanitation systems to overflow, increasing risk of infection for all health facility users, particularly cleaning staff. Overcrowded facilities may deprioritize the needs of the marginalized in using WASH facilities or receiving high-quality care. Frustration and stress may even result in assault and violence against health facility staff or marginalized groups. For example, the risk of gender violence is enhanced during a climate-related event.

What should be done

As health-care facilities struggle to maintain services, people from marginalized groups may find it more difficult to have their needs and priorities heard and recognized. In this context, GEDSI integration in WASH in health-care facilities is even more critical, in health facility planning, practice and monitoring, as well as in national policies, guidelines and plans. Efforts to strengthen WASH in health-care facilities must adapt to and mitigate the impact of climate change, particularly on marginalized groups. Increased advocacy is needed to ensure that climate change is included in all GEDSI and WASH in health-care facilities-related discourse at all levels.



Many health facilities are adapting their operations and working to mitigate the impacts of climate change. Investments in WASH should also be aligned with these efforts, supporting climate resilience and protecting the environment. For more information on how investments in WASH in health-care facilities can support climate resilience while protecting the environment, refer to the *WHO guidance for climate-resilient and environmentally sustainable health care facilities (2020)*, and the Technical fact sheet 1 (Annex 6) of *WASH FIT, second edition (2022)*.

[15] Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022, (*https://www.who.int/publications/i/item/9789240063600* , accessed on 06 October 2023)

Resource 3:

Summary of global commitments

Global commitments and relevance	
Document	**Relevance**
Sustainable Development Goals (SDGs)	The SDGs, adopted in 2015 by 193 countries, provide a framework for achieving a 'better and more sustainable future for all' by the year 2030. Several SDGs are particularly relevant to strengthening inclusive WASH at health-care facilities: **SDG 3:** Ensure healthy lives and promote well-being for all at all ages **SDG 5:** Achieve gender equality and empower all women and girls **SDG 6:** Ensure access to water and sanitation for all **SDG 8:** Promote inclusive and sustainable economic growth, employment and decent work for all **SDG 10:** Reduce inequality within and among countries.
Leave no one behind (LNOB)	With the adoption of the 2030 Agenda, UN Member States pledged to ensure 'no one will be left behind' and to 'endeavour to reach the furthest behind first'. As one of the universal values for achieving the SDGs, LNOB involves reaching the poorest of the poor and combating discrimination and rising inequalities within and among countries, and their root causes.
GEDSI in health care	
Political Declaration on Universal Health Coverage (2019)[16]	The Political Declaration identifies key action areas to frame the political objectives, guide implementation, and accelerate action towards universal health coverage (UHC). Commitments aim to achieve UHC as a social contract, leave no one behind, create a strong, enabling environment responsive to people's needs, uphold quality of care, sustain public financing, establish multi-stakeholder mechanisms, redress gender–power dynamics, and promote strong and resilient health systems.

[16] Moving together to build a healthier world. United Nations High-Level Meeting on Universal Health Coverage. UHC2030 [website]. Geneva: UHC2030; 2019 (*https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/UN_HLM_2019/UHC_Key_Asks_final.pdf*, accessed 25 August 2023).

Global commitments and relevance	
Document	**Relevance**
Joint UN Statement on Ending Discrimination in Health Settings (2017)[17]	UN entities issued a statement reaffirming their commitment to address and end discrimination in access to health-care services. They agreed to support Member States to put in place guarantees against discrimination in law, policies and regulations; empower health workers and users of health services through attention to and realization of their rights, roles and responsibilities; support accountability and compliance with the principle of non-discrimination in health-care settings; and implement the United Nations Shared Framework for Action on Combating Inequalities and Discrimination.
Resolution 75/131 adopted by the General Assembly on 14: UN Decade on Healthy Ageing 2021–2030[18]	The resolution recognizes, acknowledges and reaffirms by calling upon Member States and other stakeholders to strengthen action to prevent, monitor and address the disproportionate effects of the COVID-19 pandemic on older persons, including the particular risks that they face in accessing social protection and health services, and to ensure that health-care decisions affecting older persons respect their dignity and promote their human rights.
United Nations Convention on the Rights of Persons with Disabilities (2006)[19]	Article 25 reinforces the right of persons with disability to attain the highest standard of health care, without discrimination across gender and age. Of the Member countries of the WHO South-East Asia Region, the Convention has been signed by Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal and Sri Lanka.
United Nations Convention on the Rights of the Child (1990)[20]	Article 24 commits State Parties to provide good quality health care, clean water, nutritious food, and a clean environment and education on health and well-being so that children can stay healthy. Of Member States in the WHO South-East Asia Region, the Convention has been signed by Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal and Sri Lanka.

[17] Joint United Nations statement on ending discrimination in health care settings. Geneva: UNAIDS; 2017 (*https://www.unaids.org/en/resources/documents/2017/ending-discrimination-in-health-care-settings*, accessed 25 August 2023).

[18] Resolution adopted by the General Assembly on 14 December 2020: 75/131. United Nations Decade of Healthy Ageing (2021–2030). New York: United Nations; 2020 (*https://digitallibrary.un.org/record/3896348?ln=en*, accessed 25 August 2023).

[19] Article 25 – Health. In Resolution 44:25: Convention on the Rights of Persons with Disabilities [website]. New York: UNDESA (*https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-25-health.html*, accessed 25 August 2023).

[20] Convention on the Rights of the Child. Resolution 44/25. New York: United Nations General Assembly; 1989 (*https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_44_25.pdf*, accessed 25 August 2023).

Global commitments and relevance	
Document	**Document**
WASH in health-care facilities	
World Health Assembly Resolution WHA72.7 on water, sanitation and hygiene in health-care facilities (2019)[21]	The Resolution calls on Member States to provide universal WASH in health-care facilities, aligning with global efforts and the eight practical steps. It commits Member States to the achievement of at least 50% of all health-care facilities globally and in each region to have basic WASH services by 2022, 80% by 2025 and 100% by 2030. During the discussion on the Resolution, countries highlighted the fundamental role of WASH in health-care facilities for achieving UHC, improving quality of care and in preventing the spread of antimicrobial resistance.
WHO Charter-Health worker safety: a priority for patient safety (2020)[22]	Launched on World Patient Safety Day 2020, the charter calls for urgent and sustainable action in a number of areas, including WASH. Priority actions include ensuring 'adequate environmental services, including water, sanitation and hygiene, disinfection, and ventilation, at all health-care facilities'.
The 2018 Declaration of Astana[23]	The Declaration reinforced the commitment of countries to strengthen primary health care (PHC) for accelerated progress on UHC and the SDGs. The resulting draft operational framework for PHC outlines a series of actions to align health systems according to PHC principles. The framework for PHC presents opportunities to invest in and strengthen WASH as a foundational aspect of quality of care.

[21] World Health Assembly, 72. Patient safety: water, sanitation and hygiene in health care facilities: report by the Director-General. World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/328712, accessed 18 September 2023).

[22] Charter: Health worker safety: a priority for patient safety. Geneva: WHO; 2020 (*https://www.who.int/docs/default-source/world-patient-safety-day/health-worker-safety-charter-wpsd-17-september-2020-3-1.pdf*, accessed 25 August 2023).

[23] Declaration of Astana: Global Conference on Primary Health Care. Geneva: WHO and UNICEF; 2018 (*https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf*, accessed 25 August 2023).

STEP

1

Conduct situation analysis and assessment

The goal of Step 1 is to conduct a situation analysis and a baseline assessment to guide planning and resource mobilization. The analysis examines health and WASH policies, governance structures, and funding streams, whereas an assessment provides updated figures on WASH coverage and compliance. Together, they form the basis for prioritizing action and mobilizing resources.

Step 1 provides the baseline information on the status of GEDSI in WASH in health-care facilities. The results of the assessment guide discussion about strategies and activities to improve inclusive and equitable WASH in health-care facilities; inform revisions of national strategies and guidelines to more effectively integrate GEDSI considerations; and support stakeholder engagement.

Empowering marginalized groups: The situation analysis and assessment should engage representatives of marginalized groups throughout the process, in line with the mantra: "Nothing About Us Without Us" from the global disability advocacy movement. This will help develop a better understanding of who is being left behind and how. Health-care professionals with varied experience (e.g. in inpatient and outpatient departments), and others in the health workforce (e.g. pharmacists, laboratory technicians and cleaning staff), will also be able to provide different perspectives.

Key questions for situation analysis and assessment

A situation analysis and assessment can help identify who is at risk of being left behind in WASH in health-care facilities; how GEDSI and WASH in health-care facilities are currently approached in national policies and guidelines; and who are the influential stakeholders that can effectively lead the effort.

1. Who are the marginalized population groups?

Tools such as poverty mapping, well-being ranking, social mapping, vulnerability assessments, and other participatory appraisals can help identify population groups who fare worse on social indicators and are likely to be left behind in efforts to improve WASH in health-care facilities. Defining who the marginalized groups are is a key step for understanding the barriers they face and engaging them in activities for improving WASH. **Tool 1.1** provides guidance on how to identify population groups marginalized in WASH in health-care facilities and less likely to benefit from IPC and patient-centred care.

2. What is the status of GEDSI in policies and programmes?

A review of national policies, standards and guidelines, and programme plans should assess what data is currently available on accessibility and acceptability of WASH to health facility users and on patient-centred care, and whether any actions have been planned to address the barriers experienced by different groups.

If GEDSI is a strong element of existing policies, standards and guidelines related to WASH in health-care facilities, what were the facilitating factors that made it happen? Conversely, if GEDSI is not currently integrated, why not? Understanding the context for GEDSI integration is necessary for developing effective strategies. The review should also determine whether marginalized population groups were consulted to make sure their needs and priorities related to WASH in health-care facilities are understood and addressed.

Tool 1.2 provides a checklist to support GEDSI linked assessments of national policies, standards and guidelines related to WASH in health-care facilities. Further, consultations with with experts and representatives from marginalized groups will also support policy and programme analysis. Below is an illustrative list of stakeholders who can provide expertise to better understanding the context of GEDSI in WASH in health-care facilities and those who can help integrate GEDSI in WASH in health-care facilities.

3. Who are the stakeholders?

Alongside identification of marginalized groups and analysis of policies and programmes, developing an understanding of stakeholders is critical. Inclusive WASH in health-care facilities lies at the intersection of many domains. The process of identifying stakeholders should look at building insights on who are the stakeholders that can help integrate GEDSI in WASH in health-care facilities and what roles can they play: advocates, technical resource persons, change influencers, etc. While at this stage you will only be mapping stakeholders, ideas for the kind of stakeholders and their roles can be drawn from a tool in a subsequent chapter, i.e. **Step 3, Resource 3.2**. This resource provides examples of stakeholders, their role in holding health systems accountable for inclusive WASH.

Stakeholders well informed about GEDSI
Organisations run by or working with different marginalized groups (indigenous communities, women, persons with disabilities)
Service providers specifically working with marginalized groups, e.g. occupational therapists, volunteers and outreach teams from indigenous communities
Staff working on health and/or WASH, e.g hospital administrators, doctors, nurses, WASH engineers
Stakeholders with more power to influence change
Ministries of health, water and sanitation or environment, social welfare, gender, and/or disability
Elected representatives and local administration

Resources and Tools

Tool 1.1: Who is left behind in WASH in health-care facilities

Guidance on determining which population groups have less access to acceptable WASH in health-care facilities and are less likely to benefit from IPC and patient-centred care

Tool 1.2: Checklist for policy and programme analysis

A checklist to assess content related to GEDSI in national policies, guidelines, and standards related to WASH in health-care facilities

Tool 1.1:

Who is left behind in WASH in health-care facilities[24]

Note: General Comment No. 14 on the Right to the Highest Attainable Standard of Health states that all health services, goods and facilities must be available, accessible, acceptable and of good quality (UN CESCR, 2000). The terms availability, accessibility, acceptability and quality are known as AAAQ and are featured in the Tanahashi framework (1978). These and other parameters (+) are used below to understand populations left behind in WASH in health-care facilities.

1. Characterize and describe how different health facility users risk being left behind in relation to WASH in health-care facilities

A preliminary analysis should identify which subpopulations risk being left behind as a result of barriers in five areas, summarized as AAAQ+. An illustrative example is provided below.

	AAAQ+	Who is being left behind
A	Availability of improved WASH	**Example:** People in rural or slum areas where health facilities lack WASH.
A	Access to WASH	**Example:** Persons with disabilities, or people whose language is not used in hygiene counselling and WASH guidance. **Example:** People who risk discrimination and violence in using public WASH facilities, e.g. LGBTQIA+.
A	Acceptability of WASH	**Example:** People with different cultural beliefs about menstruation, health facility staff need for privacy.
Q	Equitable use of WASH for quality of care: IPC and patient-centred care	**Example:** Patients who experience discrimination in the health facility setting, e.g. people living with HIV (PLHIV).
+	Community/health facility user engagement in improvement of WASH	**Example:** Migrant workers speaking a different language or mothers with caregiving responsibilities for small children.

2. Explore the barriers faced by different groups of health facility users

Based on the analysis about which subpopulations risk being left behind, the assessment should explore each subpopulation's WASH-related needs at the health-care facility.

[24] Adapted from: The Innov8 approach for reviewing national health programmes to leave no one behind: Technical handbook. Geneva: WHO; 2016 (*https://apps.who.int/iris/bitstream/handle/10665/250442/9789241511391-eng.pdf?sequence=1*, accessed 25 August 2023).

Subpopulation	**Physical barriers** (natural environment, built infrastructure)	**Social and attitudinal barriers** (information, social norms, beliefs, shame)	**Institutional** (organizational rules, policies, systems and strategies)
Example (for a hypothetical health facility WASH programme): Young children	**Example:** Young children are too short to reach most toilets and handwashing stations.	**Example:** Young children are dependent on their caregivers for help. Their opinions and needs may be disregarded.	**Example:** There are no hygiene education materials that could be easily understood by children (e.g. posters).
Example (for a hypothetical health facility WASH programme): PLHIV	**Example:** If ill, may require support to use the latrine. Latrine needs to accommodate caregiver.	**Example:** Due to discrimination, the WASH needs of PLHIV may be neglected by health facility staff. They are also not invited to participate in health facility-community committees.	**Example:** HIV programmes do not include hygiene materials.

3. Use quantitative and qualitative data to verify preliminary analysis of inequalities in WASH in health facilities

Review existing quantitative and qualitative data to confirm and collect more information on the subpopulations that risk being left behind in improvements in WASH in health-care facilities.

- **Quantitative data** measure numbers and are often collected through surveys (e.g. demographic and health surveys, multiple indicator cluster surveys, etc.) or routine data reporting (e.g. from health facilities). To be useful in understanding the differences between subpopulations, the data must allow disaggregation and analysis by different subpopulation characteristics (e.g. gender, age, income, education, occupation, race or ethnicity, place of residence, migrant status, etc.)
- **Qualitative data** describe characteristics, and are often collected through interviews or focus group discussions (FGDs). Such data may provide information on specific subpopulations, which are not available through quantitative means.

AAAQ+	Populations that risk being left behind in WASH improvements	Verification done through which data sources
Increasing availability of improved WASH	**Example:** Slum residents whose health facility has no WASH at all.	**Example:** Health facility audit
Ensuring WASH accessibility	**Example:** Older adults who lack the physical dexterity to use the toilets that are currently available.	**Example:** FGDs with older patients at health-care facility
Ensuring WASH acceptability	**Example:** Women and girls who lack access to facilities for MHM.	**Example:** Patient/visitor experience interviews, interviews with health facility staff
Increasing equitable use of WASH for IPC and quality care	**Example:** Nurses and midwives who do not have a toilet separate from the patients.	**Example:** Interviews with health facility staff, health facility data on workplace infections
Community/health facility user engagement in improvements in WASH	**Example:** Adolescent girls and young women whose needs are not understood because they are considered too inexperienced to participate in committees.	**Example:** Community FGDs with identified marginalized groups

Tool 1.2:

Checklist for policy and programme analysis[25]

To prepare for the analysis, collect any national documents related to WASH in health-care facilities, such as policies, standards and guidelines. The checklist is a rapid assessment tool and will not provide you with the kind of details that a more thorough GEDSI analysis of an existing policy or programme would provide.[26] After going through the checklist, you can also follow-up with health or WASH programme managers, statistics departments or institutes, or organizations representing marginalized groups to obtain additional clarification.

Checklist for policy and programme analysis	
Question	**Comments**
Data and evidence	
Are disaggregated data presented (e.g. age, sex, disability status, etc.)?	
Do the documents identify discrepancies in WASH and health-care service delivery and provide information on their causes?	
Does the policy/programme provide data on the differential needs of specific subpopulations?	
Have knowledge and information that exist on GEDSI, WASH, and health from sources other than health indicators and/or reports been used as part of the evidence base?	
Goals and objectives	
Do the goals and objectives of the policy/programme have an explicit commitment to leaving no one behind or to reducing social inequalities?	

[25] The Innov8 approach for reviewing national health programmes to leave no one behind: Technical handbook. Geneva: WHO; 2016. (*https://apps.who.int/iris/bitstream/handle/10665/250442/9789241511391-eng.pdf?sequence=1*, accessed 25 August 2023) and Gender mainstreaming for health managers: a practical approach. Participant's notes. Geneva: WHO; 2011 (*https://apps.who.int/iris/bitstream/handle/10665/44516/9789241501064_eng.pdf?sequence=2&isAllowed=y*, accessed 25 August 2023).

[26] For example: The Gender Responsiveness Assessment Scale (GRAS) and the Gender Assessment Tool (GAT) described in the "Gender mainstreaming for health managers: a practical approach". Geneva: WHO; 2011 (*https://apps.who.int/iris/handle/10665/44516*, accessed 18 September 2023).

Checklist for policy and programme analysis	
Question	**Comments**
Do the policy/programme goals and objectives link with the gaps and needs supported by the data/evidence?	
Programme targets	
Does the policy/programme identify targets that specify marginalized groups?	
Target populations	
Does the target population of the policy/programme prioritize any subpopulations? (e.g. by gender, age groups, disability, race, ethnicity, income or education groups, people with specific occupations, religious/ faith communities, area of residence, migrants, etc.).	
Technical design	
Are interventions, services and activities differentiated for any subpopulations?	
Are the interventions, services and activities linked with evidence on the identified gaps and needs?	
Do the interventions, services and activities consider the contexts within which the target population(s) live?	
Does the design consider WASH issues that may otherwise not be discussed due to social taboos? (e.g. menstruation, incontinence).	
Does the policy/programme aim to increase availability of improved WASH in health-care facilities, especially for marginalized or under-served groups?	

Checklist for policy and programme analysis	
Question	**Comments**
Does the policy/programme aim to increase accessibility of improved WASH in health-care facilities, especially for marginalized or under-served groups?	
Does the policy/programme aim to increase acceptability of improved WASH in health-care facilities, especially for marginalized or under-served groups?	
Does the policy/programme link inclusive WASH with IPC?	
Does the policy/programme link inclusive WASH with patient-centred care?	
Have implementation difficulties been anticipated for the above set of programme interventions, especially with regard to marginalized or under-served groups?	
Does the design include training and orientation for facility staff about the specific needs, preferences and barriers faced by specific marginalized groups and what they can do to address them?	
Stakeholder engagement	
Did policy/programme development for WASH in health-care facilities include rights groups and representatives from each of the marginalized groups?	
Did policy/programme development engage a range of health facility workers such as doctors, nurses, pharmacists, laboratory technicians, cleaning staff, and others from both inpatient and outpatient departments, to provide different perspectives?	

Checklist for policy and programme analysis	
Question	**Comments**
Did policy/programme implementation or action plans identify meaningful roles and responsibilities for marginalized groups?	
Is there a mechanism for engaging marginalized population groups?	
Do any marginalized groups participate in the planning and implementation of the policy/programme?	
Monitoring and evaluation	
Are there indicators for monitoring disparities in WASH in health-care facilities?	
Are there feasible mechanisms for data collection for each of the indicators?	
Is there a plan for review and continuous monitoring of disparities?	
Do any marginalized groups participate in the monitoring, review and evaluation of the policy/programme?	
Financing	
Is there a budget for implementing activities that benefit marginalized groups, including both technical and monitoring activities?	

Case study: Multitool assessment of gender equality in WASH in health facilities in India [27, 28, 29]

To understand how women in Maharashtra, India, experience WASH at their health-care facilities, the Swiss Federal Institute of Aquatic Science and Technology and Tata Institute of Social Sciences used three methods to assess infrastructure for WASH at the facility and to obtain feedback from the users.

1. **Semi-structured interviews** to ask health facility users about WASH and topics around menstrual hygiene management (MHM), pregnancy and childbirth. The respondents represented six user groups: outpatients, inpatients, attendants, medical staff, cleaning personnel, managers and administrators, and both female and male in all groups. Special emphasis was made to include vulnerable groups such as menstruating woman, pregnant women, and postpartum women.

2. **Focus groups discussions (FGDs)** to capture the WASH-related experiences, needs and priorities of inpatients and their attendants: Participants discussed challenges related to their experiences on WASH in the health-care facility, identified the causes of the problems, and developed potential solutions.

3. **Infrastructure spot-check** to assess infrastructure for WASH at the health-care facility and triangulate the user perception data from the FGDs and semi-structured interviews.

Lessons learnt on study design: Based on the implementation of the study, the partners made several recommendations, including:

- Studies should involve lower-level staff such as attendants who play a large role in supporting WASH in the health facility.
- To understand the complexity of WASH services in health-care facilities, studies must move beyond infrastructural assessment towards a holistic evaluation that includes WASH user and provider perspectives.
- Use of multiple research methods brings added value and more comprehensive insights.

The assessment also highlighted the need to ensure that issues such as operation and maintenance of WASH facilities, MHM, interaction between users, providers and health facility management, and community engagement are not forgotten in policies and strategies on WASH in health-care facilities.

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[27] Kohler P, Renggli S, Lüthi C. WASH and gender in health care facilities: the uncharted territory. Health Care Women Int. 2019;40:3–12. doi: 10.1080/07399332.2017.1395440.

[28] Kohler P. Genderised WASH – How Indian and Ugandan health centres manage the sanitation needs of special user groups. Presentation at the WHO/UNICEF WASH in health care facilities Global Learning Event, Kathmandu, Nepal; 2017 (https://www.washinhcf.org/resource/genderised-wash-how-indian-and-ugandan-health-centres-manage-the-sanitation-needs-of-special-user-groups/, accessed 25 August 2023)

[29] Kohler P, Renggli S, Lüthi C. WASH and gender in health care facilities: the uncharted territory. Health Care Women Int. 2019;40:3–12. doi: 10.1080/07399332.2017.1395440.

STEP

2

Set targets and define roadmap

The goal of Step 2 is to develop detailed targets and a national roadmap to address gaps and estimate costs for WASH in health-care facilities. The roadmap, supported by an intersectoral national team, outlines the approach, intervention areas, responsibilities, targets, and budget for WASH improvements over a defined period of time.

To ensure that the roadmap explicitly addresses GEDSI and that GEDSI continues to be a priority during implementation and monitoring of the other practical steps, there must be a clear governance mechanism for GEDSI in WASH in health-care facilities. This involves establishing structures such as a national task force to champion GEDSI integration, and processes to regularly assess GEDSI needs, monitor progress, and improve performance.

Inclusion of marginalized groups within the task force for WASH in health-care facilities

An effective strategy to support GEDSI integration within targets and roadmaps for WASH in health-care facilities is with the support of an **intersectoral, inclusive task force**. Establishing such a task force signals dedication to promoting equity and inclusivity.

An inclusive national task force includes representatives from organizations for women, persons with disabilities, PLHIV, LGBTQIA+, and unions of health-care staff, who are instrumental in providing the task force with insights and practical suggestions on how GEDSI can be integrated in WASH policies, plans and programmes of health-care facilities. An inclusive taskforce helps ensure that diverse perspectives are considered; it also provides representatives of marginalized groups with opportunities to lead planning and improvement of WASH in health-care facilities; and allows for coordinated efforts and collaboration among different stakeholders leading to more holistic and effective solutions.

Engaging different departments of the national and local governments – such as development planning, public works, health and environmental departments – is key to achieving GEDSI in WASH targets.

"Nothing about us without us"

When seeking participation of marginalized groups in the task force, it is important to ensure that the meetings are organized and structured based on their specific needs. **Tool 2.1** provides guidance for conducting task force meetings that are inclusive.

Key areas of work for the national task force include:

- **Advocacy and awareness:** Champion GEDSI principles within the broader health-care community and raise awareness about the importance of inclusive WASH policies and practices. Inclusive WASH policies guide decision-making and ensure that sufficient resources are allocated for inclusive WASH infrastructure

and services. Strong leadership and commitment from local and political leaders at all levels will be essential to drive GEDSI integration. **Tool 2.2** provides guidance on conducting advocacy to build consensus on GEDSI in WASH in health-care facilities.

- **Leadership:** Provide strategic direction to integrate GEDSI in the roadmap and targets for WASH in health-care facilities, in implementation of plans and budgets, and review and improve activities to better meet the needs of marginalized groups.
- **Foster accountability:** Guide development of GEDSI standards, and systems to monitor and improve performance in health-care facilities *(Step 3)*.
- **Support roll-out of GEDSI activities:** Monitor and support implementation of GEDSI-related activities in the national roadmap at the local level *(Steps 4 and 5)*.
- **Capacity building:** Guide training and capacity-building initiatives to sensitize local leaders, health facility staff, and WASH stakeholders about GEDSI issues *(Step 6)*.
- **Support collaboration:** Facilitate linkages between local government and organizations representing marginalized groups to build understanding and identify ways of working together to improve WASH in health-care facilities *(Step 7)*.
- **Assessments and learning:** Guide national assessments on the status of GEDSI in WASH in health-care facilities, and evaluations of GEDSI-related activities *(Steps 1 and 8)*.

Integrating GEDSI in targets and roadmaps for WASH in health-care facilities

The integration of GEDSI activities within the national roadmap for WASH in health-care facilities will provide a plan for action, ensure that these activities are costed for, and a mechanism is identified for coordination at the national and local levels. The roadmap serves as the basis on which partners, donors and government agencies engage, track progress and target resources for GEDSI-related infrastructure and human resources.

Concerns related to GEDSI can be considered across all areas of roadmap development, from definition of relevant goals, targets and activities, budgets, and mechanisms for implementation and monitoring. **Tool 2.3** provides a checklist for inclusive roadmaps for WASH in health-care facilities.

Specific GEDSI activities can be developed in response to the barriers to WASH identified in the analysis and assessments under Step 1. In addition to addressing current barriers, the roadmap should be forward-looking to anticipate and prepare for future needs and priorities that may emerge, considering issues such as the impact of climate change. Some examples of barriers and interventions to address them are suggested in **Resource 2.1.**

Reviewing progress and adapting to ensure responsiveness to marginalized groups

The national task force should review progress regularly to identify what activities are having the intended results, and what activities are proving to be difficult. The roadmap may need to be updated to address emerging challenges or changes in the context for inclusive WASH in health-care facilities. For example, if faced with a cholera outbreak, resources may need to be diverted to accelerate WASH activities in affected geographical areas. GEDSI integration will be particularly important during emergency responses, as people who are marginalized are often those who are the most impacted.

Resources and Tools

Tool 2.1: Tips for planning and running inclusive task force meetings

Guidance on how to ensure that task force meetings support inclusion

Tool 2.2: Conducting advocacy to build consensus on GEDSI in WASH in health-care facilities

Guidance on how to engage diverse stakeholders in dialogue on how to integrate GEDSI in WASH in health-care facilities

Tool 2.3: Checklist of considerations for roadmap development

A checklist to ensure full consideration of GEDSI during development of roadmaps for WASH in health-care facilities

Resource 2.1: Examples of barriers to GEDSI integration and potential activities to address them

This resource lists some examples of physical, social, cultural, institutional, policy/legislative barriers to GEDSI integration and potential activities to address them

Tool 2.1:

Tips for planning and running inclusive task force meetings[30]

This tool offers six tips to organizing inclusive meetings to ensure equal participation of diverse task force members. It has been adapted from a World Vision and Christian Blind Mission guidance note. The United Nations Disability Inclusion Strategy also provides very detailed guidelines on how to consult and involve persons with disabilities.[31]

The tips provide a starting point: given that local contexts and individual needs will vary widely, it is best to ask all task force members what support they require to fully participate. In some situations where there are large power imbalances, separate meetings may be needed for some marginalized groups to be able to speak comfortably.

1. Identify and specifically invite people from marginalized groups

- √ Ask local organizations representing marginalized groups (e.g. women, persons with disabilities, the elderly, people from lower income or education groups, indigenous groups, LGBTQIA+, etc.) for advice on how to get the message out and invite their members to participate.
- √ Ensure that all invitations and material used to advertise the meeting or event show that marginalized groups are welcome and that the event is accessible.
- √ Meet with the representatives in advance to provide them an overview of the technical WASH content, meeting objectives, and how they can most effectively contribute.

2. Find out whether particular assistance or support is required to enable attendance and active participation in the meeting/event

- √ Ask if task force members from marginalized groups need any additional support (such as sign language interpreters or accessible transport or venue).
- √ Adjust meeting times to accommodate time constraints of specific groups, e.g. women, persons with disabilities who may need longer travel time.
- √ Ensure that it is clear who participants should contact.

3. Ensure promotional and meeting material is accessible

- √ Ask how people prefer to access written material (e.g. braille, large print or electronic format) and provide materials in this format wherever possible.
- √ Try and present information in both visual and audio formats.

[30] Adapted from: Six tips for planning and running inclusive meetings and events. Box Hill: CBM and World Vision.

[31] United Nations Disability Inclusion Strategy. Guidelines, Consulting with persons with disabilities, Indicator 5, United Nations, 2021 (*https://www.un.org/sites/un2.un.org/files/un_disability-inclusive_consultation_guidelines.pdf* , accessed on 06 October 2023)

- √ Use signs in large print and clear font to guide people to the venue or meeting room.

4. Choose an accessible venue

- √ Check that the venue is physically accessible by all users and includes accessible toilets, dining areas (if providing food), wheelchair access (ramps and wide doorways) and good lighting.
- √ Reserve seating or space for persons with disabilities and the elderly, particularly in crowded venues. Ensure there is space for wheelchair users.

5. Use inclusive communication

- √ Ask a person what type of communication is best for them – for example, sign language, lip-reading, with help from a family member. If a person uses sign language, it is important to have a sign interpreter.
- √ Open the meeting by asking participants to speak slowly and use clear language to facilitate translation, interpretation and understanding for persons with disabilities, and those for whom the language spoken is not their native language.
- √ Introduce yourself to a person with vision impairment each time before you speak.
- √ Discuss sensitive topics (e.g. menstruation) in safe spaces where women feel comfortable.

6. Facilitate active participation during the meeting/event

- √ Ask participants where they would like to be seated, to facilitate access to/from the area, and to assist lip-reading, use of sign interpreters or language translation services.
- √ Ask people from marginalized groups if they would like to be paired with another person who could help in individual or group activities.
- √ Treat the person with respect at all times and ask their opinion in discussions.

Follow-up after the meeting: obtain feedback on whether the participants were able to fully participate as equal partners.

Tool 2.2:

Conducting advocacy to build consensus on GEDSI in WASH in health-care facilities[32]

The importance of GEDSI in WASH in health-care facilities can be a difficult concept to understand and embrace. You may need to conduct advocacy to gain the support of key stakeholders for integration at the national and health facility levels.

Advocacy: The act or process of influencing decision-makers, stakeholders and other audiences to support a cause. In the context of GEDSI in WASH in health-care facilities, advocacy is strategic communication to influence policy or programme decision-making at the international, national, community and facility levels about why GEDSI is essential to ensure the full impact of WASH in health-care facilities. The engagement of marginalized groups themselves is essential to ensure that their needs are heard and to bring credibility to the activity. At the same time, you need to anticipate potential negative pushback of the advocacy effort and take steps to mitigate the impact on the marginalized groups.

Conducting an advocacy campaign includes several steps:

1. Identify the issues

Under Step 1, you defined who are the marginalized groups and the barriers they face in relation to WASH in health-care facilities. This evidence will strengthen your credibility and enable you to create a rational, convincing argument. It will also provide you with the information you need for planning, developing your messages, and carrying out the advocacy activities.

2. Prioritize issues for advocacy and select the advocacy objective

Based on the evidence, you will next identify the urgent and/or vital issues that you can influence and narrow down your focus. Do you want to:

- Integrate GEDSI into the national WASH in health-care facilities roadmap, standards or guidelines, supported by a sufficient budget?
- Confirm that the GEDSI activities in the roadmap are implemented, and WASH at health-care facilities are up to standard, including standards for GEDSI?
- Convince the district health officer, the health facility supervisor, and/or manager to integrate GEDSI into their supervision and support at health facilities?
- Persuade health facility staff that integrating GEDSI into WASH will make the facility a better place to work and result in better health outcomes?

[32] Adapted from: Advocacy Toolkit for WASH in health care facilities: Toolkit 1 Local Government. Delhi: WHO SEARO; unpublished.

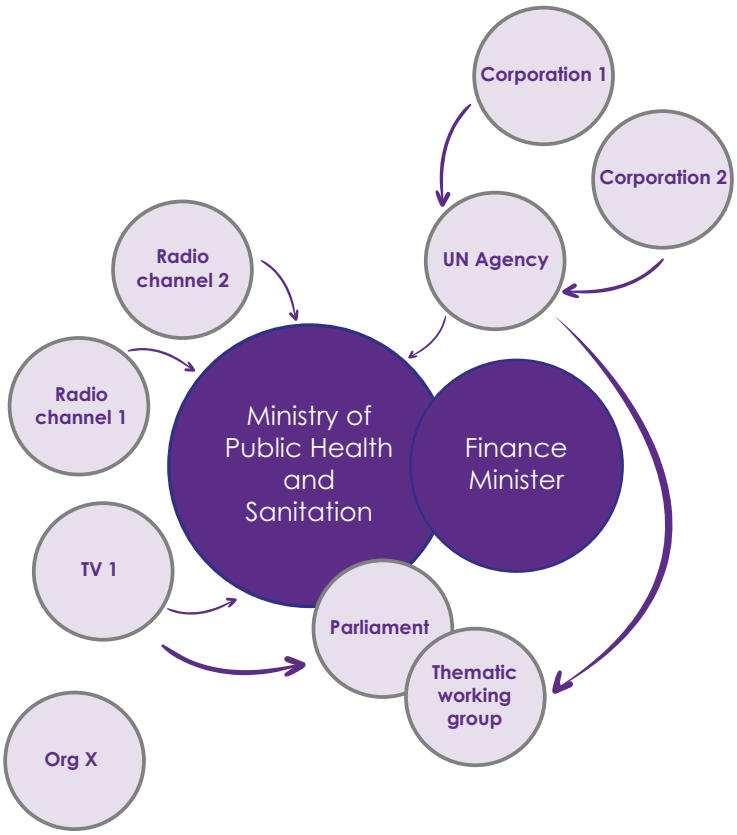
- Encourage communities and, specifically, marginalized groups within communities, to work with the health facility on integrating GEDSI in WASH?

You may choose to first focus on issues that can be easily changed – the **"low hanging fruits"** that will be a quick win and that can also be an example to the decision-maker to encourage them to support further.

3. Map the stakeholders

The next step would involve understanding who the decision-makers are and who are the influencers that can help you reach your message to the decision-makers. To understand the influence of stakeholders on a policy decision and on each other, start by listing broad categories and fill in specifics for each category (some illustrative stakeholders are described in **Step 3, Resource 3.3**). Then determine what are the relationships between the stakeholders, who influences whom, and who has the most power. Visual mapping tools such as "Power mapping", "Influence mapping", and "Chapati or Venn diagrams" can be helpful in visualizing who is an important stakeholder and who is influential. The diagram below shows how different stakeholders like media, corporations etc influence each other.

Advocacy linked influence mapping example



Based on this, stakeholders can be categorized further as below. You can tailor your advocacy on the basis of this categorization. These listings and categorizations are not static but rather change with change in the environment and context.

		Influence of the target audience on the issue		
		Low	**Medium**	**High**
Importance of the issue to the target audience	**High**	▪ Secondary audience ▪ Mitigate impacts	▪ Priority audience ▪ Collaborate with	▪ Priority audience ▪ Collaborate with
	Medium	▪ Monitor or ignore	▪ Secondary audience	▪ Priority audience ▪ Collaborate with
	Low	▪ Monitor or ignore	▪ Monitor or ignore	▪ Secondary audience ▪ Involve, build capacity

4. Select advocacy tactics

Advocacy most often entails the use of more than one tactic to be effective. Multiple ways of influencing a decision, repeated emphasis on the key advocacy messages are required to reach decision-makers. Some examples of advocacy tactics are provided below:

- **Media advocacy:** Can influence public perception and issues attracting media coverage serve as trigger for political action. However, it might be difficult to attract media attention.
- **Lobbying with the government:** Meeting influential officials, exposure visits, and events gives you the opportunity to understand the leanings of the decision-makers and address their concerns.
- **Working with champions and spokespersons:** Celebrities and technical experts can bring tailored attention to the issue. However, the message depends on their reputation and credibility.
- **Social media:** An opportunity to reach large numbers faster. However, needs incisive insights and specialization for targeting the right audience segments and positioning content.
- **Alliance building:** Useful when you need to reach multiple stakeholders and audiences. However, decision-making, follow-up and coordination can be a challenge.

Incorporate the tactics into an advocacy plan that outlines your objective and what you want to achieve (interim outcomes), who can make it happen (target audience), what they need to hear (message), how to reach them (channel), what materials/information are needed, and how will you measure success.

5. Craft an effective message

A message is a clear, concise and compelling statement about what needs to be done to integrate GEDSI in WASH in health-care facilities and why. Simple and direct messages have the greatest power to attract attention. In developing your message, you need to consider the target audience's interest and knowledge, the concerns they have, and how they can be motivated. The question is: what is in it for them?

These sample advocacy messages for key stakeholders working in the area of GEDSI in WASH in health-care facilities can help you develop your own messages based on your context. Test the messages and the materials to confirm they are effective and easily understood.

Sample audience-specific messages	
Target audience	**Sample messages**
Government health officials and working groups	Maximize the impact of WASH in health-care facilities by ensuring that it can be accessed and used by everyone. Leave no one behind! ■ Integrate a focus on marginalized groups into national standards for WASH in health-care facilities. ■ Allocate sufficient budget for ensuring that WASH improvements benefit everyone.
Government water and sanitation officials and working groups	Water and sanitation designs need to meet the needs of all users. ■ Provide sustainable management models and technical expertise on selection, operation and management of WASH infrastructure and technologies that ensure accessibility and acceptability.
Local administration, community leaders, municipality board	WASH is a priority for health facility users, resulting in satisfied patients and a better working environment. Satisfied people are happy voters. ■ Ensure marginalized groups have a voice on committees working to improve WASH in health-care facilities. ■ Allocate funds to ensure that WASH improvements at health-care facilities meet the needs of all users.

Sample audience-specific messages	
Target audience	**Sample messages**
Health facility administration	The benefits of WASH can be maximized by making sure WASH is accessible and acceptable for all users, and used to improve quality of care. ■ Ask marginalized groups about their WASH needs and priorities during a health facility WASH assessment. ■ Increase the accessibility and acceptability of WASH to all users. ■ Ensure health facility staff support WASH needs of all patients.
Health-care facility staff	Contribute to a better work environment and more satisfied patients by ensuring everyone's WASH needs and priorities are met. ■ Speak up to have your WASH needs and priorities heard. ■ Ask your patients about their WASH needs and priorities. ■ Advocate for WASH needs of your patients.
NGOs and civil society organizations (CSOs) representing marginalized groups	Everyone has an equal right to WASH in health-care facilities. ■ Provide leadership and technical support to ensure that the needs and priorities of your communities are heard. ■ Participate in a committee/task force on WASH in health-care facilities and make your voice heard. ■ Mobilize members of the marginalized groups to speak up about their WASH needs.
Members of marginalized groups	You have equal right to have accessible and acceptable WASH. ■ Engage in the health facility's WASH committee to ensure that barriers to accessibility, acceptability, and equitable use of WASH are removed. ■ Speak up to have your WASH needs and priorities heard.
Community groups	The community is strongest when everyone works together. ■ Talk about what barriers community members have faced in using WASH at the health-care facility. ■ Engage in the health facility's WASH committee to ensure that barriers to accessibility, acceptability, and equitable use of WASH are removed.

Tool 2.3:

Checklist of considerations for roadmap development

The checklist below will assist you to integrate GEDSI into planning and programming for WASH in health-care facilities by highlighting key questions for consideration.[33]

Defining the scope, vision, and target audience for WASH in health-care facilities	**Yes**	**No**
Is GEDSI reflected in the scope and vision for WASH in health-care facilities?		
Are marginalized groups involved in the design phase, as beneficiaries and as programme staff members?		
Does the target audience for WASH in health-care facilities define specific marginalized groups? If not, why not?		
Setting goals or objectives and selecting targets		
Does at least one goal or objective explicitly address GEDSI?		
Does the roadmap include targets for inclusive WASH, aligned with WHO/UNICEF Joint Monitoring Programme's (JMP) definition for basic sanitation?		
Have other stakeholders or partners, particularly representing marginalized groups, participated in setting goals and objectives?		
Developing activities		
Was the context of marginalized groups' lives, and their WASH needs and priorities at health-care facilities taken into consideration?		
Have specific activities been identified that meet the needs of different groups?		
Are all aspects of WASH considered, including water and sanitation facilities and services as well as hygiene behaviours and products?		
Do methods and activities identify ways to address social and gender norms that undermine the benefits of WASH in health-care facilities? (e.g. disrespect, mistreatment, gender bias and discrimination)		
Have stakeholders and partners, particularly from marginalized groups participated in developing activities?		

[33] Adapted from: Gender mainstreaming for health managers: A practical approach. Participant's notes. Geneva: WHO; 2011.

Defining the scope, vision, and target audience for WASH in health-care facilities	Yes	No
Do activities ensure a continuing planning, implementation and monitoring role for marginalized groups?		
Preparing a budget		
Does the budget include lines for work on GEDSI in WASH in health facilities?		
Have representatives from marginalized groups been consulted to estimate planned costs?		
Task force composition		
Does the task force include members from marginalized groups?		
Does the task force have an established mechanism for sharing information on GEDSI?		
Implementing activities		
Are mechanisms put in place to ensure that programme implementation will maintain a focus on GEDSI?		
Do programmatic materials or publications reinforce stereotypes of marginalized groups?		
Do members of marginalized groups participate equally in the implementation stage – both as beneficiaries and as programme staff members?		
Monitoring and evaluation (M&E)		
Does the M&E plan collect data that allows disaggregation for marginalized groups?		
Does the M&E plan collect and analyse data specific to marginalized groups and use the findings to refine programme design and delivery?		
Have sources of information for M&E, including those for aspects related to GEDSI, been identified?		
Does the M&E plan monitor progress towards inclusive WASH at the health-care facility?		
Have women and men, persons with disabilities, the elderly, LGBTQIA+, and people from other marginalized groups participated equally in the M&E stage – both as beneficiaries and as programme staff members?		

Resource 2.1:

Examples of barriers to GEDSI integration and potential activities to address them

Type of barrier	Illustrative activities
Policy and legislation barriers (i.e. absence of effective governance and coordination mechanisms, which can hinder GEDSI integration)	• Increase coordination between departments and units working on health, WASH, gender, disabilities, poverty, etc. for WASH in health-care facilities. • Establish and implement non-discrimination policies in the health sector. • Implement laws with mandatory access standards for WASH in health-care facilities. • Integrate GEDSI in policies, guidelines and plans related to WASH in health-care facilities. • Document and disseminate information to guide and advocate national decision-makers for more inclusive WASH at health-care facilities.
Institutional barriers (i.e. unavailability of systems and processes or infrastructure, supplies, within the health facility that may disadvantage certain groups of people)	• Train and mentor WASH and health sector managers, and health facility staff in inclusive WASH at health-care facilities. • Identify sources of funds to support WASH improvements. • Integrate GEDSI in supervision and monitoring processes. • Include hygiene supplies, such as sanitary pads or napkins for menstruation and incontinence, and personal protective equipment (PPE) in various sizes in the list of supplies for each health centre. • Ensure reasonable accommodation/adjustments for persons with disability if WASH is not accessible. • Promote health-care worker compliance with quality standards related to IPC and patient-centred care, including WASH-related practices. • Orient health-care workers to the different cultural beliefs and practices in the community (and among their patients), and to the needs of LGBTQIA+ individuals. • Provide hygiene education materials in different languages and appropriate for different cultures.

Type of barrier	Illustrative activities
	• Develop structures and processes to engage marginalized groups in planning, improving and monitoring WASH in health-care facilities, including patients, caregivers, as well as health facility staff.
Social and cultural barriers (i.e. obstacles or conflicts that may arise in the process of communication due to differences in social backgrounds, norms, beliefs and practices among individuals or groups)	• Identify and empower representatives of marginalized groups in the community and in the health facility to engage in WASH decision-making. • Provider training and community dialogue to address myths and taboos around menstruation, disability, etc. • Promote IPC and patient-centred care for *all* health facility users. • Provide separate stalls for women and men, patients and staff. • Ensure privacy and safety for WASH users at health-care facilities.
Physical barriers (i.e. structural obstacles that prevent or block mobility within the facility premises)	• Conduct health facility WASH assessments using WASH FIT or similar frameworks. • Identify resources to support infrastructure improvements such as: ❍ Install ramps instead of steps. ❍ Install handrails and/or seat for support. ❍ Place a step stool with handrails in the handwashing area so a child can properly reach the handwashing station, while also ensuring sufficient circulation space under the basin for wheelchair users. ❍ Locate washbasins and MHM disposal bins near women's toilets. ❍ Use drawings instead of letters to indicate types of WASH facilities. ❍ Include options for toilet designs that have accessible pathways and sufficient space inside for wheelchair users to be able to propel their chair, while also ensuring that the designs appeal to varying cultural norms. ❍ Install water sources in delivery rooms and maternity wards. ❍ Provide adequate lighting in toilet blocks and cubicles. ❍ Ensure availability of toilets in maternity department and that women with limited mobility (especially around time of delivery) are catered for.

Case study: GEDSI in Bhutan's national strategy for WASH in health-care facilities

Bhutan has made concerted efforts to improve sanitation and hygiene and to increase the involvement of disadvantaged groups including women-headed households, the elderly, and persons with disabilities. However, an assessment of WASH in health-care facilities by the Ministry of Health in 2019 found that although 99% of health facilities had improved toilets and 84% were usable, only 31% were gender-segregated, 16% had menstrual health and hygiene management facilities, and 31% were accessible to people with limited mobility.

The National Strategy for Water, Sanitation, and Hygiene in Health care Facilities: Framework for Action (2021–2030), was developed to address these gaps and achieve 100% coverage of health-care facilities in every setting with quality WASH services, which are equitably accessible to all, including children, women and persons with disabilities. The national working group for sanitation and hygiene which developed the strategy engaged diverse stakeholders, such as disabled people's organizations (DPOs), to ensure the needs of disadvantaged groups were addressed.

The strategy integrates GEDSI in its cross-cutting themes and across the three strategic objectives. GEDSI is particularly highlighted under Strategic Objective 1, which aims to increase equitable access to quality wash services. The target is to ensure that 80% of health-care facilities have improved and usable sanitation infrastructure by 2023, and 100% by 2030. This includes designing sanitation infrastructure with separate toilets for staff and women, with menstrual hygiene amenities, and acceptable to users with limited mobility.

Activities to strengthen GEDSI include, for example:

- Developing standard operating procedures for WASH infrastructure designs with provisions for a separate toilet for men and women, and an accessible toilet for people with restricted mobility; and
- Training health-care professionals and communities responsible for WASH to recognize and respond to specific needs of persons with disabilities, women and girls, and vulnerable populations.

STEP

3

Establish national standards and accountability mechanisms

The goal of Step 3 is to develop national WASH and health-care waste standards that can provide the basis for design, costing, implementation and operation of WASH services. Mechanisms for accountability should ensure that all facilities meet national standards.

Specific standards on GEDSI will ensure that no one is left behind in WASH improvements. The standards can then be used by a range of GEDSI stakeholders to monitor progress, hold the health system accountable, and advocate for meaningful improvements.

Integrating GEDSI in minimum standards for WASH in health-care facilities

Standards for WASH in health-care facilities should be comprehensive, actionable, and meet the needs of marginalized populations. Development of the standards should also define how they will be operationalized, implemented, resourced, supervised and monitored. These standards should be reviewed and updated to ensure responsiveness to the needs and priorities of marginalized population groups. **Resource 3.1** lists and illustrates examples of such standards.

The process of setting standards may also consider using or aligning with relevant regional and global standards, or drawing on other existing standards for WASH as outlined in the *WASH FIT, second edition (2022)*.

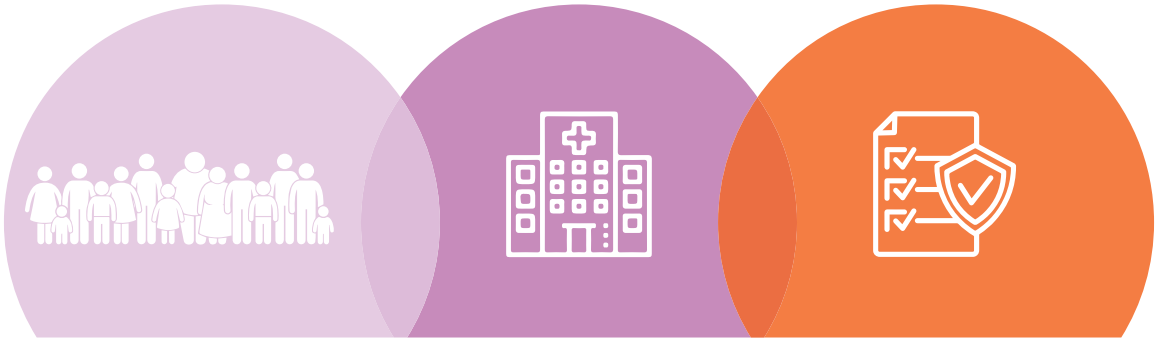
Similar to the development of the roadmap, the process to develop minimum standards should engage all relevant stakeholders through consultations, particularly representatives from marginalized groups, to establish a consensus. The standards should define not only the types of WASH infrastructure and practices for each level of health care (i.e. primary, secondary and tertiary), but also determine how to ensure compliance for the infrastructure needs. **Resource 3.2** provides examples of stakeholders, and their role in holding the health system accountable for inclusive WASH.

Health facility assessments to strengthen accountability

Regular health facility assessments, such as described under Step 4, provide information on how the facility is performing on the WASH standards developed. Assessments of WASH in health facilities are important to GEDSI for two reasons:

1. Findings of assessments hold health facilities accountable to meeting national standards on GEDSI in WASH in health-care facilities (top-down accountability).
2. Assessments also ensure that health facilities are accountable to the community (bottom-up) by asking health facility users for their feedback and using it to guide improvements.

Dual accountability through regular assessments



Accountability towards the community ← Health-care facility assessment → Accountability to national standards

Resources and Tools

Resource 3.1: Illustrative standards for WASH in health-care facilities that support GEDSI

A summary of available guidance which can support the development of WASH standards that integrate GEDSI

Resource 3.2: Illustrative list of stakeholders who hold the health system accountable for inclusive WASH

A table listing potential stakeholders, their role in holding the health system accountable, who they are accountable to, and the implications this has for GEDSI in WASH in health facilities

Resource 3.1:

Illustrative standards for WASH in health-care facilities that support GEDSI

Several resources exist in the public domain that can support the development of WASH standards that integrate GEDSI. Two resources are summarized below, with relevant standards included in the table. You can obtain additional guidance from resource documents listed in Annex 1.

- Association of Southeast Asian Nations (ASEAN) *Public Toilet Standard*:[34] While the objective of the standard is to ensure the quality, comfort, safety and proper waste management of public toilets in general at tourist destinations within the ASEAN region, the standard is also applicable to toilets in health-care facilities serving local communities. The standard contains specific criteria for: (i) the design and environmental management system; (ii) amenities and facilities; (iii) cleanliness; and (iv) safety. It also contains an audit checklist, checklist criteria, an audit manual, and clarifying illustrations. The document contains many standards related to design criteria, amenities and facilities, and safety that are relevant to GEDSI, particularly for persons with disabilities and older adults, as well as women and children.
- *Female-friendly public and community toilets: a guide for planners and decision-makers* by WaterAid:[35] The publication suggests requirements that should be met to make public toilets (such as in toilets in health-care facilities) female-friendly. The features are general descriptions rather than technical specifications and should be read and applied in conjunction with national standards and specifications.

An illustrative list of standards for inclusive WASH in health-care facilities is provided. The sources are noted below the table for ease of reference. While there is significant consensus on standards for accessible infrastructure, fewer examples of standards exist related to the other three areas of the GEDSI in WASH in health-care facilities framework: accessibility; equitable use of WASH to improve quality of care (including patient counselling); and the engagement of communities, specifically marginalized groups. In addition, while the needs of women and girls, persons with disabilities, and older adults can be found in many standards for WASH in health-care facilities, standards related to other marginalized groups, such as linguistic and ethnic minorities, people from lower income or education groups, and LGBTQIA+ have often not been included.

Annex 6 of the *WASH FIT guide, second edition (2022)* includes Technical Factsheet 2 on GEDSI, which provides guidance on improvements in maternity and neonatal wards, making WASH facilities female-friendly and, accessible and appropriate to diverse users. The suggested indicators can also serve as the basis for development of standards.

[34] ASEAN Public Toilet Standard. Jakarta: ASEAN; 2016. (*https://www.asean.org/wp-content/uploads/2012/05/ASEAN-Public-Toilet-Standard.pdf* accessed on 6th October 2023)

[35] Female-friendly public and community toilets: a guide for planners and decision makers. London: WaterAid, WSUP, UNICEF; 2018 (*https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/female-friendly-public-and-community-toilets-a-guide.pdf*, accessed 25 August 2023).

Sample standards for inclusive WASH in health-care facilities	
Area	**Examples of standards**
Women and girls, LGBTQIA+	• The ratio of fittings in male and female toilets to be 5:3, i.e. five WC for female and three WC for male toilets* • Separate toilets for male/female use exist and are clearly labelled and provide privacy for users**** • Unisex (gender neutral) or third gender toilets • Separate entrances for female and male toilets, at a sufficient distance from each other and if possible, facing different directions or separated by a wall** • A functional shower space for women, which is private and lockable, is available in the labour and delivery area****
Menstrual hygiene management	• At least one usable toilet provides the means to manage menstrual hygiene management (MHM) needs**** • Appropriate provision of the following accessories: waste bins and sanitary bins with liners (hands-free with foot pedals)* • Access to water and soap: Basin, water and soap in each toilet block, and water access inside the cubicle (tap or bucket storage) for increased privacy in managing menstruation, incontinence, diarrhoea, etc.** • Access to menstrual products such as sanitary pads** • Disposal of menstrual products: Washable bins with a lid inside the cubicle, and options for washing reusable products** • Washing and bathing units, ideally within the toilet stall, for washing menstrual materials or the body**
Limited mobility (e.g. persons with disabilities, the elderly, pregnant women, immobile patients)	• Reasonable distance between main health-care facility building and the toilet block** • Accessible path to the toilet block and accessible cubicle that is well-lit and wide enough, at least 1.2 m and ideally 1.8 m. Path is flat where possible, even unobstructed and non-slip. Where ramps are used, the gradient is no more than 1 in 15, and ideally 1 in 20. Handrails to support use of ramp** • Accessible route to be provided, which is usable even by an unassisted wheelchair user* • One or more functional toilet meets the needs of people with reduced mobility****

Sample standards for inclusive WASH in health-care facilities	
Area	**Examples of standards**
	• A door that is minimum 80 cm wide, which can be opened from the inside out or be a sliding door* • A wide, outward-opening door (80 cm is a recommended minimum width), with a railing or rope on the inside to assist with closing the door** • The cubicle's minimum size to be no less than 1.5 m wide and 2.2 m deep for the whole length* • Horizontal handrails to be fixed at the rear, sidewall adjacent to the toilet bowl and at the opposite side of the toilet bowl* • Raised toilet seat and sturdy handrails designed to support body weight extending to the (or) covering the whole inside of the cubicle** • Large bolt lock which is easier to grip** • WCs to be set between 43 cm and 48 cm above the floor* • Wash basins to be located as close as possible to the WC to allow persons with disabilities to reach it easily* • Wash basins should be set at least 110 cm from the nose of the toilet bowl and to be mounted at a maximum height of approximately 82 cm off the floor* • All features (sink, hooks, means for anal cleansing and MHM facilities) are positioned at a lower height and at suitable distances** • Where baby changing facilities are not available, double the number of larger toilet stalls to facilitate access by both persons with disabilities and caregivers with small children*
Sensory impairments	• The colour of the wall tiles for accessible public toilets should adopt strong colour contrast to cater to the needs of the visually impaired* • Announcements or audio directions to support those with visual impairments • Clear signages to support those with hearing impairments
Children	• Provision of wash basins, WC, urinals hung at child's height* • At least one unisex baby changing facility per 10 000 people* • Changing space/station for babies that is clean and safe**

Sample standards for inclusive WASH in health-care facilities	
Area	**Examples of standards**
	• Family-friendly cubicle spacious enough for a caregiver and the person they are caring for to be in at the same time without touching doors or walls** • Breastfeeding space that is private and hygienic, in contexts where breastfeeding in public is not accepted**
Privacy and security	• Safe location: Reasonably visible, balancing privacy and security considerations** • Good lighting, both internally and externally** • Adoption of a single entrance/exit, which is door-less and designed as a maze blocking the immediate view of the interior from the outside. Mirrors, urinals and cubicles should be placed away from the line of sight of the entrance/exit* • The entrance is designed to conceal the inside from passers-by, ventilation systems do not allow people outside to see or hear what is happening inside** • Solid doors and structure that users can lock from the inside**
Literacy and language	• Toilet facilities must be designated by a legible sign for each gender and for the disabled located near the entrance to each toilet facility and displayed clearly in main passageways. Signage should be commonly recognizable (female/male/unisex/third gender/disabled signage in dark colour contrasted on light, reflective background)* • Clear signs and directions with recognizable male, female, and accessible toilet symbols along with arrows and text in local language(s)**
Social, cultural, and linguistic barriers to hygiene education	• Hygiene counselling centres around the patient's WASH needs and priorities across the life course, taking into account their ethnicity, race, cultural background, and status in society as influenced by their income, education, etc. • Hygiene counselling is delivered in a child-friendly manner to ensure understanding by children • Hygiene counselling is provided in the appropriate language • Health education/community mobilization seeks to address myths and stigma around MHM and incontinence • Health education/community dialogue is tailored to include the needs of marginalized groups

Sample standards for inclusive WASH in health-care facilities	
Area	**Examples of standards**
Health provider attitudes and practices	• Awareness of GEDSI in WASH is included in health sector job descriptions and job performance appraisals*** • All new auxiliary staff, including waste handlers and those who clean, receive appropriate training on GEDSI and WASH, tailored and appropriate to their job function*** • Health sector staff identify and respond to barriers to participation of marginalized groups in consultations, field visits and training activities***

*ASEAN Public Toilet Standard. Jakarta: ASEAN; 2016. (*https://www.asean.org/wp-content/uploads/2012/05/ASEAN-Public-Toilet-Standard.pdf*)

**Female-friendly public and community toilets: a guide for planners and decision-makers. London: WaterAid, WSUP, UNICEF; 2018. (*https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/female-friendly-public-and-community-toilets-a-guide.pdf*).

*** Adapted from: Age inclusive disaster risk reduction – a toolkit. Chiang Mai: HelpAge; 2019

**** WHO and UNICEF (2022) WASH FIT: a practical guide for improving quality of care through water, sanitation and hygiene in health care facilities. Second edition (*https://iris.who.int/handle/10665/353411*).

A few illustrated examples

The illustrations below provide a broad overview of select features outlined in the Association of Southeast Asian Nations (ASEAN) Public Toilet Standard and WaterAid's Female-friendly public and community toilets: a guide for planners and decision-makers. For comprehensive details please refer to the original documents.

Outside the toilet block

Inside the toilet block

Female-friendly and disabled-friendly

Resource 3.2:

Illustrative list of stakeholders who hold the health system accountable for inclusive WASH

Stakeholder accountability matrix			
Stakeholder	**Role in holding health system accountable**	**Accountable to**	**Implications for GEDSI in WASH in health facilities**
Ministry of Health (MoH)	Oversight of health facilities and providers through policies, regulations, guidelines, etc.	To other branches of government and indirectly to citizens.	National policies and guidelines for WASH in health-care facilities must be inclusive and responsive, with sanctions and incentives to ensure compliance.
Ministry of Water and Sanitation	Oversight of WASH facilities and services through policies, regulations, guidelines, etc.		
Ministry for Women and Children, Ministry of Social Affairs, or relevant ministry for persons with disabilities	Monitor the responsiveness of the health system to the needs of women and children and persons with disabilities, and advocate for and guide improvements.		
Ministry of Planning	Coordinate various government programmes to ensure effectiveness and efficiency.		Ensure cross-ministerial coordination in development and implementation of strategies and standards for GEDSI in WASH in health-care facilities.
Health-care facility users and communities	Can influence as active customers, through health facility committees and elected officers, but traditionally weak.	To families and community members for preventing spread of infections and ensuring a healthy environment.	Users and communities, especially members of marginalized groups within communities, must be engaged in planning, improving and monitoring WASH in health-care facilities.

Stakeholder accountability matrix			
Stakeholder	**Role in holding health system accountable**	**Accountable to**	**Implications for GEDSI in WASH in health facilities**
			Feedback can also be provided through focus group discussions (FGDs) and client satisfaction surveys.
Funding agencies such as finance ministries and insurance agencies	Audit that funds are spent as planned. Provider reimbursement systems provide incentives and sanctions for quality assurance and performance.	Finance ministries accountable to other government branches. Insurance agencies are subject to finance ministries and other oversight entities.	Can advocate on integration of inclusive WASH in standards for health-care facilities, reinforced by financial incentives and sanctions.
Elected officials	Oversight of the MoH and other ministries, monitoring through committees and hearings.	To citizen voters.	Can drive or influence policies, programmes and budgets for inclusive WASH in health-care facilities.
Nongovernmental and community-based organizations e.g. disabled people's organizations (DPOs), women's groups, human rights activists, civil society	Bolster citizens' voices for advocacy and provide information on health policies, regulations, etc. so citizens can hold the health system accountable.	To funders and service users/ members.	Can promote demands for inclusive WASH.
Academia and research institutions	Monitor and evaluate health system performance. Provide data/ evidence on health-related needs.	Funders (government or private corporations/ individuals), as well as academic peers.	Can contribute data and evidence on GEDSI-related needs and barriers to WASH in health facilities, test solutions to reduce inequalities, and monitor improvements.

Stakeholder accountability matrix			
Stakeholder	**Role in holding health system accountable**	**Accountable to**	**Implications for GEDSI in WASH in health facilities**
Professional associations	Self-policing to uphold professional codes, and to ensure that training (licensing) and accreditation standards are met.	To members, and indirectly to society.	Health and WASH-related associations can train and advocate to members on inclusive WASH in health-care facilities.
Health-care providers	Can influence health facility staff through staff committees and monitoring and peer support for compliance with practice standards and guidelines.	To their facility/ organizational setting, professional association, licensing body for upholding standards, community groups, and individual patients for delivery high-quality care.	Can advocate for and ensure that health-care facilities meet their needs and priorities, as well as those of their patients and patients' caregivers.
Health-care facilities (managers)	Oversight of health-care providers and service delivery.	To government for meeting regulations for service delivery, financing and reporting. To staff/ employees.	Responsible for ensuring inclusive WASH at the health-care facility.
International donors	Can prioritize funding to drive selected issues, such as inclusive WASH in health-care facilities, which supports the achievement of globally agreed-upon SDGs.	To donor country citizens, and indirectly to the international development community.	Can advocate for and fund activities for GEDSI integration in WASH in health-care facilities.

Case study: Guaranteeing equity for women and persons with disabilities in Bangladesh through national standards for WASH in health-care facilities

To support implementation of the *National Strategy for WASH in Health care Facilities and Framework of Action for 2019–2023,* the Bangladesh Ministry of Health and Family Welfare in 2020 worked with WHO and other partners to develop the *National WASH Standards and Implementation Guidelines for Health Care Facilities in Bangladesh*.[36] The standards integrate GEDSI considerations to ensure user-friendly health-care facilities that have arrangements for female toilets, handwashing, water and sanitation.

Key sections of the document include:

Standards (chapters 3 and 4).

The standards include, for example, requirements for:

- Separate toilets for female attendants in inpatient wards.
- Outpatient toilets, which are gender segregated, also appropriate for people with limited mobility.
- Menstrual hygiene management (MHM) facilities in female toilets.
- Shower/washroom facilities that are accessible to and usable by persons with disabilities.

Similar GEDSI considerations are integrated in the chapter on WASH in health-care facilities during emergencies such as natural hazards, war, and disease outbreaks.

The implementation process (chapter 5).

The document describes the WASH FIT process and recommends that the WASH FIT team include both male and female community representatives and from NGOs (if applicable) (the assessment checklist is included in chapter 7).

The guidelines also recommend prioritizing vulnerable groups such as pregnant women, children under-five years of age, people with special needs, and immunocompromised individuals during resource allocation.

[36] National WASH Standards and Implementation Guidelines for Health Care Facilities in Bangladesh. Dhaka: Ministry of Health and Family Welfare; 2020.

Further guidance for implementation (chapter 6).

This includes guidance on:

- social and cultural considerations for sanitation facilities, such as separate toilets for women and men, including in health-care facility kitchens;
- special children's toilets in health-care settings that largely cater to children; and
- locating toilets in safe places with adequate lighting to reduce any risks, such as sexual violence.

STEP

4

Improve and maintain infrastructure

The goal of Step 4 is to improve and maintain WASH infrastructure at health-care facilities such that it meets national standards, is appropriate and suitable for the local context, the size of the facility, and the services the facility provides. Continuous quality improvement and operation and maintenance of WASH infrastructure and services in health-care facilities is critical to its functioning and involves regular assessment, planning activities to improve performance, and taking action. The WASH FIT is central to this step.

Activities under Step 4 are also instrumental to strengthening GEDSI in WASH in health-care facilities. Guidance on GEDSI integration into the WASH FIT process is provided in Technical fact sheet 2 in Annex 6 of the *WASH FIT, second edition (2022)*. **Tool 4.1** provides a checklist for assessing the level of GEDSI integration within the WASH FIT process.

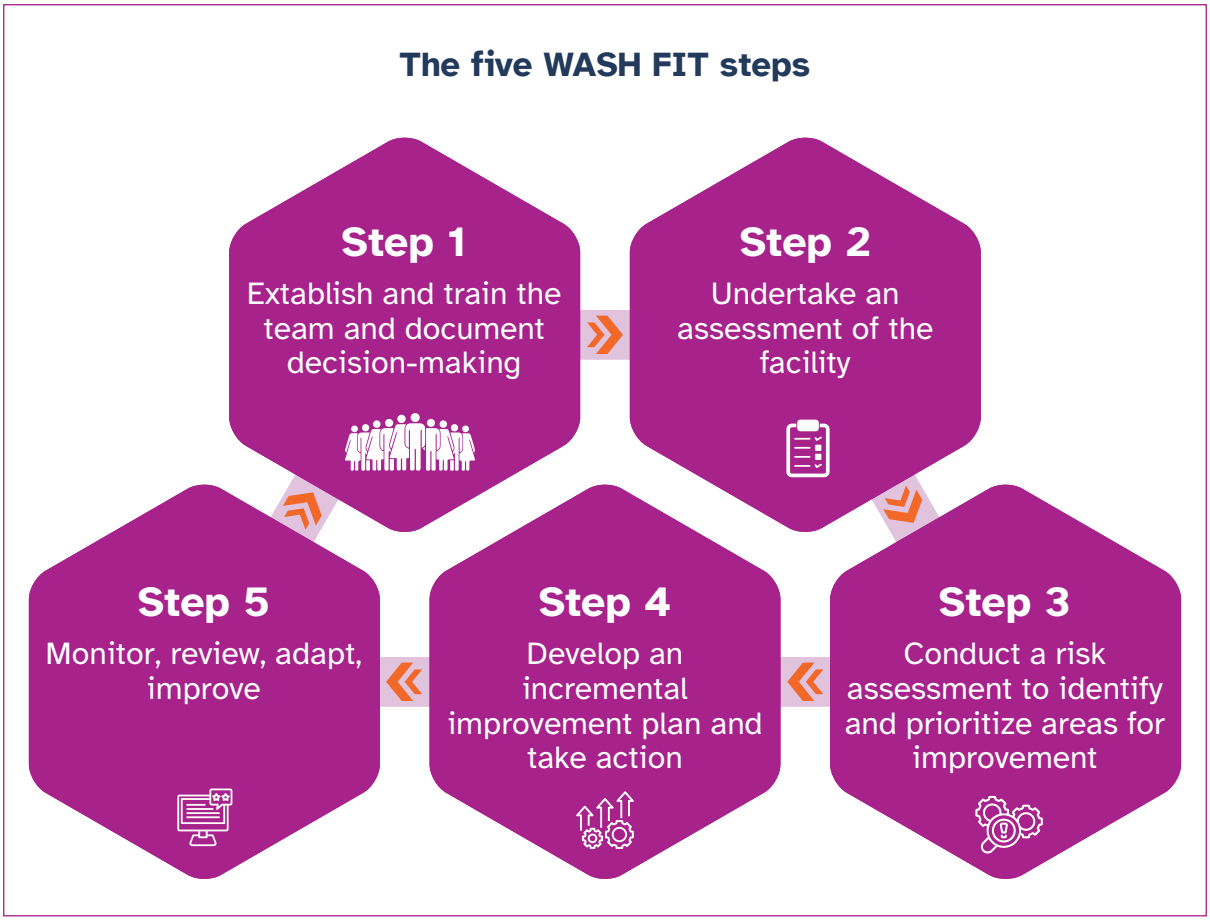
WASH FIT – National planning and preparation

The WASH FIT assessment form in Chapter 6 (Template 6.2) of the *WASH FIT, second edition (2022)* provides a list of indicators that supports a comprehensive assessment of infrastructure and services for WASH in health facilities, in order to inform an improvement plan. The assessment form should be adapted to reflect national standards and guidelines, the facility situation or particular priority issues before WASH FIT is rolled out. National level adaptation of the WASH FIT assessment form **is the first entry point for GEDSI integration**. WASH FIT assessment covers seven broad areas (i.e. water, sanitation, health-care waste management, hand hygiene, environmental cleaning, energy and environment, management and workforce), some of which provide opportunities for GEDSI integration. Adaptation and pilot testing should engage representatives from marginalized groups to ensure that WASH FIT assessment measures GEDSI needs and priorities relevant to the country context. Adaptation should also consider how to measure the impact of climate change on WASH in health-care facilities, particularly in the context of marginalized groups.

WASH FIT – Health facility implementation

The WASH FIT improvement cycle consists of five steps that are undertaken by the facility. GEDSI should be integrated into each step of the WASH FIT improvement cycle.

1. **Establish the team:** Ensure that the WASH FIT team includes representatives from marginalized groups, including health-care workers, maintenance staff, health facility users and caregivers. Women's organizations and disability groups should be involved as key partners. Team meetings should be organized in accessible locations and at convenient times, and be managed in a manner that supports equal participation. Any special needs of such groups, e.g. a sign language interpreter or wheelchair access to the discussion room also needs attention.



2. **Assess the facility:** With the support of the WASH FIT assessment form, adapted to the country context, the facility assessment should check the availability of WASH facilities and services, and examine their accessibility, acceptability and equitable use to provide quality care for all patients, particularly those who may experience disrespect and discrimination within the health-care facility, and evaluate how marginalized groups are engaged in WASH planning and monitoring. Another way to collect information relevant to GEDSI is to supplement quantitative assessment forms with qualitative methods such as interviews and FGDs. These methods may be more effective in collecting information on sensitive subjects such as harmful attitudes and discrimination towards certain groups, but require more training and time. **Tool 4.2** suggests some questions that can be useful during these discussions.

3. **Risk assessment:** Building on assessment findings, the WASH FIT team will determine the impact of problems, i.e. the level of risk associated with each problem identified by the assessment on patients, staff and visitors and rank the problems according to their risk score to show which to prioritize for improvements. Here representatives of marginalized groups can provide valuable insight on impacts that may not be obvious to people who are not from those groups. Impacts of climate change on marginalized groups should also be considered.

4. **Develop and implement improvement plan:** Based on the risk assessment and the feasibility of addressing the problem, the WASH FIT team will develop an

incremental improvement plan to support action. **Tool 4.3** provides examples of GEDSI actions and how they can be documented in the WASH FIT improvement planning template provided in Chapter 6 of the *WASH FIT, second edition (2022)*. In determining resources needed and persons responsible, the WASH FIT team should consider how to involve women, persons with disabilities, LGBTQIA+, and other marginalized groups in implementation without disproportionately increasing their work burden. **Tool 4.4** is a checklist for assessing GEDSI integration in improvement activities related to building and maintaining WASH infrastructure.

5. **Monitor, review, adapt and improve:** Regular and continuous monitoring and evaluation of progress is an important part of quality improvement activities. This can be done through regular review of progress and facility spot checks or monthly assessments and review. Marginalized groups should have a way to provide feedback as part of this process. This can be done, for example, during review meetings, through patient surveys, feedback box/telephone number/ register, informal interactions with service users, etc.

Resources and Tools

Tool 4.1: Checklist to support GEDSI integration into the WASH FIT process

A description of how to integrate GEDSI into each of the steps in the WASH FIT process.

Tool 4.2: Qualitative methods for obtaining insights into inclusive WASH

Example of questions that can be asked in interviews and FGDs, as well as guidance on organizing a brainstorming exercise to analyse whether barriers to inclusive WASH are physical, social/cultural, institutional, or are at the policy/legislation level

Tool 4.3: GEDSI in WASH FIT improvement plans

A template for prioritizing and planning next steps to improve inclusive WASH at the health-care facility

Tool 4.4: Checklist to assess GEDSI integration in improvement activities

A checklist for assessing GEDSI in plans for building and maintaining WASH infrastructure

Tool 4.1:

Checklist to support GEDSI integration into the WASH FIT process

This checklist, based on Technical fact sheet 2 (GEDSI) in Annex 6 of the *WASH FIT, second edition (2022)*,[37] can help you assess if GEDSI has been integrated into each of the five steps of the WASH FIT improvement cycle.

Checklist of GEDSI considerations			
National planning and preparation		**Yes**	**No**
1.	Gender and/or accessibility experts consulted to understand contextual issues.		
2.	Information is available on who is at risk of being left behind in WASH in health-care facilities, and the barriers they face.		
3.	Assessment findings on availability of national standards or guidelines about accessibility of WASH in health-care facilities for persons with disabilities (i.e. with difficulty in walking, seeing or hearing) are used to guide planning and adaptation.		
4.	Information is available on status of influence and extent of women's leadership in WASH and health ministries, and/or the broader health-care system.		
5.	Information is available on status of gender equality-linked policies and guidelines.		
6.	Data are available on the prevalence of gender-based violence and effective prevention interventions.		
7.	There is collaboration between government ministries responsible for WASH in health-care facilities and rights groups.		
	Additional items: ■ The WASH FIT adaptation and planning team engages influential stakeholders who can champion GEDSI integration in WASH FIT ■ Indicators align with GEDSI interventions in the national roadmap and the country's WASH standards		

[37] World Health Organization, United Nations Children's Fund (UNICEF). Water and sanitation for health facility improvement tool (WASH FIT): a practical guide for improving quality of care through water, sanitation and hygiene in health care facilities. 2nd edition. WHO; 2022 (*https://iris.who.int/handle/10665/353411*, accessed 26 August 2023).

Checklist of GEDSI considerations			
	▪ Indicators are disaggregated by gender, age, and other factors to help identify gaps from a health-facility user perspective, e.g. number of female and male latrines ▪ In adapting and finalizing indicators for the WASH FIT assessment, indicators that measure **availability** of WASH are complemented by indicators for the **accessibility** and **acceptability** to all health facility users, and the **equitable use** of WASH for IPC and to deliver patient-centred care ▪ Strategies to complement audits of WASH infrastructure with feedback from health facility users, particularly women, persons with disabilities, LGBTQIA+, and other marginalized population groups are considered		
Step 1: Establish a WASH FIT team		**Yes**	**No**
1.	The WASH FIT team has an equal gender balance.		
2.	The WASH FIT team has staff from various health facility roles and levels (cleaners, nurses, midwives, directors, managers).		
3.	The WASH FIT team has representatives from organizations of persons with disabilities.		
4.	The WASH FIT team has representatives from local women's groups.		
5.	The WASH FIT team has representatives from religious and ethnic groups.		
6.	In facilities with births, the WASH FIT team includes a woman who has delivered at the facility.		
7.	The WASH FIT team has principles or ways of working to ensure inclusivity and effective decision-making.		
8.	Team members are selected and trained to ensure that diverse groups of users feel comfortable and are able to talk openly. This may mean, for example, having female team members lead discussions with female health facility staff on experience of MHM at work, or safety, hierarchies, etc.		
	Additional items: ▪ The WASH FIT team has the trust of the community so it can effectively collect data and drive improvements.		

Checklist of GEDSI considerations			
	▪ The team is cognizant of and carefully considers the influence of existing gender and social expectations when assigning team member roles and responsibilities, particularly the common exclusion of marginalized groups from leadership positions.		
Step 2: Assess the facility		**Yes**	**No**
1.	The assessment checks delivery rooms, neonatal care unit and postnatal care rooms.		
2.	The assessment checks for female-friendly facilities and infrastructure, such as gender-segregated toilets.		
3.	The assessment teams speak to health-care workers and facility management to understand and challenge harmful attitudes and discrimination towards certain groups.		
4.	The assessment teams recognize power imbalances among health facility staff and make provisions to speak privately to marginalized staff, particularly women or workers lower in the hospital management hierarchy, among others.		
	Additional items: ▪ Team members have a shared understanding of concepts. For example, the question of whether a latrine is 'safe' may mean different things to a young man and young girls, so the survey should be specific in defining 'safe' (e.g. located near the health facility, well-lit, lockable doors). ▪ Presentation of assessment findings describes the difference in gaps related to WASH between different health facility users/ marginalized groups.		
Step 3: Risk assessment		**Yes**	**No**
1.	The difference in risk and the impact of poor WASH services on the health, safety, dignity and access with respect to **women** is categorized, scored and described.		
2.	The difference in risk and the impact of poor WASH services on the health, safety, dignity and access with respect to **children** is categorized, scored and described.		
3.	The difference in risk and the impact of poor WASH services on the health, safety, dignity and access with respect to **persons with disabilities** is categorized, scored and described.		

Checklist of GEDSI considerations			
4.	The difference in risk and the impact of poor WASH services on the health, safety, dignity and access with respect to **the elderly** is categorized, scored and described.		
5.	The difference in risk and the impact of poor WASH services on the health, safety, dignity and access with respect to **other marginalized groups** is categorized, scored and described.		
	Additional items: ▪ The potential impacts of climate change on the risks faced by marginalized groups are identified.		
Step 4: Develop and implement improvement plan		**Yes**	**No**
1.	The action plan does not increase the work burden for health facility staff, especially for women, cleaners, and carers.		
2.	The plan addresses ways of sharing the work burden equitably and outlines resources to bring in additional help.		
3.	The differential impact of planned improvements on women and men have been considered, and mitigation planned for.		
4.	Benefits of the action plan for persons with disabilities have been outlined.		
	Additional items: ▪ The plan includes actions that benefit other marginalized groups. ▪ Marginalized groups are engaged in developing and implementing solutions. ▪ Solutions address constraints on the accessibility and acceptability of care, and the equitable use of WASH for IPC and quality of care. ▪ Implementation of activities provides opportunities to businesses owned by women, persons with disabilities, or other marginalized people, or employing them.		
Step 5: Monitor, review, adapt, improve		**Yes**	**No**
1.	Mechanisms exist for women and other marginalized groups to provide feedback on WASH services and future improvements.		
	Additional items: ▪ Marginalized groups are involved in the monitoring and analysis processes. ▪ Best practices in GEDSI integration are documented and shared.		

Tool 4.2:

Qualitative methods for obtaining insights into inclusive WASH

Qualitative methods can provide insight into health facility user and community opinions and perspectives that may not be clear from health facility audits or surveys. Information should be collected from both patients and staff in both inpatient and outpatient departments, a variety of health facility staff (e.g. doctors, nurses, pharmacists, laboratory staff, cleaning staff), as well as from people of diverse genders, ages, ethnicities, income groups, etc.

In conducting interviews and FGDs, remember to protect the privacy and confidentiality of the participants. Recognize power dynamics between different groups, organize discussions separately for women and men, patients and staff, etc. to make it easier for the participants to share. It is also important to understand the functional limitations of those with disabilities. The WHO's *Functioning and Disability Disaggregation tool (FDD11),* is an instrument that can be rapidly and easily used to produce disaggregated data by disability need, and has been derived from the WHO Brief Model Disability Survey (MDS) – a larger WHO instrument that has been validated and broadly implemented in many countries. A few questions from the tool are provided as examples in the box on page 88.

Illustrative interview questions

Patients and caregivers

- What are the taboos and superstitions surrounding common health conditions such as pregnancy, childbirth, menstruation, etc. that impact how you use WASH at the health facility?
- What barriers and challenges do you face in accessing toilets and performing hygiene activities?
- Can you use the toilet, handwashing station, and the shower independently or do you require assistance? If required assistance, describe what assistance was provided (e.g. nurse, family member or equipment)? What improvements could be made?
- Do you feel safe when using the toilet and the shower? (If safe or not safe, please describe.)
- How well do the toilet and shower meet your needs? What improvements could be made?
- Are you able to obtain products to manage personal hygiene, such as pads, anal cleansing materials, soap or nappies while at the health-care facility? How? What improvements could be made?
- Are you able to obtain drinking water while at the health-care facility?
- Do health facility staff ask you about your specific WASH needs? Do they provide you with assistance when needed?

Health-care workers

- What barriers and challenges do you face in accessing toilets and performing hygiene activities?
- Do patients have different WASH needs? Are you able to respond to them? What barriers do you face in providing inclusive WASH services to your patients?
- Have you received training on GEDSI and inclusive WASH? What are the groups who are at a disadvantage in using WASH in your health facility?
- Has the health facility made efforts to improve WASH? Were your inputs sought?

Cleaning personnel

- What barriers and challenges do you face in accessing toilets and performing hygiene activities?
- Do you feel safe doing your job?
- Has the health facility made efforts to improve WASH? Were your inputs sought?

Health system managers

- Are there any existing national standards or guidelines for ensuring that all health facility users can access WASH facilities/services that they are acceptable, and that they are used to improve quality of care?
- Does the health facility have a mechanism to obtain feedback from users or from the community, especially those belonging to marginalized groups, on health facility services, including WASH? If so, how well is it functioning?
- Has WASH, particularly inclusive WASH, been discussed as part of health facility quality improvement efforts and how? What were the results?

Community leaders

- To what extent do community members understand challenges some members may face in accessing acceptable WASH services and products at the health facility, and ensuring that WASH contributes to better quality of care?
- To what extent are marginalized groups involved in decision-making in the community, or at the health-care facility?
- Does the health facility have a mechanism to obtain feedback from users or from the community on health facility services, including WASH? If so, how well is it functioning?

Organizations representing people from marginalized population groups

- What is the local situation around gender, disability, ethnicity and other people who experience marginalization?
- Are there mechanisms that enable you to participate in decision-making around WASH in health-care facilities?

Sample questions from the WHO Functioning and Disability Disaggregation tool (FDD11)

A short set of questions such as that outlined below can be used to identify the needs of persons with disabilities. The questions ask about difficulties they may have doing certain activities because of a health problem.

Respondents may be requested to answer how much difficulty they have on a scale from 1 to 5 where 1 means “no difficulty” and 5 means “extreme difficulty or cannot do the activity.” The interviewer may read aloud all response options to the respondent and **circle one response option that applies** to the context of the respondent.

	Questions	None				Extreme
1	How much difficulty do you have seeing things at a distance, even when wearing glasses?	1	2	3	4	5
2	How much difficulty do you have hearing, even when using a hearing aid?	1	2	3	4	5
3	How much difficulty do you have walking or climbing steps?	1	2	3	4	5
4	How much difficulty do you have remembering or concentrating?	1	2	3	4	5
5	How much difficulty do you have washing all over or dressing?	1	2	3	4	5
6	Because of your health, how much difficulty do you have with joining community activities, social gatherings, meetings or other activities?	1	2	3	4	5

Tool 4.3:

GEDSI in WASH FIT improvement plans

Chapter 6 (Template 6.4) of the *WASH FIT, second edition (2022)* supports health-care facilities in developing an incremental improvement plan. GEDSI activities should be part of this plan. Some examples of actions to address inclusion barriers are provided in **Resource 2.1**. Here we have an example of how a specific GEDSI action item can be included in the WASH FIT improvement template.

Example of GEDSI activities in WASH FIT improvement plan						
Indicator/problem	**Specific activities to be undertaken to address the problem**	**Quick fix (Y/N)**	**Date to be completed**	**Resources needed**	**Person(s) responsible**	**Status**
	Use a new line for each action			Financial, material and human resources		Completed/ ongoing/ not yet started/ delayed by n
Staff feel awkward feeding and washing persons with disabilities	Engage nurses to act as role models and peer mentors	Y	5 Jul	$20 for 2-hour training and honorarium for representatives of persons with disabilities	Chief medical officer	Completed
	Organize staff training on caring for persons with disabilities	N	25 Nov	District supervisor and representatives of persons with disabilities $200 for one-day training	Chief medical officer	Delayed due to supervisor schedule

Example of GEDSI activities in WASH FIT improvement plan						
Indicator/problem	**Specific activities to be undertaken to address the problem**	**Quick fix (Y/N)**	**Date to be completed**	**Resources needed**	**Person(s) responsible**	**Status**
	Use a new line for each action			Financial, material and human resources		Completed/ ongoing/ not yet started/ delayed by n
Women health-care workers lack personal protective equipment (PPE) in the right size	Procure PPE in different sizes – change sizes/ quantities procured	Y	15 Jul	Added to supply monitoring and procurement forms	Supplies manager	Ongoing
Latrines designated for persons with disabilities cleaned less frequently	Institute daily spot checks	Y	1 Jul	Integrated in maintenance in-charge rounds	Cleaning and maintenance in-charge	Ongoing
Lack of pads for women to use after delivery	Request district supervisors for increased budget for supplies	N	15 Jul	Estimated $15 per month for commercially available pads	Supplies manager	Started
	Explore procurement of locally made cloth pads	N	30 Aug	Estimated $10 for cloth pads	Supplies manager	Started
Menstruating women do not come to the facility/ cancel appointments due to shame	Organize group education to community members on myths and stigma around menstruation	N	15 Jul 15 Aug 15 Sep	Integrate in routine outreach visits Engage local women's group for follow-up with women	Nurse in-charge	Ongoing

Indicator/problem	Specific activities to be undertaken to address the problem	Quick fix (Y/N)	Date to be completed	Resources needed	Person(s) responsible	Status
	Use a new line for each action			Financial, material and human resources		Completed/ ongoing/ not yet started/ delayed by n
Limited availability of drinking water for maternity ward patients	Put large water bottle in maternity ward, refill twice daily	Y	20 Jul	Refillable water bottle and cups Include in relevant staff person's job description	Ward in-charge Food services in-charge	Ongoing
	Install drinking fountain in maternity ward	N	30 Nov	$7500 for construction labour and supplies	Maintenance in-charge	Not yet started
Young women reluctant to use WASH facilities due to lack of privacy	Install walls and curtains around toilets	N	30 Jan	Bamboo walls donated by community $100 for purchasing cloth Community donating labour $5 for monthly washing of curtains	Maintenance in-charge	Started
Latrines difficult to access due to high stairs	Replace stairs with ramp with rail	N	1 Aug	$5000 for construction labour and supplies	Maintenance in-charge	Delayed by 6 months due to budget constraints

Tool 4.4:

Checklist to assess GEDSI integration in improvement activities

The checklist below helps assess GEDSI considerations in building and maintaining WASH infrastructure. It is adapted from the guide on *Female-friendly public toilets* by WaterAid, WSUP and UNICEF.[38]

GEDSI considerations in building and maintaining WASH infrastructure		
Procurement	**Yes**	**No**
Is budget allocated to include WASH features that ensure equal accessibility, acceptability, and to support patient-centred care?		
Are inclusive, user-friendly considerations included in calls for tender from contractors and the contracts that are selected?		
Does contractor selection consider the contractor's commitment to and record of being inclusive and engaging communities?		
Operation and maintenance		
Does the budget include plan and allocation for cleaning and upkeep?		
Do the operating standards include female- and disability-friendly features?		
Is the menstrual waste disposal system culturally appropriate, safe and environment-friendly?		
Do the designated health facility caretakers include women, persons with disabilities, and other people from marginalized groups?		
Will the action plan create an increased work burden (e.g. on women, cleaners, carers), and how can this be mitigated? How can the work burden be most equitably allocated, and what resources exist (or can be accessed) to bring in additional help?		
Is there equal pay for equal work for those employed, especially women, persons with disabilities, and other people from marginalized groups?		

[38] Female-friendly public and community toilets: a guide for planners and decision makers. London: WaterAid, WSUP, UNICEF; 2018 (*https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/female-friendly-public-and-community-toilets-a-guide.pdf*, accessed 25 August 2023).

GEDSI considerations in building and maintaining WASH infrastructure		
Do the designated health facility caretakers have access to personal protective equipment (PPE) and the supplies they need to do their job well?		
Management		
Does health facility training increase understanding of inclusive WASH and patient-centred care?		
Are women, persons with disabilities, and other people from marginalized groups equally involved in operation and management?		
Are there plans to actively monitor user-friendliness of facilities being built?		

Case study: Integrating GEDSI in WASH FIT in Indonesia[39, 40, 41]

Since 2020, the Indonesian Ministry of Health (MoH) has worked with UNICEF, WHO and other partners to adapt and roll out WASH FIT across the country. GEDSI has been a key priority throughout the process. Critical to the success has been engaging organizations for persons with disability in the WASH FIT process to ensure that infrastructure is inclusive and responsive to user needs.

WASH FIT adaptation aimed to: (i) develop an improved and contextualized version of the WASH FIT for Indonesia; (ii) formulate policy recommendations for the MoH on the use of WASH FIT; and (iii) generate evidence for WASH FIT scale-up.

An initial WASH FIT training for government and partners brought together nearly 30 participants representing government and development partners to discuss the WASH FIT process, technical aspects, advocacy, and action plan development. As part of the training, participants identified and discussed their experiences with gender, persons with disabilities, the elderly, and ethnic minorities in improving WASH at health-care facilities. Discussion informed the adaptation of training materials and WASH FIT indicators to integrate GEDSI within the Indonesian context.

The subsequent national training of trainers dedicated a session specifically on GEDSI. Participants brought insights from their provinces, for example on the cultural aspects of the use of WASH facilities. They also learned the importance of inviting health facility users, especially vulnerable groups, to be part of WASH FIT assessment, and to integrate GEDSI in WASH improvement plans.

The national trainers then guided 181 *puskesmas* (primary health-care centres) in five provinces through the WASH FIT process. During implementation, the teams integrated GEDSI by involving indigenous communities on health facility WASH teams during the assessment, and by addressing barriers for persons with disabilities in improvement plans.

For example, WASH FIT organizers in East Nusa Tenggara, the southernmost province of Indonesia, decided to involve organizations representing women and persons with disabilities as WASH FIT team members and assessors. They also added additional GEDSI indicators including the availability of protective equipment in sizes appropriate for women and for men, and prioritized efforts to improve skills of health-care workers to communicate with persons with disabilities.

To learn more about the impact of WASH FIT at the local level, see the WHO Indonesia YouTube video *Inclusive transformation of WASH in Puskesmas.*

[39] Inclusive and climate resilient WASH in health care facilities: Equity and climate addressed in WASH FIT training and practice in Indonesia (Feature story). Jakarta: WHO; 2021.

[40] Practicing what is preached: Engaging women and disabled people in Indonesia.

[41] WHO strengthens WASH in health care facilities through Water and Sanitation for Health Facility Improvement Tool (WASH FIT) [website]. Geneva: WHO; 2020 (*https://www.who.int/indonesia/news/detail/26-12-2020-who-strengthens-wash-in-health-care-facilities-through-water-and-sanitation-for-health-facility-improvement-tool-(wash-fit)*, accessed 26 August 2023).

STEP

5

Monitor and review data

The goal of Step 5 is to systematically analyse, share and use data on WASH in health-care facilities to measure progress and hold stakeholders accountable. This involves embedding WASH indicators (aligned with global indicators) into routine data collection and health monitoring systems (e.g. Health Management Information Systems [HMIS]).

Monitoring is an essential component of both the national action plans for inclusive WASH in health-care facilities and health facility action plans for improvement (e.g. Step 5 of WASH FIT).

Integrating GEDSI in existing national and health-care facility monitoring systems

Monitoring systems at the national and health facility level should include indicators that can measure the progress of GEDSI in WASH in health-care facilities, in line with national standards for WASH, and health facility action plans. Women, persons with disabilities, LGBTQIA+, and other marginalized groups should be involved in identifying or developing indicators, collecting data, and interpretating findings to ensure that they are relevant and useful. GEDSI indicators can be integrated into existing, routine data collection mechanisms and health monitoring systems at the national level (e.g. HMIS) and similar systems at the health facility level. However, for short-term activities, additional data collection – using FGDs or exit interviews with marginalized patients and staff for example – may be needed to collect more in-depth data. **Resource 5.1** has examples of indicators that can be used to measure progress.

WASH FIT recommends feedback mechanisms that provide women and other diverse users (particularly those who experience marginalization) the chance to give comments and opinions so that their inputs are considered in WASH services and future improvements.

At the health facility level, there are multiple methods you can use to collect primary data for monitoring, such as:

- Interviews
- Focus group discussions (FGDs)
- Community-based survey
- Routine feedback systems (e.g. patient surveys, feedback box/telephone number/register, informal interactions with service users, etc.)
- Supervisory checklists

At the health facility level, because of the close link between WASH and IPC and patient-centred care, review of GEDSI-associated WASH indicators should become a component of the health-care facility's routine quality improvement (QI) processes. GEDSI-associated WASH indicators should also be regularly assessed as part of WASH processes such as WASH FIT. The data review should track progress on key indicators over time, aiming to identify any gaps and to determine whether WASH is becoming more inclusive. Results should also be discussed with communities and community groups engaging marginalized groups.

Utilizing findings to strengthen GEDSI in WASH in health-care facilities

Consistent monitoring and reporting helps to understand the specific needs of marginalized groups that need to be included in plans for improvement. Findings provide feedback on plans and investments in WASH, and whether key interventions undertaken by the government and other stakeholders are effective in strengthening GEDSI in WASH in health-care facilities. They may suggest additional modifications to infrastructure, organization of care, or health workforce training and supportive supervision. Review meetings should engage representatives from marginalized groups who can help translate findings into action.

Resources and Tools

Resource 5.1: Illustrative indicators to measure GEDSI integration in WASH in health-care facilities

Examples of indicators that can be used to measure progress

Resource 5.1:

Illustrative indicators to measure GEDSI integration in WASH in health-care facilities

Indicators for GEDSI integration in WASH can be found in existing documents, such as country commitments, national strategies and policies linked to inclusive WASH in health-care facilities, national WASH standards, and in the WASH FIT guide. If these are not suitable, you may need to develop custom indicators.

To ensure availability of data for different population subgroups, indicators should be disaggregated by stratifiers relevant to the health facility's plan, such as gender, age, and disability status, type of health facility staff, etc.

As you identify indicators, also consider how data on the indicator will be collected and when. Are there routine health facility data collection mechanisms that can be used to collect data on GEDSI in WASH? If new data collection mechanisms are needed, what methods can be used given the available human and financial resources? Remember that qualitative methods that involve interviews and FGDs can also be used.

The illustrative logical framework below can help with identifying indicators for various programme objectives and activities.

Illustrative results framework		
Objectives and activities	**Indicator**	**Data source**
Objective 1. Increase the proportion of health facility WASH activities planned, implemented and monitored with representatives from marginalized groups from 50% to 100% during one year.	**Outcome indicators:** • Existence of a functional platform for community health facility that supports dialogue on GEDSI in WASH. • Reduced barriers to participation in health facility WASH committee.	Interviews with key stakeholders Focus group discussions (FGDs) with marginalized groups
Activity 1. Conduct community dialogue meetings on GEDSI and WASH to identify and prioritize barriers to WASH in the health-care facility.	**Output indicators:** • Number of community/group discussions held to discuss GEDSI and WASH in the health-care facility, including cultural norms and user preferences related to WASH. • Proportion of community/group discussion members who are from marginalized groups.	Programme documentation Programme documentation

Illustrative results framework		
Objectives and activities	**Indicator**	**Data source**
Activity 2. Engage marginalized group members in the health facility/ community WASH committee.	**Output indicators:** • Proportion of health-care facilities with established and operational policies and procedures for participation of local communities, including marginalized groups, in WASH improvement (adapted from SDG indicator 6.b.1). • Women's, disability, indigenous groups and other specific users and staff (nurses, midwives, cleaners, etc.) are consulted about WASH needs and technology designs and these voices influence technology choice, placement and upkeep.** • Proportion of women (or other marginalized groups) in WASH leadership positions at the health facility (adapted from SDG indicator 5.5.2).	Document review at the health facility Programme documentation Document review at the health facility
Activity 3. Conduct regular review of the health facility's GEDSI/ WASH data engaging health facility staff and community members, particularly members of marginalized groups.	**Output indicators:** • WASH monitoring tools/indicators integrate GEDSI. • WASH action plan includes activities to strengthen GEDSI. • GEDSI discussed during health facility WASH reviews. • Proportion of review meetings with input from marginalized groups.	Programme documentation
Objective 2. Increase proportion of marginalized health facility users who report WASH is accessible and acceptable from 65% to 95% in one year.	**Outcome indicators:** • The proportion of women, persons with disabilities, LGBTQIA+, and other marginalized groups visiting the health facility who were satisfied with the WASH services provided by the facility and would recommend the facility to friends and family.* • The proportion of all women who gave birth in the health facility who were satisfied with the environment of the labour and childbirth area, including the cleanliness and proximity to toilets, disaggregated by age, ethnicity and other relevant background characteristics.*	Community survey as part of WASH health facility assessment AND/OR Question incorporated into the discharge process AND/OR FGDs with patients and staff

Illustrative results framework		
Objectives and activities	**Indicator**	**Data source**
	• The proportion of all health-care staff at the health facility who were satisfied with the WASH services and considered that these services contribute positively to providing high-quality care, disaggregated by gender and type of staff (medical, laboratory, cleaning, etc.).*	
Activity 1. Reduce physical barriers to WASH through construction and maintenance of WASH facilities and services as per national standard.	**Output indicators:** • Toilets are clearly separated/labelled for male and female or provide privacy (i.e. single stall/room) if gender neutral.** • At least one toilet is available for staff and toilet(s) is clearly separated or labelled.** • At least one functional toilet meets the needs of people with reduced mobility.** • Lighting for latrines is available where night-time services are provided and where there is not sufficient natural light to safely use the latrine during the day. Switches for lights, where relevant, are at an accessible height (max. 120 cm).** • A functional shower space for women, which is private and lockable is available in the labour and delivery area.** • Functioning hand hygiene stations *that can be reached by children and people in wheelchairs* are available at all points of care, waiting/public areas, and waste disposal area.**	Health facility WASH assessment such as WASH FIT, with integrated GEDSI content
Activity 2. Ensure that WASH facilities and products meet user needs and priorities.	**Output indicators:** • At least one usable toilet provides the means to manage menstrual hygiene management (MHM) needs.** • Proportion of patients who could access drinking water during their visit.	Health facility WASH assessment such as WASH FIT, with integrated GEDSI content

Illustrative results framework		
Objectives and activities	**Indicator**	**Data source**
	• Proportion of surveyed users satisfied with available products for MHM, incontinence, bed pans (culturally appropriate, user preferences). • Proportion of marginalized health facility users who feel safe using the WASH facilities at the health facility.	
Activity 3. Establish an environment that promotes GEDSI in WASH.	**Output indicators:** • Hand hygiene promotion materials are displayed and clearly visible *and understandable (images, large font, relevant languages*) in all wards/ treatment areas.** • Proportion of health facility users from marginalized groups having personally felt stigmatized or discriminated against in relation to their WASH needs (adapted from SDG indicator 10.3.1).	Health facility WASH assessment such as WASH FIT, with integrated GEDSI content Patient exit interview
Objective 3. Reduce hospital-acquired infections by 5% in one year.	**Outcome indicators:** • The proportion of all women who gave birth in the health facility who had a severe systemic infection or sepsis in the postnatal period, including at re-admission after delivery in the facility.* • The proportion of all women who gave birth in the health facility/neonates born who had proven hospital-acquired infections.*	Health information system
Activity 1. Train and supervise health facility staff on GEDSI and WASH as a key contributor to quality of care.	**Output indicators:** • Number of staff (medical, cleaning, etc.) trained in GEDSI in WASH, including patient-centred WASH counselling. • Provider and staff compliance with inclusive WASH, infection prevention and control (IPC) and environmental cleaning standards. • Guidelines on WASH in health-care facilities (with integrated GEDSI) available at the health facility.	Programme documentation Health facility supervision checklist Health facility WASH assessment

Illustrative results framework		
Objectives and activities	**Indicator**	**Data source**
Activity 2. Ensure management support for GEDSI for WASH.	**Output indicators:** • Adequate personal protective equipment (PPE) *in a range of sizes* is available at all times and in sufficient quantities for all cleaning staff.** • Policy and practices to improve occupational safety of cleaners and health-care waste technicians are available and implemented.** • WASH contractor selection considers the contractor's commitment to and record of being inclusive and engaging communities. • GEDSI activities included in health facility budget for WASH.	Health facility WASH assessment Health facility WASH assessment Programme documentation Health facility WASH assessment

* Outcome indicators adapted from Maternal and newborn care Standard 8: The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines, supplies and equipment for routine maternal and newborn care and management of complications, in: Standards for improving quality of maternal and newborn care in health facilities Geneva: WHO; 2016 *(https://www.who.int/publications/i/item/9789241511216, accessed 17 September 2023).*

** World Health Organization, United Nations Children's Fund (UNICEF). Water and sanitation for health facility improvement tool (WASH FIT): a practical guide for improving quality of care through water, sanitation and hygiene in health care facilities. 2nd edition. WHO; 2022 (*https://iris.who.int/handle/10665/353411*, accessed 26 August 2023).

Case study: Addressing gender equality and social inclusion, Indonesia[42]

The national roadmap for WASH in community health centres (Peta Jalan Air, Sanitasi, Higiene, and Pengelolaan Limbah di Puskesmas Tahun 2021–2030) developed by the Ministry of Health (MoH), with support from WHO, has seven strategic objectives which relate to policy and regulation, human resources for quality services, research and development, facility and infrastructure, community engagement, resilience and sustainability, and monitoring and evaluation.

The roadmap also recognizes that availability, accessibility, acceptability and quality of water sanitation and hygiene (WASH) services in health-care facilities are critical to improve patient safety and quality of care. It addresses the specific WASH needs of women and vulnerable populations, aims to prevent stigma and discrimination, and ensures that no one is left behind in access to WASH in health-care facilities.

On 18, 21 and 22 October 2021, WHO organized and led a series of virtual focus group discussions (FGDs) with key stakeholders to gather perspectives on the specific WASH needs of women and vulnerable populations in health-care facilities. The FGDs also explored both the challenges faced and promising practices in addressing those needs. The recommendations from the discussions will inform the development of the national roadmap on WASH in health-care facilities.

Women's perspectives are critical in WASH improvement efforts. Women are the main users of health services and the primary caregivers for family members. They have unique needs around the time of menstruation, pregnancy and childbirth. Therefore, the burden of poor WASH in health-care facilities falls disproportionately on women. WHO estimates that globally, up to 1 million mothers and newborns die from preventable infections linked with unclean births. Further, hospital-born babies in low-income settings are at a significantly higher risk of being affected by neonatal sepsis. Inadequate WASH infrastructure and poor hygiene practices in health-care facilities may also prevent women from seeking care.

[42] WASH in health care services for all: addressing gender equality and social inclusion (Feature story). Indonesia: WHO; 2021 (*https://www.who.int/indonesia/news/detail/13-11-2021-wash-in-healthcare-services-for-all-addressing-gender-equality-and-social-inclusion*, accessed 26 August 2023).

The WASH needs of vulnerable groups, such as persons with disabilities, older persons and children are also often overlooked, and they may face physical, institutional and social barriers when accessing WASH in health-care facilities. WASH services that are not inclusive for these groups could increase their risk of health-care associated infections and injuries and reduce their health-care utilization.

These needs were discussed in depth in the series of FGDs. On 18 October, the FGD started with five selected community health centres in East Nusa Tenggara province. Heads of community health centres, health-care workers, sanitarians and cleaning staff participated in the discussion. On 19 October, the discussion continued with civil society organizations (CSOs) and development partners who work with WASH, women's rights, children's rights and the rights of persons with disabilities in different provinces in Indonesia. Finally, on 20 October, the discussion concluded with a session with the MoH that explored the ministry's policies and practices in integrating gender and social inclusion in their programmes.

Lessons learnt from the FGDs revealed gaps in awareness, infrastructure and policies for inclusive and gender-equal WASH. While there is already awareness of the importance of, for example, inclusive toilets, it is not always addressed in the budget planning processes of health-care facilities. Further, WASH could be improved by involving vulnerable groups throughout the process, from participating in WASH assessments, to the development of improvement plans, their implementation, and monitoring of WASH services in health-care facilities.

CSOs and development partners shared some promising practices that could be replicated. These included inviting vulnerable groups as entrepreneurs to provide WASH infrastructure, organizing men's groups to promote handwashing practices, and socialization of inclusive WASH services to health-care facilities, including as part of the WASH FIT assessment.

Recommendations from the FGDs were as follows:

a. Policy and regulation

- Emphasizing government's role to promote meaningful participation of women and vulnerable groups in the development of WASH policy and guidelines

- Creating a specific mandate within the MoH to integrate gender equality and social inclusion in WASH in health-care facilities

b. Capacity-building for quality services

- Routine training on gender equality and social inclusion in WASH for all relevant actors: policy makers, health offices, health-care facility staff, relevant organizations and community representatives

c. Research and development

- Supporting research that explores specific WASH needs of vulnerable populations and innovative ways to address those needs. Support sharing of experience and learning on integration of gender equality and social inclusion in WASH in health-care facilities

d. Community engagement

- Meaningful participation of representatives from vulnerable groups in WASH improvement efforts – from planning, implementation to monitoring and evaluation

e. Monitoring and evaluation

- Advocacy to include indicators related to gender equality and social inclusion in accreditation of community health centres as well as in a Community-based Total Sanitation programme (Sanitasi Total Berbasis Masyarakat or STBM) assessment and occupational health curriculum for hospitals

WHO shared these recommendations with health officials in selected districts in East Nusa Tenggara province, CSOs and development partners and the MoH at a dissemination workshop on 29 October. The recommendations will help in the development of an inclusive roadmap for WASH in health-care facilities.

The programme on 'WASH in health-care services for all' in Indonesia has been made possible with the generous support of the Australian government.

Source: https://www.who.int/indonesia/news/detail/13-11-2021-wash-in-health care-services-for-all-addressing-genderequality-and-social-inclusion

STEP

6

Develop the health workforce

The goal of Step 6 is to ensure that health facility staff – from doctors to nurses, midwives and cleaners – gain the knowledge and skills to apply WASH and related IPC standards and guidelines in their day-to-day work. This can be achieved through pre-service training, regular professional development, and on-site coaching. The capacity-building provides the health workforce with an environment that protects their occupational health and safety, and allows them to perform their job to the best of their ability.

GEDSI considerations are important to include as part of health workforce development. Staff are responsible for ensuring that WASH at the facility is available, accessible, acceptable and used equitably to support IPC and patient-centred care for all patients. Competencies include having knowledge of GEDSI and WASH, positive attitudes, and the capacity to take action. **Tool 6.1** is a checklist outlining workforce competencies required for ensuring GEDSI in WASH in health-care facilities.

Negative attitudes towards marginalized groups are often the hardest barriers to overcome in strengthening inclusive WASH in health-care facilities, and may be the last to remain after physical and institutional barriers have been remedied. Health facility staff may not consider it appropriate to talk to girls about their menstruation needs, may disregard the cultural preferences of a pregnant woman from a different ethnic background, or may be afraid to interact with People Living with HIV (PLHIV) or with tuberculosis (TB).

Approaches to capacity-building

Several different approaches can be used to improve knowledge, attitudes and practices related to GEDSI in WASH at the health facility. Often a combination of interventions is effective. Interventions can include, for example:

Top-down:

- Leadership advocacy for a culture of quality improvement for WASH.
- Training on GEDSI to dispel myths, accompanied by supervisor follow-up mentoring, using exercises such as those included in **Tool 6.2**.
- Supervisory checklists on the availability and accessibility of WASH services in health-care facilities.
- Staff incentives for good performance.

While stand-alone sensitization and capacity-building efforts on GEDSI can be planned, integrating GEDSI into existing workforce trainings can ensure sustainability. Integration can be facilitated by:

- Adding sessions on unpacking what gender, equality, disability and social inclusion means
- Including GEDSI considerations into existing sessions to ensure that the workforce keeps GEDSI considerations in mind at all times
- Facilitating the sharing of experiences by marginalized groups
- Exposure visits to facilities with GEDSI in WASH

Within facility:

- Displaying posters on GEDSI such as the sample included in **Resource 6.1**.
- Monitoring patient feedback or regular audits on GEDSI in WASH in health facilities, and reviewing the results with the health facility staff.
- Ranking wards according to WASH FIT score.
- Tracking performance using a run chart on a wall for mutual accountability.
- Using quality improvement approaches to identify gaps in performance and develop solutions, increasing confidence of health facility staff that they can contribute to improve the quality of care.
- Peer-led learning to encourage inclusive WASH practices.

Bottom-up:

- Engaging marginalized staff as active participants on the WASH FIT team. Seeking and respecting the views of these groups can be pivotal to changing attitudes, both of the health facility staff and the marginalized groups themselves.

Health facility staff are a key source of insight and innovation. However, most staff have little power in WASH decision-making. For example, women make up 70% of the world's health-care staff, but only 25% of the leadership.[43] Staff from marginalized groups are often in menial jobs such as cleaning and waste management. Their access to information and personal protection, not to mention decision-making about WASH in health facilities, is often limited. WASH FIT and other similar WASH for health facility tools provide an opportunity for frontline health-care workers and lower-level non-clinical staff to advocate for their needs and priorities, resulting in a better, decent working environment for everyone.[44] However, they may need active support to increase participation from simple attendance to speaking up, influencing decisions, and setting their own rules.

> *"I always underestimated the talent and ingenuity of health facility cleaners until I had to train them. In fact, they trained me in the ideas they offered for overcoming limited resources, how they supported each other, and how quickly they grasped new skills and understanding about the value of cleaning."*
>
> Environmental hygiene and IPC trainer, Health centre, The Gambia

> *"Menstruating in PPE is tricky, especially if you are used to heavy flow and there's a chance you might stain your suit, as the material of our PPE is of poor quality too. It is shameful to share these things but it is obvious, so the administrators should be sensitive!"*
>
> Nurse-in-charge, India

[43] Delivered by women, led by men: A gender and equity analysis of the global health and social workforce. Geneva: World Health Organization; 2019 (Human Resources for Health Observer Series No. 24). Delivered by women, led by men: a gender and equity analysis of the global health and social workforce (*who.int*)

[44] World Health Organization, United Nations Children's Fund (UNICEF). Global progress report on water, sanitation and hygiene in health care facilities: fundamentals first. Geneva: WHO; 2020 (https://apps.who.int/iris/handle/10665/337604, accessed 26 August 2023).

Resources and Tools

Tool 6.1: Checklist for building capacities of the health workforce

The table summarizes key health workforce competencies required for ensuring GEDSI for WASH in health-care facilities

Tool 6.2: Examples of capacity-building exercises on GEDSI in WASH for the health workforce

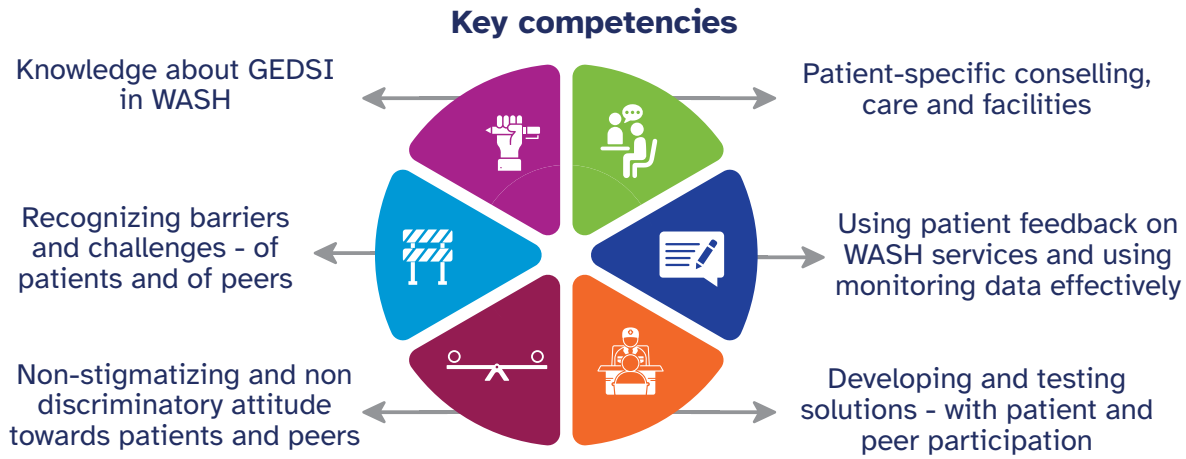
Training flashcards to share key points about GEDSI for WASH in health facilities, and a 'Wall of Barriers' group exercise to explore and understand the barriers faced by marginalized groups

Resource 6.1: Example of a job aid to enhance staff awareness and knowledge on GEDSI in WASH in health-care facilities

A job aid to remind health-care providers about how to integrate GEDSI as part of their activities related to WASH

Tool 6.1:

Checklist for building capacities of the health workforce



All members of the health workforce have a role to play in strengthening GEDSI and promoting the human rights of patients and other visitors to the health facility, as well as their peers within the facility. The table below highlights some of the key competencies required to integrate a GEDSI lens into their work. This can be used as a base checklist to examine whether the capacity-building plans cover required competencies. These competencies are by way of example, more can be added based on discussions with the WASH FIT team or partners working at the intersection of GEDSI and health care.

Sample GEDSI-linked health workforce competencies			
Cadre of health workforce	**Sample GEDSI competencies**	**Incorporated in capacity-building efforts?**	
		Yes	**No**
Clinical providers (physicians, nurses, midwives, physicians' assistants)	Knowledge of GEDSI and human rights as applied to delivering high-quality care (including WASH) to all patients regardless of their background characteristics.		
	Non-stigmatizing attitudes and non-discrimination of patients and peers, including cleaning staff.		
	Asking for patient feedback on their WASH needs and preferences, including issues that might be considered social taboos (e.g. menstruation, incontinence).		

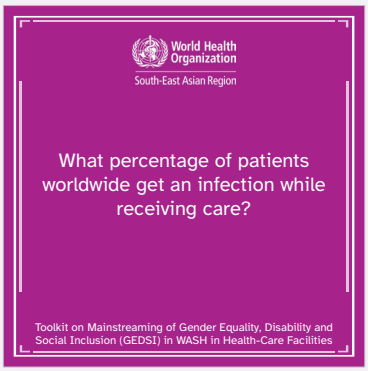
Sample GEDSI-linked health workforce competencies			
Cadre of health workforce	**Sample GEDSI competencies**	**Incorporated in capacity-building efforts?**	
		Yes	**No**
	Delivering patient-centred care, including hygiene counselling specific to the patient, infection prevention and control (IPC), and support to patients' diverse WASH needs.		
Patient advocates, social workers	Providing hygiene counselling to patients and their families in a manner that recognizes the barriers they face and identifies feasible solutions.		
	Linking patients from marginalized groups with community resources to support their WASH needs both inside and outside the health-care facility.		
Quality assurance (QA) specialists	Monitoring accessibility and acceptability of WASH, especially with respect to marginalized groups, and use to ensure quality health services.		
	Collecting data on the barriers faced by marginalized groups using quantitative and qualitative methods, possibly through community members on the QA team.		
	Engaging health facility staff, including those who are lower-paid, in developing and testing solutions to improve GEDSI for WASH in health facilities.		
	Using findings to advocate for and make changes to address GEDSI issues in WASH in health facilities.		
Cleaning/ environmental management staff	Understanding the barriers faced by marginalized groups.		
	Ensuring WASH infrastructure is responsive to the needs of all patients.		
	Identifying gaps and problems related to accessibility and acceptability of WASH, and working with other health facility staff to develop solutions.		
Health managers, supervisors	Knowledge of GEDSI for WASH.		
	Ensuring implementation of and compliance with inclusive policies.		
	Leadership and mentoring to strengthen equity in health service delivery.		
	Monitoring availability and accessibility of WASH, use for IPC and patient-centred care.		
	Providing or facilitating training on GEDSI to health facility staff.		

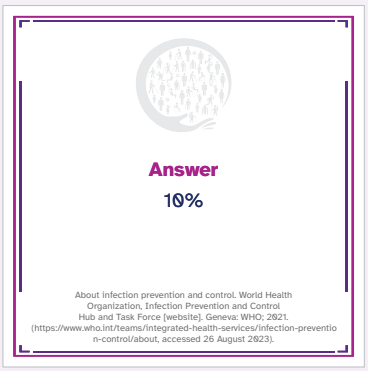
Sample GEDSI-linked health workforce competencies			
Cadre of health workforce	**Sample GEDSI competencies**	**Incorporated in capacity-building efforts?**	
		Yes	**No**
	Ensuring health facility staff, including those who are lower-paid (e.g. cleaning staff), have access to equipment and tools to protect their health.		
	Engaging diverse community members in planning and monitoring GEDSI for WASH in health-care facilities.		

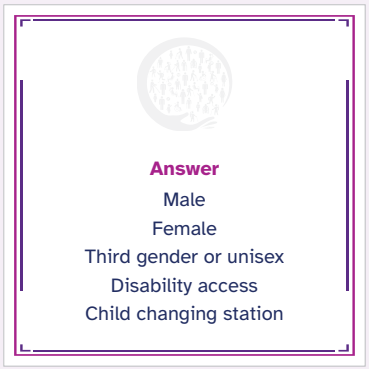
Tool 6.2:

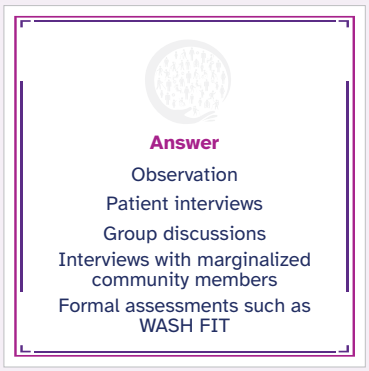
Examples of capacity-building exercises on GEDSI in WASH for the health workforce

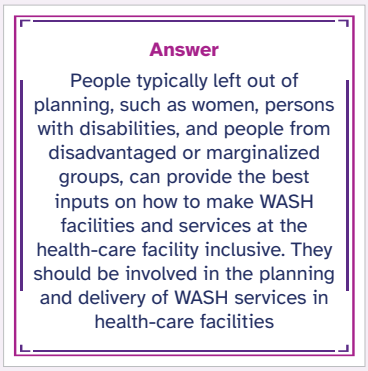
Exercise 1: Training flash cards on inclusive WASH for health facility staff











World Health Organization
South-East Asian Region

True or false:

Health facility staff have specific WASH needs and priorities.

Toolkit on Mainstreaming of Gender Equality, Disability and Social Inclusion (GEDSI) in WASH in Health-Care Facilities

Answer

Absolutely true! The needs of all facility staff should be voiced and taken into consideration when improving WASH.

World Health Organization
South-East Asian Region

What materials are needed for MHM?

Toolkit on Mainstreaming of Gender Equality, Disability and Social Inclusion (GEDSI) in WASH in Health-Care Facilities

Answer

Washable waste bin with lid, liner

Basin, water, soap

Products such as sanitary napkins

Drying rack for washing reusable products

World Health Organization
South-East Asian Region

True or false:

There are existing tools that health facilities can use to assess and improve inclusive WASH.

Toolkit on Mainstreaming of Gender Equality, Disability and Social Inclusion (GEDSI) in WASH in Health-Care Facilities

Answer

True. Two examples include WASH FIT and the Participatory Management Tool for user-friendly WASH in health-care facilities. (WaterAid, 2020).

World Health Organization
South-East Asian Region

Which of the following is true about inclusive WASH:

- improves patient satisfaction and health outcomes
- improves staff satisfaction
- increases community engagement
- reduces social inequalities between different groups of people

Toolkit on Mainstreaming of Gender Equality, Disability and Social Inclusion (GEDSI) in WASH in Health-Care Facilities

Answer

All of them.

Exercise 2: Group exercise to understand barriers to inclusive WASH in health-care facilities[45]

The **"Wall of Barriers"** exercise developed by WEDC and WaterAid helps teams identify and analyse the barriers that create problems for users in accessing WASH facilities. The tool is adapted here for use in health-care settings. Exploring and discussing the barriers to accessible and acceptable WASH support services that support quality of care and are used to strengthen GEDSI is a way to sensitize health-care workers to the diverse needs of their patients. The exercise can also be used in a community setting to increase awareness of community members (Step 7).

Step 1. Obtain resource materials

In advance of the exercise, identify case studies from resource materials such as documents or video clips about problems faced by some marginalized groups in accessing and using WASH in health-care facilities. Select 3–5 such resources. They can all be about one group, or about different groups.

Step 2. Identify barriers

Give group members a case study to read or share it with all of them. Ask the participants to write down what barriers they observe that prevent or create problems for users when trying to access or use WASH facilities. Each barrier should be written on its own piece of paper or post-it note.

Step 3. Sorting

When the participants have listed all the barriers they can think of, have them place the post-it note under one of four headings that are on the wall:

- **Physical-natural:** The person's own limitations.
- **Physical-infrastructure:** Structural obstacles that prevent or block mobility.
- **Policy/Institutional:** How policies and programmes on WASH in health-care facilities are organized and implemented.
- **Social/Cultural/Attitudinal:** Conflicts that may arise due to differences in social backgrounds, norms, beliefs and practices among individuals or groups.

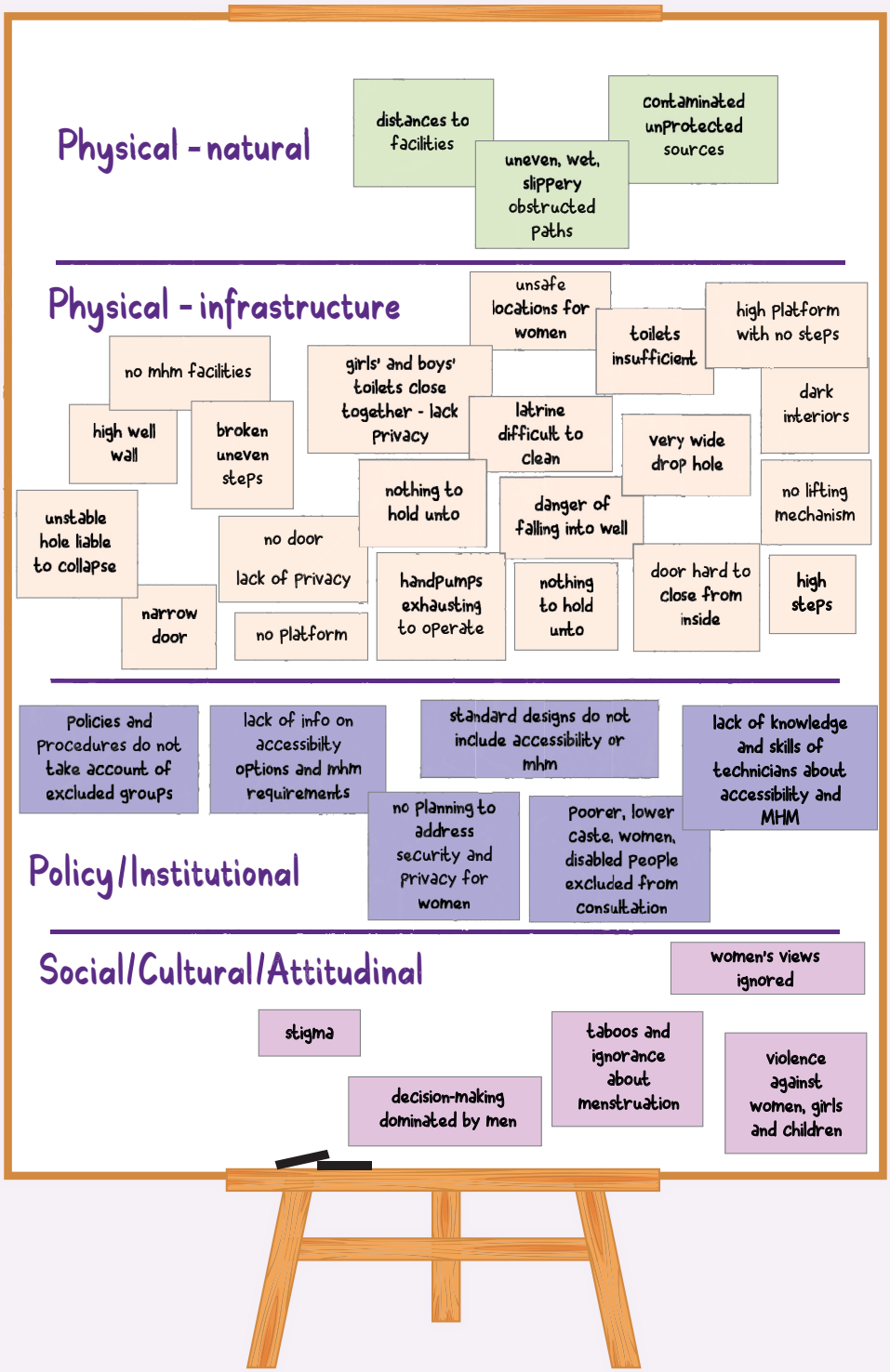
Group similar barriers together. When you have finished, you have a wall of barriers, composed of all the problems, issues and obstacles that you have identified.

[45] Adapted from: Activity Sheet 2: Identifying barriers to water, sanitation and hygeine. Loughborough: WEDC and WaterAid; 2013. (https://wedc-knowledge.lboro.ac.uk/resources/learning/EI_AS2_Identifying_barriers_v2.pdf, accessed 26 August 2023) and Jones H, Gosling L, Jansz S et al. Equity and inclusion in WASH provision – using the social model of exclusion (Powerpoint presentation). Loughborough: WEDC and WaterAid; date unavailable (https://wedc-knowledge.lboro.ac.uk/resources/learning/EI_WASH_Social_model_of_exclusion_v3.pdf, accessed 26 August 2023).

Step 4. Group discussion and summary

Ask the participants to talk about the barriers they identified.

- Are many of the barriers different?
- Are they mainly in the same category or in all different categories? Which barriers are the most common?



Resource 6.1:

Example of a job aid to enhance staff awareness and knowledge on GEDSI in WASH in health-care facilities

Case study: Integrating GEDSI into TEACH CLEAN training in Myanmar[46, 47]

A key component of the Supporting Safer Births in Myanmar Project was building health facility staff capacity in GEDSI. The project, funded by the Australian Government and the Water for Women Fund, was implemented by WaterAid in partnership with Jhpiego and in collaboration with the Ministry of Health and Sports (MoHS) in five township hospitals in the Ayeyarwady region (Myan Aung, Kyan Kin, Pantanaw, Lemyathna and Zalun).

To strengthen the capacity of health facility staff to improve GEDSI-sensitive WASH and infection prevention and control (IPC) in their facilities, the project designed and delivered the TEACH CLEAN training, which aims to improve environmental cleaning services in health facilities by focusing on the frontline workforce, specifically cleaners and those with cleaning responsibilities. The training manual included GEDSI concepts and approaches by discussing different vulnerabilities in health-care facilities, barriers in accessing WASH and IPC services in health-care facilities, and how to address it.

Cleaners in project health-care facilities received environmental cleaning training for the first time, which gave them a better understanding of cleaning processes and best practices in hospital settings. The training employed participatory exercises, such as barrier analysis and squatting exercise to understand accessibility of WASH infrastructure for persons with different disabilities.

For example, during the **'gender barrier analysis'** session, three case scenarios were provided for three groups. One scenario presented the case of an HIV-positive postpartum woman. Participants discussed the consequences of stigma and discrimination on that marginalized population, and how to prevent it, as well as humanitarian principles and work ethics in the health-care setting. The second scenario was about a woman with mental illness and no family support who came to the hospital for childbirth. Participants discussed non-judgemental behaviour and social support available in the community. The third scenario was about a person with disability and use of the hospital's toilet. Discussion highlighted the need for the sympathy and understanding towards people with special needs.

As central and regional MoHS officials were involved in TEACH CLEAN trainings as facilitators, they also gained a fuller understanding of GEDSI, WASH and IPC in health facility settings. In Kyangin, the township medical officer decided to independently fund and install GEDSI-sensitive infrastructure such as user-friendly toilets with MHM facilities, gender separate bathing facilities, and proper pathways. This demonstrates the importance of involving all health facility staff (district supervisors, nurses and cleaners) in the training to ensure the training can be applied.

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[46] Supporting Safer Births in Myanmar: Strengthening health systems to improve the quality of maternal health care. Yangon: WaterAid Myanmar; 2020 (*https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/2022-05/WASH%20in%20HCFs%20-%20Myanmar%20case%20study.pdf*, accessed 26 August 2023).

[47] Training report: Training of trainers (ToT) in Environmental Hygiene and Cleaning in Health care (TEACH-CLEAN training). Pathein City, 4-6 February 2020. Yangon: WaterAid Myanmar; 2020.

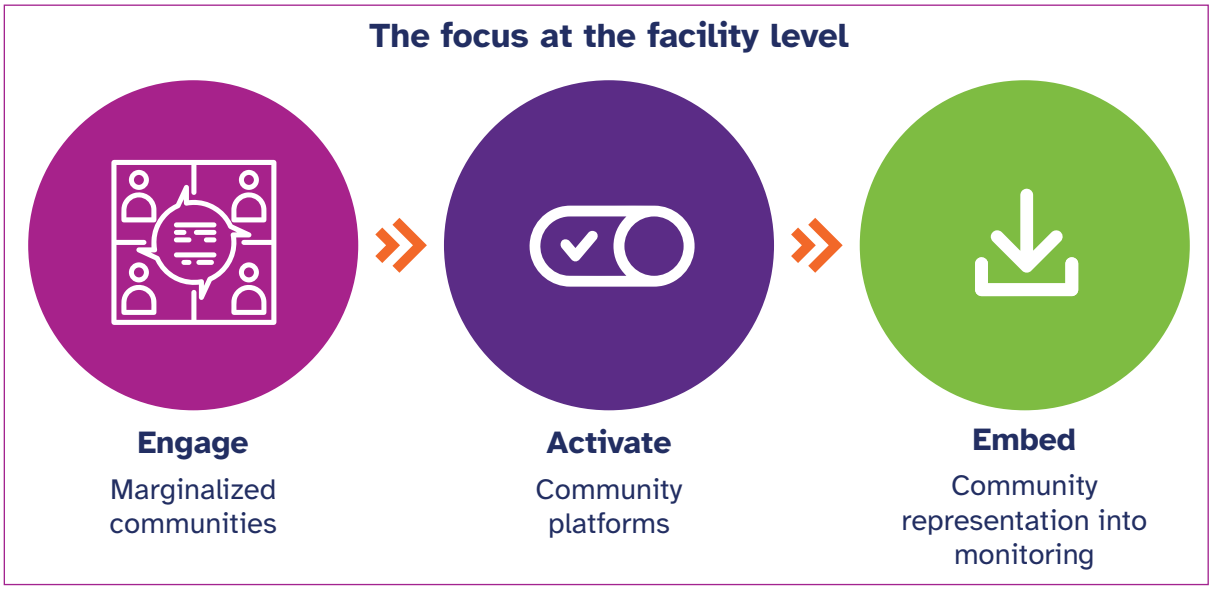
STEP

7

Engage communities

Community members serve an important role in defining, demanding, using and providing feedback on health services. Under Step 7, communities are engaged in developing WASH policies and plans, reviewing WASH coverage and implementation data, and providing feedback on health facility performance.

The engagement of community members, particularly women, persons with disabilities, LGBTQIA+, and other marginalized groups is essential for planning, improving and monitoring GEDSI integration in WASH in health-care facilities. GEDSI integration in Step 7 can be achieved through three approaches: empowering marginalized groups, activating existing community platforms, and establishing systems for community monitoring.



Engaging marginalized groups

Marginalized groups are more impacted by poor WASH in health-care facilities, while lacking representation in WASH task forces and teams that drive improvement. To address this gap, they need to be involved in activities at both the national and health facility-levels:

National and subnational level task forces	WASH FIT teams
Situation analysis and assessment of GEDSI for WASH in health-care facilities	Health facility assessment and risk assessment
Development of roadmaps and national standards	Development of improvement plan
Infrastructure improvement and health workforce development	Improvement activities
Monitoring progress and operations research	Monitoring, reviewing and adapting

Engaging these groups can be challenging, especially when they face resistance from other, typically more powerful, community members or health facility staff. They may need guidance and capacity building to effectively advocate for their rights to WASH and to participate in decision-making. In the long-run, their participation will help weaken the barriers that contributed to their marginalization in the first place.

Activating community platforms

Efforts will be more powerful when the broader community understands the importance of GEDSI integration and provides support. **Tool 7.1** is an example of a sensitization exercise that can be used with communities. **Tool 6.2** has examples of activities for health workforce sensitization and these can also be adapted for communities. Community groups and CSOs can be powerful partners as well. **Resource 7.1** provides tips for activating community platforms. **Resource 7.2** is a sample poster on GEDSI and WASH in health-care facilities for communities.

Community engagement in monitoring WASH in health-care facilities, including GEDSI

It is a key element of WASH FIT and other similar processes, as described under Step 4. Community members should be adequately prepared and supported so they can be confident that their views will be understood and addressed.

The most effective approach to engaging communities and empowering marginalized groups will vary from one community to another. Some groups may be uncomfortable to speak about conditions in the local health facility, and may prefer to provide feedback indirectly. Other groups may work through an organization that represents their interests. Yet others will be willing and comfortable to work together as part of the broader community to ensure that WASH is accessible and acceptable to everyone across the life course.

Resources and Tools

Tool 7.1: Power walk – An example of a sensitization exercise for communities on GEDSI

The power walk is an exercise that helps participants understand the impacts of marginalization and exclusion. This can be used with communities to initiate conversations on GEDSI

Also see Step 6, Tool 6.2: A group exercise to understand barriers to inclusive WASH in health-care facilities. The group exercise can be used by health facility staff as well as community members to understand the physical, institutional and social/cultural barriers to inclusive WASH in health-care facilities

Resource 7.1: Tips for activating community platforms

This resource provides simple tips to activate community platforms to support GEDSI integration

Resource 7.2: Sample poster to enhance community awareness on GEDSI in WASH in health-care facilities

A poster to create awareness among community members and provide them simple action points to increase their engagement

Tool 7.1:

Power walk – An example of a sensitization exercise for communities on GEDSI

The power walk helps participants understand how marginalized communities are impacted in different aspects of their life and provides insights into communities and population segments that wield power. Ideally, there should be 8–12 participants participating in the activity. If you have more participants in the session, 8–12 can participate in the activity and the others can observe. The use of a cloth covering the eyes helps participants stay true to character and not be influenced by others. Make changes to statements and character slips depending on your own context.

- Start the session by informing the participants that in this exercise everyone's eyes will be covered.
- Provide the instructions as below:
  - Stand horizontally across the room in one line.
  - Everyone should have the same line as their starting point.
  - Each participant will be given a character to play. They need to play that character throughout this game and respond to statements read out by the facilitator depending on whether the statement holds true for the character or not. (Hand out character slips to each participant and ensure participants do not share their character details with each other.)
  - Now cover your eyes using the cloth being handed out.
  - The facilitator will read out statements and if the statement holds true for your character, then take a step forward. If it does not, then stay where you are. Remember, you are an actor, think like the character and not as yourself.
  - Once all statements are through, you will be able to remove your eye cover.

Characters (Please add delete or modify)	Statements (Please add delete or modify)
1. 16-year-old boy 2. 16-year-old girl 3. 16-year-old girl using a wheelchair 4. 50-year-old rich man 5. 50-year-old rich woman	1. I can go to the neighbourhood market by myself. 2. My family trusts me to make my own decisions. 3. I can go out with whoever I want.

Characters (Please add delete or modify)	Statements (Please add delete or modify)
4. 50-year-old man with a visual impairment 5. 30-year-old man from an upper/ dominant caste/race (add any as culturally appropriate) 6. 30-year-old woman from an upper/ dominant caste/race (add any as culturally appropriate) 7. 30-year-old man from a lower/ marginalized caste/race (add any as culturally appropriate) 8. 30-year-old woman from a lower/ marginalized caste/race (add any as culturally appropriate) 9. 30-year-old woman from a lower/ marginalized caste/race (add any as culturally appropriate) with mobility impairment and no wheel chair 10. 6-year-old boy 11. 6-year-old girl 12. 6-year-old boy with developmental challenges	13. People at the health-care centre speak to me kindly. 14. People make fun of me. 15. I have been beaten up by parents/ strangers/spouses/providers. 16. I can reach the washbasin at the health-care facility. 17. If I have gone to the market, and I need to go to the toilet, I can find one that I am comfortable using. 18. I can take the bus whenever I want. 19. I can easily drink water from the well/tap that is meant for everyone. 20. It is easy for me to find work and earn a living. 21. I do not need assistance for bathing, going to the toilet, etc. 22. There is someone in my life that I am scared to be alone with. 23. A relative has touched me in a way that makes me uncomfortable.

- When all statements have been completed, ask everyone to open their eyes and look around the room in silence.
- Now read out the character descriptions one by one and ask the participants how far ahead do they think this character would have reached. After participants guess, ask the person playing the character to put their hands up and reveal their position. Do this for all characters. Let the participants remain in their positions.
- Now ask the following characters to raise their hands:
  - All people playing female characters
  - All people playing a character from lower/marginalized caste
  - All people playing characters with a disability
  - All people playing male characters
- Summarize the discussion reinforcing the experience of marginalization and how it impacts lives of communities.

Resource 7.1:

Tips for activating community platforms

- √ Map community groups and identify their potential interest in working towards GEDSI for WASH in health-care facilities.
- √ Identify specific organizations working on inclusion of marginalized populations, disability rights groups, etc.
- √ Meet with the groups and CSOs to share about the importance of GEDSI for WASH in health facilities, how it impacts them, and how they can be involved.
- √ Ensure participation of local health facility staff and local leaders in such meetings and sessions.
- √ Encourage community groups and CSOs to become involved with WASH FIT or other similar processes, focusing particularly on advocating for and monitoring GEDSI.
- √ Provide opportunities to build group capacity on GEDSI and WASH, and encourage the group to include GEDSI and WASH in their workplans.
- √ Support them in securing membership and representation to committees and task forces working on GEDSI in health-care facilities.

Resource 7.2:

Sample poster to enhance community awareness on GEDSI in WASH in health-care facilities

HEALTH FOR ALL INCLUDES WASH FOR ALL

Challenges faced by health facility users

I get so thirsty, but there is no water available during antenatal care.

I wish the staff toilets had better menstrual products and dustbins for disposal

Because I'm different, I'm told that I can't use the toilet!

My wheelchair doesn't fit through the doorway!

People get impatient when I'm slow in the bathroom.

I can't reach the sink!

Awareness

We all have different WASH needs across the life course, depending on our gender, age, physical and mental abilities, and other characteristics.

We are all in this together. Every person at the health-care facility needs to be able to wash their hands and use the sanitation facilities to keep the facility clean and stop the spread of infection.

High-quality care means that health facility staff wash their hands, maintain a clean environment, and make sure the patient's WASH needs are met.

Action

Talk to your health facility staff or community health leaders about ways to improve WASH at your health facility.

Volunteer your time and resources to help keep the facility and its environment clean.

Get involved in the health facility's committee for WASH.

WASH services at health-care facilities are for everyone

We all need to practice hygienic behaviours to keep the facility clean and keep ourselves healthy.

Talk to your health-care facility staff to make sure the WASH services meet your needs!

Case study: Learning from gender networks and disabled people's organizations (DPOs) in Myanmar

During 2018–2021, WaterAid, in partnership with Jhpiego and in collaboration with the Ministry of Health and Sports (MoHS) implemented the Supporting Safer Births in Myanmar Project funded by the Australian Government and the Water for Women Fund. The goal of the project was that women in Myanmar have safer births through improved quality of maternal and newborn care. This would be accomplished through health-care system strengthening by integrating gender and socially inclusive WASH and IPC, and demonstrating quality improvements at five township hospitals in the Ayeyarwady region (Myan Aung, Kyan Kin, Pantanaw, Lemyathna and Zalun). The project was aligned with the government's National Health Plan (2017–2021), which aims to provide a basic package of essential health services to everyone by 2020, and the National Strategy for Rural WASH (2016–2030), which aims to see all health facilities with adequate water supplies, toilets and handwashing facilities by 2030.

The project convened a national network of GEDSI stakeholders to engage them in WASH in health-care facilities-related issues and to consult on project plans and approaches for their expert input. Regular sessions were held between gender networks, DPOs, and the project team to build a mutual understanding of GEDSI in WASH. Several workshops were held in collaboration with rights groups to improve project staff and stakeholders' understanding of GEDSI and facilitate reflection on how to integrate GEDSI within the project context. WaterAid Myanmar also held a workshop with rights groups to familiarize them with WASH.

The regular engagement between rights groups and the project team enabled rights groups to contribute to specific activities, strengthening processes and outputs to be more gender and socially inclusive. For example, the working group was regularly consulted on infrastructure assessments and WASH in health-care facilities policies. The project developed a participatory technical assessment tool for WASH infrastructure in health-care facilities in consultation with the gender networks and DPOs.

STEP

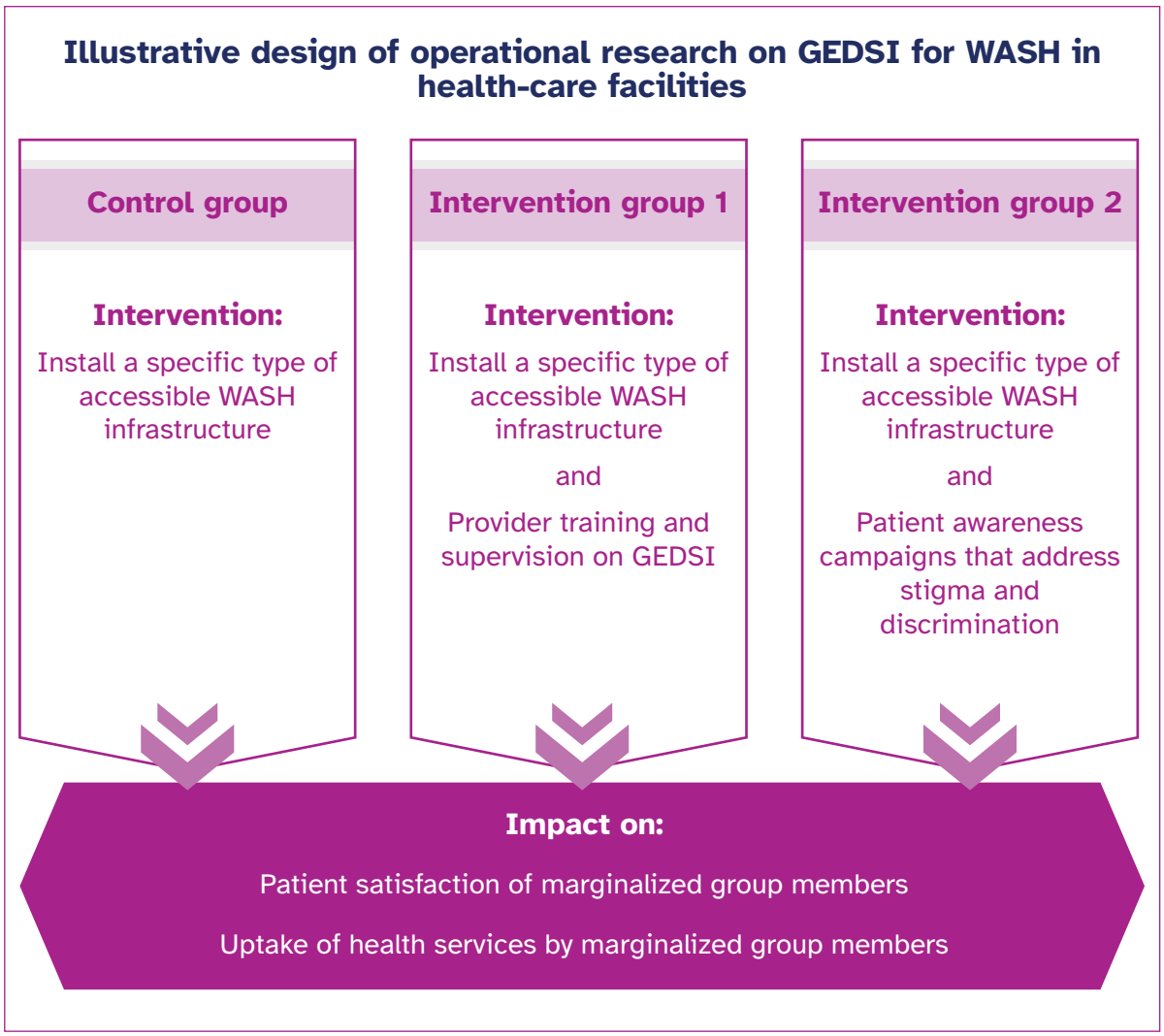
8

Conduct operational research and share learning

The goal of Step 8 is to develop a stronger evidence base, identify innovative strategies and proven approaches to improve WASH in health-care facilities, which can drive continued action and investment. Programme strategies and interventions are reviewed and tested using operational research which provides health-care facilities and programmes opportunities for **"learning by doing"**. Also known as implementation research, it evaluates alternative programme strategies to determine which has the greatest impact on quality of care, is the most efficient, cost-effective and sustainable, and has the best outcomes.

Operational research methods can also be used to test which changes or improvements in WASH in health facilities have the biggest impact on GEDSI. For example, an operational research study could test different combinations of interventions at health facilities, examine their comparative effectiveness, safety, cost and equity, and evaluate which is the best approach for the specific context.

Illustrative design of operational research on GEDSI for WASH in health-care facilities



Planning an operational research study

Operational research is most successful when it is conducted by a team that includes both researchers and implementers, in this case, health facility teams and community members working to integrate GEDSI in WASH in health-care facility.[48] While the researchers bring expertise in research methods, the implementers' role is to:

- take the lead in defining the programme problem;
- specify when the study result is needed for decision-making;
- ensure that providers and facilities cooperate with the researchers;
- use the findings in programme decision-making; and
- disseminate research findings.

The team should work together to identify the problem related to GEDSI for WASH in health-care facilities, explore the causes and develop possible interventions, and finally test selected solutions in health-care facilities, documenting the impact on the original problem. The results will inform further replication in other health-care facilities. **Tool 8.1** outlines the process for operational research and **Resource 8.1** lists additional resources that you can refer to.

Learning from experiences in integrating GEDSI in WASH in health-care facilities

Whether the results of the research indicate that the changes in the health-care facility's WASH facilities and practices proved beneficial, had no impact, or were even detrimental, it is important to share the findings so that others can learn from the experience. Because the effectiveness of any intervention is influenced by the social networks and operational environment of the participating health-care facilities, it will be important to collect and share such background information and analyse how it facilitated or hindered success, so that others can take these factors into consideration when they adapt or replicate the intervention.

[48] Guide to operational research in programmes supported by the Global Fund. Geneva: WHO, The Global Fund; 2009 (*https://www.medbox.org/document/guide-to-operational-research-in-programs-supported-by-the-global-fund#GO*, accessed 26 August 2023).

Resources and Tools

Tool 8.1: Steps in conducting operational research

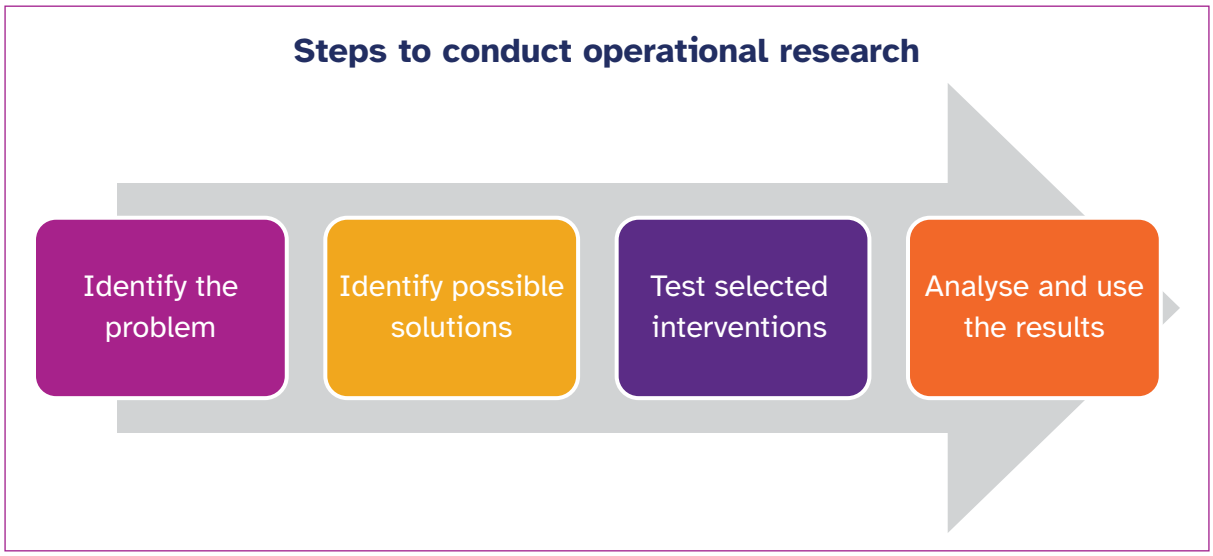
A summary of the key steps in conducting operational research

Resource 8.1: Additional guidance on operational research

A collection of resources for in-depth guidance on how to conduct operational research

Tool 8.1:

Steps in conducting operational research



1. Identify the programme problem[49]

Clearly defining what is the problem that needs to be solved is critical to being able to develop solutions. Involving different groups of people – health providers, facility staff, and diverse community members – in discussing the problem can bring new insight into pressing issues. The problem definition can also draw on the findings of WASH FIT health facility assessments.

The problem could be related to accessibility or acceptability of WASH to health facility users, the equitable use of WASH for IPC and to improve quality of care, or the engagement and empowerment of marginalized groups through WASH-related activities. Some illustrative problems could include:

- Some patients are not using the toilets or handwashing stations.
- Some patients, such as young girls, LGBTQIA+, or ethnic minority members are reluctant to use the WASH facilities provided.
- Women do not use the menstrual hygiene bins provided.
- Health-care providers and staff are not aware of the differing WASH needs of their patients.
- Despite the availability of WASH, the facility has a high rate of infections in the maternity ward.
- Health managers do not prioritize WASH improvements to better meet the needs of diverse users in the facility budget.

[49] Adapted from: Guide to operational research in programmes supported by the Global Fund. Geneva: WHO and the Global Fund; 2009 (*https://www.medbox.org/document/guide-to-operational-research-in-programs-supported-by-the-global-fund#GO*, accessed 26 August 2023).

2. Identify possible solutions

The next step is to understand the causes of the problem using the problem tree analysis or other similar tools. For example, in reference to the problems described above, *why* are mothers reluctant to use WASH facilities, *why* are health-care providers and staff not aware of the patients' WASH needs, *why* are GEDSI priorities so low in health facility WASH budgets?

Based on the root causes identified, the research task force should explore and develop possible interventions that can change the problem. Research team members who are also WASH users at the health-care facility can provide relevant suggestions about what would work for them, while external researchers or experts can provide examples of what has worked in other settings.

Solutions can take the form of infrastructure improvements, training, mentoring, or group work to increase knowledge, change attitudes, or practice new behaviours for example. Some ideas have been provided in **Step 4, Tool 4.4** on action planning. Good solutions have to be measurable, easy to implement, and sustainable. The data collection may need to determine not only whether the intervention is effective, but also how much it cost and what other resources are needed for broader implementation.

3. Test selected intervention(s)

Operational research uses a scientific method to determine whether the proposed solution(s) are effective. One approach is to collect data on the problem both before and after the intervention, comparing whether they resulted in a change.

A second approach is to implement the intervention in an "experimental" health-care facility and compare the results with another health-care facility, the "control", which did not receive the intervention.

Both quantitative and qualitative methods can be used. Quantitative methods include structured questionnaires or the analysis of service statistics. Qualitative methods include FGDs or individual interviews with service providers or clients or observational studies, e.g. observing the use of WASH practices at the health-care facility.

The same data collection process should be used across all health-care facilities or individuals being monitored.

4. Analyse and use the results

The results of the study will be important to guide decision-makers in choosing the best, and most cost-effective solutions to strengthen inclusive WASH in health-care facilities. Teams working to improve WASH in health-care facilities, including GEDSI integration for increased equity, should also seek new learning from other settings and countries.

Resource 8.1:

Additional guidance on operational research

Publications

WHO (2013) Implementation Research in Health: A Practical Guide
https://iris.who.int/handle/10665/91758

WHO and the Global Fund (2008) Guide to operational research in programmes supported by the Global Fund
https://medbox.org/document/guide-to-operational-research-in-programs-supported-by-the-global-fund#GO

The Global Fund (2008) Framework for Operations and Implementation Research in Health and Disease Control Programs
https://iris.who.int/handle/10665/44686

Websites

The Special Programme for Research and Training in Tropical Diseases (TDR): Massive open online course (MOOC) on implementation research: infectious diseases of poverty
https://tdr.who.int/

The Special Programme for Research and Training in Tropical Diseases (TDR): Implementation Research Toolkit
https://adphealth.org/irtoolkit/

The Special Programme for Research and Training in Tropical Diseases (TDR): The Structured Operational Research and Training IniTiative (SORT IT)
https://tdr.who.int/activities/sort-it-operational-research-and-training#

Annex 1.
Additional resources

Resources on WASH in health-care facilities

Publications

WHO (2023) Global SDG baseline for WASH in health care facilities: Practical steps to achieve universal WASH in health care facilities. Questions and answers
https://cdn.who.int/media/docs/default-source/wash-documents/wash-in-hcf-q-a-2april.pdf?sfvrsn=69d0d54a_6

WHO and UNICEF (2022) Water and Sanitation for Health Facility Improvement Tool (WASH FIT): A practical guide for improving quality of care through water, sanitation and hygiene in health care facilities (second edition)
https://iris.who.int/handle/10665/353411

WHO (2020) Quality health services: a planning guide
https://www.who.int/publications/i/item/9789240011632

WHO (2019) Water, sanitation and hygiene in health care facilities: practical steps to achieve universal access.
https://www.who.int/publications/i/item/9789241515511

WHO/UNICEF Joint Monitoring Programme (2018) Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals
https://www.who.int/publications/i/item/9789241514545

WHO (2017) Safe management of wastes from health care activities: A summary
https://www.who.int/publications/i/item/WHO-FWC-WSH-17.05

WHO (2016) Standards for improving quality of maternal and newborn care in health facilities
https://iris.who.int/handle/10665/249155

WHO (2008) Essential environmental health standards in health care.
(John Adams, Jamie Bartram)
https://iris.who.int/handle/10665/43767

Websites

WHO and UNICEF (2022) WASH FIT portal
https://www.washinhcf.org/wash-fit/

WASH in Health care facilities portal
https://www.washinhcf.org/

Resources on GEDSI integration in WASH in health facilities

Publications

WHO and UNICEF (2022) Water and Sanitation for Health Facility Improvement Tool (WASH FIT): A practical guide for improving quality of care through water, sanitation and hygiene in health care facilities (second edition): Technical factsheet 2: Gender equality, disability, and social inclusion (GEDSI)
https://www.washinhcf.org/wp-content/uploads/2022/04/220420_BLS21265-WHO-WASH-FIT_TF2_GEDSI_web_COMPLETE.pdf

WHO and UNICEF (2022) Water and Sanitation for Health Facility Improvement Tool (WASH FIT): WASH FIT Training Modules: GEDSI Technical Module.
https://www.washinhcf.org/wp-content/uploads/2022/05/GEDSI_MODULE_0422_COMPLETE.pptx

WaterAid (2018) Developing a participatory management tool for user-friendly WASH in health care facilities (WaterAid)
https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/developing-a-participatory-management-tool-for-user-friendly-wash-in-healthcare-facilities.pdf

WHO Western Pacific Region (2020) Disability-inclusive health services toolkit: a resource for health facilities in the Western Pacific Region
https://www.who.int/publications/i/item/9789290620020

Resources on GEDSI integration in health service delivery

Publications

WHO (2017) National Health Inequality Monitoring: a step-by-step manual
https://cdn.who.int/media/docs/default-source/gho-documents/9-june-web-version-17136-national-health-inequality-monitoring-step-by-step-manual.pdf?sfvrsn=2a9ac9a9_2

WHO (2016) The Innov8 approach for reviewing national health programmes to leave no one behind

Facilitator's manual: *https://www.who.int/publications/i/item/WHO-FWC-17.1*

Technical handbook: *https://www.who.int/publications/i/item/9789241511391*

WHO (2011) Gender mainstreaming for health managers: A practical approach

Facilitators' guide: *https://apps.who.int/iris/handle/10665/44516*

Participant's notes: *https://www.who.int/publications/i/item/9789241501057*

Websites

WHO Health Equity Assessment Toolkit (HEAT)
https://www.who.int/data/gho/health-equity/assessment_toolkit

Jhpiego Gender Analysis Toolkit for Health Systems
https://gender.jhpiego.org/analysistoolkit/

Resources on GEDSI integration in WASH

Publications

Australian Aid (2019) Gender Equality and Goal 6 – The Critical Connection
https://waterpartnership.org.au/wp-content/uploads/2019/08/Gender-Equality-and-Goal-6-The-Critical-Connection.pdf

National Disability Authority, Centre for Excellence in Universal Design (2019) Building for everyone: a universal design approach. (See chapter 6 on Sanitary facilities)
http://universaldesign.ie/Built-Environment/Building-for-Everyone

WaterAid, WSUP, UNICEF (2018) Female-friendly public and community toilets: a guide for planners and decision makers
https://washmatters.wateraid.org/publications/female-friendly-public-and-community-toilets-a-guide-for-planners-and-decision-makers

WEDC (2014) Compendium of accessible technologies for people with disabilities
https://wedc-knowledge.lboro.ac.uk/resources/learning/EI_Compendium_of_accessible_WASH_Technologies.pdf

Australian Government AusAID (2013). Accessibility design guide: universal design principles for Australia's aid program. Annex C Water, sanitation and hygiene facilities.
https://www.dfat.gov.au/sites/default/files/accessibility-design-guide.pdf

WaterAid (2012) Towards Inclusive WASH: Sharing evidence and experience from the field
https://www.ircwash.org/sites/default/files/Wateraid-2012-Towards.pdf

Websites

Water for Women
https://www.waterforwomenfund.org/en/index.aspx

WaterAid: Inclusive WASH: A Free learning portal for WASH practitioners and researchers
https://www.inclusivewash.org.au/

WEDC: Equity and Inclusion in Water, Sanitation and Hygiene Learning material
https://wedc-knowledge.lboro.ac.uk/collections/equity-inclusion/general.html

Notes

World Health Organization

REGIONAL OFFICE FOR South-East Asia