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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

WASH FOR HEALTH

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Nurse at primary health care centre, Ségou, Mali.

WASH FOR HEALTH

Foreword

World leaders recently declared that universal health coverage (UHC) and access to high quality, integrated "people centred" health services, are essential to health for all and to human security.[1] Yet, efforts to accelerate UHC and quality of care will be undermined because fundamental infrastructure and hygiene in health facilities are not in place. A WHO/UNICEF 2015 global review reported that nearly 40% of facilities lack water supplies, 19% are without sanitation and 35% do not have any hand hygiene materials.[2] Indeed, UHC may be an empty promise without adequate attention to quality, and quality initiatives will fail without adequate attention to water, sanitation and hygiene (WASH).

The lack of WASH services compromises the ability to provide safe and quality care, places both health care providers and those seeking care at substantial risk of infection-related morbidities and mortality, and poses a significant economic and social burden. Pregnant women, who are increasingly giving birth in health care facilities, and their newborns, are especially vulnerable to the consequences of poor WASH services. Among hospital-born babies in developing countries, health care associated infections are responsible for between 4% and 56% of all causes of death in the neonatal period, 75% of which occur in South-East Asia and sub-Saharan Africa.[3]

To address this major gap in services, in 2015, WHO and UNICEF (along with health and WASH partners from across the globe) committed to the vision, that by 2030, every health care facility, in every setting, should have safely managed, reliable water, sanitation and hygiene facilities and practices that meet staff and patient needs.[4] One output from this commitment has been the development of WASH FIT.

WASH FIT is a risk-based approach for improving and sustaining water, sanitation and hygiene and health care waste management infrastructure and services in health care facilities in low- and middle-income countries (LMIC). WASH FIT is an improvement tool to be used on a continuous and regular basis, to first and foremost help health care facility staff and administrators prioritize and improve services, and, second, to inform broader district, regional and national efforts to improve quality health care.

The WASH FIT guide contains practical step-by-step directions and tools for assessing and improving services. It is adapted from the water safety plan (WSP) approach recommended in the WHO *Guidelines for drinking-water quality* (WHO, 2011) and goes beyond water safety to include sanitation and hygiene, health care waste, management and staff empowerment.

WASH FIT provides an opportunity to improve WASH through a health lens. Improving WASH in health care facilities helps reduce maternal and newborn mortality and improves the quality of care so that women can deliver with dignity, further benefiting holistic health aims. Emerging and growing threats from antimicrobial resistant infections and infectious disease outbreaks can also be significantly reduced by improving WASH services. Country piloting and implementation of WASH FIT have focused on the above and evidence is emerging on how WASH FIT can strengthen, especially at the facility level, services in countries such as Cambodia, Chad, Ethiopia, Liberia and Mali.

Long-term facility improvements require national-level commitment and leadership from both WASH and health actors. WASH infrastructure and service improvements ought to be prioritized, budgeted and implemented as part of wider health systems strengthening efforts and supported with appropriate national policies and standards. Multisectoral collaborations prior to, during and following the WASH FIT implementation are especially important for implementing and institutionalizing WASH practices in health care facilities and beyond.

There is a free digital version of WASH FIT which uses the mWater digital monitoring platform to help perform assessments, track hazards and improvement actions and visualize progress over time. To use WASH FIT Digital visit https://washfit.org/#/ or the Google Play store.

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1 World Bank, WHO, UNICEF, JICA and UHC 2030 International Health Partnership (2017). Tokyo Declaration on Universal Health Coverage. December 2017. http://www.who.int/universal_health_coverage/tokyo-decleration-uhc.pdf?ua=1

2 WHO/UNICEF (2015). Water, sanitation and hygiene in health care facilities: Urgent needs and actions. Meeting report. http://www.who.int/entity/water_sanitation_health/facilities/wash-in-hcf-geneva.pdf?ua=1

3 WHO. Health care associated infections. Fact sheet. http://www.who.int/gpsc/country_work/gpsc_ccisc_fact_sheet_en.pdf?ua=1

4 For more information on the global action plan, visit www.washinhcf.org

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Abbreviations and acronyms

AMR	antimicrobial resistance
HMIS	health monitoring information systems
HWTS	household water treatment and safe storage
IPC	infection prevention and control
JMP	WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
LMIC	low- and middle-income countries
MRSA	methicillin-resistant *Staphylococcus aureus*
NGO	nongovernmental organization
SDGs	Sustainable Development Goals
SI	sanitary inspection
SOP	standard operating procedure
UHC	universal health coverage
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WASH FIT	Water and Sanitation for Health Facility Improvement Tool
WHO	World Health Organization
WSP	water safety plan


CONCOR
ZIAK
MERCK
Lilly Insulin Range
What Is a Stroke?
What Causes a Stroke?
SteriTech
sanofi pasteur

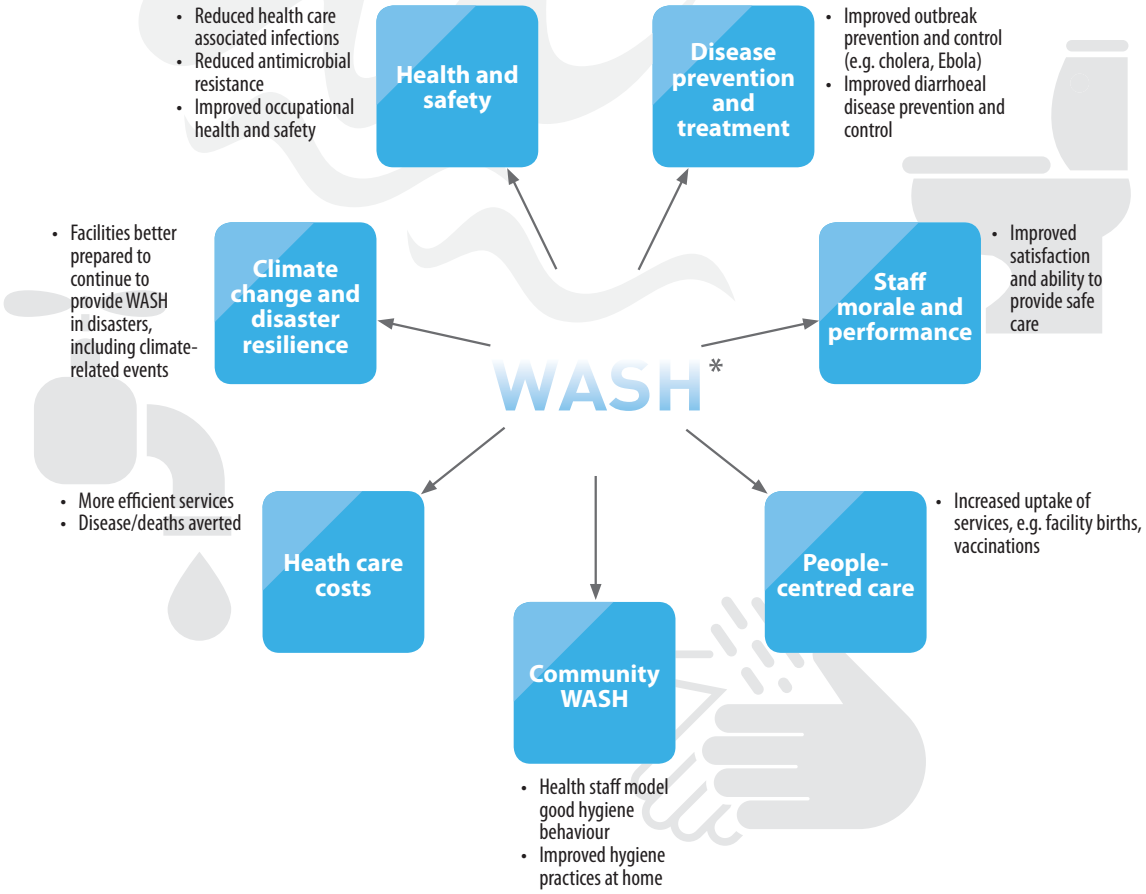
1. Introduction

Why focus on WASH in health care facilities?

WASH in health care facilities is a fundamental prerequisite for achieving national health goals and Sustainable Development Goals (SDGs) 3 (ensure healthy lives and promote well-being) and 6 (ensure availability and sustainable management of water and sanitation). Safe water, functioning hand washing facilities, latrines, and hygiene and cleaning practices are especially important for improving health outcomes linked to maternal, newborn and child health, as well as carrying out basic infection prevention and control (IPC) procedures necessary to prevent antimicrobial resistance (AMR).

In order to provide quality of care and reduce infections, health care facilities must have the appropriate infrastructure and staff capacities to provide safe, effective, equitable and people-centred services (see Figure 1.1). WASH services strengthen the resilience of health care systems to prevent disease outbreaks, allow effective responses to emergencies (including natural disasters and outbreaks) and bring emergencies under control when they occur.

Figure 1.1 Benefits of improved WASH in health care facilities



* WASH in health care facilities includes water supply, sanitation, hygiene and health care waste management.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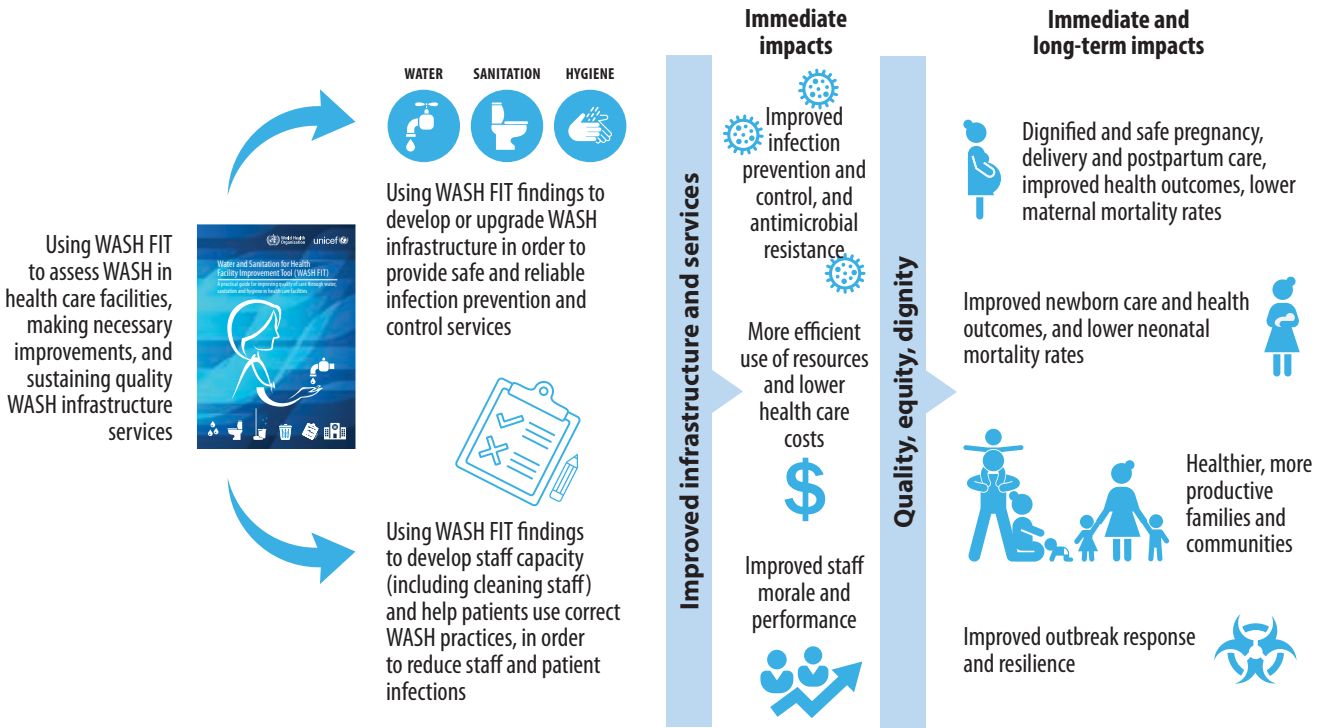
2. Overview of WASH FIT

Why use WASH FIT?

WASH FIT is a multistep, iterative process to facilitate improvements in WASH services, quality and experience of care. The specific purposes of using WASH FIT are:

- To provide a framework to develop, monitor and continuously implement an improvement plan and prioritize specific actions when resources are limited.
- To identify areas for quality improvement in facilities, including strengthening WASH and IPC policies and standards that will lead to lower infection rates, better health outcomes for patients and improved staff safety and morale.
- To facilitate the development of an enabling environment by bringing together all those who share responsibility for providing services, including legislators/policymakers, district health officers, hospital administrators, water engineers and community WASH and health groups.
- To improve the day-to-day management and operation of facilities, by systemizing the process of managing WASH services.
- To engage community members in advocating for and demanding better WASH services and in triggering positive changes in hygiene practices in households.

Figure 2.1 Impacts associated with WASH FIT



Who should use WASH FIT?

WASH FIT is designed for use by health care facility managers and staff to make improvements in settings where resources are limited. Staff may include the chief medical officer, financial administrator, doctors, nurses and persons in charge of managing water and waste. It requires a team effort.

Facility managers may want to involve people from outside of the facility to participate in the WASH FIT process. For example:

- Local, district and regional WASH and/or public works authorities in the area.
- Representatives from the community (both male and female) who can provide inputs from a facility user perspective (including change agents/influencers).
- Local and regional government authorities involved in implementing national quality health care, IPC and maternal, newborn and child health strategies for improving pregnancy-related outcomes.
- Partners, e.g. donors, nongovernmental organizations (NGOs), who can support infrastructural improvements and help ensure sustainability of WASH services.

What areas of a facility does WASH FIT cover?

WASH FIT covers four broad areas: water, sanitation (including health care waste management), hygiene (hand hygiene and environmental cleaning) and management (Figure 2.2). Each area includes indicators and targets for achieving minimum standards for maintaining a safe and clean environment. These standards are based on global standards as set out in the WHO *Essential environmental health standards in health care* (WHO, 2008) and the WHO *Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level* (WHO, 2016a).

Figure 2.2 The four domains of WASH FIT

* Hygiene includes hand hygiene and environmental disinfection. Sanitation covers faecal waste management, storm water and health care waste.

In what type of facilities should WASH FIT be used?

WASH FIT is primarily designed for use in primary health care facilities (e.g. health centres, health posts and small district hospitals) that provide outpatient services, family planning, antenatal care, maternal, newborn and child health services (including delivery). It can be adapted to more advanced facilities and/or used in conjunction with broader quality improvement efforts (e.g. improving quality of care for mothers and newborns).

How can WASH FIT be adapted for other types of facilities and settings?

WASH FIT is a framework and can be adapted for use in any type of facility. All users are encouraged to adapt the tool to suit their needs in order to meet quality improvement cycles and mechanisms implemented to improve quality of care. The broad WASH FIT process and methodology should remain the same, but the indicators and assessment (Tool 2A) can be modified to reflect local priorities and/or national standards (where they exist). This can be done in a number of ways (for more guidance, see Tools 2A, 2B and 2C: Instructions for use.

- **Reduce the number of indicators:** Some aspects of WASH may not be applicable in very small facilities (such as health posts where waste is treated off site) and a large number of items to monitor could be daunting for a small team. Indicators that are not relevant (the "advanced indicators") can be removed and only the "essential" set of indicators (shown in bold) assessed.
- **Focus on only one domain:** For facilities with limited capacity, starting by focusing on only one domain (such as health care waste management) may be more realistic than trying to monitor and improve all areas of a facility at once. In such cases, a facility may begin with assessing just one domain and once the WASH FIT process is established and staff feel more confident, WASH FIT can be scaled up to address other priority areas.
- **Add indicators:** Additional indicators may be added as necessary, to represent a higher level of service and/or to cover services provided in larger facilities.
- **Change indicators:** The indicators should be adapted to reflect national standards.
- **Integrate indicators:** Insert indicators into existing service assessments and monitoring mechanisms used in a facility, rather than introducing an additional, completely new tool.
- **Assess the facility by service area not domain:** For larger facilities, the assessment can be reordered to group indicators by service area (e.g. outpatients, delivery room) rather than domain. This can help to streamline the assessment so the team can assess all relevant indicators for a given room in one go.

What role does leadership play in WASH FIT?

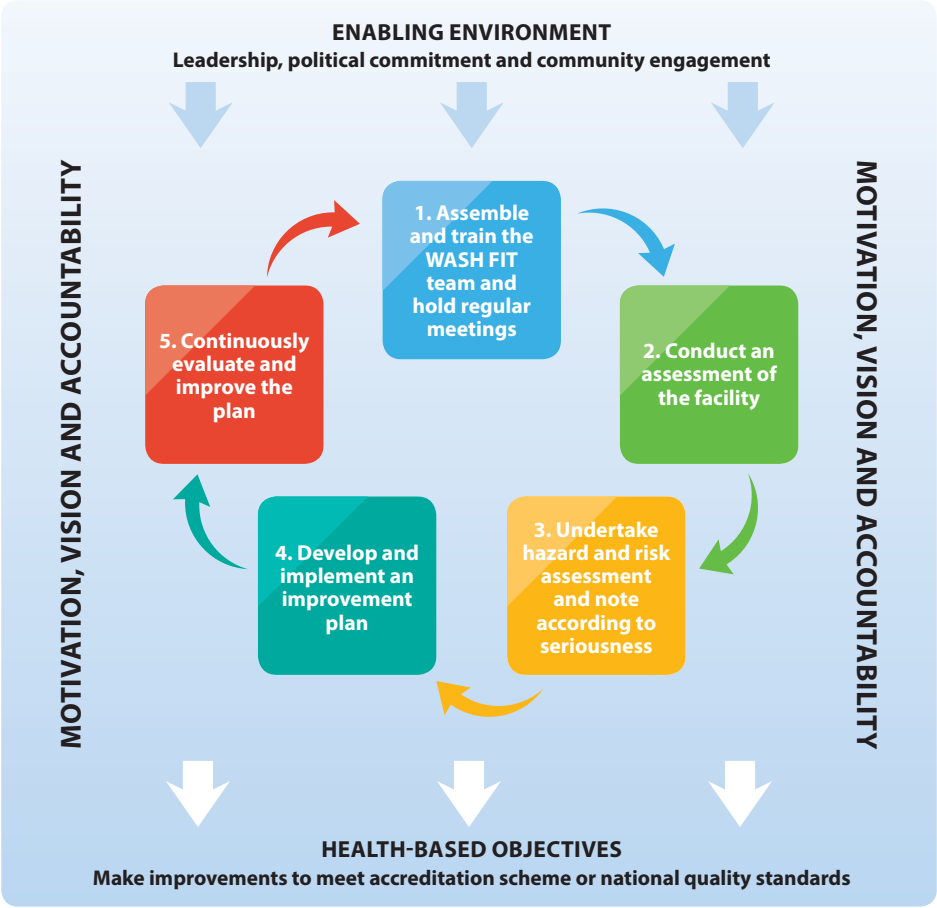
Leadership and political commitment at every level are essential for improving WASH in health care facilities. If not already in place, developing and implementing a set of national policies and standards along with accountability mechanisms that support health care facilities to improve WASH infrastructures and services is important. This requires that governments provide dedicated budgets for WASH infrastructure and services and regularly monitor WASH in health care facilities in national health monitoring information systems (HMIS).

Creating an enabling environment may require conducting advocacy activities to raise awareness about the need for WASH improvements and the value of WASH FIT in health care facilities. Local and district-focused work ought to be accompanied by national efforts. Discussions with multiple government sector leaders can result in collaborations that work synergistically to improve the standards in health care facilities and the health of all citizens.

3. The WASH FIT process

The WASH FIT process has five tasks that should be implemented sequentially (Figure 3.1). This section outlines the five tasks. Each task includes a description of the steps necessary to complete the task, a list of "dos and don'ts" to consider and instructions for using the templates. Section 5 includes a set of blank templates to use to complete each stage of the process.

Figure 3.1 WASH FIT framework and tasks



Before starting to use WASH FIT, it is important to understand the context or enabling environment in which any improvements will take place. At the start of the process, conduct a review of existing national WASH and health policies, standards, guidelines and research. In addition, identify current WASH in the health care facilities and broader related health initiatives, including those on quality care, IPC, AMR, maternal and newborn health and emergency preparedness.

Such a review should involve discussions with key stakeholders and experts to understand the priorities and challenges related to WASH in health care facilities and to determine whether there are any political, economic, social or cultural factors that may help or hinder efforts. Given the intersectoral nature of WASH, and specifically the links with health, creating an enabling environment may require prolonged policy discussions to achieve national level and sector wide endorsement and intersectoral cooperation and collaboration.

Undertaking a WASH FIT Assessment, WASH FIT Training, Bong County, Liberia.

Task 1

Assemble a WASH FIT team and hold regular meetings

The first task in the WASH FIT process requires assembling a committed team with leadership skills that can drive the process. Box 1 provides an example of two types of WASH FIT teams. It is important that all team members engage in the process and in joint decision-making. WASH FIT is a long-term process, so it is useful to create a team with a long-term vision and commitment.

Objectives for Task 1

To assemble a team that has support from the facility's administration and is committed to meeting regularly, implementing WASH FIT and following through with a plan for improving WASH in the facility.

Steps

- Create a one-page brief to explain the purpose and process of WASH FIT for team members when inviting individuals to be members of the team (refer to the Introduction).
- Invite individuals to be on the team.
- Using Tool 1A, record members of the team, their role and responsibilities and contact details.
- Hold regular team meetings.
- Using Tool 1B, document discussion items, decisions made and action points at each meeting.

Tools 1A and 1B: Instructions for use

To record team members, their roles and responsibilities and contact details. Tool 1B provides a guide for recording WASH FIT team meetings. For each WASH FIT meeting, use the meeting sheet to record the main decisions, including important follow-up actions to take. This makes it possible to keep a record of progress and the key decisions that have been agreed. It is also possible to use a simple notebook to document the meeting notes.

Box 1. Examples of WASH FIT teams

Team in a small rural facility

1. Manager (acts as team leader)
2. Nurse
3. WASH technician from the nearby community
4. Member of community health or water committee
5. Maintenance or cleaning person

Team in a district hospital

1. Chief medical director or facility administrator
2. Two members of the IPC committee, including one responsible for health care waste management
3. Nurse
4. Technician responsible for maintaining equipment
5. Member of community health or water committee
6. District health officer
7. Maintenance or cleaning staff representative

Dos and don'ts

DO

✔ **Do nominate a leader to drive the process**
Leaders should have vision and commitment. They should be trusted by the staff and have the support of facility administration and district health officials. The role of the leader is to ensure that the specific tasks and tools are being completed correctly and in a timely manner, meetings are held on a regular basis and that decisions are acted upon so that the WASH assessment progresses and leads to actions that improve WASH and health outcomes in the health care facility.

✔ **Do involve a range of people who are committed to creating a safe and clean facility**
The team should include facility managers, health care workers (of different levels), cleaners and maintenance staff, environmental health staff, local partners (e.g. district health officers) and at least one community representative (preferably someone well known in the community who can act as a champion and change agent). Local government representatives may also be involved so that they understand the process and can help to facilitate actions. Involving diverse people with a range of experiences with WASH and IPC will contribute to better problem-solving and a range of potential solutions for WASH improvement issues in the facility.

✔ **Do involve senior management at the facility and district levels**
The senior management of a facility is the gateway to changing WASH in health care facilities. Senior managers can facilitate infrastructural repairs and service enhancements by earmarking funding for such activities as fixing boreholes and adding toilets and hand washing stations.

✔ **Do involve external partners for additional support in small facilities with limited staff**
Potential partners include the district health office, local NGOs and local WASH experts, as well as IPC experts or staff from larger facilities. Involving external partners will contribute to overall health system strengthening.

✔ **Do include female staff and women on the team and seek female perspectives, including from women who have given birth at the facility**
Women should be involved, represented and consulted in all planning and decision-making discussions and activities to ensure women's and girls' needs are met throughout the facility.

✔ **Do specify the role and responsibilities of each team member at the start**
It is important that all team members understand the importance of water, sanitation, hand hygiene and hygiene practices (cleaning and disinfection) for preventing and controlling infections that may otherwise lead to disease and death. Each team member should be able to identify and evaluate potential WASH hazards and risks. Together, using the WASH FIT tools, team members can inspect a facility and report on the state of the infrastructure and services throughout the facility, the management and maintenance of the facility and the WASH behaviours of staff, patients and their families who visit the facility. The team meetings can be forums for reporting findings from the assessments and identifying and prioritizing actions necessary to improve WASH in the facility.

✔ **Do meet regularly as a team to discuss the day-to-day operation and management of WASH**
Regular communication between team members is important for completing the tasks, identifying and addressing key challenges and setting priority actions for the time between meetings. It is useful for the team to agree on decision-making processes and communication (e.g. meeting minutes, distribution of completed tools and reports) in the first meeting. Ideally, the team will meet once every week at the start (e.g. while the first facility assessment is being conducted) and at least once a month thereafter.

DON'T

✗ **Don't create a new team if there is already an established group in charge of managing quality improvements and/or an IPC committee**

WASH FIT tasks can be incorporated into the responsibilities of an existing, functional facility management or oversight team. If the existing team does not have enough representatives with WASH expertise, additional team members can be invited to join the existing team.

✗ **Don't forget to involve cleaning and maintenance staff**

Cleaning and maintenance workers (whether or not they are considered "staff" in the facility) are familiar with the ins and outs of the facility infrastructure, how WASH services are used and which WASH sites and products are most or least used in a facility. They are a crucial part of managing a health facility and are often overlooked in decision-making processes.

Task 2

Conduct an assessment of the facility

Objectives for Task 2

To use WASH FIT Tools 2A, 2B and 2C to assess a facility according to national and global standards for WASH, as a basis for making improvements.

Steps

- Review all areas of Tool 2A and decide which indicators will be assessed and monitored, which need to be adapted to national standards and whether additional indicators will be included.
- Use Tool 2A to conduct a comprehensive assessment of the facility using the agreed list of indicators; record whether each indicator meets (✚✚✚), partially meets (✚✚), or does not meet (✚), the minimum standards.
- Use Tool 2B to record the percentage of indicators which meet, partially meet or do not meet the standards in the summary tables and calculate the overall facility score (the percentage of all indicators meetings the standards), to make comparisons over time.
- Use Tool 2C to conduct the sanitary inspection (SI) and determine the level of risk from water and sanitation sources at the facility.
- Review the assessment form to ensure all information is clear and correct and all members of the team agree.
- As part of the assessment, review hygiene promotion materials, WASH and IPC guidelines and budget, make observations of infrastructure and staff behaviours (for example, whether staff respect protocols) and take pictures of the facility (if a camera is available). A series of pictures taken over time can be useful to show where improvements have been made. It can also help explain things about the facility to somebody who has not seen it.
- Repeat the assessment every six months, or more often as needed. Use a blank form for each assessment and clearly number them accordingly – Assessment "1", "2", "3" and so on.

Tools 2A, 2B and 2C: Instructions for use

Tool 2A: Indicators assessment:

This includes a list of indicators for each of the WASH domains (water, sanitation/health care waste, hygiene and management). In the first column, the core "essential" indicators to be assessed, regardless of the size of facility, are highlighted in bold text. The remaining "advanced" indicators can be considered for assessment, depending on the team's capacity. For each indicator, decide whether the facility meets the target (✚✚✚), partially meets the target (✚✚) or does not meet the target (✚). Record additional information in the notes column, for example, the reasons why a particular indicator does not meet the target. Box 2 provides suggestions for how to adapt the indicators in Tool 2A.

The indicators assessment will need to be redone every six months (or more often) to re-assess the facility and monitor how well the improvement plan is working. This continuous assessment will highlight where additional improvements are needed or if new problems have arisen. Ideally, the same people should conduct the indicators assessments each time to ensure consistency.

Some of the indicators require calculations to be made (for example, calculating the adequacy of water storage requires estimating how much water is needed each day and dividing it by the amount that can be stored; or measuring the width of the toilet door to determine if it is accessible for someone in a wheelchair). Make a note of the raw data used in these calculations in the notes column in order to refer back to them later. Ask for external support if the information needed is not available at the facility (e.g. the local health office or water supply office may have information on the quality of the facility's water or on specific national WASH or IPC guidelines).

Please note, the sanitary inspection forms (Tool 2C) are needed to answer indicator 1.2.

Box 2. Suggestions for adapting Tool 2A

1. Add additional indicators as appropriate. For example, indicators for other environmental health issues or for other departments in larger facilities, such as surgical areas and laboratories, that require more detailed assessment.
2. Remove indicators that are not relevant, particularly for smaller facilities which provide limited services. For example, if there is no inpatient department, remove 2.1 (number of toilets for inpatients). Record the total number of indicators in your assessment in the summary sheet (Tool 2B).
3. Adapt indicators to fit national standards. For example, you may have national water quality testing requirements which are not adequately covered in the current indicators.
4. The rating system could be changed to stars, numbers or a traffic light system (i.e. green, yellow, red).

Tool 2B: Record of assessment:

This is a table for recording your findings from Tool 2A. You should tally the percentage of indicators that met the standards (✚✚✚), partially met the standards (✚✚) and did not meet the standards (✚) for each WASH area. At the bottom of Tool 2B, you will be able to record the overall score for the facility. By calculating the overall percentage of indicators that meet the minimum standards, the facility can be given an overall score, for each example if 40 indicators are assessed and 30 meet the minimum standards, the facility would score 75%. This can be used to show changes over time and to make comparisons between facilities using WASH FIT.

If there were any problems with the assessment, record these in the notes box. For example, if some questions could not be filled in, make a note of why not and set a date when the indicators will be calculated. Record when and who conducted the assessment.

Tool 2C: Sanitary inspection forms:

These are a set of five forms, each with a checklist of specific questions to assess the typical risk factors associated with a respective abstraction technology or supply step (for example, the presence of animals, accumulation of faecal material, design flaws or lack of protective infrastructures). There are different options available, according to the type of water system in a facility:

- SI 1: Dug well with hand pump
- SI 2: Borehole with motorized pump
- SI 3: Public/yard taps and piped distribution
- SI 4: Rainwater harvesting
- SI 5: Storage reservoirs (which can be used in combination with any abstraction methods).

The SI forms are made up of yes/no questions, so that a "yes" answer indicates a potential risk and a "no" answer indicates no or a very low risk. At the end of each form, the number of "yes" answers should be tallied. All answers should be based on visual on-site observation and interviewing community members and/or operators by the team. Each of the five forms has a page of explanatory notes that provides descriptions for what to look for during an assessment. Note, SI forms may also be known as "sanitary surveys".

Dos and don'ts

DO

✔ **Do visit all areas in the facility, including consultation rooms, outpatient and inpatient services (if applicable) and communal and waiting areas**
Be sure to look at sanitation services, water abstraction sites, water collection points and storage facilities, hand hygiene stations and waste collection, storage and destruction sites. Ask facility staff if there are any other WASH-related areas that might have been missed.

✔ **Do walk through the facility and make observations as a team**
The assessment must be completed in person by walking through the facility and seeing all WASH-related areas in person. Doing a walk through as a team will allow the team to discuss the assessment on site and ensure that nothing is missed.

✔ **Do use the assessment information to feed into other reporting systems**
Share the assessment results with facility management and staff and with policy and decision-makers. The information collected can help to support surveillance at the facility, district and national levels.

✔ **Do carry out sanitary inspections on a regular basis (e.g. quarterly) to assess contamination risks to the water supply**
Sanitary inspections can identify potential hazards, hazardous events and problematic conditions related to water abstraction facilities, distribution systems and storage reservoirs and improvement needs in a facility's water system. Sanitary inspections should always be done whenever any water quality testing is done to better characterize health risks associated with faecal or other types of water contamination.

✔ **Do view the assessment as a learning opportunity**
Remember that the aim of the assessment is to identify areas for improvement and not as a means for criticizing or laying blame within the facility.

DON'T

✘ **Don't be afraid to ask questions when conducting the assessment**
It is important to understand how the people that work in or use the facility feel about the WASH infrastructure and services. Ask staff, caregivers and patients about their WASH-related experience within the facility. Questions should be asked in such a way that does not steer the person to a more positive or negative response.

Undertaking a WASH FIT assessment, WASH FIT training, Savannakhet Province, Lao People's Democratic Republic.

Task 3

Undertake hazard and risk assessment

Objectives for Task 3

To identify WASH-related hazards or problems; the associated risks that these hazards present to staff, general patients, pregnant mothers, newborns, caregivers and possibly the community; and the areas for improvement in the facility.

Steps

- Review all the information collected in Task 2.
- Using Tool 3, record the specific hazards (problems) (column 1) and associated risks (column 2).
- Grade each risk according to the seriousness of the hazard and feasibility of addressing it (column 3). Additionally, all hazards and risks can be plotted on a master grid to help identify priorities and inform the improvement plan.
- Record the actions to be undertaken at the facility/community and/or district/regional levels.

Tool 3: Instructions for use

This tool provides a table for recording the hazards and risks associated with each WASH area in the health care facility; the level of risk versus the feasibility of addressing a problem; and the actions to be taken at the facility/community and/or district/regional.

Box 3. Definitions of hazard and risk

Definitions

A hazard is defined as a "condition, event or circumstance that could lead to or contribute to an unplanned or undesirable event." It may also be referred to as a problem. Any indicators that do not meet the target should be considered a potential hazard.

A risk is the potential of a set of unwanted circumstances or events occurring as the result of the hazard. All hazards have associated risks.

Example

A blocked toilet is a hazard. The associated risk is that users may have to defecate in the open, contaminating the environment and creating a very unappealing health care facility. Users may also suffer health consequences from not being able to relieve themselves of a bowel movement or urine.

There are three actions to complete for the risk assessment:

1. Define the hazard(s): Table 3.1 below gives examples of how to define hazards and risk. Determine what is a "hazard" by asking questions such as: *"What services and infrastructure are lacking?" "What could go wrong with the existing infrastructure?" "Is anything being done to maintain services?"*

Write a detailed description of the hazards in column 1 of Tool 3, including the number of the indicator (from Tool 2A) to which you are referring.

List the risks associated with each hazard in column 2 of Tool 3. Think of potential risks to staff, patients, caregivers, visitors and the community.

Table 3.1 Examples of hazards and risks for WASH

	HAZARDS (problems)	RISKS
WATER	**1.1, 1.2, 1.6, 1.13:** Water not available within treatment rooms, near toilets or for showering (only available from communal tap within grounds of facility).	Women cannot wash themselves after delivery, negatively impacting their dignity and comfort and increasing infection risks. Difficult for staff, patients and their families to easily follow hand hygiene procedures, thus increasing risks of transmitting infections. Difficult to clean floors, surfaces, utensils and bed linen putting all users at risk of infection from poor environmental hygiene and accidents.
SANITATION 	**2.13:** Waste is not correctly segregated at waste generation points. **2.22:** Appropriate protective equipment for staff in charge of waste treatment and disposal is not available.	Staff, patients, visitors and community members at risk of infection from health care waste, including needle stick injuries and exposure to contaminated fluids. Staff at risk of infection during treatment and disposal of health care waste.
HYGIENE	**3.1:** No functioning hand hygiene stations at points of care.	Increased risk of patients acquiring health care associated infections, for example, newborns acquiring neonatal sepsis. Increased risk of staff acquiring infections such as methicillin-resistant *Staphylococcus aureus* (MRSA) from not washing hands during key moments and generally unclean areas in the facility.

2. Determine the seriousness of the hazard/risk (high, medium, low, unknown): The risk assessment can be done using the scale in Figure 3.2, or using risk categories (e.g. low/medium/high or less important/important/very important). The names and definitions of each category should be defined by the WASH FIT team. Some sample definitions are provided below as a guide. Box 4 provides questions to keep in mind when completing the risk assessment. Assessing the level of risk for each problem is context-specific and there is no right or wrong answer. The risk assessment should be undertaken by several individuals within the team to increase the validity of the risk assessment. Each individual conducting the risk assessment should share their conclusion about the level of risk. The team should consider each individual's conclusion to arrive at a single overall risk level.

Figure 3.2 Descriptions of levels of risk

The hazard/problem very likely results in injuries, acute and/or chronic illness, infection or an inability to provide essential services. Immediate actions need to be taken to minimize the risk.

The hazard/problem likely results in moderate health effects, discomfort or unsatisfactory services, for example unpleasant odours, unsatisfactory working conditions, minor injuries. Once the high risks issues are addressed, actions should be taken to minimize medium-level risks.

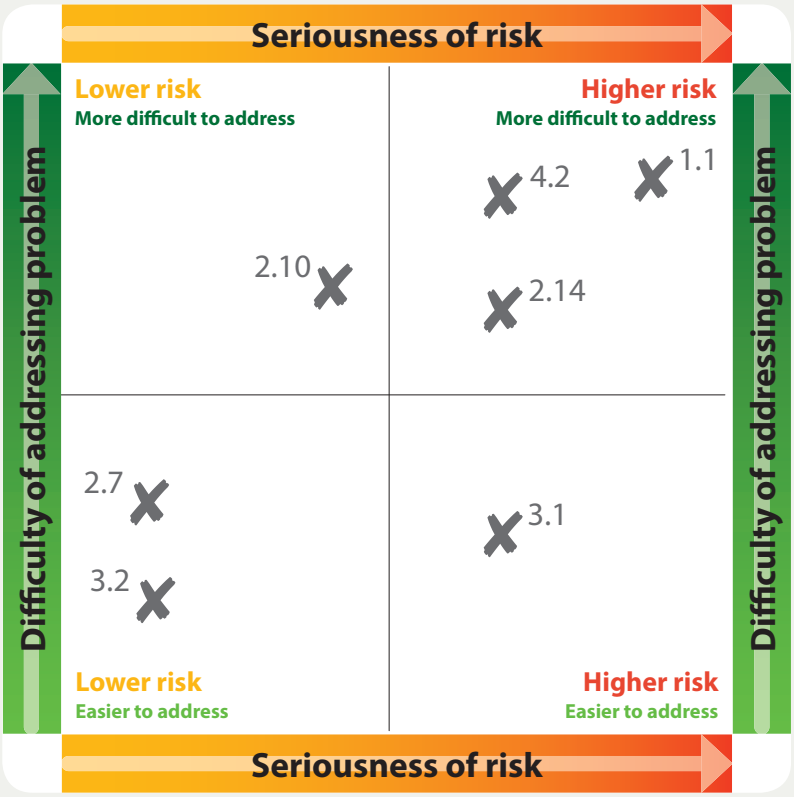
No major health affects anticipated. These risks should be addressed as resources become available and should be revisited in the future as part of the review process.

Further information is needed to categorize the risk. Some action should be taken to reduce the risk while more information is gathered.

3. Weigh the level (or seriousness) of the risk (high/medium/low/unknown) in relation to how easy or difficult it will be to take action to address the problem: Some hazards may be easier to address than others depending on the resources currently available and/or the time it will take to fix a problem. For example, it may be relatively quick and inexpensive to install hand hygiene stations at a facility, but more complex to maintain them (filling them with water each day, ensuring soap is available and that they do not drain into public areas).

Not every hazard can be addressed immediately. Column 3 in Tool 3, provides a visual way to categorize the risks and the feasibility of addressing them to help prioritize the actions to be taken. The "window" in column 3 has four squares. The top left square represents problems that are low risk, but difficult to address. The top right square is for problems that are high risk and difficult to address. The bottom left square represents problems that are low risk and easier to address, the bottom right square is for problems that are high risk, but easier to address. Figure 3.3 provides an example how to fill in the "window" for specific problems.

Figure 3.3 Categorizing problems and risks by the level of difficulty to address the problem/risk



Problems/hazards

- **1.1** No piped water system in facility
- **2.7** No record of cleaning visible in latrines
- **2.10** Lighting in latrines is insufficient
- **2.14** Waste burial pit is full
- **3.1** No hand hygiene stations at points of care
- **3.2** No hygiene promotion posters at latrines and hand hygiene stations
- **4.2** An annual WASH budget for the facility is not available

Box 4. Questions to keep in mind when completing the risk assessment

- Do seasonality and/or climate change affect WASH services and are there plans in place to cope with this?
- Where in the facility are the key areas where infections are most likely to occur due to inadequate WASH?
- What staff behaviours and attitudes contribute to delivering good WASH services? What staff behaviours and attitudes contribute to delivering poor WASH services?
- Is there a protocol in place to ensure that a hazard/problem is managed efficiently?
- What do staff and patients find most important/difficult about the WASH hazard in question?
- Have all staff been formally trained on IPC, waste management and other WASH areas as per their job descriptions?

Dos and don'ts

DO

✔ **Do consider all the potential problems and constraints relating to the facility**
Problems can be related to infrastructure (for example, lack of water storage capacity, blocked latrines or a broken incinerator) or to operation and maintenance (for example, cleaning and servicing equipment, such as respirators and incinerators), a shortage of cleaning staff or inadequate budget to buy supplies.

✔ **Do think about problems that might happen in the future**
Consider all the potential problems that *could* occur and whether there are procedures and protocols in place to fix them when they happen. Problems could be one-off occurrences (for example, seasonal water shortages or a hand pump breaking) or long-term issues (for example, no access to water within the facility).

✔ **Do consider all facility users when determining the level of risk**
Depending on how often an issue arises and how severe the consequences are, the risk to public health will vary. The WASH FIT team will need to have detailed discussions about which risks are considered more important than others. Remember that the relative importance of individual risks is different for every facility and for different users.

DON'T

✘ **Don't focus only on the negatives**
It is important to recognize good WASH practices within the facility, improvements that have already been made and where standards have already been met. It is useful to learn from successes within the facility and consider those successes when making recommendations for other similar facilities.

✘ **Don't worry that ranking risks is context-specific**
Different people will rank risks differently and that is okay. It is more important that all facility stakeholders (staff, patients, families and community members) have an opportunity to share their opinions and that the process of deciding which problems and risks are the most important is collaborative.

Task 3

Task 4

Develop an improvement plan

Objectives for Task 4

To prioritize which hazards/problems will be addressed and develop a detailed action plan outlining what improvements will be made within a given timeframe.

The WASH improvements could be achieved through a number of different mechanisms, including building new infrastructure or repairing existing infrastructure, coordinated dialogue with district and national authorities for new/revised infrastructure, writing standards and protocols to improve behaviours, training staff in a new technique or initiative and/or improving management methods.

It is important to consider the level of difficulty or ease with which the improvements can be made. For example, which changes can be made within the facility without external support, what can be done with minimal external support, and what will require substantial inputs and support at the local, district, regional or national levels.

Steps

- Review the Task 3 actions agreed upon by the team to be undertaken at the facility/community and/or district/regional levels.
- Decide on the number of actions that are feasible to implement given the allotted resources.
- Using Tool 4, record the actions and fill in details (what, who, what resources, when) for each action.
- Finalize Tool 4 and seek the necessary approvals for the improvement plan.

Tool 4: Instructions for use

This should be used to record the specific WASH improvement actions to be taken toward eliminating or reducing the hazard(s); the person or group responsible for implementing the action(s); the resources needed to accomplish the action(s); the expected date for completing the action(s); the actual completion date; and the monitoring process for each action item.

Dos and don'ts

DO

✔ **Do make the actions as specific as possible**
Specify who is responsible for ensuring the action is completed, when it will be completed and what resources are needed. The resources could be financial, technical (such as external support specialists) or someone's time. Make sure each activity is realistically achievable with the resources and time available.

✔ **Do think of improvements and preventive measures that can be made with limited resources**
Consider, for example, ensuring that a latrine or toilet and area around it are clean, providing soap and water or alcohol-based handrubs at all hand hygiene stations or putting up a poster with pictures and diagrams describing basic hand hygiene principles.

✔ **Do remember that no change is too small**
Whatever positive actions are taken will make a difference. For those action items that are more difficult to address (e.g. installing a water supply), think of small actions you can take to begin the process of change (e.g. presenting a case for a new water supply to the district authorities).

✔ **Do use the improvement plan as a basis for seeking financial or other support for larger upgrades and improvements**
A detailed plan could be used to approach the government, donors or NGOs for additional support.

DON'T

✘ **Don't focus only on the short term**
Some actions are immediate, while other actions or system upgrades may take more time and money (for example installing a water filtration unit to address microbial contamination in the water system). Think about what kind of facility and environment there should be in six months/one year/five years and even further in the future. Long-term thinking will help the team to be more ambitious and realistic. Remember, WASH FIT is a continuous process in which improvement takes place step by step over time.

Task 5

Monitor the progress of the improvement plan and make revisions as necessary

Objectives for Task 5

To continuously monitor the progress of the improvement plan toward reaching the essential (and advanced) target indicators for each WASH area and make changes to the plan as necessary to keep progress on track.

Monitoring involves using quantitative and/or qualitative methods (for example completing tracking forms or conducting observations/ inspections of facility WASH sites) on a regular basis to determine to what degree the team has achieved the WASH improvements they set out to make.

Steps

- As a team, review the improvement plan to determine whether all actions are being implemented, how far along the actions are toward completion and what further steps need to be taken to ensure that the action item will be completed by the expected completion date.
- Conduct a full WASH assessment using the WASH FIT guide every six months to evaluate the improvement in the facility using the indicators selected in Tool 2A (the list of indicators can be revised as necessary for each subsequent WASH assessment).
- Discuss the improvement plan at regular staff meetings as well as holding more detailed, regular discussions every six months with the community and wider health and WASH stakeholders.

Tool

There is no specific tool for Task 5. Use the last two columns in Tool 4 to record any revisions made to the plan. Box 5 provides a list of questions to consider when reviewing a WASH FIT improvement plan.

Dos and don'ts

✔ **Do build monitoring into staff job descriptions and divide the tasks between staff members**
Cleaners, for example, should routinely inspect latrines every day, while senior management may be responsible for budgeting and supplies and should review the budget at the end of each month.

Box 5. Questions to consider when reviewing the WASH FIT improvement plan

- Are there any new team members since WASH FIT began?
- Do existing team members need a refresher or more detailed technical training?
- Is additional support from other partners required?
- Is the information in the assessment up to date?
- Has the facility changed in any significant way since the last assessment was conducted?
- What has hindered progress and why?
- Are there new hazards and associated risks?
- What improvement actions have already been completed?
- What targets have been reached?
- What have been some of the greatest successes? What still remains challenging?
- Should other improvements be prioritized?

✔ **Do discuss the results of monitoring observations at each team meeting**

Ask each team member to provide feedback on the area for which they are responsible. Focus on the problems/hazards and risks identified for improvement, what remains to be completed and how best to make sure that the actions are all completed on time. If little or no progress is being made, the team should review the plan and brainstorm ideas to address any problems.

✔ **Do re-do the risk assessment when new problems arise**

If monitoring reveals that new problems have arisen, the team should conduct a risk assessment for the new problems, put them into context with the existing problems being addressed and re-prioritize all problems as necessary. The team should then revisit the improvement implementation plan and revise as necessary. Do record all team discussions and decisions using a team meeting sheet (Tool 1B).

DON'T

✘ **Don't be discouraged when improvement progress seems slow**

Use the team review meetings to determine where the bottlenecks are that are slowing progress and create action items to unblock the bottlenecks.

4. References

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WHO (2011). Guidelines for drinking-water quality. Fourth edition. Geneva: World Health Organization (http://www.who.int/water_sanitation_health/publications/2011/dwq_guidelines, accessed 24 January 2018).

WHO (2014). Safe management of wastes from health-care activities. Second edition. Geneva: World Health Organization (http://www.who.int/water_sanitation_health/publications/safe-management-of-wastes-from-health care-activities/en/, accessed 24 January 2018).

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WHO (2016c). Standards for improving quality of maternal and newborn care in health facilities. Geneva: World Health Organization (http://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/, accessed 24 January 2018).

WHO/UNICEF (2015). Water, sanitation and hygiene in health care facilities: Urgent needs and actions. Meeting report. Geneva: World Health Organization (http://www.who.int/water_sanitation_health/facilities/wash-in-hcf-geneva.pdf, accessed 24 January 2018).

Further reading

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WHO/UNICEF Joint Monitoring Programme (2016). Core indicators for monitoring WASH in health care facilities (https://www.washinhcf.org/documents/161125-FINAL-WASH-in-HCF-Core-Questions.pdf, accessed 24 January 2018).

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Useful websites

BabyWASH Coalition: http://babywashcoalition.org/

UNICEF, Water, Sanitation and Hygiene: http://www.unicef.org/wash/

USAID, Maternal and Child Survival Program, WASH in Health Care Facilities: https://washforhealthcare.mcsprogram.org/

WHO, Global Learning Laboratory for Quality Universal Health Coverage: http://www.integratedcare4people.org/communities/global-learning-laboratory-for-quality-universal-health-coverage/

WHO, Infection prevention and control (implementation tools and resources): http://www.who.int/infection-prevention/tools/en/

WHO, Water sanitation hygiene: http://www.who.int/water_sanitation_health/en/

WHO, Water sanitation hygiene (International Scheme to Evaluate Household Water Treatment Technologies): http://www.who.int/water_sanitation_health/water-quality/household/scheme-household-water-treatment/en/

WHO/UNICEF, Quality of Care Network for Maternal, Newborn and Child Health: http://www.who.int/maternal_child_adolescent/topics/quality-of-care/network/en/

WHO/UNICEF, WASH in Health Care Facilities: www.washinhcf.org

Drinking water station and poster installed as a result of WASH FIT, health care facility in N'Djamena, Chad.

5. Tool templates

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Tool 1A: WASH FIT team list

Date: .....

Name	Job title and organization (e.g. facility manager)	Role and responsibility on the WASH FIT team (e.g. team leader, responsible for coordinating WASH FIT)	Contact details (phone number and, if available, email)

Tool 1B: WASH FIT team meeting record sheet

Date: .....

Names of team members participating	Key issues to be discussed in the meeting	List the decisions and outcomes of each issue discussed and actions to be taken, including responsible person(s) and timeline (use an extra sheet if necessary)	Date and time of next team meeting in four weeks

Tool 1B: WASH FIT team meeting record sheet example

Date: 15 March, Bongor Health Centre

Names of team members participating	Key issues to be discussed in the meeting	List the decisions and outcomes of each issue discussed and actions to be taken, including responsible person(s) and timeline (use an extra sheet if necessary)	Date and time of next team meeting in four weeks
	1. Results of baseline facility assessment, conducted on 26 September. 2. Discussion of major hazards and completion of Tool 3. 3. How to involve the district level and extra support needed. 4. How to involve community in process, to increase buy-in of WASH FIT.	1. Some information was missing on the assessment. Team to fill in gaps, including conducting sanitary inspections and reassessing water supply. 2. Emily to ask district office for additional technical support, including possible training on cleaning and hand hygiene. 3. Githu to give a presentation on WASH FIT and the importance of WASH services at next meeting of community women's group and provide feedback at next WASH FIT meeting.	

Tool 2A: Indicators assessment

Date of assessment: ..... **Members of team conducting assessment:** .....

Notes: .....

.....

.....

1 Water * See associated note		Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
ESSENTIAL INDICATORS						
1.1*	Improved water supply piped into the facility or on premises and available	Yes, improved water supply within facility and available	Improved water supply on premises, (outside of facility building) and available	No improved water source within facility grounds, or improved supply in place but not available		
1.2*	Water services available at all times and of sufficient quantity for all uses	Yes, every day and of sufficient quantity	More than five days per week or every day but not sufficient quantity	Fewer than five days per week		
1.3*	A reliable drinking-water station is present and accessible for staff, patients and carers at all times and in all locations/wards	Yes, at all times/ wards and accessible to all	Sometimes, or only in some places or not available for all users	Not available		
1.4*	Drinking-water is safely stored in a clean bucket/tank with cover and tap	Yes	All available drinking-water points are safely stored	Not safely stored in any water points or no drinking-water available		
ADVANCED INDICATORS						
1.5	Sanitary inspection risk score (using sanitary inspection form 3)	Low risk	Medium risk	High or very high risk		

Tool 2A: Indicators assessment

1 Water * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
1.6 All endpoints (i.e. taps) are connected to an available and functioning water supply	Yes, all are connected and functioning	More than half of all endpoints are connected and functioning	No, less than half of all endpoints connected and functioning		
1.7 Water services available throughout the year (i.e. not affected by seasonality, climate change-related extreme events or other constraints)	Yes, throughout the year	Water shortages for one to two months	Water shortages for three months or more		
1.8* Water storage is sufficient to meet the needs of the facility for two days	Yes	More than 75% of needs met	Less than 75% of needs met		
1.9* Water is treated and collected for drinking with a proven technology that meets WHO performance standards	Yes	Treated but not regularly	Not treated		
1.10* Drinking-water has appropriate chlorine residual (0.2mg/L or 0.5mg/L in emergencies) or 0 *E. coli*/100 ml and is not turbid	Yes	Chlorine residual exists, but is <0.2mg/L	Not treated/do not know residual/do not have capacity to test residual/no drinking-water available		
1.11* The facility water supply is regulated according to national water quality standards (mark not applicable if no standards exist)	Yes, and water meets national standards	Yes, regulated but water does not meet standards	No regulation or testing takes place or no standards exist		
1.12 Energy is available for heating water (mark if not applicable)	Yes, always	Yes, sometimes	Never		

Tool 2A: Indicators assessment

1 Water * See associated note		Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
1.13	Energy is available for pumping water (mark if not applicable)	Yes, always	Yes, sometimes	Never		
1.14*	At least one shower or bathing area is available per 40 patients in inpatient settings and is functioning and accessible	Yes	Showers available, but no water or in disrepair or showers available but fewer than one per 40	No showers		
1.15	Shower(s) are adequately lit, including at night	Yes	Lighting infrastructure exists, but not functioning	Not adequately lit or no lighting infrastructure		

Percentage of indicators meeting targets for WATER +++	
Percentage of indicators partially meeting targets for WATER ++	
Percentage of indicators not meeting targets for WATER +	

* Notes: Water

The **indicators in bold are "essential"** and should be completed by all facilities using WASH FIT. Other indicators are considered optional and can be included if the facility has the capacity to assess them.

1.1	**Improved water sources in health care settings include piped water, boreholes/tube wells, protected wells, protected springs, rainwater and packaged or delivered water.** **This refers to the water supply for general purposes, including drinking, washing and cleaning.**
1.2	**For an intermittent piped-water supply, e.g. available eight hours per day.** **Water needs will vary depending on the type of facility and number of patients. To calculate the facility's water requirements, add up the following requirements or applicable national standards:** **Outpatients (5 L/consultation) + inpatients (40–60 L/patient/day) + operating theatre or maternity unit (100 L/intervention) + dry or supplementary feeding centre (0.5–5 L/consultation depending on waiting time) + cholera treatment centre (60 L/patient/day). Source: *Essential environmental standards in health care* (WHO, 2008).**
1.3	**Accessible means with railings, a seat and water access.**
1.4	**For more information on safe storage, see: http://www.who.int/water_sanitation_health/publications/toolkit_monitoring_evaluating/en/**
1.8	See 1.2 for water storage needs. To calculate the facility's water storage requirements, add up the following requirements needed for 24 hours or applicable national standards and multiply by two to get the total for 48 hours: Outpatients (5 L/consultation) + inpatients (40–60 L/patient/day) + operating theatre or maternity unit (100 L/intervention) + dry or supplementary feeding centre (0.5–5 L/consultation depending on waiting time) + cholera treatment centre (60 L/patient/day). Source: *Essential environmental standards in health care* (WHO, 2008). Acceptable storage methods include: clean, covered and well-maintained containers which prevent contamination from entering and are free from any cracks, leaks, etc. Such containers should also allow for water to be extracted without hands or other potentially contaminated surfaces from touching the water (i.e. through use of a tap).
1.9	Such technologies should meet one of WHO's household water treatment and safe storage (HWTS) performance categories and generally involve filters, boiling, solar, chlorine (for non-turbid water) or coagulation/flocculation. Higher performing technologies (i.e. two or three stars including membrane filters, UV and coagulants/flocculants) are recommended for vulnerable groups (i.e. those with HIV or young infants) and where the specific pathogen of concern is not known. A list can be found here: http://www.who.int/water_sanitation_health/water-quality/household/list-of-products/en/ and further information found at the WHO household water treatment site: http://www.who.int/water_sanitation_health/water-quality/household/en/ Drinking-water meets WHO *Guidelines for drinking-water quality* (2017) or national standards: http://www.who.int/water_sanitation_health/publications/drinking-water-quality-guidelines-4-including-1st-addendum/en/
1.10	Evidence of documented chlorine residuals should be available from previous testing.
1.11	Drinking water meets WHO *Guidelines for drinking-water quality* (2017) or national standards: http://www.who.int/water_sanitation_health/publications/drinking-water-quality-guidelines-4-including-1st-addendum/en/
1.14	*Global guidelines on the prevention of surgical site infection* (WHO, 2016b): http://www.who.int/gpsc/ssi-guidelines/en/

Tool 2A: Indicators assessment

Date of assessment: ..... **Members of team conducting assessment:** .....

Notes: .....

.....

.....

2 Sanitation and health care waste * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
Part A: Sanitation					
ESSENTIAL INDICATORS					
2.1* **Number of available and usable toilets or improved latrines for patients**	Four or more (outpatients) and one per 20 users (inpatients)	Sufficient number present but not all functioning or insufficient number	Less than 50% of required number of latrines available and functioning		
2.2 **Toilets or improved latrines clearly separated for staff and patients**	Yes	Separate latrines are available but not clearly separated	No separate latrines		
2.3 **Toilets or improved latrines clearly separated for male and female**	Yes	Latrines are separated for male and female, but not clearly separated	No separate latrines		
2.4* **At least one toilet or improved latrine provides the means to manage menstrual hygiene needs**	Yes	Yes, but toilet is not clean or in disrepair	No		

Tool 2A: Indicators assessment

2	Sanitation and health care waste * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
2.5*	**At least one toilet meets the needs of people with reduced mobility**	Yes	Yes, but not available or in disrepair	No toilets for disabled users		
2.6*	**Functioning hand hygiene stations within 5 m of latrines**	Yes	Present, not functioning or no water or soap	Not present		
ADVANCED INDICATORS						
2.7*	Record of cleaning toilets visible and signed by the cleaners each day	Yes	Toilets cleaned but not recorded	No record/toilets cleaned less than once a day		
2.8*	Wastewater is safely managed through use of on-site treatment (i.e. septic tank followed by drainage pit) or sent to a functioning sewer system	Yes	Present but not functioning	Not present		
2.9*	Greywater (i.e. rainwater or washwater) drainage system is in place that diverts water away from the facility (i.e. no standing water) and also protects nearby households	Yes	Yes, but not functioning and obvious pools of water	Not present		
2.10*	Latrines are adequately lit, including at night	Yes	Lighting infrastructure exists, but not functioning	Not adequately lit or no lighting infrastructure		

2 Sanitation and health care waste * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
Part B: Health care waste					
ESSENTIAL INDICATORS					
2.11 **A trained person is responsible for the management of health care waste in the health care facility**	Yes, presented and adequately trained	Appointed but not trained	Not appointed		
2.12* **Functional waste collection containers in close proximity to all waste generation points for:** **• non-infectious (general) waste** **• infectious waste** **• sharps waste**	Yes	Separate bins present but lids missing or more than three quarters full; only two bins (instead of three); or at some but not all waste generation points	No bins or separate sharps disposal		
2.13 **Waste correctly segregated at all waste generation points**	Yes	Some sorting but not all correctly or not practised throughout the facility	No sorting		
2.14 **Functional burial pit/fenced waste dump or municipal pick-up available for disposal of non-infectious (non-hazardous/general waste)**	Yes	Pit in facility but insufficient dimensions; overfilled or not fenced and locked; irregular municipal waste pick up, etc.	No pit or other disposal method used		
2.15* **Incinerator or alternative treatment technology for the treatment of infectious and sharp waste is functional and of a sufficient capacity**	Yes	Present but not functional and/or of a sufficient capacity	None present		

Tool 2A: Indicators assessment

2	Sanitation and health care waste * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
2.16	**Sufficient energy available for incineration or alternative treatment technologies (mark if not applicable)**	Yes, always	Yes, sometimes	Never		
ADVANCED INDICATORS						
2.17	Hazardous and non-hazardous waste are stored separately before being treated/disposed of or moved off site	Yes, separated storage areas available	Separated storage areas are available but with insufficient capacity or overfilled	No separated storage areas available		
2.18*	All infectious waste is stored in a protected area before treatment, for no longer than the default and safe time	Yes	Treated between 24–48 hours	Treated after 48 hours or not treated at all		
2.19*	Anatomical/pathological waste is put in a dedicated pathological waste/placenta pit, burnt in a crematory or buried in a cemetery (mark if not applicable)	Yes	Pit is present but not used or functional or overfilled or not fenced and locked	None present		
2.20*	Dedicated ash pits available for disposal of incineration ash (mark if not applicable)	Yes	Present but not functional or overfilled or not fenced and locked	None present		
2.21	Protocol or standard operating procedure (SOP) for safe management of health care waste clearly visible and legible	Yes, visible and implemented	Written but not visible or implemented	No protocol/SOP in place		

Tool 2A: Indicators assessment

2 Sanitation and health care waste * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
2.22* Appropriate protective equipment for all staff in charge of waste treatment and disposal	Yes	Some equipment available, but not for all staff, or available but damaged	None available		

Percentage of indicators meeting targets for SANITATION AND HEALTH CARE WASTE +++	
Percentage of indicators partially meeting targets for SANITATION AND HEALTH CARE WASTE ++	
Percentage of indicators not meeting targets for SANITATION AND HEALTH CARE WASTE +	

* Notes: Sanitation and health care waste

The **indicators in bold are "essential"** and should be completed by all facilities using WASH FIT. Other indicators are considered optional and can be included if the facility has the capacity to assess them.

2.1	**At least four toilets per outpatient setting (one for staff; one for female patients; one for male patients; one for disabled users). More latrines may be needed depending on the size of the facility.** **Improved sanitation facilities include flush toilets into managed sewer or septic tank and soakaway pit, VIP latrines, pit latrines with slab and composting toilets.** **To be considered usable, a toilet/latrine should have a door which is unlocked when not in use (or for which a key is available at any time) and can be locked from the inside during use, there should be no major holes in the structure, the hole or pit should not be blocked, water should be available for flush/pour flush toilets and there should be no cracks, or leaks in the toilet structure. It should be within the grounds of the facility and it should be clean as noted by absence of waste, visible dirt and excreta and insects.**
2.4	**Toilets should have a bin for disposal of waste or an area for washing, with water available.**
2.5	**A toilet can be considered to meet the needs of people with reduced mobility if it meets the following conditions: can be accessed without stairs or steps, handrails for support are attached either to the floor or sidewalls, the door is at least 80 cm wide, the toilet has a raised seat (between 40–48 cm from the floor), a backrest and the cubicle has space for circulation/manoeuvring (150 x 150 cm). The sink, tap and water outside should also be accessible and the top of the sink 75 cm from the floor (with knee clearance). Switches for lights, where relevant, should also be at an accessible height (max. 120 cm). All specifications are based on ISO 21542:2011 (Building construction – Accessibility and usability of the built environment) available at: http://www.iso.org/iso/home/store/catalogue_tc/catalogue_detail.htm?csnumber=50498**
2.6	**A functional hand hygiene station may consist of soap and water with a basin/pan for washing hands. Water should not be chlorinated. Alcohol-based handrub is not suitable for use at latrines.**
2.7	For low literacy or illiterate cleaners, this should be adapted and simplified accordingly with recognizable pictures and illustrations.
2.8, 2.9	No leakage from pipes nor soakaway pit and soakaway more than 30 m from water source, with grease trap and no visible pool of stagnant water.
2.10	Lighting for latrines is necessary in all facilities where night-time services are provided and where there is not sufficient natural light to safely use the latrine during the day.
2.12	**Functional means containers should not be more than three-quarters full, be leak-proof with a lid and clearly labelled (i.e. easily distinguishable according to a colour, label or symbol).**
2.15	**Incinerator (if designed for infectious waste and not just general waste) must follow specific design requirements (e.g. use of fire bricks/refractory bricks and mortar (vs. common building bricks) that can withstand the temperatures needed for these incinerators (greater than 800°C). For complete burning, a dual chamber incinerator is needed that reaches temperatures above 800°C and 1100°C, respectively. In case dual incinerators are not available and there is an immediate need for public health protection, small-scale incinerators might be used. This involves a compromise between the environmental impacts from controlled combustion with an overriding need to protect public health if the only alternative is indiscriminate dumping. These circumstances exist in many developing situations and small-scale incineration can be a realistic response to an immediate requirement. For guidelines, see *Safe management of wastes from health-care activities* (WHO, 2014).** **Waste may be treated off site. If so, there should be a means to confirm it is treated safely once removed from the facility premises.**
2.18	Unless a refrigerated storage room is available, storage times for infectious waste (e.g. the time between generation and treatment) should not exceed the following periods: • Temperate climate: 72 hours in winter / 48 hours in summer. • Warm climate: 48 hours during the cool season / 24 hours during the hot season. Fenced area protected from flooding plus lined and covered pit > 30 m from water source plus no unprotected health care waste is observed. If waste removed off site, both the site and the holding area (minus the pit) should comply with the above requirements.
2.19	Placenta pits: lined or unlined depending on the geology, with slab, with ventilation pipe.
2.20	Ash pits: lined or unlined depending on the geology but must prevent leaching to the environment, with slab, bottom of pit at least 1.5 m away from groundwater table. If water gets into the ash pit, it can leach pollutants into the soil.
2.22	Protective equipment for people handling waste management includes: gloves, apron, tough rubber boots.

Tool 2A: Indicators assessment

Date of assessment: ..... **Members of team conducting assessment:** .....

Notes: .....

.....

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3 Hygiene * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
Part A: Hand hygiene					
ESSENTIAL INDICATORS					
3.1* **Functioning hand hygiene stations are available at all points of care**	Yes	Stations present, but no water and/ or soap or alcohol handrub solution	Not present		
3.2* **Hand hygiene promotion materials clearly visible and understandable at key places**	Yes	Some places but not all	None		
ADVANCED INDICATORS					
3.3* Functioning hand hygiene stations are available in service areas	Yes	Stations present, but no water and/ or soap or alcohol handrub solution	Not present		
3.4* Functioning hand hygiene stations available in waste disposal area	Yes	Stations present, but no water and/ or soap	Not present		
3.5 Hand hygiene compliance activities are undertaken regularly	Yes	Compliance activities in policy, but not carried out with any regularity	No compliance activities		

Tool 2A: Indicators assessment

3 Hygiene * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
Part B: Facility environment, cleanliness and disinfection					
ESSENTIAL INDICATORS					
3.6 **The exterior of the facility is well-fenced, kept generally clean (free from solid waste, stagnant water, no animal and human faeces in or around the facility premises, etc.)**	Yes	Partly but improvements could be made/yes, sometimes	Not kept clean at all		
3.7 **General lighting sufficiently powered and adequate to ensure safe provision of health care including at night (mark if not applicable)**	Yes, always	Yes, sometimes	Never		
3.8* **Floors and horizontal work surfaces appear clean**	Yes	Some floors and work surfaces appear clean but others do not	Most and/or all floors and surfaces are visibly dirty		
3.9 **Appropriate and well maintained materials for cleaning (i.e. detergent, mops, buckets, etc.) are available**	Yes	Yes, available but not well maintained	No materials available		
3.10* **At least two pairs of household cleaning gloves and one pair of overalls or apron and boots in a good state, for each cleaning and waste disposal staff member**	Yes	Available but in poor condition	Not available		

Tool 2A: Indicators assessment

3 Hygiene * See associated note		Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
3.11	**At least one member of staff can demonstrate the correct procedures for cleaning and disinfection and apply them as required to maintain clean and safe rooms**	Yes	Procedure is known but not applied	Procedure not known or applied		
3.12	**Beds have insecticide treated nets to protect patients from mosquito-borne diseases**	Yes, on all beds	Available on some but not all beds, or available but with rips and or holes	No bed nets available		
ADVANCED INDICATORS						
3.13	A mechanism exists to track supply of IPC-related materials (such as gloves and protective equipment) to identify stock-outs	Yes	Mechanism exists but is not enforced	No mechanism exists		
3.14	Record of cleaning visible and signed by the cleaners each day	Yes	Record exists, but is not completed daily or is outdated	No record of floors and surfaces being cleaned		
3.15	Laundry facilities are available to wash linen from patient beds between each patient	Yes	Facilities exist, but are not working or not being used	No facilities and/or no linen		
3.16	The facility has sufficient natural ventilation and where the climate allows, large opening windows, skylights and other vents to optimize natural ventilation	Yes	Some ventilation but not well maintained or insufficient to produce natural ventilation	No		
3.17	Kitchen stores and prepared food is protected from flies, other insects or rats	Yes		No		

Tool 2A: Indicators assessment

3 Hygiene * See associated note	Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
3.18 Beds for patients should be separated by 2.5 m from the centre of one bed to the next and each bed has only one patient	Yes, all beds meet this guidance	Some but not all beds fit this criterion	No beds meet this criterion		

Percentage of indicators meeting targets for HYGIENE +++	
Percentage of indicators partially meeting targets for HYGIENE ++	
Percentage of indicators not meeting targets for HYGIENE +	

* Notes: Hygiene

The **indicators in bold are "essential"** and should be completed by all facilities using WASH FIT. Other indicators are considered optional and can be included if the facility has the capacity to assess them.

3.1	**Point of care is where three elements come together: the patient; the health care workers; and care or treatment involving contact with the patient or their surroundings. This may include consultation rooms, operating rooms, delivery rooms and laboratories. Hand hygiene stations should have a sink or bucket with tap and water with soap or alcohol-based handrub. There should be at least two hand hygiene stations in a ward with more than 20 beds.** **Verify that water is available from the tap.**
3.2	**Key places include at points of care, the waiting room, at the facility's entrance and within 5 m of latrines.**
3.3	Sink or bucket with tap and water with soap or alcohol-based handrub. Service areas include sterilization, laboratory, kitchen, laundry, showers, waste zone and mortuary. (Toilets are included under 2.7.)
3.4	Tap and water with soap.
3.8	**Clean as noted by absence of waste, visible dirt and excreta and insects. Environmental surfaces or objects contaminated with blood, other body fluids, secretions or excretions are cleaned and disinfected as soon as possible using standard hospital detergents/disinfectants.**
3.10	**Waste disposal staff who operate the incinerator should have an apron, gloves, goggles, face mask and boots.**

Tool 2A: Indicators assessment

Date of assessment: ..... **Members of team conducting assessment:** .....

Notes: .....

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4 Management * See associated note		Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number:____	Notes (use additional pages if necessary)
ESSENTIAL INDICATORS						
4.1	**WASH FIT or other quality improvement/management plan for the facility is in place, implemented and regularly monitored**	Yes	Complete but has not been implemented and/or is not monitored, or incomplete	No plan		
4.2*	**An annual planned budget for the facility is available and includes funding for WASH infrastructure, services, personnel and the continuous procurement of WASH items (hand hygiene products, minor supplies to repair pipes, toilets, etc.) which is sufficient to meet the needs of the facility**	Yes	Yes, but budget is insufficient	No budget		
4.3	**An up-to-date diagram of the facility management structure is clearly visible and legible**	Yes	Yes, but not up to date	Not available		
4.4	**Adequate cleaners and WASH maintenance staff are available**	Yes	Some available, but not adequate or not skilled/motivated	None available		

Tool 2A: Indicators assessment

4 Management * See associated note		Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
ADVANCED INDICATORS						
4.5	A protocol for operation and maintenance, including procurement of WASH supplies is visible, legible and implemented	Yes	Protocol exists but not implemented	No protocol		
4.6	Regular ward-based audits are undertaken to assess the availability of handrub, soap, single use towels and other hand hygiene resources	Yes	Undertaken less than once a week or assessment is incomplete	Not undertaken		
4.7	New health care personnel receive IPC training as part of their orientation programme	Yes	Some but not all staff	No training		
4.8	Health care staff are trained on WASH/ IPC each year	Yes	Staff are trained but not every year or only some staff are trained	No training		
4.9	Facility has a dedicated WASH or IPC focal person	Yes	Yes, but focal point does not have sufficient time, resources or motivation to carry out duties	No		
4.10	All staff have a job description written clearly and legibly, including WASH-related responsibilities and are regularly appraised on their performance	Yes	Some, but not all, staff have a job description or their performance is not appraised	No job description written		

Tool 2A: Indicators assessment

4 Management * See associated note		Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (use additional pages if necessary)
4.11	High performing staff are recognized and rewarded and those that do not perform are dealt with accordingly	Yes	Either high or low performers addressed but not both	No action or recognition of staff based on performance		

Percentage of indicators meeting targets for MANAGEMENT +++	
Percentage of indicators partially meeting targets for MANAGEMENT ++	
Percentage of indicators not meeting targets for MANAGEMENT +	

* Notes: Management

The **indicators in bold are "essential"** and should be completed by all facilities using WASH FIT. Other indicators are considered optional and can be included if the facility has the capacity to assess them.

4.2	**The budget refers to that used for capital and operational costs. It could be from the community management group and/or the government, according to the policies and practices in the country.**

Tool 2A: Indicators assessment example

Date of assessment: 15 March 2018 **Members of team conducting assessment:** Emily Mutambo, Jacob Safa, Githu Meru

Notes: Water engineer helped conduct the assessment as it was the first assessment and the team needed extra assistance. The assessment took a full day because it was the first time of doing such an assessment. The next assessment is likely to take less time.

Idriss and John were not available on the day of the assessment. They will look at a copy of the results at the next team meeting to make sure they agree with the rest of the team's decisions.

1 Water * See associated note		Meets target +++	Partially meets target ++	Does not meet target +	Does indicator meet the target? Mark +++ / ++ / + Assessment number: ____	Notes (continue in your WASH FIT notebook if necessary)
ESSENTIAL INDICATORS						
1.1*	**Improved water supply piped into the facility or on premises and available**	Yes, improved water supply within facility and available	Improved water supply on premises, (outside of facility building) and available	No improved water source within facility grounds, or improved supply in place but not available	+	Piped water system in place but water supply not always available.
1.2*	**Water services available at all times and of sufficient quantity for all uses**	Yes, every day and of sufficient quantity	More than five days per week or every day but not sufficient quantity	Fewer than five days per week	++	Assessment 2: Now that pipes are working, it is possible to get a greater quantity of water for the facility.
1.3*	**A reliable drinking-water station is present and accessible for staff, patients and carers at all times and in all locations/wards**	Yes, at all times/wards and accessible to all	Sometimes, or only in some places or not available for all users	Not available	+	Assessment 1: No drinking-water stations are available. Assessment 2: Drinking-water stations procured from funds from district office and installed in some places but still needed in maternity area.
1.4*	**Drinking-water is safely stored in a clean bucket/tank with cover and tap**	Yes	All available drinking-water points are safely stored	Not safely stored in any water points or no drinking-water available	+	Assessment 1: Not applicable as no drinking-water currently available. Assessment 2: Safe storage guidelines are now being followed.
ADVANCED INDICATORS						
1.5	Sanitary inspection risk score (using sanitary inspection form 3)	Low risk	Medium risk	High or very high risk	+++	SI form 3 used (piped distribution). Assessment 1: Scored 9/10.

Tool 2B: Record of assessment

Give percentage of indicators achieved for each assessment.

Domain		Assessment 1		Assessment 2		Assessment 3		Assessment 4	
		%	Notes	%	Notes	%	Notes	%	Notes
Water Total number of indicators assessed: _____	Date of assessment:								
	+++								
	++								
	+								
Sanitation and health care waste Total number of indicators assessed: _____	Date of assessment:								
	+++								
	++								
	+								
Hygiene Total number of indicators assessed: _____	Date of assessment:								
	+++								
	++								
	+								
Management Total number of indicators assessed: _____	Date of assessment:								
	+++								
	++								
	+								
Overall facility score	Date of assessment:								
	+++								
	++								
	+								

Tool 2B: Record of assessment example

Give percentage of indicators achieved for each assessment.

Domain		Assessment 1		Assessment 2		Assessment 3		Assessment 4	
		%	Notes	%	Notes	%	Notes	%	Notes
Water Total number of indicators assessed: 13	**Date of assessment:**	24 September Year 1		25 March Year 2					
	+++	5	Overall, improvements needed as fewer than half of the indicators met standards.	10	Significant improvement (number of indicators meeting standards doubled) and no areas where standards not met. Some additional progress could be made.				
	++	4		3					
	+	4		0					

Tool 2C: Sanitary inspection forms

Sanitary inspection form ❶: Dug well with hand pump

I. General information

Name of facility: ..... Location and/or name of dug well: ..... Date of inspection: .....

Weather conditions during inspection: .....

Note: If there is more than one dug well accessed by the facility, or if the facility uses other water sources (such as springs or boreholes), carry out sanitary inspections for these sources too

II. Specific questions for assessment

1. Is the source located at an unsafe distance from an unsealed latrine (i.e. a latrine in close proximity is uphill or at a location where the groundwater gradient would flow from the latrine to the water source)? ❑ Yes ❑ No
2. Is the fence absent, inadequate or faulty? ❑ Yes ❑ No
3. Can animals have access within 30 m of the well? ❑ Yes ❑ No
4. Is there any other source of pollution within 30 m of the well (such as animal breeding, farming, roads, health care waste, household waste)? ❑ Yes ❑ No
5. Is there stagnant water within 3 m of the well? ❑ Yes ❑ No
6. Is the drainage channel absent or cracked, broken or in need of cleaning? ❑ Yes ❑ No
7. Is the cement floor or slab less than 2 m in diameter around the top of the well? ❑ Yes ❑ No
8. Are there cracks in the cement floor or slab? ❑ Yes ❑ No
9. Is the hand pump loose at the point of attachment or, for rope-washer pumps, is the pump cover missing or damaged? ❑ Yes ❑ No
10. Is the well cover absent, cracked or insanitary? ❑ Yes ❑ No

Total score of risk factors as total number of "YES" answers: ____

III. Results and comments

Sanitary inspection risk score (tick appropriate box): **Very high risk** (risk score: 9–10) ❑ | **High risk** (risk score: 6–8) ❑ | **Medium risk** (risk score: 3–5) ❑ | **Low risk** (risk score: 0–2) ❑

Important points of risk noted:

■ List according to question numbers 1–10:

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■ Additional comments:

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IV. Names and signatures of assessors:

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Tool 2C: Sanitary inspection forms

Notes for SI form ❶: Dug well with hand pump

1. Is the source at an unsafe distance from a latrine?

Latrines close to groundwater supplies may affect water quality (for example, by infiltration of faecal material). Pollution of unconfined shallow aquifers poses a risk, especially in the wet season, as faecal material (and other pollutants) may flow into the water source. The risk of contamination will depend on several factors including whether the latrine is sealed, the type of soil and the direction of groundwater flow. You may need to check structures visually and/or discuss with local technicians to determine the risk. While there is no universal safe distance, a latrine being uphill of groundwater flow and/or within 30 m, would, generally, pose a risk (thus an answer of "yes").

2. Is the fence absent or faulty?

If there is no fence or if the fence is inappropriate (for example, too low or not equipped with a functioning gate) or damaged, animals (including those used for collecting the water) can access the well site. They may damage the structure and pollute the area with excreta. You will need to check both the protection of the site and whether animals are routinely in the area. If you observe either of these problems, answer "Yes".

3. Can animals have access within 30 m of the well?

If animals can access the well site or its immediate vicinity, they may damage the structure and pollute the area with excreta. You will need to check both the protection of the site and whether animals are routinely in the area. If you observe either of these problems, answer "Yes".

4. Is there any other source of pollution within 30 m of the well (such as animal breeding, cultivation, roads, garages, craft enterprises or waste)?

Animal or human faeces on the ground close to the well constitute a risk to water quality, especially when water diversion ditches are not present. Disposal of other waste (for example, household, agricultural or commercial) indicates that environmental sanitation practices are poor, which constitutes a risk to water quality. This can be confirmed by observation of the general surroundings in the community. If you find any of these practices within 30 m of the well, answer "Yes".

5. Is there stagnant water within 3 m of the well?

If pools of water accumulate around the well they may provide a route for contaminants to enter the source. If you observe spilt water or pools of water close to the well, answer "Yes".

6. Is the drainage channel absent or cracked, broken or in need of cleaning?

Poor construction or maintenance of the drainage channel leads to cracks and breaks. Especially when combined with spillage of water and poor sanitary conditions, this poses a risk to water quality. If you observe any of these problems, answer "Yes".

7. Is the cement floor or slab absent or less than 2 m in diameter around the top of the well?

The slab is built to prevent backflow of water into the well. To do this adequately it needs to be at least 2 m in diameter. If it is absent or too small, answer "Yes".

8. Are there cracks in the cement floor or slab?

Cracks, especially deep ones, in the cement may allow backflow into the water source. If you see deep cracks, answer "Yes".

9. Is the hand pump loose at the point of attachment or, for rope-washer pumps, is the pump cover missing or damaged?

A loose hand pump or a missing pump cover may allow backflow of contaminated water into the water source. If the pump is not securely attached to the pump base in the apron (or the pump cover is missing), answer "Yes".

10. Is the well cover absent, cracked or insanitary?

Absence of a cover, a cracked cover or an insanitary cover increases the likelihood of contamination entering the well. If you observe any of these problems, answer "Yes".

Tool 2C: Sanitary inspection forms

Sanitary inspection form ❷: Deep borehole with motorized pump

I. General information

Name of facility: ..... Location and/or name of borehole: ..... Date of inspection: .....

Weather conditions during inspection: .....

Note: If there is more than one borehole accessed by the facility, or if the facility uses other water sources (such as springs or dug wells), carry out sanitary inspections for these sources too.

II. Specific questions for assessment

1. Is there a latrine or sewer within 15–20 m of the extraction site/well-head? ..... ❑ Yes ❑ No
2. Is the nearest latrine a pit latrine that percolates to soil, i.e. not connected to a septic tank or sewer? ..... ❑ Yes ❑ No
3. Is there any other source of pollution (e.g. animal excreta, rubbish, surface water) within 10 m of the borehole? ..... ❑ Yes ❑ No
4. Is there an uncapped well within 15–20 m of the borehole? ..... ❑ Yes ❑ No
5. Is the drainage area around the pump house faulty? ..... ❑ Yes ❑ No
6. Is the fencing around the installation damaged in any way which would permit any unauthorized entry or allow animals access? ..... ❑ Yes ❑ No
7. Is the floor of the pump house permeable to water? ..... ❑ Yes ❑ No
8. Is the well seal unsanitary? ..... ❑ Yes ❑ No
9. Is the chlorination functioning properly? ..... ❑ Yes ❑ No
10. Is chlorine present at the sampling tap? ..... ❑ Yes ❑ No

Total score of risk factors as total number of "YES" answers: ____

III. Results and comments

Sanitary inspection risk score (tick appropriate box): **Very high risk** (risk score: 9–10) ❑ | **High risk** (risk score: 6–8) ❑ | **Medium risk** (risk score: 3–5) ❑ | **Low risk** (risk score: 0–2) ❑

Important points of risk noted:

■ List according to question numbers 1–10:

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■ Additional comments:

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IV. Names and signatures of assessors:

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Tool 2C: Sanitary inspection forms

Sanitary inspection form ❸: Public/yard taps and piped distribution

I. General information

Name of facility: ..... Date of inspection: ..... Weather conditions during inspection: .....

Location and/or name of water source(s) feeding the distribution system: .....

Location and/or name of storage reservoir feeding the distribution system (if any): .....

Note: If the distribution system is served by a storage reservoir, also carry out a sanitary inspection using SI form 5: Storage reservoirs.

II. Specific questions for assessment

Note: Fill in one form per public or yard tap under inspection. In facilities with water piped directly into the building only questions 7–10 apply. Not all taps within the facility need to be inspected in every inspection round – a selected sample is sufficient.

Public or yard tap

1. Does the tap leak? ❑ Yes ❑ No
2. Is the tap or are attachments (such as hoses) insanitary? ❑ Yes ❑ No
3. Does spilt water accumulate around the tap stand? ❑ Yes ❑ No
4. Is the area around the tap stand polluted by waste, faeces or other materials? ❑ Yes ❑ No
5. Is the area around the tap stand unfenced, allowing animals to access the area? ❑ Yes ❑ No
6. Is there a sewer or a latrine at an unsafe distance from the tap stand (generally 30 m but may be more or less depending on the gradient, geology and size of water or sewer infrastructure)? ❑ Yes ❑ No

Piped distribution

7. Are there any signs of leaks in the inspection area (for example, accumulating water)? ❑ Yes ❑ No
8. Are any of the pipes exposed above ground in the inspection area? ❑ Yes ❑ No
9. Have users report any pipe breaks within the last week? ❑ Yes ❑ No
10. Has there been discontinuity in the last 10 days? ❑ Yes ❑ No

Total score of risk factors as total number of "YES" answers: ____

III. Results and comments

Sanitary inspection risk score (tick appropriate box): ❑ **Very high risk** (risk score: 9–10) ❑ **High risk** (risk score: 6–8) ❑ **Medium risk** (risk score: 3–5) ❑ **Low risk** (risk score: 0–2)

Note: In situations where only questions 7–10 apply, the score below can be adapted as follows: "Very high" = 4; "High" = 3; "Medium" = 2; "Low" = 0–1.

Important points of risk noted:

■ List according to question numbers 1–10:

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■ Additional comments:

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IV. Names and signatures of assessors:

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Tool 2C: Sanitary inspection forms

Notes for SI form ❸: Public/yard taps and piped distribution

1. Does the tap leak?

If taps are leaking or damaged then cracks may provide a route for contaminants to enter the pipes, particularly if the distribution system is operating intermittently. Leaking taps also contribute to water wastage. During the inspection, you will need to differentiate between water from leaking taps and spilt water. If you observe leaks or damage at taps, answer "Yes".

2. Is the tap or are attachments (such as hoses) insanitary?

If the tap is contaminated, or if any attachments to the tap (such as hoses) are insanitary, collected water may be contaminated and contamination can be introduced to the distribution system. If the tap is insanitary, answer "Yes".

3. Does spilt water accumulate around the tap stand?

Any spilt water may be contaminated by runoff, especially if animals have access to the collection area. Containers may be contaminated by the spilt water during collection. Also, if cracks are present in the collection area, they may provide a route for contaminants to enter the distribution pipes, particularly if the distribution system operates intermittently. If you observe accumulation of spilt water, answer "Yes".

4. Is the area around the tap stand insanitary?

Faeces, unwanted plant growth/weeds, rubbish and other waste increases the risk of water becoming contaminated during collection – for example, by contaminating collection containers. If you observe any of these problems close to the tap, answer "Yes".

5. Is the area around the tap stand unfenced, allowing animals to access the area?

If there is no fence or if the fence is inappropriate (for example, too low or not equipped with a functioning gate) or damaged, animals (including those used for collecting the water) can access the tap stand area. They may cause damage to the taps and pollute the area or collection containers with excreta. You will need to check whether animals are routinely in the area by asking residents and by personal observation in the area (including seeing any animal excreta at the site). If you observe any of these problems or if the area is unfenced, answer "Yes".

6. Is there a sewer or a latrine at an unsafe distance from a tap stand?

Any leaks from a sewer or infiltration from a latrine could contaminate the piped water, especially if there are any cracks in the distribution system and if the distribution system operates intermittently. Groundwater may flow towards the distribution pipes from the direction of the sewer or latrine. You can observe latrines and cross-check with residents but you may need to ask relevant professionals about the location of sewers. If either a sewer or latrine is present, answer "Yes".

7. Are there any signs of leaks in the inspection area (for example, accumulating water)?

If pipes are damaged or leaking then cracks may provide a route for contaminants to enter the pipes, particularly if the distribution system operates intermittently. Watch out for stagnant water or unexpected flows of water above ground but you will need to differentiate between water from leakage and spilt water. If you observe leaks in the inspection area, answer "Yes".

8. Are any of the pipes exposed above ground in the inspection area?

Exposure of the pipe means that it is more prone to both damage (especially if by/on a road) and contamination from runoff than pipes below ground. You will need to identify the routes of the main pipelines in the inspection area. If the pipelines are exposed, answer "Yes".

9. Have users reported any pipe breaks within the last week?

Pipe breaks pose a risk to water quality as contaminants can enter the system through the break, particularly if the distribution system operates intermittently. You will need to ask residents about any pipe breaks. If breaks are reported, answer "Yes".

10. Has there been discontinuity in the last 10 days?

During discontinuities, the distribution pipes become empty and pressure differences may lead to ingress of water and silt from the soil around the pipes. As water and soil may be contaminated this poses a risk to water quality. You will need to ask residents about discontinuities. Also record the frequency and duration, if possible. If there has been a discontinuity, answer "Yes".

Tool 2C: Sanitary inspection forms

Sanitary inspection form ❹: Rainwater harvesting

I. General information

Name of facility: ..... Location and/or name of rainwater storage: ..... Date of inspection: .....

Weather conditions during inspection: .....

Note: If the facility uses other water sources (such as springs or boreholes), carry out sanitary inspections for these sources too.

II. Specific questions for assessment

1. Is there any visible contamination of the roof catchment area (plants, dirt, or excreta)? ❑ Yes ❑ No
2. Are the guttering channels that collect water dirty? ❑ Yes ❑ No
3. Is there any deficiency in the filter box at the tank inlet (e.g. lacks fine gravel)? ❑ Yes ❑ No
4. Is there any other point of entry to the tank that is not properly covered? ❑ Yes ❑ No
5. Is there any defect in the walls or top of the tank (e.g. cracks) that could let water in? ❑ Yes ❑ No
6. Is the tap leaking or otherwise defective? ❑ Yes ❑ No
7. Is the concrete floor under the tap defective or dirty? ❑ Yes ❑ No
8. Is the water collection area inadequately drained? ❑ Yes ❑ No
9. Is there any source of pollution around the tank or water collection area (e.g. excreta)? ❑ Yes ❑ No
10. Is a bucket in use and left in a place where it may become contaminated? ❑ Yes ❑ No

Total score of risk factors as total number of "YES" answers: ____

III. Results and comments

Sanitary inspection risk score (tick appropriate box): **Very high risk** (risk score: 9–10) ❑ | **High risk** (risk score: 6–8) ❑ | **Medium risk** (risk score: 3–5) ❑ | **Low risk** (risk score: 0–2) ❑

Important points of risk noted:

■ List according to question numbers 1–10:

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■ Additional comments:

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IV. Names and signatures of assessors:

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Tool 2C: Sanitary inspection forms

Sanitary inspection form ❺: Storage reservoirs

I. General information

Name of facility: ..... Date of inspection: ..... Weather conditions during inspection: .....

Location and/or name of storage reservoir: .....

Location and/or name of water source(s) feeding the reservoir: .....

Note: If there is more than one storage reservoir used in your facility, use one form for each reservoir.
If the storage reservoir feeds a piped distribution system, also carry out a SI using SI form 3: Public/yard taps and piped distribution.
If the storage reservoir is equipped with a tap for collecting water, also carry out a SI using questions 1–6 of SI form 3: Public/yard taps and piped distribution.

II. Specific questions for assessment

1. Is there any point of leakage of the pipe between source and storage reservoir? ..... ❑ Yes ❑ No
2. Is the physical infrastructure of the storage reservoir cracked or leaking? ..... ❑ Yes ❑ No
3. Is the inspection cover of the storage reservoir absent or open? ..... ❑ Yes ❑ No
4. Is the inspection cover faulty, corroded or is the concrete around the cover damaged? ..... ❑ Yes ❑ No
5. Is the inspection cover visibly dirty? ..... ❑ Yes ❑ No
6. Are screens protecting the air vents on the storage reservoir missing or damaged? ..... ❑ Yes ❑ No
7. If there is an overflow pipe, is the screen protecting it missing or damaged? ..... ❑ Yes ❑ No
8. Is there any scum or foreign object in the storage reservoir? ..... ❑ Yes ❑ No
9. Is the diversion ditch above the storage reservoir absent or non-functional? ..... ❑ Yes ❑ No
10. Is the area around the storage reservoir unfenced or is the fence damaged, allowing animals to access the area? ..... ❑ Yes ❑ No
11. Is the storage reservoir not regularly cleaned and disinfected? ..... ❑ Yes ❑ No

Total score of risk factors as total number of "YES" answers: ____

III. Results and comments

Sanitary inspection risk score (tick appropriate box): **Very high risk** (risk score: 9–11) ❑ | **High risk** (risk score: 6–8) ❑ | **Medium risk** (risk score: 3–5) ❑ | **Low risk** (risk score: 0–2) ❑

Important points of risk noted:

■ List according to question numbers 1–11:

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■ Additional comments:

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IV. Names and signatures of assessors:

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Tool 2C: Sanitary inspection forms

Notes for SI form ❺: Storage reservoirs

1. Is there any point of leakage of the pipe between source and storage reservoir?

If pipes are damaged or leaking then cracks may provide a route for contaminants to enter the pipes. Watch out for stagnant water or unexpected flows of water above ground. If you observe leaks, answer "Yes".

2. Is the physical infrastructure of the storage reservoir cracked or leaking?

Cracks allow contaminants to reach the water stored in the tank; leakage also leads to loss of water. If you find deep cracks that penetrate the tank, answer "Yes".

3. Is the inspection cover of the storage reservoir absent or open?

If there is no inspection cover, or the cover is not closed at the time of inspection, it allows contaminants (such as bird droppings or other faeces from rodents or cats) to reach the water stored in the tank rapidly, especially in wet weather. If you observe either of these problems, answer "Yes".

4. Is the inspection cover faulty, corroded or is the concrete around the cover damaged?

Corroded or damaged covers and cracked concrete surrounds allow contaminants (such as bird droppings or other faeces from rodents or cats) to reach the water stored in the tank rapidly, especially in wet weather. If you observe any of these problems, answer "Yes".

5. Is the inspection cover visibly dirty?

If the inspection cover is contaminated by faeces (for example, from birds or rodents), spider webs, insects, soil or slime, this poses a risk to water quality. If you observe any of these problems, answer "Yes".

6. Are screens protecting the air vents on the storage reservoir missing or damaged?

If there are no screens protecting the air vents, or if they are damaged, this allows insects and other animals (such as birds and rodents) to access the reservoir. This poses a risk to water quality. If you observe either of these problems, answer "Yes".

7. If there is an overflow pipe, is the screen protecting it missing or damaged?

If there are no screens protecting the overflow pipe, or if they are damaged, this allows insects and other animals (such as birds and rodents) to access the reservoir. This poses a risk to water quality. If you observe either of these problems, answer "Yes".

8. Is there any scum or foreign object in the storage reservoir?

If there is any scum floating on the surface of the water table (for example, insects, foam or algae), or if there are any other objects on the ground of the reservoir (for example, dead animals or rubbish), this poses a risk to water quality. If you observe any of these conditions, answer "Yes".

9. Is the diversion ditch above the storage reservoir absent or non-functional?

The role of the ditch is to protect the reservoir from surface runoff by directing it downhill and away from the reservoir. If the ditch is filled with waste or poorly contoured then runoff can collect and infiltrate near the reservoir, possibly causing damage to the infrastructure or posing a risk to water quality due to ingress into the reservoir. You should look for water or waste collected in the ditch. If the ditch is absent or not functioning correctly, answer "Yes".

10. Is the area around the storage reservoir unfenced or is the fence damaged, allowing animals to access the area?

If there is no fence – or if the fence is inappropriate (for example, too low or not equipped with a functioning gate) or damaged – animals (including those used for collecting the water), can access the reservoir area. They may cause damage to it and pollute the area with excreta. You will need to check whether animals are routinely in the area by asking residents and by personal observation in the area (including seeing any animal excreta at the site). If you observe any of these problems or if the area is unfenced, answer "Yes".

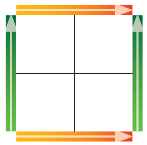
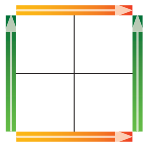
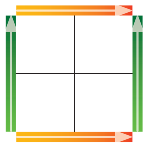
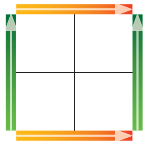
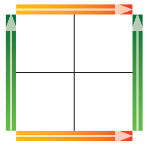
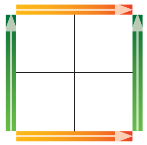
11. Is the storage tank not regularly cleaned and disinfected?

The storage tank should be washed with soap and water, then the whole of the inside wiped using 0.5% chlorine solution. This should occur three or four times per year. If this is not done, answer "No".

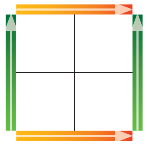
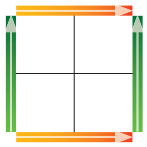
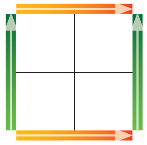
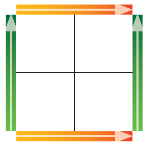
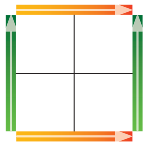
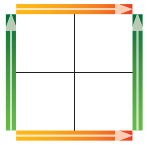
Tool 3: Hazard and risk assessment

Date of assessment: .....

Note: Three rows are provided for each domain. If more than three hazards are identified, continue on an additional sheet.

Hazards (problems) List the main hazards (problems) that you face. These will be indicators that were scored ✚ or ✚✚	**Risks** List the possible risks associated with each hazard (problem)	**Level of risk vs. feasibility of addressing problem** Place indicator number on grid for each risk (see Figure 3.3)	**Actions** Agreed actions to be undertaken either locally or at the district/ regional levels.	
			Facility/community	**District/regional**
Water				
				
				
				
Sanitation and health care waste				
				
				
				

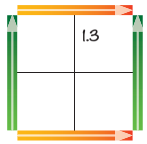
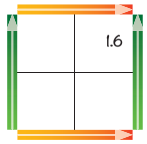
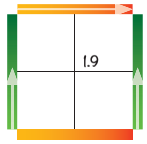
Tool 3: Hazard and risk assessment

Hazards (problems) List the main hazards (problems) that you face. These will be indicators that were scored ✚ or ✚✚	Risks List the possible risks associated with each hazard (problem)	Level of risk vs. feasibility of addressing problem Place indicator number on grid for each risk (see Figure 3.3)	Actions Agreed actions to be undertaken either locally or at the district/ regional levels.	
			Facility/community	District/regional
Hygiene				
				
				
				
Management				
				
				
				

Tool 3: Hazard and risk assessment example

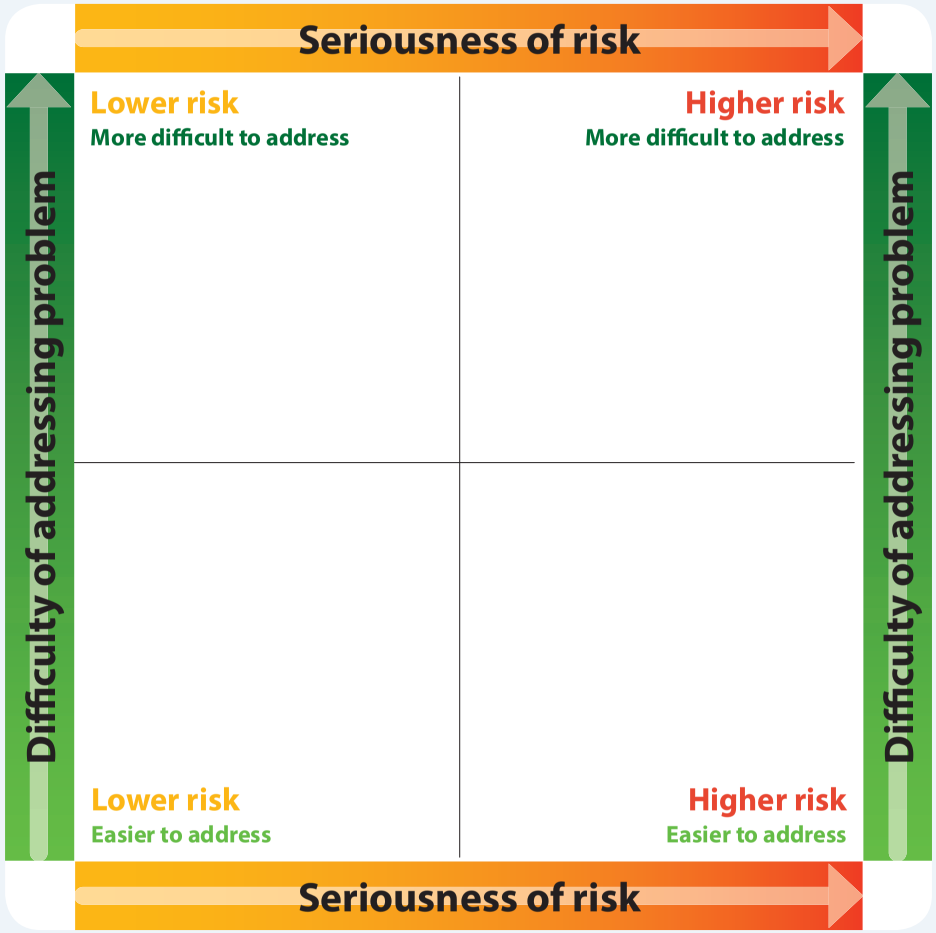
Date of assessment: 26 March 2017 (Year 1)

Note: Three rows are provided for each domain. If more than three hazards are identified, continue on an additional sheet.

Hazards (problems) List the main hazards (problems) that you face. These will be indicators that were scored ✚ or ✚✚	Risks List the possible risks associated with each hazard (problem)	Level of risk vs. feasibility of addressing problem Place indicator number on grid for each risk (see Figure 3.3)	Actions Agreed actions to be undertaken either locally or at the district/ regional levels.	
			Facility/community	District/regional
Water				
1.3 No drinking-water stations are available in the facility, therefore staff and patients are unable to drink water at facility and no water is available for swallowing medicines.	Risk of waterborne illness when patients drink unsafe water.		Facility to install covered clean container and regularly fill and chlorinate.	Authorities to extend piping into facility and install longer term filters to treat water at point of collection.
1.6 Some endpoints in the water supply are not working, taps are blocked or broken. Water is not available from the taps in the maternity ward.	Cleaning cannot be carried out as easily after delivering, leading to risk of infection for staff and patients. Water not available for hand hygiene, or for women to wash themselves after delivering. Risk of infection, less dignity for women.		Cleaners to remove debris; plumbers to repair broken pipes once parts received.	Authorities provide new pipes/valves to make repairs.
1.9 The facility does not currently treat water, and because of poor storage and handling as well as unsafe municipal supplies, water quality does not meet drinking-water standards or standards for municipal uses.	Staff and patients at risk of infection from unsafe water.		Facility to safely store water and, if possible, use chlorine treatment while longer term, more sustainable options are sought.	District authorities to work with partners to secure treatment (i.e. electro-chlorinator or filter). Regional authorities to prioritize treatment of water supplied to health care facilities.

Categorizing problems and risks by the level of difficulty to address the problem or risk

This is a second option for ranking the hazards. Plotting all the levels of risk vs. the feasibility of addressing the problem, for each hazard identified, on the following master grid can assist in developing the improvement plan and prioritizing actions (Task 4).



Problems/hazards

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Tool 4: Improvement plan

Date improvement plan written: ..... **Date Review 1:** ..... **Date Review 2:** .....

What specific improvement action will be taken to resolve the hazards identified? The actions to be taken link to the hazards recorded in Tool 3	**Who will carry out the task and is there anyone who will supervise it?** List people responsible for implementation	**What resources are needed to do it?** Resources could be staff, technical or financial	**When do you expect to complete this action?** Indicate target date	**Completion date** Once the activity has been completed, record the date of completion	**Task 5: Monitoring** **When you review the plan, how does it need to be changed?** What, if any, additional efforts are needed?	
					Review 1	**Review 2**
Water						
Sanitation and heath care waste						
Hygiene						
Management						

Tool 4: Improvement plan example

Date improvement plan written: March (Year 1) **Date Review 1:** September (Year 1) **Date Review 2:** Due March (Year 2)

What specific improvement action will be taken to resolve the hazards identified? The actions to be taken link to the hazards recorded in Tool 3	**Who will carry out the task and is there anyone who will supervise it?** List people responsible for implementation	**What resources are needed to do it?** Resources could be staff, technical or financial	**When do you expect to complete this action?** Indicate target date	**Completion date** Once the activity has been completed, record the date of completion	**Task 5: Monitoring** **When you review the plan, how does it need to be changed?** What, if any, additional efforts are needed?	
					Review 1	**Review 2**
Water						
1.3 Drinking-water stations to be bought and installed in waiting areas.	Jacob to assign budget for purchasing and source drinking-water stations. Idriss to ensure stations are installed in correct places.	US$10 per station, plus ceramic filters at US$40 each. Total US$50 x 4 needed = US$200.	15 April.	15 April.	No drinking-water available in maternity ward so additional stations need to be bought when funds are available.	
1.6 Leaks in piping will be fixed to ensure that taps are working.	Local engineer to be contracted to carry out repairs to piping.	Two days of work at a cost of US$10/day.	1 June.	5 June.	Action completed. Pipes will be monitored in case of any further leakages.	
1.9 Water for drinking-water stations will be treated using ceramic filtration.	Jacob to assign budget for purchasing and source drinking-water stations. Fatoumata responsible for treating water.	Fatoumata's time.	Ongoing activity. Treatment to start in April once materials are available.	Treatment started on 21 April 2016.	Drinking stations are not filled regularly enough when water supply is absent.	

Annex 1

Guidance for national or district level implementers and policymakers

The following section is designed for national or district level implementers who may be considering using WASH FIT. It provides a summary of best practices on how to design a training package and presents two different scenarios for implementing WASH FIT. It also includes a questionnaire to help track progress of WASH FIT implementation and a timeline template for planning WASH FIT activities.

Seek input and ownership from key WASH and health stakeholders before implementation

Conducting a training programme without the necessary planning and stakeholder engagement will not be very fruitful. Meeting with key WASH and health stakeholders to discuss training needs, other existing training packages and appropriate timelines in line with other policy and funding mechanisms is important at the outset. This includes linking with broader quality of care initiatives, health sector policy review and planning mechanisms, as well as more targeted efforts such as those to improve maternal and child health or infection prevention and control.

Engage health colleagues to ensure alignment with national quality initiatives, guidelines and standards and planning processes

When adapting WASH FIT for implementation, involve health colleagues and discuss which elements of WASH FIT can be used to implement wider quality improvements. For example, the *WHO Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level* (WHO, 2016a) and the *WHO Standards for improving quality of maternal and newborn care in health facilities* (WHO, 2016c) both include specific standards and measures for WASH. The implementation of each of these will require WASH interventions and maintenance of WASH services and therefore specific WASH FIT tools (i.e. the assessment or risk assessment forms) can be adapted and incorporated into these efforts to realize health aims.

Determine how the training will be rolled out before commencing

Consider how to roll-out training at the start. Develop a timeline, roles, responsibilities and funding requirements for rolling out training, ongoing skills development and technical support and, crucially, monitoring and evaluation.

Identify target trainees

It is important to develop clear criteria for those who will undergo training. The primary trainees will be those working in health care facilities (including cleaners and maintenance individuals) – they should be individuals who demonstrate an interest and motivation to further improve their skills and competencies. Other potential trainees include national/regional/district health and water government staff working on environmental health and/or IPC, NGO partners, facility staff, including cleaners, and community water and health committee members. It is important that supervisors of those trained are also fully supportive of facilitating the wider system changes that need to happen in order to realize many of the goals of WASH FIT.

Adapt the training materials to suit context and needs

Training should build on existing training programmes and materials. Try not to duplicate existing efforts. For example, if there is already a national training curriculum on IPC, staff may already have some existing technical

knowledge which will help them with WASH FIT. Conversely, revision and refreshers courses can also be useful. A set of modules are available to accompany this guide on the WASH in Health Care Facilities website (http://www.washinhcf.org/resources/training/).

Include a visit to a health care facility in the training

If possible, hold the training at or near a health care facility and include a visit to the facility in the training. This will enable participants to gain first-hand experience of conducting an assessment. They should use the results of the assessment to develop an example improvement plan.

Prepare a budget that reflects aims and available resources, with potential to scale-up

The training budget should realistically consider all the costs, which include the actual training, but also the follow-up support that is required to assist facilities in ongoing challenges and improvements. In addition, it is useful to consider the funds for physical supplies as even providing some minor, immediate improvements (such as hand hygiene stations, low-cost water filtration or on-site chlorine generation) can help realize major improvements in reducing health risks and set the foundation for longer term improvements such as piped water.

Options for training

There are several options or scenarios for conducting training. Two of these – running training directly in a few facilities or districts as well as a national training of trainers – are briefly summarized below.

Scenario A – Targeted facility trainings

In this scenario, the training is implemented in a few facilities or pilot districts. This involves direct training of staff (ideally in their own facility) and allows for modifications and reflections on the indicators and other tools that are required for the specific context. Such training is also an option when resources are limited and may be an opportunity to initiate WASH FIT, demonstrate success and then, based on these positive outcomes, seek additional support from government, donors and/or other partners. Finally, it helps develop a set of "model" facilities that can be used to disseminate learning and serve as reference centres for future waves of facilities that undertake WASH FIT.

Scenario B – Regional or national training

A second scenario is to conduct a training of trainers for a particular region or the entire country. In such cases, those trained will go on to train others, so it is particularly important that the trainers have both technical and training skills and experience. In order to roll-out such a programme effectively, sufficient resources are needed to ensure the material and training is eventually cascaded to all targeted health care facilities. It also means that any adaptation of the material needs to happen rapidly. The advantage is that it provides a large cohort from which to build knowledge and share lessons learned and reach many more facilities.

Continual learning and exchange

For both scenarios, it is important to provide ongoing technical assistance and provide refresher courses. It is better to do a series of shorter trainings rather than a longer, one-off training. Long trainings take people away from their facilities for a long time, which can have negative impacts, especially on small facilities where such individuals are critical to providing WASH and health care services to communities, often with many needs.

One possible option would to be establish peer-to-peer learning with another facility which is implementing WASH FIT. For example, conducting exchange visits between facilities, having staff from larger facilities provide technical support to smaller facilities or establishing an email exchange for facilities to ask each other questions. Consider having one or more "model" facilities that meet an accreditation scheme or national quality standards that can serve as examples for others to follow. This will incentivize facilities to make improvements.

Tracking progress and improving WASH FIT

Once a facility has begun to implement WASH FIT, it is essential that it is supported and guided through the process. Monitoring and evaluation require investment but are important to ensure that resources used for training are put to good use and the enabling environment for quality of care improvements is achieved. Ideally, monitoring and evaluation will be built into the health system, with district health officials tracking improvements and, during their regular facility supervisory visits, addressing aspects of WASH along with a host of other health issues. Exploring the use of digital tracking of improvements through phone applications may be a worthwhile investment to provide real-time inputs and immediate changes.

WASH FIT external follow-up visit questionnaire

For the first visit, answer all questions. You may be able to skip some questions on subsequent visits.

General information	
Name of the facility:	District:
Date of visit:	
Number of visit (e.g.1st, 2nd):	
Name(s) and organization of person conducting the visit:	
Name of the WASH FIT team member contributing to evaluation:	
Name of the WASH FIT team lead (if different):	

Has the WASH FIT process been started? ❑ Yes ❑ No

If not, why not? (tick all that apply)

- ❑ Limited understanding of methodology
- ❑ Lack of financial resources
- ❑ Limited motivation for or appreciation of WASH FIT
- ❑ Too complicated/too many forms
- ❑ Other (please describe):

Is there a WASH FIT folder/notebook available? ❑ Yes (ask to see it) ❑ No

In talking to the facility manager, do you think that leadership is engaged? (tick which applies)

❑ Yes, fully engaged and supportive of the initiative (e.g. a member of the WASH FIT team)

❑ Somewhat engaged but does not seem to be driving change

❑ Not at all engaged

Please provide additional details:

What have patient reactions been to WASH FIT? What is their attitude to it? (tick which applies)

❑ Patients are aware of WASH FIT and are engaged and supportive

❑ Patients are aware of WASH FIT but not engaged

❑ Patients are not aware of WASH FIT

Please provide additional details:

Do members of the WASH FIT team adequately understand the WASH FIT process? Ask the team to explain the WASH FIT methodology

❑ Yes, they completely understand the process and can explain it well

❑ Yes, but have only partial understanding

❑ No, limited understanding

Please provide additional details (e.g. specific areas of confusion/lack of understanding):

Task 1: Team meetings

Is there a record of the WASH FIT team? ❑ Yes ❑ No
How many members are on the team?
How many times has the team met?
How often do they meet?
What date was the last team meeting?
Are there records of the team meetings?
Make a note of the feedback you gave to the WASH FIT team (if any):

Task 2: Indicators assessment

Date of baseline assessment: (indicate if no assessment completed)
Date of most recent assessment:
What number assessment is this? ❑ 1st ❑ 2nd ❑ 3rd ❑ 4th ❑ Other
If the baseline assessment has not been completed, why not? (For example, insufficient understanding, understaffed, etc.)
Note any changes observed since the previous evaluation:
Sanitary inspection forms completed? ❑ Yes ❑ No Which form(s) was completed? (tick all that apply) ❑ **SI 1:** Dug well with hand pump
❑ **SI 2:** Borehole with motorized pump
❑ **SI 3:** Public/yard taps and piped distribution
❑ **SI 4:** Rainwater harvesting
❑ **SI 5:** Storage reservoirs (which can be used in combination with any abstraction methods)
How could the team improve their assessments? Provide the team with suggestions and feedback and make a note here:

Task 3: Hazard and risk assessment

Tool 3 filled in: ❑ Yes ❑ No

List the main problems identified

Area	Hazards/problems identified
Water	
Sanitation	
Hygiene	
Management	

Are the levels of risk assigned to the problems appropriate? ❑ Yes ❑ No

If not, provide details:

Task 4: Developing an improvement plan

Tool 4 filled in: ❑ Yes ❑ No

What actions have been taken since the last visit?

Action taken	By whom	When	Comments
e.g. Hand washing posters printed and posted outside latrines	Idriss, caretaker	5 January	Posters drawn by community members, translated into local language

Next steps

What specific actions will be taken by the WASH FIT team? Record all items identified, e.g. hold a WASH FIT team meeting on dd/mm/yy, engage facility management to lend greater support to WASH in health care facility, conduct a training for cleaners, redo the assessment etc. 1. 2. 3. 4. 5.
What actions (if any) will be taken at the district level/national level?
What kind of additional support does the facility need and what actions are necessary to obtain this support? (e.g. financial, technical training, WASH-related supplies)
Date of next visit:

General observations

Make a note of any observations about the state of the facility and progress made on the WASH FIT process:

Activity planning example

This template is intended as an example to help plan WASH FIT activities within a facility. It can be used at the national, district or facility level. It will also help those monitoring WASH FIT to keep track of activities and ensure that the process is sustained. A few example activities are provided. These can be adapted or replaced with other activities as required.

	Month											
Activity	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Share the materials and lessons learned from the WASH FIT training with the rest of the facility	✘											
All facility members to read the training materials and WASH FIT guide		✘										
Meeting to identify external partners to join the WASH FIT team		✘										
First weekly meeting of the core WASH FIT team			✘									
Present the WASH FIT methodology to the rest of the team			✘									
Complete baseline facility assessment with the whole team				✘								
First meeting with external partners					✘							
Make initial immediate improvements (e.g. install hand hygiene stations and start daily record of cleaning)					✘							
Conduct review of progress and discuss longer term improvements with the district officials											✘	
Implement improved water supply, including storage and piped water in examination rooms												✘

Annex 2
Contributors

Gratitude is extended to the following experts, policymakers and practitioners who reviewed WASH FIT with the aim of making it practical and user friendly: Benedetta Allegranzi, WHO, Geneva, Switzerland; Arshad Altaf, WHO, Geneva, Switzerland; Irene Amongin, WHO, New York, United States of America; David Baguma, African Rural University, Kampala, Uganda; Isaac Yaw Barnes, Global Alliance for Sustainable Development, Accra, Ghana; Sophie Boisson, WHO, Geneva, Switzerland; John Brogan, Terre des hommes, Lausanne, Switzerland; Romain Broseus, WaterAid, New York, United States of America; Lizette Burgers, UNICEF, New York, United States of America; John Collett, World Vision, United States of America; Suzanne Cross, Soapbox, Aberdeen, United Kingdom; Lindsay Denny, Emory University, Atlanta, United States of America; Mamadou Diallo, WaterAid, Bamako, Mali; Anil Dutt Vyas, Manipal University, Jaipur, India; Erin Flynn, WaterAid, London, United Kingdom; Rick Gelting, CDC, Atlanta, United States of America; Georgia Gon, Soapbox, Aberdeen, United Kingdom; Sufang Guo, UNICEF, Kathmandu, Nepal; Moussa Ag Hamma, Direction Nationale de la Santé, Bamako, Mali; Danielle Heiberg, WASH Advocates, Washington D.C., United States of America; Alex von Hildebrand WHO, Manila, Philippines; Chelsea Huggett, WaterAid, Melbourne, Australia; Peter Hynes, World Vision, Washington D.C., United States of America; Rick Johnston, WHO, Geneva, Switzerland; Hamit Kessaly, CSSI, N'Djamena, Chad; Claire Kilpatrick, WHO, Geneva, Switzerland; Ashley Labat, World Vision, Washington D.C., United States of America; Alison Macintyre, WaterAid, Melbourne, Australia; Fatoumata Maiga Sokona, WHO, Bamako, Mali; Bijan Manavizadeh, WASH Advocates, Washington D.C., United States of America; Joanne McGriff, Emory University, Atlanta, United States of America; Estifanos Mengistu, International Medical Corps, London, United Kingdom; Arundhati Muralidharan, WaterAid, New Delhi, India; Kannan Nadar, UNICEF, Lagos, Nigeria; Françoise Naissem, Ministry of Health, N'Djamena, Chad; Jonas Naissem, WHO, N'Djamena, Chad; Francis Ndivo, WHO, Monrovia, Liberia; Stephen Ndjorge, WHO consultant, Monrovia, Liberia; Molly Patrick, CDC, Atlanta, United States of America; Margaret Person, CDC, Atlanta, United States of America; Michaela Pfeiffer, WHO, Geneva, Switzerland; Sophary Phan, WHO, Phnom Penh, Cambodia; Alain Prual, UNICEF, Dakar, Senegal; Rob Quick, CDC, Atlanta, United States of America; Emilia Raila, UNICEF, Monrovia, Liberia; Katharine Anne Robb, Emory University, United States of America; Channa Sam Ol, WaterAid, Phnom Penh, Cambodia; Deepak Saxena, Indian Institute of Public Health, Gujarat, India; Dai Simazaki, National Institute of Public Health, Saitama, Japan; Kyla Smith, WaterAid, Ontario, Canada; Daniel Spalthoff, UNICEF, Ouagadougou, Burkina Faso; Julie Storr, WHO, Geneva, Switzerland; Masaki Tagehashi, National Institute of Public Health, Saitama, Japan; Niki Weber, CDC, Atlanta, United States of America; Megan Wilson, WaterAid, London, United Kingdom; Hanna Woodburn, WASH Advocates, United States of America; Yael Velleman, WaterAid, London, United Kingdom; Nabila Zaka, UNICEF, New York, United States of America; Raki Zghondi, WHO, Amman, Jordan.

Share feedback

Those who have used this guide are encouraged to send feedback to washinhcf@who.int to allow for future improvements and knowledge exchange. Please visit www.washinhcf.org to learn about the latest country efforts in adapting and implementing WASH FIT.

Notes

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WASH FOR HEALTH

CONTACT
Water, Sanitation, Hygiene and Health Unit
Department of Public Health, Environmental and Social Determinants of Health
World Health Organization
20 Avenue Appia
1211-Geneva 27
Switzerland
http://www.who.int/water_sanitation_health/en/