

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**

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Summary and Background

This practical guide provides a description of a risk-based, continuous improvement framework and associated tools for undertaking water, sanitation and hygiene (WASH) improvements as part of wider quality improvements in health care facilities. WASH FIT is an adaptation of the water safety plan (WSP) approach, which is recommended in the WHO *Guidelines for Drinking-water Quality* as the most effective way of ensuring continuous provision of safe drinking-water. WASH FIT extends beyond water quality to address sanitation, hygiene, health care waste and other aspects of environmental health and health care facility management and staff empowerment. As such, it also draws upon WHO's Sanitation Safety Planning as well as WHO recommendations for infection prevention and control. The guide contains a number of ready to use tools to help implement WASH FIT and step-by-step instructions for each stage.

The overall aim of using WASH FIT is to improve and sustainably maintain WASH services in health care facilities. Such services are a fundamental element of infection prevention and control, ensuring staff, patient and visitor safety, upholding universal rights to water and sanitation and ultimately providing people-centered care that fulfills the aim of quality universal health coverage (UHC).

Those who have used, or intend to use, this guide are encouraged to share feedback in order to allow for future improvements and knowledge exchange.

Please email washinhcf@who.int to share feedback and visit www.washinhcf.org to learn of the latest country efforts in adapting and implementing WASH FIT.

Abbreviations and Acronyms

CASH	Clean and Safe Hospitals campaign
HCF	Health care facilities
HWTS	Household Water Treatment and Safe Storage
IPC	Infection prevention control
JMP	Joint Monitoring Programme
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
NGO	Nongovernmental organization
SDG	Sustainable Development Goals
SI	Sanitary inspections
UHC	Universal Health Coverage
UNICEF	United Nations' Children Fund
WASH	Water, sanitation and hygiene
WASH FIT	Water and Sanitation Health Facility Improvement Tool
WSP	Water safety plan
WHO	World Health Organization

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Over 100 people took part in WASH FIT training workshops in Chad, Liberia and Mali and provided important inputs for improving and refining the tool. In addition, over 50 individuals from WHO, UNICEF, Ministries of Health and Water, and WaterAid took part in a 2016 WASH FIT West Africa workshop from Chad, the Democratic Republic of Congo, Ghana, Guinea, Liberia, Mali, Senegal and Sierra Leone and further assisted in improving the tool (WHO/UNICEF, 2016).

In addition, a group of over 50 experts, policy-makers and practitioners contributed to this document through peer review and provision of insights and text. These individuals include:

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1.0 Introduction and background

1.1 What is WASH FIT?

What it is	What it is not
<ul style="list-style-type: none">✓ A tool for facilities to use internally to prioritize and maintain WASH improvements, focusing on actions✓ Encompasses infrastructural changes, maintenance and repair as well as behavioural changes, such as hand hygiene behaviour✓ To be used as part of broader quality improvements in health care facilities✓ Comprehensive and systematic✓ Flexible and adaptable	<ul style="list-style-type: none">✗ A tool for national level monitoring of WASH in health care facilities✗ A one-size fits all approach✗ An exercise that can be completed in a day

1.2 How can this guide help?

This practical guide provides a range of tools to help improve WASH services and related cleanliness and safety aspects in a health care facility. Although implementing WASH FIT requires dedicated staff and resources, even small, incremental changes can improve the cleanliness and safety of a facility, resulting in improved health outcomes and a better experience of care.

1.3 Who should use this guide?

- Those working in a health care facility in resource-constrained settings (i.e. low- or middle-income countries)
- Members of community health or water committees
- Local and regional government authorities including those working on implementing national quality health care, IPC or maternal and child health strategies
- Partners (i.e. donors, nongovernmental organizations (NGOs)) helping to support overall quality improvements and ongoing maintenance of WASH services in health care facilities.

1.4 What type of facilities is WASH FIT for?

WASH FIT is a framework and the methodology can be adapted for use in any type of facility. However, it is largely designed for primary, and in some instances secondary, care facilities in resource-constrained settings, for example health centres, health posts, or small district hospitals which provide outpatient services, family planning, antenatal care, child and mother clinics and maternity/child delivery services.

Although it can be used in more advanced secondary and tertiary facilities, the parts of the facility where major surgical and invasive approaches take place are not covered. Efforts are underway to develop future, additional modules for such settings and users are encouraged to adapt the basic framework to meet local needs.

1.5 What parts of a facility does WASH FIT cover?

WASH FIT covers four broad areas: water, sanitation, hygiene and management. Each area includes indicators and targets for achieving minimum standards for maintaining a safe and clean environment, as set out in the WHO *Essential Environmental Health Standards in Health Care* (WHO 2008). In addition, some standards are taken from the WHO *Guidelines for the Core Components of Infection Prevention and Control Programmes* (WHO, 2016). All of the standards ought to be achievable, but many will require incremental improvements before reaching optimal level of services.

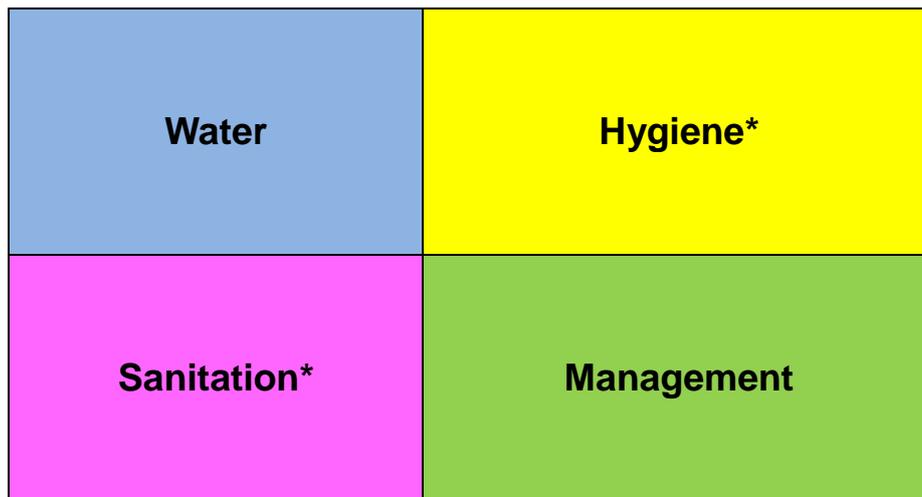


Figure 1. Four domains of WASH FIT

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

1.6 How can the tool be adapted?

WASH FIT provides one way, but not the only way for making WASH improvements. The broad methodology (see page 10) should remain the same but the assessment tool and indicators can be modified. Additional indicators may be added as necessary, to represent a higher level of service, or to cover the services provided in larger facilities. In addition, the indicators can be aligned with, and incorporated into, existing service assessments and monitoring mechanisms.

Box 1. Examples of use of WASH FIT

Where has WASH FIT been used before?

WASH FIT was first developed in 2015 and has been piloted in a number of different countries and contexts. A snapshot of examples is presented below.

Targeted facility trainings: Chad, Cholera hotspots (2015-2016)

WASH FIT was first used in Chad as part of a wider effort to improve WASH in health care facilities and households in cholera hotspot communities. Two 3-day trainings involving 50 staff from 13 health care facilities were held. Facilities were primary care facilities that also serve as cholera treatment centres with limited resources. All facilities received two to three follow-up visits from the government and project partners in the six months following the training. During the months that followed the training, all facilities made some progress in making improvements (i.e. posting handwashing reminders, cleaning and beautifying the grounds surrounding the facilities, installing handwashing stations). Facilities with committed leaders made substantially more progress than those without.

District and national training: Mali (2015-ongoing)

WASH FIT has been used to strengthen WASH in primary and secondary care facilities (all of which provide maternity and child delivery services) in two districts, as well as more widely through use by various NGO partners and the government. Two district level trainings were conducted, each with 11 facilities and district health officials taking part and a national training also took place to sensitize key WASH partners, including UNICEF and government leaders who are implementing WASH under their own efforts. In total, more than 240 facilities are currently implementing WASH FIT. While some facilities have made more progress than others, the establishment of a national taskforce and ongoing work to strengthen implementation of WASH standards, have been instrumental in driving the work at the national level. In addition, regular supervisory visits have helped motivate facilities to continue to make improvements.

National training of trainers: Liberia, Ebola recovery (2015-ongoing)

As part of post-Ebola early recovery efforts and to address serious gaps in WASH in health care facilities, the Vice President of Liberia launched a WASH and Environmental Health Package for Health Care Facilities in 2016 (Government of Liberia, 2016). To support implementation of the package, WHO and UNICEF facilitated a national training of trainers that, as of October 2016, has trained 94 trainers covering all eight districts of the country. Training lasted 4-5 days, incorporated new IPC standards and practice WASH FIT assessments in facilities allowing trainers to put theory into practice. Activities to roll-out the training to all facilities through environmental health and IPC officers as well as linking the work to the finalization and implementation of a national strategy on quality are underway.

Regional level: West Africa, country action planning (Senegal, 2016)

Eight countries (Chad, the Democratic Republic of Congo (DRC), Ghana, Guinea, Liberia, Mali, Senegal and Sierra Leone) participated in a regional workshop in Senegal in June 2016 to develop national action plans to implement WASH FIT as part of broader efforts on strengthening quality care and WASH in health care facilities. All eight countries committed to start implementation of WASH FIT, or continue existing efforts (Chad, Liberia, Mali) either at district level or nationally. Some selected activities that have taken place following the workshop are that: Senegal held a planning meeting with partners to develop a roadmap for their country action plan, Chad committed to roll-out WASH FIT to a subsequent 24 facilities (as well as continuing to monitor activities in the initial 13 facilities), Ghana is setting up a technical committee and will be conducting a national assessment on WASH in health care facilities and the DRC has included WASH indicators in the Ministry of Health's Strategic Plan for 2016-2020.

Box 2. WASH in health care facilities (HCF): the global context

Linkages with the Sustainable Development Goals (SDGs)

The SDGs provide an important platform for addressing WASH in health care facilities. The WHO/UNICEF Joint Monitoring Programme (JMP) has the official mandate to monitor global progress on SDG 6 (safely managed water and sanitation). This will involve capturing and reporting data from households, schools and health care facilities. Harmonized monitoring indicators to assess WASH services in health care facilities have been developed (JMP, 2016). In addition, WASH in HCF is important for meeting several targets under SDG 3 (good health) especially 3.1 and 3.2 on reducing maternal and neonatal mortality and 3.8 on universal health coverage. Finally, SDG 7 (clean energy) and SDG 13 (climate change) provide further momentum and resources for comprehensively addressing environmentally-sound infrastructure services in health care facilities.

Global action on WASH in health care facilities

WHO and UNICEF, along with health and WASH partners across the globe have committed to the vision, that by 2030, every health care facility, in every setting, has safely managed, reliable water, sanitation and hygiene facilities and practices that meet staff and patient needs. A 2015 WHO/UNICEF report, revealed that 38% of health care facilities in low- and middle-income countries have **no** source of water. The provision of water and soap or alcohol-based hand rubs for hand hygiene was absent in over one third of facilities, and almost one fifth of facilities did not have toilets or basic latrines (WHO/UNICEF, 2015). Action plan activities are centered around four main areas: advocacy/leadership, monitoring, evidence, and facility-based improvements, which have a strong focus on nationally and locally driven solutions (WHO/UNICEF, 2016).

What are the benefits of improving WASH services?

Achieving and maintaining WASH services in health care facilities is a critical element for a number of health aims including those linked to quality universal health coverage (UHC), infection prevention and control (IPC), and child and maternal health. Clean and safe health care facilities also increase demand and trust in services, improve the experience of care, strengthen staff morale and performance and reinforce the role of staff in setting societal hygiene norms. In addition, such services strengthen the resiliency of health systems to prevent disease outbreaks, allow effective responses to emergencies, including natural disasters and outbreaks, and bring emergencies under control when they occur (**Figure 2**). For example, a systematic review of 54 studies on quality and maternity services found that while the interpersonal behaviour of the caregiver was the most highly correlated with satisfaction, cleanliness and availability of functioning toilets and drinking-water were also important factors influencing perceptions of quality (Bleich et al, 2009). These findings are supported by cross-sectional studies in India and Bangladesh where the patient rating of services was highly correlated with clean toilets, availability of drinking-water and hand hygiene facilities (Hasan, 2007; Ray et al, 2007). Patients who are satisfied with their experience are more likely to trust and cooperate with their health care provider, and comply with treatment.

What are countries doing to address the situation?

Countries in all regions are taking action to improve WASH in HCF. For example, the Clean and Safe Hospitals (CASH) campaign in Ethiopia launched in 2015 has significantly improved WASH in 249 health care facilities through training, staff accountability, community engagement, innovative technologies and their management by the private sector, and auditing and recognizing high performing hospitals. While impact studies are ongoing, staff report improvements in satisfaction and significant uptake of services. A similar inclusive national model is being implemented in India under the name “Kayakalp” and engagement with communities to demand and seek safe and clean facilities has been noted as particularly instrumental in driving change.

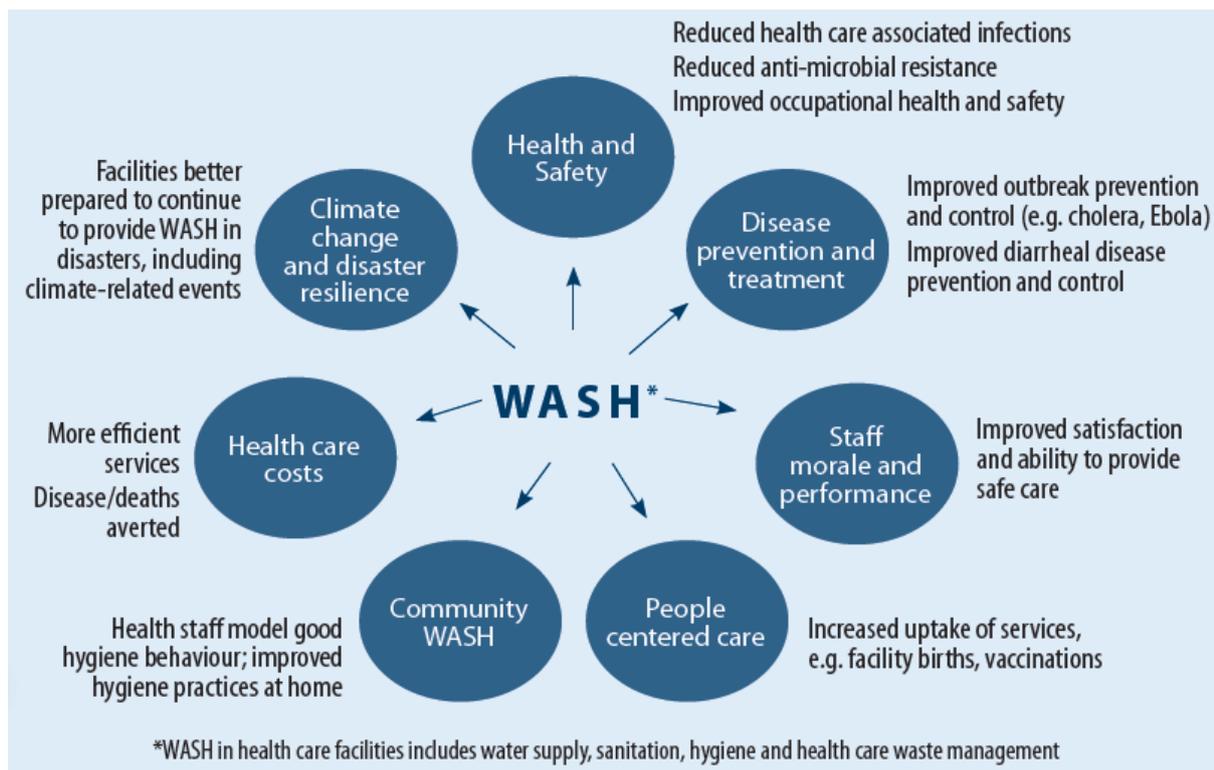


Figure 2: Benefits of WASH in health care facilities

1.7 What are the benefits of implementing WASH FIT?

- **Improves the day-to-day management and operation of a facility**, by systemizing the process of managing WASH services.
- **Encourages a team-based approach** by bringing together all those who share responsibility for providing services at the facility, including legislators/policy makers, district health officers, hospital administrators, water engineers and community WASH and health groups.
- **Engages community members**, leading to improved hygiene awareness and accountability within the community and triggering positive changes in hand hygiene and sanitary behaviour.
- **Helps identify improvement needs** and opportunities for “quick wins” – potential improvements that can be achieved with limited resources and efforts.
- **Provides a framework to develop, monitor and continuously implement an improvement plan**, and prioritize specific actions when resources are limited.

1.8 An enabling environment for WASH FIT

WASH FIT begins with leadership and political commitment. Ultimately a country or region should establish policy frameworks for sustaining implementation of WASH FIT and driving quality improvements. The enabling environment should include provisions for three areas related to WASH FIT:

- guidelines and standards for WASH in health care facilities in the national policy framework and an associated budget;
- implementation of WASH FIT by facilities; and
- monitoring and evaluation of WASH FIT.

Given the intersectoral nature of WASH and 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. Once the enabling environment exists, facilities should be better placed to make improvements to their WASH services and the quality of care.

2.0 The WASH FIT Process

WASH FIT is a framework to guide a continuous cycle of improvement, through assessments, prioritization of risk and defining specific, targeted actions. These actions should be integrated into a facility's existing activities, in particular feeding into IPC and specific quality of care improvement activities. Improvements should be made with the aim of reaching health-based targets and meeting standards included in national accreditation schemes.

Each of the five steps of the cycle is described in detail in this guide and is accompanied by a tool.

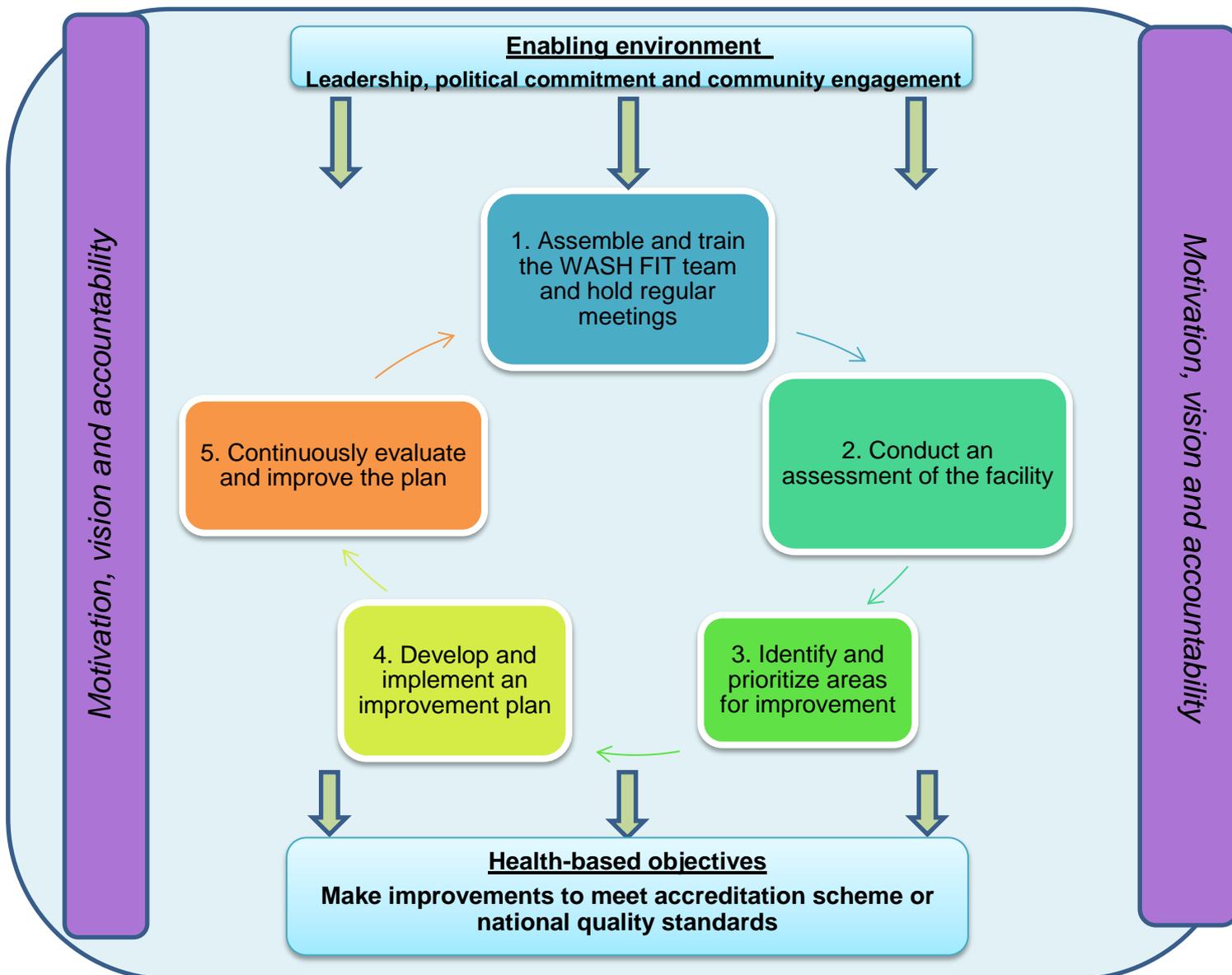


Figure 3. WASH FIT Framework

What are the key factors for success?

- **Leadership and support.**
A strong leader, whether at the facility, or at the district level, can help drive change, even when resources are limited.
- **Joint participation and decision-making.**

If all facility users, including senior management, health workers, support staff, patients and the community are involved in the process, bringing lasting change is more likely.

- **Long-term commitment.**

All users should share a common vision to improve quality of care and services and be committed to make continual improvements, however small they may be.

2.1 TASK 1. Assemble a WASH FIT team and hold regular meetings

Task 1: Objectives

To implement WASH FIT, a strong team who meet regularly, is essential. At a minimum, two to three people should be responsible for the planning and implementation of WASH FIT. In larger facilities, more people can be involved according to staff workloads.

Steps for task 1

- form a team
- record members of the team, including contact details (Tool 1a)
- hold regular team meetings
- document discussion items, decisions made and action points at each meeting (Tool 1b).

Task 1: Dos and Don'ts

DO

- **Involve a range of people who are committed to creating a safe and clean facility.**

Where possible, the team may include facility managers, cleaners and maintenance staff, environmental health staff, health care workers, local partners (e.g. district health officers), senior management, a community representative.

- **Nominate a leader to drive the process.**

Leaders should have vision and commitment. The role of such “champions” is critical – one committed individual can make a huge difference in making changes, and thereby improving the quality and safety of health services.

- **Involve senior management at the facility and district level.**

Strong leadership and management of a facility is the key to the quality of services provided. The role of management in making rapid repairs when facilities such as toilets are broken, emphasizing handwashing and general cleanliness, even in the absence of additional resources, makes an important difference.

- **Have a range of expertise on the team.**

Team members should have knowledge and experience of WASH and IPC (for example, have received IPC training) or be willing to gain relevant knowledge and experience. Importantly, they should be able to champion good WASH practices and show or develop leadership qualities throughout the process. Imagination, creativity and problem solving are all important qualities for team members. For continuity and sustainability, it is helpful to have long-term staff and community members on the team.

- **In small facilities with limited staff, involve external partners for additional support.**

Potential partners include the district health office, local NGOs and local water, sanitation and hygiene experts, as well as IPC experts or staff from other larger facilities.

- **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 consulted and involved in all decision-making to ensure women's and girls' needs are met throughout the facility.

- **Meet regularly as a team to discuss the day-to-day operation and management of WASH.**

Some guidance on frequency of WASH FIT team meetings is given in Tool 1a. Regular communication between team members is important to understand what has been done, key challenges and priority actions.

- **Specify the role and responsibilities of each team member at the start.**

Team members should understand and champion the importance of water, sanitation, hand hygiene and hygiene practices (cleaning and disinfection) for delivering quality care; be able to identify and evaluate hazards and risks; plan for regular monitoring, inspection, management and maintenance of infrastructure and services throughout the facility; monitor the behaviour of staff and patients and their families (for example, hand hygiene) and determine priorities for training and promotion activities; implement and

maintain the WASH FIT process and meet regularly to discuss necessary updates (for example, every week for the internal team and quarterly with the extended team).

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 ought to be incorporated into the roles and responsibilities of existing staff members. In doing so, it is important to consider whether the existing team is functional and if not, how it could be improved to become more efficient and motivated. Additional members can be invited to the group. Whether a new team is created or an existing team structure is used, it is important to consider ongoing refresher trainings and peer learning support groups to support continuous learning and compensate for potential high staff turnover.

- **Forget to involve cleaning and maintenance staff.**

They are a crucial part of managing a health facility and are often overlooked in decision-making processes.

Two example WASH FIT teams

A small rural facility

- Manager (acts as team leader)
- Nurse
- WASH technician from the community or nearby community
- Member of community health or water committee

District hospital

- Chief Medical Director or Facility Administrator
- Two members of the IPC committee, including one responsible for health care waste management
- Nurse
- Cleaner
- Technician, responsible for maintaining equipment
- Member of community health or water committee
- District health officer

Tool 1: Instructions for Use

Tool 1 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 which is kept at the facility to document the meeting notes.

2.2 TASK 2. Conduct an assessment of the facility

Task 2: Objectives

To begin WASH FIT, a comprehensive and accurate assessment of the facility is needed. The results of the assessment will form the basis of the WASH FIT plan.

The assessment covers the four domains: water, sanitation (including health care waste) hygiene and management. The domains are based on WHO's environmental health standards (WHO, 2008), but the assessment can be adapted to suit the context and/or national standards. Measuring the indicators is based on a three point system, with three levels for each indicator:

+++	meets minimum standards
++	meets some but not all minimum standards
+	does not meet minimum standards.

The long-term aim is that all indicators should meet minimum standards (+++). At the start of the process (i.e. at baseline), there are likely to be some indicators that are only rated + or ++. The objective is that over time, the team will work together to increase the number of indicators which meet minimum standards. The assessment forms the basis of the risk assessment (task 3).

Steps for task 2

- Review the assessment tool and decide which indicators your team will assess and monitor, which need to be adapted to national standards, and whether additional indicators will be included. The first set of shaded indicators in each domain represents the core indicators that should be assessed, regardless of the size of facility.
- Conduct a comprehensive assessment of the facility using the agreed list of indicators (tool 2a).
- Carry out sanitary inspection (tool 2b).
- Record the number of +++, ++ and + indicators in the summary tables to be able to make comparisons over time (tool 2c).
- Review the assessment form to ensure all information is clear and correct and all members of the team agree.
- Repeat the assessment every 6 months, or more often as needed.

Task 2: Dos and Don'ts

DO

- **Visit all areas in the facility, including consultation rooms, outpatient and inpatient services (if applicable) and communal and waiting areas.**

Look at sanitation services, water abstraction sites, water collection points and storage facilities, hand hygiene stations and waste collection, storage and destruction sites. Review hygiene promotion materials, WASH and IPC guidelines and budgets. The WASH FIT team will need to make observations, both of infrastructure and of staff behaviours (for example, whether staff respect protocols).

- **Involve all members of the team in the assessment.**

The team should walk through the facility together and complete the assessment by observation. The assessment cannot be done at a desk.

- **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.

- **Use the information collected to feed into other reporting systems.**

Information can help to support surveillance of a facility at the district and national levels and it is important to share such information to better inform key policy and decision-makers.

- **Carry out sanitary inspections (SI) on a regular basis (e.g. quarterly) to assess contamination risks to the water supply.**

Also known as sanitary surveys, SIs can identify potential hazards, hazardous events and problematic conditions related to water abstraction facilities, distribution systems and storage reservoirs. They help to identify improvement needs in a facility's water system. SIs should also always be done whenever any water quality testing is done in order to better characterize health risks associated with faecal or other types of water contamination.

DON'T

- **Be afraid to ask questions when conducting the assessment.**

Asking questions of staff, caregivers and patients about their experience of the facility is part of the process. It is important that the assessment is undertaken from a positive perspective, with the aim of making improvements, rather than being used as a tool to criticize or blame.

Tool 2: Instructions for Use

For each indicator, decide whether your facility meets the target (+++), partially meets the target (++) or does not meet the target (+). If this is the first assessment, record the number of + in the Assessment 1 column; if it is the second, use the second column etc. Record additional information in the notes column, for example, a note on the reasons why a particular indicator does not meet the target.

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 will highlight where additional improvements are needed or new problems have arisen. Ideally, the same people should conduct the indicators assessments each time (at baseline, six months and twelve months) 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 and on specific national WASH or IPC guidelines in health care facilities).

The sanitary inspection form is needed to answer indicator 1. 2. There are various different options available, according to the water system in your facility as follows:

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 first page of each inspection form presents a systematic **checklist of simple questions** that addresses typical **risk factors** associated with a respective abstraction technology or supply step (such as presence of animals, accumulation of faecal material, design flaws or lack of protective infrastructures). The questions are structured so that a "Yes" answer indicates a potential risk and a "No" answer indicates no or a very low risk. All answers should be based on **visual on-site observation and interviewing** community members and/or operators by the team.

Using Tool 2b, make a note of how many indicators you included in your assessment in column 1 and record the number of +++, ++ and + indicators that you scored for each domain for that assessment. 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 2b will allow you to see the results of all domains in one place and compare progress over time.

Suggestions for adapting tool 2

- ✓ Add additional indicators not included here, e.g. for other environmental health issues or for other departments in larger facilities, such as surgical areas and laboratories which require more detailed assessment.
- ✓ Remove indicators that are not relevant, particularly for smaller facilities which provide limited services e.g. if there is no inpatient department, remove 2.2 (number of toilets for inpatients). Record how many indicators were in the assessment in the summary sheet (tool 2b).
- ✓ Adapt indicators to fit national standards, e.g. you may have national water quality testing requirements which are not adequately covered in the current indicators.
- ✓ The rating system could be changed to stars, numbers or a traffic light system (i.e. green, yellow, red).

2.3 TASK 3. Risk Assessment: Identify hazards (problems), associated risks and possible areas for improvement

Task 3: Objectives

The purpose of this task is to identify what **hazards (or problems)** exist that prevent a facility from having adequate WASH services and the **risks** that these hazards pose. It is also important to reflect on what the facility is doing well and what WASH infrastructure and protocols are already in place in regards to WASH.

Steps for task 3

- Review the information collected in task 2.
- Determine the **hazards (problems)** (Tool 3, column 2) and associated **risks** (Tool 3, column 3).
- Grade each risk according to the **level of the risk** and **feasibility of addressing the problem** (Tool 3, column 4).

Task 3: Dos and Don'ts

DO

- **Consider all the potential problems and constraints relating to the facility.**

Problems can be related to infrastructure (for example lack of water storage, blocked latrines or a broken incinerator) or to operation and maintenance (for example, a shortage of cleaning staff or inadequate budget to buy supplies).

- **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 (seasonal water shortages or a hand pump breaking) or long-term issues (no access to water within the facility).

- **Consider all 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 different users.

DON'T

- **Focus only on the negatives.**

It is important to recognize good practices within the facility, where improvements have already been made and the standards which have already been met. It is useful to learn from successes within the facility and apply them elsewhere.

- **Don't worry that ranking risks is context-specific.**

Different people will rank risks differently but this is ok. It is more important that all facility stakeholders have an opportunity to share their opinions and that the process of deciding which problems and risks are the most important is collaborative. This should include staff, patients and community members.

Box 3. Hazards and risks

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 which do not meet the target should be considered a potential hazard.

A **risk** is the potential a set of unwanted circumstances or events to occur as the result of the hazard. All hazards have an associated risk, however serious it may be.

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 having to relieve themselves of a bowel movement or urine.

Tool 3: Risk Assessment

For each domain, consider what the hazards are. For example, what services and infrastructure are lacking? And what can go wrong with the existing infrastructure? Is anything being done to maintain services? Write a detailed description in the hazards column, and include the number of the indicator you are referring to. For each hazard you list, consider what the risk might be to staff, patients and visitors. Some examples are presented below.

Domain	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 <i>Staphylococcus aureus</i> (MRSA) from not washing hands during key moments and generally unclean areas in the facility.
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Level of risk vs. feasibility of addressing problem

For each hazard and risk, the perceived level of risk and the feasibility of addressing it should be graded.

Assess and describe the risk

Assessing the level of risk for each problem is often context-specific, and there is no right or wrong answer. However, the risk assessment should be undertaken by several individuals within the team as this helps to increase the validity of the risk assessment. This can be done either as group work or on an individual basis and then shared within the team to produce responses which are agreed collectively.

The risk assessment can be done using a sliding scale (as per the figure below) 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.

Risk level	Explanatory notes
High risk	The hazard/problem very likely results in injuries, acute and/or chronic illness, infection or an inability to provide essential services. Actions need to be taken to minimize the risk.
Medium risk	The hazard/problem likely results in moderate health effects, discomfort or unsatisfactory services, for example malodours, unsatisfactory working conditions, small injuries. Once the high priority risks are controlled, actions need to be taken to minimize these risks.
Low risk	No major health affects anticipated. If easy to address, the risk can/should be addressed. If not, the risk should be revisited in the future as part of the review process.
Unknown risk	Further information is needed to categorize the risk. Some action should be taken to reduce the risk while more information is gathered.

Assess how easy it is to address each risk

Some problems/hazards may be easier to address than others: how easy it will be may be based on the resources you currently have available or the time you think 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 etc.), or more complicated and time-consuming to build new latrines as this will take more time and money. Not everything can be addressed immediately so this exercise will help you to prioritize some actions over others.

The figure below provides an example using a grading scale.

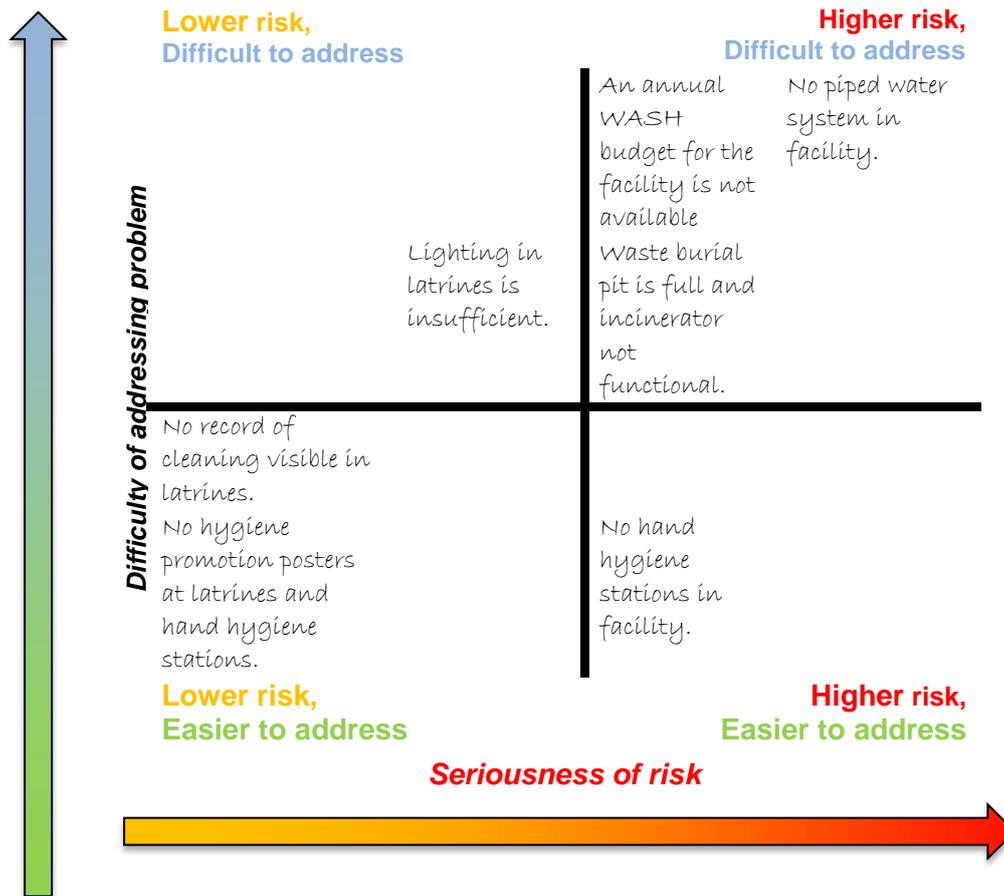


Figure 4. Categorizing risks and ability to address problems

- Questions to keep in mind when completing the Risk Assessment**
- Does seasonality and/or climate change affect WASH services and are there plans in place to cope with this?
 - Where is there an increased risk of infection in the facility due to inadequate WASH?
 - Is staff behavior and attitude appropriate and adequate to ensure the best WASH services are delivered?
 - Is there a protocol in place to ensure that the issue in question is managed efficiently?
 - What do staff and patients find most difficult about the lack of WASH services?
 - Have all staff been formally trained on IPC, waste management, etc.as per their job descriptions?

2.4 TASK 4. Develop and implement an incremental improvement plan

Task 4: Objectives

Based on the level of risk and feasibility of addressing the problem, the team should **prioritize which problems to address** and develop a detailed action plan outlining improvements that will be made. These improvements could be achieved through a number of different mechanisms: building new infrastructure or repairing existing infrastructure; coordinated dialogue with district and national authorities for new/revised infrastructure; writing standards and protocols to improve behaviour; training staff in a new technique or initiative; and/or improving management methods.

Steps for task 4

- Use the risk assessment from task 3.
- Decide on a number of actions that will be taken to address the problems already identified (Tool 4).
- Record these actions, explicitly stating **who** is responsible for them, **when** they will be done and with what **resources**.
- Keep a record of completed improvement activities in the plan, including the actual date of completion.

Task 4: Dos and Don'ts

DO

- **Make the actions as specific as possible.**

Specify who is responsible for the action, when it will be done, and what resources are needed. These 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.

- **Think of improvements and preventive measures that can be made with limited resources.**

For example, ensuring the latrine or toilet and area around it are clean, providing soap and water or alcohol-based hand rubs at all hand hygiene stations or putting up a poster with pictures and diagrams describing basic hand hygiene principles.

- **Remember that no change is too small.**

Whatever positive actions are taken will make a difference. There may be problems that you cannot address immediately (for example installing a piped water system) but it is possible to immediately address smaller, more achievable actions.

- **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

- **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 you would like to cultivate in six months/one year/five years in the future. This will help you to be more ambitious and realistic. Remember, WASH FIT is a continuous process in which improvement takes place step by step.

Tool 4: Instructions for Use

The improvement plan should include all the actions that have been agreed on, including both small, immediate actions and larger efforts. Record what specific action will be taken, who will carry out the task, and what resources are needed. You may like to start with the hazards that you have decided are easier to address. For those 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).

2.5 TASK 5. Continuously monitor the effectiveness of the plan and make revisions

Task 5: Objectives

You will need to monitor the effectiveness of the plan and to make revisions when things are not working well. Monitoring can confirm whether the facility is making progress towards reaching the target indicators in each domain and what is hindering progress. Monitoring involves regular measurements and observations by the WASH FIT team on a frequent and regular basis.

Steps for task 5

- The team should periodically review the WASH FIT documentation to check what has changed since the initial assessment.
- Conduct a full assessment every 6 months to see what has changed.
- Discuss the WASH FIT plan at regular staff meetings as well as holding more detailed discussions every 6 months with the community and wider health and WASH stakeholders.

Task 5: 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.

- **Team members should discuss the results of monitoring observations at each meeting.**

Ask each team member to provide feedback on the area they are responsible for, e.g. the water supply. Focus on the problems, key risks identified and improvements that have been planned and implemented. If no progress is being made, or monitoring reveals that new problems have arisen, a review of the plan is needed, for example coming up with additional ideas to address these problems.

- **When new problems arise, re-do the risk assessment.**

Revise the problems and associated risks and adapt the Improvement Plan accordingly. Record the discussions and decisions using a team meeting sheet.

DON'T

- **Treat WASH FIT as a one-off exercise.**

Monitoring WASH FIT should be a central part of your work. You can make observations during daily or weekly inspections, such as checking the cleanliness of latrines, the state of waste disposal bins or the presence of water and soap or alcohol-based hand rubs at hand hygiene stations.

- **Be discouraged by conducting regular assessments.**

Reviews are generally quicker than the first-time assessment, analysis and planning process.

Tools for Task 5

There is no specific tool for task 5. Use the last two columns in tool 4 to record any revisions you make to the plan.

Questions to consider when reviewing your WASH FIT 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?
- Should other improvements be prioritized?

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WHO (2016). Standards for improving quality of maternal and newborn care in health facilities. http://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/

WHO (2016). WHO International Scheme to Evaluate Household Water Treatment Technologies. List of products and disclaimers. http://www.who.int/household_water/scheme/products/en/

Useful websites

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

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

WHO/UNICEF. WASH in health care facilities knowledge portal. www.washinhcf.org

WHO. International Scheme to Evaluate Household Water Treatment Technologies. http://www.who.int/household_water/scheme/en/

WHO. Global Learning Laboratory <http://www.integratedcare4people.org/communities/global-learning-laboratory-for-quality-universal-health-coverage/>

BabyWASH Coalition. <http://babywashcoalition.org/>

4.0 Tools

- Tool 1-A. WASH FIT team list
- Tool 1-B. WASH FIT team meeting record sheet
- Tool 2-A. Indicators assessment
- Tool 2-B. Record of Assessment
- Tool 2-C. Sanitary inspection forms
- Tool 3. Risk assessment
- Tool 4. Improvement plan

Tool 1-A. WASH FIT team list

SAMPLE

Date: September 15th 2016, Bongor Health Centre

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 (e.g. phone number and if available, email)
Emily MUTAMBO	Chief Medical Officer	Overseas WASH FIT team and responsible for leadership and decision making	66 64 11 57 e.mutambo@yahoo.ke
Jacob SAFA	Treasurer	Responsible for coordinating budget, mobilization of resources, partnerships	98 66 44 00
Githu MERU	Member of Community Women's Group	Providing a voice for women in the community	73 00 51 57
Idriss KALEWA	Head of Community Organization	Coordinates and supervises district activities. Delivered two babies at facilities so representative for women's needs	66 03 63 43
John DEMBELE	Health care waste technician	Responsible for making improvements to health care waste procedures	69 64 97 43

Tool 1-A. WASH FIT team list BLANK

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 (e.g. phone number and if available, email)

Tool 1-B. WASH FIT team meeting record sheet

SAMPLE

Date of team meeting: *October 2nd 2016, 11.00am*

Names of team members participating:

*Emily MUTAMBO
Idriss KALEWA
Jacob SAFA
Githu MERU
John DEMBELE*

Key issues to be discussed in the meeting (max. 5):

- 1) Results of baseline facility assessment, conducted on September 26th 2016*
- 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*

List the actions/decisions and outcomes of each issue discussed (continue on an extra sheet if necessary):

- 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.*

Date and time of next team meeting: *October 15th 2016, 11.00am*

**Tool 1-B. WASH FIT team meeting record sheet
BLANK**

Date of team meeting:

.....

Names of team members participating:

.....
.....
.....
.....
.....

Key issues to be discussed in the meeting (max. 5):

- 1)
- 2)
- 3)
- 4)
- 5)

List the actions/decisions and outcomes of each issue discussed (continue on an extra sheet if necessary):

.....
.....
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.....

Date and time of next team meeting:

Date of assessment:

Name of assessor(s):

Tool 2-A. Indicators assessment

SAMPLE

Date of assessment	Members of team conducting assessment	Notes
24.3.2016	Emily MUTAMBO Jacob SAFA Githu MERU Idriss KALEWA John DEMBELE	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.
25.9.2016	Emily MUTAMBO Jacob SAFA Githu MERU	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.

Note: Highlighted indicators are “essential” indicators which should be completed by all facilities using WASH FIT.

1	WATER	Meets target (+++)	Partially meets target (++)	Does not meet target (+)	Does indicator meet the target? Enter number of +			Notes (continue in your WASH FIT notebook if necessary)
					Assessment 1 (baseline)	Assessment 2	Assessment 3	
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.

Date of assessment:

Name of assessor(s):

1.2	Water services available at all times and of sufficient quantity for all uses.	Yes, every day and of sufficient quantity.	More than 5 days per week or every day but not sufficient quantity.	Fewer than 5 days per week.	++	+++		Assess 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 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.	+	++		Assess 1: No drinking water stations are available Assess 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.	+	+++		Assess 1: Not applicable as no drinking water currently available Assess 2: safe storage guidelines are now being followed
1.5*	Sanitary inspection risk score (using Sanitary Inspection Form).	Low risk.	Medium risk.	High or very high risk.	+++	+++		SI form 2 used (piped distribution). Ass 1 scored 9/10.
1.6	All end points (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.	++	+++		Assess 2: Leaking pipes have been fixed.
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 1-2 months.	Water shortages for 3 months or more.	+	+		HCF is in an area with a lot of rainfall but not enough money to pay local municipality for water supply.
1.8*	Water storage is sufficient to meet the needs of the facility for 2 days.	Yes.	More than 75% of needs met.	Less than 75% of needs met.	+++	+++		Yes, which is needed because sometimes water supply is cut off by the local municipality due to inability to pay bill.

Date of assessment:

Name of assessor(s):

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.	+	++		Assess2: Water treatment has begun. Chlorine residual testing indicates that there is no consistent chlorine residual of at least 0.2 mg/l.
1.10	Drinking water has appropriate chlorine residual (0.2mg/l or 0.5mg/l in emergencies) or 0 <i>E.Coli</i> /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.	+	+++		Assess 2: Regular water testing now conducted and water tested at facility. Meets WHO standards for chlorine residual (i.e. at least 0.2 mg/l).
1.11*	National water quality standards exist and the facility water supply is regulated according to these standards.	Yes and water meets national standards.	Yes, but no regulation or testing.	No standards exist.	++	++		National standards exist but there is no regulation of standards nor any regular microbial or chemical testing of the water by the water utility.
1.12	Sufficient energy is available for pumping and boiling water (mark if not applicable).	Yes, always.	Yes, sometimes.	Never.	+++	+++		Energy available for pumping water to storage tank and water flows by gravity to taps. However, no water in showers due to limited water supply from municipality.
1.13*	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 1 per 40.	No showers.	++	+++		Assess 1: Showers available but not currently functioning, due to poor piping and blocked drains. Assess 2: Drains have been cleared and showers now working.
1.14	Shower(s) are adequately lit, including at night.	Yes.	Lighting infrastructure exists, but not functioning.	Not adequately lit or no lighting infrastructure.	+++	+++		

Date of assessment:

Name of assessor(s):

Tool 2-A. Indicators assessment BLANK

Date of assessment	Members of team conducting assessment	Notes

Date of assessment:

Name of assessor(s):

	1	WATER	Meets target (+++)	Partially meets target (++)	Does not meet target (+)	Does indicator meet the target? Enter number of +			Notes (continue in your WASH FIT notebook if necessary)
						Assessment 1 (baseline)	Assessment 2	Assessment 3	
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 5 days per week or every day but not sufficient quantity	Fewer than 5 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 not drinking water available				
Adv	1.5	Sanitary inspection risk score (using Sanitary Inspection Form).	Low risk	Medium risk	High or very high risk				

Date of assessment:

Name of assessor(s):

1.6	All end points (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 1-2 months	Water shortages for 3 months or more				
1.8*	Water storage is sufficient to meet the needs of the facility for 2 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 <i>E.Coli</i> /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*	National water quality standards exist and the facility water supply is regulated according to these standards.	Yes and water meets national standards.	Yes, but no regulation or testing.	No standards exist.				
1.12	Sufficient energy is available for pumping and boiling water (mark if not applicable).	Yes, always	Yes, sometimes	Never				
1.13*	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 1 per 40	No showers.				

Date of assessment:

Name of assessor(s):

1.14	Shower(s) are adequately lit, including at night.	Yes	Lighting infrastructure exists, but not functioning	Not adequately lit or no lighting infrastructure				
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Number of indicators meeting targets for WATER	+++				
Number of indicators partially meeting targets for WATER	++				
Number of indicators not meeting targets for WATER	+				

NOTES

1.1	Improved water sources in health care settings include piped water, boreholes/tubewells, 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 8 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 (source: WHO 2008 <i>Essential environmental standards in health care</i>) or applicable national standards. Outpatients (5 litres/consultation) + Inpatients (40–60 litres/patient/day) + Operating theatre or maternity unit (100 litres/intervention) + Dry or supplementary feeding centre (0.5–5 litres/consultation depending on waiting time) + Cholera treatment centre (60 litres/patient/day).
1.3	Accessible means with railings, a seat and water access.
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 (source: WHO 2008 <i>Essential environmental standards in health care</i>) or applicable national standards and multiply by 2 to get the total for 48 hours. Outpatients (5 litres/consultation) + Inpatients (40–60 litres/patient/day) + Operating theatre or maternity unit (100 litres/intervention) + Dry or supplementary feeding centre (0.5–5 litres/consultation depending on waiting time) + Cholera treatment centre (60 litres/patient/day). 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/household_water/scheme/products/en/ and further information found at the WHO Household Water Treatment site: http://www.who.int/household_water/scheme/en/ Drinking water meets WHO <i>Guidelines for drinking-water quality</i> (2011) or national standards: http://www.who.int/water_sanitation_health/publications/dwq-guidelines-4/en/
1.10	Evidence of documented chlorine residuals should be available from previous testing.

Date of assessment:

Name of assessor(s):

1.11	Drinking water meets WHO <i>Guidelines for drinking-water quality</i> (2011) or national standards: http://www.who.int/water_sanitation_health/publications/dwq-guidelines-4/en/
1.13	WHO 2016. Surgical Site Infection Guidelines (http://www.who.int/gpsc/ssi-guidelines/en/#)

2	SANITATION and HEALTH CARE WASTE	Meets target (+++)	Partially meets target (++)	Does not meet target (+)	Does indicator meet the target?			Notes (continue in your WASH FIT notebook if necessary)
					Enter number of +			
					Assess- ment 1 (baseline)	Assess- ment 2	Assess- ment 3	
PART A: SANITATION								
Essential indicators	2.1*	Number of available and usable toilets or improved latrines for patients.	4 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 and visitors.	Yes.	Some separate latrines but not for all three categories (staff, patients and visitors).	No separate latrines.			
	2.3	Toilets or improved latrines clearly separated for male and female.	Yes.	N/A.	No indication of gender separation.			
	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.			
	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	2.7*	Record of cleaning visible and signed by the cleaners each day.	Yes.	Toilets cleaned but not recorded.	No record / toilets cleaned less than once a day.			

Date of assessment:

Name of assessor(s):

	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.				
	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 for 1) non-infectious (general) waste, 2) infectious waste and 3) sharps waste in close proximity to all waste generation points.	Yes.	Separate bins present but lids missing or more than $\frac{3}{4}$ 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 practiced throughout the facility.	No sorting.				

Date of assessment:

Name of assessor(s):

	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.				
	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 overfilled or not fenced and locked.	None present.				

Date of assessment:

Name of assessor(s):

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 SOP (Standard Operating Procedure) 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.				
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.				
Number of indicators meeting targets for SANITATION and HEALTH CARE WASTE				+++				
Number of indicators partially meeting targets for SANITATION and HEALTH CARE WASTE				++				
Number of indicators not meeting targets for SANITATION and HEALTH CARE WASTE				+				
NOTES								
2.1	At least four toilets per outpatient setting (one for staff, and for patients: one for females, one for males, 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 40-48cm from the floor), a backrest and the cubicle has space for circulation/maneuvering (150x150 cm). The sink, tap and water outside should also be accessible and the top of the sink 75cm 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 hand rub is <i>not</i> suitable for use at latrines.							

Date of assessment:

Name of assessor(s):

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 $\frac{3}{4}$ full, be leak-proof with a lid and clearly labeled (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 WHO (2014) <i>Safe management of waste from health-care activities</i> . 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 + lined and covered pit > 30 m from water source + no unprotected health care waste is observed. If waste removed offsite, 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.

3	HYGIENE	Meets target (+++)	Partially meets target (++)	Does not meet target (+)	Does indicator meet the target?			Notes (continue in your WASH FIT notebook if necessary)
					Enter number of +			
					Assess- ment 1 (baseline)	Assess- ment 2	Assess- ment 3	

PART A: HAND HYGIENE								
3.1*	Functioning hand hygiene stations are available at all points of care.	Yes.	Stations present, but no water and/or soap or alcohol hand-rub solution.	Not present.				
3.2*	Hand hygiene promotion materials clearly visible and understandable at key places.	Yes.	Some places but not all.	None.				
3.3*	Functioning hand hygiene stations are available in service areas.	Yes.	Stations present, but no water and/or soap or alcohol hand-rub 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.				
PART B: FACILITY ENVIRONMENT, CLEANLINESS AND DISINFECTION								
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.				

Date of assessment:

Name of assessor(s):

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.				
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.				
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.				

Date of assessment:

Name of assessor(s):

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.				
3.18	Beds for patients should be separated by a distance of 2.5 metres from the centre of one bed to the other and each bed has only one patient.	Yes, all beds meet this guidance.	Some but not all beds fit this criteria.	No beds meet this criteria.				
Number of indicators meeting targets for HYGIENE				+++				
Number of indicators partially meeting targets for HYGIENE				++				
Number of indicators not meeting targets for HYGIENE				+				
NOTES								
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 his/her surroundings. This may include consultation rooms, operating rooms, delivery rooms AND laboratory. Hand hygiene stations should have a sink or bucket with tap and water with soap OR alcohol-based hand-rub. 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 hand-rub. 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.							

Date of assessment:

Name of assessor(s):

4	MANAGEMENT	Meets target (+++)	Partially meets target (++)	Does not meet target (+)	Does indicator meet the target?			Notes (continue in your WASH FIT notebook if necessary)
					Enter number of +			
					Assessment 1 (baseline)	Assessment 2	Assessment 3	
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.				
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 hand-rub, soap, single use towels and other hand hygiene resources.	Yes.	Undertaken less than once a week or assessment is incomplete.	Not undertaken.				

Date of assessment:

Name of assessor(s):

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.				
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.				
Number of indicators meeting targets for MANAGEMENT				+++				
Number of indicators partially meeting targets for MANAGEMENT				++				
Number of indicators not meeting targets for MANAGEMENT				+				
NOTES								
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 2-B: Record of assessment

SAMPLE

(Note, only water is shown here but when conducting an assessment, all domains should be assessed at once).

		Assessment 1	Assessment 2	Assessment 3	Assessment 4
Domain	Date of assessment:	24 th March 2016	25 th September 2016		
Water Total number of indicators assessed: 13	Number of indicators meeting standards	5	10		
	Number of indicators partially meeting standards	4	3		
	Number of indicators not meeting standards	4	0		
Notes		Overall, improvements needed as less than half of the indicators met standards.	Significant improvement made (doubled the number of indicators meeting standards) and in no areas are the standards not met. Some additional progress could be made.		

Tool 2-B: Record of assessment BLANK

		Assessment 1	Assessment 2	Assessment 3	Assessment 4
Domain	Date of assessment:				
Water Total number of indicators assessed: _____	Number of indicators meeting targets				
	Number of indicators partially meeting targets				
	Number of indicators not meeting targets				
Notes					
Sanitation Total number of indicators assessed: _____	Number of indicators meeting targets				
	Number of indicators partially meeting targets				
	Number of indicators not meeting targets				
Notes					

		Assessment 1	Assessment 2	Assessment 3	Assessment 4
Hygiene Total number of indicators assessed: _____	Number of indicators meeting targets				
	Number of indicators partially meeting targets				
	Number of indicators not meeting targets				
Notes					
Management Total number of indicators assessed: _____	Number of indicators meeting targets				
	Number of indicators partially meeting targets				
	Number of indicators not meeting targets				
Notes					
Overall score	Number of indicators meeting targets				
	Number of indicators partially meeting targets				
	Number of indicators not meeting targets				

SANITARY INSPECTION FORM 1
DUG WELL WITH HAND PUMP

I. General information

- a. Name of facility:
- b. Location and/or name of dug well:
- c. Date of inspection:
- d. 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)? Y/N
- 2. Is the fence absent, inadequate or faulty? Y/N
- 3. Can animals have access within 30 metres (100 feet) of the well? Y/N
- 4. Is there any other source of pollution within 30 metres (100 feet) of the well (such as animal breeding, farming, roads, health care waste, domestic garbage)? Y/N
- 5. Is there stagnant water within 3 metres of the well? Y/N
- 6. Is the drainage channel absent or cracked, broken or in need of cleaning? Y/N
- 7. Is the cement floor or slab less than 2 metres in diameter around the top of the well? Y/N
- 8. Are there cracks in the cement floor or slab? Y/N
- 9. Is the hand pump loose at the point of attachment or, for rope-washer pumps, is the pump cover missing or damaged? Y/N
- 10. Is the well cover absent, cracked or insanitary? Y/N

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

III. Results and comments

- a. 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)

- b. Important points of risk noted and reported on the reverse of this form:
 - list according to question numbers 1–10
 - additional comments.

IV. Names and signatures of assessors:

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EXPLANATORY NOTES FORM 1
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 pose 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 risk. While there is no universal safe distance, a latrine being upgradient of groundwater flow and/or within 30 m (100 feet), 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 metres (100 feet) 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 metres (100 feet) 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 metres (100 feet) of the well, answer “Yes”.

5. Is there stagnant water within 3 metres 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 metres 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 metres 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”.

SANITARY INSPECTION FORM 2
DEEP BOREHOLE WITH MOTORIZED PUMP

I. General information

- a. Name of facility:
- b. Location and/or name of borehole:
- c. Date of inspection:
- d. 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? Y/N
2. Is the nearest latrine a pit latrine that percolates to soil, i.e. not connected to a septic tank or sewer? Y/N
3. Is there any other source of pollution (e.g. animal excreta, rubbish, surface water) within 10 m of the borehole? Y/N
4. Is there an uncapped well within 15–20 m of the borehole? Y/N
5. Is the drainage area around the pump house faulty? Y/N
6. Is the fencing around the installation damaged in any way which would permit any unauthorized entry or allow animals access? Y/N
7. Is the floor of the pump house permeable to water? Y/N
8. Is the well seal unsanitary? Y/N
9. Is the chlorination functioning properly? Y/N
10. Is chlorine present at the sampling tap? Y/N

Total score of risk factors as total number of “YES” answers:

III. Results and comments

- a. 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)

- b. Important points of risk noted and reported on the reverse of this form:

- list according to question numbers 1–10
- additional comments.

IV. Names and signatures of assessors:

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SANITARY INSPECTION FORM 3
PUBLIC/YARD TAPS AND PIPED DISTRIBUTION

I. General information

- a. Name of facility:
- b. Date of inspection:
- c. Weather conditions during inspection:
- d. Location and/or name of water source(s) feeding the distribution system:
- e. 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 the form "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? Y/N
- 2. Is the tap or are attachments (such as hoses) insanitary? Y/N
- 3. Does spilt water accumulate around the tap stand? Y/N
- 4. Is the area around the tap stand polluted by waste, faeces or other materials? Y/N
- 5. Is the area around the tap stand unfenced, allowing animals to access the area? Y/N
- 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) Y/N

Piped distribution

- 7. Are there any signs of leaks in the inspection area (for example, accumulating water)? Y/N
- 8. Are any of the pipes exposed above ground in the inspection area? Y/N
- 9. Have users report any pipe breaks within the last week? Y/N
- 10. Has there been discontinuity in the last 10 days? Y/N

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

III. Results and comments

- a. Sanitary inspection risk score (*tick appropriate box*):

Note. In situations where only questions 6–10 apply, the score below can be adapted as follows: "Very high" = 5; "High" = 3–4; "Medium" = 2; "Low" = 0–1.

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)

- b. Important points of risk noted and reported on the reverse of this form:

- list according to question numbers 1–10
- additional comments.

IV. Names and signatures of assessors:

EXPLANATORY NOTES FORM 3
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, garbage 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".

SANITARY INSPECTION FORM 4
RAINWATER HARVESTING

I. General information

- a. Name of facility:
- b. Location and/or name of rainwater storage:
- c. Date of inspection:
- d. 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)? Y/N
2. Are the guttering channels that collect water dirty? Y/N
3. Is there any deficiency in the filter box at the tank inlet (e.g. lacks fine gravel)? Y/N
4. Is there any other point of entry to the tank that is not properly covered? Y/N
5. Is there any defect in the walls or top of the tank (e.g. cracks) that could let water in? Y/N
6. Is the tap leaking or otherwise defective? Y/N
7. Is the concrete floor under the tap defective or dirty? Y/N
8. Is the water collection area inadequately drained? Y/N
9. Is there any source of pollution around the tank or water collection area (e.g. excreta)? Y/N
10. Is a bucket in use and left in a place where it may become contaminated? Y/N

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

III. Results and comments

- a. 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)

- b. Important points of risk noted and reported on the reverse of this form:
- list according to question numbers 1–10
 - additional comments.

IV. Names and signatures of assessors:

.....

SANITARY INSPECTION FORM 5
STORAGE RESERVOIRS

I. General information

- a. Name of facility:
- b. Location and/or name of storage reservoir:
- c. Date of inspection:
- d. Weather conditions during inspection:
- e. 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.

Note. If the storage reservoir feeds a piped distribution system, also carry out a sanitary inspection using the form "Public/yard taps and piped distribution".

Note. If the storage reservoir is equipped with a tap for collecting water, also carry out a sanitary inspection using questions 1–5 of the form "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? Y/N
- 2. Is the physical infrastructure of the storage reservoir cracked or leaking? Y/N
- 3. Is the inspection cover of the storage reservoir absent or open? Y/N
- 4. Is the inspection cover faulty, corroded or is the concrete around the cover damaged? Y/N
- 5. Is the inspection cover visibly dirty? Y/N
- 6. Are screens protecting the air vents on the storage reservoir missing or damaged? Y/N
- 7. If there is an overflow pipe, is the screen protecting it missing or damaged? Y/N
- 8. Is there any scum or foreign object in the storage reservoir? Y/N
- 9. Is the diversion ditch above the storage reservoir absent or non-functional? Y/N
- 10. Is the area around the storage reservoir unfenced or is the fence damaged, allowing animals to access the area? Y/N
- 11. Is the storage reservoir not regularly cleaned and disinfected? Y/N

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

III. Results and comments

- a. 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)

- b. Important points of risk noted and reported on the reverse of this form:

- list according to question numbers 1–11
- additional comments.

IV. Names and signatures of assessors:.....

EXPLANATORY NOTES FORM 5
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 insanitary?**

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 garbage), 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 3-4 times/year. If this is not done, answer “No”.

Tool 3. Risk assessment

SAMPLE

Date of assessment: 24th September 2016

Domain	Hazards (Problems) <i>List up to three main hazards or problems that you face. These will be indicators that were scored + or ++.</i>	Risks <i>List the possible risks associated with each hazard (problem).</i>	Level of risk vs. feasibility of addressing problem <i>Mark a cross on the grid for each one according to the system below:</i>		Actions <i>Agreed actions to be undertaken either locally or at the district/regional levels.</i>	
			<i>Lower risk, difficult to address</i>	<i>Higher risk, difficult to address</i>	Facility/Community	District/Regional
			<i>Lower risk, easier to address</i>	<i>Higher risk, easier to address</i>		
Water	1.3 Some end points 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 deliveries 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.		x	Cleaners to remove debris; plumbers to repair broken pipes once parts received.	Authorities provide new pipes/ valves to make repairs.
	1.7 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.		x	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.
	1.9 The facility does not currently treat water and because of	Staff and patients at risk of		x	Facility to safely store water and if	District authorities to work with

Domain	Hazards (Problems) <i>List up to three main hazards or problems that you face. These will be indicators that were scored + or ++.</i>	Risks <i>List the possible risks associated with each hazard (problem).</i>	Level of risk vs. feasibility of addressing problem <i>Mark a cross on the grid for each one according to the system below:</i>		Actions <i>Agreed actions to be undertaken either locally or at the district/regional levels.</i>	
			<i>Lower risk, difficult to address</i>	<i>Higher risk, difficult to address</i>	Facility/Community	District/Regional
	<i>storage and handling as well as unsafe municipal supplies water quality does not meet drinking-water standards nor standards for municipal uses.</i>	<i>infection from unsafe water.</i>			<i>possible use chlorine treatment while longer-term more sustain-able options are sought.</i>	<i>partners to secure treatment (i.e. electro-chlorinator of filter). Regional authorities to prioritize treatment of water supplied to health care facilities.</i>

Tool 3. Risk assessment BLANK

Date of assessment: _____

Domain	Hazards (Problems) <i>List up to three main hazards or problems that you face. These will be indicators that were scored + or ++.</i>	Risks <i>List the possible risks associated with each hazard (problem).</i>	Level of risk vs. feasibility of addressing problem <i>Mark a cross on the grid for each one according to the system below:</i>		Actions <i>Agreed actions to be undertaken either locally or at the district/regional levels.</i>	
			<i>Lower risk, difficult to address</i>	<i>Higher risk, difficult to address</i>	Facility/Community	District/Regional
			<i>Lower risk, easier to address</i>	<i>Higher risk, easier to address</i>		
Water						
Sanitation and health care waste						

Domain	Hazards (Problems) <i>List up to three main hazards or problems that you face. These will be indicators that were scored + or ++.</i>	Risks <i>List the possible risks associated with each hazard (problem).</i>	Level of risk vs. feasibility of addressing problem <i>Mark a cross on the grid for each one according to the system below:</i>		Actions <i>Agreed actions to be undertaken either locally or at the district/regional levels.</i>	
			<i>Lower risk, difficult to address</i>	<i>Higher risk, difficult to address</i>	Facility/Community	District/Regional
			<i>Lower risk, easier to address</i>	<i>Higher risk, easier to address</i>		
Hygiene						
Management						

Domain	Hazards (Problems) <i>List up to three main hazards or problems that you face. These will be indicators that were scored + or ++.</i>	Risks <i>List the possible risks associated with each hazard (problem).</i>	Level of risk vs. feasibility of addressing problem <i>Mark a cross on the grid for each one according to the system below:</i>		Actions <i>Agreed actions to be undertaken either locally or at the district/regional levels.</i>	
			<i>Lower risk, difficult to address</i>	<i>Higher risk, difficult to address</i>	Facility/Community	District/Regional

Tool 4. Improvement plan

SAMPLE

Improvement plan written on: 26th March 2016 Date of 1st review: 25th September 2016 Date of 2nd review: Due in March 2017

Domain	What specific improvement action will be taken to resolve the hazards identified? <i>The actions to be taken link to the hazards recorded in tool 3.</i>	Who will carry out the task and is there anyone who will supervise it? <i>List people responsible for implementation.</i>	What resources are needed to do it? <i>"Resources" could be staff, technical or financial.</i>	When do you expect to complete this action? <i>Indicate target date.</i>	Completion date <i>Once the activity has been completed, record the date of completion.</i>	STEP 5: Monitoring When you review the plan, how does it need to be changed? <i>What, if any, additional efforts are needed?</i>	
						Review 1	Review 2
Water	1.3 Leaks in piping will be fixed to ensure that taps are working.	Local engineer to be contracted to carry out repairs to piping.	2 days of work at a cost of \$10/day.	1 June 2016	5 June 2016	Action completed. Pipes will be monitored in case of any further leakages.	
	1.7 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.	\$10 per station, plus ceramic filters at \$40 each. Total \$50 x 4 needed = \$200.	15 th April 2016	15 th April 2016	No drinking- water available in maternity ward so additional stations need to be bought when funds are available.	
	1.9 Water for drinking-water stations will be treated using ceramic filtration.	Jacob to assign budget for purchasing and source drinking- water stations. John responsible for treating water.	John's time.	Ongoing activity. Treatment to start in April once materials are available.	Treatment started on April 21 st .	Drinking stations are not filled regularly enough when water supply is absent.	

Tool 4. Improvement plan

BLANK

Date improvement plan written: Date of review 1: Date of review 2:

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

Domain	What specific improvement action will be taken to resolve the hazards identified? <i>The actions to be taken link to the hazards recorded in tool 3.</i>	Who will carry out the task and is there anyone will supervise it? <i>List people responsible for implementation</i>	What resources are needed to do it? <i>“Resources” could be staff, technical or financial.</i>	When do you expect to complete this action? <i>Indicate target date.</i>	Completion date <i>Once the activity has been completed, record the date of completion.</i>	STEP 5: Monitoring	
						When you review the plan, how does it need to be changed? <i>What, if any, additional efforts are needed?</i>	Review 1
Hygiene							
Management							

Annex 1: Guidance for national or district level implementers and policy-makers

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. Refer to the boxed text on page 10 for examples of where WASH FIT has been used to date.

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 for the Core Components of Infection Prevention and Control Programmes at the National and Facility Level* (WHO, 2016) and the *WHO Standards for improving quality of maternal and newborn care in health facilities* (WHO, 2016) both include specific standards and measures for WASH. The implementation of each of these, will thus require WASH interventions and their maintenance, 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 that will be trained. The primary trainees will be those working in health care facilities (including cleaners and maintenance individuals) and also should be individuals who demonstrate an interest and motivation to further improve their skills and competencies. 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. Other potential trainees include national/regional/district health and water government staff working on environmental health and/or infection prevention and control, NGO partners, facility staff including cleaners and community water and health committee members.

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 refresher courses can also be useful. A set of modules are available to accompany this guide in the WASH in HCF knowledge portal (<http://www.washinhcf.org/resources/training/>).

Conduct 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 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 handwashing 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 - 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 a few 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 based on these positive outcomes seek additional support from the government, donors and 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 effectively roll-out such a programme, 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 reaches 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 many 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 be to 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” facility that meets an accreditation scheme or national quality standards that can serve as an example 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 requires investment but it is 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 the monitoring and evaluation is built into the health system with district health officials tracking improvements and who during their regular facility supervisory visits are able to address aspects of WASH along with a host of health issues. Exploring 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.

1. 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):

2. First visit only

Has the WASH FIT process been started? Yes / No

If not, why not? (Circle 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 / No (ask to see it)

In talking to the facility manager, do you think that leadership is engaged?

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?

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 only partial understanding

No, limited understanding

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

3. All visits

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: dd__/mm__/yy__ (indicate if no assessment completed)

Date of most recent assessment: dd__/mm__/yy__

What number assessment is this? 1st / 2nd / 3rd / 4th

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 was completed? *Circle all that apply*

Dug well with hand pump (SI form 1)

Public/yard taps and piped distribution (SI form 2)

Storage reservoirs (SI form 3)

How could the team improve their assessments?

Provide the team with suggestions and feedback and make a note here.

Summary of findings from assessment

(For each domain list the overall score)

Task 3: 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 who	When	Comments
e.g. hand washing posters printed and posted outside latrines.	Idriss, caretaker.	5 th January 2016.	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 HCF, 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: dd__/mm__/yy__

General observations

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

