Questions to guide WASH programming: Integrating PGI and good community engagement

Use the questions below as a reminder of key considerations when assessing, designing, implementing, evaluating and coordinating WASH programmes and activities. **These questions are not exhaustive nor a one-off checklist.** Somequestions may not be relevant for emergency response. Remember that this is a flexible process; inclusive, participatory and safe WASH programming requires continuous monitoring and adjustment to activities as needed.

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|  | **Questions to ask yourself** | **Included in WASH programme?**  | **Ideas and suggestions: What can we do differently next time?**  |
| **Assessment**  | 1. Wherever possible, have you collected data disaggregated by sex, age and disability (SADD) and other context-specific variables?
2. Have you used participatory data collection methods which promote participation of persons of all gender identities, disabilities, backgrounds and ages (including child-friendly approaches for children)?
3. Which groups or individuals are at more risk of violence, stigma and marginalization and have less access to WASH facilities and services? Why?
4. What are the roles, responsibilities, specific needs and priorities relating to water, sanitation and hygiene for women, men, girls, boys, people with disabilities etc.? Make sure you think about cultural and social traditions and perceptions, household decision-making, livelihoods such as agriculture and livestock raising etc.
5. What are the barriers people face in accessing water points and sanitation and hygiene facilities, of all gender identities, ages, disabilities and backgrounds?
6. What are the roles of women and girls, men and boys, people with disabilities etc. in collecting, handling, storing, and treating water?
7. Who is involved in community decision-making for water and sanitation services, including technology selection and siting of facilities? How can everyone’s voice be heard?
 | 1.Yes2. Yes3. Yes4. Yes5. Yes6.Yes7. Yes | 1. S&A Data was collected during the first assessment. Later on, also data disaggregated on pregnancy status and disability collected. This was used as a basis for the PGI showers
2. Participatory data collection methods were utilized. Community volunteers collected some data with specific checklists. Focus group discussions were conducted.
3. Different vulnerable groups were identified (i.e PLW, Single Females, PwD). Access to toilets improved, ‘African School’ safety aspects enabled, referrals to MSF when needed and based on limited capacity. Single Men’s needs were also taken into consideration since they are also at risk of marginalization.
4. Cultural and religious traditions were identified, based on that IEC material was adapted, Volunteer schedules took into account prayer times. Community structure was taken into consideration, but it was difficult due to the diversity of the groups and their representation in the community volunteer teams.
5. Barriers related to accessing facilities were identified and removed.
6. Mainly gender-traditional roles existed
7. Communities were indirectly consulted in the design of the facilities through community volunteers. Safety aspects of the design were also taken into consideration. Sometimes external limitations hindered plans to be implemented according to community feedback, but this was communicated accordingly.
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| **Design and preparation**  | 1. Has the WASH engineer collaborated with the hygiene team for the planning and design process?
2. Have you adapted hygiene promotion messages and methods/channels for different ages, abilities, and genders? Do the hygiene promotion methods promote dialogue?
3. Have all groups had their voice heard during decision-making for operational and maintenance strategies of community water supplies and WASH facilities?
4. Are communal latrines, bathing facilities and tap-stands or water distribution points usable by all, can everybody reach the taps and use the toilets (older persons, children, pregnant women, and persons with disabilities)?
5. Can everyone, including people with disabilities, chronic illnesses and older people, access sufficient water for drinking, cooking and maintaining hygiene?
6. Are ramps, handrails and dimensions of facilities suitable for people with mobility issues, or accompanying carers?
7. Are WASH facilities secure and private (locks on the inside and lighting in and around), both by day and night?
8. Do WASH facilities provide sufficient space, privacy and facilities for managing menstrual hygiene including washing, drying and disposal of hygiene items?
9. Are the water and sanitation facilities and kits (or items) designed and provided culturally appropriate and based on user preferences?
10. Are you coordinating with Protection Gender and Inclusion (PGI) and Relief teams regarding design and distribution of hygiene kits, menstrual hygiene management kits and dignity kits?
 | 8.Yes9. Yes10. Yes11. Partial12. Yes13. Partial 14. Partial15.Yes16. Partial17. No | 1. There were constant linkages between the Hard and Soft WASH teams. This is shown in the timetable. Mainly, Soft WASH teams communicated community feedback and preferences to the Hard WASH teams.
2. HP messages were adapted to the specificities of different groups and even developed together with those groups. HP methods used promoted dialogue between different groups, which increased trust.
3. Organizations were contracted by RC; however, volunteers conducted the maintenance. Feedback from the community was gathered based on a daily feedback loop. Whatsapp groups were heavily used. Feedback was taken into consideration immediately.
4. Yes, however PGI showers were established later on in the response.
5. Water availability was no concern for anybody.
6. In later stages of the response, Inclusive showers were developed to promote access.
7. Toilets were not within RCs mandate; however showers were secured and operational during the day.
8. Sufficient place was provided for washing, in addition to single-use pads, plastic bags and bins distributed
9. RC distributed once at the beginning of the response. Sometimes, pads were considered too thin, which was not culturally appropriate
10. Hygiene Kits were ready before RC arrived, whereas they were not fully appropriate (ie Pads distributed to males) Items distributed did not take community preferences into account since these items are needed to implement HP messages (Shampoos and Soaps)
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| **Implementation**  | 1. Does the WASH team have balanced/fair representation of persons of all gender identities, ages, disabilities and backgrounds?
2. Is an open, positive attitude to diversity and inclusion used as a criteria when recruiting WASH staff and volunteers?
3. Have you recruited hygiene promotion volunteers from different backgrounds, including different ethnic groups and persons with disabilities? Can you actively recruit more diverse volunteers?
4. Have WASH staff and volunteers been trained on PGI issues?
5. Have hygiene promotion volunteers received training on discussing sensitive topics, how to communicate with people with disabilities (including their caregivers) and children?
6. Have you linked with the PGI and/or Gender-based Violence (GBV) team so that WASH staff and volunteers know where to refer people in case of a disclosure of violence or abuse?
7. Have you explored ways to partner with local or international specialist organizations (for example which work with children, or people with disabilities)?
8. Do community WASH committees have diverse and meaningful representation?
9. Are the government, partners and other stakeholders aware of WASH related PGI issues? If not, how will you advocate and encourage them to ensure that PGI is mainstreamed in their work?
 | 18. 19. 20: Yes21. Partial22. Partial23. Partial24. Partial25. N/A26. No | 1. 19. 20. Most community groups and ethnicities were represented. Hard WASH CV teams were all Males, whereas HP teams were Gender representative but did not include PwD representation. Age of CVs mirrored the main age groups of the camp population.
2. Mentioned above
3. Mentioned above
4. PGI training was not formally conducted, however booklets were distributed and discussions regarding PGI were made. RC team had an online training, but not in all rotations.
5. PGI guide was introduced to the volunteers, with basic advice on the basics of communication and main PGI consideration.
6. GBV referrals were difficult due to the multitude of actors and constantly changing roles. Referrals were conducted on a case by case basis based on the availability of actors at the time
7. UNICEF was partnered with (Collaboration could have been better). Smaller organizations were also coordinated with that focused on more specific aspects.
8. N/A
9. Awareness was raised because of the practices conducted within the RC response. Lack of awareness was apparent during WASH coordination meetings
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| **Monitoring and evaluation**  | 1. Are WASH facilities and distributed items being used as planned by different groups and individuals?
2. Are hygiene messages being understood and acted upon by women, girls, men, boys, people with disabilities, older people etc.? If behaviour change is not seen in some groups, why not, and what barriers are they facing?
3. Are you collecting feedback in a participatory way from people of all gender identities, ages, disabilities and backgrounds throughout WASH programming (before, during and after implementation)?
4. Is the complaint and feedback system accessible for persons of all gender identities, ages, disabilities and backgrounds? Have you coordinated with the Community Engagement and Accountability (CEA) team and established responsibility for following up?
5. Are WASH related facilities, distributions or services having any unforeseen impact or consequences (positive or negative) on any groups?
 | 27. Partial28. Partial29. Partial30. Partial31. Yes | 1. Daily monitoring (Observation and Transect walks) were conducted, and it has been seen that facilities were generally accepted. Cold showers were not utilized, in addition to handwashing points in cold weather. This can be improved by having more structured and tracked monitoring.
2. There was not enough time to observe practice changes. Some changes were notices such as handwashing and cleaning clothes more frequently.
3. Daily feedback was received from community volunteers and action was taken. QR codes and feedback boxes were rolled out but not utilized. Volunteers proactively solicited feedback from community members.
4. Even though community members had access to submit complaints and feedback, however, this was not fully accessible at all times.
5. Positive impact is that the different communities present became closer, and trust increased between them in addition to constant discussions between the different community groups.
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Key resources and tools

* IFRCs PGI in WASH guidance note: <https://watsanmissionassistant.org/wpcontent/uploads/2021/05/IFRC_PGI-in-WASH-Guidance-Note_final_2021.pdf>. Also available in Spanish, French and Arabic: <https://watsanmissionassistant.org/gender-and-wash/>
* [IFRCs PGI assessment question library](https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2020/03/Tool2.4.1_PGI_in_assessments_questions_library-11March20.xlsx) including guidance on collecting SADD data, and the [IFRC Rapid PGI analysis template](https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2020/03/PGI_iE_Tool-2-5_Rapid_PGI_Assessment_Analysis_Template_WORD.docx).
* IFRC Minimum standard checklists for inclusive, MHM-friendly latrines, bathing areas and solid waste management can be used for design, assessment and monitoring.[currently under revision – see live versions here: <https://drive.google.com/drive/folders/1LnjfKK9YbiHzxFBlkxpoF7YHc8kLCJRg?usp=sharing>