![WaterAid logo]

Towards Inclusive WASH

Sharing evidence and experience from the field

Poorest of the Poor

Living with HIV & AIDS

Disability

Gender

Contents

WaterAid in Timor-Leste

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Acronyms

Frequently used acronym list for Inclusive WASH

AIDS	Acquired Immune Deficiency Syndrome
ATprojects	Appropriate Technologies projects (NGO in PNG)
AusAID	The Australian Agency for International Development
CDD	Centre for Disability in Development (Bangladesh NGO)
CLTS	Community-led total sanitation
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil society organisations
DPO	Disabled people's organisation
DRR	Disaster risk reduction
EI	Equity and inclusion
FGD	Focus group discussions
HIV	Human Immunology Virus
IEC	Information, education and communication
IRC	International Water and Sanitation Centre
IWDA	International Women's Development Agency
JMP	Joint Monitoring Program
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
NEWAH	Nepal Water for Health
NGO	Non-government organisation
ODF	Open defecation free
PLHIV	People living with HIV
PNG	Papua New Guinea
PWD	People with disabilities
ToC	Theory of change
UN	United Nations
UNICEF	The United Nations Children's Fund
VDC	Village Development Committee
VIP latrine	Ventilated improved pit latrine
WASH	Water, sanitation and hygiene
WATL	WaterAid in Timor-Leste
WHO	World Health Organization
WRG	WASH Reference Group (Australia)
WSUP	Water and Sanitation for the Urban Poor
WU	Women's Union

Towards Inclusive WASH   Sharing evidence and experience from the field

Foreword

Professor Ron McCallum

Professor Ron McCallum, AO, is the first totally blind person to have been appointed to a full professorship at any Australian university, where he later served as the Dean of Law for five years. In 2011 he was appointed Senior Australian of the Year for his services as an equal rights campaigner.

In 2010, the UN General Assembly and the Human Rights Council made the breakthrough decision to explicitly recognise the human right to water and sanitation. Now it is crucial to implement these rights and turn them into a reality *for everyone*.

Recently we learnt that the world has reached the Millennium Development Goal target for drinking water and a remarkable two billion people have gained access to safe drinking water in the last twenty years. The same data, produced by UNICEF and the World Health Organisation also show that almost 800 million people still live without access to safe drinking water. The report also showed that a staggering 2.5 billion people do not enjoy their right to basic sanitation. Whilst the drinking water MDG target is one of the first to be met, it is estimated the sanitation MDG target will be the last.

These figures raise a number of questions. Foremost in my mind is who are the people not benefitting from this progress? This is because human rights are not only concerned with the percentage of people who enjoy access to sanitation and water, but also with those who do not have access, and why. When it comes to progress, it is important that we begin to see the story behind averages.

Progress on water and sanitation has been unequal with poorer countries and poorer people left behind. In sub-Saharan Africa, almost 90% of the richest fifth of the population use improved water sources, while only 35% of the poorest fifth of the population do. In countries in South Asia (India, Bangladesh and Nepal) sanitation coverage in the two poorest quintiles has shown little change between 1995 and 2008; 4 out of 5 people in these two quintiles practise open defecation.

Who are these excluded people? The poorest and unserved households include people from so-called 'lower caste', sex workers, people living with HIV and AIDS, people living with disabilities, slum dwellers, female headed households, remote communities, children and older people to name just some of the groups. This publication pays particular attention to the 33.3 million people living with HIV globally. The HIV burden often coincides with regions experiencing high levels of poverty and low levels of access to water and sanitation services and people living with HIV/AIDS and their carers need more water to maintain hygiene.

The vital role of women in water and hygiene is undeniable. A number of the case studies highlight that everything we do has a gendered impact and I was interested to read some good examples of how women's representation and voice has helped to influence decisions and better design. I was struck by the impact of the lack of menstrual hygiene for adolescent girls; I can't imagine what school would have been like for my daughter without having a private and safe toilet.

Another key focus is the more than 500 million people with disabilities in the world of which 80% live in low-income countries. The case studies also highlight the experiences of older people; this is becoming an increasingly important issue as the proportion of older people increases. We also see that many people face multiple layers of exclusion. For example, amongst the poorest of the poor as many as 1 in 5 people are likely to be disabled. Of course a person or a group can face multiple layers of discrimination.

The purpose of this publication is to shine the light on these groups and show ways in which these people are securing their rights to sanitation and water in countries around the world. A good way to do this is to start by understanding the barriers people face in accessing these basic services. The cases in this publication show that these barriers are sometimes related to technology or to economic constraints, but more commonly, the main barrier is stigma. These barriers are interlinked and reinforce each other. When these barriers are understood, we see an array of innovative ways to overcome them. Central to many of these approaches is partnering and working with excluded groups to build their power.

The result of working in this way is that people regain their **independence** and **dignity**, transforming life for them, their carers and their families. I commend the collaborative effort of the organisations involved in preparing this publication and the accompanying series of learning events that have taken place this year.

Professor Ron McCallum
2011 Senior Australian of the Year

Aiden Dockery, SNV

Towards Inclusive WASH   Sharing evidence and experience from the field

Breaking down the barriers—moving towards equity and inclusion in WASH programming

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The Human Right to Water and Sanitation

Having access to safe drinking water and sanitation is central to living a life in dignity and upholding human rights. Yet billions of people still do not enjoy these fundamental rights. The rights to water and sanitation require that these are available, accessible, safe, acceptable and affordable for all without discrimination. … The rights to water and sanitation further require an explicit focus on the most disadvantaged and marginalised… (OHCHR n.d.)

Global progress is leaving the poorest behind

Huge strides in increasing global access to water and sanitation have been made. On 6 March 2012, UNICEF announced that the Millennium Development Goals' (MDG) target for increasing access to safe drinking water had been met. Between 1990 and 2010, two billion people gained access to improved sources. But this progress at the global level masks massive disparities between regions and countries, and within countries (WHO/UNICEF 2012). Eleven per cent of the world's population, or 783 million people, are still without access to improved water sources, and 2.5 billion people still have no access to sanitation. Analysis of access by wealth quintile (WHO/UNICEF 2012) shows that the richer countries and the wealthiest people have seen the greatest improvement in water and sanitation access, while the poorest people, especially in rural areas, still lag far behind (see Analysis paper on page 17 for further discussion and graphs).

The Secretary General of the UN stated, "We have reached an important target, but we cannot stop here. Our next step must be to target the most difficult to reach, the poorest and the most disadvantaged people across the world. The United Nations General Assembly has recognised drinking water and sanitation as human rights. That means we must ensure that every person has access."

The UN General Assembly recognised access to safe drinking water and sanitation as a human right in July 2010. Equality and non-discrimination are bedrocks of human rights law, and the recognition of that right establishes states' obligations for progressive realisation of the right for all. This provides a clear mandate for the water, sanitation and hygiene (WASH) sector to focus on equity and inclusion (Box 1).

Analysis under the WHO/UNICEF Joint Monitoring Program (JMP) shows that poverty is the main cause of exclusion from improved water supply and sanitation (WHO/UNICEF 2012). There are however a number of other barriers—physical, institutional and social—which make it difficult or impossible for people to reach and use existing facilities.

Water supply and sanitation infrastructure are traditionally designed and constructed by male service providers for the 'average' user, presenting difficulties for many. Many frail older people are unable to walk as far as the common water point, and must rely on others, even having to pay others to fetch water for them. Women when heavily pregnant and people with physical disabilities find it impossible to squat in a latrine. People with chronic illnesses, including HIV, who need care and assistance and for whom good hygiene is crucial are likely to find their access to clean water reduced, often because of stigma and community misunderstanding of transmission paths.

People from minority cultures may have specific beliefs that are contrary to mainstream WASH programs, and inclusive programming has to address the specific cultural context. For example pastoralists in East Africa prioritise the needs of their cattle, so providing safe drinking water for humans has to include provision for livestock.

The paper presents three steps that can be taken to ensure that WASH programs are inclusive and promote equity for all. The first step is to **understand who is excluded and marginalised**. Secondly, to **analyse how these people are excluded from WASH**, and finally, to **design WASH programs to overcome the multiple barriers they face**.

Box 1   Why is equity and inclusion important?

Improved access and inclusion in WASH brings a range of benefits to marginalised individuals and their families, including the following:

» **Increased dignity and self-reliance for the individual:** Dignity is essential for all human beings. Accessibility, safety and privacy are particularly important for women and girls, and inclusive design enables disabled and older people to use WASH facilities independently, instead of relying on others for support.

» **Improved health and nutrition for the individual and the community:** Unhygienic sanitation practices affect everyone especially those at increased risk of opportunistic infections because of sickness or disability. People who have to crawl or need to put their hands on the floor for balance when squatting are immediately exposed to increased risk of infection, as are people living with HIV. Disabled and older people are also known to limit their food and water intake, to reduce their need for the toilet and thus the workload of the carers who support them.

In the context of total sanitation campaigns, the emphasis is on elimination of open defecation for the public good. It follows, therefore, that even a handful of people in a community still practising open defecation will impact on the health of the community. Accessible facilities therefore benefit all.

» **Education:** Many children are affected by WASH-related discrimination in schools. Adolescent girls miss school during menstruation, leading to poorer educational outcomes (Scott et al. 2009), and children with disabilities may be refused admission or drop out due to inaccessible school buildings including sanitation facilities. Anecdotally, children with disabilities are known to not eat or drink until the evening to avoid the need to use inaccessible or insufficiently private school toilets (UNDP 2006). Improving and maintaining user-friendly school latrines—child/girl/disabled-friendly—can contribute to improving the learning environment for all children (Zomerplaag and Mooijman 2004) and an inclusive ethos in school can reduce discrimination related to WASH (UNICEF 2009).

» **Good economics:** The costs of excluding a significant proportion of the community far outweigh the costs of including them. The costs of exclusion are borne primarily by the family but also by the whole community, in terms of lost economic and social contribution. An inclusive design approach to facilities and services benefits the widest range of users and the additional cost can be minimal if planned from the outset. Estimates range from as low as 5 per cent (WaterAid Madagascar 2010) to 2-3 per cent (Jones 2011) and even lower (Steinfeld 2005).

» **Gender equality:** Installing water points nearer the home reduces the time that women and girls spend fetching water and can reduce the risk of sexual harassment and assault, as do latrines that provide security and are appropriately located. Improvements for disabled or sick individuals often bring benefits to women and children in the family, since carer support tasks frequently fall most heavily on them. Support to a sick or frail older family member is often provided by a child in the family (usually a girl) who is likely to be taken out of school as a result. Inclusive and accessible facilities can reduce the workload of carers, restoring educational and employment opportunities.

Step 1: Understanding who is excluded and marginalised

It is a simple fact that people who are on the furthest margins of society have the least power, the least visibility and the least voice. They almost always live in the deepest poverty, and their rights and needs are most likely to be ignored and abused.

People are marginalised, pushed to the edges of society, for different reasons—because of who they are, where they live, their religion, ethnicity, their gender or political affiliations. The ways in which people are marginalised are determined by the social, political, and economic context in which they live. Their situation is further exacerbated by the stresses of climate change, rapid urbanisation, population growth and global economic pressures (Figure 1).

There are some whole population groups who are marginalised. For example certain caste or ethnic groups, and people who live in slums or remote rural areas. There are also others who are more likely to be marginalised across all population groups: women, disabled and older people, children and people living with HIV or other chronic illnesses (see Box 2). In the poorest communities these people are doubly disadvantaged and some people face multiple layers of discrimination, for example an elderly women, with a chronic disease, living alone, in a rural community.

Figure 1   Marginalisation in Society
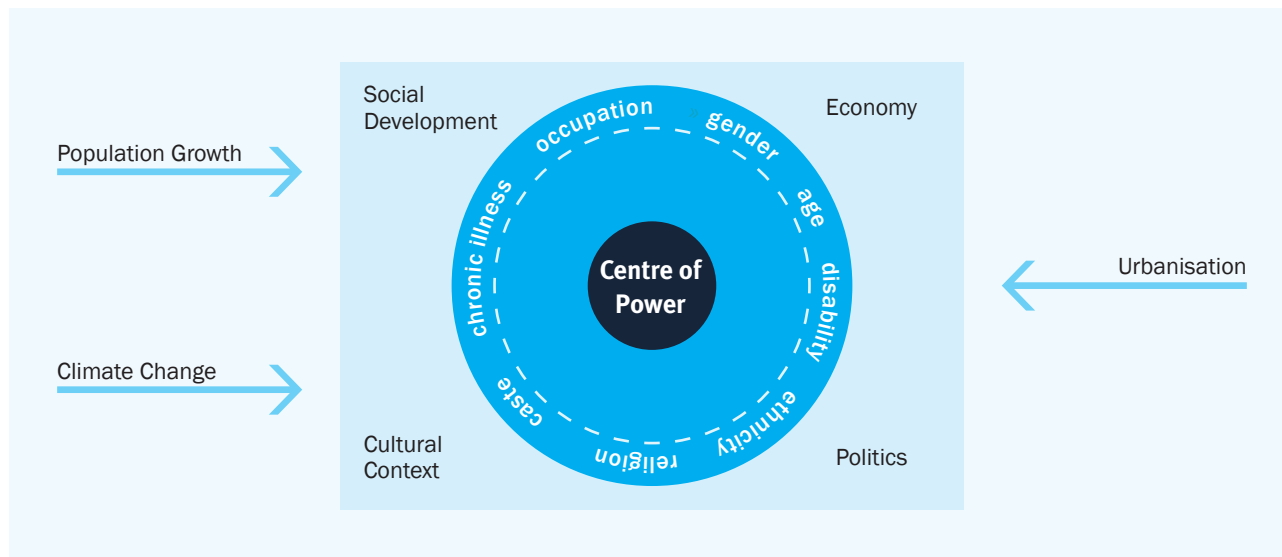
Box 2   Marginalised people are in every community

» Half the world's population are women and girls.

» 15% of the global population (over one billion people) are disabled (WHO/ World Bank 2011).

» More than one in five people in developing countries will be aged over 60 by 2050 (Helpage, nd).

» 607 million people aged 60 or older currently lack income security, the majority of whom are older women (OHCHR 2012).

» More than 33 million people in the world are living with HIV (UNAIDS 2010).

Step 2: Understanding exclusion

### The social model of inclusion

A traditional approach to dealing with excluded groups, such as people with disabilities, is to focus on their different and 'special' needs. For example, it is often assumed that their main need is for treatment or rehabilitation, requiring expensive specialist expertise and equipment, and only when they have been 'treated' can they participate in 'normal' society. This is what is referred to as the medical model of disability (Figure 2).

In fact, many disabled people find that it is society that creates more problems for them than their own impairment. With this in mind, the 'social model of disability' was developed. This model views disabled people as part of society, rather than separate, where people with impairments are disabled by a society that creates barriers to their access and participation (Figure 3). The UN points out that it is

Figure 2   Medical model of disability (Coe & Wapling 2010)

Figure 3   Socially inclusive model of disability (Coe & Wapling 2010)
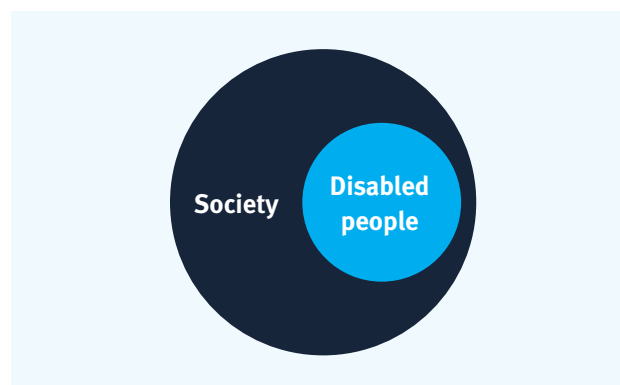
the "interaction with various barriers [that] may hinder full and effective participation in society on an equal basis with others." (UN 2006) The focus of a socially inclusive model therefore emphasises the removal of those barriers that prevent inclusion.

Barriers to access

By applying this 'social model of inclusion' to encompass a range of excluded groups, we can identify the different barriers that exclude users from water, sanitation and hygiene provision. Examples of these barriers are shown in Table 1.

Table 1 Examples of barriers to access and inclusion

Physical » Natural environment » Built infrastructure	» Long distances, rough or steep paths, muddy ground » High steps, narrow entrances, no doors, slippery or dirty floors, narrow cubicles, no light, heavy pump handles, no facilities for disposal of sanitary napkins » Inappropriate locations—risk of insecurity, lack of privacy
Institutional/ Organisational	» Lack of equality in legislation or policies, non-implementation of laws, no minimum standards, no inclusive designs, lack of knowledge, skills, or information, limited procedures for consultation with excluded group
Social/cultural/ attitudinal	» Lack of information, traditional beliefs, pity, isolation, reluctance to speak up, overprotection, stigma, prejudice, shame

The most obvious of the three are **physical barriers** in the natural and built environment, such as long distances to water points, steep steps, heavy pump handles, etc. Less obvious and harder to change are the **institutional and organisational barriers** to inclusion, such as lack of knowledge and skills of personnel, unclear policies and strategies, or no procedures for consultation with all users. Most insidious of all are the **social and attitudinal barriers**, the negative attitudes, stigma attached to certain minority groups, and misinformation about pregnancy, menstruation, disability, aging and illnesses that result in users being ostracised and excluded. These compound societal norms in which women, children, and other groups are systematically sidelined and ignored in decision making and resource allocation. These barriers can also form a vicious self-reinforcing cycle as demonstrated in Figure 4.

It is rarely effective to address one type of barrier in isolation. All the barriers need to be addressed together as they are interconnected and reinforce each other. For example, the lack of representation of marginalised groups in program design results in the creation of facilities that are inaccessible and inappropriate; improvements to physical infrastructure will not benefit stigmatised groups who are prevented from using water and sanitation facilities, and as a result live in unhygienic conditions, which reinforces the stigma.

Step 3: Designing interventions

In the scenario in Figure 4, which could also apply to a person with a disability or with a chronic illness, it is possible to identify several possible intervention points to break this cycle. For example,

» Intervention at point A could involve medication, or provision of a stick for help with balance.

» Intervention at point B could involve installing a handrail for support, and improving the drainage or floor surface to make it non-slip.

» Intervention at point F or G could involve the formation of older people's self-help groups to provide peer support for expressing needs and improving social status.

Addressing physical barriers

Many of the changes required to make the design of physical infrastructure and facilities more accessible and user-friendly are straightforward. The following types of changes can benefit anyone who, for whatever reason, finds it difficult to use existing facilities: reducing the distance to facilities, removing obstacles from paths, evening and grading paths, installing ramps instead of steps, reducing the height of steps, widening doors, installing handrails and/or seat for support. The implementation of these physical adaptations has been well documented.[1]

Approaches to improving accessibility and inclusion

The question for WASH service providers is how can these solutions be incorporated into regular WASH programs? There are three overall approaches to reducing physical barriers:

a. **An individual approach**, providing aids, equipment and adaptations to individuals, according to their needs. The advantage is that solutions are tailored to meet the needs of individuals. The disadvantage is that it can be labour intensive, and if a separate 'special' facility is provided it can cost more and may risk further isolating users. The individual approach may be more within the role of a therapist or community worker.

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[1] Practical information and examples for use in the home (Jones and Reed 2005, David et al. 2008a, 2008b, 2008c, Norman 2010, WaterAid Mali 2007, WaterAid Madagascar 2010); Sleap (2006) and USAID/HIP (2011) describe solutions specifically with older people and PLWHIV in mind; Many of these solutions have been used to make schools girl and boy child friendly and accessible (IRC 2006, Jones 2011, Rwanda Ministry of Education 2009); Two Oxfam briefing papers (2007a and 2007b) describe latrine and washing facilities for women and girls and for disabled people in refugee camps.

Figure 4 An Example of the vicious cycle of barriers
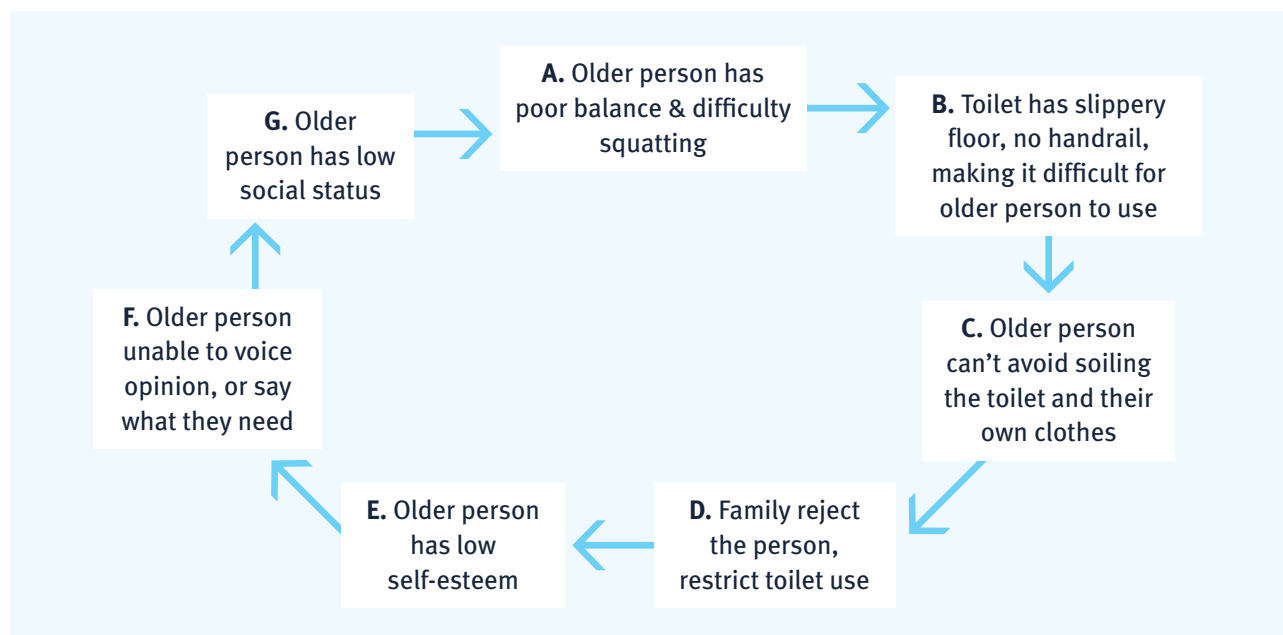
b. **Adaptation/Retro-fitting:** This approach is common, as it involves modifying or adding to existing facilities. For example, adding a handrail or seat to an existing latrine, or a ramp to provide access to an existing water point. It is an inclusive approach, making an existing facility accessible to more people, and can be done as and when it is needed, for example when a disabled child is about to enrol in primary school. On the other hand, this can be difficult or costly with some structures, for example where there are very high steps, and where a cubicle or door needs to be widened, the cost becomes prohibitively high.

c. **Inclusive Design:**[2] This involves the design and construction of facilities that are accessible and easy for all to use. It starts with consultation and involvement of users (or representatives of potential users) in defining their needs, and in helping to design and implement solutions. This approach is cost-effective when planned from the outset, inclusive and systematic—once inclusive designs of school latrines are included and mandated, these are more likely to result in widespread construction of inclusive facilities. The disadvantage is that extensive consultation and planning are needed, which can be a slow process, and even when the designs are agreed it is not guaranteed that they will be constructed as intended. If builders do not understand the reason for the different features they are likely to revert to what they know.

Inclusive design enables access for a significantly greater percentage of the population but it is highly unlikely that a single design will meet 100 per cent of the needs of all users. There will always be users with very severe disabilities or complex needs who cannot be catered for, but it is certainly possible to aim to maximise the proportion of users.

Public and household facilities—when to use which approach

A different approach may be required depending on whether the facilities are for a household or a community or institution.

Household facilities (including shared facilities): At the household level there are a limited number of users, most of whom are known, and whose current needs can be identified and near-future needs largely foreseen (e.g. ageing, pregnancy, illness). This scenario requires a basic user-friendly design and a range of accessibility features to choose from. For example, the basic design of a household latrine should provide adequate floor space and minimum entrance width, as these benefit everyone, and are the most difficult and costly to modify post-construction. Seats, handrails and ramps are easier to add later, and can be constructed with low-cost materials initially to test their benefits, and upgraded at a later date as the needs of the family change and household resources permit, along the same principles as latrine upgrading.

[2] Different countries use different terminology, including 'Universal Design', 'Design for All' and 'Barrier-free Design'. There are minor differences, but the overall principles are the same.

Communal/institutional facilities: These include latrines or water points designed for use by a number of households or by the general public, e.g. at a market, or by users of an institution, such as a health clinic or school, and are intended for use over several decades. Here there are a large number of users, many of whom are unknown, with a wide range of possible current and future needs. This scenario requires an "Inclusive Design" approach.

As has already been pointed out, however, whichever approach is used, addressing physical barriers alone is unlikely to be effective. For example, toilets in a health clinic may be fully accessible, but if health clinic staff refuse access to certain stigmatised groups then the full benefits will not be realised.

Examples of inclusive design features that benefit a wide range of users

» Minimising the difference in height between the surrounding area and a hand pump or well apron. For example, Figure 5 and Figure 6 show the same hand pump technology, both with a concrete apron, and drainage of excess water, but the installation in Figure 6 is likely to present fewer obstacles for users than in Figure 5.

Figure 5   Community hand pump in Ethiopia (A) WaterAid in Ethiopia

Figure 6   Community hand pump in Ethiopia (B) WaterAid in Ethiopia

» Constructing a well wall with different heights to suit children, people who crawl or use mobility equipment or people who may need to sit whilst drawing water, e.g. pregnant women.

» Extra space around a water point (Figure 7) or inside a latrine can be useful for everyone: for a wheelchair user to enter and turn, for a user plus helper, to move a seat to one side when not in use, for changing or washing clothes, or for washing and drying sanitary napkins (Figure 8).

Figure 7   Hand pump apron with ramp access and space for a wheelchair to turn WaterAid in Madagascar 2010

Figure 8   Additional space in school latrine cubicle for washing and drying sanitary napkins in Sylhet, Bangladesh A George 2012

Addressing institutional barriers

For infrastructure improvements to be effective and sustainable, other institutional and social barriers also need to be addressed in conjunction with the physical barriers.

These institutional barriers need to be challenged at every level—from within households, schools and communities, in local and national government, in service providers at different levels and at a global level, where priorities are agreed for resourcing, setting targets and monitoring.

Policy and legislation

Existing legislation and policies related to marginalised groups can lack strategies or guidelines for implementation, so they remain just words on paper. Many countries for example have disability legislation, of which the relevant ministries responsible for water or sanitation are completely unaware. Where they exist, accessibility laws and standards in low-income countries have largely been driven by standards in high-income countries, rather than reflecting local cultural or economic conditions, which may account for their inappropriateness and lack of implementation (WHO/ World Bank 2011).

To address these gaps, efforts are needed to:

» Bring relevant government officials, practitioners and marginalised groups together;

» Use the human right to water and sanitation and the duty of government as a 'hook';

» Document and disseminate information about good practice to show governments ways to fulfil their duties; and

» Draw lessons from good practice to provide strategy guidance for policy-makers.

Minimum standards for inclusive design

In many countries, there are nationally agreed designs for public infrastructure, such as latrines and water points in schools and health clinics. In the long-term, a systematic approach to the development of minimum standards for inclusive designs is needed. We know that technical standards should be established by consensus emerging from participation of all interested persons or institutions. This indicates that a process of partnership development and consultation is needed, with:

» Participation of [all relevant stakeholders] in developing standards;

» Laws with mandatory access standards; and

» Mechanisms to enforce compliance and penalties for non-compliance (WHO/World Bank 2011).

Sharing knowledge and information

Where lack of information is a major institutional barrier, one solution is to share information and knowledge about inclusive approaches that work. This volume of case studies will be a valuable contribution to the body of knowledge, and there are growing numbers of networks and communities of practice for disseminating information and building on experience. Major networks in the WASH sector such as the Water Supply and Sanitation Collaborative Council (WSSCC) and the Rural Water Supply Network (RWSN) are now focussing on equity, inclusion and rights. Information is needed for a range of audiences:

Information for households: For latrines that are the household responsibility, it is unrealistic to expect WASH service providers to provide individually tailored solutions. What families need is information to help them make informed choices based on their own requirements. There is now an increasing body of information on basic low-cost, user-friendly options, based on the practical experience of solutions that have worked locally, aimed at rural households, e.g. for households living with HIV (USAID/HIP 2011).

Approaches to menstrual hygiene management show the importance of providing information about puberty and menstruation to adolescent girls, parents, teachers and health workers. Girls' books in Tanzania, Bangladesh and Zimbabwe have proved very popular as a means of dispelling myths and providing practical factual information about a subject that is often shrouded in misinformation, fear and taboo.

Practical information for service delivery and practitioners: Technical guidelines for inclusive design are increasingly available through websites and resource lists (for example at wateraid.org; wedc.lboro.ac.uk; and asksource.net).

The manual on menstrual hygiene management (forthcoming from WaterAid in 2012) has examples and guidelines on how to discuss menstrual hygiene issues with communities, and with schools, teachers, parents and children, in addition to advice on infrastructure design for menstrual hygiene management.

Information for advocacy: Individual field workers and practitioners are limited in the direct changes they can make. To effect change on a wider scale, key decision-makers in relevant ministries need to be convinced, for which advocacy materials are required—brief, eye catching, with key messages and practical examples. An example of this can be seen in the briefing note on WASH and disability written by Fisher and Jones (2005).

Information about cost-benefits: Some limited studies have been carried out on the additional cost of making facilities inclusive, e.g. WaterAid in Madagascar (2010) and on the costs of accessible school sanitation in Ethiopia (Jones 2011), but further research is needed both on costs, and to provide evidence of the impact of making WASH programs inclusive.

Capacity building

A number of initiatives are raising staff awareness of the principles of equity and inclusion, within their organisations and beyond, and rolling out training for implementers on practical implementation of inclusive WASH (Box 3).

Partnerships with marginalised groups

There is a clear need for the WASH sector to **build partnerships** with other sectors both locally and globally. This may be with representative organisations of disadvantaged groups such as women's associations, disabled people's organisations (DPOs)

Box 3   Recent capacity building experiences

World Vision UK started to practically address disability inclusion in programming work in 2006 with disability awareness training of UK program staff. This was followed by disability awareness training for over 100 staff in their Ethiopia program (WVE), who then delivered this training to over 700 people in their regions throughout the country. This improved staff understanding of why disabled people need to be included, but they desired more support on how to change the way they work in WASH, and what to do differently in practice. To this end, a series of short in-country training courses were run by the Water, Engineering and Development Centre (WEDC) at Loughborough University specifically for WVE WASH advisers, infrastructure officers and local government partners, on how to make water and sanitation accessible and inclusive.

The result of the training has been that participants have begun to modify the designs of communal and school latrines. The first of these facilities are in use and the effectiveness of the designs is now being monitored. WVE WASH Division recently held a consultative meeting with disabled people's organisations (DPOs), government and disability organisations on a draft design of Disability Inclusive Latrines, which will be submitted to the government for approval.

UNICEF has initiated webinars on Accessible School Sanitation for staff globally, with presentations based on practical experience from WaterAid, World Vision Ethiopia and WEDC; the sessions have involved over 50 participants.

WSSCC have also just released an interactive module on Inclusive WASH on the DVD that is being distributed with the report of the Global Forum on Sanitation and Hygiene.

or associations of the elderly, or this may be service providers with expertise in provision for disadvantaged groups such as children, people living with HIV, disabled or older people.

Another critical lesson is that it is not just what you do, but *how* you do it and *who* you do it with. The slogan of the disability movement is "Nothing about us without us!" Users must be involved in the process of developing WASH services to make them sustainable and the WASH sector has to work with others who understand the political and the practical details of reaching excluded groups.

Pro-poor mechanisms for supply and subsidies for people who cannot pay

Social protection mechanisms and community level support structures often provide support to community members who simply cannot afford to pay tariffs, or who are physically unable to dig their own pit latrines. WASH programs need to support such mechanisms, recognising the very real challenges in communities that are impoverished and under stress from social change, climate change, and the move of young people to cities.

Equity and inclusion in WASH Monitoring

Targets and monitoring indicators influence the priorities of governments and global bodies. The failure of MDG targets to address disparities is widely recognised and demonstrated by the JMP analysis of access by wealth quintiles. WHO and UNICEF, with the Special Rapporteur on the human right to water and sanitation are now leading efforts to identify specific indicators for monitoring progress after 2015, with a strong focus on non-discrimination.

At the First Consultation on Post-2015 Monitoring of Drinking Water and Sanitation held in Berlin in May 2011, participants agreed that "the attainment of universal coverage through at least basic access to both drinking water and sanitation services should be reflected in the future targets."(WHO/UNICEF 2011) Indeed, among participants, there was almost unanimous agreement that the future target should be "Universal access to sustainable and equitable drinking water and sanitation services." (WHO/UNICEF 2011, 2)

Human rights criteria can be applied to monitor implementation of WASH, namely that services are:

» Available

» Safe

» Acceptable

» Accessible, and

» Affordable.

Further, cross cutting criteria apply, namely that services are guaranteed without discrimination; ensure participatory processes are followed; and that institutions are accountable to users. These criteria are already being applied by the groups working on global and national monitoring; and can be adapted for program level planning, monitoring and evaluation frameworks. At the program level, planning, monitoring and evaluation can also increase attention on the unserved, by ensuring baseline surveys and monitoring focuses on excluded groups.

Addressing social barriers

Negative attitudes can be effectively addressed, not as a separate issue, but incorporated into practical implementation. Seeing disadvantaged people not only as beneficiaries but as active participants in their own development, e.g. by ensuring that consultation processes proactively seek and respect the views of the marginalised and powerless, can be pivotal to changing attitudes, both of the community and of disadvantaged groups themselves.

For example where women play a more substantial role in decision making, and managing water and sanitation programs, they have gained more respect and influence generally. Hygiene education that addresses myths and taboo issues around HIV, disability and menstruation can also help to reduce attitudinal barriers.

Providing information about practical solutions also reduces attitudinal barriers by reducing fear and making service providers feel confident that they can do something to increase access.

Strengthening demand for access from excluded groups

Generations of exclusion and marginalisation make it almost impossible for many groups to represent their interests effectively with service providers and governments, and this is made worse by deep-seated prejudice in society and service providers. WASH programs seeking to be inclusive need to recognise the power dynamics and use approaches that enable the least powerful voices to speak out and challenge political neglect. Grass roots organisations working with marginalised tribal groups in India have supported people to effectively demand water and sanitation provision from local government. It can also be difficult to get access to the most socially excluded groups. For example WaterAid in Bangladesh had to negotiate with existing hierarchies to start working on WASH programs for tea pickers.

Finally, prioritising the rights of marginalised groups means challenging the status quo. Traditionally WASH providers may underestimate the importance of power relations, and consider themselves as technicians. But in the words of Paulo Freire, "washing ones hands of the conflict between the powerful and the powerless means to side with the powerful, not to be neutral." (Freire 2005) Inclusive WASH means empowering marginalised people to speak out about their WASH issues. This involves negotiating access to the powerless and working with them to increase their power.

Conclusion

We know that a large number of people are not benefiting from WASH provision, many of whom are among the most disadvantaged in the community. There are strong reasons for improving access and inclusion, not only in terms of the social benefits, but it can also make a positive contribution to poverty alleviation and economic development.

Experience shows that WASH programs can be designed to address all the barriers, at least to some extent. Technically it is not difficult to improve accessibility, which may be why most practitioners have started by addressing physical barriers. Good design and location of services can overcome most physical obstructions. The more difficult challenges are posed by institutional and social barriers in WASH provision.

The creation and implementation of non-discrimination policies can help to institutionalise a more inclusive approach to WASH. Increased voice and better representation of marginalised people, and efforts to challenge discriminatory practices, can gradually shift attitudinal barriers.

Programs need to address all the barriers, and recognise that attitudes are often the hardest to shift. Evidence is showing that increased advocacy and information provision, together with training of service providers, will help to reduce prejudice, increase awareness of the different needs and solutions, and raise demand for improved services that are accessible to all.

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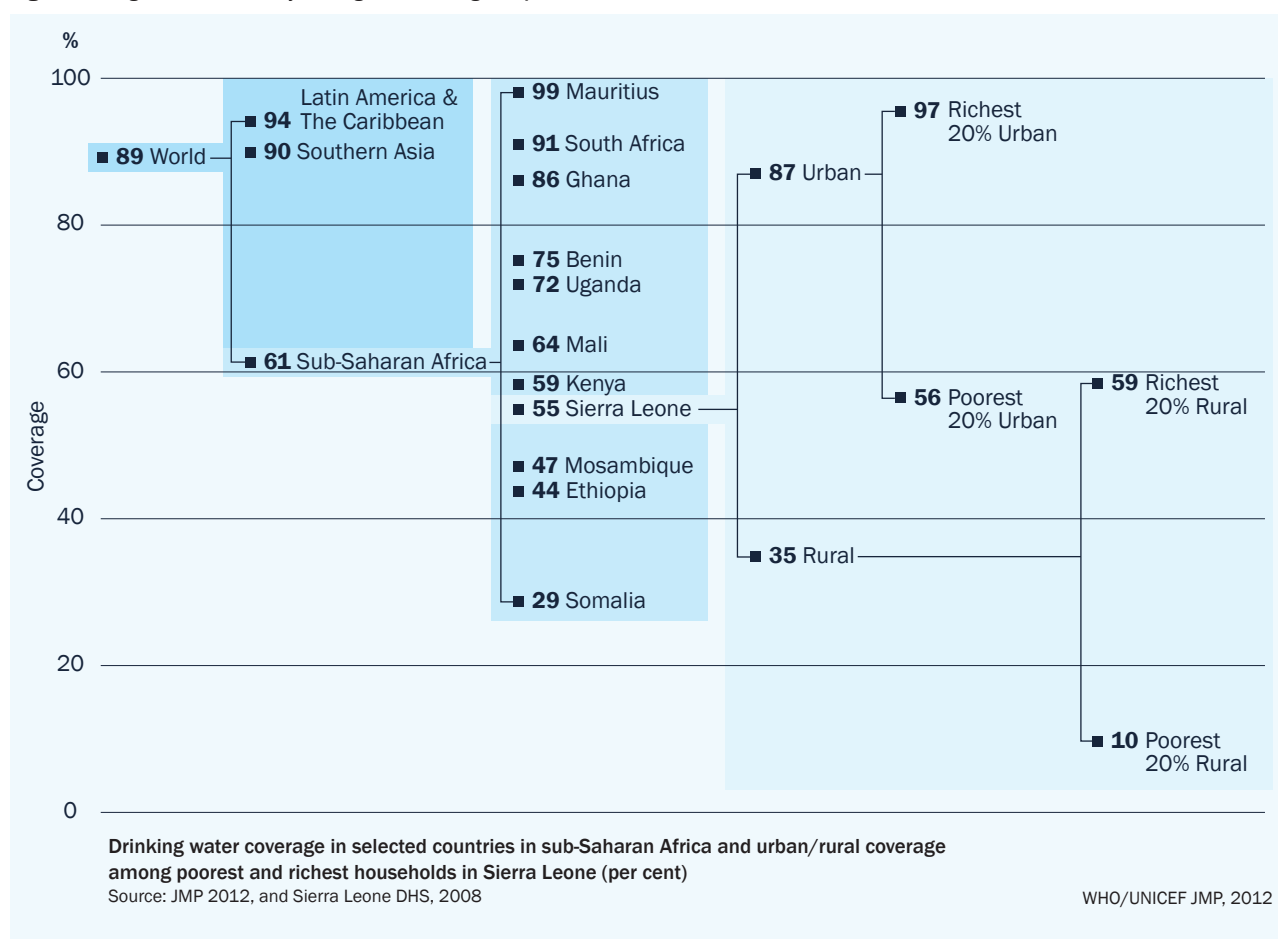
Analysis—Sharing experiences on equity and inclusion

In 2011/12, the Australian WASH Reference Group chose Inclusive WASH to be the focus of its work as a Community of Practice. The aim of this work was to provide practical skills and evidence to support practitioners' implementation of WASH projects that address the needs of all in the community. This work was supported through the AusAID NGO Cooperation Program (ANCP) Innovations Fund. This publication represents the final output of this program, and it is being disseminated in conjunction with learning workshops in Australia and an online learning portal and resource library for WASH and public health practitioners (www.inclusivewash.org.au). The task of putting this learning into practice now begins.

This publication is a record of efforts to achieve equity and inclusion in WASH programming around the world. It includes one keynote paper and 16 case studies from 13 countries. Within its pages there is a clear message that 'business as usual' is not sufficient to meet the water and sanitation rights

of traditionally excluded or marginalised groups. The case studies are therefore a story of adaptation—of technology, of process and of policy—and innovation to try something new. The editors of this publication asked authors to think about the sorts of challenges their programs did or did not address, whether they were individual, environmental, institutional or attitudinal. Case studies have been collected from across the sector (see pages 22-23) with examples from urban, rural and school programming.

Authors are from a wide range of organisations: local and international NGOs, disabled people's organisations, universities and donor programs. The majority of case studies come from South Asia and Southeast Asia, with a few from sub-Saharan Africa and the Pacific. The case studies feature work with people who persistently miss out on the benefits of development programs, including those people living with HIV, people with disabilities, female headed households,

Figure 1 Regional and country averages mask huge disparities

Drinking water coverage in selected countries in sub-Saharan Africa and urban/rural coverage among poorest and richest households in Sierra Leone (per cent)
Source: JMP 2012, and Sierra Leone DHS, 2008

WHO/UNICEF JMP, 2012

children and older people. For the purposes of organisation case studies have been divided into four themes, depending on which group of people they were focussed on—(i) disability, (ii) HIV and AIDS, (iii) gender and (iv) the poorest of the poor. The last theme is an articulation of how within poor communities many people face additional challenges that exclude them from water and sanitation for a variety of reasons. These can include their caste, remoteness, lack of tenure and profession.

Many of the case studies in this publication address the needs of people from more than one of these four themes. Likewise many people face discrimination for one or more of these reasons. These crossovers are acknowledged in the table on pages 22-23.

Why does Equity and Inclusion matter for WASH?

There is a growing body of work that suggests the current approach to measuring progress inadequately reflects the unequal distribution of development successes. For all of the MDGs, indicators are consistently worse for disadvantaged groups[1]—including remote districts, lower caste and among ethnic minorities. In the Joint Monitoring Program's 2012 update,[2] a strong case is made for looking beyond average progress rates to understand the extent that the poor are missing out on access to water and particularly sanitation, where negligible progress has been made among the poorest wealth quintiles in some countries, particularly in rural areas (Figure 1 and 2).[3,4] Additional limitations to monitoring include the under counting of vulnerable populations—including people with disabilities and those living in urban slums—who are most likely to lack improved water and sanitation facilities.

Many suggestions have been made as to how the development sector can make post-2015 development targets reflect inequality, such as measures weighted by poverty quintile, and provide incentives for actors to focus on reaching the poorest of the poor.[5] The literature shows that improvements in sanitation for poorer households bring significantly larger benefits for health (especially children's

health) than similar interventions among the richest quintiles.[6] Therefore there are additional reasons for explicitly directing WASH interventions to these groups.

In this publication's opening paper, Hazel Jones and Louisa Gosling provide a compelling overview of why the poorest households should be front-of-mind for practitioners, and why barriers to WASH access seem to persist for certain groups. What follows is a series of case studies that consider strategies to move beyond these challenges and ensure access for all.

Figure 2   The poorest per cent of the population in Southern Asia have barely benefited from improvements in sanitation

Southern Asia: Sanitation coverage trends by wealth quintiles, based on population-weighted averages from three countries, 1995-2008
Source: India: National Family Health Survey 1993, 1999, 2006; Bangladesh: DHS 1993, 1997, 2000, 2004, 2007; Nepal: DHS 1996, 2001, 2006

WHO/UNICEF JMP, 2012

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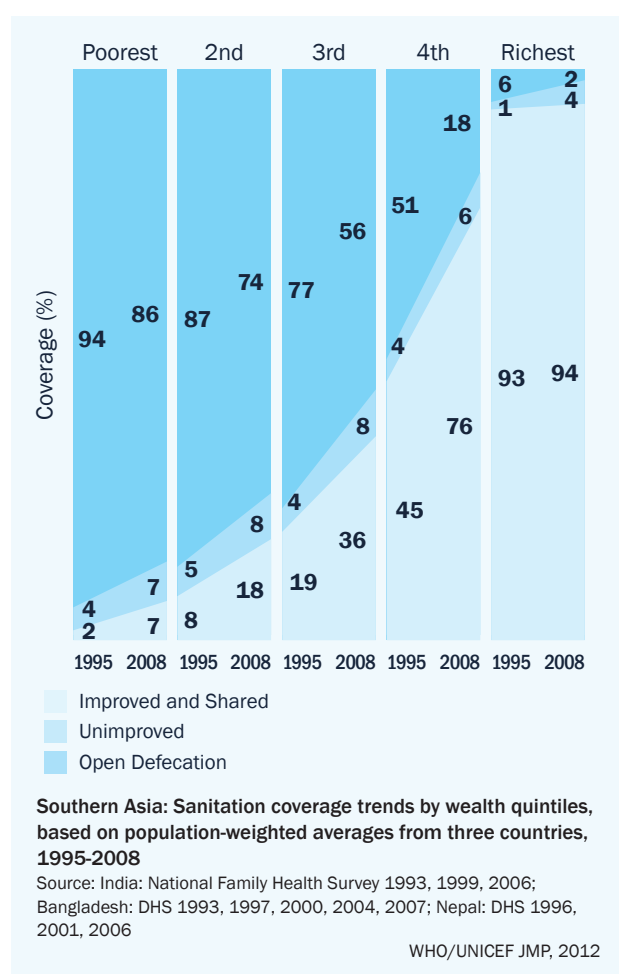
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[4] UNICEF and WHO (2012) op. cit.

[5] Melamad C. (2012) op. cit.

[6] Rheingans, R., Cumming, O., Anderson, J. and Showalter, J. (2012) op. cit.

Lessons learned from Inclusive WASH case studies

These case studies reflect the WASH sector's enthusiasm for trialling and refining approaches to equity and inclusion. Four lessons are outlined below that represent the key lessons from the case studies:

Lesson 1

Think about all the barriers (physical, institutional and attitudinal) when designing a WASH program.

Good design and the location of services can overcome most *physical* barriers that prevent many people from accessing water and sanitation facilities (for example see case studies 4, 5, 8, 9, 10, 11 and 12). The creation and implementation of inclusive policies and processes can help to overcome institutional barriers to access including ensuring the better representation of marginalised people in decision-making (see case studies 1, 7, 8, 10, 13, 15 and 16). Measures that ensure an increased voice of marginalised people along with efforts to challenge discriminatory practices can gradually shift *attitudinal* barriers (see case studies 1, 2, 3, 4 and 6).

> For examples of programs that have incorporated measures to simultaneously address physical, institutional and attitudinal barriers see case studies **1, 2, 7, 10 and 11**.

Lesson 2

Addressing stigma is core to the design of an effective inclusive WASH program, as attitudes are often the hardest barrier to overcome.

In many cases even after physical and institutional barriers have been remedied, attitudinal barriers (of the community, of the family, of the authorities) can remain the biggest challenge to universal access to WASH. Stigma lies at the heart of these attitudes and understanding stigma is a good starting point for generating strategies to tackle these attitudes.

> For examples of programs that have tried to address stigma see case studies **2, 3, 4, 7 and 10**.

Lesson 3

To make progress on equity and inclusion, a 'twin track' approach is required, using both mainstreaming and targeting.

Mainstreaming inclusion ensures the approach to WASH is based on non-discrimination and respect for human rights. Meanwhile targeting inclusion to specific vulnerable groups helps everyone's understanding of specific issues of discrimination such as gender, disability, HIV and age. Ultimately this will improve the delivery of programs to these groups.

> For examples of programs that apply a twin track approach see case studies **2, 3, 4, 6, 14 and 15**.

Lesson 4

It is critical that implementing organisations understand and support concepts of inclusion at the outset.

There are many examples of well-intentioned programs that fail to meet the users' needs because of a lack of real commitment, understanding and knowledge by the people who are responsible for constructing, maintaining and managing facilities on a daily basis. Similarly, those implementing programs benefit from a clear understanding of the value of inclusion and from the support of the managers and organisations. For organisations there is value in working closely with disabled people's organisations (DPO) to build staff and stakeholders' familiarity with people with disabilities (PWD) (case studies 10 and 7). Likewise the importance of communicating gender concepts and training male and female gender focal points as facilitators cannot be understated (case study 11), nor can the importance of having women staff in key technical roles (#15) and an organisation-wide focus on improving gender outcomes (#16).

> The following case studies have successfully understood and integrated inclusive WASH into their program delivery and organisational processes: **7, 8, 10, 11, 13, 15 and 16**.

How does this publication work?

This publication includes summaries of each of the case studies. Once you have chosen which case study you would like to read, please download the full paper from the enclosed CD or from the companion website www.inclusivewash.org.au/case-studies. Supporting materials for some of the case studies (websites, reports, tools and videos) are also available on the website and on the CD.

Snapshot of the case studies

Key to Symbols

	Poorest of the Poor		HIV and AIDS		Disability		Gender

No.	Organisation	Case study name	Location(s)	Theme	Location of change
1	WAB	Where no one has worked before: Innovations behind WaterAid's WASH work in Bangladesh tea garden communities	Bangladesh	[Poorest of the Poor, Disability]	[tree]
2	NEWAH	WASH is a connector, not a divider: An Inclusive WASH case study	Nepal	[Poorest of the Poor, HIV and AIDS, Disability]	[tree]
3	SNV	Pro-poor support mechanisms to accelerate access to improved sanitation and hygiene for all in rural Bhutan	Bhutan	[Poorest of the Poor, Disability]	[tree]
4	WSUP	Toilet design clinics in Naivasha, Kenya	Kenya	[Poorest of the Poor, Gender, Disability]	[book]
5	ATprojects	The Living with Dignity Program in Papua New Guinea	PNG	[HIV and AIDS]	[tree]
6	WaterAid in India / Create	Water, sanitation and hygiene for arresting opportunistic infections for people living with HIV and AIDS	India	[HIV and AIDS]	[buildings, tree]
7	WaterAid in Timor	Building skills in disability inclusive WASH: Perspectives from a DPO in Timor-Leste	Timor-Leste	[Disability]	[tree]
8	AusAID	Inclusive WASH facilities and the Indonesian Education System: Influencing policy to achieve results	Indonesia	[Disability]	[book]

	Rural		Urban		School

No.	Organisation	Case study name	Location(s)	Theme	Location of change
9	Handicap International	Access to WASH for people with disabilities in the locality of Madiakuy	Mali	♿	🏭
10	CDD	Disability inclusive flood action plan and WASH in a Bangladeshi community	Bangladesh	♿	🌳
11	Handicap International	Access to drinking water for people with disabilities in the town of Tenkodogo	Burkina-Faso	♿	🏭
12	EwB and LLEE	Designing gender-sensitive sanitation for floating villages	Cambodia	🧍🧍✋	🌳
13	IWDA	Putting a gender lens on WASH practice in Liquica, Timor-Leste	Timor-Leste	🧍🧍	🌳
14	Oxfam	Women's WASH platforms in Bangladesh and Cambodia	Cambodia; Bangladesh	🧍🧍	🌳
15	SNV/Plan/ISF	Working from strengths: Plan and SNV integrate gender into CLTS and hygiene approaches in Vietnam	Vietnam	🧍🧍✋	🌳
16	Plan	Working towards gender-responsive WASH at the organisational level	Vietnam	🧍🧍	N/A

Case study summaries

Poorest of the Poor

"...to be able to do these things, which I could not do in the past, gives me immense pleasure."

Biswa, older person with sight disability, Nepal

Amanda Binks, Engineers Without Borders Australia

Living with HIV & AIDS

"Those who have observed regular hygiene practices of hand washing at critical times and drinking safe water are much healthier than before."

Poonam, 30 years old, India

Mr Sanjay, CREATE

Disability

"We feel that our dignity is stripped each day when we need to depend on others to use the toilet."

A woman interviewed from Sreepur, Nepal

Gender

"...(Before) there was so much disease and more than 200 deaths one year."

A WWP member from Kratie, Cambodia

Amanda Binks, Engineers Without Borders Australia

Aiden Dockery, SNV

Poorest of the Poor

Disability

Where no one has worked before:
Innovations behind WaterAid's WASH work in Bangladesh tea garden communities

Shamim Ahmed

WaterAid in Bangladesh

WaterAid in Bangladesh

WaterAid in Bangladesh
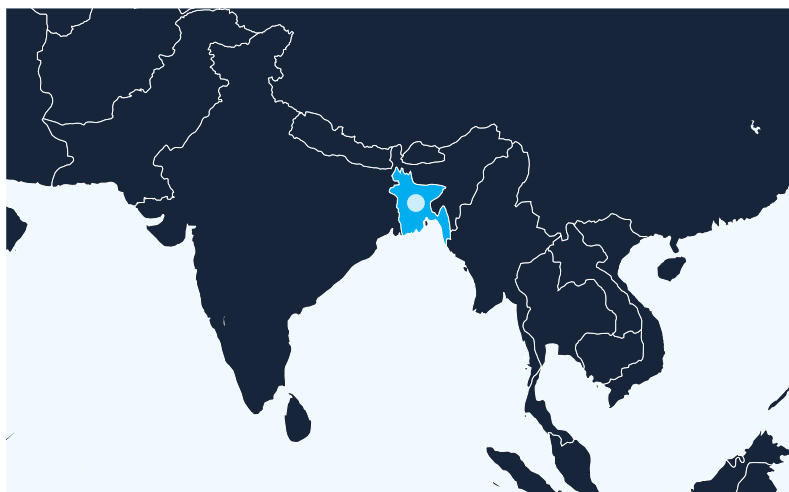
Summary

Considered to be one of the most vulnerable and marginalised groups in Bangladesh, the tea pickers of the northeast have historically eluded development interventions. Tea pickers reside in communities within the large tea estates, and are beyond the reach of government or non-government organisations (NGOs). WaterAid in Bangladesh and local partner IDEA explain how they have successfully brought water, sanitation and hygiene (WASH) to the tea pickers and their community despite the institutional and attitudinal barriers of tea garden managers and owners. The program inspired the construction of community latrines and developed resource centres to engage adults, teenagers and children in WASH issues using theatre, music, discussion, play and literature.

This program is a remarkable example of how practitioners can use persistent advocacy and innovative approaches to reach communities that otherwise lie beyond mainstream development activities. Lessons from this program have also been incorporated into a report by the UN Special Rapporteur on the human right to water and sanitation.

Case Study 01

WASH is a connector, not a divider:
An inclusive WASH case study

Bhagwati Sapkota, Bharat Bhatta, Mana Wagle Ballav, Dinesh Upreti and Amanda Binks

Nepal Water for Health (NEWAH) and Engineers Without Borders Australia

Poorest of the Poor

Disability

Living with HIV & AIDS

Summary

Residents of Nepal's remote hill areas face a number of difficulties in accessing WASH services. Socially excluded and ultra-poor community members in particular face some formidable barriers. In this paper, NEWAH, Nepal's leading WASH NGO, presents a range of tools and approaches that they have used to guide their inclusive WASH program and ensure that every community member is served appropriately and with sensitivity. These approaches include detailed household surveys, community mapping, well-being rankings and graded contribution requirements.

This paper uses the example of three households in Nepal facing the challenges of disability or HIV and AIDS to demonstrate how this approach has successfully addressed various institutional, stigma and environmental factors to facilitate their ability to access WASH. It offers strategies for practitioners who are considering a similar community-led approach to their equity and inclusion work.

Supporting Resources

» Nepal Water for Health (NEWAH) (2007) Gender and Social Inclusion Strategy (GSI), May 2007

» Equity and Inclusion data collection tools from NEWAH's baseline survey

Amanda Binks, Engineers Without Borders Australia

Case Study 02

Poorest of the Poor

Disability

Pro-poor support mechanisms to accelerate access to improved sanitation for all in rural Bhutan

T Choden and L Levaque
SNV Bhutan

Phurpa Thinley, LNW Consulting

Phurpa Thinley, LNW Consulting

Summary

In the remote area of Lhuentse in Eastern Bhutan, lack of access to improved sanitation and a high incidence of poverty continue to persist. SNV Bhutan, together with the Rural Sanitation and Hygiene Programme of the Ministry of Health, collaboratively engage in qualitative research to identify support mechanisms to assist people living in poverty to meet their aspirations for improved hygiene and sanitation.

This paper highlights an approach that employs a research methodology based on inclusion and participation, which allows communities to define their own access barriers and suggest possible solutions for improved sanitation. This community reflection results in raised awareness of the collective responsibility for sanitation, promotes the mobilisation of local leaders to source materials and labour for construction, and encourages transparency at a local level by enabling open discussion.

Case Study 03

Toilet Design Clinics in Naivasha, Kenya

Gertrude Salano

Water and Sanitation for the Urban Poor (WSUP)

Summary

The design of sanitation technologies for the urban poor should not only be sustainable but also address the specific needs of the target community. In Kenya, Water and Sanitation for the Urban Poor (WSUP) document their experiences with the development of sustainable sanitation models for the urban poor community through participatory meetings with marginalised groups. Known as Toilet Design Clinics, these meetings locate the needs of women and girls at the centre of sanitation infrastructure planning and design.

This paper highlights the contribution that school children can make to WASH design, despite normally being left out of the planning process. In this case, students proposed a number of creative and innovative solutions to improve sanitation at their school.

Design clinics have also been extend to consider latrine design in households and public spaces that meet the needs of women, people with disabilities, the elderly as well as religious groups.

WSUP

WSUP

Case Study 04

The Living with Dignity Program in Papua New Guinea

Steve Layton and Belinda Atchison
ATprojects Inc.

ATprojects

Summary

HIV and AIDS related illness is a growing epidemic in rural Papua New Guinea (PNG). By 2009 the cumulative number of HIV infections in PNG according the National AIDS Council was 34,100 (2010) but anecdotal evidence suggests this figure is now much higher. This paper explains how local NGO Appropriate Technologies (AT) projects has worked with people living with HIV and their carers to identify their households' WASH needs and collectively develop technology solutions to improve WASH access.

The case study looks at two resources developed by ATprojects under their Living with Dignity program: a personal hygiene kit and a portable water catchment. This paper describes the innovative and collaborative 'touch, feel, smell' design process that informed the development of these practical technology solutions. ATprojects demonstrate how effective and transportable design, staff training and the local sourcing of materials can be successfully used to meet the WASH needs of people living with HIV but also help them cope with discrimination due to social stigma.

Supporting Resources

Supporting video resources from the 'Real Options Series':

» **AIDS em wanem?**
ATprojects in partnership with the Catholic Family Life (Goroka) have filmed people living with HIV, their care givers, family members and people in the community who are involved in working with positive people. The aim of the project is to illustrate the challenges that people who live with HIV and AIDS and their care givers experience including: water supply access; difficulties in hygiene; lack of access to medical services and supplies; and care givers' experiences with coping and caring.
(Duration 35:26)

» **Living with dignity**
This film shows the development process that ATprojects used to design its range of simple household WASH resources for people living with HIV. The 'touch, feel, smell' method is shown as well as the components of the personal hygiene kit and prototype portable water catchment designs. Attitudinal barriers are also depicted in the film: Michael Dengi, a Provincial AIDS Coordinator, talks about how he had to break with traditional custom. Michael was the only person willing to wash and prepare a young women's body (who had died from AIDS) for burial. The young women had been abandoned by her family, and the staff of the hospital where she died were unwilling to help.
(Duration 21:28)

Case Study 05

Water, sanitation and hygiene for arresting opportunistic infections for people living with HIV and AIDS

KJ Rajeev

WaterAid in India

Summary

In line with WaterAid's equity and inclusion framework, WaterAid in India has sought to reduce barriers for improved access to sustainable WASH services for people living with HIV and AIDS in Uttar Pradesh, India.

The main objective of the program was to increase participants' understanding of and access to WASH. The program developed numerous information, education and communication materials aimed at behaviour change among HIV positive people. Another activity was to provide people living with HIV with WASH information and resources, such as chlorine tablets and hygiene kits, and through WASH corners at the community care centres where they were already receiving clinical care and treatment. The program also aimed to improve understanding among the health, HIV and AIDS and WASH sectors of the benefits of promoting WASH as a risk prevention measure for opportunistic infections among people living with HIV and AIDS and their carers. WaterAid in India recently joined the Red Ribbon Express—an HIV and AIDS advocacy train that crossed India—to further disseminate messages on HIV and WASH.

The program's innovative approach has had remarkable success in raising awareness of the link between WASH and opportunistic infections. This paper offers a great example for practitioners seeking strategies to work with the HIV community on WASH issues.

J. Jaiseelan, WaterAid in India

Mr Sanjay, CREATE

Case Study 06

Disability

Building skills in disability inclusive WASH:
Perspectives from a DPO in Timor-Leste

Joel Fernandes, Huy Nguyen and Sophie Cooke
WaterAid in Timor-Leste

WaterAid in Timor-Leste

WaterAid in Timor-Leste

Summary

Agencies working within the WASH and disability sectors in Timor-Leste organised a visit from Huy Nguyen, an engineer and wheelchair user from Australia, in order to assist with understanding how the needs of people with disabilities could be incorporated into WASH projects, especially in rural areas.

A limited awareness of the rights of people with disabilities and persistent poverty are identified as key barriers to inclusive WASH in Timor-Leste. However, the authors demonstrate that an approach that embraces inclusive standards for WASH policies, capacity-building through training workshops, committed advocacy and awareness campaigns as well as the promotion of accessibility, can positively transform community attitudes.

This paper presents a great example of how WASH organisations can work with disabled people's organisations (DPOs) as partners throughout their programming, both within communities and also with project staff and government to build the sector's capacity to respond to and understand the WASH needs of people with disabilities (PWD). Likewise, the project is an example of how the sector can build the capacity of DPOs to consider WASH in their daily interactions with PWD and advocacy work.

Supporting Resources

» BESIK (2011) Accessible tap stand technical notes for facilitator

Case Study 07

Inclusive WASH facilities and the Indonesian education system:
Influencing policy to achieve results

Isradi Alireja and Brian Spicer

AusAID

Summary

Indonesia's commitment to provide education for all Indonesian children has regularly overlooked issues facing children with disabilities, including lack of accessible latrines at public schools. The Australian Government through AusAID has expressed a commitment to meeting this need through the Australia-Indonesia Basic Education Programme 2006-2010.

This paper explains how the Indonesian Ministry of National Education and Religious Affairs was supported to integrate accessible toilets and install hand-rails to encourage school attendance for children with disabilities. Through its program, AusAID supported the Government of Indonesia to develop a national inclusive education policy, which includes WASH components.

This paper presents a successful example of how donors can advocate for policy change to improve accessibility for children with disabilities. Changing a government's policy on inclusive school design is a critical institutional milestone towards inclusion. However, this case study also shows that attitudinal barriers are equally significant when it comes to policy implementation.

Awalia Murtiana, AusAID Jakarta

Awalia Murtiana, AusAID Jakarta

Case Study 08

Disability

Access to water, hygiene and sanitation for persons with disabilities in the locality of Mandiakuy (Tominian Circle in Mali)

Cathy Dimbarre Kpehounton and Etienne Honoré Toe
Handicap International/Projet DECISIPH

Handicap International Mali

Handicap International Mali
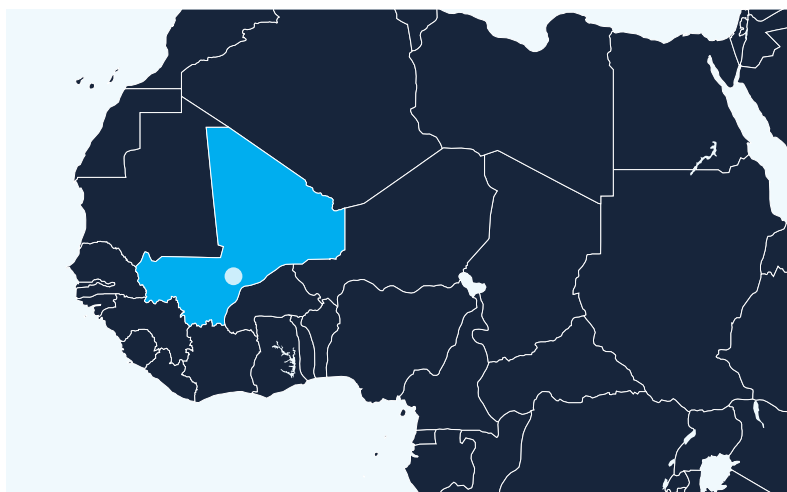
Summary

Through this WASH project, Handicap International, working in partnership with a local DPO and Messiah College, demonstrate actions that enabled people with disabilities (PWD) to gain independence to meet their own WASH needs in a small Malian city. Recognising the persistence of physical accessibility barriers, the project supported the population of Mandiakuy, including PWD, to design and construct accessible water sources and community latrines. The project also developed and disseminated technological solutions to support PWD to transport water jerry cans to their homes and manoeuver them for domestic use.

This paper demonstrates the importance of creating a network of advocacy groups. Also contributing to the success of the partnership was the sourcing of local materials for the purposes of construction. Lastly, this paper shares an important lesson for inclusive WASH programming—technological solutions that improve access to water sources can often face problems of sustainability if the more difficult barriers of stigma and discrimination against PWD are not simultaneously addressed.

Case Study 09

Disability inclusive flood action plan and WASH in a Bangladeshi community

Nazmul Bari and Broja Gopal Saha

Centre for Disability in Development (CDD)

Summary

While promoting disability inclusive water, sanitation and hygiene (WASH) is challenging at the best of times, environmental upheaval and floods add to this complexity, further restricting people with disabilities' (PWD) ability to access water and sanitation. This paper describes the pilot project Disability Inclusive Disaster Risk Reduction, which integrates disaster risk and reduction (DRR) into inclusive WASH programming.

Led by a local non-government organisation (NGO), this program was able to include PWD from the beginning, giving them the skills, confidence and assistive devices to support their participation in disaster preparedness planning. The project also acknowledged the need to involve the wider community. Guidance on the issues PWD face around WASH access was incorporated into existing community training on disaster risk reduction. As a result, the community jointly surveyed latrine locations, identified and installed appropriate tubewell technology, designed an accessible rescue boat and renovated homes and shelters to include accessible and flood-proofed water and sanitation infrastructure.
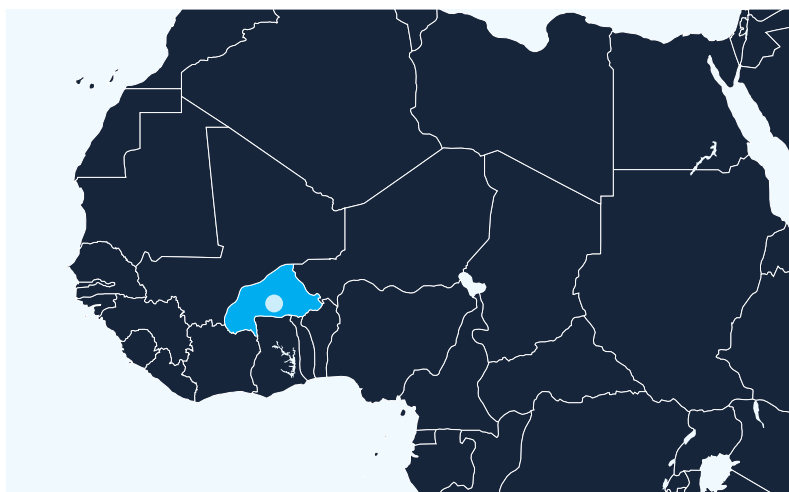
Broja Gopal Saha, CDD

CDD

Case Study 10

Disability

Access to drinking water for people with disabilities in the town of Tenkodogo (Burkina Faso)

Cathy Dimbarre Kpehounton and Dao Moussa Serge
Handicap International/Projet DECISIPH

Summary

In Burkina Faso, people living with disabilities are typically dependent upon family members for their water needs. Social stigma can compound environmental challenges and lead to their exclusion from independently accessing WASH services. WaterAid explains how Dakupa, a local NGO, has addressed environmental and institutional barriers in order to improve access to water sources for people with disabilities in one town. Solutions involve a combined effort to construct physical ramps, standpipes and handrails, and to mobilise local stakeholders committed to rights campaigning for people living with disabilities. This paper also discusses specific construction and sustainability challenges, including non-compliance with technical specifications.

HI-Burkina, Handicap International

HI-Burkina, Handicap International

Case Study 11

Designing gender-sensitive sanitation for floating villages

JM Hagan, Rob Hughes and Jady Smith

Engineers Without Borders Australia, Live & Learn Environmental Education

Summary

Floating communities on Cambodia's Tonle Sap Lake face a unique set of geographical circumstances when designing appropriate sanitation solutions for men, women and children. In this context, Engineers Without Borders Australia together with Live & Learn Environmental Education present their experiences with community-led approaches to sanitation design, including the benefits of gender segregated meetings. This paper offers examples of the practical solutions developed by community members when designing latrines that are appropriate for children, as well as men and women. It also highlights the ongoing barriers project staff face in challenging the community's views towards the importance of menstrual hygiene management facilities, particularly in schools.

Interestingly, the community's location in a world heritage listed area meant that National Park Rangers and other environmental advocates were also stakeholders in this project. Because of the environmental sensitivity of the project site, the project had a heavy focus on faecal management.

Supporting Resources

» Hagan, J (2009) *Intimate explanation of sanitation practices in Cambodia – from Live & Learn Women's Forum*, Tonle Sap Floating Latrine Project Cambodia, Live & Learn/ Engineers Without Borders, 1 September 2009
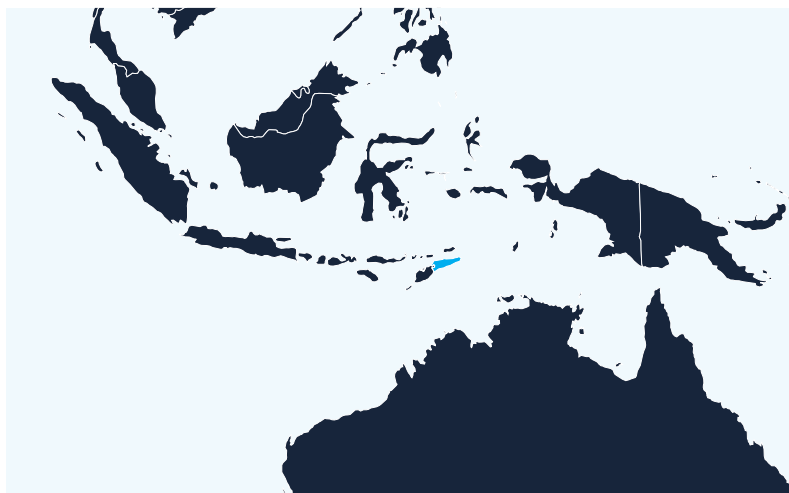

Judy Hagan, Engineers Without Borders Australia

Judy Hagan, Engineers Without Borders Australia

Case Study 12

Gender

Putting a Gender Lens on WASH Practice in Liquica, Timor-Leste

Di Kilsby

International Women's Development Agency (IWDA) with input from staff of WaterAid Australia and Timor-Leste

Di Kilsby, IWDA

Di Kilsby, IWDA

Summary

The integration of gender in water, sanitation and hygiene (WASH) is a key objective in WaterAid's programming in Timor-Leste. This paper reflects on the partnership between a WASH-specialist agency (WaterAid) and a gender-specialist agency (IWDA) and their efforts to combine community-driven gender equality into WASH programs.

The paper describes enabling factors and practical tools that have led to positive gender outcomes for WaterAid's work in Timor-Leste. These factors include the role of female and male gender focal points, wider organisational support for gender, and training for all field staff on gender concepts. Demonstrable changes in attitudes towards gender in WASH are revealed both at an organisational level and among communities in the field. This partnership strategy offers practical tools for integrating gender into programs and reflects on ongoing challenges.

Supporting Resources

» Kilsby, D (2010) *'Now we feel like respected adults': Positive change in gender roles and relations in a Timor-Leste WASH program*, Research conducted by IWDA, WaterAid in Australia and WaterAid in Timor-Leste, June 2010.

Case Study 13

Women's WASH Platforms in Bangladesh and Cambodia

Karen Greene, Gaetano Romano and Golam Morshed
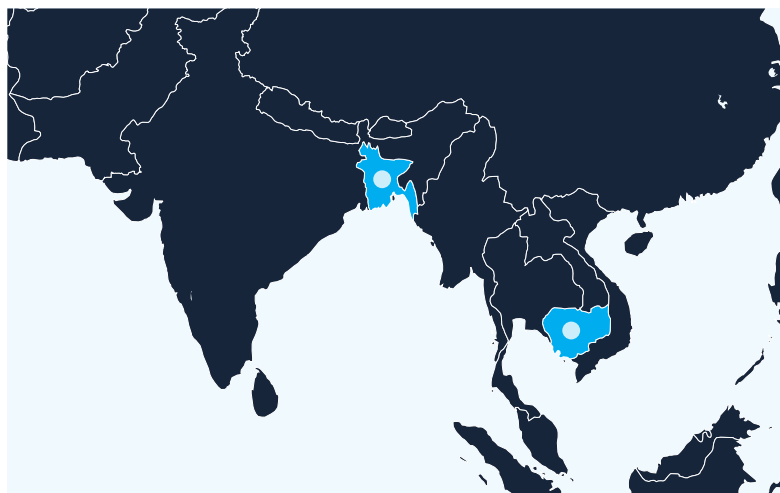
Oxfam

Summary

Women's WASH Platforms seek to mobilise volunteer groups of women in rural communities to receive training and small grants so they may undertake their own WASH projects, share lessons and engage in advocacy. Oxfam Australia recently conducted a comparative review of the relative success Women's WASH Platforms have had in two countries, Bangladesh and Cambodia. In both countries the projects aimed to empower the community to address gender imbalances in WASH and contribute to the decision-making capacity of women and girls.

This paper presents an interesting side-by-side analysis of the cultural nuances that can affect WASH programming of this type and more broadly programs with a strong gender focus. It offers practical examples of how different Women's WASH Platforms perform in different contexts and is useful for practitioners considering a similar approach in their own work.

Supporting Resources

» Greene, K (2011) *Review of Oxfam's Women's WASH Platforms in Bangladesh and Cambodia*, Prepared for the Water and Sanitation Initiative, AusAID CSO WASH Fund. Oxfam Australia. 31 December, 2011

» Video: Oxfam (2011) *Women's WASH Platforms – Improved access to WASH in the River Basin and Coastal Regions of Bangladesh*

» Worksheets: (1) Wall of barriers and (2) Breaking down barriers to WASH

Oxfam Bangladesh

Oxfam Cambodia

Case Study 14

Gender

Poorest of the Poor

Working from strengths: Plan and SNV integrate gender into community-led sanitation and hygiene approaches in Vietnam

G Halcrow, C Rowland, M Bond, J Willetts and N Carrard
Plan International, SNV Vietnam and the Institute for Sustainable Futures, University of Technology, Sydney

Aiden Dockery, SNV

Summary

Plan International, SNV Netherlands Development Organisation and the Institute for Sustainable Futures discuss how a strengths-based approach can be used to incorporate gender objectives into sanitation and hygiene programs. By applying four principles of strengths-based techniques for working effectively with women and men, the authors explain how, in the context in Vietnam, both SNV and Plan International could increase women's participation in enhanced sanitation and hygiene, improve women's decision-making capacity and promote discussion about gender roles and responsibilities in water, sanitation and hygiene (WASH).

This paper describes both the integration of the four principles into SNV's programming approach and the successful development of a gender monitoring tool based upon these four principles by Plan. The principles offer a guiding framework suitable for the development and monitoring of gender integration in WASH programmes.

Supporting Resources

» Halcrow G, Rowland C, Willetts J, Crawford J and Carrard N (2010) *Resource Guide: Working effectively with women and men in water, sanitation and hygiene programs*, International Women's Development Agency and Institute for Sustainable Futures, University of Technology Sydney, Australia.

» Researching gender outcomes in Pacific WASH Programs http://genderinpacificwash.info

Case Study 15

Working towards gender-responsive water, sanitation and hygiene at the organisational level

Lee Leong

Plan International Australia

Summary

Each year Plan International Australia (PIA) selects one crosscutting theme of focus to undertake organisational reflection and to improve practice. In 2011 this theme was gender equality. As part of this review, PIA developed a guidance diagram for its staff and programs to guide their work towards gender-responsive water, sanitation and hygiene (WASH) projects. This paper evaluates strategies that PIA has employed to build their gender in WASH capacity such as partnering with women's organisations and the use of gender policies and strategies.

This paper is useful for other organisations looking to evaluate their own practice to deliver positive gender outcomes in their WASH work. PIA shares important reflections and learnings that demonstrate why gender-responsive WASH does not happen by accident but requires approaches and lessons to be explicit.

Blick Creative

Blick Creative

Case Study 16

CD Content

The attached CD is a compilation of the materials presented in this publication. On it you will find full versions of the sixteen case studies along with supporting materials (websites, reports, tools and videos).

For more information on the supporting materials included on this CD, please refer to the relevant case study summary.

All content and supporting materials are also available for download from the Inclusive WASH website—www.inclusivewash.org.au/case-studies

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