

Water, sanitation and hygiene

A foundation of strong, resilient health systems

Global learning report
May 2022



WaterAid

Januka Bhandari, one of the liquid soap making training participants, washing her hands at the new handwashing station, Bhumlutaar health post, Kavre, Nepal. September 2020.



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Executive summary

Water, sanitation and hygiene (WASH) in healthcare facilities (HCF) is essential for providing quality care and preventing avoidable deaths. As the world faces climate change, epidemics and the ongoing COVID-19 pandemic, the need for climate-resilient, inclusive and sustainable WASH has never been more important. WASH in HCF services and behaviours need to be resilient to climate change, responsive to public health emergencies and fit to meet the diverse and changing needs of the population.

Lack of access to WASH has long undermined the quality and safety of services provided in HCF and set back progress towards universal health coverage (UHC). The COVID-19 pandemic has brought renewed focus on health systems and HCF, as well as highlighting gaps and inequalities globally. It has underlined that WASH services and behaviours in HCF are a prerequisite for infection prevention and control (IPC), for the safety of health service users and health workers, and fundamental for strong and resilient health systems that can deliver

quality healthcare during times of crisis. We need to urgently address the WASH crisis in HCF to improve the quality of health services and behaviours, strengthen pandemic preparedness and create resilient health systems.

Where WASH does exist in HCF, it is often underperforming or poorly managed. Poor sustainability of WASH is likely to be worsened by climate change impacts, devastating health systems, interrupting routine services and overwhelming HCF infrastructure – including WASH. Strengthening the systems required to maintain and restore WASH in HCF is imperative to ensure frontline services can respond to, cope with, recover from and adapt to large public health emergencies and climate-related stresses.

This learning report is based on lessons emerging from our WASH in HCF work, across the countries in which we work. We share practical experiences of system strengthening for WASH in HCF and explore examples of where progress at district and national level has been made. We hope that by capturing lessons learned and sharing approaches that have supported success, we will show where investment and action is required in order to achieve inclusive and sustainable access to WASH in all HCF. We have been working with ministries of health (MoH) and partners to improve WASH in HCF in more than twenty countries – in some cases for more than a decade.

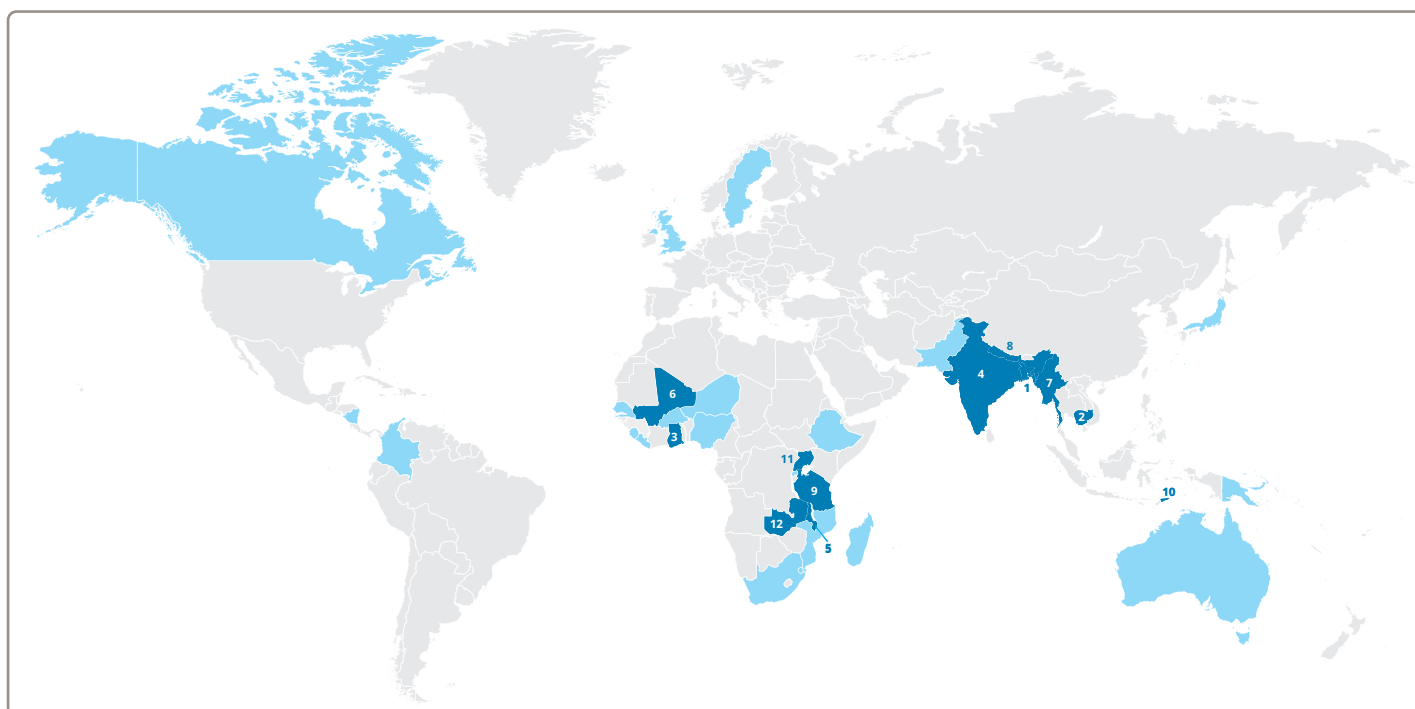
We are also building on the lessons and recommendations from our 2018 report, [***Transforming health systems: the vital role of water, sanitation and hygiene***](#). Since 2018, there has been notable progress; [**Member States of the World Health Assembly \(WHA\) adopted the world's first dedicated resolution for WASH in HCF; the first global costing estimates to achieve WASH in HCF in Least Developed Countries \(LDCs\) by 2030 have been published;**](#) and [**significant national level markers of progress have been achieved**](#)



▼ A group of children washing their hands from a homemade bamboo pipe from a spring water source in a dried up river bed. Liquica, Timor-Leste. November 2019.



WaterAid WASH in HCF country case studies



- | | | | |
|---------------|-----------|-------------|-----------------|
| 1. Bangladesh | 4. India | 7. Myanmar | 10. Timor-Leste |
| 2. Cambodia | 5. Malawi | 8. Nepal | 11. Uganda |
| 3. Ghana | 6. Mali | 9. Tanzania | 12. Zambia |

The countries in dark blue are the case studies in this report. The countries in light blue are our federation members, regional offices and country programmes.

– such as momentum towards developing costed plans for WASH in HCF and the adoption of national standards. This learning report provides an opportunity to share our lessons and be accountable for our contribution towards progress on the WASH in HCF resolution and Sustainable Development Goals (SDGs) 3 and 6.

In this report, the term 'WASH in HCF' refers to the provision of water, sanitation, hygiene, environmental cleaning and waste management services and behaviours within HCF at all levels of the health system with, as a minimum, the indicators as defined by JMP for WASH in HCF.

This learning report shares WaterAid's Theory of Change, based on our experience of working with governments and partners to improve WASH in HCF. It explores our approach to system strengthening, and how this has supported sustainable improvements in WASH

in HCF. We have gathered case studies to demonstrate how we have strengthened the technical, political and financial aspects of WASH in HCF, in partnership with governments and national and global partners. We have built links between WASH and IPC practitioners, and have worked with partners to address gaps in costed strategies for WASH in HCF.

Above all else, we have championed accountability and inclusion in WASH in HCF – strengthening the responsiveness of service providers and authorities, national and community level accountability mechanisms, and developed gender equality and social inclusion approaches to ensure WASH is available to all, in every health setting.

This report is targeted at WASH in HCF practitioners, governments, donors and WASH and health decision makers. It is not an evaluation or an exhaustive analysis of all WaterAid WASH in HCF programmes.

Recommendations



Governments, in partnership with civil society and development partners should:

- Integrate WASH in HCF as a core component in health and IPC policies, for maternal, child and newborn health, antimicrobial resistance (AMR), health security, pandemic preparedness and response programmes, and in strategies to achieve UHC.
- Incentivise cross-sectoral working and strengthen national and sub-national coordination between ministries responsible for health, finance and WASH to ensure adequate finance to support the sustainable and inclusive delivery of all aspects of WASH across the health system. Track progress against national standards on WASH in HCF within routine health monitoring systems and responsive citizen-led accountability mechanisms.
- Develop, finance and implement costed national strategies for WASH in HCF. Invest in WASH in HCF as part of broader health systems and pandemic preparedness investments, with sustainable long-term domestic and donor financing.
- Support communities to hold health and WASH duty-bearers to account for progress on WASH in HCF. This includes a commitment of time and resources (both human and financial) to scale up access to WASH in HCF and improve WASH service levels, so communities and frontline workers' demands for safe, dignified and quality care are met – and enable them to deal with shocks effectively, particularly during crises such as the COVID-19 pandemic.



WaterAid/Francis Chipanda



WaterAid/Ko Ko Htay

▲ Top: Marriam Kadangwa filling a bucket with water from a tap installed through the Deliver Life II Project, Chikwewo Health Centre, Malawi. December 2021.

Bottom: Handwashing with soap and water, in Hinthada hospital, at Hinthada township, Myanmar. March 2020.

Key lessons

National progress on WASH in HCF requires multisectoral collaboration and action – this includes government stakeholders, WASH, donors, and health practitioners, NGOs, and civil society. From our experience, we believe the following actions and approaches contribute to success (for more details see [Section 5](#)):

1. Map and understand the systemic barriers and opportunities to advance WASH in HCF to ensure interventions are relevant and impactful.
2. Partners should engage with and support government at multiple levels for decision making and action to ensure ongoing ownership of improvements.
3. Explore and define shared goals across WASH, health and other sectors.
4. Support capacity development mechanisms and processes for health and WASH workforce and government staff.
5. Generate and use country- and context-specific evidence on the status of WASH service levels and behaviours in HCF.
6. Support evidence-based design of sustainable, climate-resilient WASH in HCF services, behaviours, and delivery and management models.
7. Ensure multisector coordination between health and WASH stakeholders, across government, ministries and other stakeholders.
8. Work with communities to support and strengthen effective feedback and accountability mechanisms.
9. Adopt a people-centred approach to WASH in HCF and address barriers to health service uptake in order to uphold a people-centred approach.
10. Underpin all efforts with a focus on equitable, socially inclusive and gender responsive approaches.
11. NGO, civil society and health and WASH partners should advocate at local, sub-national and national levels of government for the prioritisation, financing, delivery and maintenance of WASH services in all HCF.
12. Convene regular reviews of the progress of health system strengthening efforts.

The structure of this report

- Section 1** Looks at our work on WASH in HCF, highlights the challenges, describes WASH and health systems, and sets out our Theory of Change.
- Section 2** Describes the approaches used to analyse and direct action to strengthen systems that are needed for sustainable, equitable WASH in HCF.
- Section 3** Explores our localised implementation for learning, adaptation and scaling.
- Section 4** Presents case studies to share our experiences of strengthening health systems for WASH in HCF from 11 countries, including evidence of change and lessons learnt.
- Section 5** Consolidates our lessons and makes recommendations for WASH and health stakeholders to support system strengthening and urgently scale up access to sustainable WASH in HCF.



Introduction

Community healthcare provider (CHCP) Nahida Aktar is giving iron tablets to Homaira, after checking her blood pressure at the Saharbarati Community clinic, Gangni, Meherpur, Bangladesh. October 2019.

Health systems worldwide strive to provide quality, equitable services that are responsive and resilient to evolving health needs. Yet the reality of constraints on health systems inhibits their ability to meet or adapt to these needs. Water, sanitation and hygiene (WASH) in healthcare facilities (HCF) – made up of five pillars: water, sanitation, hygiene, environmental cleaning and healthcare waste management – is an essential part of health systems. To accelerate gains in health outcomes and reduce health inequalities, health systems need to be fit for purpose, people-centred, evidence-informed, and resilient to climate change, emergencies and outbreaks.

Clean, safe and well-equipped HCF are critical to the achievement of several Sustainable Development Goals (SDGs); with SDG 3 aiming for good health and well-being, and SDG 6 focusing on safe water and sanitation for all.

To achieve the SDGs and targets for WASH and health, each sector must continue to recognise the relationship between access to WASH, behaviour change, IPC and health, and strengthen cross-sectoral collaboration and health systems in pursuit of Universal Health Coverage (UHC) for a fairer more equitable world.

Access to WASH is inextricably connected to human health, equality and dignity. These are clear incentives and mandates for WASH and health sectors to work together. The WASH sector cannot achieve its goal of universal, lasting access without working with the health sector and WASH in HCF stakeholders.¹ Similarly, the health sector needs to work with the WASH sector, professionals and organisations in order to deliver safe, equitable and quality healthcare.

Both the health sector and the WASH sector have shared goals to achieve and sustain healthy, disease-free populations. Within the context of WASH in HCF, there is a shared ultimate goal of improving health, quality of care and equity. This requires strong health systems that provide equitable, accessible and quality healthcare including inclusive and sustainable WASH services.

▼ Patients at the Kassena-Nankana Health Center, Ghana. October 2018.



WaterAid/Guilhem Alandry



WaterAid/Apagnawen Annankra

1. WASH in HCF stakeholders include government ministries, departments, agencies, non-governmental organisations (NGOs)/civil society organisations (CSOs) and donors implementing or funding WASH in HCF.

1.1 The challenge

WASH in HCF underpins the delivery of safe, equitable and quality healthcare, WASH services and behaviours, and is vital to reducing infections, addressing antimicrobial resistance (AMR) and saving lives. The term ‘WASH in HCF’ refers to the provision of water, sanitation, hygiene, healthcare, environmental cleaning and healthcare waste management services (including infrastructure and behaviours) within HCF at all levels of the health system.² Each of these aspects is needed in a HCF – but they are also interdependent on changes that cross-cut broader areas of the health system. These aspects cannot be improved or sustained without system strengthening action at all levels.

Despite the critical role of WASH services in quality healthcare delivery and facilitating the essential provision of infection prevention and control (IPC) (Figure 2), many HCF around the world lack these basic services. The most recent global estimates from the World Health Organization (WHO) and UNICEF indicate significant gaps in coverage, particularly in the 47 Least Developed Countries (LDCs) (Figure 1).³

Furthermore, a severe lack of data hides the full extent of the problem, particularly on sanitation, healthcare waste and environmental cleaning.³ These gaps are likely to be even greater when considering higher levels of service – such as the safe management of faecal waste and water quality – which are difficult to estimate globally due to challenges associated with data gaps.

Momentum on this issue has been growing for many years, in part driven by the first global report on the status of WASH in HCF, produced by WHO and UNICEF in 2015, which revealed an alarming situation. Since then, new partnerships and initiatives – including a number of governments championing the issue, a global call to action by the UN Secretary General in 2018, the first ever Global Taskforce on WASH in HCF and the [launch of a UN ‘Group of Friends’ in support of WASH in HCF](#) – have steadily increased attention and focus. In 2019, governments around the world unanimously agreed to a new WHA resolution⁴ on the issue, outlining priority areas of action for governments, partners and the WHO.

Figure 1: WASH in HCF status in Least Developed Countries (2019)



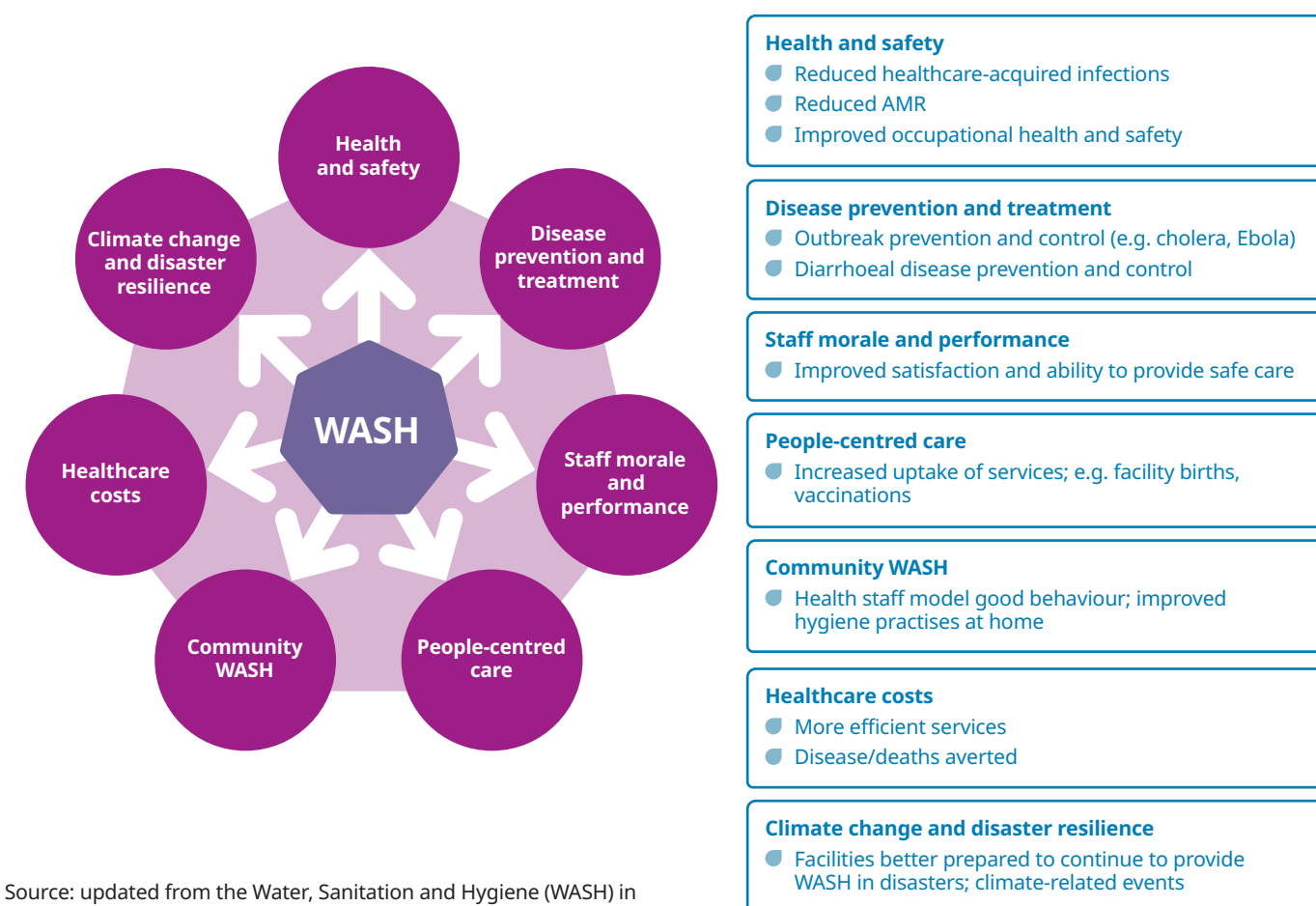
2. WHO (2018). *Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals*. Available at: who.int/publications/i/item/9789241514545 (accessed 11 Apr 2022).

3. WHO/UNICEF (2021). *Global progress report on WASH in health care facilities: Fundamentals first*. Available at: who.int/publications/i/item/9789240017542 (accessed 6 Apr 2022).

4. Seventy-Second World Health Assembly (2019). *Water, sanitation and hygiene in health care facilities*. Available at: apps.who.int/gb/ebwha/pdf_files/WHA72/A72_R7-en.pdf (accessed 7 Mar 2022).

Figure 2. The multiple benefits of sustainable, safe WASH in HCF (WHO/UNICEF)

The multiple benefits of sustainable, safe WASH in HCF



Following the adoption of the resolution, WHO and UNICEF released a report outlining eight practical steps (Figure 3) to achieve and sustain universal access to quality care through improvements in WASH in HCF.⁵ These steps offer a roadmap for countries to identify gaps, set priorities and targets, establish standards and improve and sustain infrastructure. These steps were developed from experience and learning in over 50 countries, and are reflected in the resolution – providing a helpful [framework and accountability tool](#) to help countries to track progress⁶ towards global targets on WASH in HCF.

The COVID-19 pandemic has brought renewed focus on health systems and HCF, as well as highlighting gaps and inequalities globally. It has underlined that WASH services and behaviours in HCF are fundamental for strong and resilient health systems that can deliver quality healthcare services during times of crisis.



5. WHO (2019). *WASH in healthcare facilities: Practical steps to achieve universal access to quality care*. Available at: [who.int/publications/i/item/9789241515511](https://www.who.int/publications/i/item/9789241515511) (accessed 8 Mar 2022).

6. WHO/UNICEF (2022). *WASH in health care facilities Progress tracker*. Available at: washinhcf.org/country-progress-tracker/#country-progress-tracker (accessed 8 Mar 2022).

Figure 3. Eight practical steps to improve WASH in HCF

WHO's eight practical steps



1.2 Inclusive health systems

The burden of poor WASH in HCF falls disproportionately on women and groups who are marginalised. Women represent the main users of health services and are often the primary caregivers for family members. Women also make up close to 70% of health and social care workers globally, and nearly 90% of the nursing and midwifery workforce.⁷ Up to one million mothers and newborns die every year from preventable infections linked with unhygienic birthing conditions. Inadequate WASH infrastructure and poor hygiene practises in HCF also prevent women from seeking care.⁷

WASH services that exclude the needs of women and marginalised groups put them at risk of healthcare-associated infections and injury, compromising their dignity while using services and reducing their uptake of healthcare. This is especially true for those with underlying health conditions or low immunity due to age or disability status. Improving WASH conditions can help establish trust in health services and improve health seeking behaviour, such as influencing pregnant women to seek prenatal care and facility-based delivery.⁸

▼ Tet walking down the ramp of the newly-installed user-friendly toilet at the Thlork Vien health centre, Chhouk Village, Cambodia. July 2020.



7. Boniol M, McIsaac M, Xu L, Wuliji T, Diallo K, Campbell J (2019). *Gender equity in the health workforce: analysis of 104 countries*. Health Workforce Working Paper 1. Geneva: World Health Organization. Available at: apps.who.int/iris/handle/10665/311314 (accessed 7 Mar 2022).

8. Bouzid M, Cumming O, PR Hunter (2018). What is the impact of water sanitation and hygiene in healthcare facilities on care seeking behaviour and patient satisfaction? A systematic review of the evidence from low-income and middle-income countries. *BMJ Global Health*. vol 3:e000648. Available at: [10.1136/bmjgh-2017-000648](https://doi.org/10.1136/bmjgh-2017-000648) (accessed 23 Mar 2022).

The [What Women Want campaign](#) led by the White Ribbon Alliance surveyed over one million women across 114 countries about their demands for quality reproductive and maternal healthcare. They found that, following respectful and dignified care, more than anything else, women want clean care and access to WASH in HCF.

The WASH needs of certain groups – such as people with disabilities, older people and children – are often deprioritised. They can face additional environmental, institutional and social barriers

when accessing WASH services in HCF, which can then inhibit their healthcare seeking behaviours. Our learning has shown that we must also focus on the health, wellbeing, empowerment and safety of those playing key roles for ensuring WASH in HCF standards are met – for example those who clean the HCF, manage and handle healthcare waste and sanitation workers (► see [Myanmar and Cambodia case studies](#)).

These investments can prevent stigma and discrimination – ensuring no one is left behind.



▲ Juvita (right) washing her hands from a homemade bamboo pipe from a spring water source in a dried up river bed. Vatuou Village, Maubara post-administrative area, Liquica, Timor-Leste. November 2019.

Women's groups' fight for rural WASH and health, Timor-Leste

Grupu Feto Foin sae Timor-Leste (GFFTL)'s reputation and recognition as a lead women's group in Timor-Leste was a strategic match for WaterAid. GFFTL's expertise enhanced WaterAid's ability to engage with communities on complex and gender sensitive WASH issues – leading to increased awareness on the benefits of challenging gender roles and relationships, and increasing gender equality.

WaterAid and GFFTL delivered gender equality workshops, utilising a [WASH and gender manual](#), in communities where WASH projects were being delivered. These workshops helped increase communities' understanding and knowledge on the importance of gender inclusive WASH.

WaterAid and GFFTL identified rural women's experiences of WASH as their priority for advocacy to municipality and national level governments. A key approach of their advocacy was to illuminate the challenge rural women faced in accessing health services due to the lack of WASH in HCF, and to promote women leadership for WASH in HCF. GFFTL addressed these issues with stakeholders, including at the national women's congress, with government officials, and in a meeting with the Secretary of State for Equality and Inclusion and the Women Caucus in National Parliament.

After the meetings and discussions, GFFTL witnessed that barriers to women accessing HCF, including WASH, were on the agenda in national parliament debates and during the state and parliament budget preparations.



▲ Jose, Agustinha and Agustinha live in a community where long trips to collect water are a current reality of daily life. In Timor-Leste, community-based gender equality workshops have increased understanding and knowledge on the importance of gender-inclusive WASH – helping shift the narrative and focus advocacy on women's experiences of WASH.



► Water tanks installed under the Deliver Life II project, Chikwewo Health Centre, Machinga, Malawi. December 2021.



Communities and those working on the frontline are central to the design and actions to improve WASH in HCF. Gender equality and social inclusion must be integrated into government and development partner decision-making, budgeting and planning processes to address the specific needs of women and those marginalised from WASH and healthcare.

People-centred care

Health systems are not abstract entities, they exist through and for people. People-centred health services put individuals and communities at the heart of everything they do – to provide responsive services that are coordinated both within and beyond the health sector. Approaching healthcare in this way can support improved access to care, improved health outcomes, ownership of health decision making, accountability for lasting services, improved job satisfaction, and improved efficiency and cost of services. People-centred care also ensures services are available where people need them; it strengthens connections between people and health services to support their individual needs and the needs of the communities where they live.

It is essential to respect and empower the people within health systems – those who work within them, those who make decisions that influence the nature and quality of services provided, and those who rely upon the services for their health and wellbeing. A lack of connections between service users, service providers and decision makers, can hinder effectiveness in decision making. Ultimately, this can impede the system's ability to ensure that HCF have sustainable and safe WASH services and behaviours to meet the diverse needs of staff, patients and their carers.

1.3. Systems approach

Progress to improve and sustain WASH in HCF will not be possible without considering the health system as a whole. To do this, health and WASH systems are typically broken down into more manageable components or 'building blocks' (Figure 4). The 'system' itself is all the actors (people and institutions), factors (sociocultural, economic, political, environmental, technological) and the interactions between them that influence the achievement of sustainable and safe WASH in HCF.

While many health actors may not be familiar with the WASH system building blocks and vice versa for WASH actors and the health system building blocks, both sets are largely complementary and both sectors recognise the importance of following a systems approach.

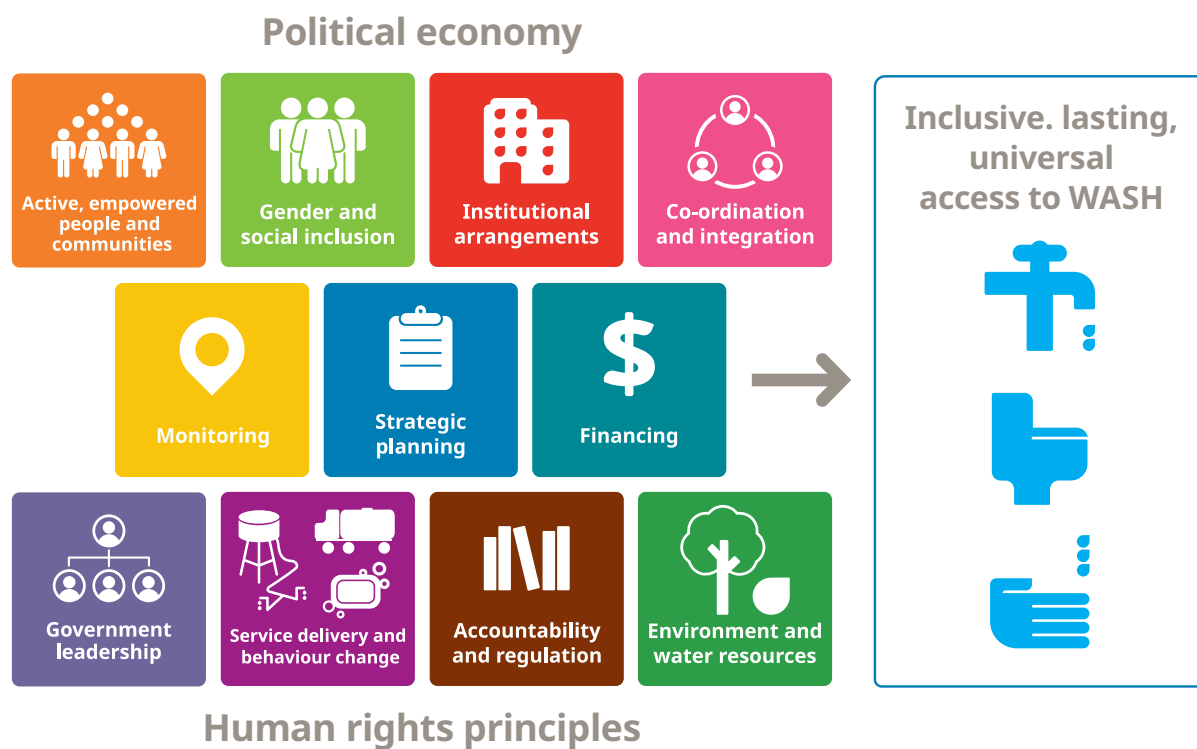
To strengthen WASH in HCF, WASH system components need to be adopted and integrated within the building blocks of the health system, which include leadership/governance, financing, access to essential medicines, health workforce, health information systems and service delivery. While building blocks help to understand and strengthen WASH and health systems, efforts must be made to understand the actors within the system, and how each building block interacts with and influences the function of another.

Barriers to inclusive and sustainable WASH in HCF exist at multiple levels, hence system strengthening efforts are needed across district, sub-national and national levels in order to ignite and sustain change at HCF level.

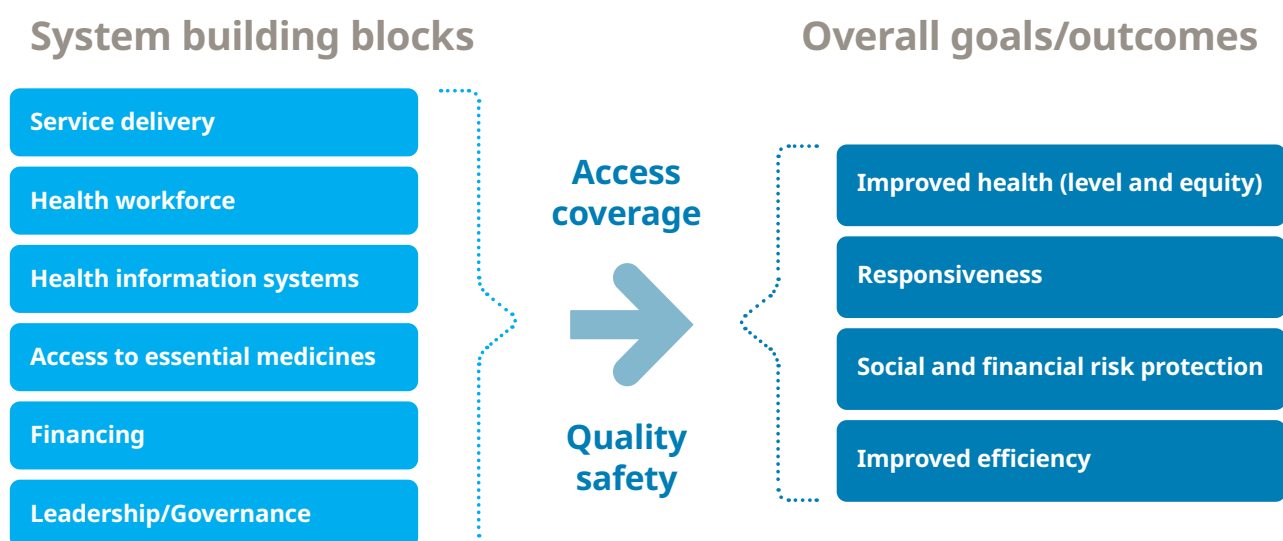
Figure 4. Interactive components of a system (both WASH and health)

Interactive components of a system

WASH system



Health system



The six building blocks of a health system: aims and desirable attributes

2

Approaches and lessons

● Tigalana Fidah, Senior Nursing Officer, washing her hands at a sink installed on the new maternity ward sanitation block, Ndejje Health Centre IV, Makindye Ssabagabo Municipality, Uganda. May 2020.



2.1 Principles of applying systems strengthening in practice

We understand that progress in WASH in HCF delivery requires consideration of the system as a whole, as described in Section 1.

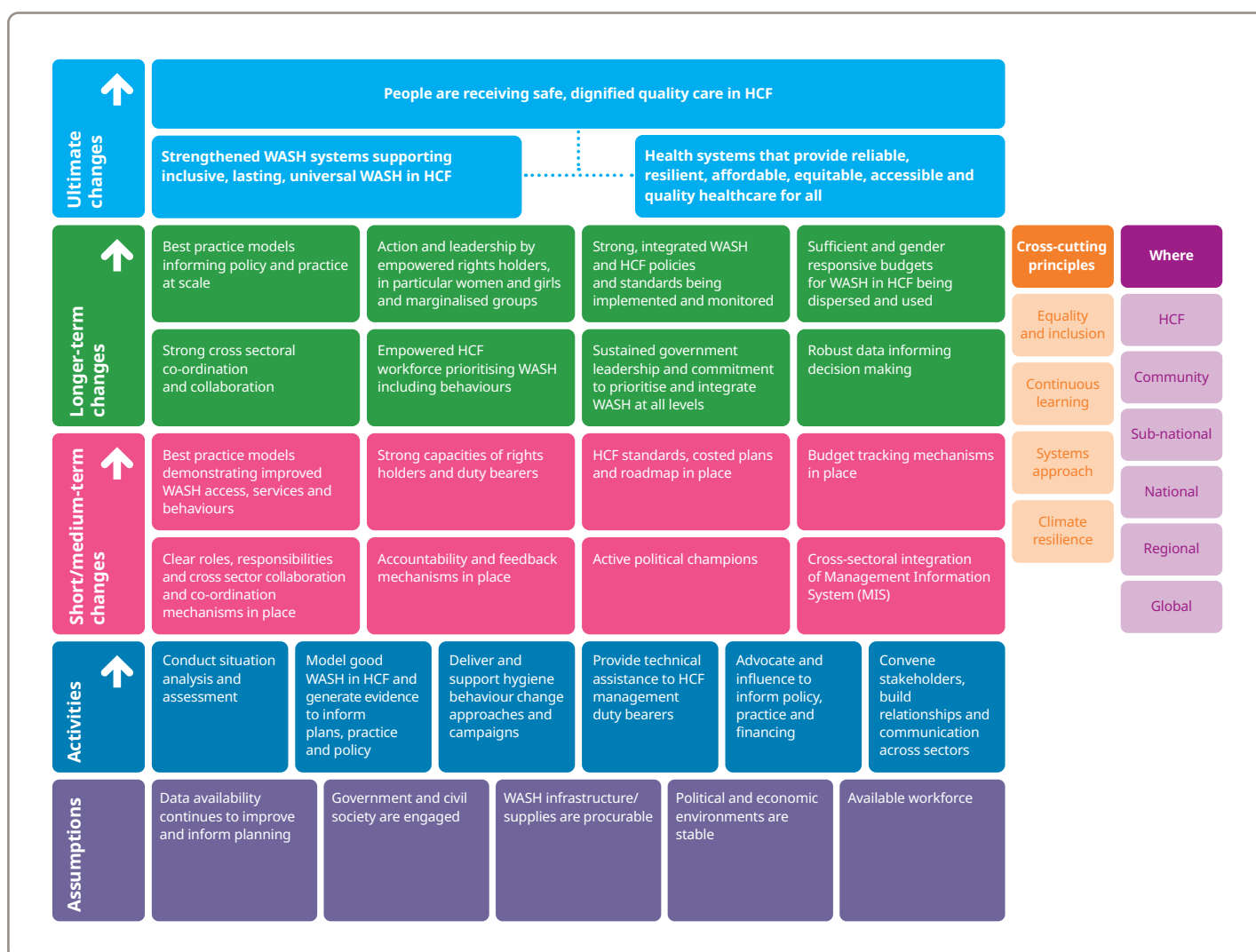
Our work, alongside our partners, on WASH in HCF has led our thinking around effective pathways and approaches for change – and we continue to learn and evolve our understanding of this within different contexts. Based on our learning to date, to see and sustain frontline service change, we need to work through the whole system in line with our Theory of Change (Figure 5).

Our Theory of Change incorporates the system ‘building blocks’ and the WHO’s eight practical steps to define how we think change happens in HCF for WASH. We [analyse existing system barriers](#)⁹ in each context, and look to understand the pathways and opportunities to improve and sustain WASH in HCF.

We work with our partners to engage with relevant stakeholders and help them understand which pathways and opportunities can catalyse changes in other parts of the system.

Strengthening the system for improved WASH in HCF involves working at multiple levels and employing a range of tactics.

Figure 5. Theory of Change



9. WHO/UNICEF also has a useful resource for understanding barriers to quality care. Available at: who.int/publications/i/item/9789240022577. We also have useful tools to help understand and navigate barriers to WASH: [Political Economy Analysis toolkit](#), [User-friendly WASH in Healthcare Facilities in Cambodia toolkit](#), [Understanding and addressing equality, non-discrimination and inclusion in water, sanitation and hygiene \(WASH\) work toolkit](#), and our [Hygiene framework](#).

These include:

- analysis, research and learning;
- localised implementation of WASH service and behaviour change delivery for change at scale (see Section 3);
- costing and technical support;
- capacity development support;
- advocacy and influencing.

2.2 What are the roles of the health and WASH sector?

Health ministries have the ultimate duty to provide safe, equitable and quality care, but this cannot be achieved without WASH. Whilst health ministries are the stewards for WASH in HCF, the responsibility for tackling barriers to achieving WASH often falls outside their direct mandate. To make progress, all relevant stakeholders will need to develop a shared vision for WASH in HCF. They will need to identify which barriers would catalyse changes in other parts of the system, and what initiatives are already in place to address these to avoid duplication of effort.

For effective system strengthening to happen, it needs to be multisectoral, conscious of the complexity and with clear ownership and accountability for actions.

Health ministries are responsible for engaging with WASH actors to draw on expertise, workforce and WASH systems. It is the health ministry's duty to develop national standards, policies, standard operating procedures (SOPs), accreditation, accountability mechanisms, monitoring, estimate resources and financing, set targets and national roadmaps, and coordinate partners so that everyone is working towards a shared goal, using the same tools and indicators.

WASH actors seeking to improve WASH in HCF should consider the WASH and health system strengthening elements needed and support coordination mechanisms, with a clear division of responsibilities and additional WASH perspectives and technical expertise.

The WASH expertise and perspective goes beyond designing and building or rehabilitating infrastructure, it cuts across issues of behaviour change, capacity of healthcare workers, water quality, operation and maintenance (O&M) of WASH services, integration of WASH and IPC, gender and social inclusion, and the inclusion of WASH in health monitoring and information systems.



► Dr Smita Singh (second from right) treats her patients at a community health centre. She brings her own bottle of water from her house as a precaution. Uttar Pradesh, India. June 2021.





● Ritik Chavariya handles medical waste collection at the Community Health Centre in Sehore District Madhya Pradesh, India. September 2018.

Spotlight on localised implementation for learning, adaptation and scale

● Sokha washing her hands at the Thlork Vien Health Centre, where WaterAid has introduced the WASH FIT tool to improve water and sanitation. Kampong Chhang province, Cambodia. July 2020.

3.1 Developing a localised WASH in HCF intervention

One way to strengthen the system, and a core aspect of our work, is modelling WASH in HCF services and behaviours in a targeted number of HCF using systems thinking. The aim is for the localised intervention to be adapted across contexts and scaled, as systems are strengthened to support better services. We support governments to demonstrate inclusive and sustainable services and processes, and then have the tools to scale up from neighbouring district through to national level.

Modelling WASH in HCF goes beyond infrastructure, facility improvement and hygiene behaviour change. We also need to look across the entire system to demonstrate services, monitoring, O&M, strengthen planning and budgeting, training and formative research that leads to strong behaviour-change focused and inclusive programmes and procedures. Sustainable WASH in HCF is interdependent on changes in multiple building blocks of the system.

Ensure government leadership from the beginning: To ensure governments remain in the driving seat of WASH in HCF, we work together to understand their priorities, strengths and limitations. We then jointly develop national and local plans of actions to address the gaps in targeted facilities or within the local, regional and national systems that support those facilities. Government leadership is vital to implementing interventions at scale.

Contextual analysis: We work with local and national governments, health and WASH actors, partners and communities to understand the barriers to inclusive and sustainable WASH in HCF. We start with a system analysis, including formative research, which is used to identify the overarching factors for poor WASH services and hygiene behaviours – such as gaps in leadership, power dynamics, monitoring, budgets, management, human resources and individual behaviours.

The system analysis is also used at the facility level to identify management, environmental determinants and people's behaviours. We also use tools, such as WHO/UNICEF's risk-based management tool, for improving WASH assessments and planning in facilities ([WASH FIT](#)).¹⁰ These analyses enable a targeted focus on context-specific challenges.

Clear roles and responsibilities: Clear roles and responsibilities with all stakeholders – including governments, NGOs, CSOs, private sector, healthcare workers and communities – are essential for the success of the localised WASH in HCF intervention. Creating opportunities for consultation and engagement with representatives from groups who are often marginalised or excluded from actively shaping health and WASH services is critical – such as women's rights organisations and organisations for people with disabilities, patients' groups, midwives' groups – and must be built in throughout the process.

At the facility level, we work to integrate across existing structures and committees (e.g., WASH, IPC, waste management, environmental health committees, etc.). ► [See the Bangladesh case study for detail on how they worked to strengthen existing community clinic committees, groups and structures to improve WASH in community clinics.](#)

► An accessible toilets at the Noapara Community Clinic. In Gangni, Meherpur, Bangladesh. October 2019.



WaterAid/Fairzana Hossen

10. WHO/UNICEF also has a useful resource for understanding barriers to quality care. Available at: who.int/publications/i/item/9789240022577. We also have useful tools to help navigate barriers to WASH: [Political Economy Analysis toolkit](#), [User-friendly WASH in Healthcare Facilities in Cambodia toolkit](#), [Understanding and addressing equality, non-discrimination and inclusion in water, sanitation and hygiene \(WASH\) work toolkit](#), and our [Hygiene framework](#).

Building the intervention: Each intervention will look different depending on the context. In our experience, there are several common areas to be addressed when working on WASH in HCF:

- **Adapt solutions for the gaps across different contexts.**

- ▶ See the [India case study](#) for detail on how they responded to emergencies.

- **Support strong management and processes, with coordination between departments at facility level.**

- **Ensure WASH services are inclusive and fit the requirements for all users and staff.**

- ▶ See the [Zambia case study](#) for detail on how they worked to ensure user friendly infrastructure.

- **Ensure quality budgeting processes are in place.**

- ▶ See the [case study from Uganda](#) for detail on how they worked to increase budget allocation for HCF.

- **Integrate IPC and WASH.** Importance of working together with both IPC and WASH colleagues, experts and focal points at HCF. Increasingly, countries are looking at IPC refresher courses, WASH integration and increased coordination across stakeholders working in IPC and WASH. Important to also connect WASH and IPC

within the broader health workforce, child/maternal health and health emergencies to drive leadership and resourcing.

- **Develop evidence-based and behaviour-centred approaches to implement hygiene behaviour change.**

Behaviour change interventions are context specific, with engaging behaviour change interventions designed through a creative process based on evidence generated through formative research. Interventions focus on changing behaviours rather than improving knowledge.

- ▶ See the [Cambodia case study](#) to see how they worked in partnership with London School of Hygiene and Tropical Medicine (LSHTM) and National Institute of Public Health (NIPH) to improve hygiene behaviours along the continuum of care for mothers and neonates.

- **Bridge gaps and convene cross-sectoral coordination and action.**

- ▶ See the [case study from Mali](#) for detail on how they worked in a cross-sectoral, multi-stakeholder partnership to improve WASH in HCF service delivery.

- **Increased collaboration across IPC and WASH colleagues,** experts and focal points at HCF. Training on IPC and WASH. IPC and WASH integration also within broader health workforce, child/maternal health and health emergencies to drive leadership and resourcing.

▶ Susan Magoma, handing over her newborn baby to her first-born daughter Rebecca, who has been taking care of her while she has been in the hospital, Nyamalinbe Dispensary, Geita District, Tanzania. June 2019.





◀ Ddungu Annet, Nursing Officer, in the labour ward, washing her hands before examining an expectant mother, Nabweru Health Centre III, Nansana Municipality, Uganda. May 2020.

- **Empower and engage community members to hold duty bearers to account.**
 - ▶ See the [Tanzania and Malawi case studies](#) for detail on how they mobilised and engaged with community members.
- **Monitor WASH services and embed this within health information systems.**
 - ▶ See the [Ghana case study](#) for detail on how community members and rights-holders feedback is incorporated into national monitoring systems through tools like community scorecards.
- **Support capacity development of the government and healthcare workforce, including healthcare workers, WASH and IPC focal points, cleaners and sanitation workers, to build capacity for WASH in HCF.**
 - ▶ See the [Myanmar case study](#) for detail on how they strengthened the capacity of healthcare workers and cleaners through the 'TEACH CLEAN' programme.
 - ▶ See the [Ghana case study](#) for detail on how they conducted training around costing for WASH in HCF.

Taking the model to scale

Working with and having buy-in from governments from the very beginning of any WASH in HCF work will ensure we leverage existing health system operations to include WASH and strengthen existing processes so it can be taken to scale.

Working across multiple ministries and actors is also important to understand what is needed to deliver and maintain WASH in HCF at scale.

Including research and learning within our programmes is crucial for improving our work and presenting the opportunity for evidence-based influencing.

▶ See the [India case study](#) for an example of applying the overarching systems thinking to our work.

▶ See the [case study from Nepal](#) for more detail of how the team influenced the development of national standards on WASH in HCF.

4 Country case studies

● Beatrice Lana, Senior Medical Assistant, is now able to wash her hands before treating patients. The new handwashing facilities has meant that sepsis cases in the centre have fallen. Katimbila Health Centre, Nkhotakota, Malawi. April 2019.





Bangladesh

Modelling WASH in community clinics



Context

By 1996, Bangladesh was well behind its goal of achieving health for all by 2000. To address those shortfalls, the Government of Bangladesh (GoB) established community clinics (CCs), one stop health centres (HCs) for every 6,000 people across the country. The CCs aimed to meet community health needs – such as family planning, nutrition services, childcare, overall antenatal and postnatal care, free basic medicines, primary care and referral – under one roof and within a half hour walking distance from their homes, even in remote areas.

The CCs are situated at the ward level (smallest local government administrative unit in Bangladesh) under the Union Parishad (lowest tier of local government), and are managed by Community Groups (CGs) and Community Support Groups (CSGs), with representation from local communities and Local Government Institutions (LGIs). The CCs are a unique Public Private Partnership initiative in Bangladesh, where the community provides the land, the government constructs the infrastructure, provides medicines and operational costs, and the local community manages it on a voluntary basis.

▼ Banoara receiving medicine from CHCP Shongita Parvin at Noapara community clinic. Noapara Gangni, Meherpur, Bangladesh. October 2019.



Barriers

The barriers to progress on WASH in HCF were due to several reasons:

- **Lack of clarity on roles and responsibilities for WASH in CCs.** Although CGs were responsible for the overall management of the CCs, in many cases, the roles and responsibilities were not clear even to the local government. In addition, CGs and CSGs at the local level were often not organised or adequately informed, leading to limited participation of CGs.
- **Issues around O&M resulted in an absence of, or poor quality, WASH facilities** as well as other aspects of CC infrastructure (such as roofing). This was in part caused by a lack of budget allocation for O&M and exacerbated by environmental challenges such as arsenic in the water supply, flooding or salinity.

The poor condition of the infrastructure neither inspired the community to seek services nor motivated the service providers (especially women healthcare workers) to provide healthcare.
- **Remoteness and an inadequate supply of medicine** for the population meant that the operation of the CCs was irregular.
- **Inadequate capacity of LGIs** on how to manage and monitor WASH in CCs, along with no accountability for budget allocation, sometimes led to duplication of funds.
- **Advocacy** was needed to support the health engineering department (HED) and fund the CC improvements.
- **Population growth meant that CCs were overwhelmed.** Each CC was built to serve 6000 people, however in reality, the clinics served more than this.

Approach

WaterAid Bangladesh started work on WASH in HCF in 2016, after the Bangladesh Ministry of Health (MoH) carried out a survey – with support from WaterAid Bangladesh, UNICEF and the WHO – which revealed the nationwide lack of WASH in CCs. WaterAid Bangladesh modelled improvements in CCs in two districts, Tahirpur upazila (subdistrict) of Sunamganj district and in Meherpur sadar upazila of Meherpur district, working with development partners, the local health directorate office and a directorate of the health department.

In 2017, WaterAid Bangladesh along with local partner SKS Foundation, facilitated the capacity and skill development of both the CGs and the duty bearers responsible for the CCs. The training for the CGs covered roles and responsibilities, basic financial management, reporting and organisation of monthly meetings. The duty bearers training for the local government institution covered roles and responsibilities, and allocation of funds from national and local government for O&M. WaterAid worked with both levels of government to advocate for funds to be allocated for O&M.

WaterAid Bangladesh created a model at the CC level so the government could replicate this across CCs to have significant impact. To assist scale up, WASH guidelines for the CCs were developed by WaterAid Bangladesh and endorsed by the GoB.

Evidence of change

The evidence is compelling, with the average flow of patients visiting the CCs in the districts in the intervention increasing by 30%.¹¹ Previously, the community lacked clarity on the remit of CCs and would travel instead, at their own cost, to the district health centres to seek care. After the intervention, the CCs were more popular and contributed to overall community health services – further improving the confidence of the stakeholders. The service provider and the CHCP were observed to be more likely to stay in the CCs for their entire workhours. Previously, providers were forced to leave the clinic if they needed to drink water or visit the toilet.

An accessibility audit led to the introduction of inclusive WASH facilities. The interventions described above contributed to around 300 women giving birth at the CCs in the last three years compared to none before as suggested by HCF recorded data.

Through capacity building in the districts, the CGs were empowered to start monitoring the work schedule, service quality, medicine disbursement, patient flow, governance, infrastructure and repair issues, monthly meetings, and community participation. The GoB adopted the model and incorporated this in their updated or new CC designs.



► Nurses working in the Fulchari Health Complex, Gaibanda, Bangladesh. 10 March 2022.

11. WaterAid India (2020). *Social Accountability and System Strengthening for water, sanitation and hygiene in South Asia*. Available at: [wateraidindia.in/publications/social-accountability-and-system-strengthening-for-water-sanitation-and-hygiene-in-south-asia](https://www.wateraidindia.in/publications/social-accountability-and-system-strengthening-for-water-sanitation-and-hygiene-in-south-asia) (accessed 8 Mar 2022).



WaterAid/Rakibul Alam Khan



▲ Nahida Aktar works at the Saharbat CC as a CHCP. Gangni, Meherpur, Bangladesh. 2019.

▶ Nahida Aktar is measuring the blood pressure of Sabina Khatun at the Saharbat CC, Gangni, Meherpur, Bangladesh. 2019.



Key lessons

- The key to success is to work at all levels of the health system. WaterAid Bangladesh started at the primary level and then moved up to the secondary and district levels.
- Coordination and contribution of all relevant stakeholders strengthens accountability and ownership among key actors. Capacity building of both communities and duty bearers helps with the overall coordination.
- WASH is often overlooked, so it is vital to bring it to the attention of other services, such as maternal care and the care of older people.
- It is important to understand all components of the system and how they function.
- When working with CCs, the wider community needs to be engaged to understand their roles and responsibilities. Following training and support from WaterAid Bangladesh, the community mobilised funds and helped monitor the project.

Conclusions and recommendations

For successful CCs with functioning WASH services, we need to engage communities and LGIs from the start.

Coordination and contribution of all relevant stakeholders helped in strengthening accountability and ownership among key actors. Capacity building at both ends – strengthening communities and duty bearers – helped in the overall coordination.

The WASH improvements enabled the other aspects of the CC to function properly, including monitoring and reporting – which improved accountability of the CCs. For example, all CHCPs have been given a laptop from the government and so reports are now online, which has led to improved communication and transparency.

Finally, making information public and increasing transparency regarding service outputs and medicine stocks helped build trust in the CCs overall.

Case study



Cambodia

Gender and inclusive WASH in HCF



Context

In 2016, the NIPH in Cambodia conducted an assessment in 117 HCF in five provinces. Approximately 39% of the surveyed HCF had access to limited sanitation – defined by the NIPH as ‘having at least three improved and usable toilets’. However, these toilets did not meet the needs of the people who are often marginalised from WASH.

The survey also found only 15% of HCF had access to basic hand hygiene at the point of care as defined by the Cambodian Standard (a functional hand hygiene station available at outpatient area, delivery room, and within 5m of toilets).

The survey highlighted that the WASH infrastructure and services in HCF was inadequate and did not meet accessibility requirements. For example, the sanitation facilities were mostly squat toilets with narrow toilet cubicles and pathways, only accessible by steps.

Following the assessment in 2016, a [guideline](#) for WASH in HCF was developed by the MoH to mandate requirements for HCF to be accessible to all users, including pregnant women and people with disabilities. Despite the inclusion of a user-friendly and people-centred approach to design in the guidelines, implementation remains a challenge.

Barriers

In the national WASH in HCF guidelines, the building brief for HCF stated that each facility should have three improved toilets, including one for women with menstrual hygiene facilities and one for people with limited mobility. Despite these guidelines, significant barriers to achieving inclusive and equitable WASH in HCF remain:

- **Lack of budget for improvements to inclusive and equitable WASH infrastructure.** The budgets assigned for HCF is often prioritised for other needs in the facilities such as WASH supplies (soap, hand hygiene materials) and for minor maintenance. This means HCF cannot achieve the basic standards required for WASH in HCF.
- **Lack of effective O&M management processes.** Health care workers/health facility directors recognise the importance of the O&M management and role of cleaners and maintenance staff, however with an already limited HCF budget, O&M is often not prioritised. Without effective O&M, sustainability of WASH infrastructure and services are at risk. The monitoring and evaluation (M&E) programme done by the MOH called the Quality Improvement (QI), is focused on monitoring service quality in HCFs, which included management, IPC, medicine management, health information system, etc. However, the score on wash indicator is only 15% as part of IPC. There is no component on improvements to WASH services. Each HCF is left on their own to do this, but they often have limited capacity or funds to do this well.
- **Lack of functioning and accessible sanitation and handwashing infrastructure** was the most common barrier faced by communities, especially pregnant women, children, older people, and people with disabilities. Despite some budget for hand hygiene facilities, the O&M needed to keep these facilities accessible and functional is lacking.

Barriers (continued)

- **Existing gender norms and roles impact on gender equality and inclusion.** For example, women cannot enforce hygienic practises among family members in the home. Further, the hand hygiene information at HCF targets women, who are assumed to be the sole primary caregiver, and overlooks men and other caregivers in the family. With adequate WASH in HCF, healthcare workers can break through social barriers that limit men and other caregivers' responsibility to change hand hygiene practises as the health of children is not only the responsibility of women care givers.

Approach

WaterAid Cambodia has been leading two initiatives to address these challenges. Firstly, on supporting key policymakers, especially the MoH, to develop and include Gender Equality and Social Inclusion (GESI) in national guidelines on WASH in HCF. Moreover, to ensure a minimum standard for accessible WASH infrastructure, WaterAid Cambodia formed a collaboration with Humanity and Inclusion (HI) to co-develop a technical design model for user-friendly and inclusive WASH facilities in HCF. For example, accessible WASH infrastructures that include menstrual hygiene facilities, separate toilets for different sexes, and accessibility standards for people with limited mobility.

WaterAid Cambodia has also been facilitating another initiative – Changing Hygiene Around Maternal Priorities (CHAMP) – to address gendered roles in maternal and neonatal caregiving. This project is in partnership with the LSHTM and NIPH to improve hygiene behaviours along the continuum of care, for mothers and neonates, while improving women's control of their own health. The project included context analysis and formative research guided by a Behaviour Centred Design approach to understand the behavioural determinants with the specific context and to help design the intervention.¹²

Evidence of change

Since the start of the intervention in 2018, the accessible WASH in HCF technical design has been rolled out in 12 HCF, of which five have allocated their budget to provide accessible WASH services to users.

With technical and financial support from WaterAid, in collaboration with HI, the MoH have developed and distributed accessibility factsheets to HCF nationwide to ensure alignment with the national standards. Healthcare workers at the sub-national level have improved knowledge and understanding of accessible WASH in HCF and the importance of user-friendly WASH facilities for all.

The preliminary findings from the CHAMP initiative indicated that a facility-based intervention had potential impact on improving hand hygiene practises among birth attendants and other caregivers during childbirth and early post-natal care in a HCF environment.¹³

Key lessons

- **Empowerment and participation of end-users.** Involvement of Disabled People's Organisations (DPOs), end-users and those who could be left behind at the design stage of the project is essential to better understand the needs of those who face challenges to access quality WASH and health services. Moreover, knowledge and understanding of healthcare professionals on inclusion needs to be strengthened.
- **Understand WASH priorities and integration into the health system.** For any accessible WASH improvement intervention tool to be effective, it must not pose a high administrative burden, and should be integrated into existing programmes, rather than as a stand-alone WASH intervention. For example, to integrate GESI considerations into WASH in HCF requires WASH and health actors to work together. WASH actors can provide the technical capacity to support healthcare workers to

12. Nalule Y, et al. (2021). Hand hygiene during facility-based childbirth in Cambodia: a theory-driven, mixed-methods observational study. *BMC Pregnancy and Childbirth*. vol 21: 429. Available at: bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-021-03901-7 (accessed 30 Mar 2022).

13. Findings from this study will be published soon.

progress WASH in HCF by working together to integrate the WASH FIT process into the MoH's current M&E programme (H-EQIP). In addition, WASH in HCF should be considered and included in relevant health programme implementation, which could be factored to achieve and accelerate UHC.

- Cross-sector partnership collaboration.** Strong national support from key partners to the MoH has contributed to WASH improvements in HCF. However, coordination between government ministries needs to be strengthened to ensure alignment and avoid duplication of efforts.
- Employ a people-centered approach for design and conduct research to inform effective policy.** The consistent provision of alcohol-based hand rubs (ABHR) in key locations of the facility is a convenient and effective supplementary measure that could be employed to improve hand hygiene compliance for new mothers and other caregivers. Strategic placements of ABHR in healthcare settings, in addition to handwashing facilities with soap and water, would increase the convenience of hand hygiene practise for the mobility-restricted mother and address hand hygiene barriers faced by the paternal and non-parental caregivers – such as restricted movement due to overcrowding in the postnatal care room, time pressure from the urgent caretaking needs and increased workload.

Conclusions and recommendations

For an inclusive, sustainable and equitable health service, it is critical to address WASH in HCF and adopt universal accessibility principles when designing WASH interventions. It is key to consider a people-centered approach for user-friendly services and address gender and inclusion factors to improve WASH in HCF.

- Health policymakers, especially MoH, should collaborate with key stakeholders and technical partners on gender and inclusion to ensure revised guidelines will embed practical WASH components that are gender sensitive and accessible.
- The current National Standard tools for the assessment of WASH in HCF should be revised to align with the newly developed national norms and standards and the Joint Monitoring Programme (JMP) WASH monitoring tools. To help facilitate this beyond the Cambodia context, WaterAid has worked with the WHO to include gender and inclusion indicators and tools within the newly revised WASH FIT manual and training package.
- Gender and inclusion should be monitored through disaggregated data and project monitoring tools.
- Policy makers should integrate disability into health service policy and programmes to ensure people with disabilities access and benefit WASH equally.
- Partnerships should be formed with organisations that represent people with disabilities and women leadership to ensure equality and inclusion considerations are represented in health education, promotion and prevention campaigns.
- Policy makers, MoH and NGOs should work together with the Ministry of Finance to acknowledge the importance of WASH in HCF.



◀ Sokha washing her hands in front of the Thlork Vien health centre, Chhouk Village, Cambodia. July 2020.



Case study



Ghana

Translating district level innovations to influence national policy and action



▲ Patients at the Kassena-Nankana West District Health Center, Ghana. October 2018.

▼ Michael Asagewe, Nurse, can now wash his hands before he treats patients at the Wuru CHPS in Ghana. October 2018.

Context

Local and district level innovations and initiatives have catalysed national level shifts and action for WASH in HCF in Ghana. Local ownership of health services and monitoring data have strengthened accountability and responsiveness to community demands. Strengthening the evidence base for WASH in HCF through improving costing data has enabled greater integration of WASH in HCF into core national strategies, including the *Ghana National Healthcare Quality Strategy*.¹⁴

Barriers

Two primary barriers to progress on WASH in HCF were identified:

- **Lack of costing data and standards for WASH in HCF.** This data gap on the cost of WASH in HCF had multiple implications. Without clear costing data to guide and target resource allocation, it has been difficult to secure much needed government and donor commitments. The lack of costing data has also held back effective inclusion of WASH in HCF in broader national strategies for health.
- **Lack of accountability of duty bearers to citizen's demands and feedback** can impede the delivery of people-centred healthcare. WaterAid Ghana identified a gap in the inclusion of WASH in localised approaches, such as the community scorecard for the accountability of health. Developed in 2018, the community scorecard engages and empowers community members to give regular feedback and propose solutions for addressing a number of quality areas, including WASH. The feedback mechanisms are linked to the national health management information systems (HMIS), meaning that it can be reviewed at facility, district and national levels.



14. MoH Republic of Ghana (2016). *Ghana National Healthcare Quality Strategy (2017-2021)*. Available at: moh.gov.gh/wp-content/uploads/2017/06/National20Quality20Strategy20Ghana.pdf (accessed 24 Mar 2022).

Approach

WaterAid Ghana worked with partners and the government to develop the country's first national, costed strategy on WASH in HCF – which was published in 2020. The strategy included a comprehensive framework for coordination and implementation, including O&M financing. WaterAid is also supporting community feedback on WASH in HCF to be part of district Health Management Information System (HMIS) monitoring.

WaterAid Ghana worked to create an interface for community engagement with rights holders. In Wa Municipality of the Upper West region of Ghana, WaterAid trained communities to carry out WASH in HCF assessments, monitoring and management using approaches like the 'community scorecard' and WASH management committees. WaterAid also worked simultaneously with duty bearers to promote accountability to the human rights to WASH in HCF.

WaterAid Ghana worked with district assemblies to develop long-term costed, strategic plans for sustainable WASH in HCF, and district officials to develop integrated WASH and health budgets. This process aimed to establish what it would cost to ensure full access to WASH services in all HCF in the respective district. Based on this data, WaterAid Ghana worked with district officials to conduct life-cycle costing analysis to estimate WASH and waste management costs and financing sources required to provide and maintain these services up to 2030.

Evidence of change

WaterAid Ghana was able to support the use of district level data and good practice to shape and influence national policy and financing decisions for health. Ghana Health Services is now planning for a national rollout of the community scorecard and engagement to improve quality, uphold health users' respect and dignity, and improve WASH and IPC. The monitoring of this scorecard will be collected through DHIS-2. This also means that the data can be immediately reviewed at the facility, district and national level. Communities continue to make changes – Kalvio Gugoro advocacy group gathered WASH evidence on their HCF and supported the community to organise a health forum. The community advocated to the District Health Services to provide services, such as electricity, drugs, a refrigerator, water and sanitation facilities, to make the facility fully functional upon completion. The community also initiated the construction of latrines and communal clean up exercises of public spaces.

A national, costed WASH strategy with a comprehensive blueprint for coordination and implementation is being disseminated across districts and regions to support improved planning and decision making for WASH in HCF. Next steps include validating this plan at regional level and engaging with development partners to support it. Finally, costs for WASH infrastructure and recurrent O&M are set out in the WASH strategy, with 80% of the projected costs financed from domestic resources. At the district level, partners have supported the development of long-term WASH plans, making budget commitments to address shortfalls.

Life-cycle costing for sustainable WASH in HCF

Using a life-cycle costing approach in WASH refers to the assessment of all costs necessary for delivering and sustaining long term water and sanitation services and hygiene behaviours at the HCF and to the population it serves.

Life-cycle costs include not only the initial, often one-off costs of installing new infrastructure or promoting practices, but also the short and long-term costs of maintaining and supporting these services and behaviours long into the future. Some examples of these costs are spare parts for minor and major maintenance or replacement, water, sanitation, waste management officer/technician salaries, local area mechanics, recurrent technical training of national and sub-national water and health staff, repeat sanitation and hygiene promotion, ongoing monitoring etc.



Patients being treated at the Kassena-Nankana Health Center in Ghana. October 2018.



Key lessons

- **A rigorous process to select and gather data.** During the costing work, it was important to be clear on what data the District Health Directorate needed to collect and use.
- **Comprehensive analysis of funding.** To move plans into implementation stage, it is essential to identify possible opportunities to fill financing gaps – across district, national and global funding sources.
- **Accountability.** Public commitments made by the district to achieve universal access to WASH by 2030 have increased momentum and accountability. WaterAid Ghana has supported follow up by community leaders and partners to ensure that the commitments are fulfilled. For example, an integrated WASH and health budget and monitoring plan was developed for each district.
- **A national costing strategy** to direct a clear plan of action and accountability enabled inclusion of WASH in HCF into key national policy and strategy documents, such as the national strategies for Healthcare Quality and AMR strategies.
- **Recognise the community's role in improving the quality and accountability of health services.** WaterAid supported a continuous process of coaching and mentoring to build community capacity, so they were able to claim their rights at the district or regional level.
- **Prioritise long term sustainability in community engagement.** WaterAid Ghana's approach ensured that the community kept moving forward without any input. The community selected volunteers for capacity building who then shared their learning with the community. The community formed and supported advocacy teams to demand better health services from duty bearers.

Conclusion and recommendations

District level improvements such as the creation of long term strategic, costing plans for WASH in HCF and the community scorecard initiative were catalysts for national change in Ghana. On the basis of this work, we recommend:

- Government and development partners that should ensure strong links between district level evidence and national and regional level decision making and planning.
- Integrated processes for community-level monitoring and accountability into national monitoring mechanisms and HMIS. Ensure these processes are supported by investment in empowering communities to take on monitoring activities and claim their rights and training of duty bearers to be responsive to their demands.
- To prioritise the collection and assessment of WASH in HCF life-cycle costing data to inform a national costing strategy for WASH in HCF.



India

A health systems approach to integrating WASH in HCF



Context

India has among the highest rates of maternal and neonatal mortality in the world, a leading cause of which is sepsis – accounting for 11% of maternal deaths.¹⁵ The Government of India has taken steps to improve maternal and child health under the National Health Mission.

The Janani Shishu Suraksha Yojana entitles all women to a free delivery at a public HCF to ensure safe childbirth. Other initiatives, such as Swachhata Guidelines and Kayakalp Guidelines, and the Labour Room Quality Improvement Initiative (LaQShYa), also aim to enhance quality of care in HCF.

The results of the government's steps to provide quality care is compelling – with the proportion of women who give birth in a HCF in India now increasing significantly from 38.7% in 2005–06 to 78.9% in 2015–16.^{16,17} Starting in 2018, the Government of India has focused on transforming existing sub-centres and primary HCF into wholistic **Health and Wellness Centres** to provide comprehensive healthcare, including services for mothers and young children.

Barriers

Evidence from studies and assessments, and interactions from healthcare providers in public HCF in rural and urban India have highlighted critical impediments to improve WASH services across all levels of the public healthcare system:

- When **WASH amenities** are available, they require improvement in terms of adequacy, accessibility, functionality and quality.
- **Solid, liquid and medical wastes are poorly managed in facilities** – which lack appropriate infrastructure and capacity for segregation and treatment.
- **Facility-specific guidelines and training** on facility cleanliness, IPC and personal protective equipment (PPE) are poorly and inconsistently implemented.
- **Lack of financing in primary HCF.** Investments in infrastructure and training are concentrated in the tertiary care facilities, having a high patient load and offering a range of health services. However, primary HCF, located closest to communities, need improvement, with limited investments and human resource capacities.
- **Investments in WASH compete with other critical investments** required for healthcare staff and treatment services (e.g., equipment and medicines).
- **Limited recognition that WASH is a critical component for quality of care, disease prevention and health promotion**, with the potential to contribute to improved treatment outcomes alongside curative efforts.
- **Staff structure in HCF** require medical professionals to attend to the management of the facility as well. Participatory management structures, such as the Rogi Kalyan Samiti (Hospital Management Committees), are not functional in many facilities.

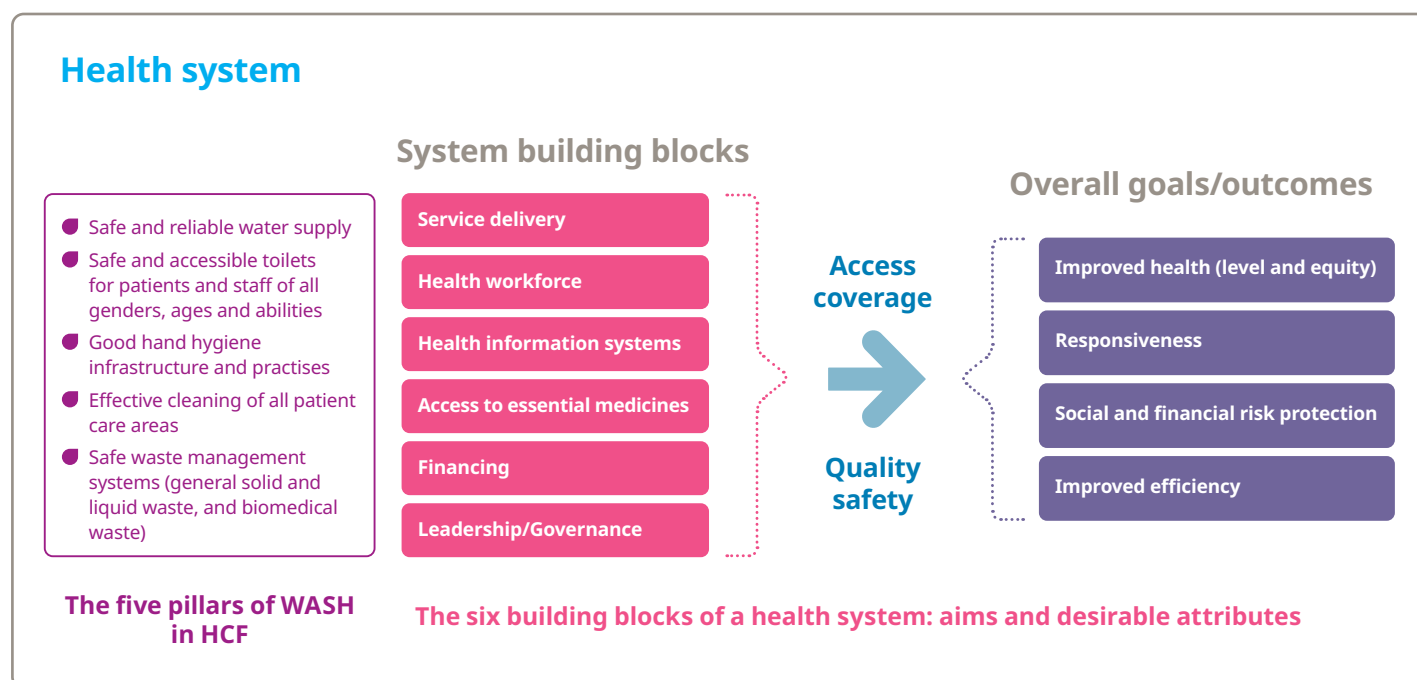


15. Say L, et al. (2014). Global causes of maternal death : a WHO systematic analysis. *Lancet Global Health*. vol 2, no 6, E323–E333. Available at: doi.org/10.1016/S2214-109X(14)70227-X (accessed 6 Apr 2022).

16. International Institute for Population Sciences (IIPS) and Macro International (2007). *National Family Health Survey (NFHS-3), 2005–06: India: IIPS*.

17. International Institute for Population Sciences (IIPS) and ICF (2017). *National Family Health Survey (NFHS-4), 2015–16: India*. Mumbai: IIPS.

Figure 6. Integrating WASH into the health system building blocks



Approach

Achieving the goals of the Global Action Plan for WASH in HCF and implementing the eight practical steps for universal access to quality care in India calls for an approach that strengthens health systems, whereby WASH is positioned within the health systems building blocks, namely leadership and governance; healthcare financing; health workforce; medical products and technologies; information and research; and service delivery (Figure 6).¹⁸

Safe and sustainable WASH interventions in HCF in India fall under five inter-related components: leadership, institutionalising processes, capacity building, monitoring mechanisms and research, and responsive and resilient solutions (technologies and innovations). In this case study, we will be focusing on responsive and resilient solutions, outlining how we have responded to emergencies, including natural disasters and public health emergencies. HCF with responsive and resilient WASH services strengthen treatment services and prevent the spread of infections, especially among communities who are vulnerable to these emergencies.

Evidence of change

In 2018, the Southern State of Kerala was devastated by floods, which impacted communities and the HCF serving them. In collaboration with the WHO, WaterAid India worked with the Wyanad District administration to undertake intensive WASH assessments of HCF and anganwadis (early childcare and development institutions). As part of this assessment, WaterAid India developed facility improvement plans, carried out WASH related renovations and construction in 12 HCF and 50 anganwadis, in addition we distributed water filters to 243 anganwadis.

All infrastructure renovations were undertaken with a focus on 'resilience' given the vulnerability of this area to natural disasters. Unique interventions in Wyanad HCF and anganwadis were the restoration of dug wells, installation of water filters, training on the use of water quality testing kits, and rainwater harvesting (RWH) systems.

In the northern State of Uttar Pradesh, WaterAid India invested in critical infrastructure in a community health centre and primary

18. WHO (2010). *Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies*. Available at: wpro.who.int/health_services/health_systems_framework/en/ (accessed 24 Mar 2022).



► Head Nurse Madhubala Awasti washes her hands after assisting patients in a ward of a community health centre. Uttar Pradesh, India. June 2021.

healthcare institution, including RWH systems. These RWH systems provided water for handwashing and to flush toilets. The Rogi Kalyan Samiti was focused on the importance of WASH infrastructure O&M, including the need for budgetary allocations for O&M. These actions led to the Government passing a Government Order to have RWH systems in HCF as standard as standard in Uttar Pradesh.

The Government was engaged throughout this process to ensure continuity beyond the project period, and to institutionalise regular assessments and budgetary allocations for WASH improvements, and O&M.

Key lessons

- Increase financing and investments to ensure adequate WASH as part of broader health system strengthening. Such financing should include regular O&M of WASH infrastructure; training and capacity building of healthcare providers; mandated institutions on WASH; hygiene and IPC; and strong social and behaviour change campaigns to promote hygiene among all HCF staff, patients and their caregivers.
- Strengthen the structure, processes and actions of mandated structures like Rogi Kalyan Samitis and IPC committees in public HCF, to build their focus on strengthening and maintaining HCF infrastructure and services, including that of WASH.
- Strengthen community level institutions and their ownership and participation in HCF processes, for improving healthcare services including the better provision of WASH services in these facilities. Communities can also be sensitised on the importance of WASH in HCF, and their rights as patients and caregivers to demand WASH secure facilities.



WaterAid/Anindito Mukherjee

Conclusions and recommendations

From our work on system strengthening, we can make the following recommendations:

- Governments should allocate increased financing to ensure adequate and resilient WASH in HCF.
- Policy makers should include WASH services in HCF as core priorities in all critical health policy documents (e.g., State and National health policies, patient rights/citizens charters, Indian Public Health Standards), programmes (e.g., home-based newborn care, antenatal care, health and wellness centres) relevant to quality of care, respectful maternity care and UHC.
- Governments should regularly review and assess WASH status in HCF within health-related standards (e.g., Indian Public health Standards), monitoring systems (e.g., Kayakalp) and independent facility level surveys. Use the findings to inform action plans and budgetary allocations to improve WASH facilities, systems and standards.



Malawi

Community engagement – the case of Chikwewo Health Centre



Context

The passing of the WASH in HCF resolution during the 2019 WHA was a catalyst for the transformation of health systems. In Malawi, WaterAid's lobbying contributed to repeated commitments by the Minister of Health to ensure the development and implementation of a WASH in HCF improvement roadmap that will catalyse WASH improvements in HCF, like the Chikwewo Health Centre.

The Chikwewo Health Centre is situated in Traditional Authority Chikwewo in Machinga District, 91km from Machinga District Hospital – with a population of 107,003. The HCF has struggled with WASH problems since its water systems were vandalised in January 2016 and has since relied on a borehole fitted with a hand pump located at a neighbouring primary school. The hospital staff and guardians have been competing with the school children and surrounding community to access the water – which in turn has compromised the quality of the centre's health services.

Barriers

Key barriers identified to progress on WASH in Chikwewo Health Centre included:

- **Inadequate O&M of WASH facilities.** Most times, the maintenance committee lacked enough financial resources to maintain the facility.
- **Insufficient number of security guards increased risk of vandalism.** Vandalism is a result of limited community participation in health service delivery, and inadequate ownership of the WASH infrastructure.
- **Low staff retention numbers and understaffing.** Due to lack of running water and sanitation facilities for both patients and staff, which is a particular burden for women health workers, the centre has been understaffed for a number of years and struggled with staff retention. Staff were requesting transfers from the facility or did not report for work once posted to the facility.
- **Lack of handwashing facilities and IPC.** Medical staff and patients seeking care were unable to wash their hands due to lack of handwashing facilities, soap and piped water supply. This impacted on the overall hygiene practices and IPC measures – putting the lives of the patients and health workers at risk.
- **Lack of gender responsive WASH facilities.** Expectant mothers were not interested in delivering their babies at the centre due to lack of safe and private WASH facilities. Most women opted to deliver at home, and some even waited until the last minute to come to the centre for delivery.

◀ Mary Khobiri, nurse and midwife, now has a place to wash her hands at the Mangamba Health Centre, thanks to the UKAID funded Deliver Life project. April 2019.



WaterAid/Dennis Lupenga



WaterAid/Dennis Lupenga

◀ The old borehole was a ten-minute walk from Chikwewo Health Centre. Patients had to walk there to collect water. Now through the Deliver Life II project, this facility has toilets for both patients and staff, bathrooms for pregnant women, a reticulated water supply system, an incinerator, and a placenta pit. Machinga, Malawi. September 2019.

Approach

Deliver Life II is a project funded with UK aid through the support of the Scottish Government and Scottish Water to help bring WASH to women, girls and children in the southern region of Malawi. It started in October 2018 and will run until March 2023 – so far it has modelled WASH in four HCF, one of which was Chikwewo.

A system strengthening approach was implemented at Chikwewo health centre through community participation and ownership to both enhance O&M and curb vandalism. For example, the community has come up with income generating activities to finance O&M including, growing & selling maize, sweet potatoes & groundnuts and operating bicycle storage for clients (at a fee) who come to seek services at Chikwewo. In addition, a life-cycle cost analysis exercise supported O&M committees at district and facility level to plan for sustainable WASH services. Capacity strengthening of healthcare workers was delivered through IPC and WASH training, this included waste management, hand hygiene and environmental cleaning.

The project continues to support the district council to develop SDG responsive District Strategy Investment Plans (DSIPs) and increase the allocation of funds to WASH at district level.

The WASH in HCF model at Chikwewo – including the WASH package, designs and standards – was used to demonstrate potential for scale up with the MoH and other stakeholders.

Evidence of change

After IPC and WASH training was delivered to healthcare workers through the project, and the publication of new IPC and WASH guidelines, improvement plans were developed at an HCF level on different aspects of IPC – such as waste management, hand hygiene and environmental cleaning. These improvement plans were then implemented by healthcare staff. A district IPC coordinator conducts quarterly supervisions at the health facilities to check on progress, and through this observed that IPC is now effectively practiced at the centre – by healthcare workers and patients alike.

Monitoring and engagement of healthcare workers has indicated that improvements in the working environment at the centre has increased staff motivation.

The MoH has recommended the WASH package designs and standards modelled at Chikwewo to other HCF across Malawi through presenting to the Safe Motherhood sub-technical working group, and is influencing other WASH stakeholders to adopt the package – which includes guidance on incinerators, ash pits, placenta pits, latrines, toilets and reticulate water supply systems – for scaling up safe and sustainable WASH.



Key lessons

- Community involvement and ownership contributes to an improved quality of WASH services. In the Deliver Life II Project, community members supervised construction works at the facility, which meant the contractors adhered to specified standards.
- Community involvement contributes to financial savings and improves sanitary conditions. For example, at Chikwewo, community volunteers mobilised bins to dispose of solid waste at the facility, which also allowed the facility to save money on contractors.
- Sustained engagement and conversations with government ministries, departments and officers helps prioritise and integrate WASH and IPC. Our conversations so far have led to the development of revised national IPC WASH guidelines in Malawi. Deliver Life II is supporting the roll out and adoption of these revised guidelines in the project's target HCF.
- Evidence generated from studies and projects can be leveraged to influence national strategies and roadmaps. WaterAid Malawi utilised studies to influence the inclusion of WASH in institutions as a standalone theme in the National Sanitation and Hygiene Strategy (NSHS) 2018–2024. The Deliver Life II project also generated evidence that is influencing the content of Malawi's WASH in HCF improvement roadmap.
- The identification of service provision gaps can lead to the establishment of new partnerships. Our work has profiled WASH service provision gaps in HCF and attracted donors to partner with WaterAid in their priority districts.

► Borehole installed under the Deliver Life II project, Nsisi village, Machinga, Malawi. December 2021.

Conclusions and recommendations

The work in Chikwewo demonstrated the importance of community engagement when modelling WASH in HCF. Community engagement and ownership led to improved quality of WASH services and cost saving. From our work in Malawi, we have made the following recommendations:

- To improve and sustain WASH service delivery and behaviour change in HCF, the Government of Malawi will need to increase financial allocation to local governments. This will then meet the policy prescribed minimum threshold of 5% of all national budget resources being channelled to the district councils, and will position them to better cater for the O&M of WASH in HCF.
- The MoH should strengthen community participation in the delivery of health services through ensuring that there is a complete loop from conducting service delivery satisfaction surveys and exit interviews, to giving feedback to communities on the findings, and taking action on the issues identified.
- NGOs should have an in depth understanding of the barriers to sustainable WASH services in HCF and invest in long term systematic interventions to address the blockages and break the cycle.





Mali

Partnerships and coordination for effective WASH services in HCF



Context

The 2014 Ebola virus epidemic in Mali highlighted the deadly consequences of a lack of WASH in HCF. This was also the time for change, with UN member states announcing the shift to a new sustainable development agenda, with the transition from the Millennium Development Goals (MDGs) to the SDGs, and the start of the national 2016/21 country intervention strategy.

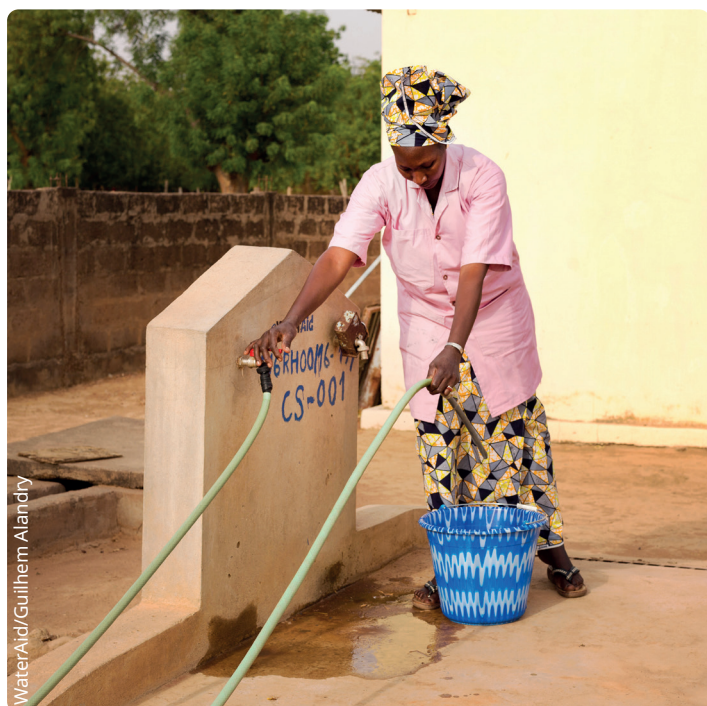
WaterAid Mali implemented a WASH project from January 2015 to December 2017 in 23 HCF in the districts of Bla (Segou region) and Koro (Mopti region) in collaboration with Centers for Disease Control and Prevention (CDC), WHO, Ministry of Health and Public Hygiene (MSHP), Territorial Collectivities (TCs), Community Health Associations (ASACOs), and local NGO partners (ALPHALOG, APROFEM and ARAFD).

▼ Abibatou Diarra, Midwife, collects clean water from a tap installed by Wateraid at Diaramana Health Centre, Cercle de Bla, Segou Region, Mali. April 2018.

Barriers

Through the WASH in HCF project, WaterAid Mali identified four factors that contributed to inadequate WASH services in the HCF:

- **Insufficient data on WASH coverage in the HCF.** Information at the national level is only very rarely collected through evaluations on a representative sample and hasn't used JMP global indicators.¹⁹ This means there is no comprehensive up to date national data on WASH coverage in HCF.
- **Funding prioritised for households over HCF.** Historically, bilateral agreements, private foundations and governments have prioritised WASH services in households (as per MDGs).
- **Inadequate capacity and governance.** Lack of technical and financial resources allocated to WASH and weak governance of the ASACOs – who are responsible for managing community-based HCF, including WASH. This weak governance is characterised by a poor understanding of their roles and responsibilities, as well as problems of management and financial capacity.
- **Unfavourable environment for inter-sectoral initiatives.** Coordination between the health and WASH sectors is weak in Mali, with a lack of clarity on the roles and responsibilities of the different ministries responsible for health and WASH. As such, responsibility and accountability is split between two sectors.



19. *Global progress report on water, sanitation and hygiene in health care facilities: fundamentals first*. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.



◀ Setou Diallo, 45, a member of the Benkadi women's group, standing with her two daughters Korotimi and Foune at home in Kakounouso, Samabogo, Bla district, Segou, Mali. October 2019.

Approach

To address these obstacles, WaterAid Mali, CDC, National Directorate of Health/Direction Nationale de la Santé (DNS) and the WHO implemented a multi-stakeholder project with the following key focus areas:

1. Analysis of the baseline situation and accessibility (by WaterAid Mali, CDC and the DNS).
2. Provision of WASH services and promotion of behaviour change (by WaterAid Mali).
3. Capacity building at local and national levels (by WaterAid Mali, WHO and the DNS).
4. Improving planning and coordination between actors to create an enabling environment (by WHO and the DNS).

The above areas were implemented in an adaptive, multi-stakeholder approach and a specialised partnership. As seen above, the partnership utilised the various organisations' respective strengths by leading on different areas of implementation. A working group has been set up to facilitate coordination between the project implementation areas, in addition to coordinating the development of national norms and standards.

Evidence of change

Once the project was complete, all 23 targeted HCF had access to water and sanitation (including solid waste management) and cleaning staff. In addition, an Environmental Health Management Plan (using WASH FIT) that supports the sustainable management of WASH was developed and put in place in all 23 HCF.

Throughout the project, the collaboration of the three partners – DNS, WHO, WaterAid Mali – helped facilitate the points of view and the ability to adapt plans as challenges arose.

A national WASH-Health Task Force was re-launched in 2016 to coordinate sector efforts, share lessons from the field and promote work to improve WASH in HCF nationwide. This taskforce serves as a platform for discussion, chaired by the Public Hygiene and Sanitation Division of the National Health Directorate. As a result of this taskforce, several key documents have been approved including the [Minimum WASH in Health Care Facilities Package](#) (*Paquet minimum pour l'accès à l'eau potable, l'hygiène et l'assainissement dans les établissements de santé au Mali*), the [National WASH Strategic Plan](#) (*Plan stratégique national pour l'amélioration des conditions d'accès à l'eau potable, l'hygiène et l'assainissement dans les établissements de santé au Mali 2017-2021*) and guidelines (*Le guide technique des infrastructures dans les centres de santé*), and protocols (*Directives nationales de prévention et de contrôle des infections* – a catalogue of technologies to guide high quality service delivery in HCF).

The project outcomes have been utilised as evidence for advocacy and awareness raising by WaterAid in Mali for additional action on WASH in HCF. In addition, the results of the CDC study on perinatal infections and the practise of handwashing by health personnel was key in achieving our evidence-based advocacy aims. WaterAid Mali has recently worked with the National Directorate of Health to contextualise JMP WASH indicators, into the health information system on DHIS-2 at the national level, for monitoring progress on WASH in HCF.

Key lessons

These partnerships re-emphasised that universal access to sustainable WASH requires opportunities to innovate, learn, disseminate and scale up models. In particular, the following lessons emerged:

- The Ministry of Health is ultimately responsible for ensuring WASH in HCF is planned, implemented, monitored and reported. So, the leadership of the health staff and their accountability throughout the entire process, from planning to reporting, were key factors for the success of the project and its sustainability.
- Collaboration with specialised partners contributed to a more effective way of working and clear roles and responsibilities leveraged each organisations' strengths.
- Learning and experience sharing within the Task Force was a key contributing factor to the improvement of framework documents and policies – which meant the project was able to adapt as it continued.
- Evidence obtained in the implementation of the project facilitated the commitment of parliamentarians to WaterAid's advocacy campaign for the reduction of malnutrition, neonatal and child mortality.
- The availability of WASH services combined with evidence-based behaviour change interventions facilitated the adoption of good hygiene practises among both health staff, patients and carers.
- WASH in HCF can be used as an entry point within communities for district-wide approaches to WASH and system strengthening more generally.

► Oumar Malle, centre, chief of Dankoumani, holding a meeting with community members in his village, Bla district, Segou region, Mali. October 2019.



Conclusions and recommendations

Leveraging partners' respective strengths and establishing robust coordination mechanisms is critical for achieving quality WASH in HCF.

Based on the evidence and lessons learned, a model WASH in HCF intervention should:

- Adopt an adaptive, evidence-based approach that maximises the return on investment in the health sector and demonstrates the importance of WASH to development.
- Fit into the existing multi-stakeholder framework or, where appropriate, create an enabling environment for good sector coordination and the definition of harmonised normative and regulatory documents.
- Combine sustainable WASH service delivery and evidence-based advocacy for health system strengthening and universal access to sustainable WASH.
- In addition, at the national level, Ministries should establish coordination mechanisms between WASH and health.



WaterAid/Basile Ouedraogo



Myanmar

Supporting Safer Births in Myanmar project



Context

In Myanmar, the WASH and IPC situation in HCF is unclear due to the lack of nationally representative data. When WASH facilities are present, these often do not meet the minimum WHO standards. Since WaterAid Myanmar's establishment in 2016, two research pieces on WASH in HCF have been conducted in collaboration with the Ministry of Health and Sports (MoHS). The findings from these studies were used to improve the conditions of WASH and IPC in HCF in Myanmar under WaterAid Myanmar's flagship WASH in HCF project, Supporting Safer Births in Myanmar (SSBP).

The SSBP project was due to be completed by December 2022. However, following the military coup in Myanmar on 1 February 2021, WaterAid has ceased to engage with government institutions. Health workers around the country have been involved in the civil disobedience movement in protest of the coup. In this context, continuing the SSBP was no longer feasible and WaterAid – through consultation with GHD and DFAT – agreed to conclude the project in June 2021.

▼ A nurse and Ma Tin Tin Aye with her baby in Lemyethna hospital, Ayeyarwady Region, Myanmar. March 2020.



Barriers

Throughout the SSBP project, the following barriers to progress on gender and socially inclusive WASH in HCF were identified:

- **WASH and IPC financing.** There was no dedicated financing for WASH and IPC facilities within HCF budget allocations in Myanmar.
- **Lack of awareness on gender and social exclusion.** Key stakeholders such as the MoHS and HCF staff at different levels have limited awareness of gender and social inclusive WASH and IPC.
- **Lack of coordination with organisations.** There was a lack of regular coordination mechanisms around inclusive WASH in HCF and no formal consultation with DPOs or women's rights groups.
- **Underrepresentation for all WASH and HCF users.** User voices and feedback, including those of women and groups who are marginalised, were rarely integrated into design and improvement of WASH in HCF.
- **Lack of waste management solutions.** Limited facilities are provided for healthcare waste management by township municipalities.
- **COVID-19 restrictions.** During the COVID-19 pandemic, travel restrictions, quarantine requirements and limited access to HCF meant that improvements to HCF were reduced.



Approach

To address these critical barriers to progress on gender and socially inclusive WASH in HCF, WaterAid Myanmar – in partnership with Jhpiego and in collaboration with the MoHS – implemented the SSPB project with funding from the Australian Government (DFAT) Water for Women Fund.

The project's goal was for 'Myanmar women to have safer births through improved quality of maternal and newborn care', through healthcare system strengthening by integrating Gender and Socially Inclusive (GSI) Water, Sanitation and Hygiene and IPC; and demonstrating quality improvements (QI) at five township hospitals in the Ayeyarwady Region.

Several coordination mechanisms were implemented through the SSPB project with representation from various relevant ministries and a wide range of stakeholders, including DPOs and women's rights groups. A capacity building package called **'TEACH CLEAN'** and a QI approach – which aimed at good hygiene practises among hospital cleaning staff and nurses – was also delivered through the project.

Evidence of change

After SSPB the project activities, government staff demonstrated increased openness to gender and social inclusion concepts. Central and Regional MoHS officials were fully involved throughout the project, including in the development and delivery of the TEACH CLEAN training. The TEACH CLEAN training package has been designed with a gender and social inclusion lens, so participating in the process helped MoHS staff gain understanding of the concepts involved.

HCF staff, including managers, nurses and cleaners, demonstrated improved practises around hygiene and waste management and sense of ownership for WASH and IPC following the TEACH CLEAN training. For example, Kyangin Township Medical Officer independently funded and installed inclusive infrastructure such as: user-friendly toilets within menstrual health and hygiene facilities, separate sex bathing facilities, and proper pathways.

Cleaning staff and junior nurses were invited to join the QI committees after the TEACH CLEAN training. The inclusion of cleaners and nurses, who are often women, in the QI committee, has provided them the opportunity to participate in decision-making processes, which are often dominated by doctors (primarily men).

Healthcare waste management in township hospitals was significantly improved when a Township Health Working Group (including members from General Administration Department and township municipal department) and a QI committee was well established and functioning.

◀ Mg Min refills water in a water bottle from water tank supplied drinking water in Lemyethna hospital, Ayeyarwady Region, Myanmar. March 2020.





▲ Nurses take care of their patients in one of the baby rooms of Hinthada hospital, at Hinthada township, Myanmar. March 2020.

Conclusions and recommendations

The SSBP project has been a catalyst for change. Through this, WaterAid Myanmar has worked to strengthen coordination mechanisms and capacity of health workers to deliver gender and socially inclusive WASH in HCF.

When implementing projects aimed at achieving gender and socially inclusive WASH in HCF, we recommend to:

- Build in ongoing capacity development and supervision for project staff and stakeholders (such as MoHS officials and HCF staff) and target groups to ensure ongoing implementation of GSI.
- Strengthen partnerships with women's rights group and DPOs, with allocated budget, and bring them on board early. Incorporate them in formal coordination mechanisms to strengthen their influence with the MoHS on GSI.
- Identify and establish critical coordination mechanisms across all levels early in the project (for example, regional advocacy meetings were critical for influencing change at HCF level). This requires understanding the local context and MoHS structure at the intervention design phase.

Key lessons

- Creating a shared understanding of gender and social inclusion concepts and approaches amongst project stakeholders from the beginning will improve intervention designs. The project team also needs to understand how to translate these concepts into measurable change within the design and monitoring processes.
- Robust set up of project governance structures and coordination mechanisms accelerates project activities, promotes engagement across national, regional, township and facility levels and different stakeholders, and facilitates effective coordination.
- Involving rights groups as more active partners from the start allows them to take on a more significant role in designing and implementing project activities – which leads to more effective influencing.
- A 'softer advocacy approach' using informal and formal communication can prove a successful strategy when facing government resistance on gender and social inclusion issues.
- Recruiting a project manager who has an in depth understanding of the local health systems leads to more effective interaction with various officials across multiple complex systems.
- Harmonising of quality (IPC) and WASH improvement processes is important to ensure timely infrastructure development and renovations, buy in from health workers and sustainability.

Case study



Nepal

Journey of WASH in HCF

National Standard endorsement



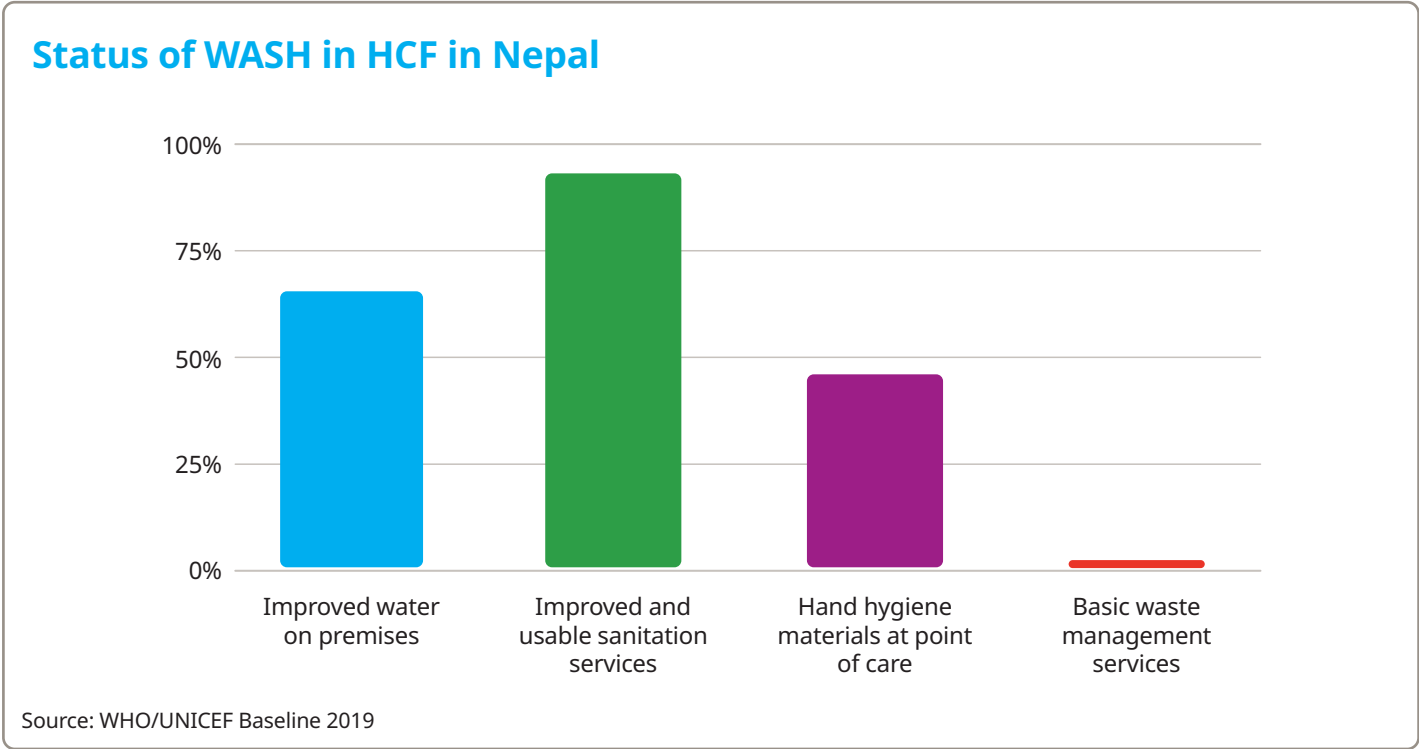
Context

Against the backdrop of the global review conducted by the WHO and UNICEF in 2015 on the importance of WASH in HCF, the Constitution of Nepal established ‘access to safe water and sanitation’ as fundamental human rights. To support this, the Ministry of Water Supply developed a Total Sanitation guideline to eliminate open defecation and create an environment where everyone, everywhere has access to WASH facilities. Despite significant progress in improving basic drinking water and sanitation coverage in Nepal, WASH in HCF remains a challenge. Figure 7 is an example of this contrast, it shows how more than one-third (36%) of HCF lack improved water on premises, 8% have no improved and usable sanitation services, less than half (46%) have hand hygiene materials at the point of care, and just 1% with basic waste management services.²⁰

► These inclusive and user friendly WASH facilities at Jamuni Health post were constructed by WaterAid Nepal and its implementing partner Backward Society Education (BASE).



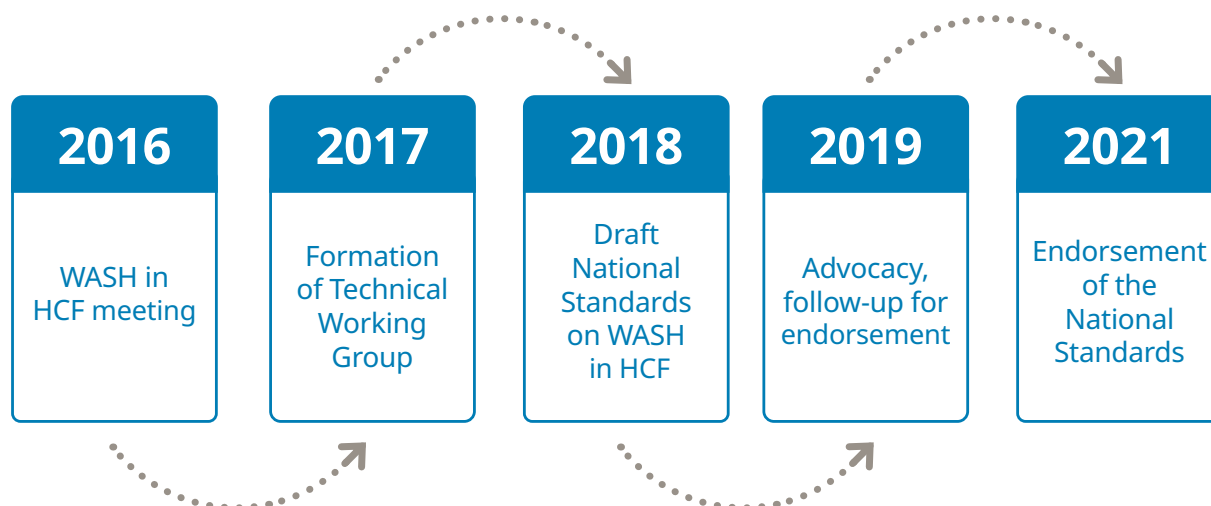
Figure 7: Status of WASH in HCF in Nepal



20. WHO (2021). *Global progress report on WASH in health care facilities: Fundamentals first*. Available at: [who.int/publications/i/item/9789240017542](https://www.who.int/publications/i/item/9789240017542) (accessed 6 Apr 2022).

Figure 8. Timeline of National Standard development

Timeline of National Standards development



Blockages

Some of the barriers to progress on WASH in HCF in Nepal were as follows:

- **Lack of reporting and data.** There was a significant gap in evidence on the status of WASH HCF, and no data on which organisations were working in this area.
- **Lack of clear roles.** During 2016, there was no assigned body within Ministry of Health and Population (MoHP) to look at the WASH in HCF agenda. In early 2017, it was decided by MoHP to give the responsibilities to the Management Division.
- **Lack of waste management solutions.** There was limited work around healthcare waste management, which poses a risk for human and environmental health.
- **Lack of national standards on WASH in HCF.** The HCF worked to WHO guidelines, but did not have nationally contextualised standards.
- **Limited HCF WASH indicators or guidance for all levels of HCF.** There was only a minimum service standard for district level hospitals, which had limited WASH indicators.

Approach

WaterAid Nepal conducted an assessment of WASH in 20 different HCF in three districts, Siraha, Sindhuli and Makwanpur. As a result, evidence was generated and then shared in different health sector forums.

WaterAid Nepal collaborated with the WHO to conduct a policy dialogue on the integration of SDGs 3 and 6 in the presence of higher-level dignitaries from the MoHP, the National Planning Commission and the Department of Water Supply and Sewerage. During the policy dialogue meeting, the Health secretary guided a discussion with the Management Division and shared the evidence and ideas on WASH in HCF.

WaterAid Nepal, with coordination from the Management Division, conducted a review meeting asking different organisations working on WASH in HCF to share their plans and programmes. As a result, a technical working group (TWG) on WASH in HCF at the Federal level in Nepal was formed in 2017 under the MoHP, Management Division – with WaterAid Nepal acting as secretariat.

The TWG provided technical support in drafting the National Standards for WASH in HCF and carried out necessary follow-up activities and advocacy for its endorsement. As the secretariat to the TWG, WaterAid Nepal continuously advocated to finalise the National Standard and its endorsement with MoHP on a regular basis. Furthermore, the WHA resolution of 2019 on WASH in HCF also acted as an amplifying affect for Nepal's National Standard for WASH in HCF to be endorsed. Since then, the Management Division has already geared up to develop a costed roadmap for WASH in HCF.

As a result of continuous advocacy and follow up, the MoHP endorsed the WASH in HCF National Standard in July 2021.

The TWG formed during the standard development process was active and self-motivated. Two parallel TWGs were also formed during that time – one for healthcare waste management and another for WASH in HCF, both with similar members and interrelated issues – discussion around merging the two TWGs is ongoing. MoHP is committed to develop a roadmap of WASH in HCF to support the implementation of the WASH in HCF national standards. Similarly, orientation programmes on the standards at provincial level are also underway.

▼ Sunita Kharel is a Senior Auxiliary Nurse and Midwife at Bhumlutaar health post where a contactless handwashing station has been set up to help stop the spread of COVID-19, Kavre, Nepal. September 2020.



Key lessons

- Evidence based advocacy helped grab the attention of stakeholders and officials working on MoHP to prioritise WASH in HCF.
- Regular coordination and support among government and stakeholders also played an essential role to maintain the interest to work on WASH in HCF.
- Ownership and dedication of the stakeholders played a crucial role in getting the standards endorsed. Despite the challenging transitional political situation during the national standards development process, it was the motivation and ownership from government and TWG Members that made the endorsement possible. Individual champions within the MoHP are critical and can guide the process of endorsement and advocate for increase action on WASH in HCF.

Conclusions and recommendations

The endorsement of the National Standard on WASH in HCF is a success story in itself. The standards help identify and address gaps, improve the WASH status in HCF, and safeguard high quality service delivery.

From the formation of TWG to drafting the standards and advocating for its endorsement, WaterAid Nepal has been a driving force throughout the process.

When implementing WASH in HCF interventions, our recommendation is for:

- Governments to involve all TWG members in the implementation process.
- An action plan, guideline or road map, along with the required budget standards for the implementation of the standard, to be developed at the start of the process.
- The national standards to be accompanied by an orientation and sensitisation programme to avoid delays in implementation.

Case study



Tanzania

Multiple approaches to increase WASH for health outcomes



Context

Even though the Geita Region is bordered by Lake Victoria, through a baseline study we determined that there was limited access to water in HCF and at community level in Geita and Nyang'whale districts. Common sources of water for households, facilities and schools included seasonal boreholes, unprotected wells and dams. Women had to travel long distances to collect water, even when they were pregnant. This was particularly challenging for the pregnant women who had no choice but to bring a bucket of water to the maternity ward.

The lack of water and handwashing facilities meant that hygiene practises were difficult to uphold and IPC impossible to sustain. Availability and use of toilet facilities in HCF was an area that needed to be addressed to improve faeces disposal and help minimise disease transmission. Further to these practical issues, it was clear that women's participation in decision making was very low, with only few women able to make decisions regarding their health and other household matters.

▼ Nyaganga Juma Samuel, 37, nurse and midwife, showing Modesita Hamisi, 28, how to keep her newborn baby comfortable, Nyamalinbe Dispensary, Geita District, Tanzania. June 2020.



WaterAid/James Kiyimba

Barriers

Through a baseline survey, in depth interviews and focus group discussions with district officials, village leaders and community members, we determined the following barriers:

- **Limited funds were allocated by district councils for WASH in HCF** to improve WASH in HCF. For example, this meant that the allocated annual budget was inadequate to ensure every health facility has reliable source of safe water. This is partly attributed by lack of joint efforts between health and water department to advocate for water availability during Council meetings.
- **Weak integration of WASH** during HCF planning at the District Council Level, leading to poor prioritisation of WASH in HCF.
- We found there was weak integration of sanitation and hygiene messages into community health workers' scope of work.
- **Poor knowledge in the community** on women's empowerment and their ability to make decisions to seek and utilise reliable health services for themselves and their families.

Approach

We implemented the Tanzania 'Deliver Life' project over 4 years in the Geita and Nyang'whale districts, which in addition to the construction of infrastructure focused on generating change through engaging with community and government advocates. Project delivery included the following activities:

- Constructing WASH infrastructure at 12 HCF, increasing access to running water within facilities, flushing toilets and handwashing stations to the maternity wards, operating rooms, and other areas within the facility through partners' engagement.
- Training 1,906 community health workers and skilled birth attendants (SBA) on the provision of gender-sensitive services and best practices in WASH.
- Identifying, training and mentoring 878 community change agents to influence peers on positive WASH practises, including the impact of gender inequalities.
- Awareness-raising campaigns on available WASH services using local influencers and artists who used a mixture of role play, engagement with local women and people in the waiting room to raise awareness on WASH in HCF.
- In collaboration with the Local Government Authority, advocating for the inclusion of women in community water and environmental committees. The former community water committee (COWSO) were women-led and had a role to maintain and expand water infrastructures including use the collected fund to expand water services to the community, including HCF to increase the number of people who has access to water and increase the collection as well.
- Orienting local leaders on WASH issues for improved budgeting and planning for WASH in HCF.

Table 1. Coverage of delivery services among women with a live birth in the two years preceding the survey in Geita and Nyang'whale districts, at baseline²¹ (2016) and endline²² (2020)

	Baseline	Endline		
	Total % (95% CI)	Geita % (95% CI)	Nyang'whale % (95% CI)	Total % (95% CI)
Skilled Birth Attendants (clinician, nurse, midwife)	59 (51–66)	79 (73–84)	75 (70–80)	78 (74–83)
Place of birth				
Home	46 (39–53)	16 (12–20)	23 (17–28)	17 (14–21)
Hospital	15 (12–19)	13 (10–16)	16 (12–20)	14 (11–16)
Clinic/health centre	23 (18–28)	37 (30–43)	41 (34–47)	37 (32–43)
Dispensary	16 (12–21)	33 (27–38)	19 (13–25)	30 (25–35)

21. Baseline survey conducted by DAMAX Solutions Co. Ltd with technical and financial support from Amref Health Africa and WaterAid Tanzania.

22. Endline survey conducted by Tanzania Institute of Monitoring and Evaluation (TIME) with technical and financial support from Amref Health Africa, Christian Children's Fund of Canada (CCFC), The Hospital for Sick Children's Centre for Global Child Health (SickKids) and WaterAid.

Evidence of change

The project contributed to significant improvement in the experience of women who deliver their babies at all HCF in the Geita and Nyang'whale districts. For example, women are no longer required to bring their own buckets of water during delivery. In addition, before the intervention, only 59% of women surveyed had an SBA present during the birth process – that statistic rose to 78% after the intervention.

These measures have contributed to improved access to sanitation and hygiene services and there has been a decrease in sepsis cases.

The end line evaluation for the project indicated that HCF have included the project activities in their plans – such as repair and maintenance of infrastructure built by the project. We were able to reach 729,093 community members through education and awareness-raising campaigns on available WASH services using local influencers. As a result of the advocating through the Local Government Authority, we recruited 247 COWSO members, which are women-led community water and environment management committees.

Key lessons

- Inclusion of different stakeholders from the project design to inception is very important in enhancing participation, ownership, awareness, and sustainability of the project. It is particularly important to include political leaders who are responsible for allocating government funds. The project team cooperated with the whole regional and local administration from higher to lower levels, which made it easier to understand the project and further increase the commitment to achieve the project goal.
- Since the water supply is handed over from the COWSO to the new community-based water and sanitation organization (CBWSO), institutional capacity needs to be strengthened. The CBWSO is a community organisation with the same responsibilities as the COWSO but involves additional members such as teachers, doctors, government staff.

For sustainability purposes, the CBWSO water projects should be integrated within the formal government operational board/agency (water utility) to potentially raise revenue for O&M and contribute to extensions of the project.

- The proper technical design and successful construction of RWH can help to solve water challenges in HCF throughout the year.
- Access to WASH in HCF increases trust in the health services to give birth in facilities in comfort and safety as opposed to at home.

Conclusions and recommendations

From our work in the Geita region, we recommend that the actors' different roles are understood and supported as follows:

- **Government at all levels.** The government should ensure adequate funds are allocated and disbursed in the sub-national level office to cover for the cost related to O&M, renovation and expansion of WASH services in the HCF. Sustainability and expansion of project activities require the commitment of the government from the national to the local levels and other key partners.
- **Health facility.** HCF governing committee should meet regularly to review their roles and to make a follow up of the facilities to ensure the achievements made in WASH in HCF are sustained and expanded/replicated.
- **Community.** We recommend that where the community has responsibility for water supply, the CBWSO should use collected funds to expand water services to the community including public institutions like HCF. This will increase the number of people who have access to water and increase the revenue for CBWSO. In long run, the whole community will have access to water. The CBWSO should have forums with village leaders and national assignee water governance bodies/agencies to discuss water issues in the respective village to avoid interference and conflict of interest between the organisations and ensure everyone is working toward the same goal.

Case study



Uganda

Evidence driving action



● Jalia Nabukeer, midwife, washing her hands outside the outpatient department block before attending to patients at Katabi Health Centre III, Wakiso District, Uganda. February 2022.

WaterAid/James Kyimba

Context

WASH in HCF has been an advocacy objective for WaterAid Uganda since 2016, with an aim to shift the national narrative following the 2019 WHA resolution. The strategy was to generate evidence for WASH in HCF to inform government policy and standardisation of services – and work to improve awareness of the problem and attract powerful champions to drive forward national access.

WaterAid Uganda prioritised the strengthening of data and monitoring to uphold quality standards for WASH in HCF. However, a lack of WASH service levels baseline data and context-specific guidance to inform these changes hindered progress.

Barriers

The main barriers to progress on WASH in HCF were:

- **Absence of reporting and data.** A lack of clear information on gaps in service levels and weaknesses in management and financing of WASH facilities was a major barrier to moving the WASH in HCF agenda forward. This lack of data from Kampala and beyond hindered effective progress on improving access.
- **Lack of context-specific national standards** for quality WASH in HCF across Uganda.

Approach

WaterAid Uganda implemented a data gathering process for WASH in HCF in 2018 – which covered a large area to assist the MoH with data-based planning – and used this to engage and influence actors and decision makers. The initial assessment identified the actors, factors, gaps and relationships in the provision of WASH in HCF.

By 2020, and upon registering COVID-19 cases in Uganda, WaterAid initiated an assessment of WASH in HCF status in border towns; these towns were earmarked as critical to control the spread of the virus in Uganda. Following this, in partnership with UNICEF, WaterAid Uganda supported the MoH to conduct a nation-wide assessment of WASH in HCF using the [mWater tool](#), to build a comprehensive picture of the baseline data.

The data highlighted an urgent need for political leadership to drive the scale up of WASH in HCF services. WaterAid used the global WASH days to engage high level political players to support the development of the national guidelines for WASH in HCF. In partnership with UNICEF, WaterAid Uganda then supported the MoH to develop and follow through approval of the WASH in HCF national guidelines. This was achieved by facilitating national and regional consultation meetings and providing technical assistance to support the development of the guidelines.

▼ **Jalia Nabukeera, 29, enrolled midwife,** disposing off medical waste in a burning chamber (incinerator), Katabi Health Centre III, Wakiso District, Uganda. February 2022.



Evidence of change

There has been an initial commitment set out in national guidelines to increase resource allocation of water and sanitation, and preventive and promotive healthcare by 30%. This resource allocation comes from the Primary Health Care budget that goes to the HCF from the Central Ministry of Health.

Despite this success, the promised funds are not being allocated to WASH at facility level. WaterAid Uganda is working with local partners to highlight this challenge and help facility managers to plan and use this funding to improve WASH in HCF. The findings from the WASH in HCF assessment triggered discussions between the MoH, UNICEF and other WASH development partners around the development of national guidelines for WASH in HCF. This included establishing a National Task Team drawn from MoH, Ministry for Water and Environment, WaterAid, UNICEF and USAID to spearhead the development of the guidelines.

National standards and guidelines for WASH in HCF have been developed and validated by stakeholders. Once these are approved by the MoH the focus will shift to roll-out and uptake. The leadership of the MoH and involvement of Kampala Capital City Authority (KCCA) on conducting the WASH in HCF assessment helped to ensure that the evidence gathered through the process then informed the content of the national guidelines. The guidelines will help to set a standard for WASH in HCF and make provisions for ensuring their adequate O&M.

Key lessons

Catalysing change in WASH in HCF was achieved in a number of ways:

- **Capacity building:** Building the capacity of line ministries, departments and agencies to lead the advocacy and evidence generation work is important to ensure ownership of the data and sustainability of actions. By situating the work within government mandated institutions and working in the background, WaterAid Uganda was able to support government ownership.



◀ Tigalana Fidah, Senior Nursing Officer, getting safe drinking water from a water purifier located at a busy children's immunisation centre, Ndejje Health Centre IV, Makindye Ssabagabo Municipality, Uganda. May 2020.

- **Flexibility:** Initially only planned for the Greater Kampala metropolitan area, flexibility on expanding the WASH in HCF assessment in partnership with other stakeholders led to a longer process – but meant that the results were owned and actioned by the sector.
- **Build diverse partnerships:** Working in partnership with academia, technical people, policy makers, and political allies helped to strengthen collective voice. Emory and Makerere universities strengthened the credibility and rigour of the findings – and WaterAid provided the technical capacity and expertise. The MoH was able to scale up the assessment and use the results to support policy and guideline development. Political allies had the power to ensure the new standards and guidelines were adopted.
- **Securing early ownership of data and engagement:** Engaging stakeholders at all stages of the process helped gather support from decision makers. Presenting the evidence in a simple and target-audience appropriate format was instrumental in triggering a sense of urgency at the different levels of administration, including national and decentralised administrative units.
- **Ensuring quality in data collection and strategic dissemination:** WaterAid Uganda used the data generated to publish rigorous evidence on the status of WASH in HCF, with a focus on maternal, newborn and child health outcomes (MNCH). Publishing studies in peer reviewed journals enhanced the credibility of the evidence and framing it around MNCH outcomes increased engagement with the findings.

Conclusions and recommendations

Evidence and data are key catalysts for change. WaterAid Uganda nurtured broad ownership of the evidence gathering process between ministry, political and academic champions from the start – establishing a diverse group of actors and decision makers with the right mix of skills and power.

Garnering the buy-in to the concept prior to collecting data enabled the diverse stakeholders to recognise their contribution to the journey, which further increased their commitment. Co-creating the study with all target stakeholders required a longer process than collecting data alone. Working in this way was more effective than publishing the results of the assessment and then looking for engagement and uptake of scale results. Engaging decision makers with the power to influence WASH meant that WaterAid Uganda was able to ensure that national policy and guidance was driven by evidence. WaterAid Uganda recommends:

- Decision makers should establish collective plans and actions to close WASH related service gaps.
- WASH and HCF actors should collaborate to generate evidence, leverage respective skills, and enhance ownership and commitment to act on the findings.



Zambia

Gender and social inclusion in WASH in HCF



Context

WaterAid Zambia, its implementing partners and sector stakeholders, have undertaken several assessment surveys for WASH in HCF that have highlighted the dire need for the improvement of WASH services in these settings. In addition, national statistics²³ show at least 60% of HCF provide less than a basic service for water, 7% of facilities do not have a toilet and some have no WASH services.²⁴

The lack of WASH services in HCF has a particular impact on the ability and willingness of pregnant women, older people and people living with disabilities to access HCF services who are subject to the indignity of using dirty, unsafe facilities with no privacy, and some fear contracting an infection due to poor IPC. This can lead to risk of further health complications due to delays in accessing timely treatment.

▼ Olice Namuswa, the cleaner at Sinde Rural Health Center prepares to wash hospital linen at a public water point. Kazungula District, Zambia. October 2018.



Barriers

At the beginning of WaterAid Zambia's WASH in HCF project, we identified the following barriers:

- The MoH, have provided high level advocacy and leadership in ensuring that WASH in HCF receive the requisite attention. However, WASH in HCF is often not prioritised at the facility level, leading to a lack of adequate plans and budgets for sustainable services.
- Inclusive access to WASH was treated as an optional add-on in standards and policies for WASH in HCF.
- Lack of standard drawings at the local level led to inconsistent, and at times poor quality, WASH infrastructure.
- There were gaps between policy and practice. For example, when the MoH pledged their commitment to the provision of accessible toilets, many contractors lacked the skills and experience to achieve this goal.
- There were misconceptions that inclusive WASH in HCF meant focussing on specific kinds of disabilities – meaning provisions were not made for other kinds of disabilities like sight impairment and autism. This was likely caused by insufficient data around universal design, and exclusion of people with disabilities and DPOs in decision making around WASH in HCF.

23. WHO/UNICEF (2019). *Joint Monitoring Programme*. Available at: washdata.org/ (accessed 29 Mar 2022).

24. WHO/UNICEF/JMP (2019). *WASH in Health Care Facilities Global Baseline Report 2019*. Available at: unwater.org/app/uploads/2019/05/JMP-2019-wash-in-hcf.pdf (accessed 25 Mar 2022).

Approach

WaterAid Zambia is implementing a WASH in HCF project *Resolution to Revolution* between 2020–2023 targeting 60 HCF in four Districts of Mwandi and Sesheke District in Western Province, Kazungula and Monze Districts in Southern Province, to develop quality and inclusive models for WASH in HCF.

Partnerships were built with communities, community-based organisations and a wide range of governmental agencies to ensure that needs were understood and facilities maintained. For example, WaterAid Zambia established a memorandum of understanding with the Zambia Alliance for People living with Disabilities (ZAPD) to assess the accessibility of facilities, pinpoint areas of improvement, and ensure national standards were properly inclusive. The project then developed model facilities that demonstrated how these standards could be delivered in practice.

Accountability mechanisms including mobilisation and capacity/skills development through a human rights-based approach in existing community structures – like the mother's support groups and neighbourhood health committees – will ensure that communities are able to hold duty bearers to account and all facilities meet national standards.

Evidence of change

The project is ongoing, but after two years we are already seeing emerging evidence of change. We have observed increased attendance of HCF for maternal health and OPD (outpatient department).

After two years, through output verification exercises, we observed that quality, inclusivity and consistency of WASH in targeted HCF was improved using practical tools. We developed practical tools which enabled stakeholders to take a systematic and consistent approach across all HCF and integrated these tools into existing systems. For example, for the design, construction and handover process, a toolkit and checklists were used in addressing access for all at every stage. These checklists were linked to the certification and payment process – this helped ensure that contractors achieved their goals in making the WASH services in the HCF inclusive and accessible. We worked with vendors and partners to understand the minimum quality standards through quality standard workshops, which aimed to operationalise the standards.

Through building model facilities for WASH in HCF that fulfil the needs of the communities, we were able to demonstrate an example of a quality and inclusive WASH in HCF. These HCF were used as a visualisation tool, and through



◀ Sheila Ngwenya, the Nurse in Charge of Sinda Rural Health Center, which does not have clean running water. Kazungula District, Zambia. October 2018.

visits to the facility, partners came to understand accessibility concerns and get practical insight on how to achieve inclusive access to WASH in planning, design and construction. Evidence generated through the project fed into the development of national standards for inclusive WASH in HCF. We supported the MoH, to develop standards for WASH in HCF and the adaptation of WASHFIT into a national WASH in HCF Assessment Tool. The standards and tools were developed to enable a more realistic assessment of the HCF for improved healthcare service provision and reduction of healthcare-associated infections. The MoU WaterAid established with ZAPD has been instrumental in ensuring the national standards respond to the needs of people with disabilities. There have been more outreach activities focusing on women and girls undertaken at HCF level.

Key lessons

We operate a continuous iteration of WASH in HCF programming and continue to compile key learning on an ongoing basis, [see this recent learning report for more detail](#):

- It is crucial to understand the relationships and power dynamics within each community and engage with representative groups. We consulted facility-level structures – such as the Safe Motherhood Action Groups (SMAGs), Neighbourhood Health Committees (NHCs), Disabled People's Organisations (DPOs) and service users. This enabled us to ensure that we created WASH services in HCF that were inclusive and met the needs of each community.
- Tools for achieving inclusive access to WASH can help ensure national standards are achieved with consistency and quality of implementation. Linking tools like checklists to certification and payment processes can give additional incentives to contractors to ensure the WASH services in HCF are fully inclusive.
- Consultative process with all stakeholders, including national government line ministries, local authorities and communities, throughout project design, yields ownership and sustained outcomes.
- Throughout the project period, build on and leverage existing tools, skills and experience of vendors and community members for successful realisation of outputs.

Conclusions and recommendations

Partnering with community-based organisations, government agencies and DPOs ensures that user needs are fully understood. WaterAid Zambia's partnership with ZAPD meant that the accessibility audits of facilities informed the development of national standards.

Drawing on the successes of this project, to ensure sustained and inclusive outcomes, we recommend:

- Donors should move away from one-off 'projectised' approaches, and instead focus on system strengthening across all components that are necessary to sustain inclusive WASH in HCF.
- Governments and NGOs should build capacity of healthcare staff to manage WASH services – with training in practical steps, reporting procedures and financial management – to ensure WASH service and behaviour outcomes are sustained.
- Governments and stakeholders should collaborate and partner with DPOs to ensure national and local standards are inclusive of all disabilities and aspects of universal design are considered throughout implementation.
- A WASH in HCF Assessment Tool developed based on international standards should continue to be applied by the Government to monitor and gather evidence and clarity on the accessibility of HCF across Zambia.
- All stakeholders should consider inclusive access to WASH as integral part of all initiatives and standards for WASH in HCF. Throughout collaborations, design of facilities, implementation and conversations around national standards, inclusion should be considered a core and indispensable requirement for WASH in HCF.
- All stakeholders should continue to build capacity of community groups, so they are able to hold duty bearers to account and demand inclusive, quality WASH in HCF. Duty-bearers must encourage and respond to community voices through existing structures, such as council forums.



Conclusions



● Oumou Traore, Matron, at Diaramana Health Centre, Cercle de Bla, Segou Region, Mali. April 2018.



Conclusion

WASH in HCF underpins many health outcomes and is essential for the achievement of UHC. For too long, the lack of safe and sustainable WASH in HCF has resulted in the spread of disease and poor health outcomes. It creates unsafe environments for health workers and their patients and leads to poor resilience to climate and health shocks. Understanding the context-specific barriers to progress on WASH in HCF is essential to develop effective approaches and solutions to improve WASH and health outcomes.

By sharing lessons from our work on WASH in HCF, we hope to spark discussion and debate about effective pathways to urgently scale up WASH in HCF. We have a new global organisational strategy in which we will continue to prioritise our work with the health sector to increase ownership of WASH in HCF and promote cross-sectoral action to end this crisis. Under this new global strategy, we remain committed to learning from our work (and others), and continuing to share our lessons and analysis.

This section consolidates our lessons on approaches to system strengthening and securing progress on WASH in HCF in different country contexts. We also make recommendations to WASH and health stakeholders on steps to take to promote change.

▼ Younoussa Samake is the Technical Director of Bogoni Health Centre, which now has clean water, decent toilets and hygiene facilities on site. Bla district, Segou region, Mali. October 2019.



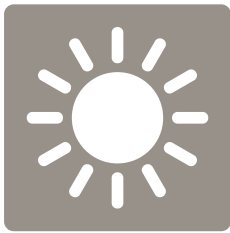
WaterAid/Basile Ouedraogo

Key lessons

Health systems are characterised by complexities and interactions between different actors and factors. Health and WASH actors both agree on the importance of system strengthening, however, ultimately, system strengthening activities must result in improved service levels and delivery – with a focus on people and improved health outcomes. It is important to maintain focus on this when considering lessons from system strengthening.

Although all national contexts are different, we have identified common lessons from the different countries in which we work. From our experience, we conclude that the following actions by government and partners are crucial to achieve progress at national level on WASH in HCF:

- 1. Map and understand existing health system priorities and limitations,** modalities of WASH delivery, targets, policies, political economy, health system organisation and service delivery systems from the outset. This will identify blockages and priorities and contextualise plans and reform agendas to strengthen the health system.
- 2. Partners should engage with and support government at multiple levels for decision making and action** to ensure ongoing ownership of improvements. Know at what levels actions and decisions can happen and be specific to facility and district or regional and national levels. For example, targeting district level decision makers on how district level resources are planned and committed, and support data use for this.
- 3. Explore and define shared goals** across WASH, health and other sectors. Work with stakeholders to map incentives and harness them to ensure sectors work together and achieve joint goals.
- 4. Support capacity development mechanisms and processes for health and WASH workforce and government staff.** Improve skills and capacities to develop and implement equitable and sustainable WASH in HCF guidelines and standards. Build government, health workforce and community capacity relevant to WASH in HCF (e.g. within IPC, financing, hygiene behaviour change, gender and social inclusions and O&M).
- 5. Generate and use country- and context-specific evidence and monitor data** to inform evidence-based planning, decision-making and implementation. Use methods that identify access to services, system and individual determinants of poor WASH, behaviours – such as use of harmonised monitoring (e.g., WASH FIT) – behaviour-centred approaches, recommendations targeted from the facility to national level, operational research and learning. Collect data regularly in monitoring to use for planning, decision making and course correction. Ensure clear recommendations and standards targeted from the facility to national level are drawn from evidence and data, and continue to support operational research and learning.
- 6. Support evidence-based design of sustainable, climate-resilient WASH in HCF delivery and management models** to help identify behavioural and environmental determinants specific to the context. This will include, for example, working with facilities to improve WASH services and behaviours – such as infrastructure improvements and embedding sustainable behaviour change (behaviours linked to hand hygiene, toilets, water, food hygiene, waste management, environmental cleaning and IPC) of health staff and health service users. These can then be used as models to advocate for taking change to scale.



► Bedding from the Sinde Rural Health Center being dried after washing. Kazungula District, Zambia. October 2018.



WaterAid/Chileshe Chanda

7. **Ensure multisector coordination between health and WASH stakeholders** across government and ministries, involving multiple actors and at multiple levels – including researchers/academia, UN agencies, NGOs, CSOs, communities, existing community health committees and healthcare professional groups. Support stakeholders to remain actively involved in processes for joint decision making, improved planning and budgeting, aligning action to maximise impact, accountability and sustainability.
8. **Work with communities to support and strengthen effective feedback and accountability mechanisms** that work with existing community structures and are culturally appropriate and acceptable, and inclusive of groups who are marginalised. Work with HCF and decision makers to hold duty-bearers to account for the human rights to health, water and sanitation.
9. **Adopt a people-centred approach** and address barriers to service uptake. Uphold a leave no one behind and human rights-based approach within efforts to improve WASH in HCF. This means supporting meaningful consultation, participation and leadership by groups such as DPOs, village committees and women's groups. Ensure people-centred care, underpinned by adequate WASH services that meet the needs of all health service users.
10. **Underpin all efforts with a focus on equitable, socially inclusive and gender-responsive approaches.** This can be achieved by targeting efforts where access to WASH and health services is poorest. Engage communities, the health workforce and service users – especially women and groups who are marginalised – in holding duty-bearers to account and participating in decision making. Ensure infrastructure and behaviour change programmes meet the needs of everyone, no matter their gender, age or ability. Recognise the frontline workforce reliance on members of staff who are women and ensure their WASH needs are met safely and in a way that supports their work and well-being.
11. **NGOs, civil society and health and WASH partners should advocate at local, sub-national and national levels of government** for the prioritisation, financing, delivery and maintenance of WASH services in all HCF. Governments must embed these actions across all health efforts, including maternal, child and newborn health, IPC, sexual and reproductive health rights (SRHR) AMR, health security, pandemic preparedness and response, quality of care and UHC.
12. **Convene regular reviews of the progress of health system strengthening efforts,** formulate and action remedial reforms, set targets and share learning and research about what works for communities and at facility, sub-national, national and global levels.

Call to action

Our global experience of working with governments, partners and communities to improve WASH in HCF proves that significant progress is possible. We call on health and WASH decision makers to commit now to strengthen health systems by ensuring sustainable and inclusive improvements to WASH in all healthcare settings.

This requires commitment and action from governments, funders, health and WASH practitioners, fellow NGOs and civil society. The priorities for actions towards securing progress on WASH in HCF are outlined below:

National and local governments led by MoH, should:

- Develop, implement and regularly update costed national strategies for WASH in HCF to ensure every HCF has an adequate, safe and reliable water supply; safe and accessible toilets for patients and staff of all genders, ages and abilities; good hand hygiene facilities (with soap and water and/or alcohol-based hand rub); routine, effective cleaning; and safe waste management. Integrate targets for WASH in HCF services and behaviours into policies and strategies for all relevant health priorities.
- Establish and implement transparent national minimum standards and guidelines for WASH in healthcare settings and seek to move service levels beyond basic WASH to achieve nationally-defined advanced levels of service and WASH infrastructure.
- Strengthen national and sub-national coordination between ministries responsible for health, finance and WASH to ensure adequate finance to support the delivery of all aspects of WASH across the health system.
- Invest in a sufficient and well-trained health workforce with the skills to address WASH issues, including WASH behaviours. This includes strong pre-service and ongoing in-service education and training programmes for all levels of staff.

- Integrate WASH in HCF indicators in existing national and sub-national monitoring mechanisms (e.g., Health MIS and/or Water Supply MIS), and use data to prioritise investment, maintenance and rehabilitation and track WASH components within the health system.
- Support effective and responsive citizen-led accountability mechanisms to ensure equitable standards for WASH in HCF are enforced.

Donor agencies and international financial institutions should:

- Prioritise WASH in HCF in health strategies and funding mechanisms, especially those linked to maternal, child and newborn health, IPC, sexual and reproductive health rights (SRHR) AMR, health security, pandemic preparedness and response, quality of care and UHC.
- Design flexible funding to support and incentivise government-led health systems, strengthening efforts that prioritise and target WASH. This includes changes in behaviours, services, policies and strategies, monitoring and decision-making processes, resource allocations and coordination, and institutional arrangements. Organisational management processes and donor reporting requirements must enable adaptive management of programmes.

- Align funding to support system-wide approaches and deliver national costed roadmaps and strategies for WASH in HCF, including incentivising governments to contribute to domestic financing for WASH in HCF improvements and maintenance.
- Support approaches that empower women and girls and local communities, and help to embed community and patient-focussed accountability mechanisms.

Health and WASH practitioners, NGOs and civil society should:

- Support communities to hold health and WASH duty-bearers to account and for inclusion in decision-making activities towards accessible and inclusive services for all.
- Direct efforts towards strengthening the whole health system to deliver integrated, holistic programming and improve the safety and quality of care.
- Facilitate strong national and sub-national cross-sectoral working groups to ensure all WASH in HCF work aligns with and strengthens government health efforts, service delivery and behaviour change in HCF.
- Invest time in understanding the context and building relationships to have a common understanding of key stakeholders, barriers, power dynamics, and effective entry points, action and change.
- Gather examples and evidence of WASH in HCF financing to support the development and financing of costed national and district strategies within broader health planning and financing.
- Support WASH and health coordination and plan for sustained engagement, working in partnership with governments, communities and WASH and health stakeholders over time.
- Prioritise gathering and sharing practical lessons. Foster a culture of regular review, reflection and adaptation (internally and externally), and encourage the sharing of challenges and failures, as well as successes.



A healthcare facility without WASH should not be called a healthcare facility.²⁵ Health systems that fail to ensure adequate WASH services and behaviours to uphold quality care standards cannot be considered prepared or resilient to future climate and health shocks or capable of fully allowing patients to remain safe, dignified and healthy.

Conventional health system strengthening approaches do not always involve a detailed analysis of the systemic barriers to WASH in HCF service levels or dedicated action on this issue. However, understanding and addressing barriers and dealing with complexity is essential to securing context-specific change – particularly for the delivery of frontline services. Our experience working directly with HCF and with all levels of government highlights the importance of combining broader efforts to improve WASH services at HCF with efforts to strengthen related systems.

This report highlights a serious need to strengthen accountability mechanisms, improve leadership, coordination and planning, to track and target financing, and to dismantle social barriers that exclude people from claiming their right to quality healthcare. None of these elements are new to the WASH or health sectors. However, system strengthening provides a means of understanding where and when these actions are needed to achieve change and sustained impact.

We believe that system strengthening for inclusive, lasting WASH in HCF as described in this report, will transform people's experience and quality of healthcare and build trust and resilience in health systems. It will also lead to better, lasting and more inclusive outcomes for health and safe and dignified healthcare.

25. Quoted from Dr. Maria Neira, Director of Public Health and Environment, World Health Organization.



◀ Nahida Aktar is a CHCP working at the Saharabati Community clinic, Gangni, Meherpur, Bangladesh. October 2019.

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We dedicate this report and show our solidarity with health workers, cleaners and sanitation workers. Together, your work ensures we have safe, clean and dignified care in healthcare facilities. Thank you.

WaterAid is an international not-for-profit, determined to make clean water, decent toilets and good hygiene normal for everyone, everywhere within a generation. Only by tackling these three essentials in ways that last can people change their lives for good.

