

SNV

WASH in HCF

WASH ^{IN} HEALTH CARE FACILITIES

FOR BETTER HEALTH CARE SERVICES



@WHO/UNICEF

SNV

Why WASH in HCF?

- ambition was area-wide coverage and health care facilities are always present in those areas, we did not -or rarely- include them
- City Sanitation plan but HCF was not included
- In March 2018, the UN launched a global Call for Action on WASH in HCFs, calling to improve WASH services to help strengthen health systems and deliver on our promise for universal health coverage.

Why WASH in HCF?

- A renewed attention to the fact that both WASH and health are human rights. The human right to the best available health care cannot be realised without basic WASH services.
- WASH in HCF is a pre-condition for infection prevention and control.
 - *"...The healthcare setting might even become the epicentre of outbreaks of certain diseases, such as typhus or diarrhoea."* - WHO (2008)
- While infection prevention and control (IPC) is a key area of attention in the health care sector, many IPC measures are not possible without basic WASH services.
- Credibility of public health programmes promoting sanitation and key hygiene behaviours could be affected if health workers cannot practice safe hygiene behaviours in their work.

SDG targets related to WASH in HCFs

- 3.1 By 2030, **reduce the global maternal mortality** ratio to less than 70 per 100,000 live births.
- 3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming **to reduce neonatal mortality** to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
- 3.8 Achieve universal health coverage, including financial risk protection, **access to quality essential health-care services** and access to safe, effective, quality and affordable essential medicines and vaccines for all.
 - 5.1 End all forms of **discrimination against all women and** girls everywhere
 - 5.5 Ensure **women's full and effective participation and equal opportunities for leadership** at all levels of decision making in political, economic and public life
- 6.1 By 2030, **achieve universal and equitable access** to safe and affordable **drinking water** for all
- 6.2 By 2030, **achieve access to adequate and equitable sanitation and hygiene for all** and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations
- 6.3 By 2030, improve water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally

STATUS OF WASH IN HCFs

part of the standard SDG monitoring by the JMP with five in sub-indicator ladders

- Hand hygiene at points of care
- Health care waste management
- Environmental cleaning

Water	Sanitation	Hand hygiene	Health care waste	Environmental cleaning
Advanced service To be defined at national level	Advanced service To be defined at national level	Advanced service To be defined at national level	Advanced service To be defined at national level	Advanced service To be defined at national level
Basic service Water is available from an improved source ¹⁸ located on premises.	Basic service Improved sanitation facilities ¹⁸ are usable with at least one toilet dedicated for staff, at least one sex-separated toilet with menstrual hygiene facilities, and at least one toilet accessible for people with limited mobility.	Basic service Functional hand hygiene facilities (with water and soap and/or alcohol-based hand rub) are available at points of care, and within 5 meters of toilets.	Basic service Waste is safely segregated into at least three bins and sharps and infectious waste are treated and disposed of safely.	Basic service Basic protocols for cleaning available, and staff with cleaning responsibilities have all received training.
Limited service An improved water source is within 500 meters of the facility, but not all requirements for basic service are met.	Limited service At least one improved sanitation facility, but not all requirements for basic service are met.	Limited service Functional hand hygiene facilities are available at either points of care or toilets, but not both.	Limited service There is limited separation and/or treatment and disposal of sharps and infectious waste, but not all requirements for basic service are met.	Limited service There are cleaning protocols, or at least some staff have received training on cleaning.
No service Water is taken from unprotected dug wells or springs, or surface water sources; or an improved source that is more than 500 m from the facility; or the facility has no water source.	No service Toilet facilities are unimproved (pit latrines without a slab or platform, hanging latrines and bucket latrines), or there are no toilets or latrines at the facility.	No service No functional hand hygiene facilities are available at either points of care or toilets.	No service There are no separate bins for sharps or infectious waste, and sharps and/or infectious waste are not treated/disposed of.	No service No cleaning protocols are available, and no staff have received training on cleaning.

Source: WASH in HCF: Practical Steps to achieve Universal to quality care. WHO/UNICEF

Barriers to providing WASH in health care facilities

■ **Incomplete standards**

- Many countries lack a set of coherent standards for WASH in health care facilities. Even where standards do exist, implementation is often curtailed by lack of funding or interest.
- Approximately 80% of the 78 countries that participated in the 2017 WHO-led Global Analysis and Assessment of Sanitation and Water (GLAAS) survey reported that they had a policy for WASH or infection prevention and control, but fewer than 25% of these policies were fully funded and implemented (24).
- If WASH in health care facilities is addressed at all, it often occurs in isolation, buried in the environmental health unit within the Ministry of Health. Environmental health units are often under-funded and disconnected from other key health programmes, making it difficult to include WASH in health care facility standards and costed WASH services in other areas of health, such as quality care, maternal and child health, and outbreak preparedness and response. Furthermore, few mechanisms and incentives exist for cross-sectoral collaboration between health, environmental health, and other ministries including local government and finance.

Barriers to providing WASH in health care facilities

▪ **Inadequate monitoring**

- Monitoring efforts for WASH have also fallen short. Until recently, only a handful of national health monitoring systems collected meaningful information on WASH in health care facilities. In most cases, the only available data came from externally-conducted facility assessments.
- Without reliable data on the quality of WASH services, disaggregated by facility type and location, it has been difficult to understand and respond to needs and develop costed plans for improvements.
- The 2015 WHO/UNICEF landscape report on WASH in health care facilities (25) extracted WASH data from assessments of over 54,000 facilities.
- The more recent 2019 Joint Monitoring Programme (JMP) report, however, compiled data from over 560,000 facilities. Using the JMP to monitor WASH in health care facilities should lead to significant improvements in monitoring efforts.

Barriers to providing WASH in health care facilities

■ **Disease-specific budgeting**

- Many national health budgets are organized by disease area, with line items for routine costs, such as vaccines and medicines, rather than for cross-cutting health-systems functions like WASH. As a result, health facilities often lack funds for capital infrastructure investments and ongoing operation and maintenance as well as for overlooked functions such as cleaning and waste management.
- While many countries have decentralized budgeting responsibilities, few local revenue schemes exist to generate funds for WASH in health care facilities, especially in rural areas.

■ **Disempowered workforce**

- Staff in health care facilities are usually overburdened and have neither the incentives nor the training to improve and manage WASH services. Facility administrators, health care providers, and patients often consider inadequate WASH to be intractable, particularly if improvements are thought to require costly basic infrastructure.

<https://www.washinhc.org/resource/wash-in-health-care-facilities-practical-steps-for-universal-access-to-quality-care/>

Barriers to providing WASH in health care facilities

- **Poor WASH infrastructure**

- Most low-income countries and many pockets within middle-income countries lack fully-functioning, safely managed municipal water and sanitation services. Without municipal services, health care facilities may require large capital investments that are beyond the financial means of health budgets.
- Investing in WASH infrastructure and providing ongoing operation and maintenance will require effective intersectoral collaboration. Such collaboration is also needed for tackling looming problems such as AntiMicrobial Resistance (AMR) where lack of WASH in health care facilities leads to preventable infections and where faecal waste from facilities could provide a pathway to AMR in the environment

THE CONSEQUENCES OF POOR WASH AND COMPROMISED IPC

Lack of WASH in health care facilities



Compromised IPC practices

- 1 Increased risk of healthcare-associated infections (HAI)
- 2 Increased risk of spread of HAI
- 3 Increased burden of expensive, hard-to-treat and life-threatening resistant infections
- 4 Decrease in patient confidence in health care

Overreliance on preventive use of antibiotics

High health care costs and poor health outcomes

Increased use of antibiotics to treat preventable infections

Increased resistance

Source: Tackling AMR. WHO/UNICEF

SNV ACTIVITIES IN WASH IN HCFs

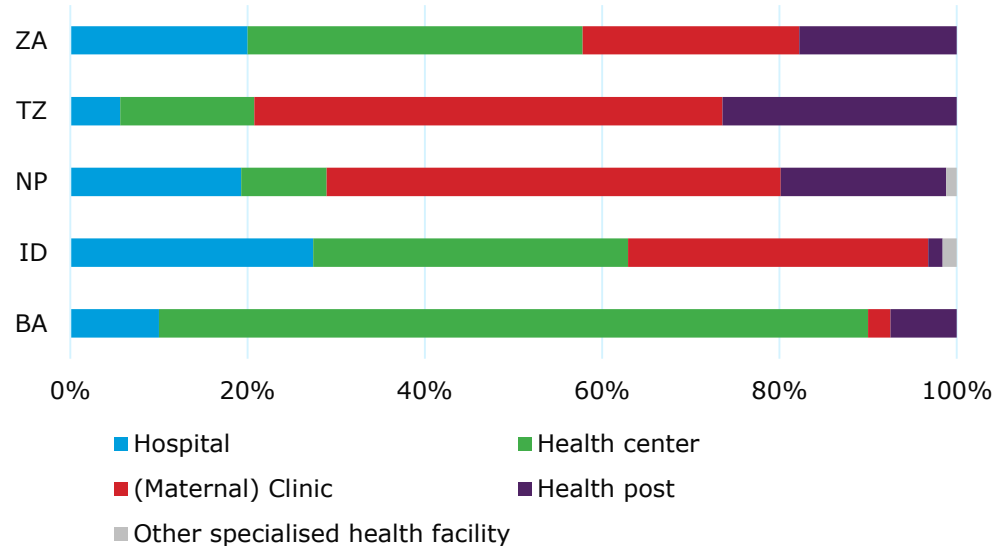
- Health and Hygiene Activity (HHA) in Nepal (started 2016)
- USSHD- HCFs 5 countries (started 2017)
- Beyond the Finish Line- Bhutan, Laos (started 2017)

**Brief findings from Baseline on
Health Care Facility under
Urban Sanitation & Hygiene for Health and Development (USHHD)
(16 Cities 5 Countries)**

Background

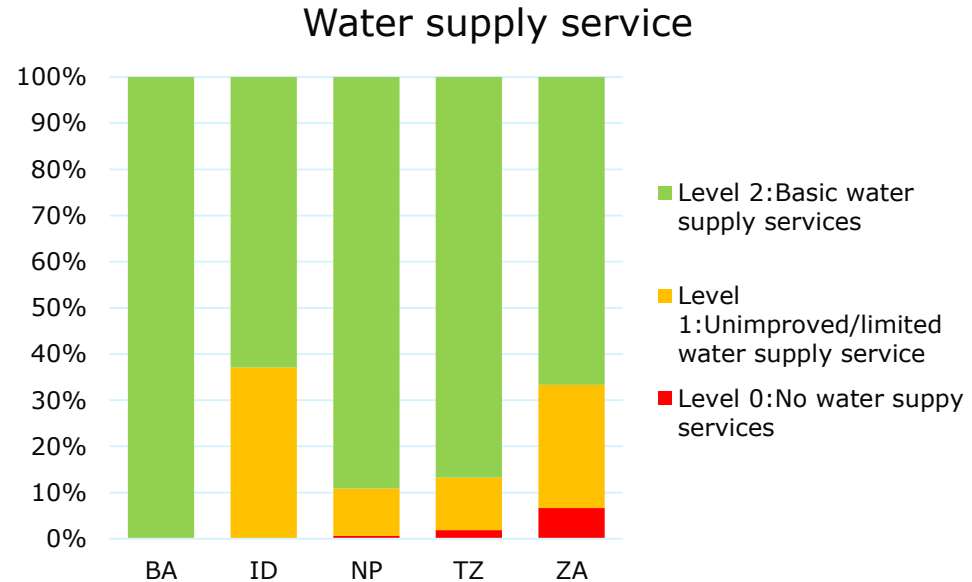
- In May 2018, a survey of health facilities was conducted in 16 cities across 5 countries (Bangladesh, Indonesia, Nepal, Tanzania and Zambia).
- The sample was 366 facilities, of which 65 hospitals.
- 136 publicly managed, 195 private for-profit entities.
- Large variations: Asian countries more privately managed facilities; Tanzania has 17% of faith-based facilities and in Zambia 85% is publicly managed.

Type of health facility surveyed per country



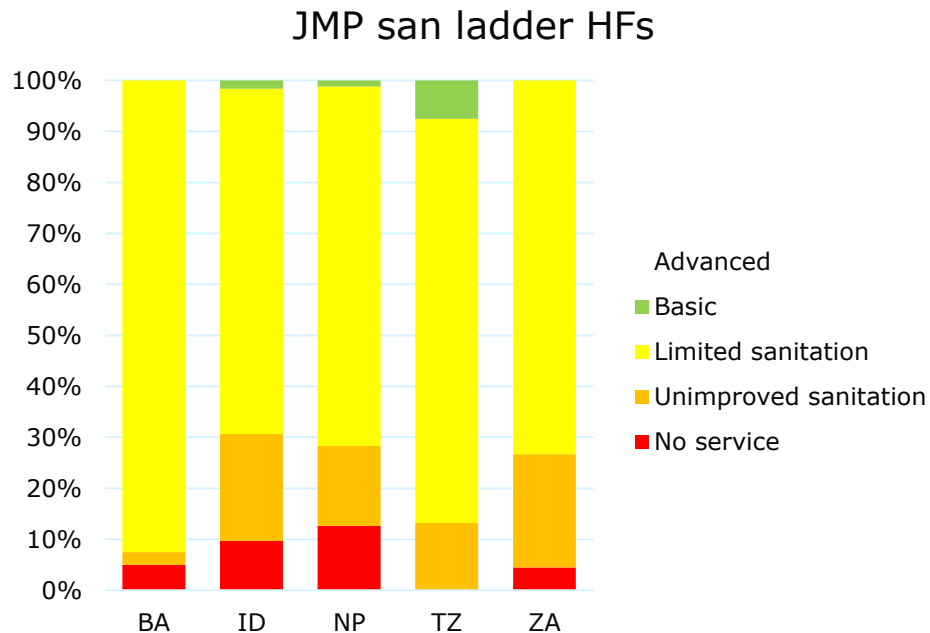
Access to water supply services (aligned with JMP)

- As can be seen on the right, the majority of health facilities surveyed have basic water supply services.
- Limited services in Indonesia (37%) and Zambia (27%), are related to not having a connection on the premises (10% Indonesia, 16% Zambia) no water observed (34% Indonesia, 11% Zambia). A further 7% in Zambia has no water source or uses surface water.



Sanitation situation (ladder aligned with JMP¹)

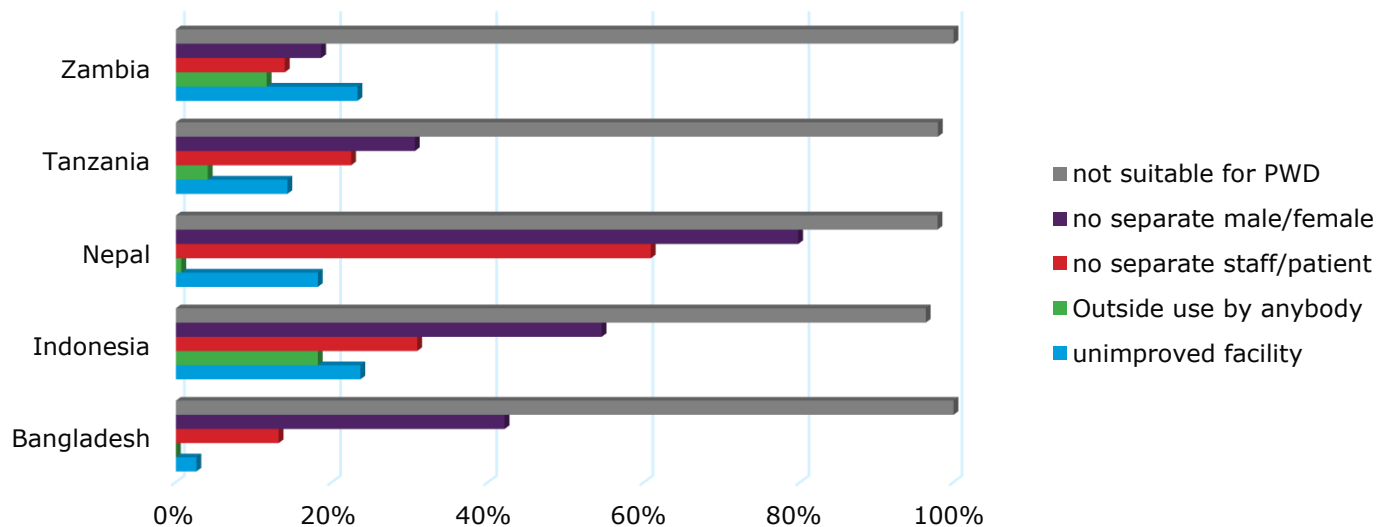
- As can be seen in the graph, the vast majority of health facilities surveyed have limited or unimproved sanitation services.
- Health facilities with no services in Nepal, indicated using services in neighbouring houses, while in Indonesia in communal toilets.
- None of the health facilities has advanced sanitation services.



1. Note that in this graph, limited and unimproved services are disaggregated

Why are so many health facilities classified as having limited service

- The biggest issue is the **lack of suitable facilities for people with disability**. A second issue the lack of **separate male and female toilets**, thirdly the facility being **unimproved**.
- There are 95 facilities with in-patient and out-patient services, 30% of these do not have separate toilet facilities. The biggest issue in Nepal (61% don't have).



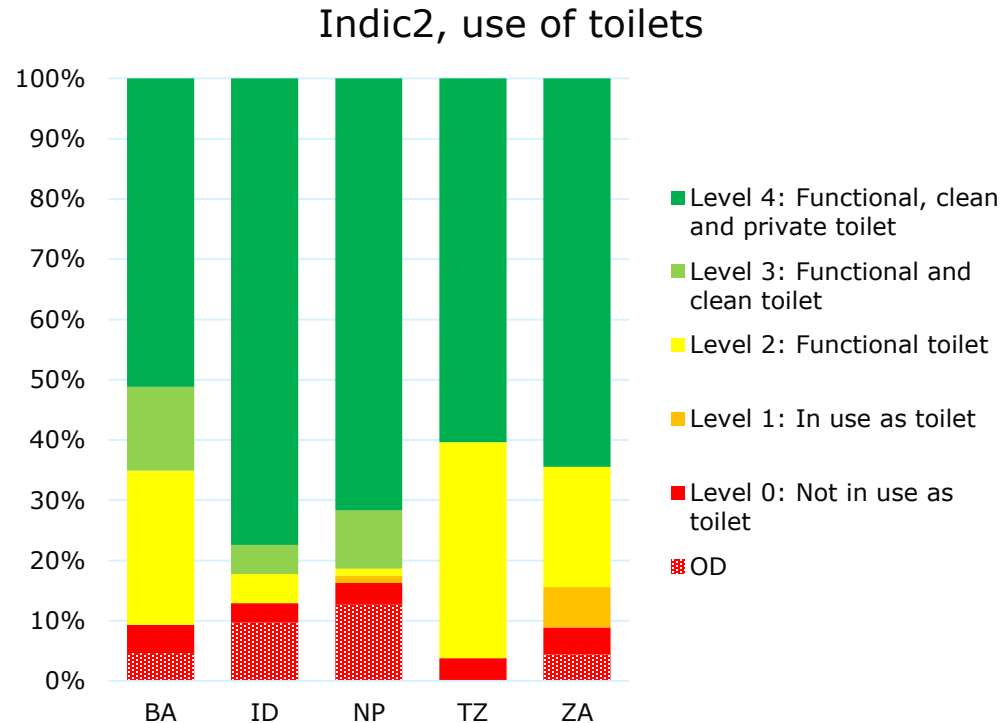
Type of adjustments for sanitation for PWD

(only for health facilities with facilities for PWD)

	Ramp	Handles	Seating toilet	Extra space
Bangladesh	1	0	0	0
Indonesia	2	3	2	2
Nepal	5	3	5	0
Tanzania	1	1	5	4
Zambia	0	0	0	0

Indicator 2, use of toilets

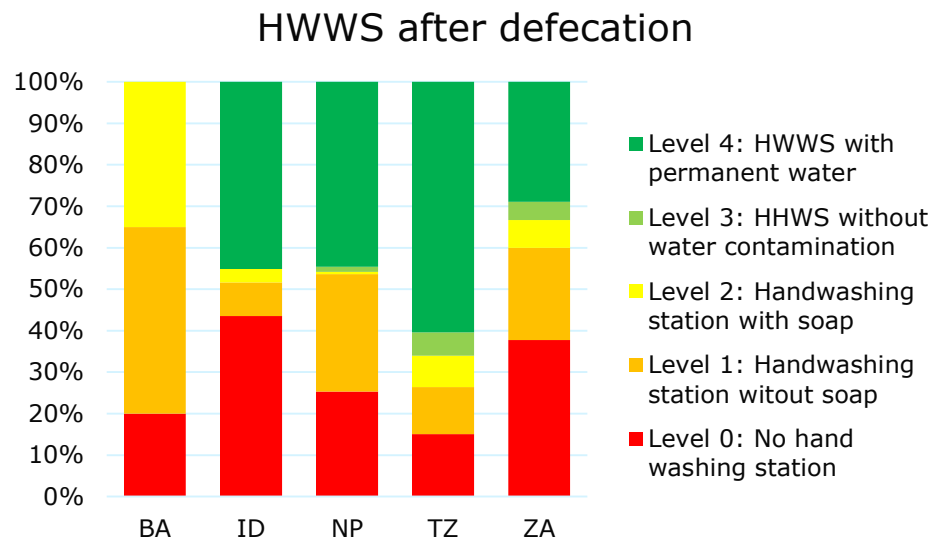
- Indicator 2 was calculated observing toilet blocks. The level reflects the situation in $\geq 50\%$ of cubicles in both toilet blocks.
- As can be seen on the right, the majority of health facilities **has functional, clean and even private toilets**.
- However, there are some **challenges in use, and cleanliness issues** particularly in Bangladesh, Tanzania and Zambia.



Note that these scores have been defined looking at various toilet blocks

Hand washing with soap after defecation

- Hand washing stations should be within 5 meters distance of the observed toilet blocks.
- No hand washing station in Indonesia (44%) and Zambia (38%), reflects no toilet, hand washing station further than 5 metres (ID, 18%; ZA, 7%) and no hand washing station (ID, 16%; ZA, 10%). Furthermore in Zambia, 11% does not have signs of water.

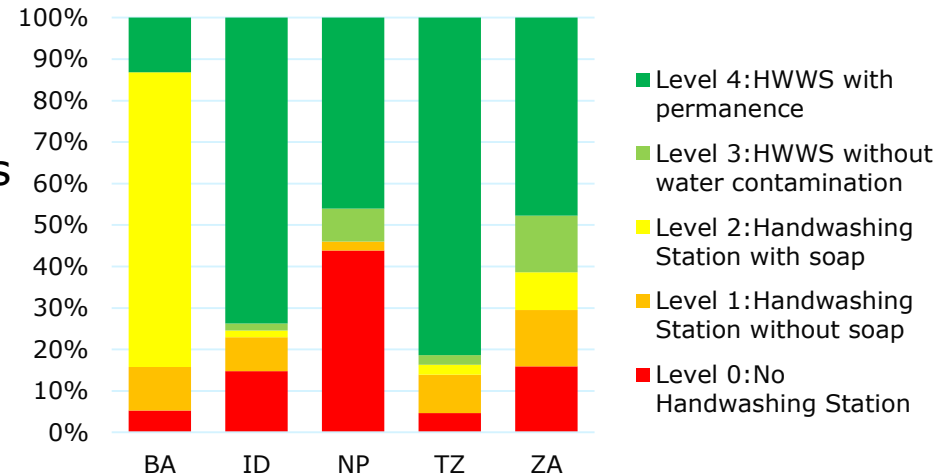


Note that this indicator is not observed in health facilities without a toilet

Hand washing with soap at points of care

- Hand washing at points of care was observed sampling up to 2 rooms.
- The hand washing station should be in the room or within 2 meters.
- The picture is mixed. Bangladesh has a challenge with the type of hand washing station (not preventing contamination).
- Nepal shows 44% without HW station, of which 10% beyond 2 meters and 11% with no hand washing station at all.

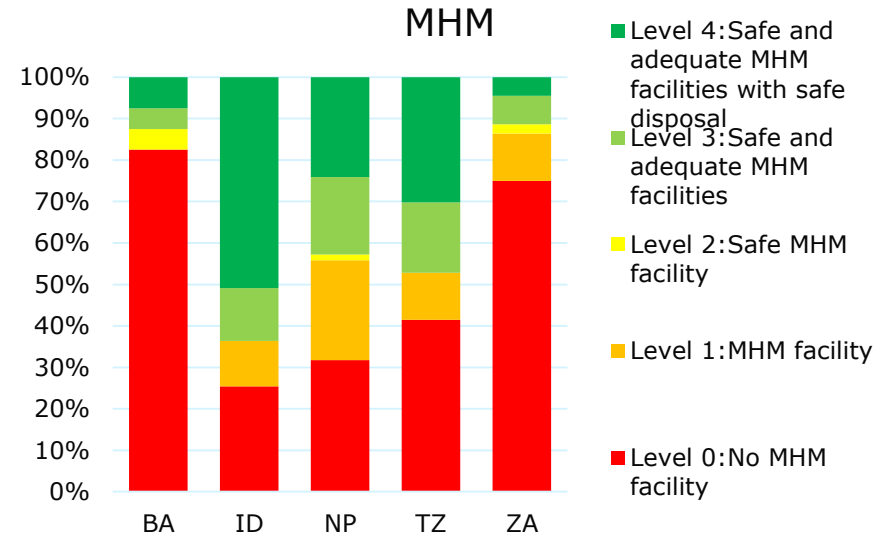
HWWS at points of care



- Use of an alcohol based rub is near to zero except for Indonesia (29%) and Nepal (16%) of facilities.

Menstrual hygiene management (MHM)

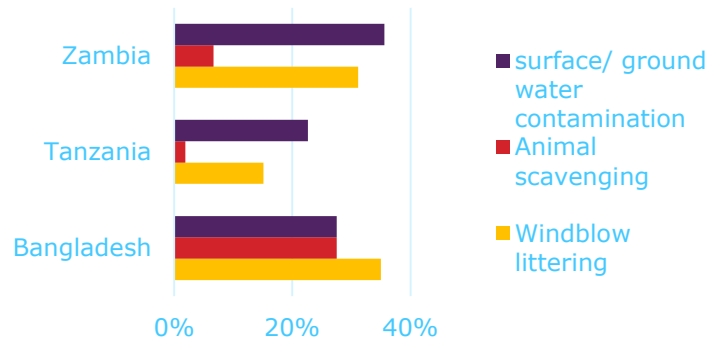
- As for indicator 2, provisions for MHM are observing toilet blocks or if a separate place is provided, in that place. The level reflects the situation in $\geq 50\%$ of cubicles in both toilet blocks.
- For Bangladesh, the high % red is due to the response of “no private place for changing”, in spite of the presence of toilets.
- For Zambia the high % red is partially due to no place, and partially blank for toilets for males only.



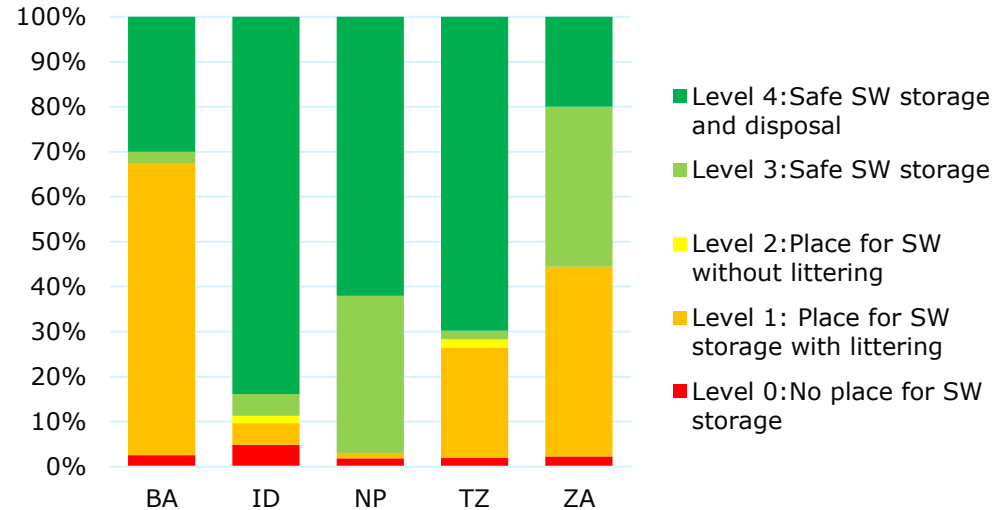
Solid waste management on premises

- Bangladesh (65%) and Zambia (42%), and 25% of facilities in Tanzania, have a littering challenge with solid waste on premises.

Causes of littering on premises



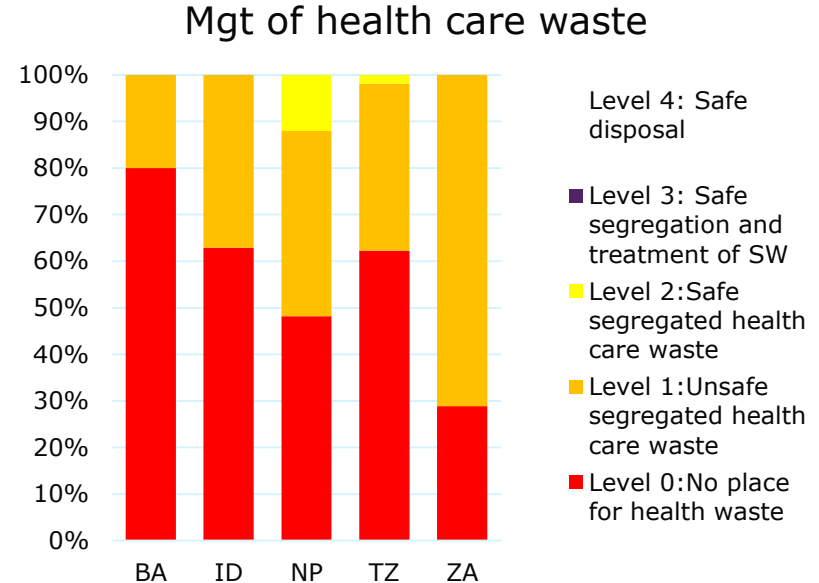
Solid waste mgt on the premises



- In Tanzania and Zambia, 25% respect 38% disposes solid waste in the toilet.

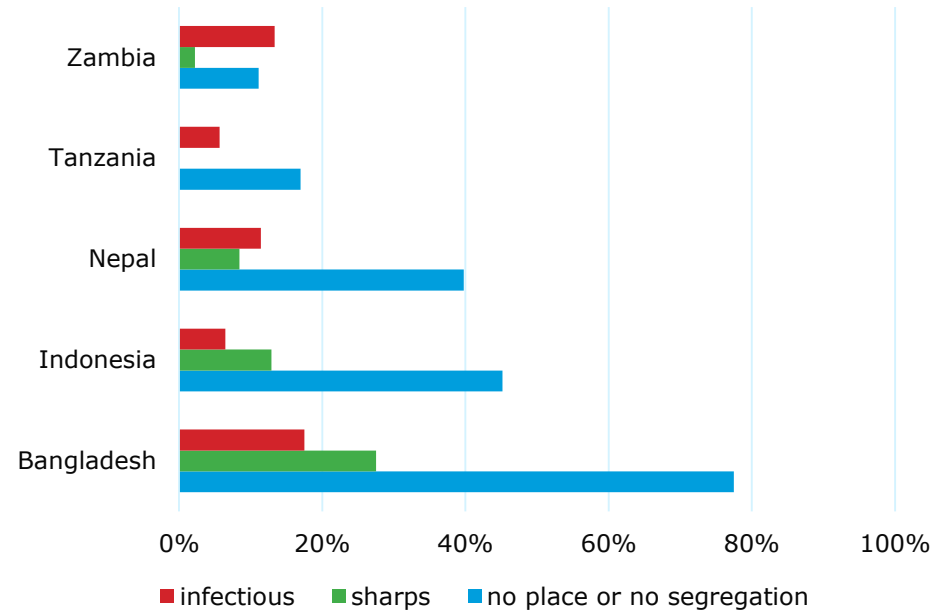
Management of health care waste

- Most health facilities have no specific place or do not segregate the three main types of waste: sharps, infectious waste, general waste
- The remainder segregates but not according to standards.
- Only in Nepal (12%) and in Tanzania (2%) health care waste is properly segregated, but not treated.



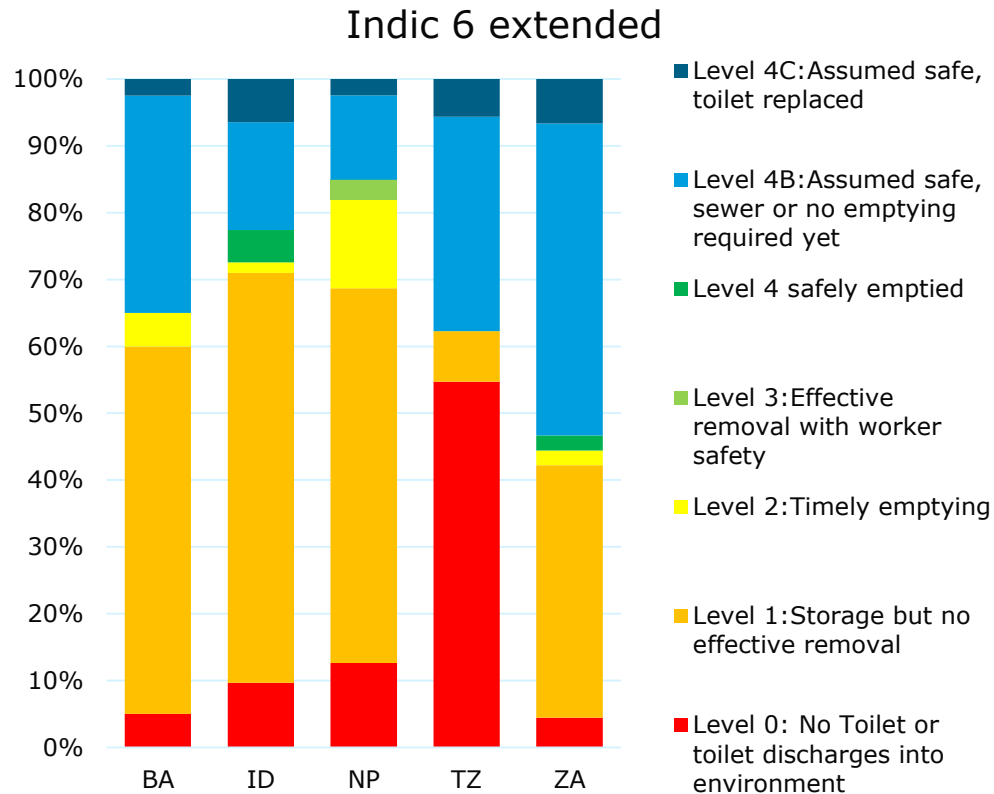
What is the main problem with segregation?

- Main challenge seems to be that one of the three wastes is not segregated. Particularly in the Asian countries.
- Secondly the safety of segregation of infectious waste (Asia and Africa) and sharps (mostly Asia).



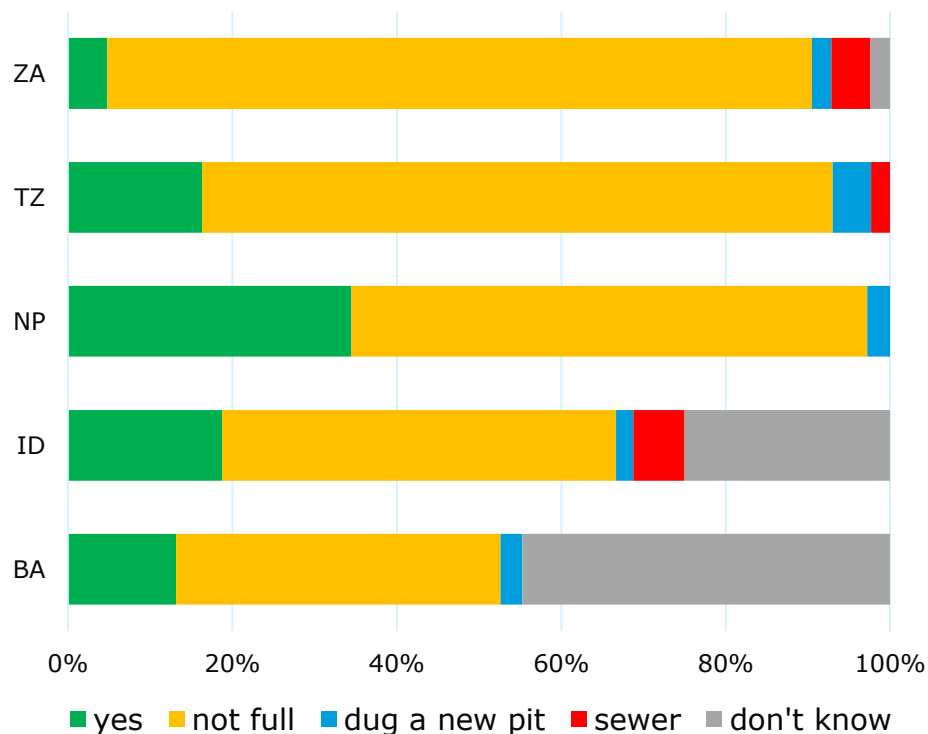
Emptying

- Why is TZ this red (54%)?
- Safely emptied ID 4.8%, Zambia 2%
- Timeliness of emptying the main limitation, though worker safety is also a limitation in Bangladesh and Nepal particularly.
- We need to look deeper into the timely emptying of HCFs to see if this is correct.

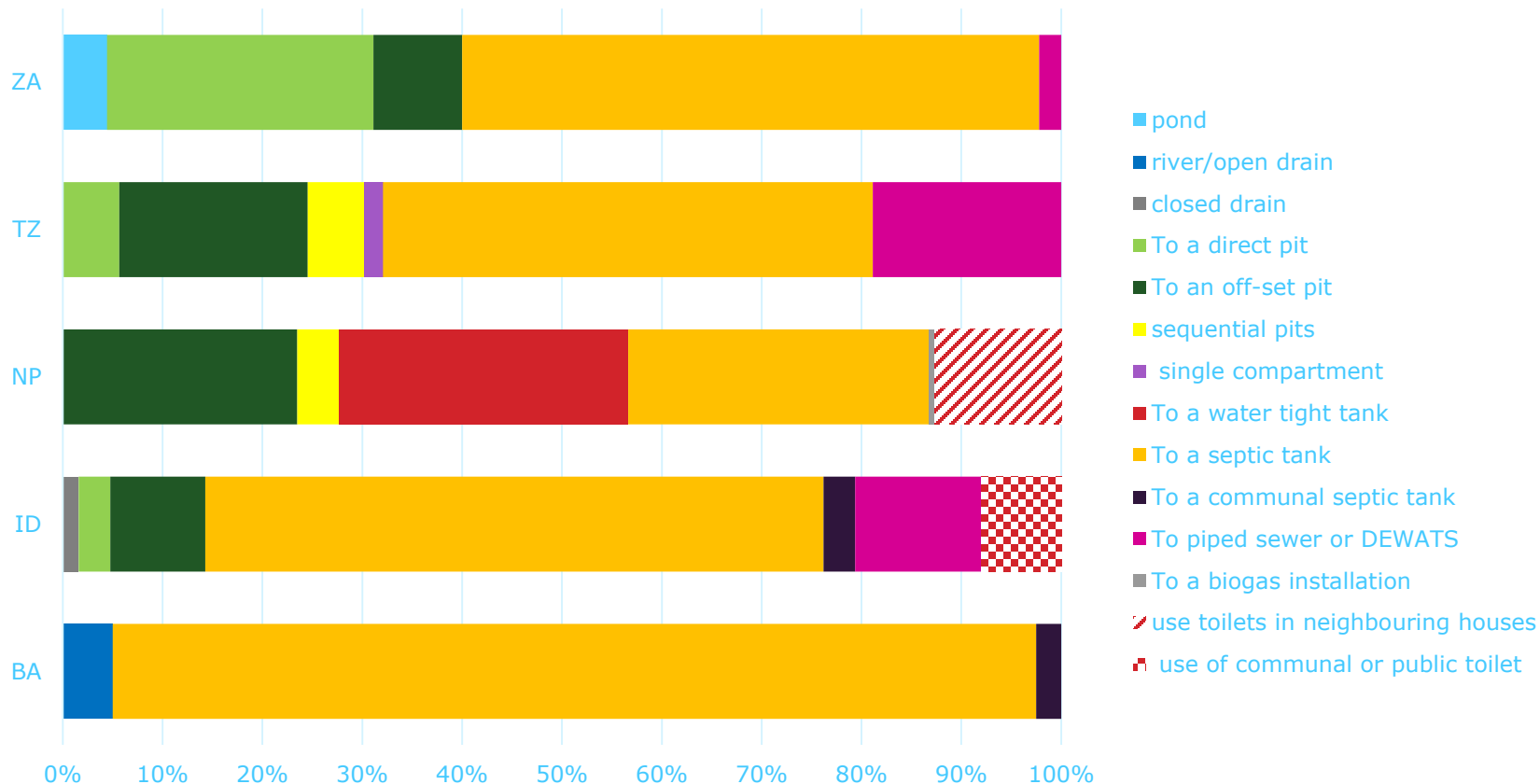


Did you ever empty your pit? (FSM14 without blanks)

- Aside from Bangladesh and Indonesia, where there are high “don’t know’s”, most pits have not been emptied.
- We used average pit dimensions, was this correct?

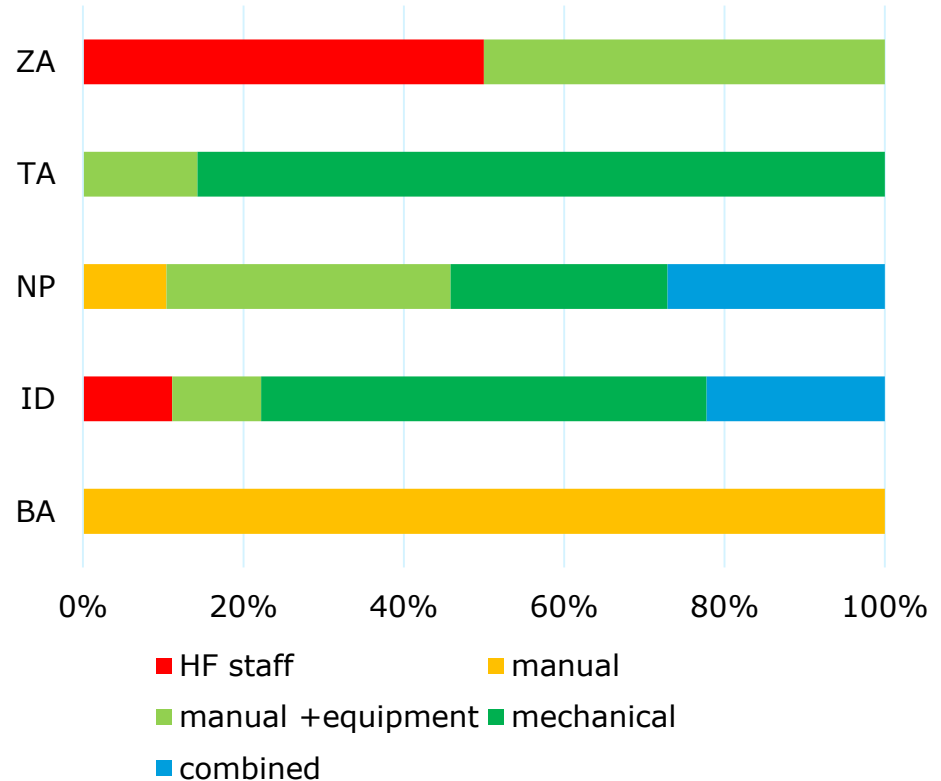


Where do the faeces go?



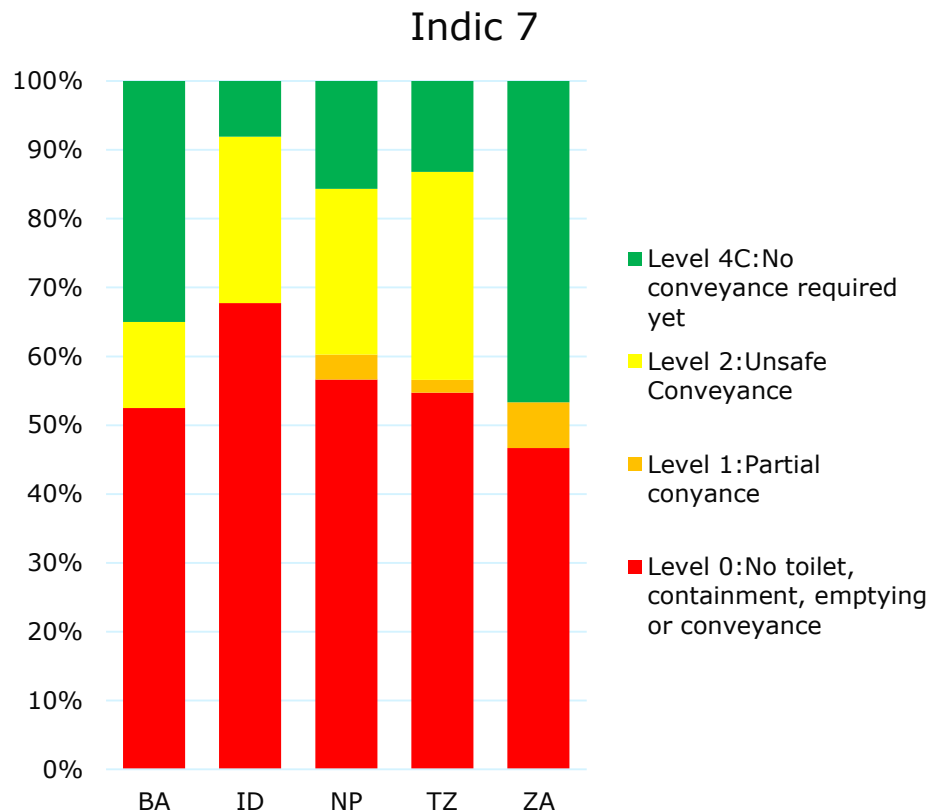
Who empties? (sample is too small)

- Sample is too small to get an indication (except Nepal).
- Still shocking that it's sometimes the health facility staff themselves.



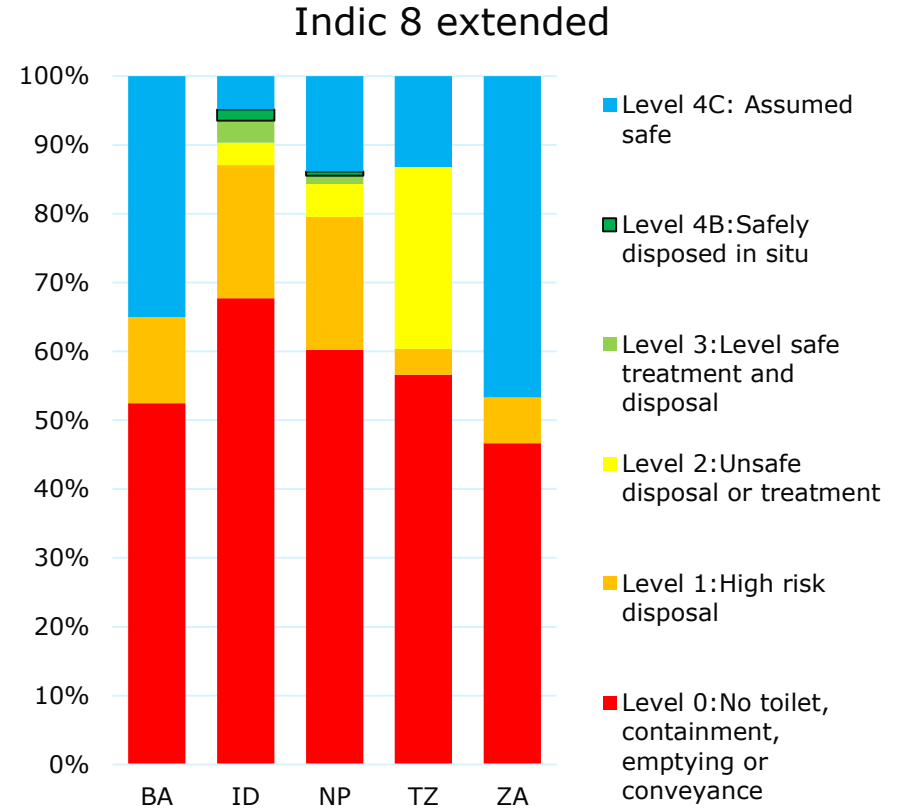
Transport

- Aside from the timely and safe emptying (see previous indicator), the challenge in BA, ID, NP, TZ is the safety of conveyance.



Disposal/ re-use

- Indonesia 4.8% safely disposed in-situ, Nepal: 0.006% 😊



Major Findings

- The majority of health facilities have basic water supply services.
- The challenge lies in sanitation, hygiene and waste management.
- The vast majority has limited sanitation service, due to the lack of suitable facilities for people with disability. A second issue the lack of separate male and female toilets, thirdly the facility being unimproved. In Bangladesh and Zambia, MHM provisions was also a gap.
- Handwashing, both at point of care and after defecation, was below benchmark.
- In Bangladesh, Tanzania and Zambia, cleanliness of toilets was an issue.
- About half of the facilities surveyed did not segregate all 3 types of health care waste, the other half did segregate, but safety of segregation was not up to standard.
- Management of on-site sanitation, e.g. safe timely emptying, safe disposal of waste was not on the radar in nearly all places. Perhaps HCFs (and higher levels) should have a plan for short- and long-term maintenance of sanitation facilities.