

WASH FIT implementation

Selected case studies

March 2022

The following document accompanies the WASH FIT second edition and contains a selection of case studies of WASH FIT implementation from around the world. The case studies present only selected aspects of implementation. Search “WASH FIT” in the resource section of the WASH in health care facilities knowledge portal to find more detailed country examples:

www.washinhcf.org/resources

As of March 2022, WASH FIT has, or is currently, being used in the following **42** countries: Bhutan, Burundi, Cambodia, Chad, Comoros, Democratic Republic of Congo, Ecuador, Ethiopia, Ghana, Guatemala, Guinea, Guinea-Bissau, Haiti, India, Indonesia, Iraq, Kenya, Lao PDR, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, Nicaragua, Niger, Peru, Philippines, Rwanda, Sierra Leone, South Sudan, Tajikistan, Tanzania, Togo, Uganda, Venezuela, Viet Nam, Zambia and Zimbabwe.

These efforts range in scale and duration, from relatively small-scale efforts led by implementing partners in a few facilities to government-led national efforts, where WASH FIT processes are embedded in health systems monitoring and quality improvement efforts.

There may be additional countries also using WASH FIT. If you have an example to share, please share your experiences using this [online survey](#). These could be featured in forthcoming issues of the WASH in health care facilities newsletter and/or be added to www.washinhcf.org. They will also help WHO and UNICEF to better evaluate the success of WASH FIT in the future.

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1. The Philippines

Adapting the assessment tool to the Philippines context (2019-)



Photo: A visit to a WASH FIT facility is supported by WHO

Through a period of stakeholder consultations, WASH FIT was adapted to the Philippines context in 2019. The Philippines has a large number of policies and standards available which apply to WASH in health care facilities (visit www.washinhcf.org/resources and search for Philippines). These were used as reference against which the WASH FIT indicators were compared and adapted. Indicators were altered to align with existing national policies and guidelines, new indicators added, some removed that were not applicable and some terminology simplified for easier comprehension at *barangay* (primary health) level. A total of sixty-seven indicators were included in the final assessment tool. The table below shows how some indicators were adapted to the national context.

Annex 3 of the WASH FIT guide provides guidance on how to adapt the assessment to the local context.

Sample of Philippines adapted indicators

Original WASH FIT indicator	Type of change	Philippines revised indicator	Revised explanatory notes
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Water is treated and collected for drinking with a proven technology that meets WHO performance standards	Replaced global standards with national standards	Water is treated and collected for drinking with a proven technology that meets 2017 Philippine National Standards for Drinking Water	Such technologies should meet one of WHO's household water treatment and safe storage (HWTS) performance categories and generally involve filters, boiling, solar, chlorine (for non-turbid water) or coagulation/flocculation and/or 2017 Phil. National Standards for Drinking Water (PNSDW).
Drinking-water has appropriate chlorine residual (0.2mg/L or 0.5mg/L in emergencies) or 0 E. coli/100 ml and is not turbid	Threshold for drinking water quality changed	Drinking-water has appropriate chlorine residual (0.3mg/L) or < 1 E. coli/100 ml and is not turbid.	
Energy is available for heating water (mark if not applicable)	Indicator deleted to simplify assessment and reduce number of indicators		
At least one shower or bathing area is available per 40 patients in in-patient settings and is functioning and accessible.	Indicator adapted and made specific to birthing facilities	For birthing facilities, at least one bathroom is available for staff and patients for a facility with less than six (6) bed ward capacity	Toilet and bathroom is a common facility for staff and patient for a clinic with less than six (6) bed ward capacity, otherwise, an additional toilet and bathroom shall be provided commensurate to the increase in beds. Source: <i>Administrative Order No. 2016-0042 Annex C – Planning and Design Guidelines for Birthing Homes</i> , DOH - Health Facilities and Services Bureau
At least one toilet or improved latrine provides the means to manage menstrual hygiene needs	Change of terminology to make more culturally relevant	At least one toilet should have a bin for disposal of soiled sanitary napkins	
At least one toilet meets the needs of people with reduced mobility	Criteria for disability toilets updated to Philippines standards.		Criteria adapted according to <i>Batas Pambansa 344 - " An Act to Enhance the Mobility of Disabled Persons by Requiring Certain Buildings, Institutions, Establishments & Public Utilities to Install Facilities & Other Devices"</i>
	Developed new indicator , not included in first edition of WASH FIT	For birthing facilities, the toilet shall have the basic fixtures of water closet and lavatory with sufficient grab bars for patients.	Toilet and bathroom are common for staff and patients in clinics with less than six (6) bed ward capacity. Source: <i>Administrative Order No. 2016-0042 Annex C – Planning and Design Guidelines for Birthing Homes</i> , DOH - Health Facilities and Services Bureau

A data visualization and dashboard has been developed using Kobo Toolbox and Power BI. Further adaptations for use in hospitals are planned. Feedback from the first facilities using WASH FIT show that the tool has been well-received and inspires positive change.

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“Before starting WASH FIT, I thought the way WASH services were managed and the hygiene practices passed on to me by previous health workers from [the facility] were acceptable, and that improvements were not needed or too much effort. But after doing steps 1 and 2 (setting up the team, conducting the assessment) collectively we identified many items that need improving [such as de-clogging drains, increasing ventilation and staff training for waste management]. These are things we can do ourselves that benefit the staff and the clientele we are serving. The time will come for me to be transferred to another facility, I can hand over the facility to the next health worker together with the WASH FIT plan with the overall rating, that he/she can use as the baseline for further improvement”.

Nurse, WASH FIT pilot health centre, Greater Manila, The Philippines, 2019.

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Photo: Checking for availability of water during a WASH FIT assessment

2. Indonesia

Using a small starter grant to get WASH FIT up and running in a faith-based facility in a rural area (2018)

Following receipt of a small grant of funds (approximately 1,000 USD), a faith-based facility in West Timor, Indonesia began using WASH FIT. A local NGO adapted the tool for local use¹ and the smaller context of the clinic, adding a “transect walk” through the facility. The NGO instigated talks and negotiations with the Governance Board of the facility and Executive Board knowing that any changes would need to be approved of and supported at that level. As a faith-based organization, WASH FIT was presented from a different perspective as a way of motivating engagement and adopting change. This helped the managers get on a path of making improvements in a range of areas, not just WASH. The team used a CLTS (community-led total sanitation) approach during the transect walks and found it to be very effective for instigating change.

The funds were used for a number of small, but successful improvements: refer to the table for examples of low-, medium- and higher-cost interventions.



“In the initial 3-6 month implementation there were heaps of improvements made including hand washing stations, community volunteers cleaned up rubbish, bins installed in a number of locations, rosters for cleaning, unused water troughs next to unused toilets emptied (mosquito breeding grounds!), septic tanks sealed properly, leaking pipes fixed, leaking water meter fixed and cleaning rosters implemented. Toilets were also improved by adding designations for male/female, putting new bins in all toilets (especially for menstrual hygiene management and assigning responsibility for emptying them to female nurses, due to cultural reasons), and improving lighting as this was a barrier for using the toilets. Most of the above has had sustained use and the hygiene/health messaging in outpatient clinics continues. We don't have half as much rubbish around the yard and don't have patients throwing rubbish out of windows anymore because of a new feeling of collective responsibility. The new sink in the kitchen was a great investment especially with us all working and cleaning up the kitchen. No more mice, and dishes are washed in the sink, not on the floor in the small dirty room bedside the kitchen”.



Improvements in Indonesia, sorted by cost

	No/low-cost	Medium cost	Higher cost
Water	Ensure drinking water stations full each morning	Treat water Regularly test water quality Fix leaking pipes	New borehole dug to address water shortages

¹ A representative of the NGO attended a WASH FIT training at an international conference and subsequently ran a facility training for all staff.

Sanitation	Add signage to toilets Clean and check toilets daily	Build ramp to toilets, add grab rails for improved access Sealing septic tank	
Health care waste	Install segregation bins Reminders to segregate Facility cleaning campaign to tidy up waste areas	Transport of waste offsite to centralised waste treatment centres	Waste treatment technology Installation of solar panels to power waste equipment
Hand hygiene	Hand hygiene reminders Check and refill hand hygiene stations each morning	Regular training of staff	
Cleaning	Training on correct cleaning technique Purchasing additional supplies (mops, buckets, disinfectants)	Building/assigning a designated cleaning station/area to keep supplies separate	Hiring an additional cleaner to increase capacity

The facility in Indonesia also developed their **own risk assessment method**: ranking problems according to perceived relative risk. Indicators that do not meet targets are sorted by relative risk, ranking from lowest to highest risk without scoring. This was done by writing all problems on small pieces of paper and sorting them into a line. The top third were considered the highest risk and addressed first, the middle third medium risk and the bottom third, the lowest risk.

Further to this local effort, the Ministry of Health with WHO began more widespread roll out of WASH FIT in 2020. A virtual, five-session training took place in October 2020 (with government and development partners, including UNICEF, Plan International, Doctors Without Borders and SNV). Adapting the training to an online platform, the training included a video tour of a local facility to simulate a field visit and allow participants to conduct a virtual WASH FIT assessment. WASH FIT was piloted in 185 PHCs in five provinces in collaboration with UNICEF. The assessments applied gender, equity, disability and social inclusion (GEDSI) training and principles in various ways, including facility site selection (remote districts where vulnerable groups are served); encouraging involvement of indigenous communities in WASH teams and during the assessment; and addressing barriers for persons with disabilities in the improvement plans.



- Addressing gender goes beyond safe, private and clean toilets; women’s voices and agency must be included in WASH and quality improvements in health care facilities
- WASH FIT tool has been effective for empowering staff and incremental improvements
- Need technical resource persons to design prototypes for new disability-friendly healthcare facilities, climate resilient/green safe health care facilities
- Inclusion of local disability and women’s groups in training, WASH assessments and improvement plans has led to more gender inclusive technologies, designs and frameworks.



Implementation sites across Indonesia

Further reading

WHO Feature story: “WASH in healthcare services for all: addressing gender equality and social inclusion” <https://www.who.int/indonesia/news/detail/13-11-2021-wash-in-healthcare-services-for-all-addressing-gender-equality-and-social-inclusion>

Video of a visit to a facility to conduct a WASH FIT assessment used in online training: <https://youtu.be/p4xnllHuUCw> (audio in Bahasa with selected subtitles in English).

3. Kenya

Developing an improvement plan and taking action - assigning responsibility for making improvements in public hospitals

As part of a research study linked to averting antimicrobial resistance in Kenya, a modified version of the WASH FIT assessment was developed to evaluate WASH services and identify improvements in fourteen public hospitals (Maina et al. 2019a). The study team, familiar with the Kenyan health care system and its management, examined all 65 indicators in a bid to understand how the indicators related to one another and assign them to domains linked to the persons/offices who would be responsible for action to improve WASH. Responsibility for monitoring all indicators and making improvements were assigned to three groups of stakeholders: county/regional level, senior hospital management and hospital infection prevention and control committees. These levels of responsibility were confirmed through a series of interviews with health care workers and a subsequent large stakeholder workshop. Broadly, county government is concerned with indicators that are beyond the control of hospital leadership (this level might be a sub-national or national government in countries where resources are not fully devolved) such as setting the budget, staffing levels and material upkeep of hospitals. The second level, the hospital health management team (the medical superintendent, health administrative officer, the nursing officer in charge and the departmental heads) are responsible for items such as water treatment, wastewater and grey water disposal, and having health care waste infrastructure (waste pits, functional incinerator/autoclave). Finally, the hospital infection prevention and control committee is responsible for more ward-level items such as waste segregation, hand hygiene, cleaning and staff training.

Following completion of the WASH FIT assessments, aggregate scores were generated for whole facilities and individual wards and used to illustrate performance variation and link findings to specific levels of health system accountability. Hospital managers and health workers were involved in the process to help contextualize and interpret the scores (Maina et al. 2019b). Whereas it was found that the senior hospital management can make some improvements, input and support from the national and regional governments were found to be essential to improve WASH, identified as the basic foundation for averting nosocomial infections and the spread of AMR as part of safe, quality hospital care in Kenya.

Further reading:

- Maina et al. (2019a) *Evaluating the foundations that help avert antimicrobial resistance: Performance of essential water sanitation and hygiene functions in hospitals and requirements for action in Kenya*. Plos One <https://doi.org/10.1371/journal.pone.0222922>
- Maina et al. (2019b) *Extending the use of the World Health Organizations' water sanitation and hygiene assessment tool for surveys in hospitals – from WASH-FIT to WASH-FAST*. Plos One: <https://doi.org/10.1371/journal.pone.0226548>

4. Lao PDR

Use of WASH FIT to improve implementation of new standards and guidelines for greening and strengthening WASH services (2017-)

A 2014 service availability and readiness assessment in Lao PDR showed that less than half of health centres and district hospitals had improved water and sanitation services. The Ministry of Health (MoH) subsequently prioritized the development of guidelines, policies and strategies including Essential Environmental Health Standards for Health Facilities (2017) and the Rural WASH Strategy and National Plans of Action (2018-2030) and a set of health care waste management regulations. The need to establish a nationwide monitoring system, provide systematic operational funding support, enhance staff capacity to manage WASH operation and maintenance (O&M) in facilities and develop more “climate smart” standards was identified. In 2017, MoH began implementing WASH FIT in 2017 in two flood and drought prone provinces to ensure that health care facilities meet climate-smart standards for infrastructure. A series of trainings took place in preparation: a national training to develop master, central and provincial trainers who are based in the Center for Environmental Health and Water; three hospital-level trainings and a series of study visits by MoH at “model facilities” to learn about best practices, particularly for health care waste management.

The MoH has begun implementing a set of comprehensive interventions in two provincial hospitals, forty district hospitals, and eight health centres to make them “Safe, Clean and Climate Resilient” (SCCR) by making buildings and operations more resilient, supplying green technologies such as autoclaves. Training, WASH FIT assessments, improvement and monitoring plans were developed along with supportive supervision of staff by the district health office to ensure that improvements were maintained. Examples of “green” improvements included replacing broken light bulbs with LEDs, phasing out mercury-containing devices, installing water tanks on raised platforms and pumps in hospitals where water interruptions have occurred due to low water pressure or water scarcity during the dry season. Finally, general repairs to WASH infrastructure were undertaken, including rehabilitating hand washing stations, toilets, water filters and tanks, sharps pits and waste management facilities and building pit latrines.

Prior to COVID-19, the MoH had difficulties mobilizing resources for WASH improvements. Since 2020, over 2 million USD has been mobilized from a number of donors (Pandemic Emergency Financing Facility of World Bank, BMZ (Germany), LuxDev, DFAT Australia and UHC Japan) to boost the national initiative in 62 health care facilities in six provinces and Vientiane (the capital). Money has gone to procuring autoclaves, water tanks, hand hygiene stations and other infrastructure as well as to run WASH FIT trainings and deliver ongoing supportive supervision. Forty-four national trainers have been trained on use of WASH FIT who provide ongoing technical support and follow up to facilities.

5. Bangladesh

Adaptation and improving stakeholder engagement and sustainability through use of WASH FIT in Cox's Bazaar settlement (2018-)

Following a baseline assessment of 250 temporary, semi-permanent and permanent health care facilities in the Cox's Bazaar settlement WASH FIT implementation began. At the start, one third of health facilities had water quality which did not meet Bangladesh national standards for drinking water and 22% were without functional, improved toilets. Between August 2018 - September 2019, 21 healthcare facilities (primary and secondary) underwent training/capacity building and on the job training, coaching and mentoring and fact-finding visits. Since then, a further 163 health care facilities have been added and a total of 414 professionals (health care facility managers, doctors, nurses, WASH and IPC focal points) received WASH FIT training.

An assessment (key informants interview, observations and qualitative assessments) conducted twelve months later, found that the aggregated sum of 65 core and additional indicators showed that facilities increased their percentage of meeting standards from 29% at baseline to 67% at end-line. In all facilities, the water domain had the highest percentage of indicators meeting standards, with an average of 67% at baseline and 81% at end-line (12 months later) [see figure]. All facilities increased access to improved water supply on premises, increased water storage with 2-days buffer capacity, and improved drinking water quality at the point of use through regular chlorination. On average, the facilities using WASH FIT increased the overall percentage of indicators meeting standards from 29% at baseline to 67% at end-line.

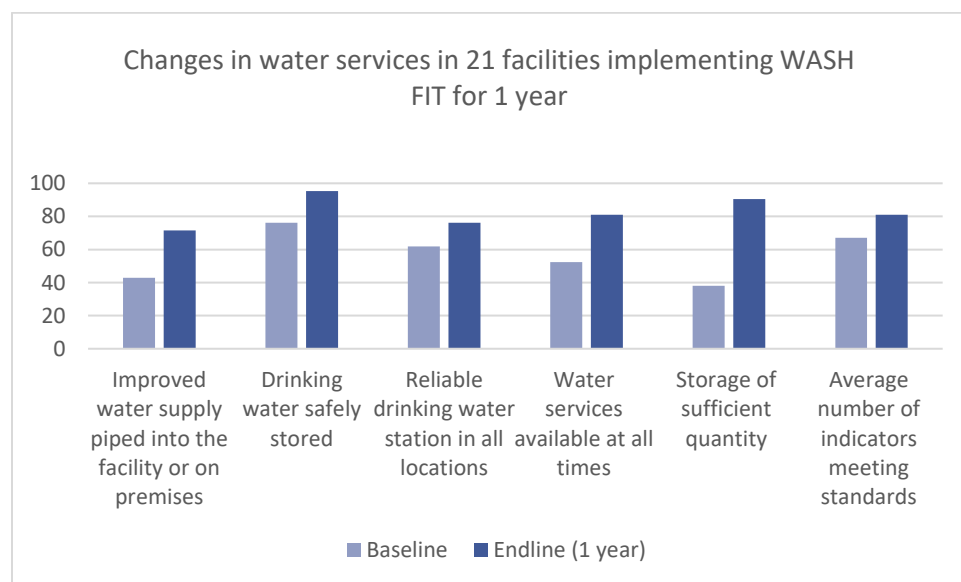


Figure: Improvements in water services after one year of WASH FIT implementation

Results of the initial risk-hazard assessment gave credibility in, and led to the endorsement of, the improvement plan by the health facility management. It also led to the creation of facility WASH FIT committees which were responsible for addressing WASH and IPC improvements.

These committees held regular meetings, providing a platform for all facility staff to share experiences, ideas and best practices and encourage individuals to take action. In these facilities, WASH FIT reportedly helped staff to become more aware of how best to use the limited resources available in the crisis context. Staff also felt that using WASH FIT improved occupational safety and helped change staff and patient behaviour, thus improving quality of care. Interviews with facility staff also demonstrated that using WASH FIT increased staff realization that both WASH and IPC are prerequisites for improving quality of care. Half of the facility managers recognised that there could not be effective infection prevention and control without adequate WASH services in their healthcare facilities.

Despite promising improvements observed in most of the healthcare facilities, there were challenges in sustaining them. An absence of sustainable financing for the operation and maintenance of facilities and services and lack of engagement of WASH sector/partners in the process were major barriers for improving WASH facilities and services. Recommendations were made to conduct coordination meetings with WASH and health sector partners to exchange best practices and to conduct regular refresher trainings with all implementers. Engaging decision makers in the process is critical; where approval was not obtained from the senior management for the access to a facility (even after a long series of communication) supportive supervision activities could not take place. More supportive supervision and training of WASH/IPC focal persons who could contribute to the WASH FIT process is needed to ensure that improvements remain in place.

Further reading:

Summary of implementation in Cox's Bazaar: <https://washinhcf.org/resource/wash-fit-implementation-in-rohingya-camps-in-coxs-bazar-bangladesh/>

WASH FIT guide in Bangla: <https://washinhcf.org/resource/wash-fit-bangla-version/>

6. Bhutan

Assigning responsibility for reporting and reflecting on progress to determine allocation of resources

WASH FIT was piloted in nine facilities in 2019. The Bhutanese Public Health Engineering Department (PHED) (Ministry of Health), led the consultation process to adapt WASH FIT to the Bhutanese context in close consultation with all relevant programmes under the Ministry of Health (AMR, IPC, emergency health programme, Quality and Safety Division) and all relevant stakeholders (Jigme Dorji Wangchuk National Referral Hospital, Royal Centres for Disease Control and the District Health sector) and WASH partners (WHO, UNICEF and SNV).

The WASH FIT assessment was reviewed by a team with mixed technical backgrounds (clinical, public health and engineering) to ensure all areas were covered. A shortened version of the assessment with only 26 indicators was agreed. Responsibility for reporting progress against the WASH FIT indicators was assigned at each level: primary health care (PHC) in-charges should submit reports from their facility to the District Health Sector on a quarterly/biannually basis; district level teams should verify the data and submit to PHED; PHED along with the relevant agencies should review the reports and plan and take remedial action as necessary.

A primary health care centre was selected to host a two-day training for health assistants and support staff (cleaners, sweepers, technicians and caretakers) from all health care facilities in the selected district. Elected local government officials were also included.

The WASH FIT pilot process brought local government officials (district and sub-district level) and PHCs to think, self-reflect, assess the risks and consequences which in turn triggered participatory discussion and coordination. It also provided a platform to work together to improve facilities and services in communities. Through the process, local government officials recognized the need to support health care facilities, including allocation of adequate resources during planning and budgeting. The process also provided an opportunity for the Ministry of Health, particularly PHED, to further refine, review, adapt and improve the WASH FIT methodology and tools to fit the context and needs of different health care facilities. This will be used in sustaining, scaling up, designing and developing a larger programme of WASH interventions by the Ministry of Health.

Further reading:

Training and implementation report: <https://washinhcf.org/resource/report-on-wash-fit-in-all-15-health-facilities-under-lhuentse-district-bhutan-2020/>

7. Tajikistan

How WASH FIT can influence national actions: Use of WASH FIT leading to development of a national health strategy and integration of WASH with AMR

In 2016, an advisor to the Minister of Health attended a regional meeting on Sustainable health services (Bonn, 24-25 October 2016) where WASH FIT was discussed. At the time, Tajikistan was preparing to launch the *International Decade of Action: Water for Sustainable Development 2018–2028*, while undergoing national health care reform. It was an opportune moment to secure the interest and commitment of the wider Ministry of Health and Social Protection (MHSP). In April 2018, the Ministry of Health organized a national training of trainers and began a pilot of WASH FIT in selected health facilities, with technical support of WHO. Concurrently, WASH FIT was introduced at a national roundtable on WASH in health care facilities, which included key stakeholders from the Ministry of Health and Social Protection, Ministry of Finance, Sanitary Epidemiological Services, and development agencies who agreed there was a need to review and strengthen existing national policies and regulations.

The health ministry took the lead to integrate WASH requirements into policies and standards already in place and those under development. Informed by the findings of the policy review, WASH was embedded in the National action plan on AMR for 2018-2022. Furthermore, the new National Health Strategy (pending adoption in 2021) includes a component on WASH in health care facilities as a priority strategic area which focuses *inter alia* on strengthening the standards, improving WASH conditions at the facility level by using WASH FIT, ensuring appropriate financing and effective coordination and partnerships. The targets included conducting a comprehensive assessment of WASH conditions in health care facilities and undertaking necessary rehabilitation, in particular in maternity hospitals.

Finally, the process resulted in improved collaboration with partners such as Oxfam who committed to work on WASH in health care facilities and use WASH FIT as their tool for implementing and sustaining improvements, with a renewed focus on maintenance of services. In 2020, the MHSP conducted a national survey on WASH in health care facilities with funding by JICA from COVID-19 emergency funds and technically supported by WHO. UNICEF mobilized resources for implementation of the large-scale project on WASH in health care facilities, funded by the European Commission. In 2021, the FAO/OIE/WHO tripartite *One health project for combatting AMR* in Tajikistan was approved by the AMR Multi-partner trust fund to include WASH/IPC related activities (e.g. WASH FIT). In May 2021, MoHSP set up a Coordination Platform for WASH in health care facilities to strengthen coordinated planning and implementation of WASH improvements with stronger cooperation between development partners.

8. Ecuador

Using WASH FIT to improve water quality in priority peri-urban areas

As a result of COVID-19, UNICEF Ecuador started to use WASH FIT as a way to draw attention and understand the status of WASH in health care facilities nationally, as no reliable assessment indicating progress had existed before COVID-19. While members of the WASH sector were aware of needs at the local level, there was no evidence to plan for necessary improvements with authorities. Introducing WASH FIT during COVID-19 meant limited engagement from the health sector who were busy with testing, vaccination and critical care for COVID-19 patients.

Funding from USAID was used to conduct assessments in peri-urban areas in two provinces with a low prevalence of COVID-19 but bordering affected provinces. In total, twenty-four facilities were surveyed with limited WASH services. WASH FIT was conducted alongside water quality testing (residual chlorine); where no residual chlorine was found in the water supply, electrolytic chlorination devices were provided. WASH FIT was used to show improvements, and there was an overall good response from health workers because they were able to upload improvements, including the improved chlorine levels in water supply, from the devices provided.

The Ministry of Health is planning to undertake similar assessments nationally, following the success of the scale up of a similar model of assessment in schools (the WASH Sustainability Index Tool (WASH SIT)). Political leadership due to changes in government is a barrier to long-term sustainability.

9. Mali

Using WASH FIT in an ongoing emergency situation (2015-)

Mali was one of the first countries to implement WASH FIT (called locally “*Plan de gestion de santé environnementale*” (PGSE)), which was rolled out by the Ministry of Health as part of a three-year project between WHO, CDC and WaterAid in 2015. Subsequently, other organizations (World Vision, IRC, Terre des hommes) have adopted and adapted the tool, simplifying it for smaller facilities (reducing the number of indicators by half) and using locally drawn illustrations to help guide improvements (see photo). To date, approximately 120 small, rural facilities have used the tool.

The Ministry of Health conducts supervisory visits to districts implementing WASH FIT to oversee progress and coordinate the different partners working there. The aim of these missions is to inspect facilities, provide support to staff and identify any ongoing challenges. At the end of each visit, an action plan to respond to any problems identified is developed. Worsening security in central and northern Mali continues to make it difficult for both partner and government focal points to access some health care facilities, further emphasizing the role of the community in managing services and supporting good hygiene. In particular, women’s groups and community management associations (ASACOs) develop recommendations and contribute to improvements (e.g. fixing pipes, regular cleaning, etc.). In one district, a public hearing was held to present the findings of a WASH FIT assessment (see photo), where the community successfully demanded investment in improvement plans from the municipality. These feedback mechanisms take into account members of the community with low-literacy and are part of a feedback loop where input is reviewed, discussed and acted upon.



Photo: Community group discussing WASH FIT action plan

Having routine data collection mechanisms through WASH FIT are important for more rapidly identifying failures in WASH services and targeting resources. In 2020, COVID-19-relevant indicators have been integrated into WASH FIT, which in turn provides useful data for district

and facility level planning. WASH indicators have also been integrated into the national HMIS which will provide an opportunity for further regular data collection.

Drawings to illustrate WASH FIT indicators for rural primary health care facilities



Further reading:

Simplified WASH FIT assessment [French] <https://washinhcf.org/resource/simplified-wash-fit-assessment-for-use-in-mali-2018/>

10. List of WASH FIT publications

- **Zimbabwe:** Hirai et al. (2021) Using the Water and Sanitation for Health Facility Improvement Tool (WASH FIT) in Zimbabwe: A Cross-Sectional Study of Water, Sanitation and Hygiene Services in 50 COVID-19 Isolation Facilities. *Int. J. Environ. Res. Public Health*. <https://doi.org/10.3390/ijerph18115641>
- **Ghana:** Ashinyo et al. (2021) Evaluation of water, sanitation and hygiene status of COVID-19 healthcare facilities in Ghana using the WASH FIT approach. *Journal of Water, Sanitation and Hygiene for Development*. <https://doi.org/10.2166/washdev.2021.254>
- **General:** Weber et al. (2019) *A conceptual evaluation framework for the water and sanitation for health facility improvement tool (WASH FIT)* *Journal of Water, Sanitation and Hygiene for Development*. <https://doi.org/10.2166/washdev.2019.090>
- **Kenya:** Maina et al. (2019) *Evaluating the foundations that help avert antimicrobial resistance: Performance of essential water sanitation and hygiene functions in hospitals and requirements for action in Kenya*. *Plos One* <https://doi.org/10.1371/journal.pone.0222922>
- **Kenya:** Maina et al. (2019) *Extending the use of the World Health Organizations' water sanitation and hygiene assessment tool for surveys in hospitals – from WASH-FIT to WASH-FAST*. *Plos One*: <https://doi.org/10.1371/journal.pone.0226548>
- **Togo:** Weber et al. (2018) *Strengthening Healthcare Facilities Through Water, Sanitation, and Hygiene (WASH) Improvements: A Pilot Evaluation of “WASH FIT” in Togo*. *Health Security* <https://doi.org/10.2166/washdev.2019.090>