ACHIEVING QUALITY UNIVERSAL HEALTH COVERAGE THROUGH BETTER WATER, SANITATION AND HYGIENE SERVICES IN HEALTH CARE FACILITIES

A focus on **Cambodia** and **Ethiopia**

World Health Organization

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INTRODUCTION

Water, sanitation and hygiene (WASH) in health care facilities (HCFs) are essential for improving quality within the context of universal health coverage (UHC). Focused attention to this triangulation between quality, UHC[1] and WASH can catalyse improvements in a number of other areas including health and safety, service delivery, staff moral and performance, health care costs and disaster/outbreak resilience as well as being linked to, and integrated with, improvements in infection prevention and control. With nearly 40% of HCFs in low- and middle-income countries lacking improved water and nearly 20% without sanitation, there is much to be done to improve WASH services. WASH is a necessary prerequisite to achieve quality UHC and its implementation as such, will shape health systems across the world.

UHC is a global health priority and part of the Sustainable Development Goals (SDGs) under target 3.8. WASH in health care facilities is also implicitly and explicitly captured in the 2030 Agenda for Sustainable Development with the terms “universal” and “for all” in SDG Targets 6.1 and 6.2, which recognizes that access to water and sanitation is a basic human right.

The WHO/UNICEF Global Action Plan for WASH in HCFs recognises that sustained improvements in WASH in HCFs require integration between quality of care efforts and WASH. To date, little evidence is available on how such integration occurs at country level. To address this knowledge gap, WHO has conducted several in-depth situational analysis in countries that are undertaking actions to improve WASH in HCFs as part of their quality of care improvement efforts. The purpose of the situation analyses was to capture mechanisms that “jointly support” WASH in HCF and quality of care improvements and also identify barriers and challenges to implementing and sustaining these improvements.

1 WHO states that universal health coverage (UHC) “means that all people and communities can use the promotive, preventative, curative, rehabilitative and palliative health services they need, of suffic ient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”.

OBJECTIVES

(1) Describe the system level changes to support integration of WASH in HCF improvements and practices into quality of care mechanisms.

(2) Understand how changes in attitudes and behaviours can be made at the national, regional, district and facility levels to sustain these improvements.

(3) Identify bottlenecks that prevent improvements in WASH services or enablers where improvements have been made and sustained in areas such as leadership, policy, financing, monitoring & evaluation, evidence and facility improvements.

(4) Develop recommendations with the Ministry of Health (MoH) and key stakeholders for improving quality efforts and WASH services, within the context of UHC.

APPROACHES[2]

(1) A rapid review of policy and standards documents, and assessment tools, including documentation related to quality and UHC to identify key linkage points between quality, UHC and WASH.

(2) Key informant interviews with stakeholders at the district, regional and national levels, including government, NGOs, facilities, staff members and communities.

(3) Assessments of facilities and related WASH in HCF activities such as the application of existing assessment tools and interventions in regional and district facilities.

2 Note that this approach is non-prescriptive and was developed in collaboration with countries.

CAMBODIA

GENERAL

Population	15.3 million
Number of facilities in country: health centres	1 141
referral hospitals	99

HEALTH[3][4]

Maternal mortality ratio per 100 000 live births (2017)	161
Neonatal mortality rate per 1000 live births (2014)	18
Diarrhoeal diseases (0-5 years) (%) (2014)	12.8
Births attended by a skilled health professional (%) (2014)	89.0
Life expectancy at birth (m/f, years) (2015)	66.6/70.7
Total expenditure on health per capita (USD) (2014)	70
Total expenditure on health as % of GDP (2014)	6.3

WASH[1][9]

Access to basic water supply (%)[2]	91
Access to basic sanitation (%)[3]	39
Access to basic hand hygiene (%)[4]	15
Basic health care waste management (%)[5]	10

POPULATION ACCESS TO WASH[9]

Population using basic drinking water sources (%) (2015)	75 (urban 96, rural 70)
Population using basic sanitation facilities (%) (2015)	49 (urban 88, rural 39)

1 Coverage of WASH in health facilities (referral hospital, outpatient departments and health centres). None of the assessed HCFs had basic sanitation as defined by JMP: HCFs with improved toilets located on the premises that are functional at the time of visit, with at least one designated for women/girls with facilities to manage menstrual hygiene needs, one separated for staff, and one meeting the needs of people with limited mobility.
2 % of HCFs with water available from improved sources on premises (2016).
3 % of HCFs with at least three improved and usable toilets.
4 % of HCFs with functional hand hygiene station available at outpatient departments and delivery room/area and within five meters of toilets.
5 % of HCFs where waste is segregated in consultation area and infectious/sharps wastes are treated/disposed of safely.

ETHIOPIA

GENERAL[6][8]

Population in thousands	90 602
Number of facilities in country: hospitals	125 existing, 185 under construction
health centres	3 245
health posts	16 048

HEALTH[6][8][10]

Maternal mortality ratio per 100 000 live births (2015)	353 (247-567)
Neonatal mortality rate per 1000 live births (2015)	28 (18-41)
Diarrhoeal (0-5 years) (%)	17.8
Births attended by a skilled health professional (%) (2015)	28
Life expectancy at birth (m/f, years) (2015)	62.8/66.8
Total expenditure on health per capita (USD)	73
Total expenditure on health as % of GDP (2014)	4.9

WASH[8][9]

Coverage of WASH in facilities	
Improved water source (%) (2014)	77 (urban 94, rural 65)
Access to piped water (%) (2014)	52 (urban 83, rural 30)
Coverage of WASH in health posts	
Improved water source (%) (2014)	45 (urban 50, rural 45)
Access to piper water (%) (2014)	3 (urban 28, rural 2)

POPULATION ACCESS TO WASH[8][9]

Population using improved drinking water sources (%) (2015)	57 (urban 93, rural 49)
Population using improved water sanitation facilities (%) (2015)	28 (urban 27, rural 28)
Mortality rate attributed to unsafe WASH services (per 100 000)	29.6

CAMBODIA

CHALLENGES AND BOTTLENECKS

- **Leadership and management:** Though WASH is acknowledged in health policies and incorporated in quality of care improvement mechanisms, it is not consistently represented across all policy documents and mechanisms.

- **Policy and standards:** Currently there are no agreed minimum standards for WASH in HCF.

- **Financial resources:** The new results-based financing mechanism, namely the service delivery grant, is not clearly understood by all health managers, and there are no explicit permissions to use the grant for WASH and IPC expenditure.

- **Empowerment:** There is a lack of leadership and knowledge of WASH and IPC at the facility level.

- **Governance:** There is no formal coordination mechanism or agreement on alignment of WASH in HCF targets between the Ministry of Health and ministries responsible for WASH such as the Ministry of Rural Development.

ENABLING FACTORS

- There is high level commitment to improve quality of care. Quality is at the forefront of the new National Health Strategic Plan 2016-2020.

- There is strong recognition from all health partners including national policy makers and Health Equity and Quality Improvement Project (H-EQIP) members that WASH should underpin quality of care.

- Cross-sector commitment: There are targets for universal access to household WASH by 2025. The Ministry of Rural Development has set targets for 70% access to improved WASH in health centres and schools by 2025. The MoH has set targets for all 95% of health facilities to have basic water supply and 90% of health facilities to have basic sanitation by 2020.

- There is an informal active multi-sectorial working group on WASH in HCF led by the Department of Hospital Services that includes representation from development partners, NGOs and research institutes. This group works cooperatively to align all activities and support the implementation of WASH in HCF improvements as part of quality of care mechanisms.

- The H-EQIP, co-funded by the Government and development partners, has made financing available through lump sum and performance-based grants that allow an opportunity for WASH improvements at the facility level.

- Scaling up of social health protection schemes, in particular the health equity fund and social health insurance for salaried workers and civil servants, provides a platform for developing and implementing an accreditation process for public and private facilities.

ETHIOPIA

CHALLENGES AND BOTTLENECKS

- **Leadership and management:** Integration and coordination of national activities is limited, resulting in duplication of efforts in some areas (eg. multiple WASH programs).
- **Financial resources:** Limited WASH budget, dated and deficient infrastructure (e.g. water supply, sewerage system, electricity, space constraints, and old buildings). Budget constraints prevent renovation of infrastructure, training and capacity building.
- **Support:** Limited implementation support and guidance to support facilities to make improvements once problems have been identified. The current audit tool does not cover all relevant aspects of global standards for WASH and IPC.
- **Training:** Lack of a specialized health work force (environmental health workers, medical specialists) and training for WASH and IPC standards.
- **Advocacy:** Lack of awareness of the importance of IPC, WASH, safety and quality in health care facilities and the community.

ENABLING FACTORS

- High level leadership, governance and political commitment.
- Strong involvement of senior management at facilities implementing CASH.
- The decentralised health system enhance local autonomy to manage budgets and services according to needs.
- Involvement of influential public figures as CASH ambassadors have helped to raise its profile.
- Lead CASH hospitals provide support, mentorship and technical advice to health facilities in their catchment area through facility visits and supervision of CASH activities and audits.
- Changing the attitudes and behaviour of all staff and patients by ensuring that everyone is involved and motivated to make improvements has been important to drive change in health care facilities.