# SCALING UP EFFECTIVE WATER, SANITATION, AND HYGIENE SERVICES THROUGH FAITH-BASED HEALTH CARE NETWORKS

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## SCOPE

Localized efforts to address gaps in water, sanitation, and hygiene (WASH) and infection prevention and control (IPC) services in health care facilities (HCFs) through health networks are well documented, but there is limited research on how to increase the scale of effective interventions by orders of magnitude. For example, how can WASH services be improved not only in 20 HCFs, but in 200 or 2,000?

Faith-based HCFs constitute a significant portion of health services in many low- and middle-income countries. As private, non-profit HCFs, they are often outside the planning and purview of health system planners who primarily focus on publicly-owned facilities. Partially as a result, in several countries, faith-based HCFs are organized into networks that support business operations and quality improvement (QI) activities for their members and improve coordination with governments. These networks are a natural organizing platform for scaling up WASH in HCFs.

This brief draws upon the U.S. Agency for International Development's (USAID) MOMENTUM Country and Global Leadership project's 2020–2022 implementation of WASH improvements in 199 HCFs in Bangladesh, Ghana, India, Sierra Leone, and Uganda, including 44 faith-based facilities in Ghana, Sierra Leone, and Uganda. It intends to support faith-based networks to take WASH activities to scale and suggest ways to achieve scaling through limited, medium-level, and significant investments. WASH is a component of IPC and, in this brief, it refers to HCF waste management and environmental cleaning along with water, sanitation, and hygiene.[1]

## BACKGROUND

In 2019, the World Health Organization (WHO) issued a resolution calling on countries to ensure water and sanitation in HCFs.[2] Soon after, COVID-19 significantly disrupted health systems globally, highlighting the critical need for strengthening facility readiness in WASH and IPC for good quality care and to respond adequately to the pandemic. There is more information now on WASH in HCFs than before; a report issued in 2022 highlights that too many HCFs still lack access to basic water, sanitation, hygiene, waste management, and environmental cleaning in low- and middle-income countries.[1]

From 2020 to 2022, a WASH project through the MOMENTUM Country and Global Leadership project provided WASH technical and capacity development assistance concurrently in clusters of HCFs in five countries: Bangladesh, Ghana, India, Sierra Leone, and Uganda. The project sought to improve WASH in HCFs in these countries, focusing on maternal and child health care services during the outbreak of COVID-19, including three key activities:

1. Rapid improvements in HCF WASH readiness and COVID-19 patient management, to maintain essential services and protect staff and patients
2. Hub-spoke mentorship platforms to continue and sustain progress
3. Sub-national government technical and capacity development assistance to sustain support services and monitor and enforce WASH response plans

The work was carried out in assessment and strengthening phases through a five-step process that included assessment and prioritization, procurement and civil works, virtual platform moderation, QI training and support, and data review facilitation.

Given the lack of national assessment tools, the project created a comprehensive assessment tool based on WHO's WASH FiT and IPCAF tools, as well as the Clean Clinic Approach Assessment Tool and emerging indicators used in the early days of the COVID-19 pandemic response. A range of other tools to improve WASH in HCFs are also available. These tools are intended to be used in a variety of contexts and some modifications to account for different country contexts and variations in needs should be considered.

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[1] WHO. 2022. Progress on WASH in health care facilities 2000–2021: special focus on WASH and infection prevention and control (IPC). https://washdata.org/sites/default/files/2022-08/jmp-2022-wash-hcf-launch.pdf

[2] Seventy-second World Health Assembly. 2019. Water, sanitation and hygiene in health care facilities. https://apps.who.int/iris/bitstream/handle/10665/329290/A72_R7-en.pdf

This WASH work shows that it is possible to make improvements in WASH readiness in HCFs in a short period of time and with a package of minimal support in the areas of infrastructure, supply, training, mentoring, and data collection and use.

Though this work took place during the COVID-19 pandemic, when there was significant focus on the rapid implementation of WASH measures, the project offers lessons in multi-country efforts to sustainably scale up WASH utilizing faith networks in a variety of contexts and conditions.

Experience gained in this project, along with guidance from global actors such as the WHO, help frame the scope of WASH and actions needed to embed and sustain it within health systems and networks.[3] This guidance can help faith-based networks shape WASH programs within national systems and in partnerships with public sectors.

This project involved faith-based networks and facilities, including the Christian Health Association of Ghana (CHAG), the Uganda Protestant Medical Bureau (UPMB), the Uganda Catholic Medical Bureau (UCMB), and the Christian Health Association of Sierra Leone (CHASL). There are 970 facilities in this network: 326 total facilities in the CHAG network, 602 facilities in UPMB and UCMB networks, and 42 in the CHASL network. This project worked with 44 of these faith-based facilities, ranging from remote rural clinics to urban health care centers.

## WORKING THROUGH FAITH-BASED HEALTH CARE FACILITIES

Thousands of HCFs, including faith-based HCFs, exist outside the government sphere. Some are designated by national governments as the de facto government presence in a local community. In 15 countries in sub-Saharan Africa alone, there are more than 8,331 Christian HCFs, community-based health programs, health training institutions, and drug supply organizations. Of these, 5% are national-level hospitals, 9% are district hospitals, 45% are outpatient health centers, and 33% are local health outposts or dispensaries. Despite this reach, faith-based facilities are regularly excluded from government planning and may not receive the same level of resources as government facilities.

The owners of faith-based HCFs agree to be organized under umbrellas of networks or health associations to advance their mission and/or specific business interests. Such networks include: Christian health associations (e.g., CHAG), Islamic associations (e.g., Uganda Islamic Medical Bureau), or a blend of professional associations and health networks (e.g., the Christian Medical Association of India or the Catholic Health Association of India). Certain non-governmental organizations become de facto networks by supporting the coordination of groups of facilities (e.g., Muhammadiyah in Indonesia).[4]

Many networks directly support or oversee business operations or can enter into business agreements on the behalf of HCF owners (e.g., local churches). A health network may provide the following value to their member facilities:

- Capacity for pooled procurement for medicines and supplies
- Common projects and joint procurement of contractors, training, and data
- A ready-made knowledge network within a context of performance-based accountability
- Representing with government and international partners, organizing advocacy, and stimulating national and local engagement on budget and policy

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[3] 4 Ways to Approach WASH Challenges in Health Care Facilities during the COVID-19 Pandemic - USAID MOMENTUM

[4] https://muhammadiyah.or.id/

Faith-based networks may have existing partnerships with local and national governments and other supporting partners, which further aid coordination on WASH initiatives.

The capacity of such faith-based health networks varies. In some countries, health networks are well established, with over 50 years of experience and tens of millions of dollars of donor funds. Other countries, where the networks are nascent or serve a smaller population, have not benefited from the scale of larger counterparts.

Management systems within health networks also differ across urban and rural geographies and across hospitals, health centers, and dispensaries. Virtual communication platforms, made essential during the COVID-19 pandemic, have strengthened faith-based networks and member facility experiences by providing new avenues for networks to stay in regular communication (e.g., to learn across facilities, to address challenges, provide trainings) with their facilities, remotely.

It is common for faith-based networks to be simultaneously addressing HIV, tuberculosis, and malaria; providing healthy timing and spacing of pregnancies and safe surgery; and addressing emergent issues such as population displacement, epidemics or pandemics.

The scale and capacity of faith-based HCFs and networks make them natural and essential partners to scale up WASH strategies.

This brief intends to distill the learnings of faith-based partners from Ghana, Uganda, and Sierra Leone and describe how to scale up effective implementation of WASH programming in faith-based networks. This brief is based on the review of WASH project documents and global references, including tools and approaches, and feedback from partners. This work contributes to the United Nations Sustainable Development Goal 6: Clean Water and Sanitation.[5]

# SCALING WASH PROGRAMMING

Meaningful efforts to scale WASH activities in multiple facilities include a combination of activities that require low, medium, and significant external financial investments for staff effort, data systems, or infrastructure requirements. Much can be accomplished with low and medium external financial investments.

### INVESTMENT SCENARIOS TO SCALE WASH IN HEALTH CARE FACILITIES

| Low Financial Investment Needed | Medium Financial Investment Needed | Significant Financial Investment Needed |
|---|---|---|
| • Identify needs<br>• Formalize management and oversight responsibilities<br>• Sensitize and advocate with leaders<br>• Develop action plans | • Collect routine data and use data management systems<br>• Create networks for capacity improvements in QI systems and purchases for economies of scale | • Train HCF staff, including cleaners; share best practices across facilities<br>• Identify broad-based support opportunities for facility-based infrastructure and information technology |

The following sections explain how faith-based health networks can scale WASH efforts throughout their network of facilities, regardless of the level of external resources available to them.

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# 1. START WITH ACTIVITIES THAT REQUIRE LOW OR LIMITED EXTERNAL FINANCIAL RESOURCES

Faith-based networks are often dependent on external resources to help them make sustainable changes and actualize improvements to their infrastructure, policies, and practices. However, external resources are not always available or consistent. Platforms should be established ideally before major donor investment is made. This section shares strategies for faith-based networks to effectively scale WASH programming when they have limited access to external resources.

## WHAT NEEDS TO BE SCALED?

To scale WASH, HCFs within a network need to agree on what to prioritize before detailed planning can begin (e.g., infrastructure, supplies, staffing, information technology [IT], virtual and in-person training and support).

WASH FIT provides a facility-based framework to assess priorities to guide a network to identify its focus area and:

1. Assess and prioritize across facilities on whether to focus on improving water supply, sanitary facilities, waste disposal, cleaning services, or a combination of these. Any one of these improvements may require substantial later investment. WASH FIT can help HCFs identify where they should start making improvements when funds are available.

2. Determine HCF selection criteria, taking into account the unique elements of rural versus urban contexts, considering issues such as rural areas may have fewer supplies and services. Peri-urban areas may have more supplies and service options. For example, urban hospitals and health centers may have access to water from a national system while rural HCFs may not. Urban HCFs may have larger patient populations, therefore more impact. Rural facilities may lack professional WASH services or municipal services, which may be a reason to either prioritize or not select them. Consider whether a particular area or region has greater need or existing resources that support rapid scale.

## WHAT MANAGEMENT AND OVERSIGHT IS NEEDED?

Strong management is important to embed WASH as a component of health services and drive progress in making and sustaining improvements. To accomplish this:

1. Embed WASH in routine planning and budgeting. Make operational resources, supplies, and infrastructure for WASH a routine part of annual procurement plans among facilities along with their corresponding management, similar to how essential medicines are prioritized.[6]

2. Identify a champion or WASH desk. A single focal point within the network would help advocate for WASH and encourage network members, keeping the strengths of a network in mind.

3. Access regional and international platforms. For example, coordinate with global partners or other networks that could establish WASH secretariats to provide regional support and facilitate collaboration across countries.

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[6] Implementing the Clean Clinic Approach Improves Water, Sanitation, and Hygiene Quality in Health Facilities in the Western Highlands of Guatemala. Lopez J, et al. Global Health: Science and Practice 2020, 8 (2) 256-269. https://www.ghspjournal.org/content/8/2/256

The WASH program completed videos[7] to tell the story about faith-based partners and the WASH program. These videos highlighted work in specific facilities, which gives rise to an additional scaling factor that was not formally part of the initiative:

4. Recognize success and achievements. Health networks could, for example, recognize or designate facilities as "clean clinics" and feature them in local media. This is highly motivational.

## WHAT SENSITIZATION AND ADVOCACY IS NECESSARY?

Health networks can increase sensitization among local leaders and communities about the need for WASH efforts. Political leaders may not know how poor hygiene increases reinfection or negatively affects outcomes. Local community leaders could support WASH efforts in their communities, making it easier for community participants and staff alike to take steps to implement WASH. Simple workshops, meetings, and public addresses over radio or through newspapers can help make more people aware of this.

Health care networks can create detailed action plans that lay out what WASH activities the network is currently implementing within their broad base of HCFs and what specific WASH changes the network would take on at scale if they had additional resources. This would allow networks to have agreed-upon goals to improve their WASH measures and they would be ready with an implementation plan if and when more resources became available. Strategic, ready-to-go action plans are also attractive to potential funders, as this indicates that WASH is a priority for the network and thought leadership has already been invested to lay the groundwork for WASH enhancements.

# 2. INITIATE ACTIVITIES WHERE MEDIUM FINANCIAL INVESTMENTS ARE FEASIBLE

Several activities can start with medium-level investments. Enhancing data management and beginning to address health system capacity are good examples.

## WHAT DATA AND DATA MANAGEMENT SYSTEMS ARE NEEDED?

Comprehensive data are needed for managers to make informed decisions on QI and resource allocation. Data on health outcomes and associated costs will also allow managers to quantify any time and resources savings associated with improved WASH.[6] Specific ideas include:

1. Measure progress and share data with IPC committees and QI teams. Be sure to help facilities understand how to use the data to track improvements and know if the training activities were changing behaviors in the facility.

2. Use data to identify lower performing facilities in need of assistance. This way, supportive supervision can be more efficiently directed where it is needed the most. Higher performing facilities may provide peer mentoring support for lower performing facilities.

3. Use a digital data collection platform that is widely available and free to use. This project used mWater/Solstice with faith-based networks and HCFs and their stakeholders to collectively assess and prioritize HCF needs and evaluate progress using a shared and free-to-use system. Another example of a digital data collection platform is the KoBo Toolbox,[8] which USAID funded in 2013 to transform its use into

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[7] Helping Faith-Based Facilities in Ghana Improve Infection Prevention and Control - YouTube; Keeping Ghanaian Health Facilities Safe during COVID-19 - YouTube

[8] https://www.kobotoolbox.org

an extensive platform for humanitarian data collection. Also, Hilton Foundation and Global Water Challenge are creating a WASH in HCF system on the water point data exchange program (WPDx).[9] HCF and district staff should be oriented to use free data management systems—and adapt them as needed—including beginning with a simplified set of data points to monitor. Remote collection of data can be cost effective.

## WHAT "NETWORK" CAPACITY SHOULD BE STRENGTHENED?

WASH capacity should grow throughout the health networks and facilities. This project demonstrated the value of reaching strategic staff cadres and utilizing QI and cross-training to ensure that everyone reinforces WASH principles. However, comprehensive planning and capacity building for networks are needed, starting with following the framework of the WHO's health system building blocks.

Understanding the limitations and the potential of network capacity can add value to a proposal seeking funding, by presenting realistic targets framed with self-identified limitations.

# 3. SEEK ENHANCED EXTERNAL FINANCIAL INVESTMENTS

Several areas of enhanced investment will be needed to extend capacity strengthening and facility improvement.

## WHAT WASH CAPACITIES REQUIRE STRENGTHENING AND HOW?

Trained HCF and district QI coaches were effective in providing QI support to MOMENTUM partner HCFs, which resulted in improvements in hand washing and use of personal protective equipment among the staff in all MOMENTUM-supported HCFs. Virtual mentoring and coaching assisted in providing real-time support to facilities and on-site training and supportive supervision conducted for low-performing facilities helped in addressing challenges. Recommendations from this program include:

1. Train the cleaning staff. In some WASH efforts, clinical staff are trained but cleaners are not. This is an oversight that should not be ignored in efforts to scale WASH.

2. Conduct virtual training and coaching when possible. Include a combination of virtual and in-person support as resources, time, and budgets allow, while being mindful of cadre needs. For example, staff who are semi-literate and have limited or no skills to use IT might not be able to benefit directly from virtual support and will need on-site support.

3. Support, motivate, and compensate staff time to support WASH training. This includes providing internet connection or reimbursing staff's internet costs so that staff can participate in virtual sessions.

4. Integrate virtual mentorship through Zoom sharing sessions and moderated WhatsApp groups to increase the reach and support to geographically diverse facilities at low cost.

5. Share knowledge of successful practices. In this project, virtual information sharing across facilities and districts expedited networking, problem solving, and the adoption of best practices. Supporting virtual communities of learning to remain active will facilitate continuity of learning, timely information sharing, and exchange of best practices while reducing the need for physical interactions should that continue to be important.

6. Rely on QI teams to address identified problems. QI helps facilities understand root causes of facility-specific challenges and uses change ideas to address them.

7. Consider innovative approaches for capacity strengthening, for example rotating staff within network HCFs to provide coaching.

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[9] https://www.waterpointdata.org

## WHAT BROAD-BASED RESOURCES AND SOURCES OF SUPPORT ARE NEEDED?

Resources are needed for scale and sustainability. WASH in HCFs must be embedded in the regular standard-setting, budgeting, and programming of health systems.

**CREATE BROAD-BASED FUNDING PROPOSALS:** Countries with domestic resources for WASH have been most successful in achieving coverage of quality WASH.[10]

1. Estimate the costs of WASH programming at a system level. Include infrastructure, supplies, capacity strengthening, supervision, IT, and data management. While small investments at $10,000 can make a significant difference in a primary HCF, 100 institutions would need USD $1 million. Urban hospitals, including those at the tertiary level, may need larger financial investments.[11]

2. Work with national stakeholders to develop plans and mobilize funding—from both domestic and donor sources.

3. Use internal assessments and prioritization activities to directly request funding from donors and international faith-based partners in a way that supports networks instead of individual HCFs.

4. Share data within health networks on actual costs to benchmark future estimates.

**PRIORITIZE INFRASTRUCTURE AND SUPPLY NEEDS:** WASH supplies, especially for hygiene, cleaning, and waste management, are needed to sustain WASH readiness improvements. The lack of some basic supplies were bottlenecks to following WASH protocols in many HCFs supported under this program. Facilities need to be repaired and maintained. Ensuring support for supplies and repairs will be critical for scale and sustainability.

1. Include WASH infrastructure investments, coupled with clear operations and maintenance plans.

2. Utilize the recently published Essential Supply List For Infection Prevention and Control in Health Care Facilities as a reference document for scaled WASH initiatives. WASH stakeholders should continue advocating for the adoption of a nationally contextualized essential supply list for WASH and IPC.

**DEEPEN ACCESS TO INFORMATION TECHNOLOGY:** Scaling training and monitoring requires consistent and reliable IT for online/virtual training, coaching, and mentoring. In this project, not all facilities had regular access to reliable data networks. Baseline assessments to establish availability of resources, including internet connectivity, devices, and IT support staff, enabled initial good planning to support virtual platforms of learning. Future plans should anticipate that this situation will change.

1. Assess and keep current information about HCF internet and electricity. Provide material and IT technical support to increase or maintain HCF video communications capabilities.

2. Anticipate other equipment needs, such as laptops and modems, that support facilities.

3. Link network HCFs and their staff through WhatsApp and Zoom to allow for inter-facility interactions and participation of staff at multiple levels and cadres.

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[10] Opinion: Vaccines are important, but what about water? Devex. https://www.devex.com/news/opinion-vaccines-are-important-but-what-about-water-100285

[11] Ross I, et al. Costs of hand hygiene for all in household settings: estimating the price tag for the 46 least developed countries. *BMJ Global Health* 2021;**6:**e007361. https://gh.bmj.com/content/6/12/e007361

# FINAL CONSIDERATIONS

***WASH interventions must be sustained over time despite fluctuations in available funding; the work of the health network must be maintained.*** Scaling WASH requires planning, setting priorities, and building on the strengths of being part of a network. It is important to acknowledge that everything cannot be done at once, but phasing the strengthening and expanding of WASH can be supported with the use of simplified tools and approaches for varying conditions in urban and rural areas and for different levels of HCFs, aligning with national standards. Planning for the future (e.g., plans for expanded access to national water systems or waste management options) will ensure that networks can avail themselves of these resources as they move to scale with WASH.

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