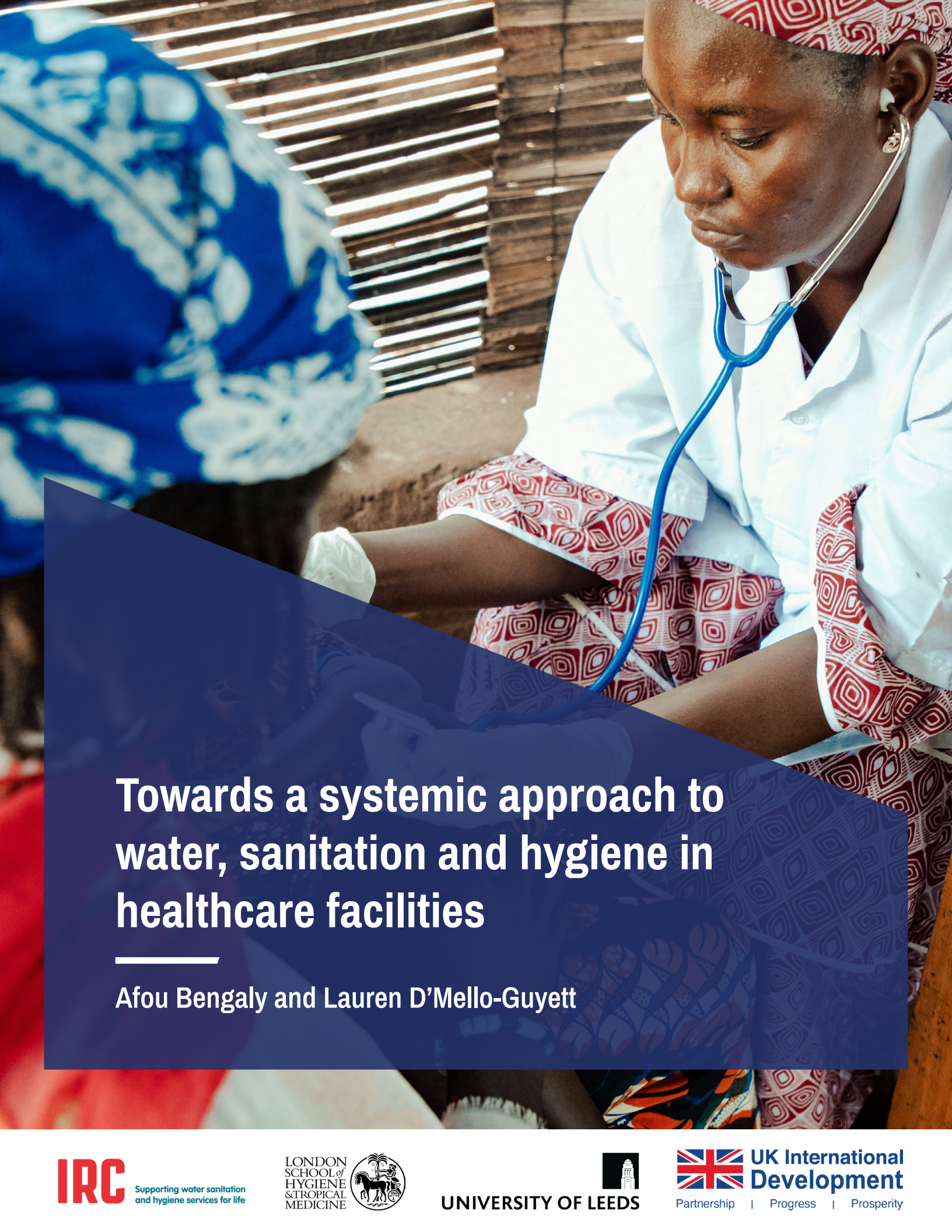




Towards a systemic approach to water, sanitation and hygiene in healthcare facilities

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About the project

The WASH Systems for Health (2023-2026) project supports governments in sub-Saharan Africa and South Asia to strengthen the systems needed to establish resilient and inclusive WASH services and end the preventable deaths of mothers, young children and infants. It aims to improve health, and education outcomes. Global project partners include the London School of Hygiene and Tropical Medicine (LSHTM), the University of Leeds, and IRC acting as the consortium lead. The project operates in Bangladesh and Nepal (led by WaterAid Bangladesh, including SNV); Malawi and Tanzania (led by SNV, including Water For People); and Nigeria and Sierra Leone (led by Self Help Africa, including Goal). The project is funded by UKAid/FCDO.

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Glossary

Health: A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization (WHO) Constitution, 1946; reaffirmed in the Alma-Ata Declaration, 1978).

Health systems: A health system consists of all organisations, people, and actions whose primary intent is to promote, restore or maintain health (WHO, 2007).

Healthcare facilities: Encompass all formally recognised facilities that provide healthcare, including primary (health posts and clinics), secondary and tertiary (district or national hospitals), public and private (including faith-run) and temporary structures designed for emergency contexts (e.g., cholera treatment centres). They may be in urban or rural areas (WHO, 2020).

Infection Prevention and Control (IPC) is broadly defined as the scientific approaches and practical solutions designed to prevent harm caused by infection to patients and health workers associated with the delivery of healthcare. It is a unique speciality encompassing and overlapping with almost every healthcare programme and system in healthcare (WHO, 2020).

Universal Health Coverage (UHC) means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Without WASH services, the goal of UHC cannot be achieved.

WASH in healthcare facilities: The provision of water, sanitation, hygiene, healthcare waste management, environmental cleaning infrastructure, energy and services across all parts of a facility (WHO, 2020).

WASH FIT: A risk-based, quality improvement tool for healthcare facilities, covering key aspects of WASH services: water; sanitation; hand hygiene; environmental cleaning; healthcare waste management; and selected aspects of energy, building and facility management, developed by WHO and UNICEF in 2015 and since used in over 30 countries (WHO, 2022b).

WASH system: All the social, technical, institutional, environmental, and financial factors, actors, motivations, and interactions that influence WASH service delivery in a given context (Huston & Moriarty, 2018).

Abbreviations and acronyms

BB	Building blocks	JMP	Joint Monitoring Programme
DHIS2	District Health Information Software 2	UNICEF	United Nations Children's Fund
HCF	Healthcare facility	WASH	Water, sanitation and hygiene
HMIS	Health Management Information System	WHO	World Health Organization
HSS	Health systems strengthening		

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Executive summary

Improving water, sanitation and hygiene in healthcare facilities is not simply an infrastructure challenge, it is a core health system issue. Reliable water, sanitation, hygiene, healthcare waste management, and electricity services are fundamental to infection prevention and control (IPC), patient safety, and the delivery of quality care. Yet in many countries, these essential services remain fragmented, and project driven, limiting sustainability and undermining progress towards Universal Health Coverage (UHC) and health security.

This learning brief demonstrates that sustainable improvements in WASH in healthcare facilities are achieved not through isolated investments, but by strengthening the underlying systems that govern how services are planned, financed, delivered and monitored. Applying a systems approach, linking WASH to health policies, financing mechanisms, workforce capacity, governance structures, and information systems enables countries to move from temporary gains to lasting health outcomes.

Drawing on global evidence and country experiences from Ethiopia, Ghana, Nigeria, Bangladesh, Sierra Leone, Mali and others, the brief highlights practical entry points for integrating WASH into core health system functions. It goes beyond existing guidance by translating systems thinking into actionable strategies that can be adapted across contexts and levels of the health system. This includes grounding the analysis in the WHO/UNICEF Eight Practical Steps for universal access to quality WASH in healthcare facilities — the global action framework against which 101 countries reported to the UN General Assembly in 2024, and the benchmark through which progress on systems strengthening is currently measured at national and international level.

This brief is primarily designed for health sector decision makers and practitioners while also supporting WASH actors to engage more effectively with health systems. It provides a structured approach, organised around the six WHO health system building blocks, complemented by real world examples and guiding questions to support application at national, sub-national, and facility levels. The six WHO health system building blocks provide the primary analytical lens; the Eight Practical Steps provide the action pathway for country-level implementation; and the WASH systems building blocks offer additional institutional depth for diagnosing service delivery constraints.

Key messages

WASH in HCFs is foundational to quality and equitable healthcare.

Safe water, sanitation, hygiene, waste management, and electricity are non-negotiable for infection prevention, patient safety, and dignity. Without these, essential health services cannot function effectively, jeopardising maternal and neonatal outcomes, care-seeking behaviour, and trust in the health system.

From infrastructure to systems: a paradigm shift is required.

Sustainable progress depends on embedding WASH within the core functions of the health system, planning, budgeting, supervision, and monitoring, rather than treating it as a one-off investment. Aligning WASH interventions with WHO's Six Health System Building Blocks ensures coherence between service delivery, financing, information systems, governance, and human resources.

Leadership, governance, and financing drive sustainability.

National ownership, clear institutional mandates, and predictable financing are the backbone of resilient WASH in HCFs. Ministries of Health must integrate WASH into health sector policies, budgets, and monitoring frameworks. Dedicated budget lines, costing tools (such as WASH FIT 2.0), and blended financing models help secure sustained investment beyond project cycles.

Data, equity, and resilience ensure accountability and inclusion.

Embedding WASH indicators in Health Management Information Systems (HMIS/DHIS2) enables continuous monitoring and transparency. Climate-resilient, gender-sensitive, and disability-inclusive designs ensure that facilities remain functional and accessible to all, especially in fragile or high-risk contexts. Data-driven learning loops turn accountability into sustained improvement.

1. Introduction

Water, sanitation, hygiene (WASH), waste management, and electricity in healthcare facilities (HCFs) are fundamental to safe, functional, and resilient health systems. When these services fail, quality of care is compromised. Patients are exposed to avoidable infection risks, health workers cannot practise safely, and trust in health systems is weakened.

Recent global monitoring continues to show major gaps in essential services in healthcare facilities. While coverage has improved in many settings, too many facilities still lack basic water, hand hygiene, safe sanitation, waste management and reliable electricity. These are not minor infrastructure gaps. These translate into real-world consequences: a midwife delivering without running water, a clinician unable to sterilise equipment, or patients leaving the hospital with preventable infections.

Global estimates illustrate the scale of the challenge. Around 78% of HCFs had a basic water service¹, while 57% had basic hand hygiene services² (WHO & UNICEF, 2025). Although 92% of HCFs had access to improved sanitation facilities, service usability and quality remain uneven. In addition, many facilities still lack systems for safe segregation of healthcare waste³, and electricity remains unavailable or unreliable in many low-resource settings, particularly in sub-Saharan Africa (WHO & UNICEF, 2025). Together, these gaps leave 3.85 billion people reliant on care in environments where the simplest, most cost-effective infection prevention measures cannot be guaranteed.

For Ministries of Health, district authorities and implementing partners, the central challenge is not only to expand infrastructure, but to ensure that these services are planned, financed, monitored and maintained as part of the health system.

1.1 Why WASH, waste and electricity matter for health systems

Infection prevention control and antimicrobial resistance

WASH, waste management and electricity are essential foundations for infection prevention and control. Without water, hand hygiene facilities, cleaning supplies, safe waste systems and reliable power, healthcare facilities cannot consistently maintain safe clinical environments. This increases the risk of healthcare-associated infections (HCAIs), including sepsis and surgical site infections (SSIs), and undermines wider efforts to address antimicrobial resistance (AMR).

Hand hygiene remains one of the most effective measures for reducing transmission of pathogens in healthcare settings, yet many facilities still lack the basic services needed to support it (Pittet et al., 2000). Poor environmental hygiene, inadequate waste management and unreliable power further weaken infection prevention efforts and can turn facilities into sites of transmission rather than protection (WHO, 2023). For this reason, WASH in healthcare facilities should be understood as a core component of quality of care, not an optional support service (WHO, 2025).

Essential service delivery and care seeking

The effects of inadequate services extend beyond infection prevention. Safe WASH, waste management and electricity are necessary for routine health service delivery, including maternal and newborn care (Campbell et al., 2015; UNICEF, 2019b; Watson et al., 2019), immunisation, outpatient services and emergency care. Facilities cannot provide safe childbirth care, sterilise equipment, maintain clean environments, or store vaccines reliably without these services in place (WHO, 2020)- all of which are essential for achieving universal health coverage (UHC) and health equity.

1 78% of HCFs had a basic water service, 11% had a limited service, and 11% had no service.

2 57% of HCFs had basic hand hygiene services, 34% had limited services, and 9% had no service. Additionally, 70% of HCFs had hand hygiene (soap and water or alcohol-based hand rub) available at points of care, while 68% had soap and water available at toilets.

3 71% of HCFs had materials for safe segregation of healthcare waste, 29% lacked these materials and systems

Poor conditions also affect whether people seek care and whether they trust the services they receive (Bouzid *et al.*, 2018). Women may delay or avoid facility-based care where toilets are unsafe, private washing spaces are unavailable, or overall hygiene is poor (UNICEF, 2019b; WHO & UNICEF, 2023a). In many settings, weak WASH services also affect the dignity, safety and working conditions of the predominantly female health workforce. Strengthening these services is therefore important, not only for clinical outcomes, but also for care seeking, staff well-being and public confidence in the health system.

Climate resilience, epidemic- and pandemic preparedness

Healthcare facilities must remain operational during disease outbreaks, climate shocks and other disruptions. WASH, waste management and electricity are central to such resilience. Safe water, hygiene facilities, waste systems and reliable power support outbreak prevention and response, continuity of care, communications, cold chains, lighting and the operation of essential equipment (WHO & UNICEF, 2023b, 2024).

For health security and epidemic preparedness, WASH is critical for outbreak response. Experience from outbreaks such as Ebola and cholera has shown that facilities without adequate WASH and IPC measures can amplify transmission risks. At the same time, floods, droughts, extreme heat and power disruptions increasingly threaten the continuity of services. Climate-resilient infrastructure, including safer water systems, non-burning waste treatment options and appropriate electrification approaches such as solar power, can help facilities remain functional under stress. Investments in WASH and electricity should therefore be seen as part of both health security and climate adaptation.

Equity and social inclusion

The consequences of inadequate services are not shared equally. Facilities in fragile, conflict-affected and underserved settings are often the least well equipped, deepening existing inequities in access to safe care. Global averages can mask these disparities, particularly in least developed countries and fragile contexts where basic service gaps remain much larger (WHO & UNICEF, 2025).

Women and girls are disproportionately affected where facilities lack private, safe and functional sanitation and hygiene services, including for menstrual health needs (Gender and Public Health Emergencies, 2024; UNICEF, 2019a). This matters for both patients and health workers, particularly as the health workforce is mainly female. People with disabilities may also face major barriers where toilets, handwashing facilities and care environments are not designed for accessibility (Mactaggart *et al.*, 2021; Scherer *et al.*, 2021; Wilbur *et al.*, 2019). A systems approach to WASH in healthcare facilities must therefore address inclusion explicitly, ensuring that services are not only present, but usable, safe and accessible for all.

1.2 From problem to opportunity

Recognising the importance of WASH in HCFs is necessary, but it is not sufficient. In many countries, these services still struggle to secure consistent political priority, clear institutional ownership and sustainable financing. The challenge is therefore both to raise WASH higher on the health agenda and to embed it within routine health system functions. This means:

- Integrating WASH into health sector planning and budgeting,
- Linking it to quality of care and IPC systems,
- Strengthening monitoring and accountability, including functionality and quality of WASH services,
- Building capacity and accountability at every level, from facility committees to national policymakers, to ensure that facility improvements can be maintained over time.

The next sections outline how a systems lens can help identify bottlenecks, clarify responsibilities and support more sustainable action.

2. Context and systems lens: shifting to a systems approach

Despite international commitments under the Sustainable Development Goals (SDGs), WASH in HCFs is often addressed through short-term projects rather than embedded within routine health systems strengthening. Improvements achieved during health emergencies or donor-supported programmes may not be sustained when institutional responsibilities, financing mechanisms, and accountability systems remain weak (IRC WASH, 2022; WHO, 2020).

Sustained progress therefore requires a shift from delivering infrastructure alone to embedding WASH within the core functions of health systems. This includes integrating WASH considerations into planning, budgeting, supervision, monitoring, and quality improvement processes across national, district, and facility levels.

This section introduces a systems perspective for understanding how sustainable WASH services in HCFs are maintained. It focuses on how actors, institutional arrangements and systems functions interact to support sustainable and quality delivery. It also highlights the enabling environment needed to sustain services over time, including governance arrangements, financing, regulatory frameworks, data systems and accountability processes.

2.1 Why a systems approach matters

A systems lens positions WASH as an integral component of a functional health system, aligning with the Six Health System Building Blocks (WHO, 2007, 2017) and WASH Systems Framework (Huston & Moriarty, 2018). This approach recognises that sustainable WASH outcomes depend on coherent action across leadership/governance, financing, human resources, service delivery, information systems, and appropriate technologies.

In many contexts, an initial scan or diagnostic of the WASH system can surface so many issues that organisations and their local authority partners feel unsure where to begin. One way to reduce this uncertainty is to use collaborative capacity to agree who is best placed to strengthen different components of the system (Lockwood & Smits, 2011). In other cases, government leadership may set clear priorities that partners are expected to align with. The entry can then be selected either by focusing on the most critical bottlenecks that block progress, or by targeting “**quick wins**” that build momentum and trust for deeper collaboration.

Ideally, the system analysis process also helps identify leverage points—areas where a relatively small shift can unlock wider system-level change. A further step is to clarify the most appropriate level at which to focus effort, for example at national sector level, district (or equivalent) level, community level, or within specific institutions such as the service authority or service provider. Being deliberate about the amount of effort helps determine which actors need to be engaged, partnered with, or strengthened—whether government, civil society organisations, private sector actors, or faith-based groups—so that the right capacities and relationships are in place to deliver change.

Examples of entry points for systems strengthening: In Kabarole (Uganda), IRC used service level data collection as an entry point. This provided an objective lens through which to view the system and bring stakeholders together to assess why things were the way they were. A robust service-level assessment improved understanding of the system and was used for advocacy and to stimulate solution development by different users of the data (IRC WASH, 2014).

Adopting a systems approach enables countries to diagnose bottlenecks, coordinate multi-sectoral solutions, and measure performance beyond infrastructure outputs. It shifts the focus from inputs to institutional capacity and long-term service reliability (WHO, 2020).

A systems lens helps you see the connections between actors, functions, and incentives that determine whether WASH services in health facilities are reliable, equitable, and safe. This is confirmed in **WHO & UNICEF: Practical Steps to Achieve Universal Access to Quality Care (WHO, 2019)**.

Box 1: Eight practical steps to achieve universal access to quality WASH in health care facilities

These eight steps represent a distillation of what works across more than 50 countries. They are presented sequentially but may be implemented in different orders and at multiple levels simultaneously — facility, subnational and national. Together they form a continuous improvement cycle, not a one-off process. WHO & UNICEF · Published 2019 · Reaffirmed in the 2023 UN General Assembly Resolution

Phase 1 — Enabling environment

1	Conduct situation analysis and assessment The first step involves a comprehensive analysis of the enabling environment for WASH in health care facilities, covering national health and WASH policies, governance structures, institutional arrangements, funding streams and key stakeholders. Countries should also assess current WASH coverage and compliance levels across facility types — from primary health posts to district hospitals — to identify gaps and establish a baseline for tracking progress.
2	Set targets and define roadmap Based on the situation analysis, countries develop a national costed roadmap with clear, time-bound targets to address identified gaps. This includes estimating capital investment needs, rehabilitation requirements and recurrent operational costs. A joint WASH-health taskforce or technical working group is recommended as an effective multi-sectoral mechanism to drive the process and ensure ownership across ministries.
3	Establish national standards and accountability mechanisms Countries define minimum standards — a set of requirements specifying the infrastructure and resources necessary to deliver sustainable WASH services — and establish accountability mechanisms to ensure compliance. These mechanisms include regulation, facility accreditation and licensing, community scorecards and feedback systems that hold both facilities and government accountable for progress.

Phase 2 — Implementation and monitoring

4	Improve infrastructure and maintenance At the facility level, countries select, install, operate and maintain WASH infrastructure to ensure reliable and functional services — including safe water supply, sanitation, hand hygiene stations, health care waste management systems and environmental cleaning. WASH FIT (the WHO/UNICEF Water and Sanitation for Health Facility Improvement Tool) provides a structured, risk-based continuous improvement framework for this step.
5	Monitor and review data Progress is tracked through regular monitoring of WASH indicators at facility, subnational and national levels, ideally integrated into national Health Management Information Systems (HMIS) and reported through the WHO/UNICEF Joint Monitoring Programme (JMP). Data must be reviewed systematically to inform decision-making, identify persistent gaps and trigger corrective action at all levels of the health system.
6	Develop health workforce Sustaining WASH improvements requires building the skills and knowledge of health care workers, facility managers and cleaning staff. Capacity-building efforts cover hygiene practices, infection prevention and control (IPC), health care waste management, and practical use of tools such as WASH FIT. Workforce development must be embedded in pre-service and in-service training curricula.

Phase 3 — Sustainability and learning

7	Engage communities Community members and community organisations play an important role in ensuring that health care facilities provide the level of care citizens deserve and expect. Involve patients, communities, and civil society in the design, demand, and accountability for WASH services.
8	Conduct operational research and share learning Generating evidence on what works — and what does not — is essential to accelerate progress. Countries are encouraged to document implementation lessons, evaluate the cost-effectiveness of WASH interventions in health care facilities, and share findings across national and global learning platforms. Cross-country knowledge exchange, as promoted by the WHO/UNICEF WASH in HCF Community of Practice, is key to scaling up proven approaches.

Continuous improvement cycle: Countries may begin at different steps and progress at different paces depending on context. Steps 1–8 are iterative — completing a cycle informs the next round of analysis, planning and action.

A systems approach invites you to explore **why** it broke, **who** was meant to fix it, and **what** in the institutional set-up stopped that from happening.

Key questions to consider when using a systems approach for WASH in healthcare facilities:

Who is responsible for what aspects of the healthcare facility? Or for the WASH system as it relates to healthcare facilities?

- How are decisions made, and by whom?
- How are funds allocated and monitored?
- What motivates staff to maintain WASH facilities over time?

2.2 Linking WASH systems and health systems

For this brief, the Health System Building Blocks serve as the primary organising lens, given the audience of health practitioners and decision-makers. The Eight Practical Steps (WHO/UNICEF) provide the most direct-action pathway: governments across 101 countries have reported against them, and they represent the framework through which progress on WASH in HCFs is currently measured at national and global level (WHO, 2019). The WASH Systems Building Blocks offer complementary institutional depth — particularly for diagnosing governance and service delivery bottlenecks — and are referenced throughout to enrich analysis where relevant.

The **Health Systems Strengthening Framework**, which describes the core functions required for a well-performing health system. These include six building blocks: leadership and governance, health financing, the health workforce, service delivery, health information systems, and access to essential medicines and technologies. The six building blocks of a health system include (Figure 1):

- Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.
- A well-performing health workforce is one which works in ways that are responsive, fair, and efficient to achieve the best health outcomes possible, given available resources and circumstances, i.e., sufficient in number, appropriately qualified, competent, responsive, and productive.
- A well-functioning health information system ensures production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.
- A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and promotes their scientifically sound and cost-effective use.
- A good health financing system raises adequate funds for health in ways that ensure people can use the services they need and are protected from financial catastrophe or impoverishment associated with having to pay for them.
- Leadership and governance ensure strategic policy frameworks exist and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system design, and accountability

The second is the **WASH Systems Strengthening Framework**, which focuses on the institutional arrangements required to deliver sustainable WASH services. It emphasises coordinated action across nine building blocks: governance, service delivery models, financing arrangements, monitoring systems, and mechanisms for learning and adaptation.

The WHO health system framework

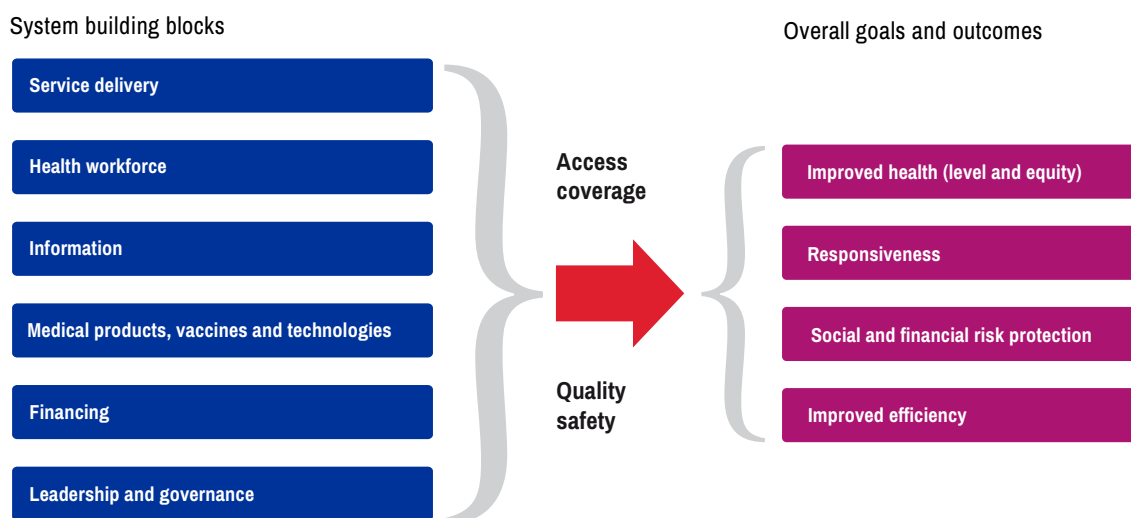


Figure 1: Health systems strengthening framework. Adapted from WHO, 2007, Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action.

The framework presented in this brief brings together three complementary layers: Health System Building Blocks, WASH System Building Blocks and the Eight Practical Steps. The building blocks serve as the theoretical architecture for understanding system performance and constraints, while the Eight Practical Steps provide the practical action pathway through which these systemic principles can be applied and operationalised in practice.

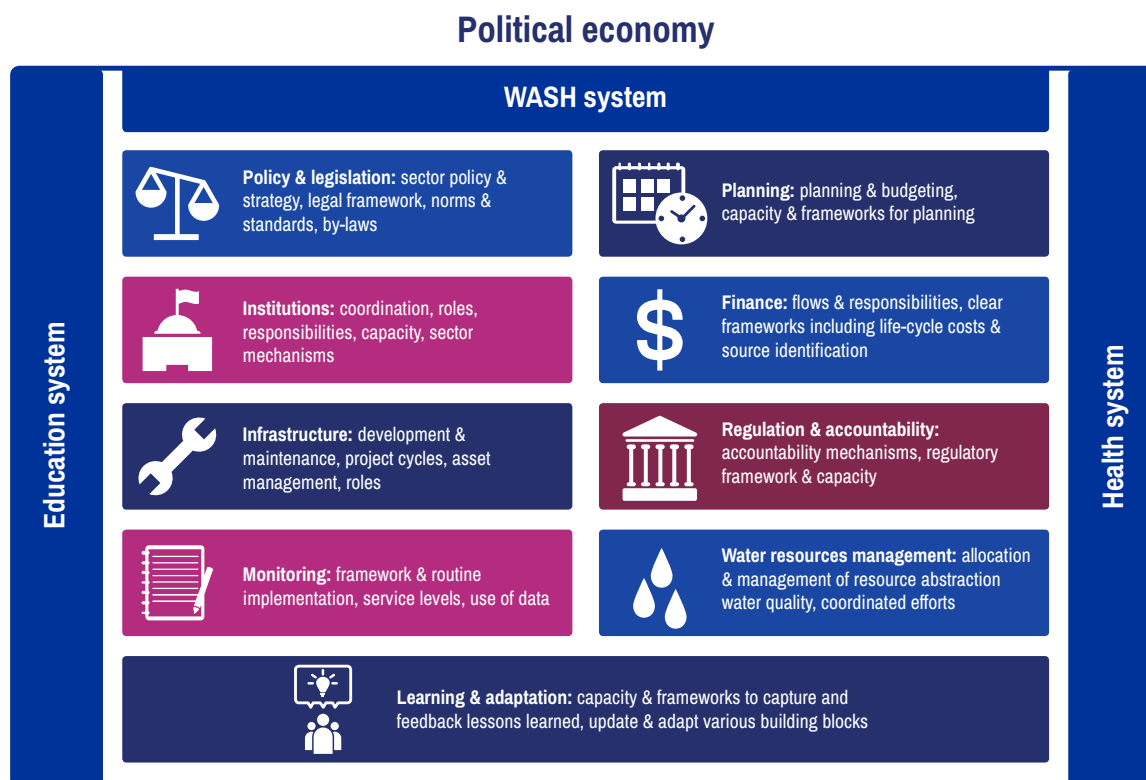


Figure 2: WASH systems strengthening framework (Huston & Moriarty, 2018).

2.3 Using systems frameworks to diagnose bottlenecks

Systems frameworks can help governments and partners diagnose where constraints occur and identify opportunities for strengthening services. This may include examining whether WASH is integrated into national health policies and planning processes, whether budgets exist for facility maintenance, whether supervisory systems monitor WASH indicators, and whether data systems capture service functionality. This is how process could be initiated:

- **Conduct a situational analysis of the enabling environment for WASH in healthcare facilities:** Are there national health and WASH policies? Are there governance structures, institutional arrangements and funding streams in place?
- **Locate your entry point.** For example, you could strengthen supervision systems (workforce), add WASH indicators to HMIS (information systems), or advocate for budget lines (financing).
- **Connect levels.** Ensure that national policies translate into district and facility action, and that data from healthcare facilities feeds back into national planning.
- **Build feedback loops.** Create mechanisms, such as joint sector reviews or learning platforms, where health and WASH actors reflect and adapt together.

2.4 Linking the health systems building blocks to the eight practical steps

The six WHO Health System Building Blocks provide the primary organising lens for this brief, as they are most familiar to health practitioners and policy makers. The WHO/UNICEF Practical Steps to Achieve Universal Access to Quality WASH in Healthcare Facilities (WHO, 2019) — the action framework against which 101 countries reported following the 2023 UN General Assembly Resolution — are mapped directly to these building blocks, translating concepts into country-level action. The WASH Systems Framework complements this by highlighting the broader institutional and service delivery arrangements required to sustain WASH services over time.

The value of using these frameworks together lies not in comparing them but in understanding their practical implication for improving WASH in healthcare facilities. In particular, this combined lens helps translate system concepts into concrete actions, such as developing costed roadmaps, strengthening monitoring systems, and embedding WASH into routine health system functions; key priorities reflected in the WHO/UNICEF Practical Steps (WHO, 2019) and a Global Framework for Action (WHO & UNICEF, 2024).

Strengthening the link to action frameworks

To maximise impact, the insight from this comparative mapping should be directly linked to country-level action. Particularly through:

- The WHO and UNICEF eight practical steps which provide a structured pathway from assessment to sustainable service delivery
- The Global Framework for Action which supports countries in translating commitment into implementation

For example:

- Coasted road map (Practical Step 2) directly operationalises the financing building block
- Monitoring systems (Practical Step 5) align with health information systems
- Workforce development (Practical Step 6) reinforces both health workforce and learning systems
- Governance and standards (Practical Step 3) link to leadership, regulation, and accountability

This alignment ensures that systems strengthening efforts are not only conceptual but anchored in practical country-led processes.

Table 1: Mapping health system building blocks to the WHO/UNICEF eight practical steps for WASH in healthcare facilities.

Health system building block	What it addresses in WASH in HCFs	Most relevant Practical Step (s)	How the Step operationalises the building block	Gap or note for practitioners
Leadership & Governance	Policy frameworks, institutional mandates, coordination mechanisms, and accountability across ministries and levels	Step 1 – Situation analysis Step 2 – Costed roadmap Step 3 – National standards & accountability	Step 1 – maps the enabling environment (policies, governance, stakeholders). Step 2 – formalises a joint taskforce and costed plan. Step 3 – establishes the standards, licensing, and accountability mechanisms that governance requires to function.	Strong alignment. The Steps explicitly call for multi-sectoral taskforces, national guidelines, and accountability mechanisms - all core governance functions.
Health Financing	Dedicated budget lines, life-cycle costing (capital and operation and maintenance), blended financing, results-based financing, and budget tracking for WASH in HCFs.	Step 2 – Costed roadmap (primary) Step 5 – Monitor and review data (budget tracking)	Step 2 requires a national costed roadmap estimating capital rehabilitation, and recurrent operation and management needs - the primary entry point for the finance building block. Step 5 monitoring can be extended to track budget execution and expenditure transparency.	Partial gap. The Steps do not include a dedicated financing step. Costed roadmaps (Step 2) address investment planning but not sustained financing strategy, budget integration, or O&M funding.
Health Workforce	Competency in WASH/ IPC roles and accountability pre-service and in-service training, mentoring, and supervision.	Step 6 - Develop health workforce (primary) Step 8 - Operational research and learning.	Step 6 directly addresses building staff skills and embedding WASH/IPC in pre-service and in-service training curricula. Step 8 reinforces this through learning, documentation of what works, and peer exchange across facilities and countries.	Strong alignment. The step explicitly calls for embedding WASH capacity in training curricula and professional development.
Service delivery	Reliable, continuous, inclusive WASH services at facility level, maintenance systems, quality improvement cycle (WASH FIT), community accountability.	Step 4 - Infrastructure maintenance (primary) Step 7 - Engage communities.	Step 4 is the facility level delivery step selecting, installing, operating, and maintaining WASH infrastructure using WASH FIT for continuous improvements. Step 7 extends service delivery accountability to communities and civil society, reinforcing demand and oversight.	Strong alignment. WASH FIT (Step 4) bridges the service delivery building block with facility-level practice and continuous quality improvement.

Health information systems	Integration of WASH indicators into HMIS/DHIS2; data use for planning and accountability; JMP alignment; public dashboards.	Step 1 - Situation analysis (assessment) Step 5 – Monitor and review data (primary) Step 8 - Operational research and learning.	Step 5 requires integrating WASH indicators into HMIS/DHIS2 and JMP. And using data to inform decision at all levels, directly operationalising this BB. Step 1 establishes the baseline. Step 8 closes the loop through evidence generation and learning.	Strong alignment. Steps 5 is the most direct expression of this BB, supported by the WHO/ UNICEF country tracked JMP reporting.
Medical products, vaccines & technologies	Fit the context of infrastructure development or improvement of technical standards, supply chain (soap, PPE, chlorine), climate-resilient technologies, and maintenance systems	Step 3 – National standards & accountability Step 4 - Infrastructure maintenance (primary) Step 8 - Operational research and learning	Step 3 establishes technical and infrastructure standards. Step 4 requires selecting, installing, and maintaining fit-for-context infrastructure. Step 8 supports technology validation and sharing of innovation across countries.	Moderate alignment. Steps address infrastructure well but are less explicit on supply chain management and technology validation areas where this BB adds relevant depth.

Observation— the financing gap in the Eight Practical Steps: While the Eight Practical Steps provide a strong action framework, practitioners should note that dedicated financing receives less attention than other system functions. Step 2 (costed roadmap) touches on financing by requiring cost estimates for capital investment and recurrent costs, but a stand-alone step on sustainable financing mechanisms is absent. The WHO Health System Building Blocks compensate for this gap: the Financing building block explicitly addresses life-cycle costing, budget integration, and sustainable resourcing. Using both frameworks together therefore gives a more complete picture — the Steps provide the practical sequence; the Health System Building Blocks ensure that financing remains a first-order concern throughout.

2.5 Applying this in practice

A systems approach can support programme design, policy dialogue, and implementation of WASH in HCFs. For example:

- **During programme design:** mapping system functions can help to identify gaps that require strengthening.
- **During policy engagement:** framing WASH within familiar health system concepts such as quality of care, financing, HMIS, and workforce can support alignment with national priorities.
- **During implementation:** joint planning processes between WASH and health actors can help to align budgets, responsibilities and timelines.
- **In monitoring and learning:** integrating WASH indicators into existing health information systems helps avoid parallel reporting structures.

A systems approach does not represent a separate strategy. Rather, it strengthens the institutional processes that enable infrastructure and services to function reliably over time. By strengthening governance, financing, workforce capacity and accountability, the systems approach helps ensure that WASH infrastructure continues to function long after the programme investments end.

3. Example interventions and experiences

Global guidance on WASH in healthcare facilities is clear: interventions work best when they are **context-specific, adaptive, and embedded in health-systems strengthening** rather than delivered as stand-alone projects (Huston & Moriarty, 2018). The latest WHO/UNICEF JMP updates and companion guidance emphasise integrating WASH with quality of care, IPC, and resilience planning, while tracking progress with standard indicators (WHO & UNICEF, 2023a).

The following examples illustrate how countries and partners are applying systems approaches to strengthen WASH in health-care facilities. We organise this section by the six WHO Health System Building Blocks: (1) leadership & governance, (2) health financing, (3) health workforce, (4) service delivery, (5) health information systems, and (6) medical products & technologies (here, WASH infrastructure & supplies). Equity and climate resilience are included at the end, giving an overview of approaches.

3.1 Leadership and governance

Strong leadership and clear institutional mandates are essential for sustained WASH in HCFs. Fragmented coordination, unclear policies, and limited accountability often undermine progress – no single ministry can do it alone. Countries that have made rapid progress typically establish national policies or guidelines, task forces or WASH FIT working groups, with clearly defined roles, coordination mechanisms across sectors, and facility- and district-level oversight structures.

Key considerations

1. **Strengthen or establish coordination mechanisms.** Advocate for a national or district WASH-in-HCF committee that includes health, WASH, and infrastructure ministries and/or departments. To influence policy, set road maps, monitor progress and filter local experiences for learning and informed decision-taking.
2. **Clarify institutional responsibilities.** Help define who leads policy, financing, supervision, and maintenance, and document these roles in terms of reference (ToRs) or national guidelines.
3. **Champion multi-sector engagement.** Encourage regular coordination between the Ministry of Health and other relevant ministries (water, finance, environment, and local government).
4. **Link WASH governance to existing health structures.** Embed WASH oversight into quality-of-care or IPC committees rather than creating new vertical systems.

Examples

- **Mali** – The National Task Force on WASH in Healthcare Facilities offers a strong example of government-led, multi-partner governance in West Africa. Established in 2014 during the Ebola crisis and formalised by Ministerial decree in 2022 (Ministère de la Santé et du Développement Social, 2022a), the Task Force, co-led by the Ministry of Health and Social Development and WHO, with WaterAid, Terre des hommes, World Vision and IRC – coordinated national standards, field implementation and cross-partner learning over more than a decade. Key outputs include national WASH minimum package guidelines (Ministère de la Santé et du Développement Social, 2015), documentation and contextualisation of the WASH FIT approach (Ministère de la Santé et du Développement Social, 2022b), a comprehensive national biomedical waste management manual (Ministère de la Santé et du Développement Social, 2023a), and the National Strategic Plan for WASH in HCF 2023–2027 (Ministère de la Santé et du Développement Social, 2023b). In terms of the Eight Practical Steps, Mali's experience directly illustrates Step 1 (situation analysis and assessment: establishing a baseline of WASH coverage across facility types) and Step 2 (setting targets and defining a roadmap: the Task Force's multi-year coordination translated directly into the National Strategic Plan for WASH in HCFs 2023–2027). Practitioners working with the Eight Practical Steps will recognise both processes clearly in this example.
- **Ethiopia** – *Healthcare Facilities WASH Guideline* (2021) brought together ministries of health, finance, and WASH to

develop a unified strategy and monitor progress to set roles across system levels and calls for committees at facility and district levels to supervise maintenance and IPC (Ministry of Health Ethiopia, 2021).

- **Bangladesh** – A National Technical Committee, led by the Directorate of Health with participation of WHO, UNICEF, Terres des Hommes and WaterAid, meets quarterly to provide governance oversight of programmes. The committee's establishment sparked the development and implementation of the National Strategy for WASH in HCFs (2019–2023) and created a coordinated framework under the Directorate General of Health Services to align partners and standardise implementation (Ministry of Health and Family Welfare, 2023).
- **Nigeria** – The National WASH in HCFs Steering Committee, established in 2021, includes representatives from the Federal Ministry of Health, Water Resources, Environment, and development partners, such as UNICEF and the World Bank. The committee has been instrumental in developing National Guidelines on WASH in Health Facilities (2021) which define responsibilities across sectors (Federal Ministry of Health Nigeria, 2022).
- **Ghana** – The government established a joint IPC/WASH Task force to provide greater leadership and a clearer strategic direction. The Task force adapted and implemented WASH FIT, a quality improvement tool, and worked to include IPC/WASH standards into key national strategies and policies, specifically the *National Healthcare Quality Strategy (2017–2021)*.



Guiding questions to apply to your context

- Is there a functional national or sub-national coordination platform for WASH in healthcare facilities with clear roles and mandates?
- Are institutional responsibilities (policy, financing, supervision, maintenance) clearly defined across all levels?
- How are cross-ministerial decisions (health, water, finance, energy) coordinated and implemented?
- What accountability mechanisms ensure that commitments translate into action?

3.2 Financing

Reliable financing mechanisms that reward sustained functionality and quality are the backbone of sustainable WASH in HCFs. Yet, many facilities rely on short-term project funding that ends before systems for long-term service delivery are in place. A systems approach reframes financing and links budgets, incentives, and accountability so that WASH is **costed, funded, and monitored** through existing health sector processes.

Key considerations

1. **Integrate WASH into health budgets.** Include WASH and IPC as budget lines in national and sub-national health plans. Link these to service quality or facility accreditation processes.
2. **Advocate for life-cycle costing.** Support ministries and concerned actors to plan for the full costs of infrastructure and services, including maintenance, repairs, and consumables (soap, alcohol-based hand rub (ABHR), chlorine, personal protective equipment (PPE)).
3. **Use incentives to reward sustained functionality.** Include WASH performance indicators in results-based financing (RBF) or performance-based payment schemes to ensure continued service quality.
4. **Improve budget tracking and transparency.** Strengthen financial monitoring systems that show how dedicated WASH funds are allocated and used via dashboards or expenditure tracking tools.
5. **Blend domestic and external funding.** Channel ODA through the health system and ensure expenditures are aligned with national planning and budgeting processes / cycles, reducing duplication and ensuring co-financing for priority

investments.

Examples

- **Senegal** – World Bank health quality projects have used performance/results-based financing, with WASH/IPC indicators included in service packages (World Bank, 2024).
- **Ethiopia** – **The National WASH in HCF Guidelines** (2021) call for resourcing of O&M and integrating WASH into health sector planning with costed roadmaps (Ministry of Health Ethiopia, 2022).
- **Nigeria** – WASH accountability dashboards improved fund tracking and reduced corruption. The dashboards, launched in 2020, increased transparency in WASH spending (Federal Ministry of Health Nigeria, 2021).
- **Global** – WHO/UNICEF recommend costing tools (e.g., WASH FIT costing module) and blended partner financing for sustainability (WHO, 2022b).



Guiding questions to apply to your context

- Are there dedicated budget lines for WASH and IPC at national, district, or facility levels?
- Who is responsible for O&M, and is it adequately funded?
- Are financial incentives or funding mechanisms linked to service quality and functionality?
- How are external funds aligned with national systems to ensure sustainability and co-financing?

3.3 Health workforce

Competent, supported staff are central to sustained WASH services. Even the best infrastructure will fail if health workers lack the time, knowledge, or resources to operate and maintain it. Building workforce capacity is therefore not only about training but also about embedding responsibility, ongoing mentorship, and accountability for WASH into routine practice.

Key considerations

1. **Integrate WASH and IPC into pre-service and in-service training.** Work with professional councils, nursing and midwifery schools, and medical colleges to ensure WASH competencies are part of core curricula.
2. **Provide on-the-job mentoring and supportive supervision.** Encourage regular supervision visits that include WASH and IPC performance reviews. Use WASH FIT or IPC scorecards to track progress.
3. **Clarify roles and accountability.** Define who is responsible for maintaining WASH standards in each facility, from cleaners and maintenance staff to nurses and administrators.
4. **Recognise and reward performance.** Use facility recognition schemes or peer-learning exchanges to sustain motivation for hygiene and environmental cleaning.
5. **Empower healthcare facility management.** Create WASH or IPC committees that meet regularly to review data, raise repair needs, and mobilise local resources for small improvements.

Examples

- **Malawi** – Facility managers used WASH FIT assessments to identify gaps and implement improvements such as hand hygiene stations and plumbing fixes (UNICEF Malawi, 2023).
- **Malawi** – A WASH FIT training report for Embangweni, Malawi, documents the process of training facility staff, applying assessments, and developing action plans (CCAP Synod of Livingstonia's Health and Development

Departments, 2017).

- **India** – Government staff and partners developed policies, technical guidelines, and standard operating procedures to improve the safety and cleanliness of outpatient departments, labour rooms, newborn care units, postnatal wards, and nutrition rehabilitation centres (Ministry of Health and Family Welfare Government of India).
- **Ghana** – IPC/WASH modules were integrated into nursing and midwifery curricula, resulting in improved hand hygiene compliance among graduates (WHO, 2023).
- **Global** – WASH FIT have a series of case studies show how mentoring and peer learning improve retention and sustain behaviour change (WHO, 2022a).



Guiding questions to apply to your context

- Are WASH and IPC competencies included in national training curricula and job descriptions?
- Do supervision and performance review systems include WASH indicators?
- Are cleaners, maintenance staff, and facility managers adequately trained and recognised?
- How are frontline staff equipped to respond when systems or supplies fail?

3.4 Service delivery

Reliable WASH services are a cornerstone of quality healthcare. Yet in many health facilities, even where infrastructure exists, systems for operation, maintenance, and continuous improvement are weak. Embedding WASH into **routine healthcare service delivery** means treating it as a daily practice of risk management and quality improvement, not a one-off infrastructure project. WASH FIT offers a continuous quality improvement (CQI) tool, helping healthcare staff prioritise risks, implement fixes, and revisit progress in cycles by focusing on adaptability, ownership, and continuous improvement (WHO, 2022b). When embedded in national quality/IPC frameworks, it strengthens sustainability.

Key considerations

1. **Embed WASH FIT into quality improvement systems and health systems annual planning.** Use WASH FIT assessments alongside existing quality-of-care or IPC review tools to prioritise risks, plan improvements, and track progress.
2. **Link infrastructure to management systems.** Ensure that every new WASH, waste management or electricity investment comes with a maintenance plan, assigned responsibilities, and a budget.
3. **Support continuity of services.** Explore resilient technologies, solar-powered water systems, gravity-fed schemes, or on-site waste treatment that maintain functionality during outages or emergencies.
4. **Build ownership through teams.** Facilitate regular WASH review meetings with facility staff, encouraging joint analysis of data and simple problem-solving.
5. **Integrate WASH indicators into supervision visits.** Encourage district and regional supervisors to review WASH conditions during standard facility inspections rather than as separate exercises.

Examples

- **Sierra Leone** – UNICEF documented solarised water systems that reduced downtime and supported continuity during Ebola and COVID-19 outbreaks (SE for ALL, 2023; UNICEF).
- **Malawi** – Solar pumping systems stabilised access to safe water in rural HCFs (UNICEF, 2020).
- **Zambia** – WHO IPC assessments (IPCAF) illustrate how structured IPC and WASH strengthen service quality (Mudenda

et al., 2025).

- **Global** – WASH FIT is now used in over 70 countries, with evidence of improvements when embedded in planning and supervision (WHO, 2022a).
- **Global** – Evidence from rural health clinics in low-income settings shows that WASH access improvements are closely tied to quality improvement interventions, such as WASH FIT (Lineberger et al., 2025; Mmanga et al., 2020).



Guiding questions to apply to your context

- Is WASH fully integrated into the facility's quality improvement and IPC systems or treated as a separate activity?
- Are there standard operating procedures for cleaning, waste management, and water safety?
- How are WASH conditions regularly assessed and improved (e.g., through WASH Fit)?
- What technologies or approaches could make services more reliable during power or water disruptions?

3.5 Health management information systems

Countries progress faster when WASH/IPC indicators are integrated into routine HMIS/DHIS2 data collection processes alongside quality-of-care metrics. Without reliable data, it's impossible to plan, budget, or hold facilities to account for service quality. The JMP provides core questions and service ladders, which countries include in their national dashboards. Because some indicators (e.g., cleanliness) require on-site checks, HMIS reporting is complemented by WASH FIT audits and supervisory visits.

Key considerations

1. **Integrate WASH indicators into HMIS or DHIS2.** Start with a small set of essential metrics (e.g., presence of water at points of care, waste segregation practices, hand hygiene supplies) and expand over time.
2. **Use WASH FIT data to complement routine monitoring systems.** Facilities can collect and review data quarterly, with summaries fed into district or national dashboards.
3. **Align indicators across sectors.** Work with WASH, finance, environment, and energy sectors to ensure data on infrastructure, maintenance, and service continuity are compatible.
4. **Encourage data use, not just collection.** Support facility managers to interpret results, identify gaps, and take action. Data should inform supervision, planning, and resource allocation.
5. **Promote transparency and learning.** Publicly share progress reports or dashboards where feasible; visibility helps drive accountability and peer learning.

Examples

- **Cambodia** – WASH in HCFs was included as an indicator of quality of care, which is linked to performance-based financing (WaterAid, 2015).
- **Uganda** – is one of a handful of countries to have successfully incorporated indicators for WASH in healthcare facilities in a digital platform, "District Health Information Software 2", DHIS2 (Ministry of Health Uganda, 2018)
- **Global** – JMP core indicators and ladders now standardise measurement across five WASH domains in HCFs (WHO & UNICEF).
- **Global** – The Health Facility Profile toolkit that is part of DHIS2 provides design patterns to track WASH and IPC in national systems (DHIS2).

- **Global** – Country commitments include integrating WASH/IPC indicators into health policies and monitoring systems as part of the WHO/UNICEF country tracker for WASH in HCFs. This tracker, which directly operationalises Step 5 (Monitor and review data) of the Eight Practical Steps, documents progress at country level across all eight steps and provides a global picture of systems-strengthening momentum. Countries that have integrated WASH indicators into HMIS/DHIS2 are typically the most advanced in the tracker, reinforcing the case for embedding monitoring in routine health information systems rather than parallel structures (WHO & UNICEF).



Guiding questions to apply to your context

- Are WASH indicators included in your national or district HMIS/DHIS2 and routinely reported?
- How frequently are WASH conditions assessed or updated?
- Are data used for decision-making at facility, district, and national levels?
- How are data transparency and accountability ensured (e.g., dashboards, public reporting)?

3.6 Medical products and technologies (WASH infrastructure and supplies)

Durable WASH services depend on fit-for-context infrastructure and assured supplies. A systems approach treats WASH infrastructure and commodities as essential health assets, not as add-ons. This means aligning technical standards, procurement, and maintenance systems within existing health sector processes. It also means designing infrastructure that can withstand environmental shocks and meet the needs of all users.

Key considerations

1. **Integrate WASH infrastructure into national standards and investment plans.** Align with Ministry of Health and public works guidelines so that facility designs include safe water, sanitation, waste management, and electricity as minimum requirements. It also means that new technologies, designs and equipment should be subjected to testing and validation, and formal approval processes by the responsible MoH actors before being used in the health system.
2. **Prioritise maintenance and supply chains.** Ensure procurement systems include essential hygiene and waste management products (soap, chlorine, ABHR, PPE). Build local capacity for routine maintenance and spare parts management.
3. **Design for resilience.** Incorporate climate- and context-appropriate technologies such as solar-powered water systems, flood-proof sanitation, or greywater reuse in water-scarce regions.
4. **Plan for inclusivity.** Design facilities that are accessible to all users, including people with disabilities and those needing menstrual hygiene facilities.
5. **Coordinate across sectors.** Collaborate with ministries responsible for water, energy, and environment to harmonise infrastructure standards and leverage co-financing opportunities.

Examples

- **Mozambique** (Cabo Delgado): Strengthening resilience of WASH in HCFs following climate shocks. Following the destruction caused by Cyclone Chido in December 2024, which affected over 455,000 people and damaged health facilities in Cabo Delgado, Helvetas supported the rehabilitation of six healthcare facilities in Mecúfi district through the Swiss funded Cabo Delgado health promotion project. Interventions went beyond infrastructure repair (water systems, sanitation, electricity and buildings) to include climate resilience reconstruction and prior community hygiene promotion which contributed to preventing disease outbreaks such as cholera. This example highlights the importance

of integrating WASH systems strengthening, resilience and preparedness into health systems to ensure continuity of safe care during and after shocks (Helvetas, 2025).

- **Sierra Leone** – Established healthcare waste management systems, and new technical and operational manuals were incorporated into a training package for healthcare waste workers (SE for ALL, 2023).
- **Global** – WHO/UNICEF progress reports document common gaps and solutions for infrastructure and supplies (WHO & UNICEF).



Guiding questions to apply to your context

- Are WASH and energy requirements integrated into health facility design and construction standards?
- Do national procurement systems include essential hygiene and waste management supplies?
- Is there a funded and functional maintenance system (including spare parts and technical capacity)?
- Are infrastructure and technologies climate-resilient and inclusive (gender, disability)?

3.7 Cross-cutting equity and climate

WASH in healthcare facilities is about more than infrastructure; it's about dignity, safety, and resilience. Across the building blocks, recent global reporting stresses inclusive design and disaggregated monitoring (e.g., gender, disability), and calls for climate-risk screening of health facilities, so WASH investments withstand floods, droughts, and heat. Embedding these concerns within leadership and governance, financing, training of the health workforce, service delivery, and HMIS (information) ensures they move from pilot features to standard practice. For practitioners, this means asking *who benefits, who is excluded, and how systems can adapt* before designing or upgrading any facility.

Key considerations

1. **Design for inclusion.** Ensure that all new or rehabilitated facilities meet accessibility standards, including wide doorways, ramps, handrails, and accessible toilets for people with limited mobility.
2. **Integrate gender and menstrual health needs.** Include private, secure spaces for menstrual hygiene management for both patients and staff. Provide adequate disposal facilities and access to water and soap in all toilets.
3. **Prioritise the most vulnerable settings.** Use data to identify facilities serving marginalised populations, such as rural, conflict-affected, or disaster-prone areas, and target these for investment first.
4. **Plan for climate resilience.** Include risk assessments in infrastructure planning and use technologies suited to local conditions, solar power, rainwater harvesting, or elevated sanitation systems where needed.
5. **Coordinate across sectors.** Work with environment, energy, and disaster management agencies to integrate health facilities into broader climate adaptation and disaster preparedness plans.



Guiding questions to apply to your context:

- Are WASH facilities accessible to people with disabilities and older adults?
- Do facility designs consider gender and menstrual hygiene needs?
- Are climate and disaster risks assessed before new construction or rehabilitation?
- Are the most vulnerable or high-risk healthcare facilities prioritised for WASH and energy upgrades?

4. Conclusion and recommendations

This learning brief demonstrates that sustainable WASH in healthcare facilities is fundamentally a systems challenge, not only an infrastructure issue. Drawing on evidence and experiences across multiple countries, it shows that strengthening WASH systems within the health system transforms the reliability, safety, and equity of healthcare delivery. Using the six WHO Health System Building Blocks and cross-cutting themes of equity and climate resilience, it provides a framework to help practitioners, policy makers, and partners operationalise systems thinking in practice.

WASH in healthcare facilities underpins global health and development priorities. It directly contributes to SDG3 (health) and SDG6 (water and sanitation) and is essential for achieving Universal Health Coverage (UHC), Infection Prevention and Control (IPC) and health security. It is also a critical investment in preparedness and resilience, protecting lives during outbreaks, safeguarding health workers, and enabling continuity of care during climate shocks.

Key lessons and systemic enablers

Across the countries reviewed, five common enablers underpin lasting improvements in WASH in HCFs:

- **Policy and institutional integration** – Countries that have embedded WASH into national health strategies, policies, and guidelines (e.g., Mali, Ethiopia, Nigeria, Bangladesh) demonstrate stronger ownership and accountability. Clear institutional mandates and coordination mechanisms across ministries are prerequisites for sustainability.
- **Predictable and blended financing** – Dedicated WASH budget lines within health sector plans, complemented by co-financing from local governments, donors, and private partners, ensure that services are maintained beyond project cycles. Tools such as WASH FIT costing and results-based financing (RBF) strengthen transparency and efficiency.
- **Data, monitoring, and learning systems** – Integration of WASH indicators into **HMIS/DHIS2** platforms enables performance tracking, evidence-based planning, and joint accountability. Periodic WASH FIT assessments and public dashboards foster learning and community trust.
- **Empowered and competent workforce** – When WASH and IPC are part of pre-service curricula, supervision systems, and professional recognition, health workers become drivers of hygiene culture and continuous quality improvement.
- **Equity, inclusion, and climate resilience** – Facilities designed with accessibility, gender, and climate risks in mind ensure no one is left behind. Integrating these dimensions into policies and standards transforms WASH from a service issue into a human rights and resilience agenda.

Strengthening WASH systems through the health system

To sustain improvements, countries must move beyond short-term infrastructure projects towards systems strengthening, building the policies, institutions, capacities, and financing mechanisms that keep WASH services functional over time.

For practitioners, whether you are a health planner, medical officer, engineer, or development partner, this means embedding WASH into the same systems that deliver care:

- Integrating it into health policies and budgets,
- Aligning it with workforce development and supervision,
- Ensuring it is measured through health information systems, and
- Maintaining it through routine management and accountability structures.

Strong WASH systems make strong health systems, and vice versa. Each reinforces the other.

If you work at the national level,

- **Institutionalise WASH in health sector policy and financing.** Include WASH and IPC in health strategies, performance frameworks, and national budgets aligned with SDG and UHC goals. Use the WHO/UNICEF Eight Practical Steps as the structured national pathway: begin with a situation analysis (Step 1), develop a national costing roadmap (Step 2), and establish minimum standards supported by accountability mechanisms (Step 3).
- **Coordinate across ministries.** Bring together health, water, energy, environment, and finance actors to build a shared roadmap for WASH in HCFs and monitor progress collectively. A joint WASH-health taskforce (as called for in Practical Step 2) is the designated mechanism for this coordination, providing a multi-sectoral governance structure with clear mandate and shared accountability for implementation and progress reporting.
- **Invest in system functions, not just infrastructure.** Introduce budget lines for WASH in HCFs and allocate resources for maintenance, capacity building, and monitoring to sustain service functionality beyond project timelines.

If you work at the district or regional level,

- **Embed WASH in supervision and performance management.** Use existing health management structures to review WASH and IPC data during district performance reviews.
- **Champion local resource mobilisation.** Advocate for O&M funds and integrate WASH needs into district development plans.
- **Create learning loops.** Facilitate experience sharing between facilities and districts through peer networks, joint reviews, and mentorship.
- **Build accountability through transparency.** Display WASH performance scorecards in facilities and district offices to enhance oversight and community trust.

If you work at the facility level,

- **Integrate WASH into quality improvement.** Use WASH FIT or similar tools to identify risks and plan actions as part of facility improvement cycles.
- **Empower facility managers.** Encourage shared responsibility between clinicians, engineers, cleaners, and administrators. Everyone has a role in maintaining a safe environment.
- **Foster a culture of care and accountability.** Promote teamwork and pride in maintaining cleanliness, safety, and patient dignity as part of clinical excellence.
- **Ensure inclusive and climate-smart design.** Upgrade or build facilities that meet accessibility standards, provide menstrual hygiene spaces, and use resilient technologies such as solar power and flood-proof sanitation.

Working together across professions and sectors

Sustained progress depends on collaboration between disciplines. Doctors, nurses, environmental health officers, engineers, and administrators each hold a piece of the system. Strengthening WASH systems in healthcare facilities demands shared language, joint planning, and respect for each other's expertise.

The transition from fragmented projects to system-wide solutions is both necessary and achievable. Countries are already demonstrating that when WASH is institutionalised within health systems, supported by governance, financing, data, and work-force capacity, services become more reliable, infections decline, and trust in the health system increases. The 101 countries that reported against the WHO/UNICEF Eight Practical Steps to the UN General Assembly in 2024 demonstrate that this is not only possible but already underway. The Steps, grounded in the health system building blocks, provide the shared language and accountability framework that makes system-wide change measurable and comparable across contexts.

This learning brief provides a roadmap for that transformation: a menu of systems-strengthening actions and lessons you can adapt in your own context. Use it to diagnose bottlenecks, convene sectors, and design solutions that last.

5. Annex

Methods used to develop the learning brief

This learning brief was developed through a structured process combining a literature review, targeted case study analysis, and iterative validation with practitioners and experts working on WASH in healthcare facilities (HCFs).

Literature review

A rapid but comprehensive review of both peer-reviewed and grey literature was conducted between [insert months/year]. Databases such as PubMed, Scopus, and Google Scholar were searched using combinations of terms related to “*WASH in healthcare facilities*,” “*health systems strengthening*,” “*infection prevention and control*,” “*systems approach*,” and “*governance and financing*.” Grey literature from WHO, UNICEF, IRC, WaterAid, SNV, and other partners was also included. The review aimed to identify:

- Documented experiences and evaluations of WASH in HCFs implementation,
- Policy and governance mechanisms influencing sustainability, and
- Lessons linking WASH to the six WHO Health System Building Blocks.

Findings were synthesised thematically, focusing on enabling environments, financing mechanisms, capacity development, service delivery models, and monitoring and accountability systems.

Case study extraction

Complementary case studies were identified from multiple countries through the WASH Systems for Health consortium and partner networks. Each case study followed a pre-defined template to ensure comparability, covering:

- Context and background,
- Key interventions and actors,
- Systemic enablers and bottlenecks,
- Outcomes, and
- Lessons for sustainability and scale-up.

Thematic discussion points were used to extract cross-cutting insights across sites (e.g., governance, financing, and data systems).

Internal and external review

Draft findings were reviewed internally by consortium partners and subject-matter experts from WHO, UNICEF, and SNV, and externally by practitioners working in WASH in HCFs and systems strengthening. Feedback focused on accuracy, policy relevance, and alignment with ongoing global initiatives such as the WHO/UNICEF Joint Monitoring Programme (JMP) and the 2023 UN Resolution on WASH in HCFs.

Revisions incorporated reviewer input to ensure that the brief reflects the most current thinking and practical experiences from national and sub-national implementation.

Scope and limitations

While the review sought to capture global experiences, most examples come from low- and middle-income countries where data and documentation were available. The brief prioritises lessons with direct relevance to health systems strengthening and may not capture all ongoing innovations in infrastructure or technology.

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