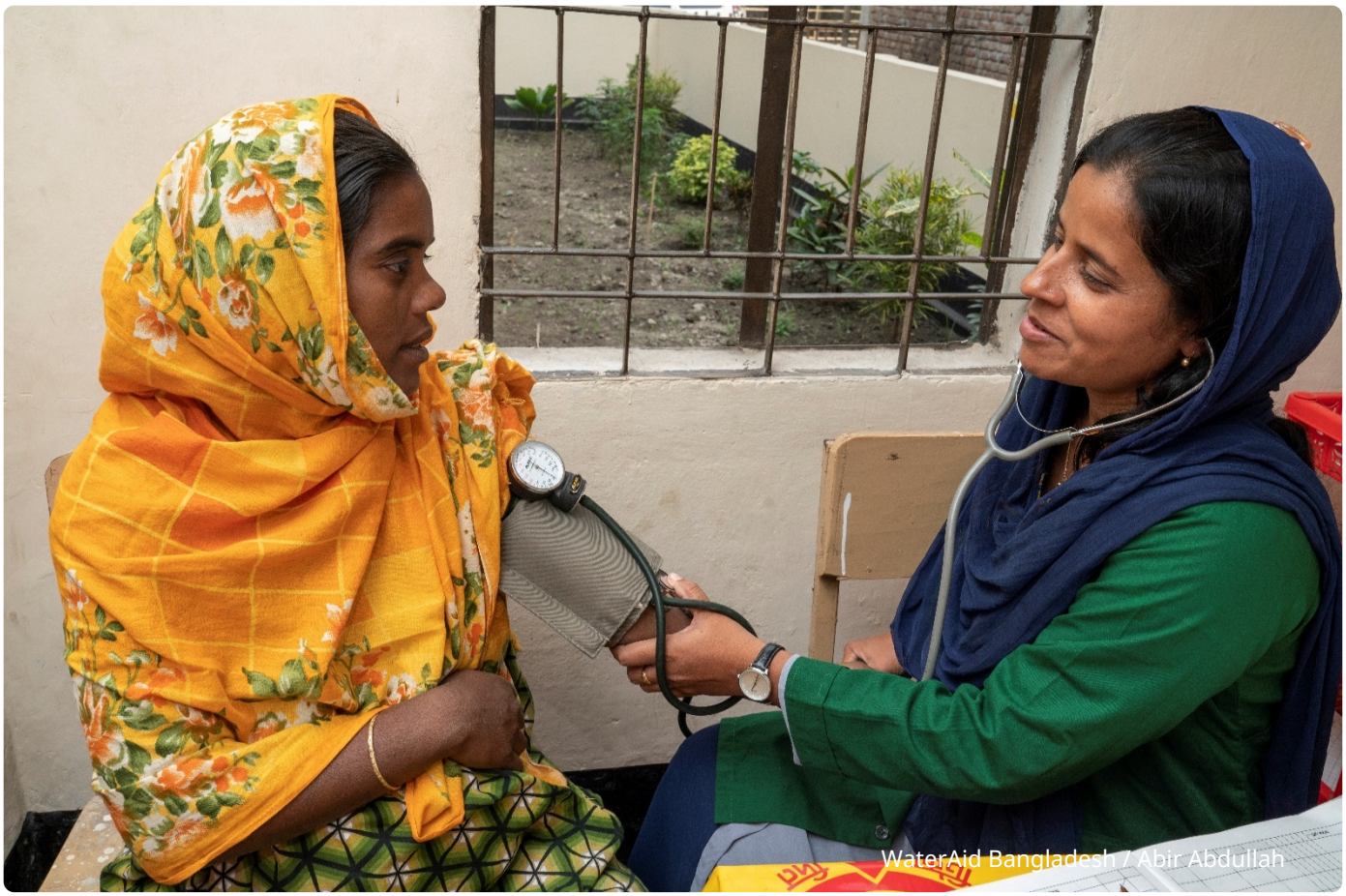
Learning note

HSBC Water Programme

WASH in healthcare facilities

Lessons learned from Bangladesh and Ghana



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1. Introduction

In 2012, HSBC launched its Water Programme to tackle the global water crisis, bringing together the expertise of Earthwatch, WaterAid and WWF to do so. During its eight years, we strengthened clean water, decent toilet and good hygiene systems, changing normal for marginalised communities in six countries: Bangladesh, Ghana, India, Nepal, Nigeria and Pakistan.

In the second phase of the programme (HWPII), running from 2017-2019, we also focused on capturing learnings from the programme. A series of learning notes have been produced to inform policy and practice.

One of the HSBC Water Programme's intended outcomes is strengthening integration of water, sanitation and hygiene (WASH) in schools and healthcare facilities (HCFs). Several of the participating country programmes have been improving services at HCFs and enhancing accountabiliy mechanisms for both users and and service providers with a view to prioritising WASH in health policies, plans and budgets at the district and local levels. This learning note aims to document and draw out lessons learned by two country programmes – Bangladesh and Ghana – in strenghthening the systems for improved and sustainable WASH in HCFs. Such lessons learned can provide insights for other programmes seeking to design and implement WASH in HCFs in different contexts.

In both countries, analysis of WASH in HCF service levels showed very poor coverage and functionality.[1] A WaterAid Bangladesh nationwide assessment in 2018 showed that in the Tahirpur sub-district of Sunamganj district only 6% of community clinics had a water supply, 20% of clinics had handwashing facilities and no clinics had functional toilets. In the Gangni sub-district of Meherpur district, 46% of community clinics had a functional water supply, 63% had partially functional toilets, and no clinics had handwashing facilities.

WaterAid Ghana's national assessment showed that only one of the 18 healthcare facilities assessed in Wa Municipality had a piped water supply into the facility. At the remaining 17 facilities, health workers and visitors relied on boreholes within their premises, or communal boreholes, with some relying on water from tankers. 44% of the assessed HCFs did not have toilets for visitors, while 11% of the toilets were in such a poor state that they had been abandoned. According to Ghana's Health Facilities Regulatory Agency (HEFRA), adequate water supply, clean toilet facilities and adequate management of both general and biological waste are minimum requirements for all Community Health and Planning Services (CHPS). However, there was no clarity on the design of these facilities and implementation has been fraught with challenges including access to water and sanitation services for both visitors and staff.

For both Bangladesh and Ghana, the lack of design standards for WASH in HCFs, systemic weaknesses in management and maintenance, and inadequate WASH functionality had become major barriers in the provision of quality healthcare. The lack of clean drinking water, proper toilets and handwashing facilities posed challenges for visitors, particularly pregnant women, older people and people with disabilities.

[1] An assessment carried out on community clinics in Bangladesh (World Bank, 2019) revealed that fewer than 36% had improved water supply functionally, 30% had no functional sanitation facilities, and only 16% had two functional latrines on-site.

2. Building successful models of WASH in HCFs

HWPII adopted our approach of "delivering some, building capacity and influencing the rest". The aim was to develop a successful model of WASH infrastructure and services in HCFs while influencing government at all levels to adopt and replicate these models.

In Ghana, we and our partners implemented the WASH in Healthcare Facilities project in the Wa Municipality of Ghana's upper west region (2017-2020). The project applied learning from the challenges and successes of HWPI, which sought to reduce water and sanitation poverty within the Wa Municipality at the community and household level. During HWPII, WaterAid Ghana worked with Busa, Charia and Charingu Health Centres and Boli CHPS. WaterAid Bangladesh, in partnership with the SKS Foundation and ERA, initiated a 'WASH in Health' project as part of HWPII to improve the WASH situation of 45 community clinics in the sub-districts of Tahirpur in Sunamganj district and Gangni in Meherpur district.

To demonstrate how WASH facilities in HCFs could be improved, WaterAid and partners sought to **rehabilitate or construct inclusive WASH facilities**. The model facilities have access to clean drinking water sources and running water supplies, gender-segregated toilets for patients with disabled access cubicles, and handwashing stations. In Ghana, maternity ward bathrooms with toilets were also renovated or constructed.

In both countries, **capacity building** activities were conducted with community members, healthcare workers and health officials at local government institutions. These activities were aimed at developing knowledge, skills and practices to:

- improve inclusive WASH service and functionality levels;
- promote behavioural change for sanitation and hygiene practices;
- plan, finance and maintain facilities in the long-term, and;
- strengthen accountability mechanisms among patients, neighbouring communities and government duty-bearers.

Specific approaches included:

Inclusive and improved services: In Ghana, 84 healthworkers were trained in WHO's WASH Facility Improvement Tool (WASHFIT). The tool was administered in six healthcare facilities and recommendations were forwarded to the Municipal Health Directorate for infrastructural improvement of the facilities.

Health and hygiene behaviour change: WASH-Infection Prevention and Control (WASH-IPC) training was held with 60 healthworkers in Ghana drawn from all healthcare facilities in the municipality. The healthworkers committed to ensuring handwashing with soap at all service delivery points. In Bangladesh, Tahirpur and Gangni Upazila health department officials were trained to facilitate sessions on WASH, health and nutrition at the community level.

Planning and financing for sustained functionality: Through training on the Life Cycle Cost Analysis (LCCA) approach, staff from the Municipal Health Directorate and Assembly in Ghana were equipped with the knowledge and skills necessary to balance WASH investment with other key costs such as operations and maintenance (O&M), capital maintenance and direct support costs. In both countries, community health or WASH management teams were trained in O&M and financial good practices (e.g. using bank accounts or other saving systems to ensure funding for ongoing O&M).

Accountability and rights (Human Rights Based Approach, or HRBA): Health workers in Ghana were trained to deepen their understanding on their obligations towards fulfilling the rights of their clients. In Bangladesh, the project engaged local government agencies and health service providers to make them accountable for providing sustainable services effectively and efficiently to the community.

Stakeholder collaboration: in both countries, we collaborated with local organisations and engaged local health authorities and key stakeholders to co-create and drive the WASH in HCF initiatives.

For example in Ghana, although the project was developed in the knowledge that WASH access in HCFs in the municipality was sub-standard, we did not enter the municipality armed with prescriptive solutions to their problems. Instead, we conducted a survey on the WASH status of HCFs and then worked collaboratively with the Municipal Assembly and the Municipal Health Directorate to identify the HCFs requiring interventions. Similarly, we undertook in-depth formative research on sanitation and hygiene behaviours in the municipality, with results leading to the formation of a creative team to develop a hygiene promotion package and communication stragegy appropriate for the context.

In Bangladesh, we incorporated basic water quality testing options for the first time in respective *upazila* (sub-district) health complexes of Meherpur. This involved training technicians and developing a partnership with the Institute of Epidemiology, Disease Control and Research, the government facility conducting health research and emergency management.

3. Achievements

WaterAid Bangladesh and WaterAid Ghana have reported various results from their projects at both local and national levels; laying the groundwork for further scale-up and replication.

HCF performance: At the local level, improved operations at HCFs have led to higher visitor numbers. For example, Bangladesh reported that the project has helped HCFs remain open and operate full working hours. From September 2017 to December 2019, the project provided WASH services to 369,003 visitors and, so far, 177 institutional births have been completed in community clinics which could not previously support deliveries. In Ghana, the HRBA training sessions for healthworkers included practical exercises where participants visited a HCF to identify challenges to health service delivery. Participants developed strategies to address the identified challenges when protecting the rights of patients.

Potential health impacts: Although difficult to directly attribute to the project, Meherpur district has not experienced a cholera (or notable watery diarrhoea) outbreak since 2017.[2] The project reportedly contributed to significant improvements in hygiene behaviour change within the district thanks to our district-wide approach (DWA). Beyond support to the HCFs, the DWA engaged WASH promoters and WASH volunteers in the community to conduct household visits and raise awareness of household level hygiene improvements.

Resource leverage: In Meherpur, the *upazila* administration also distributed wheelchairs to all community clinics in the sub-district from their development fund, ensuring accessibility for

[2] There had been two outbreaks during 2016 and 2017.

thousands of older patients, pregnant women and people with disabilities. Tahirpur clinics have also set up local donation boxes for community members to support maintenance. In Ghana, following from the LCCA training, costed action plans for WASH investments in HCFs were developed with the municipality.

Supply chain strengthening: WaterAid Bangladesh reported that the project has successfully built a stronger supply chain, even in very remote and hard-to-reach areas, by mobilizing both local communities and the private sector to support service improvement. For example, mobile sanitation vendors are now carrying sanitation materials to the doorstep of community members.

Influencing the rest: Our WASH designs and development plans for community clinics in Bangladesh attracted the attention and interest of the National Health Directorate. Leveraging this interest, we collaborated with other INGOs and UN agencies, and enlisted help from the Community Based Health Care team of the Directorate-General of Health Services, Ministry of Health and Family Welfare (MoHFW), to create a comprehensive WASH guideline for community clinics. This was endorsed by the MoHFW in 2019.

In Ghana, HCF toilets were connected to biodigesters for faecal sludge management; the biodigesters were in turn connected to the limited solar mechanised water systems which supplied the healthcare facilities. These facility designs and models were adopted by the Municipal Assembly for the construction of six mechanised water systems in six communities. The project also provided us with the opportunity to construct the country's first double chamber incinerators, which have generated interest from multiple sector stakeholders. Similarly, the Municipal Health Directorate replicated the project's WASH-IPC training for the remaining 170 health workers across the municipality.

4. Lessons learned

The success factors, challenges and unintended outcomes of the projects in Bangladesh and Ghana generated the following lessons:

Collaboration and partnering: Involving duty bearers at all stages of project implementation is key to success. In Ghana, staff from the Municipal Assembly and Municipal Health Directorate were part of the project start-up meeting, which gave all stakeholders the same understanding of the project and clarified their roles and responsibilities. Their involvement in joint monitoring and support visits allowed them to make inputs into the interventions. This was vital for influencing the Municipal Assembly to adopt the facility designs and models and for the Municipal Health Directorate to cascade the WASH-IPC training to additional healthworkers in the municipality. In addition, collaborative working with the national office of the Ghana Health Service led to the adoption of the double chamber incinerator design and the translation of this design on the ground. In Bangladesh, routine community advocacy activities were, at times, interrupted by the frequent transfer of local government officials, so additional project orientation and rapport building initiatives were needed to mitigate the impact.

Address stakeholder resistance: The project in Wa, Ghana experienced some delays when one of the proposed intervention communities rejected the solar mechanisation of the communal borehole for use by both the community and the health centre. This was despite the involvement of the Municipal Chief Executive and the Municipal Health Director explaining that solar mechanisation would not burden them with the likelihood of disconnection for non-payment of bills. Similarly, in Bangladesh, local stakeholders were initially negative about the project. However, gradual

implementation of the project in both countries with a focus on accountability and generating a team spirit, helped to build the necessary buy-in from relevant local stakeholders and generate support from local health offices.

Fundraising: An unintended outcome of the project for WaterAid Ghana was its ability to engage other donors and leverage additional funds to fill the WASH in Health project's funding gap, e.g. Australian Aid awarded funding for the provision of sanitation facilities in two new HCFs in the municipality.

Mainstreaming interventions into routine activities of health workers: The hygiene campaign in Wa with households and HCFs – the Clean Community Campaign – was very successful. By December 2019, over 12,000 people had been exposed to motivational and engaging hygiene behaviour change messages and activities through touch points like child welfare clinics, ante-natal clinics and pregnancy clinics. The campaign made the most of the routine practices of frontline healthworkers, managing to reach high numbers of people.

5. Next steps and sustainability

Both Country Programmes (CPs) have taken steps to ensure the sustainability of WASH in HCFs, notably through training community health and/or WASH management teams in the O&M and ongoing financing of facilities. In addition, some of the projects' activities will continue even after HWPII funding ends. For example, Ghana's Clean Community Campaign is ongoing and has provided a great opportunity to follow up and provide technical support to the gains made during project implemention. WaterAid Bangladesh has also highlighted that a follow-up phase to conduct a sustainability check would be useful to support and adjust long-term sustainability actions, and could help to better extract learning for future projects.

Internally, the lessons learned from implementation of these projects will be key to improving our future programming for WASH in HCFs. Both CPs are hopeful that initial changes made to design standards and plans will be replicated and scaled-up further by government counterparts to influence WASH in HCFs at the national level.

6. Conclusion

WASH in HCFs, particularly in community level health centres and clinics, has proven successful and paved the way for national advocacy to upgrade and improve services more widely. Both projects have shown the importance of collaboratively working with partners and duty bearers in order to influence them. The involvement of local community groups has also contributed to the successful implementation and follow-up of renovation work and the implementation of services. In both Ghana and Bangladesh, although WASH infrastructure provision/improvement was only demonstrated in a smaller number of HCFs, the approach managed to generate buy-in from government duty bearers and has provided them with models for replication.

7. Acknowledgements

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