Implementation of the water and sanitation for health facility improvement tool (WASH FIT): global report

World Health Organization

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Improving water, sanitation, hygiene and waste services in health care facilities: global report

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Abbreviations

GEDSI	gender equality, disability and social inclusion
IEC	information, education, communication
IPC	infection prevention and control
MOHCC	Ministry of Health and Childcare
MOHFW	Ministry of Health and Family Welfare
PHC	primary health care
SSP	sanitation safety plan
WASH	water, sanitation and hygiene
WASH FIT	Water and sanitation for health facility improvement tool
WSP	water safety plan

1 Summary

1.1 Scope of document

This document provides a short analysis of the application of the Water and Sanitation for Health Facility Improvement tool (WASH FIT), along with case studies from a select number of countries which illustrate different approaches for implementing and scaling up the tool. Recommendations for improving WASH FIT, its implementation and integration with health, energy and climate efforts are also included.

The uptake of WASH FIT continues to grow in every region, with increasing numbers of countries adapting and adopting it as the nationally approved mechanism for improving quality of care through WASH. That said, numerous gaps and challenges remain.

1.2 List of case studies

Key findings

Use of WASH FIT has steadily increased since it was first launched in 2015.	WASH FIT has been introduced and is being implemented to varying degrees in **71 countries** across every region of the world.
WASH FIT is being adapted for use in diverse settings: development, conflict/ humanitarian, outbreak, middle income.	**31%** of countries using WASH FIT are classified as being in fragile and conflict-affected situations *(1)*, **27%** are low-income countries and **24%** are upper-middle or high income,[1] showing **great diversity in application** of the tool.
Users note multiple benefits from implementing the risk-based, incremental improvement approach.	More than **80%** of respondents **indicated improved institutional performance** and better operation and maintenance, and over **75%** noted improved patient and staff satisfaction, clarification of roles and responsibilities, and better targeting of resources.
WASH FIT provides data and a framework for supporting health systems strengthening, especially around monitoring, health workforce and delivering quality of care.	Countries have used WASH FIT to **develop baseline estimates** to highlight the urgency for action, to support implementation of updated standards and to provide more details on the quality and sustainability of WASH and waste services, to better understand and address gaps in quality of care.
Governments are actively involved in implementation in over half of countries where the tool is being used.	**65%** of countries indicated that their ministry of health has **validated a national version** of the tool but fewer than one in four countries are implementing the tool nationally.
National trainings have created capacity for implementation and engagement of stakeholders.	**National trainings** are an essential first step in the WASH FIT process but must be accompanied by a concrete plan for implementation and roll-out.
Funding is one of the most cited challenges hampering implementation.	In most countries, **resources** to roll out WASH FIT nationwide, support ongoing mentoring and monitoring, invest in necessary infrastructure improvements and fund operation and maintenance are **far from sufficient.** Funding for implementation is three times as likely to come from donors than government, indicating a lack of sustainable financing.

Recommendations

More work is needed to institutionalize WASH FIT within existing government programmes and health activities.	Scaling up and achieving impact requires that WASH FIT is incorporated into existing **national curricula and professional development platforms,** and that mentoring and monitoring are integrated into the activities and responsibilities of existing health bodies (e.g. district health teams, regional centres for disease control). Furthermore, WASH FIT processes should be incorporated into local, facility and municipal decision-making and budgeting.

[1] Note: countries may be classified as both low-income and in fragile and conflict-affected situations, so some countries may be counted twice in these percentages.

Recommendations

Training should be accompanied by resources and a plan to support implementation and operational monitoring.	At least **10 countries** have reported trainings about which little is known/reported on; before trainings take place, **a plan with resources dedicated to supporting implementation,** including site visits and follow-up with facilities, should be in place.
Improving implementation and outcomes requires increased monitoring and review of changes in water, sanitation and hygiene (WASH) and waste services, as well as quality of care measures.	**Collecting baseline WASH FIT scores** and updating these at regular intervals post implementation is important for informing staff and managers on progress and areas that need further attention. A summary of results should be shared with users and the wider community, as this is important for buy-in and generating investment. In addition, assessing other potential benefits (e.g. staff and patient satisfaction, uptake of services, quality of operation and maintenance) may help make the case for greater investment.
Greater use of and sharing of experience in using digital tools for data collection and ongoing implementation are needed.	Such tools have multiple advantages, allowing for **real-time data collection, tracking and sharing.** However, an understanding of user needs, who will own the data and the financial viability of digital tools is essential.
Financing and funding should be planned for and include local engagement of municipalities.	**Funding is critical** for the roll-out of training, infrastructure improvements and meeting the costs of operating and maintaining improvements. Both trainings and individual facility plans require a realistic budget with high-value investments prioritized. This also involves regular tracking of budgets and expenditure to better understand and support budgetary needs and effective financing models.
Streamlining WASH FIT with other health and climate tools is important for more holistic and effective approaches, and to reduce administrative burden.	Where other facility-level tools are being used (i.e. for infection prevention and control, primary health care, antimicrobial resistance, climate and sustainability, emergency readiness and resilience), WASH FIT should be **integrated into existing activities** and mechanisms for quality improvement. This includes joint training, reduced and aligned indicators for regular monitoring, and cross-sectoral budgeting.
Each step of the WASH FIT process should involve climate, gender, disability and equity experts and representatives.	It is especially important that draft WASH FIT improvement plans are reviewed by and **incorporate input from climate, community, gender, disability and ethnic groups,** and that such groups conduct regular reviews to ensure that WASH FIT results in processes and services that support equity, human rights and universal quality services for all.
In emergencies, WASH FIT processes should be abbreviated.	A **smaller set of essential indicators** should be used, and overlaps with infection prevention and control and infrastructure investments made more explicit. Working with emergency logisticians, infection prevention and control, diagnostics and vaccine experts to adapt the approach could be of great value.

© WHO Indonesia. A carer helps a patient access a disability-friendly toilet at a primary health care facility in Indonesia.

2 Background

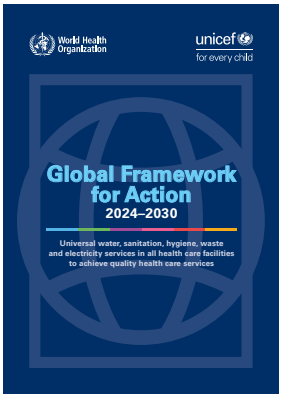
Fully functioning water, sanitation and hygiene (WASH), health care waste management and electricity services are critical aspects of infection prevention and control (IPC) practices and ensuring patient safety and quality of care. Such services are also essential for creating an environment that supports the dignity and human rights of all care seekers, especially mothers, neonates, children and care providers. WASH and waste services are also critical for preventing and effectively responding to disease outbreaks. Tragically, large gaps remain in these basic services (see Box 1). These gaps threaten the safety of patients and caregivers, and can have severe environmental consequences. All WASH, waste and electricity services must also support the broader comprehensive approach to safe, climate-resilient and environmentally sustainable health care facilities, given the impact of climate change on health *(2)*.

Box 1. Global status of WASH services in health care facilities

In 2022, an estimated one in five health care facilities (22%) globally lacked basic water services, affecting 1.7 billion people, including 874 million people globally who accessed health care facilities with no water at all *(3)*. Hygiene services remain limited: 39% of health care facilities lacked basic hygiene services and similar gaps exist for sanitation and health care waste management. Close to 1 billion people in low- and lower-middle-income countries are estimated to be served by health care facilities that either lacked access to electricity (433 million people) or had an unreliable electricity supply (478 million people)[2] *(4)*.

[2] These figures refer to four developing regions: Latin America and the Caribbean, the Middle East and North Africa, South Asia, and sub-Saharan Africa.

2.1 Global strategy on WASH, waste and electricity in health care facilities



The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), the co-facilitators of global work on WASH, waste and electricity in health care facilities, launched a Global Framework for Action (2024–2030) to accelerate progress and focus collective efforts *(5)*. The Framework has a strong focus on integration with health, including primary health care, and outlines operational targets and action in three main areas: integration, policy and governance; service levels; and equity, inclusivity and community engagement. The data in this report feed directly into service level reporting and broader global efforts. Such efforts have recently been bolstered by a United Nations General Assembly resolution on sustainable, safe and universal water, sanitation, hygiene, waste and electricity services in health care facilities, which all 193 United Nations Member States unanimously adopted in December 2023 *(6)*. The Framework specifically calls out WASH FIT as a proven tool for supporting incremental improvements in health care facilities to achieve global and national targets.

2.2 A comprehensive approach for improving WASH, waste and electricity services

The Water and Sanitation for Health Facility Improvement tool (WASH FIT) is a risk-based management tool for health care facilities, covering key aspects of WASH services across seven domains: water, sanitation, hand hygiene, environmental cleaning, health care waste management and selected aspects of energy, building and facility management. It also covers two cross-cutting themes, with indicators integrated across the seven domains: climate resilience, and gender equality and inclusiveness.


© WHO/ Andrei Krepkih. Electricity powers essential equipment at a district hospital in Ukraine.

The tool provides a framework for developing, monitoring and continuously implementing an improvement plan (covering infrastructure, behaviours, and operation and maintenance) and for prioritizing specific WASH actions that are climate resilient, equitable and inclusive. It uses a five-step cyclical process undertaken at the facility (see Figure 1. WASH FIT five-step cycle), which is based on the WHO water safety planning and sanitation safety planning methodologies *(7, 8)* (see Box 2). These methodologies are well established as effective approaches to reduce water and sanitation-related health risks and improve the quality of such services.

Figure 1. WASH FIT five-step cycle

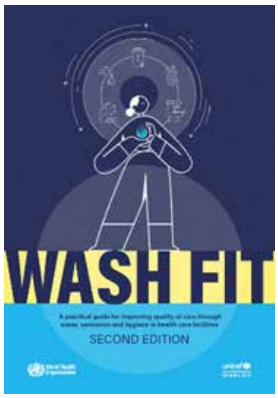
Box 2. Water and sanitation safety planning

Water safety planning is a proactive risk assessment and risk management approach that includes all steps in the water supply chain, from catchment to consumer. Water safety plans (WSPs) are recommended by WHO as the most effective means of consistently ensuring the safety of a drinking-water supply *(9)*. WSPs have been implemented in more than 90 countries globally *(10)*, and at least 70 countries have included WSPs in policies and regulations to support better management of water quality and prevent and reduce the risk of waterborne disease.[3]

Sanitation safety planning follows a similar approach, and focuses on assessing and managing risks to ensure the safe use and disposal of human waste. Sanitation safety plans (SSPs) can support WSPs by managing sanitation-related risks to drinking-water supplies.

WASH FIT builds on WSP and SSP principles and steps, and has been tailored to reflect health care settings, including a more comprehensive assessment looking beyond water and sanitation to address other critical areas, such as health care waste management, hand hygiene and electricity.

[3] Source: WHO internal database of countries with validated WSP policies.

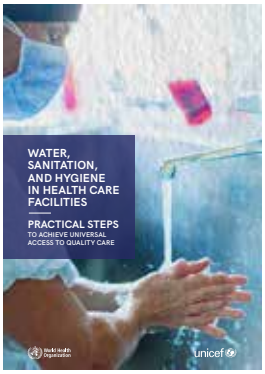


WASH FIT guides the planning and implementation of WASH and waste improvements as part of wider quality and IPC improvement efforts. It also helps to bring together all those who share responsibility for providing WASH and waste services, including legislators and policy-makers, district health officers, hospital administrators, water and sanitation engineers, climate and environmental specialists, and users to address gaps in a more comprehensive, coordinated manner. Its aim is to improve WASH services, resulting in improved quality of care and health outcomes through fewer infections, greater uptake of services and more productive and confident health care staff. For more information on the scope and methodology of WASH FIT, refer to the WASH FIT guide *(11)*.

Bridging wider efforts with WASH FIT through the Global Knowledge Portal (www.washinhcf.org)

Supporting learning, knowledge exchange and a global community of practice is an important part of implementing the Global Framework for Action. To support this work, WHO and UNICEF manage a global knowledge portal which includes data on national efforts to improve services (i.e. the practical steps), country tools and resources, and the latest insights from the field. In addition, the knowledge portal has a dedicated portal for WASH FIT training, fact sheets and assessment tools.

2.3 Supporting systems strengthening and improving WASH and waste services in health care facilities



In 2019, WHO and UNICEF outlined a set of eight practical steps for strengthening systems to improve and sustain WASH and waste services in health care facilities *(12)*. These steps form the basis and framework for national action and commitments on this topic made at the World Health Assembly in 2019 *(13)* and at the United Nations General Assembly in 2023 *(6)*. They are a distillation of things that have been shown to work in over 50 countries, and were developed through a multiyear, iterative process facilitated by WHO and UNICEF. Use of WASH FIT (and other risk-based improvement tools) is a major part of advancing Step 4 ("improve and maintain infrastructure"), but also has links to other steps (see Table 1. WASH FIT and the 8 Practical Steps). WASH FIT therefore complements the practical steps and supports facility-based improvements.

Table 1. WASH FIT and the 8 Practical Steps

WASH FIT and the practical steps are complementary. The practical steps guide WASH FIT implementation and in turn, use of WASH FIT can help achieve each of the practical steps.

Practical Step	Practical Step → WASH FIT	WASH FIT → Practical Step
1 Situational analysis and assessment	Identifies facilities (or geographical regions) that would benefit from using WASH FIT. Provides an opportunity to review any existing WASH FIT efforts and make adaptations as needed	Informs future analyses and generates data for national estimates
2 National targets and roadmap	Sets out targets, timelines and budgets for WASH FIT implementation	Informs progress on meeting targets and facilitates risk-based, sustainable improvements to meet targets
3 National standards	Recommends use of WASH FIT and WASH FIT is adapted in line with national standards to ensure all partners work to a common approach	Guides facilities using WASH FIT to make improvements to meet national standards
4 Improve and maintain infrastructure	WASH FIT can be used as the recommended approach to improve facility infrastructure (and may be used in tandem with existing national programmes)	Helps facilities to improve infrastructure systematically, comprehensively and sustainably to be more GEDSI and climate friendly
5 Monitor and review data	Select WASH FIT indicators integrated into health management information system to harmonize and streamline data collection	Generates regular data for decision-making, feeding into health systems planning and resource allocation
6 Health workforce development	National and subnational trainings on WASH FIT and relevant technical areas (e.g., water quality management, hand hygiene, waste management)	Upskills workforce through continuous professional development, leading to happier, healthier, more productive staff
7 Community engagement	Community members identify top priorities and actions that meet community needs, as integral members of the team	Provides a mechanism for community engagement and enables community voice within assessment, improvement planning, operational processes and increases accountability
8 Operational research and learning	Informs use of WASH FIT	Generates evidence for operational learning

2.4 Background and use of WASH FIT

WASH FIT was first piloted in 2015 and officially launched in 2018. A second edition was published in 2022, with additional indicators and guidance on safe management of services, gender, equity and inclusiveness, and climate resilience and sustainability. As part of the update, a complete package was developed to support implementation, including training slides and materials, assessment forms, checklists, fact sheets and a trainer's manual *(14)*. Interest in and uptake of WASH FIT has continued to grow, with new countries reporting use of the tool every year since 2015. Anecdotal evidence of its positive impact has been described in every region. However, it has been difficult to quantify how many countries are using it, in what way and to what outcomes.

WHO Academy WASH FIT training course

In 2024, an online training package, hosted on the WHO Academy, was launched. This comprehensive course has 13 modules, including an introductory module, representing one module for each of the five steps of the WASH FIT cycle, a module on scaling-up and six technical modules covering water, sanitation, health care waste, hand hygiene, environmental cleaning, and gender, equity, disability and social inclusion (GEDSI) in WASH FIT. Everyone participating in an in-person WASH FIT training is advised to take the online course first. The course can be accessed at **https://whoacademy.org/**

3 Methodology

An online survey (in Arabic, English, French and Spanish) was shared with WHO and UNICEF regional and country offices, implementing partners and through the WHO/UNICEF *WASH in health care facilities* newsletter between September 2023 and January 2024. Countries and organizations known to be using WASH FIT, or who had participated in training, were also contacted directly to request their completion of the survey and were asked to coordinate their responses to provide one survey response per country. Where needed, respondents were contacted to clarify or supplement information provided through the survey. The survey included questions on implementation and evaluation of WASH FIT. A copy of the survey can be found in Annex 2. Information was analysed qualitatively, and no attempt was made to calculate the number of facilities using WASH FIT or populations reached, due to some countries not sharing this information.

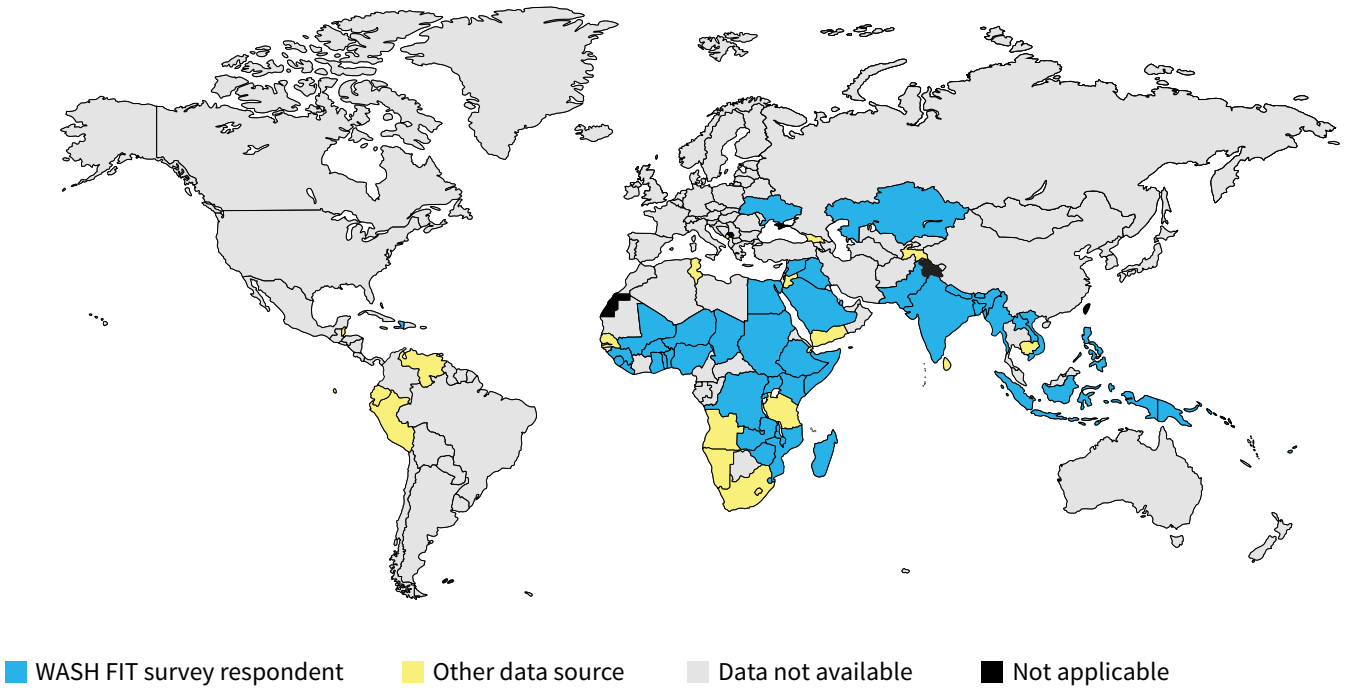
© WHO/Fanjan Combrink. Discussions outside a health care facility in Kenya.

4 Findings

4.1 Countries implementing WASH FIT

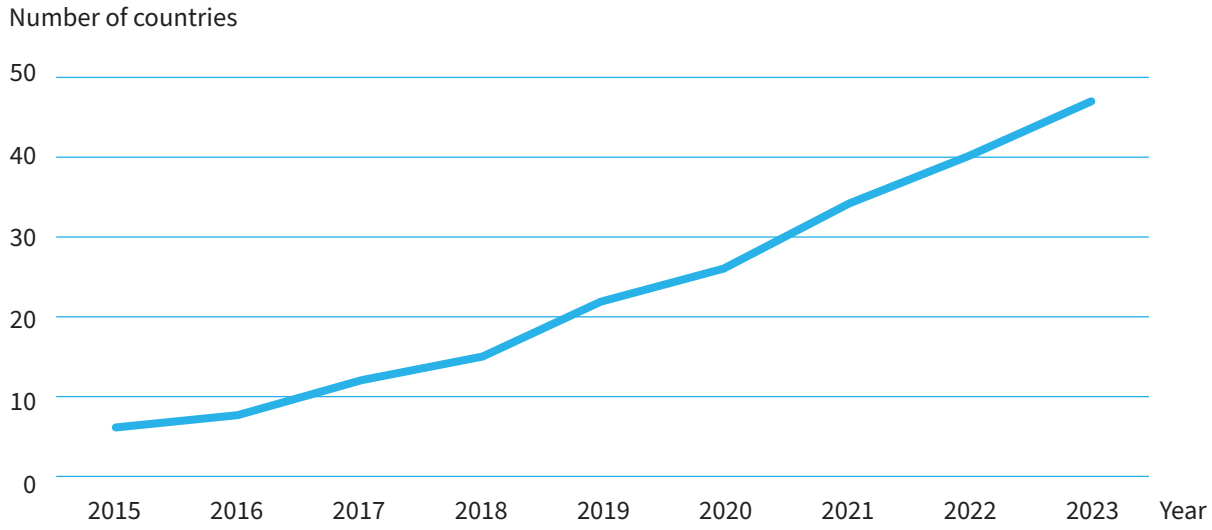
Fifty-six countries responded to the survey. Of these, seven countries stated that they had not yet begun to use WASH FIT, nor conducted any training, leaving a total of 49 countries to be included in the analysis. At least one country in every WHO region is using WASH FIT, but the Region of the Americas is notably underrepresented (see Figure 2. All countries known to be implementing WASH FIT and respective data sources). The survey was completed by representatives from ministries of health, WHO and UNICEF country offices, and other implementing partners.[4] Figure 3 shows the number of countries who responded to the survey and are implementing WASH FIT. More countries have started to use WASH FIT in recent years, particularly since the launch of the second edition of WASH FIT in 2022 *(11)*.

Figure 2. All countries known to be implementing WASH FIT and respective data sources



[4] The following partners responded to the survey: Africa Centres for Disease Control and Prevention, Christ Soldiers Foundation (Ghana), Concern Worldwide, Helvetas, IRC, SNV, Swiss Church Aid/HEKS, Terre des hommes, WaterAid, World Vision.

Figure 3. Cumulative number of countries using WASH FIT by year (among those responding to the survey)



A further 22 countries, who did not respond to the survey, are known to be implementing WASH FIT. This brings the total number of countries using WASH FIT to **71.** This information is based on reports and information on **www.washinhcf.org,** targeted follow-up with countries and partners and *a priori* knowledge. Some of these countries have only participated in or conducted training, and others are at more advanced stages of implementation (see section 4.3). These countries have been included in the analysis where information is known. For a list of all countries (those responding to the survey and other data sources), refer to Annex 1.

4.2 Training

Of those countries responding to the survey, 21 reported having completed one or two trainings and 22 countries had completed three or more. Not all countries provided details on the level of training delivered, however many countries indicated that they have conducted training at both national and local levels (**Bangladesh, Benin, Eswatini, Ethiopia, Fiji, Ghana, Indonesia, Kenya, Lao People's Democratic Republic, Maldives, Mali, Mozambique, Niger, Papua New Guinea, Philippines, Rwanda, Ukraine**). At the local level, trainings mostly tend to be delivered by local government, but in some instances are delivered by partners (as in **Nepal, Papua New Guinea, Sudan, Uganda**). In **Mozambique**, trainings are now being followed by one to two years of coaching provided to facility teams under agreements with partners (including Helvetas, SNV and WaterAid). In some instances, an initial pilot training took place with no further training budgeted or planned for (e.g. **Angola, Djibouti, Haiti**). The case studies from **Georgia** and **Indonesia** provide two examples of how training can be scaled up nationally.

In addition to those countries participating in the survey, several other countries have participated in national and regional trainings, but are yet to start implementing WASH FIT in facilities (**Benin, Namibia, Nigeria, Malawi, Sierra Leone, South Africa, South Sudan, Tanzania, Gambia, Zambia, Zimbabwe**). In 2023, regional trainings took place in east Africa with nine countries participating (**Ethiopia, Kenya, Malawi, Mozambique, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe**). Most of these countries have started implementing WASH FIT to some degree.

Case study

Nationally accredited training package in Indonesia

To scale up training and implementation in **Indonesia**, the Ministry of Health, with support from UNICEF, developed a training module and tutorial videos which have been accredited by the Human Development Department of the Ministry. Training is being scaled up in late 2024 with a six-day training to be completed by national and provincial level participants, including 38 provincial health offices, the Ministry of Health training centre, health academia and health workers in selected hospitals. Those who complete the training will become accredited Master Trainers.

Case study

WASH FIT is part of continuing medical education curriculum for family doctors in Georgia

UNICEF **Georgia** supported the adaptation of WASH FIT to the context in Georgia, which was subsequently validated by the national health authorities. Ten master trainers from Georgian Medical Holding underwent a WASH FIT training of trainers, going on to train a further 2617 personnel from 935 rural primary health care (PHC) facilities nationwide (out of a possible 2295 PHC facilities) over the course of 67 sessions. A WASH FIT training course has been developed for doctors from rural PHC facilities, and has bene accredited for integration into the continuing medical education curriculum for family doctors.

4.3 Scope of implementation

Globally, WASH FIT has been used in a range of health care facilities, including all facility types (primary, secondary and tertiary), temporary and mobile facilities in camps and humanitarian emergency settlements, facilities in rural and urban areas, and public, private and faith-based facilities. These facilities deliver a diverse range of health service provision, including inpatient, outpatient, maternity, neonatal, paediatric, medical, surgical, family planning and laboratory services. There are also examples of WASH FIT being used to improve the skills of facility and health staff in pandemic response, cholera treatment or COVID-19 recovery.

4.3.1 National-level adoption and scale-up

Based on the survey, 28 countries are implementing WASH FIT at a large or national scale and 19 countries are implementing the tool on a small scale or are still in a pilot phase (see Box 3 for a definition of the scope of implementation used). Countries were asked if WASH FIT was formally endorsed by their ministry of health in policies or legislation. In 22 countries, WASH FIT has been formally endorsed by the ministry of health in policies and legislation, while in 21 countries this has not been done or endorsement status is unknown. In 31 countries (65%), the ministry of health has validated a national version of the assessment tool. Some countries have also developed WASH FIT guidelines. In **Montenegro**, these have been used as an advocacy tool in primary health settings and in the **Philippines**, there is a strong focus on climate.

Box 3

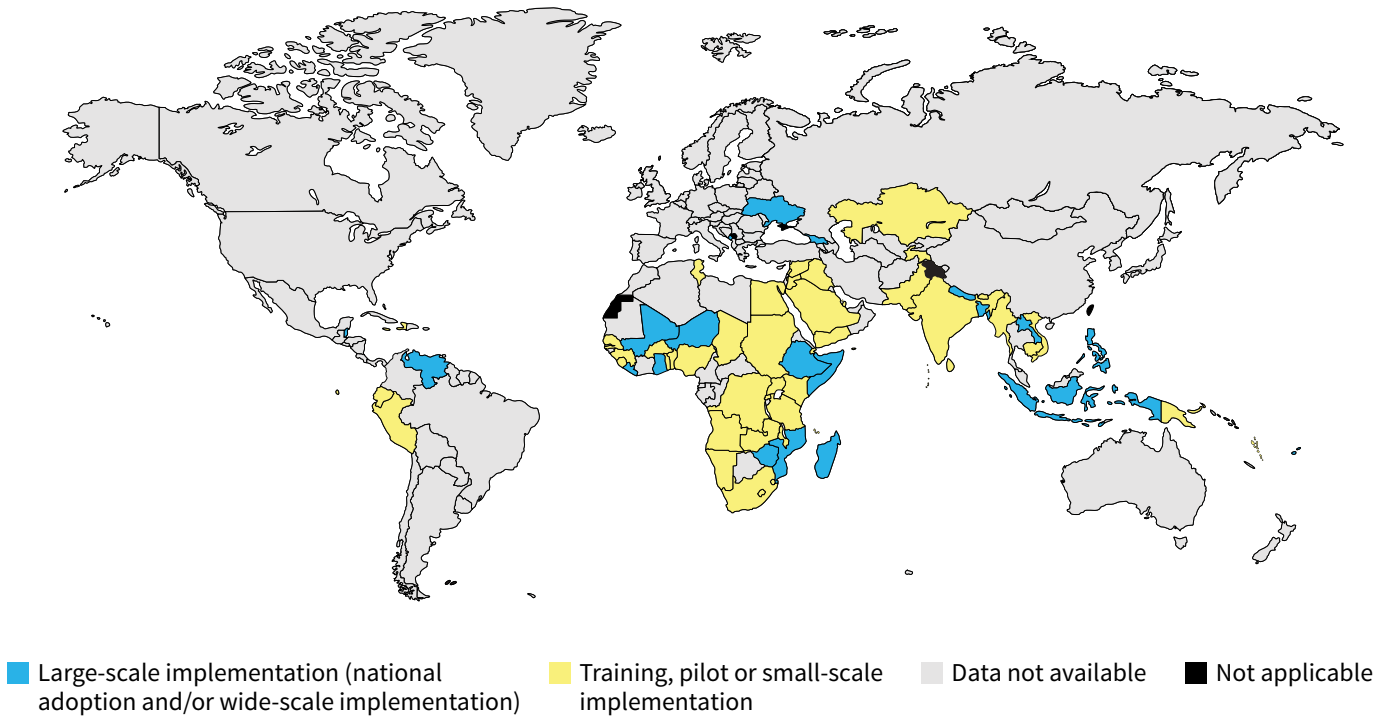
Pilot/small-scale versus large-scale implementation: a definition

One aim of the evaluation was to understand the scale of WASH FIT implementation. Figure 4 shows the scale of implementation of countries known to be using WASH FIT.

Pilot or small-scale implementation involves training a small number of facility staff with limited follow-up activities and funds. Governments may be involved in such efforts but often only at the local level and links to national policies, strategies and government funding are often minimal.

Large-scale implementation involves training at a national level, including the adoption of WASH FIT as an official mechanism to implement national standards and/or achieve specific health or WASH goals. Several hundred or more facilities will be engaged, there is a follow-up mechanism (e.g. regular supportive supervision and visits to facilities) and there is evidence of both small, immediate (e.g. waste bins for segregation) and large, longer-term (e.g. new piping or additional water storage/supply installed) improvements. At a large scale, local and national stakeholders are engaged to support implementation, are aligned with other related efforts and contribute to resourcing.

Figure 4. Global overview of WASH FIT implementation status



Case study

Use of WASH FIT as an advocacy tool in PHC facilities in Montenegro

In Montenegro, WASH FIT guidelines have been adapted to the national context, promoted and disseminated through the health system *(15)*. Adaptation included developing four national standard operating procedures, including guidelines for cleaning personnel on maintaining adequate hygiene in health institutions, on managing medical waste in a health facility, on adequately managing WASH services for health institution management teams and on calculating the costs of maintaining wash services.

Local advocacy efforts with PHC managers as well as training for critical staff delivered by the National Institute of Public Health on hand and environmental hygiene, IPC measures, and cleaning and waste management procedures have taken place. In total, 31 health care facilities have been visited and assessed, including all 18 of the country's PHC facilities. In parallel, cleaning guidelines and protocols have been developed, with defined, step-by-step techniques for specific tasks and cleaning schedules, the use and management of cleaning agents, and roles and responsibilities for cleaning tasks. These have been implemented as part of the WASH FIT process.

4.3.2 Number of facilities using WASH FIT globally

A lack of data means that it is not possible to provide an estimate of the total number of health care facilities which are implementing WASH FIT globally. In many countries, the numbers are still relatively small (fewer than 50) and are mostly partner-led efforts without sustainable funding. Table 2 summarizes a selection of countries known to have larger-scale implementation and/or national adoption.

Table 2: Examples of countries with national adoption and scale-up

Country	Total health care facilities	Facilities implementing WASH FIT	Year started	Further details
Bangladesh	>17 000	200	2017	The majority of WASH FIT implementation occurs in Cox's Bazar which hosts over 1 million refugees, but national training in 2024 kick-started a wider roll-out.
Fiji	>200	221	2023	All data collected at facility level are shared with the government for transparency and follow-up. An evaluation is planned for the end of 2024.
Georgia	2 295[a]	935	2023	2 600 personnel from rural PHC facilities have been trained by 10 master trainers from the Georgian Medical Holding.
Indonesia	13 000	600	2018	Rolled out mainly in PHC facilities with a strong focus on gender, equity, disability and social inclusion.
Liberia	856	285	2015	Started in response to Ebola outbreak and integrated into district health team plans and follow-up.
Mali	1 640	328	2015	Started in response to a large cholera outbreak and adapted to meet the evolving humanitarian and conflict situation.
Montenegro	>30[b]	31	2023	Used to assess all of the country's PHC facilities and as an advocacy tool for facility staff.
Philippines	>40 000	538	2019	Implemented across 18 regions with a primary focus on climate resiliency and strong government leadership, as reflected in national policies and guidelines.
Zimbabwe	1 700	150	2020	WASH FIT digitized and accompanied by a costing tool to inform investment. Monitoring now done within Ministry of Health online monitoring system which has informed national costing estimates and led to increased allocations.

[a] PHC facilities

[b] Public sector facilities

Case study

Scale-up and institutionalization in Mozambique

In **Mozambique**, WASH FIT has been implemented as part of a broad strategy for improving WASH in health care facilities since 2019. Led by the Ministry of Health with support from UNICEF, WHO and implementing partners (including Helvetas, SNV and WaterAid), a national working group on WASH in health care facilities was established, which includes WASH FIT implementation as one of its core activities. After translating the tool into Portuguese, national and subnational trainings took place, reaching all 11 provinces between 2021 and 2023. To reach the 205 facilities in the UNICEF programme and to increase the effectiveness of implementation, supportive supervision via one-year coaching partnerships from civil society organizations were introduced. To scale up this effort across the country, the second edition of WASH FIT (version 2.0, 2022) is being translated into Portuguese for future endorsement by the Ministry of Health. Improvement plans are being piloted by the Ministry of Health in one province for integration in facility annual development plans. Further trainings will be rolled out by the National Institute of Health, and participating facilities will receive recognition of their efforts through WASH FIT certification. Budgets are however limited, both at the national level to continue training (without ongoing partner funding), and at the facility level to help facilities address needs. With partners all using the same version of WASH FIT, this is making it easier to institutionalize WASH FIT within the Ministry of Health as the recommended quality improvement tool.

© UNICEF/ Ricardo Franco. Drinking water access outside a health care facility in Mozambique.

4.4 WASH FIT data influencing local and national decision-making and resource allocation

While the main intention of WASH FIT is for data to be used and shared within facilities to enable improvements to be made, there is also value in sharing data beyond individual facilities. In 28 countries, WASH FIT data are being shared with subnational and national structures and decision-makers. This sharing ranged in frequency from being on an ad-hoc basis or depending on results (n=7), to annually (n=10), quarterly (n=4) or monthly (n=4). Three countries were still collecting baseline data or setting up systems and had not yet started data sharing.

In **Eswatini**, WASH FIT decision-making currently happens at the national level, however regional managers have recommended sharing WASH FIT data at regional levels to enable more targeted interventions. In **Fiji**, data will be used as part of the sector review and to inform a costed plan for donors. In **Nepal**, some local governments have started using WASH FIT information for annual planning and budget allocations. For example, in one small town, the government leveraged US$ 25 000 in 24 months to carry out improvements identified through WASH FIT. While fund allocations vary by municipality, nearly all have made substantial investments (on average covering 30% of improvement costs). Many municipalities shifted their investment priorities from larger projects to more critical interventions in high-risk areas. Improvement plans were instrumental in guiding these decisions by clearly identifying gaps.

In **Mali**, public hearings are held at which findings from WASH FIT assessments are presented to the community so that they can request investment from the local municipality. Facilities engage with community health committees and use data to agree on priority investments. One example of this is the installation of tiling in treatment rooms to improve the ease and effectiveness of environmental cleaning, as well as the installation of new latrines that meet the needs of women, children and those with impaired mobility.

Case study

Over 13 000 Indonesian facilities using national data collection portal

In **Indonesia**, an online data portal called SIKELIM, managed by the Ministry of Health and set up with support from WHO, is used to review progress and inform planning. As of December 2023, 13 000 hospitals and *puskesmas* (PHC facilities), out of a total 13 685 facilities, have submitted data to the portal on the status of WASH services. These data are based on the WHO/UNICEF Joint Monitoring Programme core questions (submitted annually). The dashboard also includes WASH FIT indicators, allowing any facilities using the tool to also share a more comprehensive list of indicators electronically (submitted biannually). Of the 13 000 facilities included in SIKELIM, 601 *puskesmas* have submitted WASH FIT data and 233 have carried out improvements.

Data collected through the portal are automatically shared with the municipal and provincial governments, and are in turn used by the Ministry of Health to set national and local targets and to allocate resources at the national and provincial levels. In particular, the Ministry is interested in understanding the budgets required (budgeted and spent) for health care waste management, consistently the least well performing domain where the biggest gaps lie. In a country like Indonesia where facilities are spread across 514 districts on thousands of islands, electronic data collection is particularly vital as it saves times and precious resources.

Domain	Total (RS & PKM) n = 11.629	Kota* n = 1.479	Desa* n = 7.155	RS n = 2.753	Puskesmas n = 8.939	Pemerintah* n = 9.896	Swasta* n = 1.658
Air	3175 (27.2%)	424 (28.7%)	2181 (30.5%)	477 (17.3%)	2698 (30.2%)	2927 (29.6%)	218 (13.1%)
Sanitasi	3321 (28.4%)	469 (31.7%)	2165 (30.3%)	588 (21.4%)	2733 (30.6%)	2955 (29.9%)	328 (19.8%)
Limbah	1413 (12.1%)	139 (9.4%)	1007 (14.1%)	218 (7.9%)	1195 (13.4%)	1292 (13.1%)	103 (6.2%)
Higiene	4439 (38.0%)	637 (43.1%)	2845 (39.8%)	839 (30.5%)	3600 (40.3%)	3922 (39.6%)	462 (27.9%)
Kebersihan	3198 (27.4%)	473 (32.0%)	2195 (30.7%)	444 (16.1%)	2754 (30.8%)	2964 (30.0%)	200 (12.1%)

* Sesuai klasifikasi data fasyankes yang tersedia didatabase SIKELIM (Desember 2023)

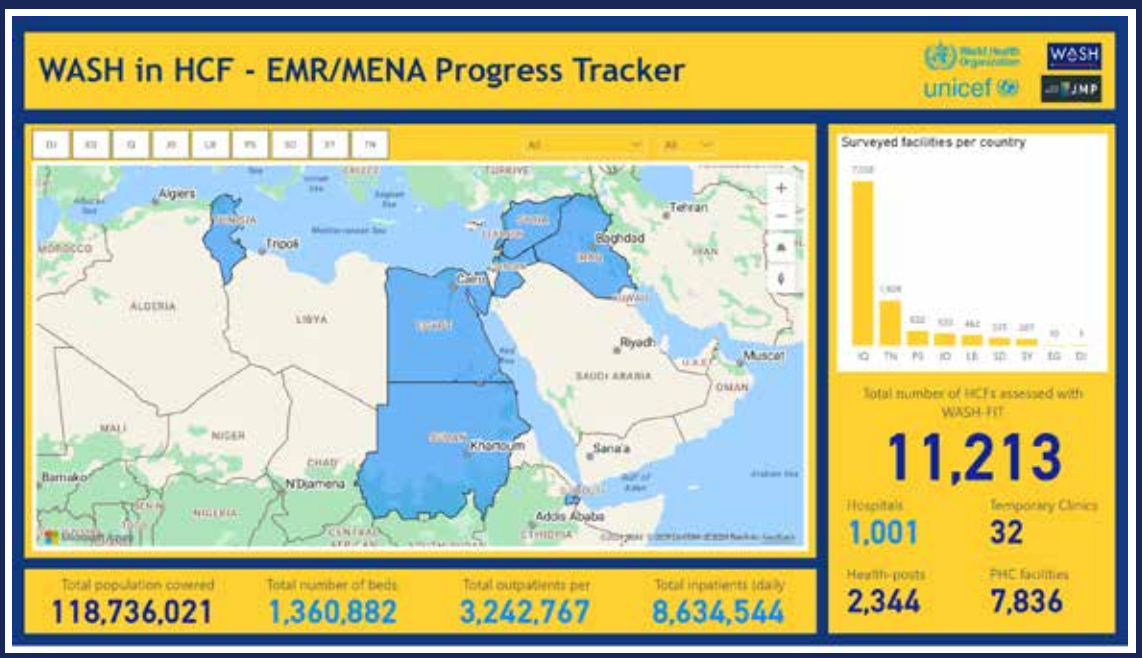
A snapshot from SIKELIM showing the percentage of facilities meeting basic services
Air: water; sanitasi: sanitation; limbah: waste; kebersihan: environmental cleaning.
Pemerintah: government; swasta: private; RS: hospital, PKM: *puskesmas.*

Case study

Regional data sharing using online dashboards in the Middle East

At the regional level, nine countries and territories in the Middle East are using data visualization to track progress on WASH FIT indicators. To date, 11 213 facilities have conducted assessments of services since 2021–2022, and the data are shown in an online dashboard developed by UNICEF. The countries and territories are **Djibouti, Egypt, Iraq, Jordan, Lebanon, occupied Palestinian territory**, **Sudan, Syrian Arab Republic** and **Tunisia**. **Morocco** and **Yemen** are planning to conduct assessments in late 2024 and will also be included in the dashboard. The coverage of facilities in these countries is high: 100% of facilities in **Iraq** (n=4295) and **Jordan** (n=1858) and 80% of facilities in **Tunisia**, **occupied Palestinian territory** and **Sudan** are included in the tracker. Across all the facilities surveyed, only 19.8% of indicators met basic services (as defined by WASH FIT indicators), while 8.1% had no service.

In **Iraq,** assessments were conducted again in 2023–2024, and these showed that significant progress had been made. Only 6% of facilities met basic services at baseline, increasing to 40% in 2024. The data visualizer also allows users to track progress in specific indicators, for example “piped water on premises” improved by 66% across all facilities, and helps identify key priorities for WASH interventions, which were mostly related to sanitation, environmental cleaning and water.



Case study

Electronic data collection and visualization in Venezuela used as an advocacy tool

In **Venezuela**, a data visualization dashboard using KoboToolbox and Power BI was developed, initially as a tool for the WASH Cluster to obtain baseline data and to measure progress on WASH and IPC implementation in health care facilities. KoboToolbox facilitated efficient data collection due to its easy, mobile-friendly interface, standardized data, real-time monitoring (instant access to analyse survey data), and cost and time savings (no need for manual data entry on paper, saving resources and reducing errors). KoboToolbox promotes information sharing, while allowing data privacy. Power BI enables visualization of complex data (showing charts, graphs and maps together) and the interactive dashboard creates dynamic visualizations that allow users to explore and interact with survey data. Importantly, it shows data insights and trends, enabling comparisons between facilities, states and over time (before, during and after intervention). Between 2020 and 2023, 205 facilities (60 hospitals, 145 PHC facilities) in 15 states conducted WASH FIT assessments and many made improvements. Over three years, major progress was made in sanitation and waste management (improvements of 34% and 39%, respectively), with least progress made on water access (9%) and environmental cleaning (4%). There was a slow decline in hand hygiene (-6%), highlighting the need to reinforce services and practices. The dashboard and data provided a valuable advocacy tool and the data generated were used to focus and prioritize activities and resources, and as part of reporting back to donors.

4.5 Costing, budgeting and financing

One core element of developing WASH FIT improvement plans is costing priority actions and presenting such costs to decision-makers. While WASH FIT does not provide costing guidance, there are several global tools that provide benchmark figures *(16)*. Furthermore, given the local specificity and fluctuating nature of supply costs, most countries need to refine any global or regional figures to obtain local figures. WASH FIT encourages the procurement of supplies on the local market to support greater sustainability, reduce the carbon footprint associated with transport and ensure compatibility with existing infrastructure. In several countries, including the **Philippines**, **Ukraine** and **Zimbabwe** (see Zimbabwe case study), costs were systematically calculated as part of improvement planning.

Costed improvement plans are an important lever for securing additional resources. For example, in **Ukraine**, facilities were able to present costed plans to local municipalities, who in turn provided funds to improve water piping and storage, and at one hospital install a new borehole. Costed plans are also important for understanding budgetary needs to cover operation and maintenance expenses and for advocating for budget increases at the facility level.

In **Nepal**, although some municipalities are beginning to include specific WASH FIT budget lines, no funds are specifically allocated to match these budget lines. However, WASH FIT has helped facilities to prioritize essential WASH needs, rather than purchasing items such as office chairs. Health and education are generally not seen as priorities for local leadership, but strong advocacy has shown that this challenge can be overcome.

Costing of WASH FIT in Zimbabwe: the power of data for advocacy and investment

COVID-19 was a major catalyst for implementing WASH FIT in **Zimbabwe**. It was first used in 50 COVID-19 isolation facilities to assess and conduct minor infrastructure upgrades. A year later, the assessment tool was digitized and integrated into Ministry of Health and Childcare (MOHCC) systems and rolled out to a further 100 health care facilities with additional training (national master trainers cascading to subnational levels), planning, improvements and monitoring. In 2022, UNICEF, in close collaboration with MOHCC, developed a costing tool to help quantify the average costs of using WASH FIT and necessary improvements. An estimate of the total budget requirements for each WASH FIT domain (water, sanitation, etc.) was calculated across 100 facilities using the following inputs: facility location (urban/rural), facility type (hospital/PHC), catchment population, number of beds, facility staff and average score per WASH FIT domain. This information was then used to calculate soft intervention costs and operational costs based on the number of facility staff and the estimated cost of training and supplies. The overall estimated national budget required for infrastructure (one-off capital costs), operational costs (annual costs) and supplies (on-off soft expenditure) was US$ 116 million. These estimates have been used to advocate for increased government expenditure. As a result, the MOHCC has significantly increased investment and is now monitoring WASH status in health care facilities monthly. One of the biggest factors for success has been the integration of data collection into existing MOHCC structures, rather than creating a parallel system.

4.6 Integration with other health programmes

WASH FIT facilitates multisectoral programming by bringing together all those who share responsibility for providing WASH services, including legislators and policy-makers, district health officers, hospital administrators, water and sanitation engineers, climate and environmental specialists, and users. The following section provides some examples of where WASH FIT has been used to address related areas: environmental sustainability and climate resilience, GEDSI, IPC and outbreaks/emergencies.

4.6.1 Environmental sustainability and climate resilience

With growing health threats associated with climate change and environmental degradation, all health care facilities need to implement measures to strengthen the resiliency and sustainability of their WASH, waste and energy services. The *WHO guidance for climate-resilient and environmentally sustainable health care facilities (2)* sets out four fundamental requirements for providing safe and quality care. One of these is sustainable and safe management of water, sanitation and health care waste services. The WASH FIT methodology incorporates elements of this guidance, including indicators that can be systematically monitored and improved to strengthen adaptation and resilience. Table 3. Comparison of WASH FIT and climate resiliency tools provides a simple comparison of the two tools. Examples of how WASH FIT is being integrated with, and used to support, climate resilience and sustainability efforts in **Bangladesh**, the **Philippines** and **Lao People's Democratic Republic** are summarized below.

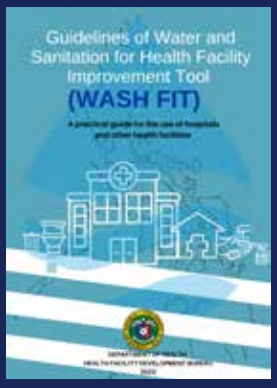
© WHO/Henitsoa Rafalia. A Reference Hospital badly damaged by tropical cyclone Batsirai in 2022.

Table 3. Comparison of WASH FIT and climate resiliency tools

	WASH FIT	Climate resilience and sustainability
Subject	Water, sanitation, hygiene, waste, environmental cleaning, electricity services, facility management	Climate-related risks to health workforce, WASH, energy, infrastructure, technologies and products
Scope	Latest status of facility and daily operations	Future planning against emergencies and disasters
Assessment methodology	Self-assessment tool with essential and advanced indicators	Scenario planning, vulnerability mapping, development of resilience strategies
Outcomes	Actionable plans, implementation and ongoing monitoring of plans	Strategies for resilience, including heatwave response protocols
Temporal focus	Short to medium term	Long-term climate risk adaptation
Target users/audience	Health facility staff, health sector	Health facility staff, environmental management, urban planning
Improvement cycle	Based on quality improvement approach; priority planning, implementation, monitoring	Assessment and actions are combined; no guidance on prioritization and incremental improvements

Case study

Adaptation and national adoption of WASH FIT in the Philippines, with a focus on climate resilience



The Philippines was one of the first countries to publish its own country-specific guidelines on the use of WASH FIT *(17)* and to formalize the tool through national policies and standards. The WASH FIT guidelines are aligned with the technical standards and guidelines for Green and Safe Health Facilities (2021) and the Philippine Health Facility Development Plan (2020–2040), the country's roadmap to accessible health care. These policies focus on modern, resilient and sustainable health care systems and underscore the need for efficient management and use of resources. The National Environment and Health Action Plan (2023–2030) stipulates that WASH FIT be used to help strengthen the capacity of the health care system to respond to climate change, and calls for improvement in the natural and built environments to enable people to improve their health. The WASH FIT guidelines also include elements of water safety and sanitation safety planning.

In 2020, the Department of Health reviewed the global WASH FIT indicators and reduced the number to a smaller set which were considered essential in the face of COVID-19. With the support of UNICEF, the Department of Health also developed a digital reporting platform with a suite of tools to give staff and health facility managers offline access to the self-assessment form and a real-time online dashboard for quick analysis. This simplified version was developed to allow the straightforward application of the tool and the prompt development of WASH improvement plans by WASH FIT multisectoral teams.

To date, the tool has been used in 538 facilities in 18 subregions of the Philippines. Costing data are collected by facilities, and these have been used to influence donors and local funding sources. Examples of improvements resulting from these funds include the procurement of two 30 m^3 water tanks (at a cost of approximately US$ 20 000) installed in a facility in Baguio City. In Aklan Province, facilities were provided with a budget of between US$ 1000 and US$ 10 000 under a project funded by the Korea International Cooperation Agency. These funds were spent on water tanks, pumps, toilets, water dispensers, handwashing facilities and solar panels. Other donors and partners (e.g. the European Union and the United States Agency for International Development) are supporting the installation of solar panels at health care facilities and exploring the development of guidelines on plumbing for health in the context of WASH FIT. To address challenges in implementation (namely accessing sufficient funds for necessary improvements), additional experts were hired at the national, regional and provincial levels to cascade training. These experts also helped to reward the top performers (based on a three-star rating system) as a means of motivating local government units to continue to make improvements.

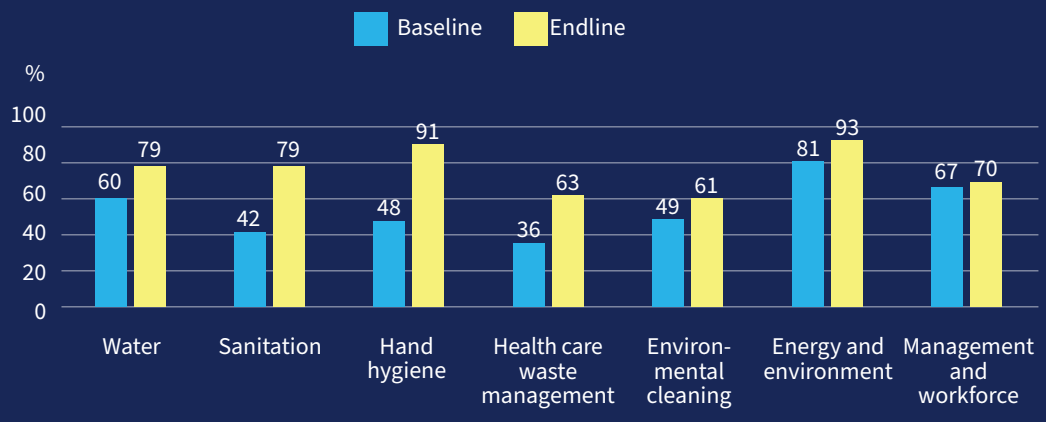
Case study

Implementation of WASH FIT with a focus on systems strengthening and climate in Bangladesh

The **Bangladesh** Ministry of Health and Family Welfare (MOHFW), with support from UNICEF, executed a quality improvement initiative focusing on enhancing IPC during COVID-19, and subsequently expanded this to implement WASH FIT through a health system strengthening approach. The MOHFW has implemented WASH FIT in 32 facilities, using a locally adapted version of the tool translated into Bangla. Improvements have been made in all seven domains, with biggest gains in hand hygiene scores (48% to 91%) and sanitation (42% to 79%) (see graph). Following training from national to local levels, WASH FIT teams were created within hospital management teams or quality improvement committees in each facility, i.e. using existing structures. These teams organize regular monthly meetings to review progress and identify action points. District-level WASH FIT review workshops are organized with facility managers to evaluate outcomes and facilitate support from engineering departments. UNICEF is also supporting implementation research to identify barriers to and enablers of WASH FIT implementation for scaling-up purposes. Information, education and communication (IEC) materials have been developed, with plans to print and distribute them to all facilities. UNICEF Bangladesh is advocating for the MOHFW to include WASH in the remit of quality improvement committees and scale up WASH FIT implementation across all facilities in the country. These experiences will help to revitalize the national technical committee on WASH in health care facilities and to develop the associated national strategy and action plan.

Further WASH FIT implementation is planned in 50 facilities in climate-vulnerable areas, although this work has been put on hold due to funding challenges. Bangladesh has gained significant experience on the modalities of implementation after implementing the tool in humanitarian emergency settlements. Previously, WASH FIT was implemented in approximately 200 health care facilities, including PHC centres, health posts, field hospitals, community clinics, health subcentres and upazila health complexes. More than 550 health and WASH professionals (engineers, facility managers, doctors, nurses and allied staff) were trained on WASH FIT over the course of 20–30 classroom and field-based trainings. A large database of WASH FIT indicators and a video documentary were also developed.

Comparison of WASH FIT scores from baseline to endline



Case study

Integration with a national climate initiative provides a means of scaling up in Lao People's Democratic Republic

WASH FIT was introduced in **Lao People's Democratic Republic** in 2017, and the initial pilot completed in 2019. It was subsequently integrated within the national Safe, Clean, Green and Climate Resilient (SCGCR) Hospitals initiative. Situating WASH FIT under a bigger, government-led programme provided the necessary mechanism to scale it up across the country. A total of 125 district hospitals (more than 90% of all district hospitals in the country) have benefited from training and are implementing WASH FIT. Anecdotal evidence shows the best success has been in improving water quality management, sanitation and hand hygiene. Waste management was consistently the weakest of all domains and has been the hardest area to improve, particularly in rural areas where municipal waste management infrastructure is also lacking. To address this, a sixth step was added to WASH FIT, where hospitals assess waste separately and develop a stand-alone improvement plan. Three model hospitals, spread across the country, regularly put on study demonstrations on waste management and IPC for staff from other facilities in their region. These have proved invaluable as a way of inspiring change. Ad-hoc visits from WHO to facilities have also been useful for on-site troubleshooting.

To complement the SCGCR initiative, WASH indicators were integrated into the district health information system in 2023, and regular data collection and reporting are expected from 2025, providing a formal means of evaluating WASH FIT performance nationally. The World Bank has also included WASH FIT indicators in its health centre improvement plan. Working through the Ministry of Health, approximately 800 health centres have conducted assessments to identify risks, based on which they must improve services to receive performance-based financing (approximately US$ 6000 per year per facility).

4.6.2 Gender equality, disability and social inclusion (GEDSI)

The planning, design and management of WASH services in health care facilities must consider the accessibility, safety, privacy, social appropriateness or acceptability, dignity and comfort of a facility's many different users. These users may include women in labour and menstruating women; infants and children; older people; people with disabilities; individuals with religious or cultural practices and beliefs; and people experiencing injury, illness or incontinence. WASH FIT includes indicators that address GEDSI issues, and guidance to make the WASH FIT process inclusive and equitable. Certain countries and regions are using WASH FIT successfully to address these issues, such as in the **Middle East** and **Indonesia** (see case studies).

Case study

Use of the dashboard to raise awareness of GEDSI in the Middle East

In eight countries and territories which contribute to the regional WASH FIT dashboard in the **Middle East**, a GEDSI score was created, based on five GEDSI-related indicators.[5] This showed, for the first time, that little consideration was given to GEDSI in facilities: out of 11 123 surveyed facilities, more than 80% had limited or no GEDSI-sensitive services (51% had no such services at all), the worst performing of any domain. Generating these metrics has proved to be very valuable for initiating discussions at the national level about the needs of women and vulnerable groups, something which was previously rarely considered.

© WHO/Sebastian Liste. A female health care worker treats a patient in Islamabad, Pakistan

[5] These five indicators were gender separation of toilets, toilets with availability of menstrual hygiene management, toilets meeting the needs of people with reduced mobility, availability of functional showers/space for women to bathe and involvement of marginalized groups in identifying WASH needs.

Case study

Using WASH FIT to make facilities more accessible in Indonesia

With support from city governments, nine *puskesmas* (PHC facilities) in two cities in Lampung Province have worked to make their facilities more inclusive and gender responsive. This work was led by SNV Indonesia and its local partner Yayasan Konservasi Way Seputih, who worked to improve services. One *puskesmas* added ramps to the entrance and toilets, widened toilet doors from 80 to 100 cm to allow wheelchairs to enter and exit more easily, and equipped toilets with extra curtains to enhance user privacy. In another, the WASH FIT task force has started to prioritize menstrual hygiene management in the female toilet, through provision of menstrual hygiene products, particularly for adolescents and postpartum women. They also changed the facility's registration process and waiting room to prioritize people with disabilities, along with pregnant women and elderly patients. The head of the facility said "*we have plenty of patients with disabilities, elderly and pregnant women. They have the same rights to health care services, and we prioritize the more vulnerable population groups to be served [here.]*"

The make-up of the WASH FIT teams, which included representatives of people with disabilities, women, young people and religious organizations who live in the surrounding area of each *puskesmas,* was critical to success: each facility can gather direct feedback from its users and feels a responsibility to fulfil its duty to the surrounding community. The participatory approach, where all WASH FIT indicators were discussed collectively without participants being told what improvements should be made, led to more enthusiasm among staff and management about them improving their services. Support from city governments and mayors was also helpful.

Building on this work, the Ministry of Health is planning to conduct a situational analysis for mainstreaming GEDSI in WASH to provide a baseline from a policy and programme perspective at the national level and in selected districts (Padang City, West Sumatera Province; Balikpapan City, East Kalimantan Province; Bantul District, Jogjakarta Province).

© WHO/Indonesia. A patient uses a disability-friendly bathroom at a primary health care facility in Indonesia.

4.6.3 Linking WASH FIT with infection prevention and control

WASH is a minimum requirement for achieving strong and effective IPC programmes and for implementing good IPC practices *(18, 19, 20)*. The integration of WASH and IPC is further strengthened through the Global Action Plan and Monitoring Framework for IPC (2024–2030), which emphasizes the criticality of WASH and includes several targets and indicators covering WASH in health care facilities *(21)*. To support IPC implementation, assessment tools and implementation guides are available *(22, 23)*. Conducting WASH FIT alongside these approaches supports more in-depth and holistic assessment and action planning on WASH and IPC. Integrated WASH and IPC approaches are increasingly being employed at the country level, including in Ukraine (see case study).

Case study

Integrating WASH and IPC in Ukraine shows that small improvements catalyse larger improvements, even in wartime

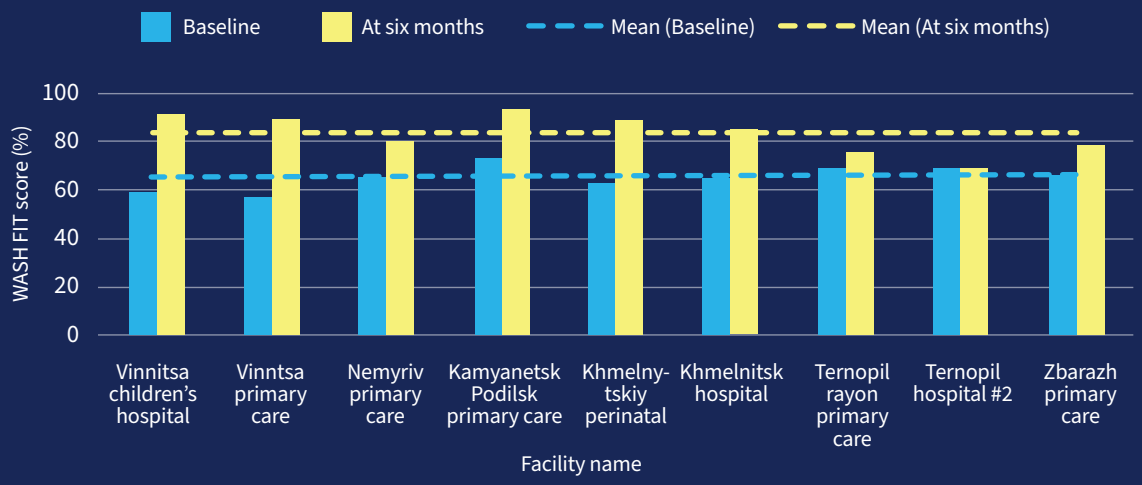
As of 2024, an estimated 9.6 million people in **Ukraine** are in need of assistance to meet their basic water, sanitation and hygiene needs *(24)*. As part of broader efforts to strengthen the resilience and safety of water and sanitation services in Ukraine, WHO, the Ministry of Health, the Ukrainian Public Health Centre and Regional Centres for Disease Prevention and Control, with the United States Centers for Disease Control and Prevention, have been working since 2022 to facilitate service improvements in health care facilities through WASH, alongside strengthening national polices and standards. One aspect of this is WASH FIT implementation.

In total, 18 model pilot facilities in central and eastern Ukraine (near the front line) have been engaged, through training, mentoring and seed funding, to jointly implement WASH FIT and the WHO Infection Prevention and Control Assessment Framework (IPCAF) *(23)*. Support includes hands-on training on waste management, cleaning and hand hygiene – all areas where staff indicated they would like more support. Partners, including UNICEF, are supporting an additional 200 facilities throughout Ukraine to implement WASH FIT. Seed funding supported small improvements such as provision of waste segregation bins and hand hygiene materials. Through advocacy around initial WASH FIT results and engagement with local municipalities, facilities were able to raise funding for larger-scale investments such as new boreholes, water storage tanks and improved plumbing.

Overall, the WASH FIT process catalysed facilities to make positive changes. In the nine pilot facilities where data could be collected (nine were inaccessible due to the war), facilities more effectively managed water-related risks, replaced broken taps, improved waste management practices (ceasing outdated practices like chlorine disinfection of waste) and installed backup water supply sources. The graph below shows the overall change in WASH FIT scores of the nine pilot facilities where data were available. After six months, the greatest improvements were observed in health care waste and hand hygiene with, on average, a 67% and 69% increase in six-month post-implementation scores, compared to baseline. The effort has shown that small improvements can be made even with limited resources and during a time of conflict, and that these can catalyse larger improvements and investment.

Health-based national standards, regular on-site training and mentoring, and professional capacity-building programmes helped drive improvements. Engaging and strengthening national public health entities are critical for institutionalization and scale-up efforts. Subsequent work has been focused on integrating WASH FIT into national legislation, ensuring that the Ukrainian Regional Centres for Disease Control and Prevention have the capacity to lead training and mentoring, and to integrate WASH FIT indicators into national monitoring systems.

WASH FIT scores at baseline and six months post-intervention



© WHO/Maggie Montgomery. A WASH FIT assessment is conducted in a district hospital in Bila Tserkva, Ukraine

4.6.4 Using WASH FIT in acute and chronic emergencies

Emergencies can refer to slow- and rapid-onset situations and complex political emergencies in all countries. They can include disasters, a term which mostly refers to natural disasters, such as those arising from extreme weather events (e.g. hurricanes/typhoons, flooding), drought, earthquakes and disease, as well as situations arising from war, conflict and mass migration. Many health systems around the world are underprepared and unable to deliver basic services, and become even more stretched when undergoing an acute or chronic emergency, rendering them unable to respond to disease outbreaks and deliver quality care. WASH FIT provides a framework for facilities to meet the requirements for basic services and thereby strengthen preparedness and response capacities for these situations. WASH FIT has been used in several emergency contexts, ranging from acute emergencies caused by climate-related events to chronic emergencies resulting from conflict and displacement. In **Ukraine**, WASH FIT is being used to strengthen resiliency and respond to the effects of conflict.

In **Yemen**, WASH FIT was adopted during the COVID-19 pandemic to assess WASH services in health care facilities targeted for use as isolation units. A technical working group, under the Health and WASH clusters, took the lead on implementing the tool in those health care facilities, supported by partners who went on to use WASH FIT to identify the biggest challenges, find available resources to address each of these challenges, and determine roles and responsibilities. However, consistent implementation was difficult as there was limited capacity for conducting assessments and identifying priorities in some facilities. Damage to handwashing sinks and taps by users was also frequent. Based on the findings, WHO supported the Ministry of Health with an operation and maintenance training package for staff working in health care facilities, and provided a toolbox to help facilities fix plumbing issues more quickly and easily.

© WHO/Arabella Hayter. A WASH FIT team discusses assessment results at a district hospital in rural Mali.

WASH FIT was adapted for use in Gaza in the **occupied Palestinian territory** using a simplified assessment consisting of 27 questions (as agreed by the WASH Cluster). One notable adaptation was the inclusion of the number of persons sheltering in a facility under the total number of patients, something which greatly affects water quantity and latrine requirements. The most common problems identified were water quality in hospitals, sanitation (due to overcrowding), poor environmental cleaning and disinfection due to a lack of supplies, disposal of waste and general disruption to routine services. Taps being stolen and damage to handwashing sinks was also frequent.

Ongoing conflict and sociopolitical instability are a challenge for WASH FIT implementation in the Sahel, notably in **Burkina Faso, Chad**, **Mali** and **Niger**. Some facilities are out of reach to staff from the Ministry of Health, WHO, UNICEF and other implementing partners, making it difficult to introduce improvements, provide ongoing support and track progress over time. In **Chad**, ongoing instability (and climate change) has led to an influx of refugees to new areas in the east and south of the country and around Lake Chad, taking attention away from systems strengthening and diverting what limited resources are available to focus on emergency response.

In **Niger**, the United States Centers for Disease Control and Prevention (CDC), IRC and World Vision were supporting WASH FIT improvements in 15 facilities but found that three facilities could not be reached due to ongoing conflict and insecurity. While staff from these facilities benefited from capacity-building and received supplies, evaluations and follow-up could not be conducted, providing no evidence of actual WASH FIT use. Those facilities using WASH FIT have done so to varying levels of quality, as they are hampered by turnover of government staff, who get assigned to other districts or regions. WASH FIT is at the scale-up stage, under the leadership of the Ministry of Health, with a growing number of partners interested and supporting, and the membership of the WASH FIT Technical Working Group increasing from 10 to 20.

Using WASH FIT to assess and improve cholera treatment centres in Lebanon

In **Lebanon**, three versions of the WASH FIT assessment tool were developed for PHC facilities, dispensaries and hospitals, and approved by the Ministry of Health. Assessments were then carried out by eight appointed officers in 463 health care facilities, including 31 governmental hospitals, 289 PHC facilities and 143 dispensaries. A company was contracted to sample and test the water in the selected facilities for free chlorine, *E. coli* and total coliforms.

Among the PHC facilities assessed, 50 facilities in high-risk cholera areas were considered. Those with the lowest WASH FIT scores were prioritized for WASH improvements, and a bill of quantities with an estimated cost for the improvements was prepared in 16 high-priority facilities. Based on these results and the available budget, 12 PHC facilities were then selected for WASH improvements, benefiting the more than 180 000 Lebanese and Syrian people accessing those facilities.

The improvements included: i) installation of new water treatment units to provide safe and clean drinking water in the facility; ii) rehabilitation and/or construction of toilet facilities (including sanitary wear, tiling, painting, pipes and fittings) to ensure that facilities were separated by gender, for people with disabilities and for patients/staff; iii) rehabilitation and/or construction of handwashing stations in medical points of care (i.e. consultation rooms) where possible; and iv) installation of cooling units for adequate infectious waste storage, electrical repairs/installations, and installation of a wastewater treatment plant for one PHC facility.

© WHO/Tom Vierusgeneral. Part of the Wainibokasi Rural Hospital located nar Nausori. Fiji.

4.7 Evaluation of WASH FIT outcomes and perceived benefits

Forty-five per cent of countries responding to the survey stated that they had not conducted any evaluation of WASH FIT outcomes and impacts, meaning that the availability of WASH FIT effectiveness data is limited. This could be due to the fact that the tool has been implemented for only a short period, in addition to limited resources for gathering data. Six countries (**Fiji, Indonesia, Lao People's Democratic Republic, Kenya, Uganda, Vanuatu**) stated that they had plans to conduct an evaluation. These findings are consistent with a review conducted by the Water Institute at the University of North Carolina, which looked at all available published evidence of WASH FIT data and found published results to be few (see Box 4).

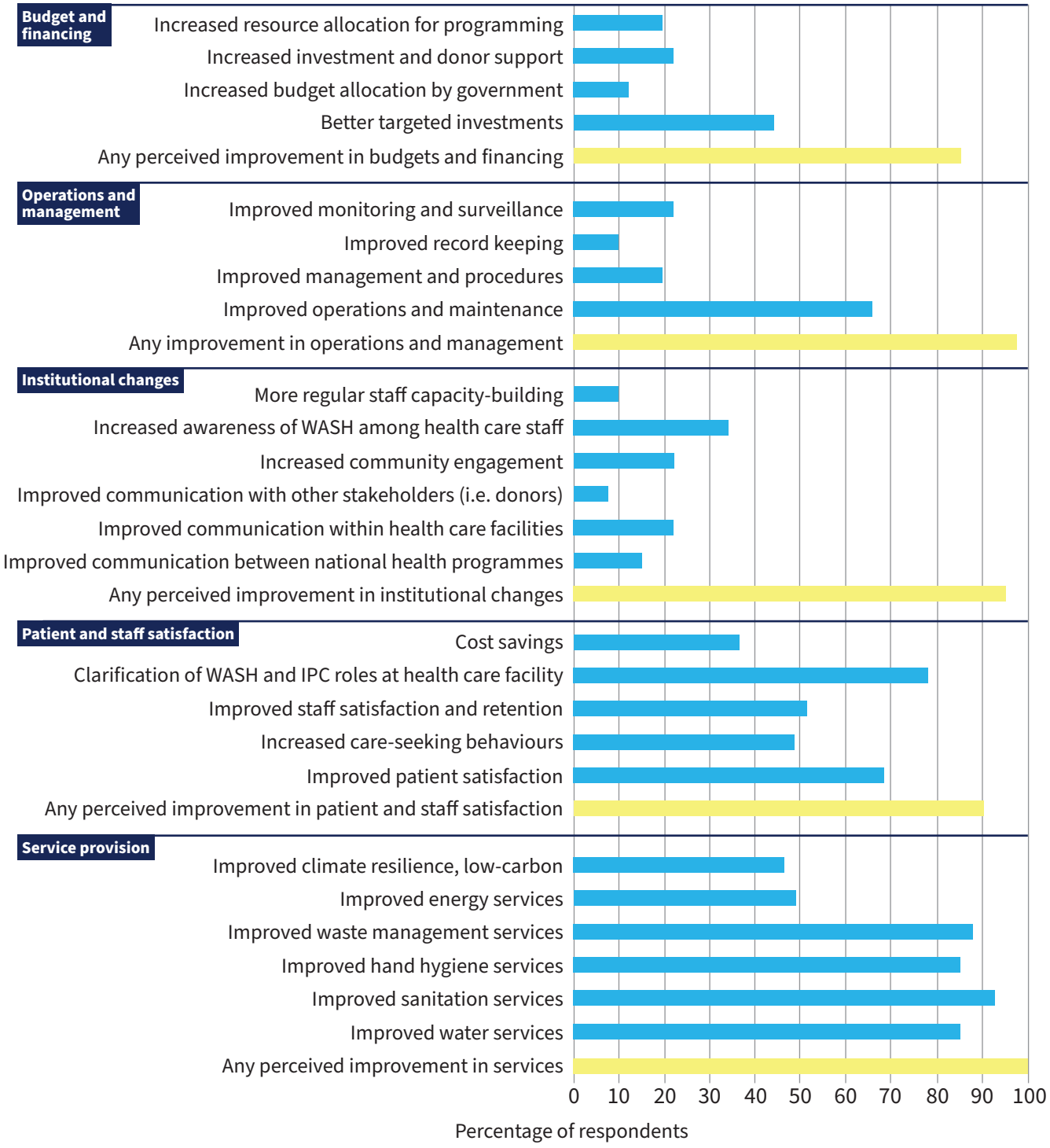
Box 4

A 2024 review by the Water Institute at the University of North Carolina examined the effectiveness of WASH FIT and found that WASH FIT plausibly improved WASH service levels, but evidence was weak and insufficient to evaluate downstream health impacts. However, this review was based on the limited amount of published evidence available *(25)*.

Of the 24 studies included in the review, 10 studies reported that WASH FIT contributed to policy changes or informed government decisions to scale up WASH FIT. Four studies reported that WASH FIT implementation helped improve collaboration with government entities. Seven studies reported that WASH FIT helped justify allocated budgets for WASH services. Twelve studies also noted improvements in occupational safety or knowledge, attitudes or practices among health care staff, patients or community members. Most of these changes were reported qualitatively through interviews or observations. Finally, four studies indicated that WASH FIT helped improve community engagement by creating new avenues and incentives for health care workers to engage with community members.

However, an overwhelming majority of those responding to the survey perceived WASH FIT to have had a positive impact. One hundred per cent thought it had improved service provision, 98% perceived improved operational efficiency and management, 90% perceived increased patient and staff satisfaction, and 85% perceived more precise investment targeting in WASH for health care facilities (see Figure 5. Perceived improvements due to WASH FIT). There was also improved awareness of risk factors and of the importance of WASH for quality of care among health care workers and, specifically, among support staff in **Malawi**, **Nepal** (see case study) and **Togo**. In **Viet Nam**, WASH FIT has helped facilities to address and improve climate resiliency.

Figure 5. Perceived improvements due to WASH FIT



Case study

Motivation of cleaning staff and evaluation of WASH FIT outcomes in Nepal

© WHO/Robic Upadhayay. WASH FIT training at Dhungrekhola health post

In **Nepal**, cleaners were found to be more motivated in their work due to WASH FIT. Being part of the WASH FIT committee gave cleaners (known locally as *Karyalaya Sahayogi*) a formal role in the WASH decision-making process within the facility. This recognition not only validated their crucial role but also empowered them with a sense of responsibility and ownership and their formal involvement in decision-making made them feel respected and acknowledged for their contributions, which was not the case before. Additionally, WASH FIT offered valuable training, enhancing their skills and confidence, while improved conditions made their working environment more pleasant and efficient. Other feedback shows that the integration of new areas (energy management, gender inclusivity and climate change adaptation) in WASH FIT 2.0 has significantly enriched the programme and its outcomes. Initial lessons learned include the importance of reliable energy for operational continuity, the benefits of gender-sensitive approaches for equitable health outcomes, and the need for climate-resilient infrastructure and practices to ensure sustainability. These additions have contributed to more comprehensive and effective WASH interventions, leading to enhanced health and safety in health care facilities.

© WHO/Robic Upadhayay. Puspa from Dhungrekhola health post in WASH FIT training

“The training has made me realize that there is a lot of improvement needed at my health facility, I am determined to work to turn things around.”

Auxiliary nurse midwife, after participating in a WASH FIT training.

An evaluation of WASH FIT projects across three countries (**Benin, Mali, Nepal**) by the Swiss Water and Sanitation Consortium found that, through its participatory approach, and simple and easily understood indicators, WASH FIT had enabled the introduction of structured cleaning rosters, mechanisms for monitoring, needs and risk assessments, clear outputs of workplans for day-to-day and future operations and simple, easily communicated improvement plans that can be costed. These are all invaluable for advocacy and fundraising. WASH FIT was found to have a significant positive impact on the cleanliness of the working environment, staff motivation and safety. Anecdotally, infection rates were reduced and patient attendance increased in some facilities; however, no reliable monitoring data were available to confirm this. Interviewees were consistently positive about the project, as were patients: *"people want to have their babies [here at a health care facility in Benin], instead of at home. One man gave a donation to the centre after his wife gave birth here because he was so pleased to have access to the service*."

Factors that may explain the effectiveness of WASH FIT	Barriers to sustainability
1. Participatory approach with an inclusive team	1. Limited local sources of funding: longstanding budgetary commitments
2. Easy-to-understand indicators	2. Poor ownership by local government
3. Output of a clear, prioritized, structured workplan for future improvements	3. No formal adoption of WASH FIT in national policy/guidelines
4. Output of a clear, structured workplan for day-to-day operations	4. Poor staff and community engagement
5. Facilitated costing and budgeting of improvement plans	5. Staff turnover and loss of institutional knowledge
6. Tangible, simple advocacy tool	

Source: Swiss Water and Sanitation Consortium *(26)*

The engagement of each facility with community health committees to agree where investment should be made mostly ensured that investments targeted priority issues within each facility, for example, the installation of tiling in treatment rooms to improve the ease and effectiveness of environmental cleaning. Where a facility prioritized improving its WASH FIT score rather than specific, identified needs, funds have not necessarily been used efficiently. One example is the installation of a bio-sand filter at a facility in **Nepal**, where insufficient research was carried out to confirm whether such a filter was necessary. In addition, almost all the toilets adapted for people with disabilities that were installed focused on a lack of physical mobility, but with minimal investment they could have been made friendly for people who are vision impaired or who need hearing aids.

Case study

Evaluation of WASH FIT in Burkina Faso

Burkina Faso, with financial support from UNICEF and the CDC, began implementing WASH FIT in 43 facilities in 2020–2022, and conducted an evaluation to determine its success two years later. Health care facilities undertook WASH assessments using digital data collection on KoboToolbox and followed these with infrastructure improvements. The evaluation looked at the impact of WASH FIT, and lessons learned that would enable UNICEF and other WASH actors to better replicate the model in different regions of the country. During the evaluation, facilities reported an average overall improvement in their WASH FIT score of 34% (35% for water, 29% for sanitation, 33% for hand hygiene and 32% for facility management). Success was attributed to multiple factors. The tool is well aligned with the strategic objectives of the National Drinking Water Supply Programme (2016–2030) and the National Wastewater and Excreta Sanitation Programme (2016–2030), which represent the programmatic framework for all drinking water, hygiene and sanitation interventions in urban and rural areas in Burkina Faso. Involving facility staff, community members and local district authorities in developing the improvement plan was also helpful. Facility managers became more committed to maintaining services (where resources permitted) and local stakeholders (town halls, community groups and WASH FIT committees) more actively supported facilities to make improvements. IEC materials used as part of the process motivated health workers and communities to improve hygiene in health care facilities, and this in turn had a positive effect on WASH practices in households. Factors found to hamper performance were the deteriorating security situation and the wrong choice of intervention period (during violent and torrential rain), resulting in some localities becoming inaccessible, delays in the execution of activities and a lack of financial resources (leading to the breakdown of infrastructure, non-completion of certain activities outlined in improvement plans and an inability to pay for cleaning, operation and maintenance). The dilapidation of some buildings, coupled with the absence of fencing around some facilities, increased the risk of vandalism and insecurity of people and property, meaning improvements were less sustainable in these cases. Strategies to increase success in future include better mechanisms for endogenous financing of improvement plans, more community engagement, stakeholder capacity-building, putting municipalities at the heart of WASH FIT and increasing their leadership within facility management. Finally, taking gender and equity into account at all stages will make results more sustainable. Overall, WASH FIT was well received and deemed to be successful.

4.8 Main challenges to implementation

By far the most cited barrier to implementation was limited financing for WASH FIT (n=17, 35%), including overreliance (or complete reliance) on donor funding and a lack of local funds. This was followed by lack of government buy-in and leadership (n=11), limited technical capacity (illiteracy, limited staff capacity, tool too complex, no ongoing support) (n=9), reluctance of facility staff, including senior management, to engage (n=7) and staff turnover (n=1). A lack of collaboration between different stakeholders and poorly defined roles and responsibilities were cited as challenges in five countries.

There are numerous challenges related to funding, as recognized by 24 countries (50%). Funds are needed both to initiate the WASH FIT process and then to make and maintain improvements. It is typically difficult to find funding to procure WASH and waste supplies and materials (e.g. autoclaves,

bins, needle destroyers, cleaning products) or even to make small infrastructure improvements (e.g. water system or water storage upgrades, construction of waste storage building, or modifications to make toilets more accessible for staff, patients and people with limited mobility). A lot of government funding goes towards staff, leaving little for repairs and improvements. Complicated bureaucracy can also make it difficult to release funds as and when they are needed, even when available. Federal and provincial governments need to have a dedicated budget as part of their annual planning and allow local governments to access resources from it. In the absence of national coordination of WASH FIT activities among partners, funding gaps are not addressed coherently, adding another challenge.

Other barriers included difficulties in accessing facilities due to challenging security situations or outbreaks (n=4), or for geographical reasons where facilities are spread out across large distances/ multiple islands, making them hard to reach (n=2). Where countries are undergoing periods of insecurity, conflict and war, WASH FIT has suffered against competing government priorities. A lack of national standards and policies (n=3) and a legal framework or mandate for the tool (n=2) was also a problem. In two countries, other facility-based approaches run in parallel, resulting in limited buy-in for WASH FIT.

In the **Democratic Republic of the Congo**, parallel approaches (i.e. different facility-based improvement tools) and a lack of interest and information among public services prevented the continued implementation of WASH FIT. In **Chad**, one of the first countries to pilot WASH FIT, implementation ceased after project funding ended at a time when the country's health system has come under new pressures from climate change and political instability. A lack of funding was also cited by the **Maldives** and **Togo**.

4.9 Data limitations

There are several important limitations to the data used in this analysis. Firstly, not all countries who are known to have used WASH FIT participated in the survey, meaning the number of countries sharing information provides an underestimation of the scale of implementation. Secondly, although countries were asked to submit one consolidated response each, multiple entries were received from some countries. This led to some discrepancies in data and suggests that there is limited communication and collaboration at a national level (and thus a lack of institutionalization). Where multiple responses were submitted, many of the answers were contradictory, with different responses according to the type of respondent (i.e. government or non-government). This makes it difficult to determine the accuracy of some information, despite attempts to contact respondents for verification.

WASH FIT is designed as a flexible framework that can be adapted and implemented according to the national or local context, making cross-country comparisons and analysis difficult. The overarching purpose of WASH FIT is to offer a tool to support facilities to make improvements. It is not designed to generate global data or analysis. In addition, there are relatively few WASH FIT publications, and reporting of programmes and outcomes is incomplete and inconsistent. Statistical analysis of data was therefore not possible. Data from the survey were supplemented with information and case studies from other countries, however these additional countries were not included in any quantitative analysis, thus adding potential bias into these calculations.

5 Recommendations

The uptake of WASH FIT continues to grow in every region, with increasing numbers of countries adapting and adopting it as the nationally approved mechanism for improving quality of care through WASH. That said, numerous gaps and challenges remain, as highlighted throughout this document. The following provides some recommendations in response to the challenges identified. The following provides some recommendations in response to the challenges identified. They are presented thematically and can be applied by users at the national and subnational levels.

Institutionalization

Overall, there is a clear need for better institutionalization to ensure that all stakeholders use a common approach, based on a nationally validated set of indicators. Risk analysis and prioritization of improvements support health sector and local government planning processes. These, in turn, need to be linked to consistent, long-term financing of WASH FIT and WASH improvements. At the national level, and as a basic requirement, the tool should be aligned with national standards and any existing programmes, and validated by the ministry of health, with clearly defined roles and responsibilities for everyone involved (local and national government, partners, health workers). This can be done through a national WASH FIT technical working group or as part of a broader group responsible for WASH or quality improvement. A dedicated focal person for WASH FIT at the national and local levels can also help to sustain progress. WASH FIT cannot be sustainably integrated without governments and health authorities providing support for ongoing staff training and funding the operation and maintenance of infrastructure through the municipal budgeting process.

Professional Training

WASH FIT capacity and sustainability will be greatly improved through a professional training programme. Public health professionals at local levels should be trained as certified WASH FIT trainers, and the programme should be institutionalized by making it part of a process of continuous education. It should become part of the mandate of local health authorities and thus linked to legislation and regulation. Training should be accompanied by supervisory or mentoring visits to health care facilities to facilitate WASH services assessment, identification of needs, development of improvement plans and progress tracking. Staff turnover in the health care field is frequently high, and having an established professional programme with an onboarding element for new staff and regular professional development for all staff is important. This is already in place in several countries, but needs to become more common.

Monitoring

Regular monitoring and review of WASH FIT implementation is important to maintain effort and make course corrections. This includes sharing WASH FIT facility-level data with subnational and national decision-makers on a regular basis. Online data collection and visualization tools can simplify and automate this process. Data visualization is also a powerful way of prioritizing resource allocation. There are existing online tools which can be used with relatively few resources and limited technical skills. More transparent reporting of all indicators captured in WASH FIT assessments is needed, particularly for follow-up and long-term monitoring after initial improvement plans are implemented. Making the results of assessments more accessible to community members so that they understand how the facility is performing may also increase the demand for better services and accountability.

Improved monitoring of key impact indicators, such as infection rates, will also add to the evidence base and increase the likelihood of further investment. Short-term opportunities exist to improve evidence by more comprehensively reporting WASH FIT assessments and exploiting data on health impacts within health management information systems. In the long term, experimental studies are recommended. This evidence is important to ensure that funds invested in WASH FIT implementation are used effectively and that opportunities to adapt and refine WASH FIT are fully realized as the tool continues to grow in use and influence.

Greater use of digital tools for data collection and ongoing implementation is needed, and experience of using these tools must be shared. Such tools allow for real-time data collection, tracking and sharing but a thoughtful assessment of user need, data ownership and the financial viability of digital tools is essential. Digital feedback loops are key in continuous improvement, to help feed information on what has happened in the past into new activities.

Community Engagement

Anecdotal evidence across a range of settings demonstrates that it is vital to engage WASH FIT facility teams and the local community if WASH FIT is to be successful. Strong and dynamic leadership from managers and community health committee leaders has shown clear benefits. Where senior leaders are not committed to a collaborative approach and community leadership is weak, the opportunities to advocate for funding are much reduced. Communities can verify where needs are greatest and which improvements would be most beneficial, ensuring that precious resources are used to best effect.

Financing

Financing and funding should be planned and include cross-sectoral and local engagement of municipalities. Funding is critical to roll out, improve infrastructure and carry out ongoing operation and maintenance. Both trainings and individual facility plans require a realistic budget, prioritizing high-value investments. This also involves regular budget and expenditure tracking to better understand and support budgetary needs and effective financing models.

Integration

Each step of the WASH FIT process should involve climate, gender, disability and equity experts and representatives. It is especially important that draft WASH FIT improvement plans are regularly reviewed

by and incorporate input from climate, gender, disability and ethnic groups. This will ensure that WASH FIT results in processes and services that support climate resilience and sustainability, equity, human rights and universal quality services for all.

Streamlining WASH FIT with other health and climate tools is important for more holistic and effective approaches, and to reduce administrative burden. Where other facility-level tools are being used (for IPC, PHC, climate and sustainability, emergency readiness and resilience), WASH FIT should be integrated into existing activities and mechanisms for quality improvement. This includes joint training, reduced and aligned indicators for regular monitoring, and cross-sectoral budgeting.

Emergency Response

For emergencies, WASH FIT processes should be abbreviated with a shorter list of essential indicators, and overlaps with IPC and infrastructure investment made more explicit. WASH FIT has been used and adapted for use in several humanitarian emergencies (e.g. Cox's Bazar (**Bangladesh**), Gaza, **Iraq**, **Ukraine**, **Yemen**) but it is less well designed for outbreaks where decisions have to be made rapidly, facilities may be temporary, and the focus is on containing and controlling an outbreak. Working with emergency logisticians, IPC and diagnostics experts, and vaccine teams (as emergencies frequently generate surges in health care waste) to modify the approach could be of great value.

© WHO/Kiana Hayeri. Women and children using facilities in a hospital in Afghanistan

6 Conclusion

The need to improve water, sanitation, hygiene and waste services in health care facilities is urgent and massive. As this evaluation has shown, the WASH FIT approach provides a sensible and easily understood methodology for implementing risk-based, incremental improvements. More rigour is needed to better understand the processes that support and sustain scale-up, as well as both the tangible and perceived benefits (including economic) of such efforts. With 71 countries known to be using WASH FIT and a growing global community familiar with the approach, it is an opportune moment to redouble efforts with more documentation, monitoring and integration alongside related health and climate efforts. Most importantly, users, patients, their carers and health facility staff deserve and have the right to safe and sustainable WASH and waste services. Improving how and where WASH FIT is implemented and integrated with other approaches can help fill this important gap and meet this fundamental right.

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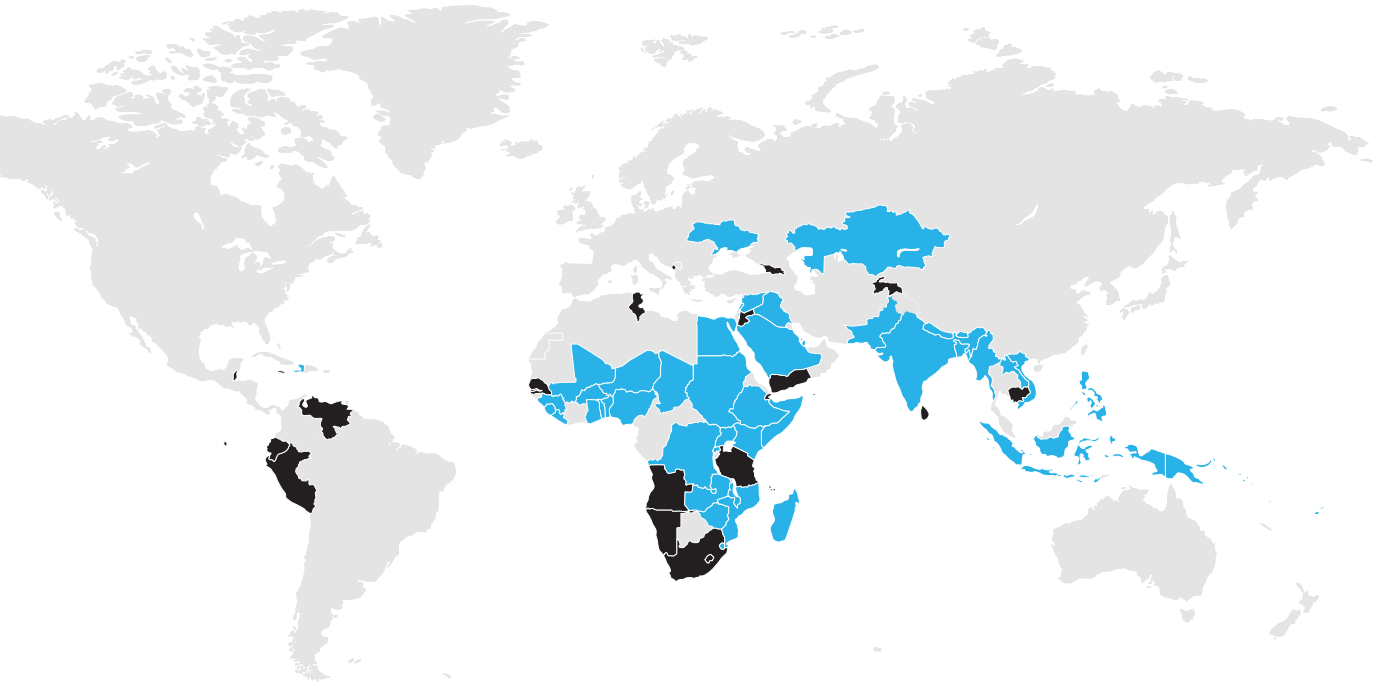
Annex 1: Countries which have conducted training or implementation of WASH FIT



The following

71 countries

are known to be using, or have used, WASH FIT. Countries in blue responded to the survey and have been included in the quantitative analysis presented in this report. Countries vary in their level of implementation: some have only conducted training, while others have gone on to carry out small-scale implementation or pilots, or large-scale implementation.

Angola, Bahrain, Bangladesh, Belize, Benin, Bhutan, Burkina Faso, Cambodia, Chad, Comoros, Djibouti, Democratic Republic of the Congo, Ecuador, Egypt, Eswatini, Ethiopia, Fiji, Gambia (Republic of the), Georgia, Ghana, Guinea, Haiti, India, Indonesia, Iraq, Jamaica, Jordan, Kazakhstan, Kenya, Lao People's Democratic Republic, Lebanon, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Montenegro, Mozambique, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, occupied Palestinian territory, Papua New Guinea, Peru, Philippines, Qatar, Rwanda, Saudi Arabia, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Sri Lanka, Syrian Arab Republic, Tajikistan, Togo, Tunisia, Uganda, Ukraine, United Republic of Tanzania, Vanuatu, Venezuela, Viet Nam, Yemen, Zambia, Zimbabwe.

Annex 2: Survey questionnaire

A copy of the survey is provided here. The original survey was administered using an online form and therefore the appearance and usability was different to the version presented here.

A. BASIC INFORMATION

1. Country
2. Name
3. Email address
4. Organization
5. What kind of organization or agency do you work for?
   a. National
   b. State/ Sub-national government
   c. Municipal government
   d. WHO country Office
   e. UNICEF country Office
   f. Non-governmental organization/Civil Society
   g. Other
6. Position within organization
7. At what stage of WASH FIT are you?
   a. Not yet started (no training conducted) but planning to use WASH FIT
   b. Conducted training but not started implementation yet
   c. Started implementing WASH FIT
8. If you have not yet started WASH FIT, please provide a brief description of how you are intending to use WASH FIT. Consider training, scope of implementation (number of facilities), timeline of proposed activities, how WASH FIT will be adapted to your context etc.

B. TRAINING

9. How many times has WASH FIT training taken place?
   a. Never
   b. 1–2 times
   c. 3 or more times
10. Have the WHO and UNICEF training manual and modules been used for trainings?
11. What did you like about these materials?
12. What gaps are there and what types/topics would you like to see in future training materials?

13. Who is responsible for training at each level (national/subnational/facility) and how is training cascaded between these levels?
14. Which of the following groups have received training?
    a. Health care facility managers
    b. Planning and policy personnel
    c. Health personnel/clinicians (e.g. doctors, nurses)
    d. Non-clinical personnel (e.g. cleaners, waste handlers)
    e. Personnel from non-governmental and community-based organizations
    f. Other
15. Has WASH FIT been included in the national curriculum for health care authorities and health workers?
16. Have you started implementing WASH FIT?
17. If you have conducted training but not yet started implementation, please describe next steps

C. SCOPE OF WASH FIT IMPLEMENTATION

18. In what year did implementation start?
19. Is WASH FIT implementation ongoing? *Note, to be considered ongoing, facilities must be regularly conducting assessments and making improvements or concrete plans exist to do so).*
20. If no, in what year did WASH FIT implementation cease?
21. Why did it stop?
22. What types of facilities have implemented WASH FIT?
    a. Primary care facility
    b. Hospital
    c. Temporary/mobile/camp facility
    d. Other
23. How many of the following facilities have implemented WASH FIT?
    a. Primary care facility:
    b. Hospital:
    c. Temporary/mobile/camp facility
    d. Other
24. In total how many are rural facilities?
25. In total how many are private facilities?
26. Overall, how is WASH FIT being rolled out? Select all that apply.
    a. Roll out nationwide, government-led
    b. Roll out in select regions, government-led
    c. Small-scale pilot, government-led
    d. Partner-led
    e. Other
27. Please list all organization or institutions involved in WASH FIT and how they coordinate.

28. Have the WASH FIT assessment indicators been contextualized/adapted for the country?
29. If yes, is this WASH FIT assessment Validated by the Ministry of Health?
30. Does the roll out of WASH FIT cover all seven domains? (water, sanitation, hand hygiene, health care waste, cleaning, electricity and management.)
31. If no, please indicate which domains the roll out of WASH FIT covers:
32. Is there any thematic focus to the WASH FIT roll out? (Select all that apply)
    a. Climate resilience and sustainability
    b. Gender equity, disability and social inclusion (GEDSI)
    c. Emergencies
    d. Quality of care/Quality improvement
    e. Integration with other health programme (e.g. IPC/AMR/patient safety)
    f. Other

D. INSTITUTIONAL ARRANGEMENTS AND POLICIES

33. Is WASH FIT formally endorsed by the Ministry of Health in policies/ legislation? Please specify policies and share link/upload a copy.
34. Please list relevant policies/legislations and include links if available
35. Is there a dedicated national focal point for WASH FIT and WASH in health care facilities in the government?
36. Is WASH FIT part of a costed roadmap or strategy for WASH in health care facilities?

E. DATA

37. How are WASH FIT assessment data collected at the facility by WASH FIT teams? (Select all that apply)
    a. Paper-based form
    b. WASH FIT Excel spreadsheet
    c. Online form – KoboToolbox
    d. Online form – mWater
    e. Other
38. Please provide a link to online data collection tools if available.
39. Are facility-level WASH FIT data shared with sub-national and national decision makers?
40. How often are the results shared?
    a. Annual
    b. Semi-annual
    c. Monthly
    d. Other
41. How are WASH FIT data used for decision making and by whom? (E.g. used in sector review, for allocation of the resources)

F. OUTCOMES RESULTING FROM WASH FIT

42. Has there been any evaluation of WASH FIT implementation?
43. Please provide links to any relevant supporting documents. *Consider impact assessments and reports, data (including before and after WASH FIT implementation and Improvements), user and staff satisfaction surveys.*
44. If no, please provide information on how you are planning to measure and document the outcomes of WASH FIT implementation in the future.
45. Which of the following outcomes have been identified as a result of WASH FIT Implementation? Select all that apply.

WASH, waste and electricity services

a. Improved water services
b. Improved sanitation services
c. Improved hand hygiene services
d. Improved healthcare waste management services on facility levels
e. Improved energy supply
f. Improved climate change resilience, sustainability, switching to low-carbon technologies

Patient and staff satisfaction

a. Improved patient satisfaction
b. Increase in care-seeking behaviour
c. Improved staff satisfaction and retention
d. Clarification of roles and responsibilities for WASH/IPC
e. Cost savings
f. Other

Institutional changes

a. Improved communication and collaboration between different health program at national/ sub-national level
b. Improved communication and collaboration between senior management, health care and support staff at facility level
c. Improved communication and collaboration with other stakeholders (e.g. local health agency, development agency)
d. Improved opportunities for dialogue between facility users/community and facility management around improvements in facility services, including WASH conditions
e. Increased awareness, knowledge, and understanding among staff of importance of WASH services
f. More regular capacity building and training activities for the health workforce
g. Other

Operations and management

a. Improved operation and maintenance of WASH, waste and electricity infrastructure
b. Improved managerial and operational procedures at health facilities
c. Improved record keeping of WASH consumables and improved management of supplies
d. Improved monitoring (operational and verification) and surveillance
e. Other

Budgets and financing

a. Better targeting of investments by health facilities/ national and sub-national health authorities to address key needs or quick wins
b. Increased allocation of funds from national / state / local government budget
c. Increased financial donor support/investment in system wide improvements
d. Increased resource allocation to supporting programs (e.g. training)
e. Other

46. Please list any other outcomes not previously mentioned
47. Has anything at the facility worsened as a result of WASH FIT? If yes, provide details.

G. BUDGETING & FINANCING

48. How is WASH FIT being funded? (Select all that apply)
    a. Government funds (MOH or other)
    b. Donor/partner funding
    c. Other
49. What percentage of funds are from each of the above sources?
50. What challenges are faced in accessing funds for WASH FIT implementation?
51. What costing data on WASH FIT implementation are collected? *Consider all data related to training, mentoring, consumables, upgrades to water and sanitation systems, operations and maintenance)*
52. Have WASH FIT costing data and/or tracking of costs and financing needs helped support greater resourcing for WASH overall?
53. If yes, please explain what data were used, how, and who was influenced.

H. CHALLENGES AND ENABLING FACTORS

54. What have been the main barriers to implementing WASH FIT?
55. What strategies have been used to resolve these barriers? *e.g. seeking external support, discussing of problems with senior management*
56. What additional support do facilities need to successfully implement WASH FIT?

I. OTHER

57. Please include any additional information related to WASH FIT not previously covered.

Annex 3: Further reading: WASH FIT publications

The following papers are presented in chronological order.

1. Weber N, Martinsen AL, Sani A, Assigbley EKE, Azzouz C, Hayter A et al. Strengthening healthcare facilities through water, sanitation, and hygiene (WASH) improvements: a pilot evaluation of "WASH FIT" in Togo. Health Secur. 2018; 6 (1) (https://doi.org/10.1089/hs.2018.0042).
2. Weber N, Patrick M, Hayter A, Martinsen AL, Gelting R. A conceptual evaluation framework for the water and sanitation for health facility improvement tool (WASH FIT). J. Water Sanit. Hyg. Dev. 2019; 9 (2): 380–391 (https://doi.org/10.2166/washdev.2019.090).
3. Maina M, Tosas-Auguet O, McKnight J, Zosi M, Kimemia G, Mwaniki P. Extending the use of the World Health Organisations' water sanitation and hygiene assessment tool for surveys in hospitals – from WASH-FIT to WASH-FAST. PLoS ONE. 2019; 14(12):e0226548 (https://doi.org/10.1371/journal.pone.0226548).
4. Maina M, Tosas-Auguet O, McKnight J, Zosi M, Kimemia G, Mwaniki P. Evaluating the foundations that help avert antimicrobial resistance: performance of essential water sanitation and hygiene functions in hospitals and requirements for action in Kenya. PLoS ONE. 2019; 14(10): e0222922 (https://doi.org/10.1371/journal.pone.0222922).
5. Ashinyo ME, Amegah KE, Dubik SD, Ntow-Kummi G, Adjei MK, Amponsah J et al. Evaluation of water, sanitation and hygiene status of COVID-19 healthcare facilities in Ghana using the WASH FIT approach. J. Water Sanit. Hyg. Dev. 2021; 11 (3): 398–404 (https://doi.org/10.2166/washdev.2021.254).
6. Hirai M, Nyamandi V, Siachema C, Shirihuru N, Dhoba L, Baggen A et al. Using the water and sanitation for health facility improvement tool (WASH FIT) in Zimbabwe: a cross-sectional study of water, sanitation and hygiene services in 50 COVID-19 isolation facilities. Int. J. Environ. Res. Public Health. 2021; 18(11):5641 (https://doi.org/10.3390/ijerph18115641).
7. Sehar B, Yaqoob M, Hanif A, Akhter AM, Gilani SA. Development of health care facilities in rural areas of District Bagh, Azad Jammu, and Kashmir: a study of the application of the WASH-FIT tool. Journal of Sheikh Zayed Medical College (JSZMC). 2022; 13(3); Article 3 (https://doi.org/10.47883/jszmc.v13i3.235).
8. Kabir A, Shahnewaz MM, Arif HM, Assefa WB, Haque BATMR, Hayter A et al. WASH FIT implementation in Rohingya camps in Cox's Bazar Bangladesh – results after 1 year. J. Water Sanit. Hyg. Dev. 2023; 13(11): 866–874 (https://doi.org/10.2166/washdev.2023.268).
9. Lineberger H, Cronk R, Kpodzro S, Salzberg A, Anderson DM. Does WASH FIT improve water, sanitation, and hygiene and related health impacts in healthcare facilities? A systematic review. medRxiv. 2024 (https://doi.org/10.1101/2024.04.05.24305396).
10. Kpodzro S, Cronk R, Lineberger H, Lansing L, Anderson DM. Implementation and adaptation of WASH FIT in healthcare facilities: a systematic scoping review. medRxiv. 2024 (https://doi.org/10.1101/2024.08.15.24312073).

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