AN EVALUATION OF THE SWISS WATER AND SANITATION CONSORTIUM (SWSC) SIGNATURE APPROACH OF WASH FIT IN HEALTHCARE FACILITIES

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DISCLAIMER

The document covers an external evaluation for WASH in healthcare facilities (WASH FIT) and its implementation in targeted countries (Mali, Benin and Nepal). The views expressed herein should not be taken in any way to reflect the official opinion of Swiss Water and Sanitation Consortium (SWSC), and Oxfam Consults is not responsible for any use that may be made of the information it contains.

The final evaluation report provides substantial evidence based on the evaluation data to understand some of the research themes outlined in the inception report.

The views expressed in this paper are strictly those of the Evaluation Team.

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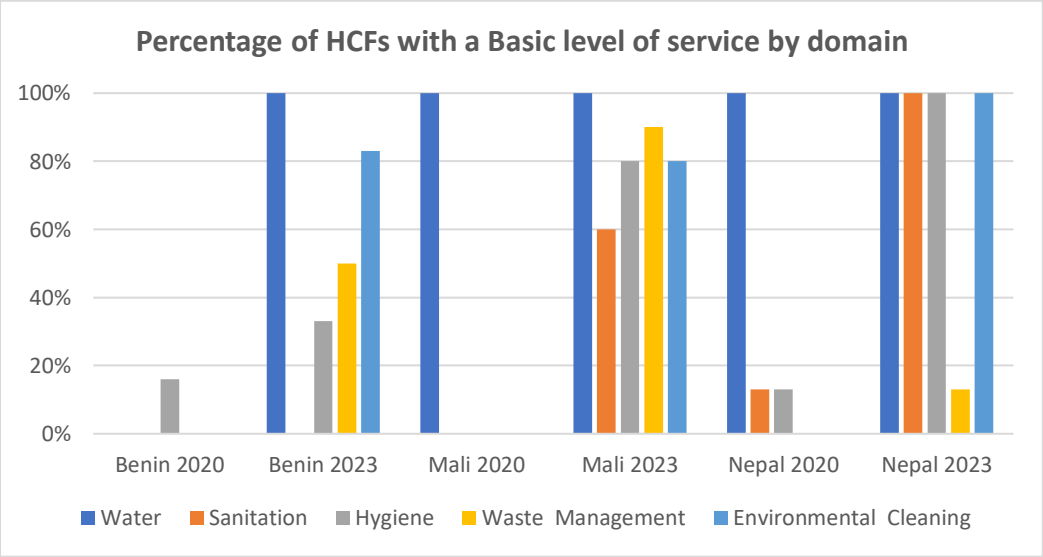
EXECUTIVE SUMMARY

WASH FIT is a framework to guide continuous quality improvement in WASH in healthcare facilities (HCFs). It addresses five primary WASH domains: water, sanitation, healthcare waste management, hand hygiene and environmental cleaning. This external evaluation, commissioned by SWSC, examines the relevance and value of WASH FIT for health system strengthening and highlights learning and good practices to inform the next phase in 2023–27. It examines three projects in different countries: Benin (led by SWSC's implementing partner Helvetas) and Mali and Nepal (led by SWSC's implementing partner Terre des Hommes (Tdh)). It examines the projects through the lens of the six Development Assistance Committee (DAC) criteria and five research themes that assess the changes delivered in WASH service levels and their impacts, stakeholders' perspectives and the extent to which WASH FIT is integrated into state health services.

The methodology provides a consistent (and therefore comparable) approach for each of the three countries. It included a secondary document review and primary data collection through semi-structured key informant interviews, focus group discussions and site observations. The HCFs selected provided a range of scales and service levels, based on their different (previously measured) levels on the Joint Monitoring Programme (JMP) service ladder. Four HCFs were visited in both Benin and Mali, and five in Nepal.

All three projects were effective as measured by their improvement in JMP WASH service level indicators and as defined by SWSC's criteria of 'success', with Benin scoring 83% and Mali and Nepal 100%.



Although significant, without a baseline of comparison or control WASH projects, these rates cannot be wholly attributed to the WASH FIT approach. The new water supply infrastructure in Benin would have resulted in improvements even without WASH FIT. Yet the majority of HCFs in Nepal and Mali already had established water supply infrastructure, and both projects have seen strong improvements in their service levels for sanitation, hygiene and environmental cleaning. In addition, SWSC's funding leveraged Investments in WASH from the community or government in all three countries, increased staff motivation and, in some HCFs, improved community relationships.

The evaluation asked what factors enabled or hindered these changes. Enabling factors, common to all or most projects, included an innovative and active implementing partner, the active engagement of the local or national government, high levels of integration with local or national systems, ambitious and motivated HCF managers, a participatory approach and motivated communities. The WASH FIT tool was enabling through its participatory approach, simple and easily understood indicators, its introduction of structured mechanisms (cleaning rosters, monitoring, needs and risk assessments) and its clear outputs of workplans for day-to-day and future operations and simple, easily communicated improvement plans that can be costed – invaluable for advocacy and fundraising.

In Benin – and Mali particularly, where WASH FIT was implemented in 250 HCFs between 2016 and 2022[1] by WHO, UNICEF, USAID, Tdh, IRC WaSH, WaterAid and WorldVision – the approach has often been enthusiastically embraced by government. WASH FIT is well practised at the HCF level, and there are early signs of acceptance of the tool at the national level. For example, in Nepal the national roadmap for WASH in HCFs acknowledges that the WASH FIT tool should be implemented in health posts across the country and uses WASH costing developed by Tdh.

WASH FIT is relevant to the needs of HCFs and local populations and coherent with existing national policies and standards for WASH in HCFs. However, the sustainability of the improvements made by the projects is uncertain. Hindrances mostly concern funding of ongoing operation and maintenance (O&M) and further improvements, degrees of ownership by local government and integration with national policies. Government support has not translated into government finance in all project areas. Budgets for maintenance and infrastructure rely on external funding. Lack of money for expensive investments hinders improvements in key areas such as solid waste management. Variable leadership and weak community engagement are additional vulnerabilities in some HCFs. As WASH FIT is not yet embedded in the health system, high staff turnover is an issue for all the projects, leading to lost institutional knowledge about the approach at all levels, from individual HCFs to senior government officials.

It was not possible to directly compare the efficiency of each project, as the context and investment needs for each were significantly different. However, respondents and project data indicate that costs were reasonably low, and that the projects were implemented on time. With one exception in Nepal, the selected investments were appropriate for the needs. The projects have had a significant positive impact on the cleanliness of the working environment, staff motivation and safety. Anecdotally, infection rates have been reduced and patient attendance has increased in some HCFs; however, no reliable monitoring data was available to confirm this. Interviewees were consistently positive about the project, as were the patients: 'People want to have their babies here [a Benin HCF], 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.'

Overall, the WASH FIT tool and process have been widely welcomed at all levels within the health systems of Benin, Mali and Nepal, from the individual HCF all the way up to the Ministry of Health (MoH). The process is seen as relevant to both small HCFs and larger hospitals at national level. It aligns with the existing hygiene strategy within healthcare, as documented in the national health policies of all three countries. In Benin and Mali, where no tool has

[1] Workshop for adapting WASH FIT indicators, Ségou, December 2022.

previously been in place to support improved WASH in HCFs, WASH FIT is regarded as the preferred tool by the MoH. In Nepal, where an existing monitoring system (the Minimum Service Standards (MSS)) is in place, WASH FIT is seen as a complementary tool and the integration of the WASH FIT indicators into MSS is seen as the way forward.

However, the integration of WASH FIT will not be sustainable without governments and health authorities providing support for ongoing staff training and funding the O&M of infrastructure through the municipal budgeting process. Although access to funding is likely to remain a challenge for HCFs in improving and maintaining services, the success of advocacy to date has indicated that additional funds can nevertheless be raised. Improved monitoring of key impact indicators, such as infection rates, is essential to add to WASH FIT's evidence base and to strengthen its fundraising capacity and influence. Adequate support, resourcing and training in advocacy could yield tangible financial results. Where highly motivated HCF managers have been identified, responsibility for municipal-level advocacy should be devolved to HCF personnel and management committees. National-level advocacy with government, other agencies implementing relevant projects and major donors (such as USAID) is time-consuming but critical to wider take-up, and teams need dedicated, additional advocacy resources.

CHAPTER 1: INTRODUCTION

SWSC's assessment of WASH FIT to date is that, while promising, its use within WASH in HCF programming lacks a solid evidence base and proof of concept. SWSC has developed an evidence-building strategy for Phase III that is being rolled out in 2022–23. As part of this strategy the Consortium Management Unit (CMU) has commissioned this in-depth external evaluation for WASH in HCFs, focused on three projects each in different countries that have demonstrated significant involvement and progress in implementing WASH FIT. The three countries considered are Benin, where the project is led by SWSC's implementing partner Helvetas, and Mali and Nepal, where the projects are led by implementing partner Terre des Hommes (Tdh). Detailed individual evaluation reports are available for each country in Annexes E, F and G. This report provides a synthesis of the evaluation findings across the three projects and a comparison of the learning and good practices within those differing contexts.

1.1 EVALUATION CRITERIA AND RESEARCH THEMES

This evaluation sets out to examine the relevance and value of WASH FIT for health system strengthening and to highlight learning and good practices in methodologies and processes to inform future phases of SWSC programming. It focuses on evidence indicating that the signature approach does or does not deliver results and on how it works best.

The following criteria are evaluated:

1. EFFECTIVENESS: The extent to which the signature approach achieved, or is expected to achieve, its objectives.
2. EFFICIENCY: The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.
3. SUSTAINABILITY: The extent to which the net benefits of the intervention continue or are likely to continue.
4. IMPACT: The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended higher-level effects.
5. RELEVANCE: The extent to which the intervention objectives and design respond to the needs of beneficiaries and to the policies and priorities of national institutions and in-country partners, and the extent to which they will continue to do so if circumstances change.
6. COHERENCE: The compatibility of the intervention with other interventions in a country, sector or institution.

Furthermore, the following specific research themes for WASH in HCF programming through WASH FIT have been identified and are considered:

1. Quantitative and qualitative changes in WASH service levels (as per JMP service ladder) and any correlation with the use of WASH FIT over time (how WASH FIT was used and by whom, number and frequency of cycles, etc.).
2. Comparing changes in WASH service levels among the selected projects while identifying enabling or hindering contextual factors (related to WASH FIT or other programming aspects).

3. Stakeholders' perspectives on the value of WASH FIT (HCF medical staff, non-medical/cleaning staff, community management committee members, local government authorities, health authorities).
4. Progress on integrating WASH FIT within municipal and/or health system service provision, including planning processes and resource/service provision and how results were achieved (including through advocacy).
5. Correlation of improved WASH in HCF services to changes, if any, in i) the number of annual patient visits; ii) staff experiences of infection prevention and control measures and safety of working environment; and iii) HCF revenue over the life of the project.

1.2 WHAT IS WASH FIT?

WASH FIT is a framework designed to guide a continuous cycle of improvement, through assessments, prioritization of risk and defining specific, targeted actions for WASH in healthcare facilities. WASH FIT covers five primary WASH domains: water, sanitation, healthcare waste management, hand hygiene and environmental cleaning. Each area includes a list of indicators and targets for achieving minimum standards for maintaining a safe and clean environment that contributes to infection and prevention control. In addition, there are two domains that are needed to support WASH infrastructure and practices: energy and environment, and management and personnel. Finally, there are two cross-cutting themes, with indicators integrated across the seven domains: climate resilience, and gender equality and inclusiveness (GEI).

Figure 1: WASH FIT framework

For the purposes of this evaluation only the five primary WASH domains were reviewed, although there was some consideration of gender equality and inclusiveness. Energy, environment and GEI were included by WHO/UNICEF in the second edition of WASH FIT (April 2022) and there was no opportunity to integrate these into the WASH FIT programming cycles in Phase III.

CHAPTER 2: EVALUATION METHODOLOGY

The methodology was designed to provide a consistent (and therefore comparable) approach for each of the three countries. Each country evaluation then adapted the methodology according to its specific context. Different tools and processes were used during the process of evaluating the project. The study began with a secondary document review, which was followed by multiple online interviews and collection of other primary data, including key informant interviews (KIIs), focus group discussions (FGDs) and site observation. Data collected during the interviews and observations was recorded on paper by hand; audio recording of interviews, to enable clarification of report details, was carried out with interviewees who were willing to be recorded. These recordings have been deleted in line with ethical research protocols.

2.1 DOCUMENT REVIEW

As part of the review process, a range of project documents provided by the CMU was reviewed. The documents reviewed included project proposals, budgets, reports, costings and other key datasets such as Facility Evaluation Tool (FACET) data and JMP indicators. In addition to the project documents, national standards were reviewed in each country: the National Policy for Health (2018–30) in Benin; and in Nepal the National Standard for WASH in Health Care Facilities (HCF), the Handbook on Environmental Health, Healthcare Waste Management, Water, Sanitation and Hygiene (2020) and the operation and maintenance (O&M) document of Thakurbaba Municipality. The draft National Strategic Plan (2023–27) for Mali is not yet available for review but was referred to by some of the key informants who were involved in writing it.

2.2 ONLINE INTERVIEWS/F2F MEETINGS

Semi-structured interviews were carried out online with the CMU while face-to-face and/or online meetings were conducted with country project teams to understand key project-related information and to share the evaluation methodology and create the field visit plans. The findings from the field-level studies were shared and/or discussed with the country teams to validate all the information received from the field where necessary.

2.3 FIELD RESEARCH

In consultation with the country project teams, HCFs were selected for field visits to interview staff and carry out detailed observation, using semi-structured interviews and an observation checklist. The intent was to choose up to four HCFs for evaluation in each country based on different success rates (according to their JMP outcomes), and with a range of scales and available facilities. However, the HCFs in Benin and Mali were necessarily restricted by security

concerns and therefore visits were made to those HCFs that the evaluators were able to safely access.

Four HCFs were visited in Benin: Libanté, Saonzi and Bobena in Segbana District and Sonnou in Banikoara District.

Four HCFs were visited in Mali: Zanabougou, Wondobougou and Diamarabougou community health centres and the Markala reference health centre.

Five HCFs were visited in Nepal: Khairapur HCF, Khairichandranpur, Sanoshree, Mohammadpur, Deudakala HCF (observation only).

2.3.1 Key informant interviews (KIIs)

HCF staff were interviewed using structured questions to enable data gathering on learning and good practices on the methodologies and processes used by the facility. Local and national government representatives were interviewed through semi-structured interviews to gain insight into the engagement of government and the integration of WASH FIT into national and local health system service provision, protocols and standards. The list of key informants (KIs) for each country is presented in the individual country report annexes.

A comprehensive list of questions was developed to meet the requirements of the terms of reference (ToR). The KIs represented a broad range of activities and actors, both within and outside of the project, and therefore the same questions were not necessarily asked of each KI, although they were all selected from the list. The full list of interview questions is provided in Annex A.

2.3.2 Focus group discussions (FGDs)

FGDs with patients and visitors were conducted where possible in each HCF to understand how WASH FIT has made a difference to their experience of using WASH facilities in the HCFs. The FGD questions are provided in Annex B.

2.3.3 Observation

Observation of the status of WASH in HCFs (JMP service levels and functionality) was compared with the most recent SWSC FACET data in the selected HCFs. The details of the observations are provided in the individual country reports. The observation checklist is provided in Annex C.

CHAPTER 3: FINDINGS

3.1 EVALUATION CRITERIA

3.1.1 Effectiveness

The extent to which the signature approach achieved, or is expected to achieve, its objectives.

SWSC defined the criteria for the project to be 'successful' as:

a) any services at 'No service' at baseline must have progressed to at least 'Limited' service by the end of the project;

b) services at 'Basic' level at baseline must maintain the same level by the end of the project; and

c) at least one cycle of WASH FIT has been implemented (all five steps).

With this definition of 'successful', Benin can be judged to have an 83% project success rate. This is primarily due to the provision of water infrastructure at the HCFs, which has enabled significant improvements in the water and environmental cleaning WASH FIT domains from a baseline measure of 'No service'. However, no progress was made at any of the HCFs on sanitation, which remain at 'Limited' service, and only one HCF improved the indicator score for hygiene.

In Mali and Nepal, the project success rate is 100%: no services are at 'No service' level, all services that were at 'Basic' level at baseline have remained so, and at least one cycle of WASH FIT has been implemented.

Without a control project for comparison that has the same infrastructure but does not apply the signature approach, it is not possible to say whether these success rates can be attributed solely to the application of that approach.

The evaluation sought to find factors that have contributed to SWSC's assessment of success, exploring additional factors and results.

Factors that have an impact on the effectiveness of the approach and are common to all/most projects:

- Innovative and active implementing partner
- Engagement of the local or national government
- Level of integration with local or national systems
- Leveraging of funds from local municipalities/government
- Ambitious and motivated HCF manager
- Motivated staff
- Increased awareness of cleaning/infection protection and control
- Engaged community (through dialogue and participatory approach)
- Improved HCF/community relations (partly through provision of new services, also through a participatory approach).

Factors that may explain the effectiveness of the WASH FIT tool itself:

1. Participatory approach with an inclusive WASH FIT team
2. Easy-to-understand indicators
3. Output of a clear, prioritized, structured workplan for future improvements
4. Output of a clear, structured workplan for day-to-day operations
5. Facilitated costing and budgeting of improvement plans
6. Tangible, simple tool for advocacy.

3.1.2 Efficiency

The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.

Each of the projects has made significant investments in infrastructure and the benefits that this has delivered are significant for the implementation of the WASH FIT approach.

A table comparing investment costs (in CHF) is provided in Annex D.

Overall, the cost per beneficiary is shown as CHF 33.00 for Benin, CHF 3.80 for Mali and CHF 1.37 for Nepal. The significantly higher cost per beneficiary in Benin reflects the need for greater investment in basic WASH infrastructure at the start of the project: CHF 166,207 compared with CHF 55,978 in Mali and CHF 34,928 in Nepal. A greater investment was also required in training and orientation to operate and maintain this new infrastructure: CHF 32,869 in Benin compared with CHF 12,066 in Nepal.

There is no data available to indicate how the overall cost per beneficiary compares with similar projects in each country, which would be a more accurate measure of the economic impact of the signature approach. As the investment needs for each of the three projects were significantly different, it is also difficult to provide any constructive comparison of economic value.

All KIs stated that the time and effort involved in executing the WASH FIT process have been worthwhile for the positive outcomes they have seen in the service domains. The engagement of each HCF with community health committees to agree where investment should be made has mostly ensured that these investments have been targeted to priority issues within each HCF. A good example of this is the installation of tiling in the treatment rooms at Wondoubougou HCF (Mali) to improve the ease and effectiveness of environmental cleaning.

Where a project has prioritized improving its WASH FIT score rather than needs as prioritized by the community/HCF, funds have not necessarily been used efficiently. One example is the installation of a biosand filter at Sanoshree HCF (Nepal), where insufficient research was carried out to confirm whether a filter was necessary. In addition, almost all the toilets adapted for people with disabilities installed in the HCFs are focused on physical immobility, but with minimal investment they could have been made friendly for people who are vision-impaired or who need hearing aids. These two examples highlight the need for sufficient backstopping support from technical persons in the WASH FIT team to ensure that these improvements are appropriate.

ll projects stated that budgets for supplies and maintenance, which are provided by local government or the municipality, have been insufficient. Average annual costs for WASH supplies and consumables per HCF are CHF 5,409 in Benin, CHF 20,8192,258 in Mali and CHF 1,171 in Nepal. The high figure for Mali is caused by the much higher need for supplies and consumables in the CSREFs (district-level referral health centres), which operate at a larger scale with more beneficiaries than the smaller community healthcare centres (CSCOM)s. Annual costs for WASH supplies and consumables for the CSCOMs in Mali are CHF 1,304, comparable to the costs for HCFs in Nepal, whilst those for the larger CSREFs have significantly higher costs of CHF 4,482 reflecting their operation at a larger scale with more beneficiaries. It is unclear why the costs for the Benin HCFs are so high and the data provided should be reviewed. None

of the HCFs in Benin had soap available at handwashing points, and HCF managers stated that this was due to limited funds. Likewise, KIs in Nepal highlighted that the budget for supplies and maintenance were not sufficient.

In order to make a worthwhile comparison between the projects it would be necessary to conduct an in-depth financial evaluation, reviewing supplies and maintenance data by HCF to ensure that it is equivalent, financial data from all parties within Phase III and financial data on investments within any of the HCFs in the first two phases of the project and from any other organizations (e.g. solar lighting in Benin HCFs). This data was not comprehensively available to the evaluators and so this financial assessment provides only a broad comparison. To fully understand the efficiency of the financial investments made for each of the projects, a detailed financial evaluation and analysis would be recommended.

It must be noted that the investments made in many of the HCFs have provided an incentive to raise funds for other improvements. In Bobena HCF (Benin) the Mayor's Office (Mairie) funded an extension of the water supply to a second standpipe elsewhere in the village. In Zanabougou CSCOM (Mali) community leaders have funded the installation of three latrines in health centres. In Nepal 30% of the total project costs were provided by the local government on the basis of the WASH implementation plan developed through the WASH FIT process.

Overall, it can be concluded that the intervention has been carried out in a timely way and with reasonable economy.

3.1.3 Sustainability

The extent to which the net benefits of the intervention continue or are likely to continue.

In all cases, the investments made in WASH infrastructure will continue to benefit the HCFs and communities beyond the lifetime of the project. However, there are common themes regarding threats/opportunities for longer-term sustainability.

3.1.3.1 Funding

Ongoing funding for all the project areas is a concern. In Benin there is already a shortfall of funding for WASH supplies and consumables and, although the HCFs have a dedicated budget for maintenance, some of the WASH facilities (such as handwashing stations and incinerators) have not been maintained, indicating that the maintenance budget is insufficient. There is no budget line in the local government budget for HCFs. Similarly, in Mali the investments made by the community health committees are not enough to cover day-to-day needs. Here the town halls have integrated a budget line but have not allocated a dedicated budget. In Nepal, although funding plans have been made for O&M, and an O&M account has been established in seven out of eight HCFs along with funding allocations in some, staff are not confident that O&M funding would continue in their HCFs if there were heavy cuts to the budget at municipal level (except in Thakurbaba.)

Establishing a clear mechanism for funding from local government is essential to the sustainability of WASH FIT in all the projects. In Benin, the improvement plans issuing from the

WASH FIT process are sent to the manager responsible for environmental sanitation within the municipality and could be included within the budgeting process. In Mali, the budget line for O&M has been established and requires advocacy to ensure that the funding is provided. In Thakurbaba Municipality in Nepal, an O&M policy and procedure have been endorsed and a separate fund for O&M has been allocated, and lessons can be learned from this. The HCF staff recognize the important role that the WASH FIT scoring system has played in advocating to local government for this financial support, and the local government in Thakurbaba is more sensitized to WASH in HCF needs than other municipalities.

In all three countries there is an opportunity to use the improvement plans developed by the WASH FIT assessment to advocate for a process of regular and reliable funding in the local municipal budget. Current advocacy levels within Phase III of the SWSC project have been necessarily limited in Benin while the approach was being established within the HCFs. In Nepal advocacy has been required over multiple municipalities, which has limited the impact that it could achieve, particularly as small teams are fully occupied with implementation. Phase IV must include dedicated resources to enable advocacy at a range of levels within local and national governments.

3.1.3.2 Ownership by local government

While local government in all three countries is broadly supportive of WASH FIT and is showing engagement with the projects led by Tdh and Helvetas, there is a lack of ownership of the signature approach. In Benin, the project is the first and only example of WASH FIT currently in action and there have been limited project resources available to build a solid understanding at all levels within local government departments. The local government KIs regard Helvetas as the lead implementer, and increasingly municipalities are asking for the WASH FIT process to be implemented in their districts. In Mali there has been a commitment by local government but no resulting financial investment, aggravated by the unstable security context and ongoing uncertainty over the schedule for municipal elections. Although some municipalities are beginning to include specific budget lines, no funds are specifically allocated In Nepal and health and education are generally not priorities for local leadership, as they are not seen as topics that might help with re-election to government; however, strong advocacy in Thakurbaba Municipality has shown that this challenge can be overcome. A continuation of dedicated resources for advocacy is required in Phase IV.

3.1.3.3 Integration in national policy/guidelines

Progress towards integration within national policy and guidelines varies significantly by country. In Benin and Mali there is strong support for WASH FIT as it is seen as already aligning with national policy. In Benin there is a strong indication that the government will include WASH FIT in policy and guidelines at the next revision of national policy. New national policy guidelines have just been drafted in Mali and KIs have stated that the WASH FIT indicators have been integrated into these guidelines. In Nepal, WASH FIT is currently regarded by HCF staff solely as a parallel tool for monitoring rather than as a tool for planning, implementation and monitoring. There is a common understanding that it can add value to the existing Minimum Service Standards (MSS) self-assessment tool, but KIs stated that there was no strong evidence to justify a future plan for integrating this into the MSS. However, WASH FIT costing developed from the project in Nepal has been used as a reference for developing a national costed roadmap for WASH in HCFs. This is a significant achievement to contribute to the

national roadmap through the investments made by Tdh, despite other significant actors in play in healthcare. In addition, the national roadmap states (about WASH FIT): 'Health and WASH sectors in Nepal should gradually extend collaboration in institutionalizing and strengthening the implementation of this tool at scale in hospitals and suitably in other HCFs by familiarizing its principles and methodologies at the provincial and district level authorities.'

Further advocacy is required in all three countries together with WHO and UNICEF, who are key stakeholders in establishing WASH FIT globally.

3.1.3.4 Staff and community engagement

All projects identified the engagement of the HCF team and the local community as being essential to the success of WASH FIT. Strong and dynamic leadership from HCF managers and community health committee leaders have shown clear benefits to projects such as that in Bobena (Benin). Where the HCF manager is not committed to the collaborative approach and the community leadership is weak, the opportunities to advocate for funding are much reduced.

3.1.3.5 Staff turnover

A major challenge to maintaining staff engagement is that of staff turnover, which affects both HCF and government staff. At many of the HCFs, new staff members have inherited a WASH FIT process in which they have not been involved from the beginning. New government staff are not aware of the existence of WASH FIT. Ongoing training is required to ensure that each new staff member has been trained in the WASH FIT process, and clear handover mechanisms are needed to ensure that knowledge is not lost in the process.

The overall conclusion is that the continued effective application of WASH FIT within the HCFs in all projects will not be sustainable without the government and health authorities fully adopting the process and providing support for ongoing training of staff and funding of the O&M of infrastructure. This is likely to be easier in countries that have no existing continuous quality improvement or monitoring tool for WASH in HCFs, such as Benin , where WASH FIT can fill that gap.

In all three countries, the opportunity for ensuring sustainability will be impacted by the advocacy of Phase IV.

3.1.4 Impact

The extent to which the intervention has generated or is expected to generate significant positive or negative, intended, or unintended higher-level effects.

The target population
The projects have had a significant positive impact upon the communities that the HCFs service. Community relations, specifically between the HCFs and the community HCF management committees, are reported by all projects to have improved and in most there is strong engagement by the committees with the WASH FIT process. All HCF staff and visitors have welcomed the increased cleanliness of the working environment and the positive impact that this has had in terms of staff motivation and safety. In Nepal HCF staff have witnessed

improved cleanliness from visitors, who now refrain from dropping litter in the facility and instead use the bins provided. Both Benin and Nepal reported an improvement in staff understanding of the potential risks of unhygienic behaviour and the link between infection control and environmental cleaning. However, no quantitative data was available to confirm whether infection control has improved.

The health system

WASH FIT has had impacts on the systems of all the HCFs in which it has been implemented, in particular regarding environmental cleaning and the segregation of solid waste. The application of the indicators, providing a simple way of measuring the five WASH domains in HCF services, has enabled both HCF staff and the community to see how the facilities have improved services and prioritized where funds for further improvement should be allocated. It has also changed social norms in terms of improving dialogue between the staff of HCFs and the communities they serve. In Benin and Mali, where no monitoring system has been in use beyond the JMP indicators, there is a clear appetite for adopting this system within all HCFs to support monitoring, while creating a participatory and continuous quality improvement process. KIIs with HCFs in Nepal gave the impression that they consider WASH FIT to be a monitoring tool similar to MSS, though HCFs do also use it as a planning tool. There is a consensus that the WASH FIT indicators should be embedded within the MSS.

There is enough evidence to show that if the WASH FIT indicators are used to improve service levels, then with proper financing WASH services in HCFs can be improved.

In-country mainstreaming of WASH FIT

Plans are in place to implement WASH FIT more widely in all three countries, with support from the respective Ministries of Health. In Benin, five of the 12 regional departments have requested that plans for the WASH FIT approach be implemented in their areas; while in Mali Tdh is implementing WASH FIT in all its interventions in health facilities. The WASH FIT approach is also supported by WHO, UNICEF, USAID, World Vision, IRC WaSH and WaterAid (which pioneered the approach in Mali). In Nepal Tdh, together with WHO and UNICEF, is advocating to integrate WASH FIT in national policy and to practise and scale it up across a wider area.

In all three countries, WHO and UNICEF are key stakeholders in advocacy for the implementation of WASH FIT. Helvetas is the first and only organization implementing the approach in Benin and is viewed as a key partner in this effort by UNICEF and the national government. Tdh plays an active role within the WASH taskforce in Mali and is viewed as a significant partner in implementation at local level. WHO has indicated that it would welcome Tdh being more active and vocal at national level. In Nepal, the Tdh project is influencing the national roadmap for WASH in HCFs, and this is acknowledged by the government. Tdh is one of the players advocating for WASH FIT in the health sector, and although the Department of Health Services considers WHO and UNICEF to be the biggest players, Tdh is way ahead in implementing WASH FIT. It has even provided technical support to UNICEF in implementation and is currently scaling up work in two provinces of Nepal to support the government in identifying appropriate technology for waste management in HCFs. Its work in Bardiya is considered to be one of the best implementations of WASH FIT in Nepal.

3.1.5 Relevance

The extent to which the intervention's objectives and design respond to the needs of beneficiaries, and the extent to which they will continue to do so if circumstances change.

The HCFs in Benin lacked a water supply, which is fundamental to the provision of hygiene and environmental cleaning, and so the installation of water supplies was essential to meet beneficiary needs. In Mali, the targeted HCFs had basic water services, which enabled the teams to significantly improve hygiene, sanitation and waste management, especially in CSCOMs. In Nepal improvements were also made in the areas of hygiene, sanitation and environmental cleaning but there were limited improvements in waste management in HCFs. However, Tdh has led some innovative work in support of the government to identify appropriate technology for waste management by generating evidence on waste segregation and categorization across HCFs. This is a good progress in building more evidence and knowledge in the waste management sector.

All KIs stated that the WASH FIT process and design resulted in a clear, structured approach to identifying and prioritizing improvements in WASH facilities within HCFs. The collaborative approach, when correctly implemented and with the appropriate research, enables the needs of beneficiaries, i.e. staff, patients and visitors, to be considered and prioritized.

In Benin, WASH FIT was in an early stage of adoption during the COVID-19 pandemic and was seen as a constructive approach to aiding infection control.

In Mali during COVID-19, to ensure improvement in WASH services, the tool was adapted to a rapid WASH FIT version and was adopted by a WASH task force in health centres. It enhanced the implementation of the approach despite the restrictions and challenges.

3.1.6 Coherence

The compatibility of the intervention with other interventions in a country, sector or institution, and with the policies and priorities of national institutions and in-country partners.

Stakeholders in all three projects at national and regional levels recognize WASH FIT as a valuable tool with strong alignment with existing national policies and standards for WASH in healthcare facilities.

Benin is less advanced in implementing any interventions in WASH in HCFs than either Mali or Nepal. The WASH FIT project led by Helvetas is seen as a significant step forward in making improvements in this area and Helvetas is viewed as the leader in implementation. The MoH is firmly supportive of the initiative and has indicated that WASH FIT will be integrated into the new national policy guidelines for WASH in HCFs.

Between 2016 and 2022, 250 health centres in Mali were implementing WASH FIT, supported by various partners. The WASH taskforce in health centres coordinated by the MoH, in which Tdh actively participates, is a forum for exchange and learning around this approach. Tdh has piloted innovations in the approach by proposing the use of FACET for evaluating WASH needs and WASH service levels in order to support authorities in selecting HCF for interventions with WASH FIT, and the creation of an off-the-shelf version of RANAS for determining decisive factors in the

design of behaviour change interventions for hand hygiene and waste segregation. The WASH FIT indicators contextualized for Mali as part of the adaptation of the WASH FIT workshop are now integrated into the DHIS2 health data management system.[1]

In Nepal, following the collective engagement of different actors, including Tdh, at the national level, the national roadmap for WASH in HCFs 2023–30 acknowledges the need to implement the WASH FIT approach at all levels of HCFs. Tdh was requested to provide technical backstopping support in Madhesh Pradesh (Terai) to assist UNICEF in implementing WASH FIT. However, national government KIs stated that there was not enough evidence from the investment made by Tdh to change national policy. Nevertheless, at the national level in Nepal, the programme implemented by Tdh is coherent with interventions by other actors. Tdh's current programme has provided practical evidence from the implementation of WASH FIT in HCFs for updating WASH FIT II at the country level. In addition, the WASH FIT costing developed by Tdh through the programme has been used as a reference while developing the national roadmap for WASH in HCFs. Tdh is working very closely with WHO and UNICEF and is also a member of the Thematic Working Group and technical working group where all implementations of WASH in HCFs are discussed. This has reduced the risk of any duplication and has increased the coherence of the implementation.

USAID has been active within Benin, working on behaviour change for the prevention of infection in HCFs for the past five years, but it has not engaged with WASH FIT. In Nepal, USAID is the largest investor in the work of Improving WASH in HCFs but it has not used the WASH FIT approach. However, in Mali USAID is working actively with the approach and took an active part in the national workshop for contextualizing the WASH FIT indicators.

The lack of engagement of USAID with WASH FIT in both Benin and Nepal is a significant concern for any progress of the approach within other institutions. Advocacy to USAID is recommended to understand where there may be opportunities for the organization to adopt or integrate WASH FIT within existing or future programmes.

CHAPTER 4: RESEARCH THEMES

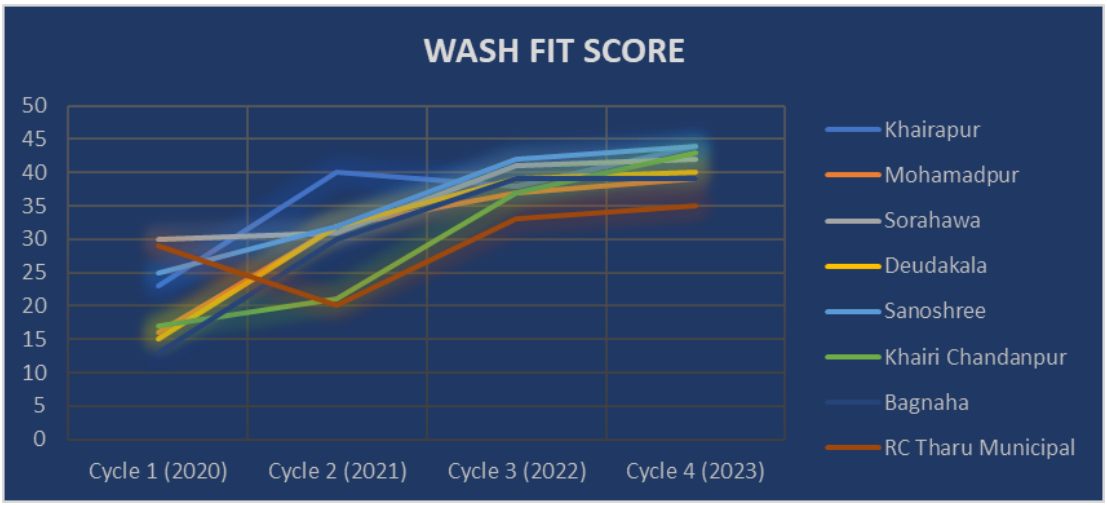
4.1 QUANTITATIVE AND QUALITATIVE CHANGES IN WASH SERVICE LEVELS (AS PER JMP SERVICE LADDER)

The JMP-defined service levels are used for reviewing quantitative and qualitative changes in WASH service levels in Benin, as there is insufficient WASH FIT data from projects where only one WASH FIT cycle has been completed. All HCFs in all three of the projects have been successful in at least maintaining their baseline level of service by the end of the project, and many have made significant improvements. For Benin, it is not clear how much of the

[1] DHIS2 is a free and open-source software platform for the collection, reporting, analysis and dissemination of aggregate and individual-level data. The most common use of DHIS2 is for health data, where it can be implemented for individual health programmes and/or as a national-scale health management information system. https://dhis2.org/

improvement can be attributed to the application of the WASH FIT process, however. The investment in water supply infrastructure has been fundamental to the provision of WASH services and this would have resulted in improvements even without the approach. However, the majority of HCFs in Nepal and Mali already had established water supply infrastructure and both projects have seen strong improvements in JMP-defined service levels for sanitation, hygiene and environmental cleaning. The Benin HCFs, where it was first necessary to build and operate water supply infrastructure, have only carried out one cycle of the WASH FIT approach. By comparison, the Nepal HCFs have carried out four WASH FIT cycles and show improved WASH FIT scores over time, as shown in Figure 2 .

Figure 2: Change in number of indicators fully met in eight HCFs, out of 53 WASH FIT indicators selected for Nepal, 2020–23



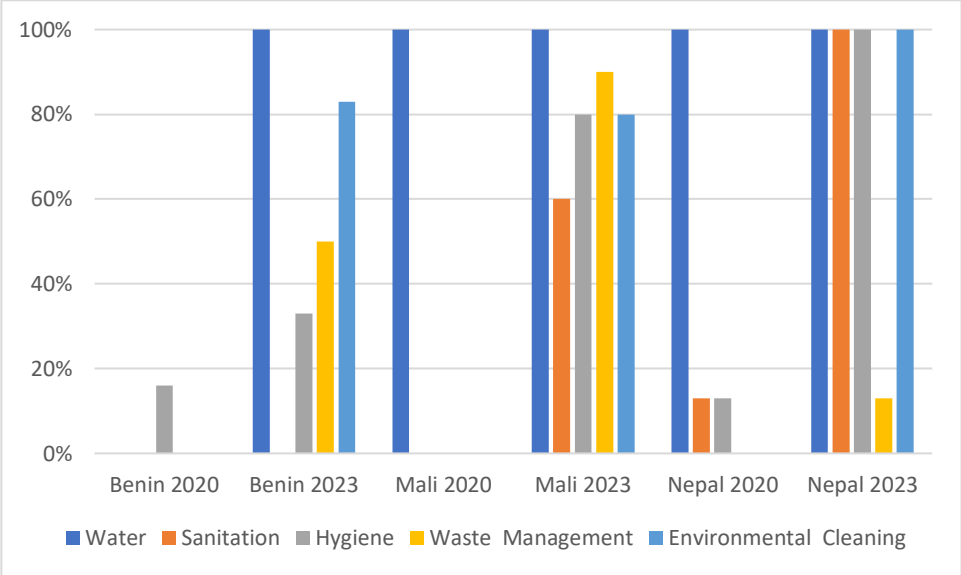
It was noted that the WASH FIT indicator scores did not appear to be proactively used in Benin or Mali, where FACET/JMP indicators still seem to be the dominant measure of improvements, although the WASH FIT improvement plans were frequently displayed in the HCFs. WASH FIT improvement plans in Mali have been shared with stakeholders (municipality, populations and regional health district representatives). By contrast, in Nepal the WASH FIT scores were displayed in all of the HCFs visited and are clearly used proactively as part of the improvement process. Tdh adapted the WASH FIT process, changing the number of indicators used, in 2020 to support the COVID-19 response in Mali. Between 2020 and 2023, each HCF carried out at least two WASH FIT cycles, and up to three cycles for some HCFs.

4.2 COMPARISON OF WASH SERVICE LEVEL CHANGES AND ENABLING/HINDERING CONTEXTUAL FACTORS

Figure 3 shows a comparison by country of the percentage of HCFs that were at a 'Basic' level of service for each service domain, as defined by the JMP service ladder, at the start of the

projects in 2020 and then in 2023 at the time of the evaluation.[1] The projects that had an established water supply at the outset can clearly be seen to have made greater progress towards achieving a basic level of service in the other domains. The availability of water is a significant enabling factor in progressing the other service domains.

Figure 3: Percentage of HCFs with a basic level of service by domain, as defined by JMP service ladder



The most significant changes to WASH service levels in Benin have been in the domains of water, where all HCFs are now at a basic level of service, and environmental cleaning where five of the six HCFs have achieved a basic level of service. The introduction of waste segregation at source, to improve waste management, has had a positive impact on this domain, and this can be attributed solely to the implementation of WASH FIT. There was no improvement in sanitation and limited improvement in hygiene, and this can be partially attributed to lack of funding available for the improvements and/or maintenance that would be required.

In Mali and Nepal, the availability of water enabled investment to focus on improving sanitation and the other service domains. The Mali HCFs have made progress in all domains. The project has enabled investment in latrines and handwashing, having a significant impact on sanitation and hygiene. Tdh intends to use the RANAS approach to behaviour change communication to support improvements in biomedical waste management, but this has not yet been implemented. Thus, no improvements can be attributed to RANAS at this point.

Nepal had a basic level of water service at all the HCFs at the start of the project, and all domains apart from waste management have now achieved a basic level of service. Waste management has been the domain least impacted by WASH FIT. The introduction of colour-coded bins in HCFs to enable sorting of waste at source has been widely adopted but infectious waste disposal by incineration has seen little progress due to the amount of investment required and the availability of proper technology. However, to tackle the issue of

[1] For those HCFs that were not visited during the evaluation, the JMP data is assumed to be the same as for 2022.

lack of cost-effective technological solutions, the project prioritized a study on the characterization and quantification of wastes produced in rural setting to enable an evidence-based assessment of appropriate technology. This is a good start to tackle the existing gap identified in the waste management.

A further enabling factor in service level changes in the current projects can be seen in the earlier implementation of the WASH FIT approach in a country and wider adoption by other NGOs. The WASH Task Force, initiated in 2015 in Mali, has been a key forum for exchange and experimentation for the WASH FIT tool. Tdh is an active member of the task force, and this provides a strong enabling complementary context for the Tdh project. WHO first advocated for WASH FIT in Nepal in 2017, and other organizations in the country besides Tdh are implementing the approach. By contrast, Helvetas is the only implementer of WASH FIT in Benin and the project is the first pilot for WASH FIT, commencing in 2021.

Section 3.1.1 'Effectiveness' describes the key factors that contribute to the success of the project and to the effectiveness of the WASH FIT tool itself.

4.3 STAKEHOLDERS' PERSPECTIVES ON THE VALUE OF WASH FIT

All stakeholders expressed a positive attitude towards the WASH FIT tool. It is valued most highly by HCF staff who can see the direct positive impact it has on their work environment and improvements in health service facilities in terms of water, sanitation, hygiene, waste management and environmental cleaning. It is seen as a strong framework that provides clear systems for managing WASH in HCFs and for providing a structured improvement plan. In all the projects it has improved communications and dialogue between each of the HCFs and their local community, engaging the population with the improvements made. However, the value of the improvement plan as a tool for advocacy for funding has not often been recognized by HCF managers or by local government health coordinators who are in a position to allocate or influence the allocation of funds.

Quantitative data available for changes in patient numbers was not regarded as being representative of the impact of WASH FIT due to the impact of COVID-19 over 2020 and 2021, but anecdotal evidence from HCF managers points to a reduction in infection rates. In addition, statements from KIs indicate that the increased cleanliness of the HCFs is having a positive impact upon their use by the local population:

'Now that the centre has access to water in the delivery room, it is regarded by the community as very clean. People want to have their babies here, 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.' (HCF Manager, Benin)

'After WASH FIT was set up, everyone felt more concerned about hygiene and sanitation. On vaccination days, if someone throws away their cotton swab another person picks it up.' (Patient Visitor, Mali)

In addition, in several cases the process has improved the relationship between the HCF and the local community it serves:

'We had to reject requests to drink water from the filter available in the HCF because it was only for office staff and had a very limited capacity. However, after the installation of a biosand filter we can offer safe drinking water to visitors. This has made us look good in front of the visitors and they do not feel excluded in the service. Interestingly, I have a feeling that this has brought visitors and staff closer to each other.' (Health post In charge, Nepal)

'Since WASH FIT started, when I shared the difficulties of collecting rubbish in the health centre compound, the old women's associations have always helped me by coming to clean up regularly.' (Hygiene technicien, Mali)

'Since WASH FIT, there is more trust between the local people, the Community Health Associations (ASACO), the health staff and the municipal authorities. Before, ASACO was suspected of mismanaging the money, but since then people have understood the needs and ASACO has the support of the people.' (HCF Manager, Mali)

The improvements to services and the positive impacts on the local community are inspiring further ambitions in some HCF managers:

'Though there are still needs in waste management regarding treatment and final disposal, the HCF has shown a significantly improved status of WASH services in the past year i.e. from 45% in the first WASH FIT assessment to 75% in the second assessment done in August 2021. With sufficient land area, support from government and stakeholders and dedicated staff, our HCF can be made as a dream model of Bardiya district.' (Health Post In charge Nepal)

Where the local municipality has engaged with the implementation of WASH FIT, there is a recognition of the positive long-term impacts that improved WASH in HCFs can have on the community:

'While other municipalities are investing huge amounts of money on roads and buildings, I am investing 45% of the total municipal budget in health and education. I am of the view that only with proper health and education can we create a better future for the population in the lowest quintile. I support this initiative from Geruwa and that is why I have initiated an O&M fund for WASH in all HCFs and have allocated five lakhs (approximately $5,000) in my administrative area.' (Nepal)

4.4 PROGRESS ON INTEGRATING WASH FIT WITHIN MUNICIPAL AND/OR HEALTH SYSTEM SERVICE PROVISION

There has been limited progress on integrating WASH FIT with municipal and/or health system service provision in all of the projects. While local municipalities have provided strong verbal support in Benin and Nepal, no concrete evidence of WASH FIT being integrated into their systems has yet been seen; this would be clearly demonstrated by inclusion in funding and budget allocation or by integration into other existing systems of monitoring and evaluation. Mali, on the other hand, is gradually incorporating elements of the WASH FIT approach. At national level, the health system is gradually integrating WASH FIT indicators into the health information system. At national level, the health system is gradually integrating WASH FIT indicators into the health information system. The national strategic plan for improving access to water, hygiene and sanitation in health facilities now incorporates recommendations

resulting from the use of the WASH FIT tool. In Nepal this may be further aggravated by the fact that only one or two HCFs in a municipality have been using WASH FIT, so it is still seen as a new project rather than a transformational approach. Funding remains a serious barrier to progress on integration.

Where concerted advocacy has been applied by the implementing partner, there is evidence of greater integration of the WASH FIT process into municipal health service provision. This is demonstrated in Thakurbaba Municipality (Nepal) where an O&M policy and procedure have been endorsed and a separate fund for O&M has now been allocated. There are opportunities for lessons learned within this municipality.

In all the projects, where the HCF manager or management team are motivated and engaged the approach has been much more readily integrated into standard operational procedures within the HCF. However, staff turnover is a barrier to this: where new staff are not well trained in the signature approach, they have no sense of ownership of the WASH FIT evaluation workplan that they inherit, or the motivation to carry out a further WASH FIT cycle.

Proactive and motivated community leaders have been seen to have a strong positive impact on the effective implementation of WASH FIT as they engage in its collaborative approach, as witnessed in communities such as Bobena in Benin. This community engagement has led to support in the form of additional funding of WASH services by the local mayor's office.

Although in Nepal there is no intention to adopt WASH FIT as a national standard with dedicated finance, the approach is already recognized in the national roadmap. This opens up an opportunity to integrate the approach into the existing MSS monitoring system. However, a critical discussion is needed on how this integration can be achieved. Some of the essential WASH FIT indicators have been integrated into the DHIS2 health monitoring system which is used in Mali, and WASH FIT is becoming the reference tool at national level for improving WASH services in health centres. As there is no existing system in Benin, there is an opportunity for WASH FIT to become the system adopted nationally for improving WASH services in healthcare centres, and KIs have indicated that this is being progressed.

4.5 CORRELATION OF IMPROVED WASH IN HCF SERVICES WITH CHANGES

The correlation of improved WASH in HCF services with changes in i) the number of annual patient visits; ii) staff experiences of infection prevention and control measures and safety of the working environment; and iii) HCF revenue over the life of the project is primarily qualitative rather than quantitative. The baselines of the projects were not established with the intent of evaluating economic efficiency, impact on infection rates or changes in patient/visitor numbers at the HCFs.

Where there has been an investment in infrastructure in an HCF, it is difficult to distinguish any improvements in WASH in HCF services that are correlated solely with the application of WASH FIT. In Benin, once the water system was in operation and the WASH FIT training was completed, there was no apparent improvement in services as measured by the JMP service ladder.

Data for patient numbers attending HCFs in all three countries was provided for 2020 and 2022. As the comparison is primarily with data from the time of the COVID-19 pandemic, this data is

not regarded as reliable and no clear correlation with improvement of services can be made. None of the projects reported a change in infection rates, but as data for infection rates was not being collected any reported change would be anecdotal.

All HCF staff and focus groups reported an improvement in cleanliness in the facilities since the implementation of WASH FIT, with one KI saying that the use of cleaning rosters had led to this improvement. In Benin and Nepal there was a clear correlation, as stated by HCF managers, between improved WASH in HCF services and staff experiences of infection prevention and control measures and safety of the working environment. HCF revenue over the life of the projects was frequently stated by managers to have decreased due to additional maintenance of the infrastructure, which was not in place before, although no quantitative data was available to confirm this.

CHAPTER 5: CONCLUSIONS AND ANALYSIS

The WASH FIT tool and process have been widely welcomed at all levels within the health systems of Benin, Mali and Nepal, from the HCF level all the way up to the Ministry of Health. The process is seen as being relevant to both small HCFs and larger hospitals at national level. It aligns with the existing hygiene strategy within healthcare, as documented in the national health policies of all three countries. In Benin and Mali, where there has been no previous tool in place to support improved WASH in healthcare facilities, WASH FIT is regarded as the preferred tool by the MoH. In Nepal, where an existing monitoring system (the MSS) is in place, WASH FIT is seen as a complementary tool and the integration of the WASH FIT indicators into the MSS is seen as the way forward. However, there is a need for a critical discussion on how WASH FIT is integrated into the MSS.

Applying the SWSC criteria for successful implementation of WASH FIT, the projects have had a high success rate, with Mali and Nepal 100% successful and Benin 83% successful. Mali and Nepal have shown improvements in almost all service areas. The slow progress in waste management in Nepal to go beyond 'limited' waste services was due to budget limitations and lack of technology and not due to ineffectiveness of the tool. Benin has seen significant improvements in water and environmental cleaning but none in sanitation, where no investment has been made.

The success criteria as defined within the ToR of the evaluation provide an indication of success based on specific outputs for each project. In addition, the evaluation endeavoured to provide a broader view of success and progress within the three projects.

Factors that have had impacts on the effectiveness of the approach, either as a hindrance or a positive effect, and are common to all projects, include:

1. Innovative and active implementing partner
2. Engagement of the local or national government
3. Level of integration with local or national systems

4. Leveraging funds
5. Ambitious and motivated HCF manager
6. Motivated staff
7. Increased awareness of cleaning/infection control
8. Engaged community (through dialogue and participatory approach)
9. Improved HCF/community relations (partly through provision of new services, also through a participatory approach).

Factors that may explain the effectiveness of the WASH FIT tool itself include:

1. Participatory approach with an inclusive WASH FIT team
2. Easy-to-understand indicators
3. Output of a clear, prioritized, structured workplan for future improvements
4. Output of a clear, structured workplan for day-to-day operations
5. Facilitated costing and budgeting of improvement plans
6. Tangible, simple tool for advocacy.

All HCFs have carried out at least one WASH FIT cycle and no adaptions were necessary. The WASH FIT process has been demonstrated to be well constructed for use within both large and small HCFs and is relatively straightforward, if in parts a little cumbersome (risk assessment), to apply. The assessment process for risk in waste management would benefit from some further support guidelines beyond the example provided in the WASH FIT manual.

All stakeholders within HCFs where WASH FIT has been applied are fully supportive of the tool. Although the process is time-consuming for staff, they can see the positive improvements it provides in terms of WASH service provision, in particular the cleanliness of the HCFs and improved safety and infection control for staff and visitors. The positive engagement and motivation of HCF staff and community health associations are seen in all projects to have had a substantial positive impact on the success of the project. This in turn has improved community relations.

Where there has been dedicated advocacy from the implementing partner to a municipality, it has shown that further funds can be leveraged to support the service. This has been shown to be of particular value in Nepal, where a significant amount of funding was leveraged from the municipality. Strong community and HCF staff motivation has supported the success of advocacy to leverage further funds for investment in some HCFs in Benin and Mali. Although the additional funds leveraged in these two countries were much less than in Nepal, they have nevertheless had a significant beneficial impact on the communities involved.

Therefore, the signature approach has mostly achieved its objective and there is enough evidence for it to be considered as an effective tool to improve WASH service levels in HCFs, and a relevant and valuable tool for health system strengthening.

Barriers to sustainability are identified as:

1. Local sources of funding: longstanding budgetary commitments
2. Ownership by local government
3. Formal adoption of WASH FIT in national policy/guidelines
4. Poor staff and community engagement
5. Staff turnover and loss of institutional knowledge.

A comparative cost analysis of the WASH FIT projects, or cost per beneficiary, is not possible as the baseline starting points are too diverse. The Benin HCFs had no water supply, and a large investment in infrastructure was required at the outset of the project. WASH FIT is more established as an approach in Mali and Nepal, where the HCFs had better baseline infrastructure. Nepal had significantly more funding for advocacy than the other two projects.

Advocacy within Mali has been very successful, with the integration of the WASH FIT indicators into the DHIS2 system, the health information system used at national level. In addition, advocacy has progressed the institutionalization of WASH FIT as the reference tool for WASH in HCFs and the willingness of the MoH to scale up WASH FIT at national level. The integration of WASH FIT into policy is advocated by Tdh, WHO and UNICEF, which is now reflected in the national roadmap. Moving forward, the integration of the indicators into the MSS would be a significant milestone and would have a positive impact on the adoption of WASH FIT in Nepal. Advocacy for integration of WASH FIT into Benin's national policy is making progress but is not as advanced as that for Mali.

The lack of a control project example meant that the evaluation was not able to truly measure the success of the signature approach separately from the impact of financial investment in WASH infrastructure, particularly in Benin, where HCFs typically had poorer facilities than in Mali and Nepal. Any results available from other WASH FIT interventions, such as those implemented by USAID in Mali, may provide some useful comparators on factors for success and barriers to sustainability.

The projects did not have monitoring frameworks in place to track the impact of the WASH FIT approach beyond the JMP indicators. Significant parameters that would provide further evidence for the impact of WASH FIT, such as infection control and patient attendance, would be valuable for future evaluation.

An improved assessment of the context for funding opportunities would aid the targeting of advocacy. Where highly motivated HCF managers have been identified, it may be possible to devolve some responsibility for municipal advocacy to the HCF level. Some support would be required in the form of training or coaching of individuals. However, where the economic or political situation of the country is particularly unstable, it may be unlikely to achieve any significant funding, even with dedicated advocacy.

An improved assessment of the context would help finesse the approach for advocacy where it is unlikely that the WASH FIT approach will be fully adopted at national level. For example, in Nepal at the outset of the project the ambition for WASH FIT to be nationally adopted could have been modified. In light of the existing MSS system, an adapted approach could have been considered to advocate for how it could be integrated into the existing MSS. The advocacy process in Nepal is now working towards this integration, but only after effort and resources have been expended on seeking a more comprehensive acceptance of WASH FIT within national policies. Potentially the route for integrating it into national policy is first by integrating it within the MSS and then by expansion of the full potential of the approach in infrastructure and management improvements, consideration of environmental and climate impacts and so on.

CHAPTER 6: RECOMMENDATIONS

1. DEDICATED ADVOCACY IN PHASE IV

Advocacy will play an important role for Tdh and Helvetas in Phase IV of the SWSC WASH FIT project. Two primary outcomes of advocacy are needed:

(a) Establishing financial support for WASH FIT improvement plans at local level through the municipal budgetary process
(b) For the approach to be adopted at national level within policies and processes.

For all projects, it is recommended that SWSC's six-step process for designing and implementing advocacy interventions is revisited:

1. Message
2. Target/decision-maker
3. Messengers
4. Timing
5. Platform/approach
6. Follow-up.

Identifying the target/decision-makers for these two points of advocacy as well as the messenger(s) is essential to the success of the advocacy. All of the projects have been actively engaged with the key stakeholders in municipal budgetary processes. A review is recommended of who these key stakeholders are and whether they are in fact the key decision-makers to enable financial support to be provided for the WASH FIT improvement plans. To date, advocacy for funding has primarily been led by the implementing partners, Tdh and Helvetas, but there is a need to keep HCF staff on the front line in future advocacy. Engaging HCF management and community leaders as active messengers in the advocacy process will strengthen the message delivered. In addition, supporting the establishment of a process whereby the municipality receives and reviews the improvement plans directly from the HCFs may enable HCF managers to realize their own opportunities for advocacy.

In Nepal, lessons learned from the success in leveraging funds from Thakurbaba Municipality can be documented and shared with other projects.

Also in Nepal, an understanding is needed of the contradiction between WASH FIT being seen as an 'add-on' to the MSS while the national roadmap states: 'Health and WASH sectors in Nepal should gradually extend collaboration in institutionalizing and strengthening the implementation of this tool at scale in hospitals and suitably in other HCFs….' Efforts to leverage and fully integrate WASH FIT to contribute to strengthening the health system's capacity to improve and maintain infrastructure, develop the health workforce and engage communities/good governance should continue.

Additional targets for advocacy should include other agencies or organizations that can either implement WASH FIT or provide complementary support to the WASH FIT process, such as USAID in Benin and Espaces Communaux Citoyens d'Interpellation Démocratique (EICD) in Mali.

Evidence from this evaluation and existing project information will provide support to the advocacy process. In particular:

1. Reported increase in staff awareness of links between cleaning and infection control
2. Strengthened community/HCF relations and dialogue
3. Easy-to-understand indicators for WASH improvement
4. Demonstration of a structured workplan for day-to-day operations
5. Prioritized, structured workplan for future improvements providing a timeframe for investment.

Evidence of a link between the application of WASH FIT and a reduction in infection rates would provide support for the advocacy process.

The development of an 'advocacy brief' using information and data gathered in this evaluation would provide strong support to the advocacy process.

2. IMPROVED MONITORING

An improved monitoring framework for all projects is necessary to provide an evidence base for the impact of WASH FIT on health system strengthening. Recommendations for improving monitoring are:

- Ensure that basic monitoring data (e.g. infection rates, patient attendance) are routinely collected.
- Collaborate with organizations implementing relevant projects, such as USAID, or coordinating national WASH programmes, such as the MoH, UNICEF and WHO, to share and compare key performance indicators and learning about different approaches.
- Confirm with HCFs that changes in WASH FIT scores are of value.

3. ONGOING OPERATION AND MAINTENANCE

The sustainability of all the projects is significantly affected by the ongoing funding of operation and maintenance. Again, lessons learned from leveraging funds from Thakurbaba Municipality for O&M may be applicable for all projects. As well as the important role of advocacy to identify and establish dedicated funds for O&M, the projects must ensure that a comprehensive exit strategy has been put in place at each HCF. Clear O&M guidelines must be in place, including contacts for suppliers and maintenance support for all aspects of the WASH infrastructure. HCF managers may need support on budgetary planning and allocation.

The development of a clear process for O&M funding will support a 'systems strengthening' approach for all projects, with the key steps being:

i) Understanding who currently pays for O&M supplies and services for each HCF
ii) Establishing what is the future vision of system actors for who pays for and ensures O&M
iii) Co-designing interventions with system actors to cover these costs.

4. CAPACITY-BUILDING

Ongoing training and capacity-building, led by local and regional government, is required to ensure that each new HCF staff member has been trained on the WASH FIT process, and clear handover mechanisms are needed to ensure that knowledge is not lost in the process.

5. HCFS WITHIN ONE MUNICIPALITY

For future projects, it is recommended that the HCFs selected for implementation of the WASH FIT process are all within one or two municipalities to enable a stronger focus on advocacy with the key stakeholders within that municipality and to maximize the impact of project resources.

6. WASTE MANAGEMENT RISK ASSESSMENT

A review of the waste management risk assessment process is recommended to support this part of the process and make it easier for the WASH FIT team to carry out. The WASH FIT manual provides only one example of risk assessment for waste management: 'No functioning waste treatment technology (autoclave broken).' Further examples of common risks in waste disposal can be provided to HCFs, such as in waste segregation and treatment.

ANNEX A: KEY INFORMANT INTERVIEW QUESTIONS

ANNEX B: FOCUS GROUP DISCUSSION QUESTIONS

ANNEX C: OBSERVATION CHECKLIST

ANNEX D: PROJECT COSTING COMPARISON

ANNEX E: BENIN COUNTRY REPORT

ANNEX F: MALI COUNTRY REPORT

ANNEX G: NEPAL COUNTRY REPORT