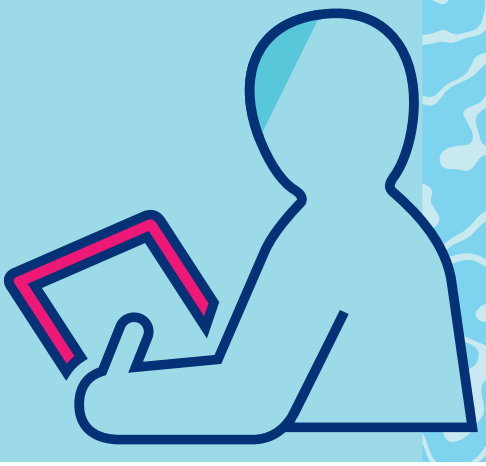
Understanding barriers to quality of care

An approach for conducting a situational analysis of water, sanitation and hygiene (WASH) and quality in health care facilities

WASH in Health Care Facilities



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Contents

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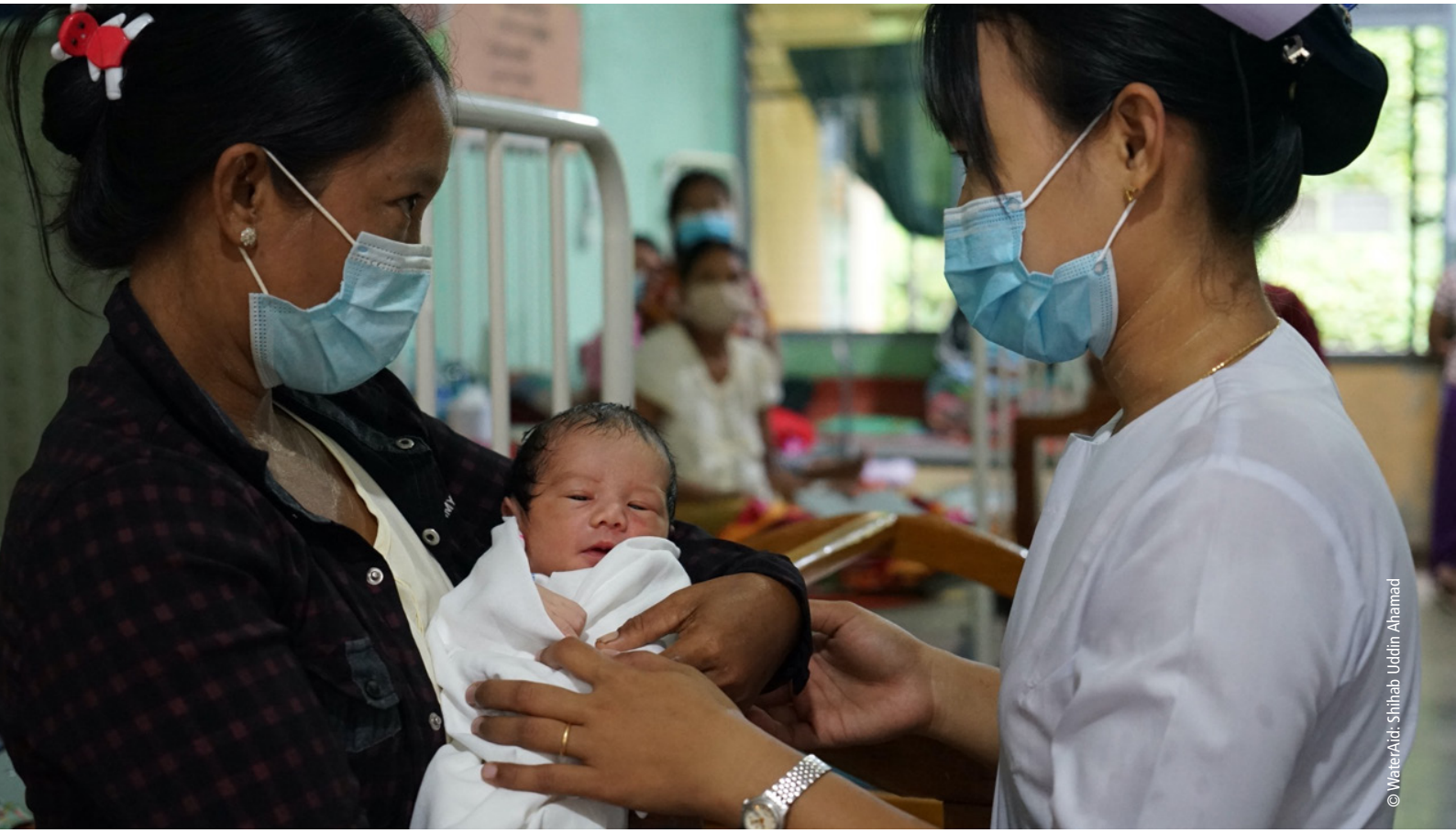


Abbreviations

AMR	antimicrobial resistance
IPC	infection prevention and control
MCH	maternal and child health
MoHSPP	Ministry of Health and Social Protection of the Population
OECD	Organisation for Economic Co-operation and Development
QI	quality improvement
SDG	Sustainable Development Goals
TWG	technical working group
UHC	universal health coverage
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

Background

This document describes an approach for conducting a national **situational analysis** of water, sanitation and hygiene (WASH) as a basis for improving quality of care (herein referred to as quality, as defined in Box 1). A situational analysis is the first of the eight practical steps recommended by WHO and UNICEF as a means to trigger action to improve and sustain WASH in health care facilities, a prerequisite for providing quality care *(1)*.

This document describes the process from the initial preparatory stages, including triggers for action, through data collection and analysis to the dissemination of results. Each element of the approach is described and possible limitations and mechanisms to mitigate these are explored. The document is intended for use by national governments, UN organisations and partners wishing to better understand how to conduct a national situational analysis of WASH in health care facilities and quality in order to understand policy gaps, raise awareness of problems, tailor interventions and advocate for additional financing. It also helps identify strengths, weaknesses and opportunities for action.

The approach described here is based on the experiences of previous analyses undertaken in Cambodia (2017), Ethiopia (2016 and 2018), Ghana (2019), Hungary (2019), Rwanda (2019), Serbia (2019) and Tajikistan (2018) *(2–6)*. In addition, this approach was discussed and improved during the 2019 WASH in health care facilities global meeting held in Livingstone, Zambia *(7)*.

Introduction

The availability of water, sanitation and hygiene (WASH) services in health care facilities, especially in maternity and primary-care settings where they are often absent, supports core aspects of quality, equity and dignity for all people. Recent data from WHO and UNICEF show that globally, one in four health care facilities lack basic water services, one in ten have no sanitation services and one in three have neither hand hygiene facilities at the point of care nor systems to segregate waste[1]. In Least Developed Countries, the gaps are even greater, where twice as many facilities lack basic water and sanitation services.

Basic WASH services in health care facilities are fundamental for providing quality care, fulfilling human rights, upholding patient dignity and retaining health care workers and for ensuring that universal health coverage (UHC) and primary health care commitments, as detailed in the UHC High Level Declaration *(8)* and the Astana Declaration *(9)*, are achieved. The Lancet Global Health Commission estimates that 8.6 million deaths per year across 137 low and middle-income countries are due to inadequate access to quality care *(10)*. Of these, 3.6 million are people who did not access the health system, while 5.0 million are those who sought care but received poor quality care. The report, jointly authored by WHO, the World Bank and the Organisation for Economic Co-operation and Development (OECD), makes clear that poor WASH services impact the quality of care that can be delivered in health facilities *(11)*, thus the availability of WASH services must be prioritized in national planning to improve access to quality health services *(10, 12)*.

In order to improve and sustain WASH services in health care facilities, a set of eight practical steps have been identified (Annex 1) *(1)*. The first of these is to conduct a national situational analysis and assessment of WASH in health care facilities which provides the foundation for planning, prioritization and resource mobilization.

Why should a situational analysis be carried out? All countries committed to addressing WASH in health care facilities through their unanimous support of the 2019 World Health Assembly Resolution on WASH in health care facilities (herein referred to as the Resolution), which urges Members States to "conduct comprehensive assessments according to

Box 1. Definition of quality health care services

Improvements in health care delivery requires a deliberate focus on the quality of health services, which involves providing effective, safe, and people-centered care. High-quality health services involve the right care, at the right time, responding to the service users' needs and preferences, while minimizing harm and resource waste *(12)*. WHO defines quality of care as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge" (14)*. WASH services are fundamental to providing quality care as they enable good infection prevention and control practices, support patient safety, and allow for care to be delivered in a dignified, clean and respectful environment.

[1] WHO/UNICEF, 2020. Latest data on WASH in health care facilities. https://washdata.org/data/healthcare#!/

the national context" as the point of departure *(13)*. The results of the situational analysis provide the basis and rationale for all other subsequent activities, by understanding why things are as they are, identifying needs and priorities, possible solutions and facilitates target setting which is based on evidence and data. If there are any existing data (either anecdotal or nationally representative) pointing to problems with WASH service provision or quality of care, a situational analysis should be conducted to explore the underlying reasons.

A situational analysis should inform the development of a costed roadmap for strengthening and sustaining targeted, multisectoral action with realistic and incremental national targets and provide the rational for policy revision and updates. It should be noted that of 110 countries surveyed for the 2019 UN Global Analysis of Sanitation and Drinking-water, 94% had policies on WASH in health care facilities but only half of these were costed *(15)*. Not only is there a need for more countries to develop costed roadmaps and national policies but the global WHO/UNICEF estimates for access to WASH in health care facilities have also highlighted major data gaps in many countries, indicating a critical need to support countries to undertake systematic situational analyses and assess conditions.

Objectives and scope

A comprehensive situational analysis consists of two main parts:

1. Analysis of the enabling environment[1] which includes a review of policies, standards, regulations, resources (human and financial), institutional arrangements, surveillance and monitoring. General areas of investigation should include the roles and responsibilities of different government entities and partners, including responsibilities for implementation of services at municipal and facility levels, alignment of organizational and national priorities and coordination and collaboration between entities; availability and functionality of organizational structures (e.g. national taskforce); financing mechanisms; trust between providers and users; community engagement mechanisms and health-seeking behaviours. The analysis should consider how WASH in health care facilities contributes to wider efforts to provide quality health services and health system strengthening. It should also identify funding streams, budget planning and allocations and indicators of performance. The primary objectives will vary according to each country context and government's priorities: it may be one component of a broader quality of care assessment (potentially providing more buy-in from the health sector) or a standalone exercise. The areas of investigation suggested here are not intended to be an exhaustive list.

2. Assessment of WASH service provision across all types of health care facilities, either analysing existing data or undertaking a targeted sub-national or national assessment to determine the coverage of WASH services in a given area. Note that for many countries, a national assessment is too expensive without a lot of external resources and a targeted sub-national assessment can be just as effective.

This document focuses on the **analysis of the enabling environment**. For more information on how to carry out a national assessment of service provision, refer to Box 2 (note, that a comprehensive explanation is beyond the scope of this document).

Box 2. Situational analysis vs. assessment of service provision

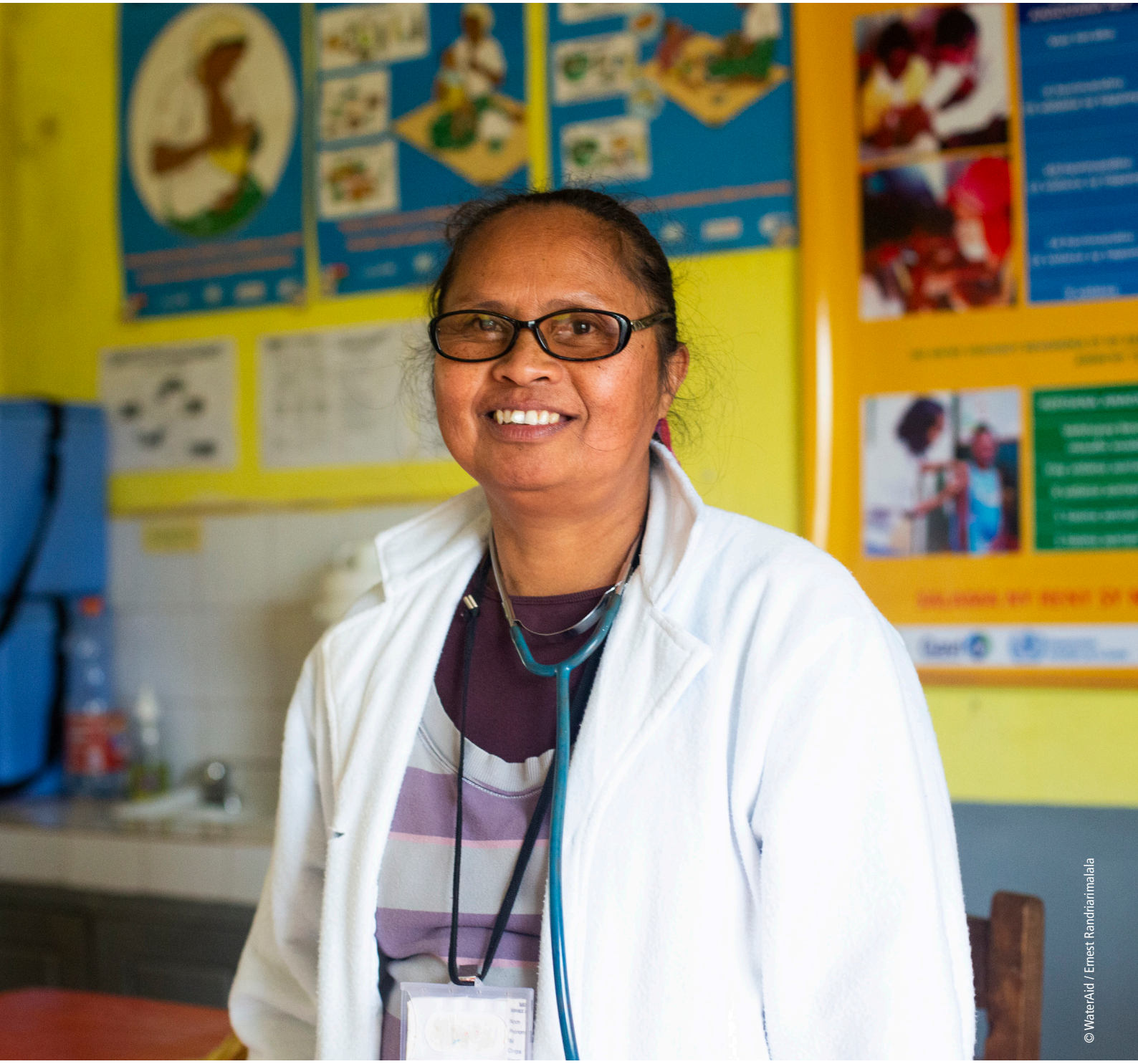
National surveys and censuses of service provision can be time consuming and expensive. It may be more feasible and sensible to begin with a sub-national assessment in a few representative districts to determine key gaps to begin to address them immediately. At the same time, embedding WASH indicators into existing health monitoring systems provides an opportunity to obtain nationally representative data in a systematic and sustainable manner.

Where funds are limited, a targeted sub-national survey in specific regions and districts can help inform and kick-start action and generate political will while more comprehensive surveys and monitoring, including through health information systems, can be planned and conducted. The WHO/UNICEF global indicators for monitoring WASH in health care facilities provide an important starting point and allow countries to determine progress towards meeting the Sustainable Development Goals (SDG) and for country comparisons *(16)*. At a minimum, calculating basic service levels for water, sanitation, hand hygiene, waste management and environmental cleaning is required.

For more information on conducting assessments, refer to the WHO/UNICEF Joint Monitoring Programme Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals document *(16)* and Annex 2 for a list of questions.

[1] An enabling environment is a set of interrelated conditions that impact the capacity of actors to initiate and manage development and improvement processes in a sustained and effective manner. Source: Thindwa J et al. Enabling Environments for Civic Engagement in PRSP Countries; Social Development Notes No. 82. Washington D.C., USA: World Bank; 2003.

While some of the information collected may not be new to all stakeholders, compiling, analysing and distilling it can bring new insights about important barriers and how they can be overcome. Publishing and disseminating the results can help to raise awareness about WASH in health care facilities and its links with quality of care and universal health coverage. This is critical in order to prioritize and take necessary, and context-specific, action.



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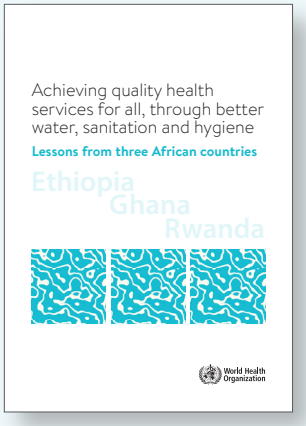
Approach and practicalities

The following section describes each stage of the process, followed by a description of possible limitations.

1. Define scope, methodology, responsibilities and resources
2. Review and analysis of enabling environment (policy review and informant interviews)
3. Field visits: facility assessments
4. Data analysis and report preparation
5. Dissemination and next steps.

Overview of approach and findings from a situational analysis conducted in three Africa countries: *(4)*



APPROACH

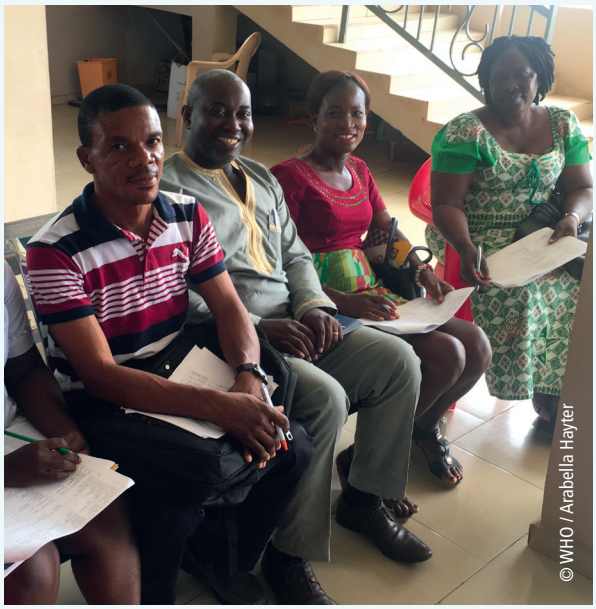
1) A rapid review of national policies and strategies relating to WASH, quality and health systems strengthening (1–2 weeks prior to country mission)

2) A joint mission by the WHO Quality Team and Water, Sanitation, Hygiene and Health unit, in collaboration with the national Government, WHO Country Office of each respective country, and WHO African Regional Office (7–10 days), consisting of:
   a) Interviews with relevant Government departments, partners (e.g. UNICEF, UNDP) and NGOs (e.g. WaterAid, World Vision, IRC) (8–15 interviews, each 1–2 hours long)
   b) Facility assessments (minimum of five per country, depending on available time, with half to one day spent at each facility, depending on facility size)*.
   c) Debriefing by external team with all stakeholders involved in the interviews and members of facility senior management teams to discuss and agree proposed recommendations prior to dissemination (2–4 hours, with 10–30 participants).

** All interviews were done in English except in Ethiopia where a team of six Government staff who spoke Amharic were trained to conduct the interviews.*

FINDINGS

The following factors were found to be important for influencing improvements in WASH services and thus quality of health service delivery across the three countries:



High-level support and political commitment through the Ministry of Health, President, or Prime Minister's Office. Well-known figures (such as sporting celebrities in Ethiopia) who act as champions or "ambassadors" at the local level can further elevate the issue.

Local ownership and community engagement helps to sustain progress and ensure interventions and quality improvement activities are tailored to the local setting.

Using national and local media to connect and engage with communities helps to educate communities about relevant health risks, available local services, and share ways that communities can improve and advocate for their individual health (particularly in Ghana).

Creating champions within the health facility can help to ensure accountability, sustainability and good practice throughout.

Keeping leadership consistent throughout periods of change (at the national, district or facility level) is key to sustaining momentum of ongoing work.

Using multiple mechanisms for encouraging behaviour change, including incentivising and motivating staff, mentorship, involving staff and communities in decision-making processes, increasing accountability (between staff, leadership, patients and throughout the health system, especially in Rwanda through performance contracts) improving governance and management of health care organizations and systems, and creating a trusting facility environment where staff and patients feel comfortable speaking up about their concerns

Monitoring mechanisms which ensure regular data collection, reporting and analysis of WASH services to drive quality improvements.

Creating budget lines for WASH services within national policies and strategies to support implementation of national targets.

Involving staff in the development of facility mission statements and values to empower staff, create a sense of ownership, trust and collaboration throughout a health facility.

Cross-sector coordination and communication between sectors (since WASH and health are often in different government departments) to ensure alignment of approaches and efficiency.

For more detailed results, refer to WHO (2020). Achieving quality health services for all through better water, sanitation and hygiene. Lessons from three African countries *(4)*.

1. Defining scope, methodology, responsibilities and resources

The preparatory phase involves agreeing and setting the scope, objectives and methodology of the work and determining the time and resources required to complete it. Information sources and resource persons should be identified and the process for analysis and dissemination agreed. These may be refined as the work is carried out.

A situational analysis should be a government-driven and owned process based on national priorities and context. One government department or organisation should take the lead and coordinate stakeholders, pulling different pieces of the analysis together and monitoring progress towards the objectives. The lead organisation may be the Ministry of Health (for example the Division of Environmental Health, as in Hungary), Water, Planning or other relevant ministry, national institutions for public health (as in Serbia), the department for hygiene, sanitary and/or epidemiological services (as in Tajikistan), or local district or regional governments and authorities. Alternatively, a national university, academic body or professional organisation (e.g. the national association of plumbing/hospital engineers or national standards authority) may lead the analysis. To offer a wider perspective and avoid a bias in results, it is recommended that the analysis is conducted jointly in collaboration with a range of health colleagues, for example from health systems, quality, maternal and child health (MCH), patient safety, antimicrobial resistance (AMR), nutrition or infection prevention and control (IPC). To coordinate these different actors, a technical working group (TWG) or coordination body which brings stakeholders together may be useful. This may be a time-limited group or part of an existing national TWG on WASH, quality or other area.

Relevant government approvals to conduct the analysis should be procured where necessary and involved authorities should then agree on the proposed methodology and objectives of the analysis, approach and future dissemination strategy. Dedicated resources (human and financial) will be needed for each step (development of the methodology, field work and data collection, analysis of results and planning, dissemination) and commitment for this should be agreed at the start. Experience shows that analyses generally take three months but may take longer (particularly during the time of COVID-19) so sufficient resources (human and financial) should be allocated for the duration of the work. It may be that an initial analysis is a modest effort carried out with minimal resources (i.e. a quick purely-desk based scoping study or with only a few facilities visited), which might be required before resources are given to support a broader analysis and assessment.

Box 3. Conducting a situational analysis in the time of COVID-19

Conducting an analysis during the time of COVID-19 will be more difficult, due to restrictions on movement (limiting the ability to visit health care facilities), stretched resources and competing government priorities. Understanding the gaps in service provision and policies is important to understand how best to fight COVID-19 effectively and thus the need to conduct an analysis should not be ignored.

Potential ways to mitigate the impact of COVID-19 on this approach include:

- Conducting information gathering exercises online (e.g. through online surveys or interviews) or by phone, preventing the need for face-to-face interactions
- Reducing the number of health facilities surveys and working with local resources and expertise (e.g. community health workers)
- Reducing the scope of the analysis and only following up on specific, known gaps, with the potential to conduct more detailed assessments in future.

2. Analysis of the enabling environment

Critical building blocks of the enabling environment for WASH in health care facilities include the legal framework and policy landscape, political leadership, institutional arrangements and capacity for implementation, sector and service monitoring and budgeting and financing[1]. Annex 3 describes these building blocks with a list of suggested indicators that may be used to identify the enablers and challenges. The analysis will help to identify what functional and programmatic areas in the health and WASH sector related to the provision of WASH services require more attention. In Tajikistan, the analysis involved a review of scientific and grey literature, policies and expert interviews; in Hungary, the analysis included a review of the literature, policies and existing data from international analyses such as GLAAS. Further details on the how to review the policy landscape are provided below.

The aim of the analysis is to establish the enablers and challenges (or barriers) for strengthening each building block of the enabling environment. Enablers are those elements that are observed or partly observed in the country that could facilitate improvement towards establishing and strengthening implementation of WASH services in health care facilities. Challenges are related to gaps or shortcomings (i.e. because systems, requirements or resources are absent or in place but insufficient) that may hinder progress in WASH in health care facilities improvements. An example of a potential enabler and challenge related to 'sector and service monitoring' is presented below (Box 4).

Box 4. An example of a potential enabler and challenge

Sector and service monitoring

Enablers	Challenges
A surveillance system is well established, regulated by national legislation and led by the national and local bodies for sanitary and epidemiological surveillance, covering all health care facilities in the country.	No national analysis of surveillance data – data are not used to inform policies nor translated into action plans; inspections are not as regular as required, frequency depends on the local office, and enforcement mechanisms do not exist.

Each indicator is graded using a traffic-light system: 1) green: the specific aspects are observed; 2) orange: the specific aspects were partly observed or were observed but present significant shortcomings (described later); 3) red: the specific aspects were not observed. Box 5 presents a snapshot of sector and service monitoring results from an analysis conducted in Serbia. A written analysis of each indicator may also be useful for generating more detailed recommendations. Other structural factors (e.g. demography, geography) and institutional factors (e.g. level of decentralization) outside the WASH sector are not considered, although they may also have an influence on the efficiency and performance of WASH improvements. If an analysis of the enabling environment reveals insufficient information to fully understand the provision and sustainability of WASH services in the health care services, additional factors outside of the WASH sector may also need to be considered.

[1] Adapted from the UNICEF Water, Sanitation and Hygiene Bottleneck Analysis Tool (WASH BAT), source: Strengthening enabling environment for water, sanitation and hygiene (WASH); guidance note. New York: United Nations Children's Fund; 2016 (https://washenablingenvironment.wordpress.com/guidance/). Refer to Annex 3 for further explanation.

Box 5. Snapshot of results from "National situational analysis of WASH in health care facilities in Serbia" (2020) *(5)*

Sector and service monitoring	Indicator	Score
	Public health surveillance and monitoring systems are in place and functional	
	Monitoring is regularly conducted	
	Monitoring is comprehensive and includes all WASH dimensions	
	Monitoring is conducted systematically through use of surveillance checklists	
	Monitoring measures availability and functionality of WASH services	
	Monitoring reflects internationally recommended indicators and definitions (e.g. WHO/UNICEF/ SDG 6 indicators	
	Monitoring is national (all health care services in all regions in urban and rural areas)	
	Monitoring data are used to develop, review and implement policies and targets at the national level	
	A national overview of access to WASH in health care facilities is available	

2.i Policy review

The policy landscape is one component of the enabling environment. A policy review should identify all existing standards, policies and strategies across the health sector that include reference to WASH in health care facilities, whether or not they are specific to WASH and/or quality of care. It may extend to an investigation of the institutional arrangements and partners involved in policy implementation. National and subnational documents should be included as well as any existing health systems analyses. It may be difficult to know what policies exist and which should be included. Starting with one key document such as the national health strategy and reviewing all those policies referenced within may help. Other documents might be identified through the process of talking to officials. For a list of suggested subject areas and keywords to search for, refer to Table 1.

Table 1. Keywords and types of documents to inform the policy review (list is not exhaustive)*

Topics to consider

- health sector/health systems
- health care accreditation
- water
- environment
- hygiene
- environmental sustainability and climate change resilience
- health-care associated infections
- antimicrobial resistance or stewardship
- patient safety
- quality (of care) / improvement
- public health
- access to persons with disabilities
- health insurance schemes
- private health care providers
- sanitation
- urban/rural water and sanitation services
- healthcare/medical / solid waste management
- infection, prevention and control
- quality of care
- COVID-19
- maternal and child health
- quality improvement
- health care/public facility construction

Types of documents – keywords

- regulatory document / regulations
- act or decree (national or local government)
- scheme
- norms and/or standards
- standard operating procedures
- plan
- national action plan
- law
- strategy / strategic plan
- handbook
- policy
- guideline
- training programme

Note: This list is intended as a guide as is not exhaustive.

The review will provide an important foundation for all subsequent activities (for example identifying new areas of investigation) sufficient time should be dedicated to this activity. Documents may not be available online so time spent with staff in person is important to ensure a comprehensive analysis. Suggested themes for analysing and assessing policy documents and national strategic directions on quality documents are included in Annex 4.

Considerations for reviewing policy documents

- How do the standards compare to WHO or other relevant global standards and to standards from other countries? Are there any critical elements missing?
- Are the regulations in question national or locally applied? What are the potential successes and constraining factors?
- Is the policy in question legally-binding? If so, what mechanisms or incentives are in place to ensure compliance? Are there consequences for not complying?
- Is the plan or strategy costed and/or budgeted?
- Are there accountability mechanisms to track implementation progress?

Reviewing the national direction on quality and/or strategy to better integrate WASH

Considering how a country has integrated (or is trying to integrate) WASH within health efforts or the national direction on quality is important. The WHO Handbook for National Quality Policy and Strategy *(12)* provides a framework, with eight national planning elements, for countries looking to initiate or strengthen their national direction on quality. For the purpose of this approach, these eight elements have been adapted to include WASH (Box 6) and include guidance for providing recommendations to Ministries following a situational analysis. This approach can also be adapted to facility level. Detailed questions, covering the eight elements, are provided in Annex 4.

Box 6. Eight national planning elements of the NQPS handbook, adapted to include WASH

1. Integrate WASH into **health sector priorities and/or** national quality priorities
2. Review the **national definition of quality** and, where applicable, **facility definition of quality** to explore the alignment with WASH
3. Determine the engagement of **WASH stakeholder**s at the national and facility levels in the development and implementation of the national quality policy and strategy (NQPS)
4. Review available **situational analyses** to understand the current and historical status of quality work and policy and how WASH can be incorporated
5. Learn about the **governance and organizational structures** for quality and WASH - and the interface between these two areas
6. Determine **methods and interventions** being used for quality improvement and how WASH is integrated into these interventions
7. Review the structure of **health management information systems** and **data systems** for WASH within quality reporting
8. For **quality indicators and core measures**, determine whether data on provision of WASH in the health service is routinely collected as part of the HMIS.

2.ii Semi-structured informant interviews

Expert interviews are an efficient and recognized method of gathering in-depth knowledge and experience in a short period of time and provide an opportunity to gather data or information not revealed by a desk review. Interviews can provide varied and sometimes conflicting accounts as expert knowledge is multidimensional and interviews may elicit interpretative (or explanatory) knowledge, obtained from the subjective interpretation of experience, and people's procedural (or process) knowledge *(17)*. For this reason, it is important to conduct a sufficient number with a range of stakeholders and to triangulate the information collected by the policy review and site visits. There is no set number of people that should be interviewed: it may become clear when little or no new information is collected through interviews that enough have been included in the sample. The number will vary, but could be as little as five or as many as fifteen. Interviews should include national and sub-national levels (including within health care facilities, refer to 3. Facility assessments below), civil society and private organisations, community members and facility staff. Box 7 contains a list of stakeholders to consider. It will likely not be possible to talk to everyone, due to time restrictions or potentially reluctance to engage.

At the start of each interview, introduce the aims and objectives of the work and focus on a small number of key points with opportunity for the discussion to move to areas which are not planned. The interviews should be about information exchange, not just taking people's time without giving anything in return. In Tajikistan, the interview process consisted of semi-structured interviews conducted as a conversation, with an interview guide (a simple list of questions) for obtaining information about particular topics, yet with room for sequence flexibility and changes in the question form or focus. This was in accordance with the interviewing process defined by Kvale *(18)*. Interviews were limited to one hour and were recorded if the interviewee agreed. The interview recordings were then transcribed in order to conduct a content analysis within a set of dimensions (selected *a priori*) to identify "meaning units" – context or content related words or sentences – useful for easy understanding and comparison *(19)*.

Having identified the main stakeholders, some time may be needed to encourage them to participate in the process. Building a case for how WASH in health care facilities is fundamental to overall quality of care may encourage stakeholders to participate, although such an approach may need to be tailored to different audiences. The "case" may be built around health (fewer infections, preventing AMR), economic (reduced healthcare costs, more productive workforce) or social (greater dignity for patients and health workers) benefits of improving WASH in health care facilities. It may be that work on WASH in health care facilities upholds the 2019 Resolution which received unanimous approval by every country (and thus the country in question has an obligation to respond). Lastly, the country may benefit from additional external support from partners and/or provide a good example to other countries as they make progress.

Box 7. Potential interviewees for a situational analysis and their role

Potential interviewees*
Ministry of Health, including the following divisions — Oversight and lead for WASH in health care facilities and integration of WASH with health sector and programmes Environmental/Occupational Health Quality Directorate/Cabinet Maternal and Child Health Communicable Diseases Vaccines Health financing
Ministry of Water — collaborate with Ministry of Health on WASH infrastructure construction, operation and maintenance
Ministry of Environment — regulate and support waste management and infrastructure; climate change
Ministry of Finance — help mobilize local resources
Ministry of Rural Development — mobilize resources and local support
Ministry of Local Government — mobilize resources and local support
Ministry of Information or information division within the Ministry of Health — assist with existing data and help plan and conduct data collection
Mayor and other local government officers — ensure enabling environment, mobilize local organizations, assign personnel for WASH operation and maintenance, and help with data collection
Local utilities — operate and maintain municipal WASH infrastructure and services
NGOs, both WASH and health-focused — assist with implementation and training activities, help mobilize financial resources, advocacy
Community organizations/civil society: women's groups, water committees — provide oversight of activities, generate demand for improved services, and assist with implementation
Private sector partners: water companies, manufacturers of consumer products — soap etc.
Professional bodies: water companies, manufacturers of consumer products e.g. quality, hospital engineers, plumbers, midwives
Regulatory authorities
National health insurance agency

* Facility level interviews are not included in this list as these are detailed under 3. Facility assessments.

3. Facility assessments

A comprehensive situational analysis should include facility visits (walk-through infrastructure assessments) to confirm the validity of monitoring information and service provision data as well as the implementation of policies and regulations. They provide an opportunity to obtain insights from senior management, staff, care seekers and WASH, health and other community groups through on-site structured interviews.

Walk-through assessments are not intended to provide a formal, statistically rigorous assessment but should give an idea of the services provided and overall conditions[1]. Some degree of representative sampling is nevertheless encouraged (i.e. using random selection and some basic statistical methods), to ensure a range of facilities are visited. This should include a selection of primary health care facilities to district and/or national hospitals; rural and urban facilities; different geographical or administrative regions; public, private and faith-based facilities; and those using different technologies for water, sanitation and waste. If WASH coverage data are already available, these can be used to select a range of representative facilities to visit. In large countries, obtaining geographic diversity can be time consuming and expensive but should be factored in to the budget and timetable where possible; this will help decide how to best support the development of fair and equitable programmes and policies. Including some "showcase" facilities may also be useful to identify inspiring examples and best practices on which to base recommendations.

Site visits can be as formal and comprehensive as needed or as time allows. On average, half a day should be allowed to visit a district level hospital, while a small-medium primary or secondary health care facility can usually be assessed in 1.5–3 hours, particularly if there is more than one assessor available to conduct interviews. At the minimum, a walkthrough of the main patient areas (outpatient department, maternity, surgery) and infrastructure (water supply and storage, toilets, hand hygiene facilities, waste storage and treatment areas) is recommended (see Box 8). Using the indicators from the WASH FIT assessment template *(20)* may be useful to guide the assessment but other tools (existing local surveys, WASH CON, FACET, IPC facility assessments[2]) can also be used. Taking photos can also be used to validate information but ensure that consent is taken from the Ministry of Health and/or head of the facility at the start of the visit and with any individuals included in photos.

Box 8. Guidance for walk-through assessments

Walk-through infrastructure assessments may look at the following:

- **Water:** availability and accessibility to services, quantity and quality of water, operation and maintenance of water supply systems;
- **Sanitation:** availability, accessibility and quality of services, usability, safety, sex-separation of toilets, menstrual hygiene management, operation and maintenance;
- **Hygiene:** hand hygiene at points of care and at toilets, availability of soap and alcohol-based hand rub, procurement procedures, hygiene promotion materials and activities;
- **Health care waste management:** behaviours, training and infrastructure linked to waste segregation, storage, transport, treatment and disposal;
- **Environmental cleaning and disinfection:** staffing, standard operating procedures for cleaning and disinfection, equipment, supplies, procurement and laundry.

[1] A full, statistically-rigorous assessment may be carried out simultaneously, as in Serbia. An explanation of sampling methodology is however, beyond the scope of this document.

[2] For a full list of facility-based assessment tools, refer to Annex 4 of WASH in health care facilities: Practical steps to achieve universal access to quality care.

Facility-level interviews are also recommended (Box 9). The number will vary according to the size of facility and time available, but ideally should include the facility manager (chief medical officer, chief operating officer, administrator or equivalent), clinical staff (doctor, nurse and/or midwife), technical staff (IPC, WASH or quality focal points) and non-clinical support staff (cleaners, janitors, health care waste technicians) and community representative. For patients and the community, consider how to involve representatives from at-risk groups, including those with disabilities, mothers, the elderly and indigenous populations. All interviews are verbal so no literacy is required to participate.

Box 9. Suggested topics for facility-level interviews

Facility-level interviews may cover the following topics:

- **Policy:** Review of relevant policies for WASH, IPC and quality activities, how they are adapted from the national level and implemented?
- **Health facility culture:** is there a values and mission statement? Is there a culture of learning? Are there patient and staff feedback mechanisms? Are there accountability measures in place?
- **Measurement:** are there WASH or quality indictors and are these measured, analysed and acted upon regularly?; Is there a monitoring program for quality improvement (QI) activities?
- **Quality activities:** have there been any QI projects completed and if so, does the health facility have any improvement data?
- **Leadership:** is there strong leadership buy-in for QI, WASH; is there a quality or WASH focal point? And is there a communication system for reporting and coordinating quality and WASH issues?

Depending on the scope of interviews and the local context, permission for conducting interviews with patients and the community should be sought in advance, in line with local and national protocols, including obtaining ethical approval(s) where necessary[1]. Interviewees should have the option to stop at any time, their responses anonymised and they should be assured that their responses will not affect the care they receive or their employment.

It may be difficult to get accurate information from interviews particularly in settings where there is not a culture of criticizing authority or demanding better services. This could be mitigated in part by holding focus groups rather than individual interviews and using trained facilitators who speak the local language, for example from a local university or community organization (if available). Other methods for getting anonymous feedback might include patient and staff satisfaction surveys, comment books or boxes.

Box 10. Additional guidance for facility visits

Often facilities that are chosen for visits receive many external visitors and they may feel overburdened. During one facility visit, staff expressed frustration that while they frequently gave their time to host external visitors, they did not receive anything in return. A short training at the facility, for example on a relevant technical issue like health care waste management or water quality testing, may be welcome in return. This should be planned with the facility and district health office in advance to ensure the training is of maximum use.

At the end of any visit, the assessment team should meet with the facility manager or administrator to provide feedback on the findings of the visit. *Were there specific areas for improvement identified? What major gaps were identified? What was the facility doing well? Providing facility-specific reports with key data following the visit is also important.*

[1] WHO guidance and templates for seeking informed consent is available at https://www.who.int/ethics/review-committee/informed_consent/en/

4. Data analysis, report preparation and dissemination: providing recommendations for further action and follow up

Results and recommendations for further action may be structured around the eight practical steps, elements of the Resolution or other national and context-specific priorities derived from the analysis. Those audiences interested in setting or updating the links between WASH and national strategic directions on quality, may wish to structure the results and recommendations around the eight elements of the NQPS (Box 9). However the results are structured, they should answer the key questions set at the start of the exercise and each element should have clear recommendations for action and follow up, including a timeline, responsible organisation or person(s) and a budget.

5. Dissemination and next steps

Following completion of the data collection and analysis, a stakeholder consultation and discussion of the results should be held. (Where the analysis is conducted by an organisation other than the Ministry of Health, a preliminary validation of the results by the government may be required prior to this stakeholder consultation.) Dissemination could be done at a national level roundtable, led by the Ministry of Health, where inputs and reflection are invited from all those who participated in the analysis, as well as staff and senior management of the facilities that were visited, other partners and donors. This provides an opportunity for further triangulation and validation of results.

Wider dissemination of the final report with the regional and global community (for example via www.washinhcf.org, at conferences or other events) is also important for other countries and partners to learn from. Dissemination will also avoid duplication of efforts, particularly where multiple partners and NGOs are active in a country or region.

Finally, the results of the situational analysis should be used as the foundation for developing a national costed roadmap and set of national targets (the second of the eight practical steps). This process may be started at the stakeholder consultation to maintain momentum. Some of those individuals and organisations who have contributed to the process may also form the core of a national multisectoral coordination mechanism (technical working group, taskforce or equivalent) to align and strengthen collaborative efforts. This will help driver progress and support the delivery of all aspects of safe WASH and quality throughout the health system.

Limitations

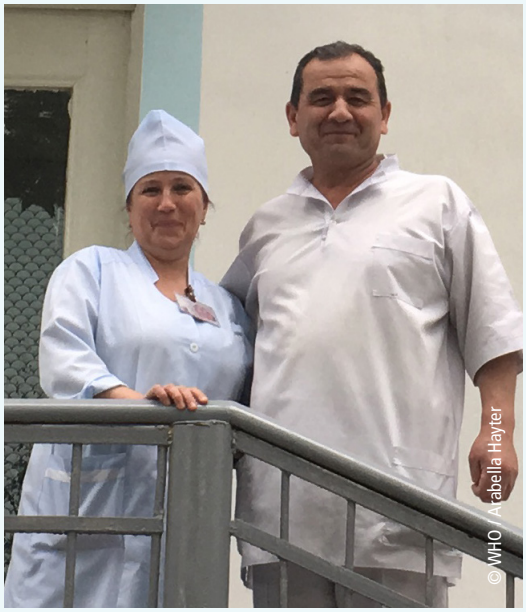
Conducting a situational analysis takes time and a balance between the time and resources available and depth of analysis will be needed. Scheduling conflicts and competing priorities may make it difficult to engage some people, meaning important perspectives will be missing. Limited time and budget also affects the number of facilities that can be visited and assessed. To reduce the impact of this, it is important to verify findings and triangulate with existing assessments and national surveillance data wherever available. These facility visits should not be seen as an alternative to a comprehensive survey assessment or a methodology for surveillance but are intended to give a snapshot of conditions and validate information collected through other sources.

How have results from previous national situational analyses in the European Region been used?

Tajikistan (2018)

Methodology and timeframe:

- A review of the regulatory framework, including relevant policies landscape and standards, using a questionnaire compiled by the Ministry of Health and Social Protection of the Population (MoHSPP), alongside a screening of selected legal documents and a desk review of grey literature;
- Semi-structured interviews with key actors, including staff from the MoHSPP and facilities;
- Visits to selected health care facilities
- Facility visits and interviews took place over one month. The review also made use of information collected during a one-day national roundtable with national and development partners, which allowed a preliminary mapping of relevant partner projects.



Results and impact:

- WASH in health care facilities was integrated into the revised version of the National Health Strategy, informed by findings of the national assessment and taking into account key actions stipulated in the Resolution, all of which aim to provide access to quality services by 2030;
- WASH was immediately integrated into the *National Action Plan to Tackle Antimicrobial Resistance in the Republic of Tajikistan*, which was adopted in 2018 by the joint order of the Ministry of Health and Social Protection, Ministry of Agriculture and Committee on Food Security;
- a new standard (*"SanPin"*) on WASH in health care facilities was developed, outlining the means to improve WASH in health care facilities (namely effective governance, sustainable financing and workforce provision);
- a national commitment to improve WASH in health care facilities and for further collaboration with partners and donors was signed by the Ministry of Health;
- other partners (UNICEF and Oxfam) committed to scaling up their work on WASH in health care facilities, including support in implementing WASH FIT[1];
- the Ministry of Health, in collaboration with UNICEF, initiated a programme for the rehabilitation of WASH services in selected maternity wards; and
- planning for completing a national baseline analysis (with the support of World Bank and UNICEF) was initiated.

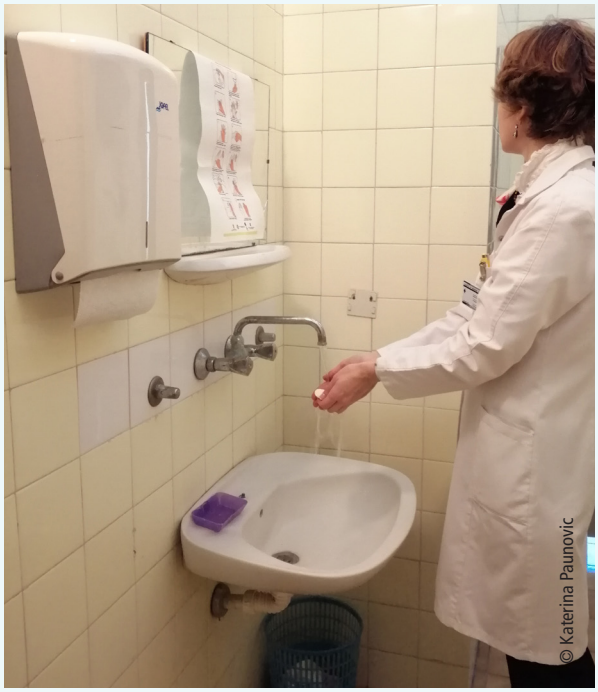
[1] WHO/UNICEF (2018) Water and Sanitation for Health Facility Improvement Tool, available at https://www.who.int/water_sanitation_health/publications/water-and-sanitation-for-health-facility-improvement-tool/en/

Serbia (2019) *(5)*

Methodology and timeframe

- A survey on WASH conditions in 320 health care facilities, conducted over 2 months, using onsite observations, structured interviews and water quality testing for microbiological and chemical parameters. Facilities were identified from the national registry to be representative of the number and type of health care facilities at the national level.
- a qualitative assessment of the enabling environment through a desk review of policies and implementation mechanisms and semi-structured interviews with a limited number of key stakeholders at different levels.

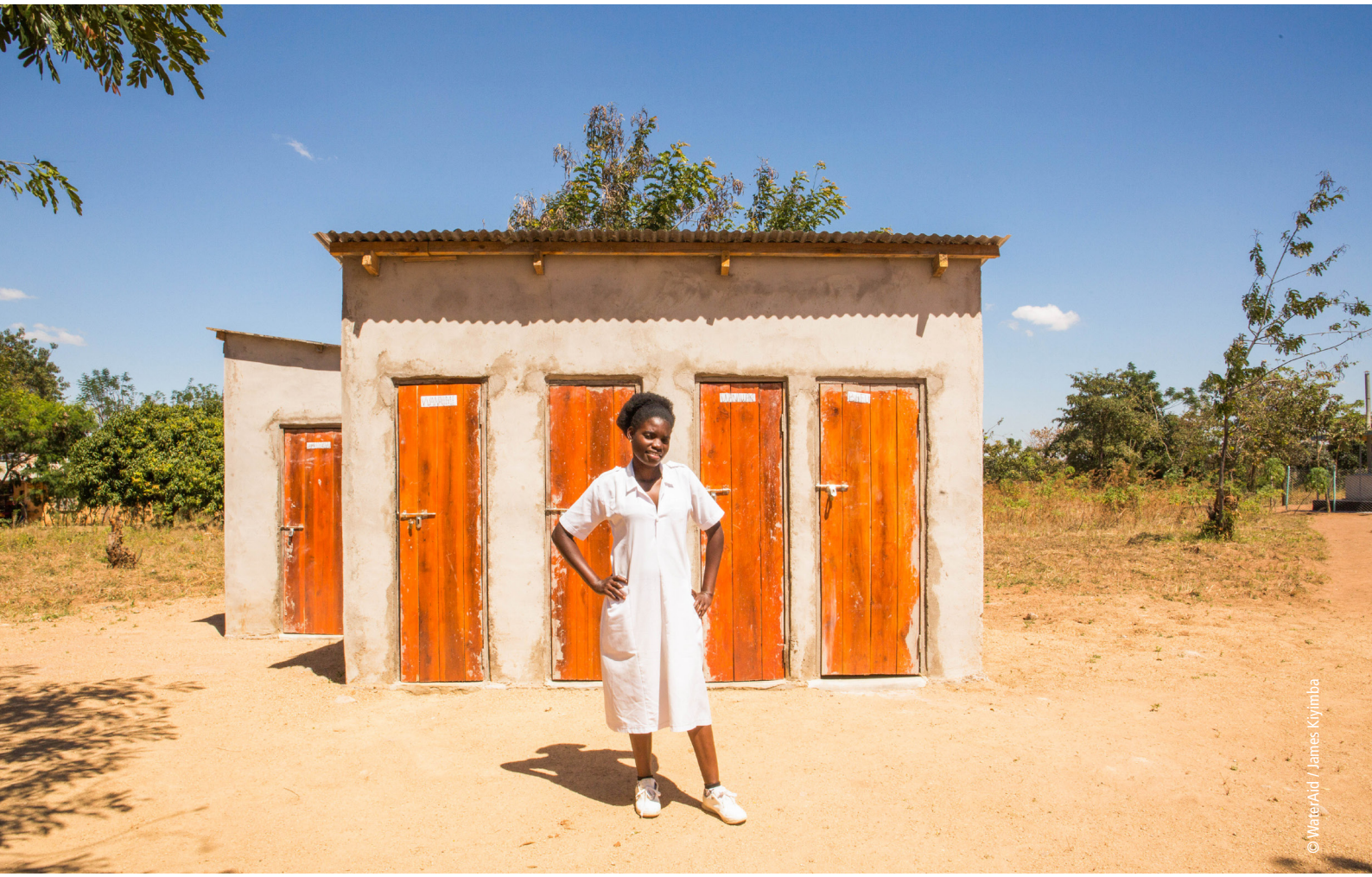
Results and impact:



- a stronger collaboration across the Ministry of Health departments with responsibilities for WASH services and environmental cleaning and between the Ministry of Health and the Ministry of Environment for waste and wastewater management;
- planning for developing a new set of practical guidelines to support policy implementation, in particular on operation and maintenance of water supplies in health care facilities, hygiene and cleaning and waste management;
- WASH being integrated into a new IPC rulebook (a regulatory document) and encouraged better collaboration between WASH, IPC and patient safety departments at the facility-level;
- identification of a need to develop guidance and structured training materials to support health care facilities to implement legal requirements for WASH;
- a review of existing national targets within the framework and formulation of dedicated targets on WASH in health care facilities in the context of the European UNECE/WHO Protocol on Water and Health;
- formulation of advanced WASH service level indicators which will be integrated into routine surveillance and monitoring of WASH and for reporting progress towards implementation of SDG 6; and
- the Ministry of Health agreed to integrate WASH into the national AMR plan during the next review (scheduled every three years). In the meantime, measures to strengthen hand hygiene in intensive care units for the prevention of AMR have been implemented.

Conclusion

A situational analysis provides decision makers with the necessary knowledge and evidence to take action to improve WASH in health care facilities with concrete follow up actions. The results should inform the development of national targets and a road map towards achieving universal and sustainable access to quality health care, as recommended in the 2019 Resolution on WASH in health care facilities. Experience from a number of countries has shown that such analyses provide an important mechanism both for bringing diverse stakeholders together to jointly analyse and problem solve as well as for a more holistic and comprehensive understanding of the factors, gaps and way forward in improving and sustaining WASH in health care facilities.



Annex 1: Practical Steps for Universal Access to Quality Care

1. **Conduct situation analysis and assessment.**
A situation analysis examines health and WASH policies, governance structures, and funding streams, whereas an assessment provides updated figures on WASH coverage and compliance. Together, these documents form the basis for prioritizing action and mobilizing resources.

2. **Set targets and define roadmap.**
The roadmap, supported by an intersectoral national team, should clearly define the approach, intervention areas, responsibilities, targets, and budget for WASH improvements over a defined time period.

3. **Establish national standards and accountability mechanisms.**
National standards should reflect the national context and provide the basis for design, costing, implementation and operation of WASH services. Accountability mechanisms should ensure that all facilities meet national standards.

4. **Improve and maintain infrastructure.**
WASH infrastructure should be improved to meet national standards and be accompanied by policies, resources, and strategies to keep infrastructure and services operational over time.

5. **Monitor and review data.**
WASH indicators can be integrated into routine data collection and review processes for health care. The data can be used to measure progress and hold stakeholders accountable.

6. **Develop health workforce.**
All workers engaged in the health system, from doctors, to nurses, midwives, and cleaners should have access to up-to-date information on WASH and infection prevention and control practices during pre-service training and as part of regular professional development.

7. **Engage communities.**
Community members serve an important role in defining, demanding, using and providing feedback on health services. They ought to be included in the development of WASH policies and in the regular review of WASH coverage and implementation data.

8. **Conduct operational research and share learning.**
External review and research is important for testing and scaling-up innovative approaches and reflecting on and revising programmatic strategies.

For a full explanation of the practical steps and case studies which illustrate them, refer to WHO & UNICEF. 2019 *WASH in health care facilities: Practical steps for universal access to quality care.* https://www.who.int/water_sanitation_health/publications/wash-in-health-care-facilities/en/

Annex 2: Core questions for monitoring WASH in health care facility service provision

The following provides a list of questions on WASH in health care facilities, adapted for a survey format, which could be used in an assessment of service provision. They are adapted from the WHO/UNICEF Joint Monitoring Programme's *Core questions for monitoring WASH in health care facilities in the Sustainable Development Goals*.

1. Main water source (select one):

- ☐ Piped
- ☐ Tube well/borehole
- ☐ Protected dug well
- ☐ Unprotected dug well
- ☐ Protected spring
- ☐ Unprotected spring
- ☐ Rain water
- ☐ Tanker truck
- ☐ Surface water (river/lake/canal)
- ☐ No water source
- ☐ Other: .....

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2. Main water source is on premises:

- ☐ Yes
- ☐ Off premises but up to 500 m
- ☐ More than 500 m

3. Water from main source is currently available:

- ☐ Yes
- ☐ No

4. Number of usable (available, functional, private) toilets for health care facility: ..... (insert number)

5. Type of toilets/latrines (select one – most common):

- ☐ Flush/pour-flush to sewer
- ☐ Flush/pour-flush to tank or pit
- ☐ Flush/pour-flush to open drain
- ☐ Pit latrine with slab/covered
- ☐ Pit latrine without slab/open
- ☐ Bucket
- ☐ Hanging toilet/latrine
- ☐ None

6. Toilets separated for staff and patients:

- ☐ Yes
- ☐ No

7. Toilets separated for male and female patients:

☐ Yes ☐ No

8. Female toilets have facilities to manage menstrual hygiene needs (covered bin, and/or water and soap):

☐ Yes ☐ No

9. At least one toilet accessible to people with limited mobility:

☐ Yes ☐ No

10. Soap and water (or alcohol-based hand rub) currently available in consultation rooms:

☐ Yes ☐ Partially (e.g. lacking materials) ☐ No

11. Soap and water currently available at toilets:

☐ Yes, within 5 m of toilets ☐ Yes, more than 5 m from toilets ☐ No, no soap and/or no water

12. Sharps, infectious and general waste are safely separated into three bins in consultation room:

☐ Yes ☐ Somewhat (bins are full, include other waste, or only 1 or 2 available) ☐ No

13. Treatment/disposal of sharps waste:

☐ Autoclave
☐ Incinerator (other)
☐ Not treated, but buried in lined, protected pit
☐ Open dumping without treatment
☐ Not treated and added to general waste
☐ Other: .....

☐ Incinerator (2 chamber, 850–1000 °C)
☐ Burning in protected pit
☐ Not treated, but collected for medical waste disposal
☐ Open burning

.....

.....

14. Treatment/disposal of infectious waste:

- ☐ Autoclave
- ☐ Incinerator (other)
- ☐ Not treated, but buried in lined, protected pit
- ☐ Open dumping without treatment
- ☐ Not treated and added to general waste
- ☐ Incinerator (2 chamber, 850–1000 °C)
- ☐ Burning in protected pit
- ☐ Not treated, but collected for medical waste disposal
- ☐ Open burning
- ☐ Other: .....

.....

.....

15. Protocols for cleaning (floor, sink, spillage of blood or bodily fluid) and cleaning schedule are available:

☐ Yes ☐ No

16. All staff responsible for cleaning have received training:

☐ Yes ☐ Not all trained ☐ None trained

Annex 3: Analysing the enabling environment for WASH in health care facilities

The table below shows selected building blocks and indicators of an enabling environment, adapted from the building blocks of the UNICEF Water, Sanitation and Hygiene Bottleneck Analysis Tool (WASH BAT).

Each indicator is graded using a traffic-light system: **1) green:** the specific aspects are observed; **2) orange:** the specific aspects were partly observed or were observed but present significant shortcomings (described later); **3) red:** the specific aspects were not observed.

Dimensions	Indicators	Score
Legal framework, policy landscape and political leadership	A legal framework exists	
	Policy and regulations, containing national service norms, is approved	
	Policy and regulations are comprehensive of all dimensions of WASH	
	Policy and regulations include the human right to water and sanitation and are inclusive	
	Requirements are in line with the WHO (2008) Essential Environmental Health Standards in Health Care	
	Requirements are legally binding	
	Requirements are in line with emerging issues (e.g. COVID-19, Legionella, AMR, healthcare associated infections and sepsis)	
	Targets on WASH in health care facilities are drafted or approved	
	Accountability mechanisms are clearly defined	
	There is an ongoing national or sub-national plan/programme targeted at implementing and improving compliance with the law for WASH in health care facilities	
	WASH is reflected as a component in programmes targeted at quality care, universal health care, mother and child health, AMR, climate policies, etc.	
	Political leaders promote and commit to accelerate improved WASH services	
Institutional arrangements and capacity development for implementation	Institutional roles are clearly defined	
	Coordination and cooperation are in place: Interdepartmental, intergovernmental, and broader (all relevant stakeholders)	
	Roles are clearly defined at the local level	
	The national authorities oversee the work of the local authorities for WASH in health care facilities	
	Roles are clearly defined at the facility level	
	Enforcement mechanisms are regulated/in place	
	WASH dimensions are included in the education of medical personnel (doctors and nurses)	
	Structured trainings for non-health staff in health care facilities are established and comprehensively address WASH	
	Research is conducted to collect in-depth data on the situation and identify best interventions in the local context	

Dimensions	Indicators	Score
Sector and service monitoring	Monitoring systems are in place	
	Monitoring is regularly conducted	
	Monitoring comprehensive of all WASH dimensions	
	Monitoring is conducted systematically through use of surveillance checklists	
	Monitoring measures availability and functionality	
	Monitoring reflects international indicators and definitions (WHO/UNICEF/SDG 6)	
	Monitoring is conducted nationally	
	Monitoring data are used to develop, review and implement policies and targets at the national level	
	A national overview on WASH in health care facilities is available	
Budgeting & financing	There is a specific financial plan/budget line for WASH in place	
	Monitoring of expenditures and needs is conducted systematically and used for planning	
	A national overview of annual expenditure for WASH in health care facilities is available, including segregated data for urban and rural facilities	
	Funding allocation matches government priorities	
	Funding allocation is sufficient to meet local needs	
	Donors investments and projects are coordinated at the national level	

Annex 4: Suggested themes for analysing and assessing policy and planning documents

The questions below are intended to guide the interview process. It is not an exhaustive list. The questions are based on past situational analyses and have been co-developed with health systems focal points where analyses have been conducted.

Level	Area of enquiry	Suggested questions and additional guidance for analysis
National	National Health Strategic Plans and Health Policy	Are quality and WASH defined according to the national and local context? Is quality specifically referenced in national planning documents and is quality a national priority? Are there any current or proposed national level initiatives to improve quality? What, if any, specific budgetary provision is there for quality activities?
	National legislation and regulation relevant to health care quality and safety	What regulatory and legislative requirements exist for governing and ensuring quality? *Consider licensing of health providers & professionals, external evaluation of health facilities, professional bodies legislation, accreditation etc.*
	National Monitoring and Evaluation Plans	How is national surveillance regulated? What measures and indicators exist for quality of care *(consider proxy indicators with relevance to quality and WASH)*. Do these include WASH (including health care waste management), IPC and patient safety?
	National Health Information Policy/Strategy	Is quality a priority/objective in the National Health Information Policy or Strategy? *Consider the following:* • *National level quality measurement framework* • *Systems for performance feedback to providers and professionals* • *Inclusion of WASH indicators in health information system* • *Mechanisms for making data on health service performance publicly available*
	Water, sanitation and hygiene (WASH)/ patient safety / IPC policy/ strategy/ plans	What strategies, standards, guidelines, implementation and improvement tools exist for WASH (including health care waste management) in health care facilities, IPC and patient safety? Do any reference national quality and/or improvement efforts and to what extent are the strategies aligned?
	Basic package of essential health services	Is there a published package of essential health services? If so, does it specify criteria related to the various domains of quality? Is WASH included in the package?
	National emergency documents	Is there a strategy or a plan in place to maintain quality health service delivery during times of conflict, disaster or other public health emergency? (e.g. strategic framework for emergency preparedness).
	National COVID-19 preparedness, response and recovery plans	Is there a strategy in place to prepare for, respond to and recover from COVID-19? Is WASH, particularly ensuring access to hand hygiene for all, mainstreamed throughout these plans? Are these plans costed?
	National and health facility patient rights and/or charters	Is there a patient charter of rights? Does it include quality?
	Standards of care	Do standards exists and if so, how are they aligned with the existing national quality policy or strategy? Identify if there are published facility standards for WASH, and if WASH needs are integrated within other disease/ population/facility-specific standards (e.g. quality of care for mothers and newborns).
	Private sector	Is the private sector involved in WASH service delivery in health care facilities? If so, what kind of business model do they employ? What are the main successes or failures? What regulations, including those on quality, exist for private providers of health care? How are these enforced?
	Existing national surveys, surveillance data and statistics	Collect all available data on coverage of WASH services (according to WHO/UNICEF JMP definitions where available), IPC practices and major maternal and child health outcomes.
	National health information management systems	What are the tracer indicators for quality and WASH? Are WASH indicators included in national health management information systems or disease surveillance? How often are data collected and are they analysed? Are data used to influence decision-making and funding allocations? If no indicators are included, what is the process for updating national monitoring systems?

Level	Area of enquiry	Suggested questions and additional guidance for analysis
National	Partnerships and institutional arrangements	Which government entities have responsibility for WASH and quality? Do these entities have sufficient budget? How do the different entities work together? Is this collaboration formalized in any way? Is there a national level taskforce, technical working group or entity responsible for WASH in health care facilities? If so, are there terms of reference, how often do they meet and what have they achieved so far? Who are the key partners and what is their role in supporting government priorities? To what extent do they work towards or independently of government priorities?
	Financing	How is WASH in healthcare financed? *Consider source of financing, distribution mechanisms, decision body, etc.* Do health care facilities have a specific WASH budget? From the total annual budget allocated to facilities, what percentage goes to WASH and IPC? To what extent are quality and WASH in health care facilities in particular, financed through public and/or private funding? What percentage of budget comes from user fees? What are the biggest constraints on the facility budget (e.g. percentage of budget for human resources)? Is there a national health insurance scheme? How successful is this? Is there an overview of the financial needs/gaps with respect to WASH and IPC in health care facilities?
Sub-national/ regional	Sub-national health strategies and plans	Is quality included and if so, does the quality strategy and/or plan align with the national direction? Are WASH services included in this? Review existing operational plans at the sub-national/district/regional level to understand how quality of care is placed and implemented upon? Review how quality and WASH services are placed within the governance structure at the sub-national level Understand how community and patients are placed and engaged within planning and execution of quality health services? Examine how health service strategies are designed, planned, monitored and implemented? Are quality and WASH services ever mentioned, and are quality and WASH stakeholders involved in the process? Study how quality and WASH services are budgeted at the sub-national level.
	Health system decentralisation	To what extent do regions, districts and communities have autonomy to manage health service delivery? What mechanisms are in place to coordinate work between national and district levels? Are district health management (DHM) teams active? Are they involved in decision making relating to quality and WASH? How autonomous are DHMs? To what extent are quality and WASH in health care facilities a priority of DHMs and how do DHM set their priorities? What are the strengths and weaknesses of DHMs (e.g. their organizational capacity and management)?
Facility level	Facility level quality improvement strategies and plans	At the facility level, are there strategies, tools or improvement strategies for WASH, IPC, patient safety or quality improvement. Is there funding allocated for implementation of the strategy? To what extent is it aligned with the national and regional directions on quality? Are there any mechanisms to facilitate learning and feedback as part of quality improvement? What is needed (technically, financially, culturally) to support quality and WASH improvements at the facility level? What is required of different types of staff in making these improvements? What entry points are there for sparking wider change (e.g. hand hygiene)? How can a culture of change be encouraged at every level? What is the perceived and/or real impact of WASH and quality UHC on people-centred care?
	Facility IPC/WASH planning documents	Are WASH & IPC services budgeted for? Is there mention of quality within these documents?
	Community engagement	What issues do the community face linked to WASH in health care facilities (e.g. improper treatment or disposal of health care waste, unsafe management of faecal waste)? What is the role of the community and how can this be strengthened (especially for WASH improvements)? Are there any active community groups or committees? How might the community be empowered to demand and support higher quality and better WASH services?

Annex 5: Questions for interviews with stakeholders from all levels of the health system

Level[a]	Target audience	Objectives	Questions	Probe questions
National	1. Quality Directorate within the MOH/ 2. Relevant directorates working on WASH and quality 3. Relevant departments supporting the Quality Directorate	To understand the current national direction on quality and further understand desk review of documents.	What are 3 – 5 factors that impact on the strengths and weaknesses of the national health system in your country?	What makes these impactful? Who are the key actors?
			Is there a budget line related to WASH in quality-related activities?	How is this budget allocated? Are there other additional financial sources and/or partners contributing towards funding quality or WASH activities?
			What are the main health priorities in your country? What are the main WASH priorities? What are the main quality priorities?	What targets exist for the main priorities?
			What are the ongoing opportunities & challenges in quality?	How should these opportunities be utilized? How should these challenges be addressed?
			What governance and accountability structures on quality exist between the levels of the health system?	Is there a long-term strategic plan? Are you aware of the national goals aimed at improving quality of care?
			How does WASH impact/influence with the wider work on quality?	What are the improvement aims, objectives and intended outcomes of WASH services?
			How is the quality strategy and/or policy being implemented?	What are activities planned for in order to achieve the priorities?
			How do you see WASH services being a part of the national direction on quality?	What objectives and aims are set for WASH to improve quality?
			What are the WASH targets? What are the quality targets?	Are these being achieved? Are the not being achieved?
			What communications channels exist between national WASH and quality teams?	Is this communication effective?
			What are the monitoring mechanisms for quality and WASH?	What are the indicators? Are there data collections by other ministries? How are data collected. How are data used?
			How health services are delivered across the system? Where do these sit?	Does the private sector play a role in this?

[a] Also build in flexibility to interview other key stakeholders, depending on the setting, such as national health insurance or external evaluation bodies.

Level[a]	Target audience	Objectives	Questions	Probe questions
District/facility level	1. Facility quality and WASH focal points 2. Facility managers / chief medical officer 3. Facility staff (clinical and non-clinical)	1. Determine monitoring systems, operational planning, improvement approaches around current WASH and quality priorities. 2. Determine leadership/ management health facility structures, budgeting for quality and WASH related efforts 3. Learn about staff experience with WASH and quality efforts 4. Determine influence of leadership and management on QoC. 5. Ascertain if health workers are adhering to national clinical standards.	Describe the demographics of the facility.	How many beds/patients? How many staff? What services are provided? What population is served? What is the catchment area?
			What are the main quality improvement and measurement initiatives?	Is there a dedicated position or team for quality? Is there a hospital wide quality committee? How is the concept of quality viewed among staff?
			Is there a facility policy, strategy or plan on quality?	Does the facility use any national policy or strategy on quality?
			What are the organizational values in your work setting?	
			Are there published standards for quality of care?	Do staff have access to clinical guidelines for common conditions? Are these routinely followed? Is Adherence to standards and protocols monitored? Is there a patient charter?
			What data is used for giving feedback to providers and managers? What is the process for reporting the data to the region?	What data is routinely collected at the facility? Is reporting electronic or paper based? How is the data used to assess quality of care?
			How is the hospital/health centre funded? Do gaps exist and what are the critical gaps that should be addressed?	Can patients pay for a better standard of care? What resources (financial and technical) has the county committed to improve quality of care?
			Is there regular training for clinical staff?	Are staff trained in quality/IPC/WASH?
			Is there an IPC focal point or nurse?	Are handwashing facilities available? Are there sufficient toilets for patients?
			Is there a system to record and act on patient safety incidents?	Is there a complaints/patient and staff survey system?
			When was the facility built/renovated?	Does the building provide sufficient shelter from the elements? Is there a reliable electricity supply?
			What local community structures could be used to improve quality?	Is there a mechanism for patients and community members to contribute to the running of the facility?
			Is research and evidence routinely used to guide clinical care?	Does the facility participate in research?
			Who has the authority to set and change priorities?	How are decisions made about how to spend the budget?
			Does the facility undergo any external assessment?	Is this compulsory or voluntary? accreditation process?
			What are the main challenges to improve quality of care?	Do you feel that your employer engages with you? If so, what stands out?
			From your experience, is this facility similar to others in the standard of care that it provides?	
			Would you be happy to have your friends and family treated here, given the standard of care?	Do you feel proud about your work? Do you feel your employer feels proud about you?
			Do you think the national direction on quality might have any impact on this facility?	What extra resource, training or other input would help you to deliver quality care?

[a] Also build in flexibility to interview other key stakeholders, depending on the setting, such as national health insurance or external evaluation bodies.

Level[a]	Target audience	Objectives	Questions	Probe questions
Community/ patient/family			How have existing community structures and networks been engaged in the planning, decision-making, and implementation of quality improvement activities at the health facility?	What has the community engagement been in relation to the provision of better quality services in health facilities? What should the role of the community be in achieving this?
			What are the most pressing issues and concerns in the community?	How can the community be better engaged?
			The last time you needed health care: Where did you go? What was your experience with Quality and WASH?	What went well? What could have been done differently?
			What does quality of care mean to you?	What are the most pressings concerns for you at the health facility in relation to WASH?
			What can be done to improve quality and WASH services at the health facility?	Do you feel engaged and empowered to suggest this to the health facility?
			Please describe what quality of care means to you.	
			Please describe what motivates you to utilize the services provided at this facility?	
			Do you feel like you can trust the facility? The health service providers within the facility?	
NGO/ International organizations	Development agencies, faith-based organizations and NGOs working on Health, quality and WASH	Determine which stakeholders support WASH and Quality initiatives, approaches employed, facilities/ districts involved and programmes within each country.	What are the governance structures within your organizations? How does this support national and local government priorities?	To which person/body is health centre management accountable?
			Does your organization provide financial support for either WASH and/or Quality?	
			What are your reporting lines for the work you do to support national programs?	

[a] Also build in flexibility to interview other key stakeholders, depending on the setting, such as national health insurance or external evaluation bodies.

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