FINAL

Guidelines
for
Hygiene Promotion in Health Facilities
and
other Public Places in Nigeria

2015

Guidelines
for
Hygiene Promotion in Health Facilities
and
other Public Places in Nigeria

Content

*****

Abbreviation /Acronym

BHCs	Basic Health Centres
CHCs	Comprehensive Health Centres
CHCOMs	Community Health Committees
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CHORBN	Community Health Officers' Registration Board of Nigeria
CLTS	Community Led Total Sanitation
EHO	Environment Health Officer
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
GLAAS	Global Analysis and Assessment of Sanitation and Drinking-water
GAPPD	Global Action Plan to Eliminate Childhood Pneumonia and Diarrhoea
GTFCC	Global Task Force on Cholera Control
HCF	Health Care Facility
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
JMP	WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation
JCHEWs	Junior Community Health Extension Workers
LGA	Local Government Area
MDGs	Millennium Development Goals
MSS	Midwives Service Scheme
NPHCDA	National Primary Health Care Development Agency of Nigeria
NGO	Non-Governmental Organization
NHP	National Health Policy
PHC	Primary Health Care
PHCs	Primary Health Centres
PPE	Personal Protective Equipment
RNHP	Revised National Health Policy
SURE-P-MCH	Subsidy Reinvestment and Empowerment Program, Maternal and Child Health ()
UN	United Nations
UNICEF	United Nations' Children's Fund
VDC	Village Development Committee
WASH	Water, Sanitation and Hygiene
WASHCOM	Water, Sanitation and Hygiene Committee
WHS	Ward Health System
WHO	World Health Organization

******

1. ABOUT THESE GUIDELINES:

a) These guidelines are about implementation of hygiene promotion (HP) in Public Health Care (PHC) facilities and at other public places (rural markets, weekly markets and Inter-state taxi/transport stands) in Nigeria**. T**he guidelines prioritizes basic information and approaches to implement hygiene promotion and sanitation activities in PHC facilities, such as Basic Health Clinics (BHCs), Primary Health Centers (PHCs) and Comprehensive Health Centers (CHCs) and other public places with-in a LGA with provision of adequate WASH facilities, capacity building of all relevant health professional and other stakeholders engaged with public places and carrying out various activities related with domains of hygiene.

b) The guidelines highlight the linkages and synergy for hygiene promotion efforts between 'in and through schools', 'in communities', 'CLTS efforts' and 'in PHC facilities' along with 'at public places'. The focus of guidelines is to make all relevant health professional and other stakeholders involved at public places about relationship between 'good hygiene and good health', by explaining that how lack of hygiene and sanitation at health facilities may lead to spread of infection among patients, pregnant women, new born babies and health workers themselves. Similarly, lack of sanitation and hygiene at public places may lead to spread of diseases/infections to the large population.

c) The guidelines emphasising on flagging of various hardware and software interventions at each of the health facility as well as at public places for protection of children, mothers and vulnerable population from various infections and water/sanitation related diseases.

d) The guidelines consider a strong linkage with-in a LGA between communities, health facilities, schools and public places/markets. Thus, determined a role of Village Development Committees (VDCs), WASHCOMs to support health facilities and public places with provision of safe water source and hygienic toilets and provisions for hand washing with soap (wash basin).

e) The guidelines may pave a way to make a few changes in existing training and other manuals by incorporating certain role and responsibilities as well as certain activities interfacing at community level, health facilities and public places/markets.

f) The guidelines are based on key framework of National Hygiene Promotion Strategy of Nigeria (2015), which emphasises on high visibility of hygiene promotion activities and phase-wise implementation of domains of hygiene.

g) These guidelines along with all relevant IEC materials will be available for reference and dissemination of information at each Primary Health Care (PHC) facility, where the programme will be implemented, besides other stakeholders at LGA, state and national level.

*****

2. BACKGROUND

2.1 Global:-

- In 2015, UNICEF and WHO for the first time brought out a report[1] related with global assessment of the extent to which health care facilities provide essential water, sanitation and hygiene (WASH) services. Drawing on data representing 66,101 facilities in 54 low- and middle-income countries (including Nigeria), the report concludes that 38% of facilities lack access even to basic levels of WASH, 19% did not have improved sanitation and 35% did not have water and soap for hand washing. When a higher level of service was factored in, the situation deteriorated significantly. Large disparities existed within countries and among types of facilities. This lack of services compromises the ability to provide basic, routine services, such as child delivery and compromises the ability to prevent and control infections.

- Primary health care facilities are frequently the first point of care, especially for those in rural areas. They also are critical in responding to disease outbreaks, such as cholera or Ebola. Yet, without WASH services, the ability of health care workers to carry out proper infection prevention and control measures and demonstrate to communities safe WASH practices, both of which are especially important in controlling and stopping outbreaks, is greatly compromised.

- Only 25% of 86 countries, responding to the Global Analysis and Assessment of Sanitation and Drinking water (GLAAS) survey[2], a UN-Water initiative coordinated by WHO reported having a fully implemented plan or policy for drinking-water and sanitation in health care facilities. In countries for which data on provision of water and national plans were available, countries with national plans had a greater proportion of facilities with water services, suggesting national policies are an important element of improving services.

- WASH services provide for water availability and quality, presence of sanitation facilities and availability of soap and water for hand washing. The presentation of results focus largely on water availability as there were very limited data on water quality, sanitation and hygiene. In addition, a brief summary of data on the safe disposal of health care waste was provided.

- The report shows that a large number of health care centres lack the most basic water, sanitation, and hand washing facilities. In the African region, 42 per cent of facilities lacked an improved water source within 500 metres. This is far below the WHO minimum standards, which call for water supplies on premises. The review generally found sanitation facilities to be more common than water facilities,

[1] WASH in health care facilities: status in low and middle income countries and way forward – UNICEF and WHO 2015

[2] WHO 2014

though as some of the surveys did not include observation of sanitation facilities, results may be inflated and may include non-functional or locked facilities.

- Lack of basic water, sanitation and hygiene facilities compromises the ability of health care workers to carry out proper infection prevention and control measures and demonstrate safe WASH practices to communities, both of which are especially important in controlling and stopping outbreaks. In Sub Sahara Africa WASH status in health facilities are alarming. The data shows – (i) No improved water source within 500 metre – in 42% health facilities, (ii) No improved sanitation – in 16% health facilities (iii) No soap for hand washing – in 36% health facilities.

- Score of people die every day around the world from infections acquired while receiving health care. Organisms that cause nosocomial infection (hospital-acquired infections) in health care settings are most commonly transmitted by the hands of health care workers and other hospital personnel. Hand hygiene is the single most important procedure in preventing nosocomial infection.

- If health care facilities are overcrowded and WASH services are inadequate, then patients, staff, carers and neighbours of the health care facility may face unacceptable risks of infection. The health-care facilities might even become the epicentre of outbreaks of certain diseases, such as cholera, Ebola and other epidemics.

- Whenever, there is a surge in the number of patients as a result of disease outbreak or trauma related injuries, then the overcrowding of wards may contribute significantly to the increase in risks of disease transmission and also requirement for WASH services in health facilities may increase significantly. Possible those health centres may be having insufficient numbers of toilets, bathing facilities and hand washing stations to cope with demand. Besides, they may not have sufficient numbers of support staff to deal with additional infection control, cleaning, disinfection, and waste collection requirements.

- The Disease Control and Prevention (CDC) recommends hand-washing before and after contact with every patient. The recommendation on hand hygiene has recently been updated, and hand washing has been replaced by hand rub as the standard of care. In the community, hand hygiene has been acknowledged as an important measure to prevent and control infectious diseases and can significantly reduce the burden of disease, in particular among children in developing countries.

2.2 Nigeria

- In Nigeria, in 1988, a National Health Policy (NHP) was formulated to achieve quality health for all citizens. After 16 years of that, in September 2004, the

health policy was reviewed in context with Millennium Development Goals (MDGs) and a new policy was launched[3], as the Revised National Health Policy (RNHP).

- The revised policy outlined the goals, structure, strategy, and policy direction of the health care delivery system in Nigeria. Roles and responsibilities of different tiers of government, including non-governmental organisations, were clearly defined. The policy's overall long-term goal was to provide adequate access to primary, secondary, and tertiary health care services for the entire Nigerian population through a functional referral system.

- The overall objective of the Revised National Health Policy was to strengthen the national health system, so that it will be able to provide effective, efficient, quality, accessible and affordable health services.

- The national health policy identified Primary Health Care (PHC) as the framework to achieve improved health for the population. PHC services included **health education**; adequate nutrition; **safe water and sanitation**; reproductive health, including family planning; immunization against five major infectious diseases; provision of essential drugs; and disease control.

- Nigeria's health sector is described by wide regional disparities in status, service delivery, and resource availability. To give priority to Maternal and Child Health (MCH), the Federal Government of Nigeria (FGN) initiated several interventions including the Midwives Service Scheme (MSS), the Subsidy Reinvestment and Empowerment Program, Maternal and Child Health (SURE-P-MCH). The systematic PHC infrastructure build-up through the Ward Health System (WHS) was initiated in the year 2000 to improve equitable access to essential health services. The system was aimed on the harmonization of PHC services across electoral wards with the construction of model PHC facilities in underserved areas.

- In Nigeria, Primary Health Care (PHC) facilities are functioning under National Primary Health Care Development Agency of Nigeria (NPHCDA), supervised by Federal Ministry of Health (FMoH). These facilities play a vital role within the community, by providing essential medical care to the sick, serving as resource centres for prevention, and serving as part of an early warning network of communicable diseases among others.

- The PHC facilities are manned by health professionals like Community Health Officers (CHO), Community Health Extension Workers (CHEWs) and Junior Community Health Extension Workers (JCHEWs), who are serving the rural

[3] Federal Ministry of Health

communities, where the Federal Government constructed BHCs, PHCs and CHCs. It is estimated that Nigeria has over 120,000 Community Health Practitioners. These professional are licensed by the Community Health Officers' Registration Board of Nigeria (CHORBN) to see patients, write prescriptions and carry certain medical procedures.

- Under the National Health Policy (NHP), the PHC service includes provision of safe water and sanitation as well as health education. Although, provision of hygiene promotion in health facilities has not been specifically mentioned in NHP, but the task and areas defined for the job of Environment Health Officers (EHOs), attached to PHC facilities, has the hygiene promotion embedded along with sanitation promotion.

- Many PHC facilities, in Nigeria may not be adhere to minimum Water, Sanitation and Hygiene (WASH) standards in order to provide an adequate and safe level of health-care in addition to minimizing the nosocomial (hospital-acquired infections) risk to patients, staff and carers and the infectious risk to surrounding communities. Generally, PHC facilities are environments with a high prevalence of infectious disease agents.

- Although National Primary Health Care Development Agency of Nigeria (NPHCDA), has created new infrastructure/buildings for PHC facilities in many LGAs, but possible due to lack of electricity, maintenance, cleanliness, in many of those buildings may not be having adequate and sustainable supply of safe water. Similarly, toilets may be having problems due to unhygienic maintenance. Many facilities may not be having soap to wash hands after attending patients. In absence of water and soap, the use of alcohol based hand-rub is not practiced in PHC facilities in Nigeria. Otherwise also, a minuscule per cent of people use alcohol based hand rub for hand hygiene practices.

- Hygiene promotion in public places (rural/weekly markets and Inter-state taxi/transport stand) has a complex problem in Nigeria. Due to overall low coverage of sanitation, prevailing poor hygienic conditions and general attitude of masses towards safe sanitation and hygiene, the improved sanitation and hygiene at public places was never a priority of authorities and market committees. The pathetic conditions of toilets at filling stations (patrol pumps) are the reflections of attitude of people towards sanitation and hygiene. In majority of filling stations the toilets are full of raw and dry excreta and without supply of water.

- In some market places, community toilets and bathing space has been running on “pay and use” basis, but there is need of improvement in those facilities as well construction of new facilities in those places, where till now no public toilets are available.

*****

3. WHY NEED OF WASH SERVICES AND HYGIENE PROMOTION IN HEALTH FACILITIES

- PHC facilities are normally the initial point of care, especially for those in rural areas. They also are vital in reacting to disease outbreaks, such as Cholera or Ebola. But, health facilities without WASH services, compromise the ability to provide safe care and pose serious health risks to those seeking treatment. It also, compromise the efforts of health care staff to carry out infection prevention and control measures and demonstrate/motivate to communities safe WASH practices. **Improving WASH services and** WASH related **behaviour in health care facilities is achievable and has positive ripple effects on** WASH **practices in homes.**

- "The consequences of poor WASH services in health care facilities are numerous. Health care associated infections affect hundreds of millions of patients every year, with 15% of patients estimated to develop one or more infections during a hospital stay (Allegranzi et al., 2011). The burden of infections is especially high in newborns. Sepsis and other severe infections are globally major killers and estimated to cause 430,000 deaths annually. The risks associated with sepsis are 34 times greater in low resource settings (Oza et al., 2015). Lack of access to water and sanitation in health care facilities may discourage women from giving birth in these facilities or cause delays in care-seeking (Velleman et al., 2014). Conversely, improving WASH conditions can help establish trust in health services and encourage mothers to seek prenatal care and deliver in facilities rather than at home - important elements of the strategy to reduce maternal mortality (Russo et al., 2012)"[4].

- In Nigeria, decisive action and interventions are needed to improve WASH services in PHC facilities in a systemic way along with capacity building of health care staff for mandatory practices of hygiene related behaviours, especially hand hygiene, maintenance of sanitation facilities and handling of water for drinking and other purposes. The rationales to enhance WASH in health care facilities are many - advanced quality of care, minimal health care related infections and progressive improvements in staff morale. Improving WASH services will involve a number of basics, such as - starting with leadership from the health sector, sustained technical inputs from WASH sector and political commitment from FGN, State governments, LGA leadership and elected leadership of designated area.

[4] World Health Organization

- Generally, it is seen that health care staff usually wash hands with soap when the hands are visibly soiled or contaminated, after removal of gloves and contact with patients. This improvement may be due to enhanced awareness of the risk of transmitting infection in health care settings, rise in the occurrence of health care associated infections, better policies and guidelines for infection control, along with periodic education/sensitization and training of health care staff.

- The improved behaviour of health care staff for hand hygiene practices get knocked when there is lack of water/no water, lack or shortage of sinks or inconveniently located sinks, lack of soap, lack or inadequate towels and insufficient time. Similarly, hand hygiene get blow in consulting rooms where there are no sinks or reluctance by health care staff of washing hands in-between the every patient or each time before wearing/removing gloves. In these circumstances, it is suggested to use of alcohol based hand rub, which will break-off the cross-contamination chain and disease burden.

- Thus, there is a need of advocacy for promotion of hand de-contamination agents such as alcohol-based hand rub, which may help to solve common problems associated with hand-hygiene.

- Promotion of hygiene and sanitation in PHC facilities is essential because they offer an important point of entry for raising the profile of hygiene and sanitation, as well as improving the environmental health conditions in the **communities. Staff of PHC facilities must adhere to good hygiene practices** while attending patients and keeping the facilities disinfected. Besides, they could demonstrate good hygienic practices to others - patients, visitors, by performing activities such as :
  - Washing hands with soap at critical times (besides washing hands with soap before and after attending every patient); (See Annexure-I "***Hand Hygiene in Health Facilities***[5]***"***);
  - Disinfecting floors and surfaces;
  - Using toilets properly and keeping it clean, and
  - Safe handling, drinking and use of water for health care needs.

- These guidelines consider "staff of PHC facilities as agent for change" with expectation to motivate others, including patients and visitors and nearby communities for adopting good hygienic practices.

- These guidelines in Nigeria will give a direction to ensure that all PHC facilities have adequate patient-friendly WASH facilities and hygiene

[5] WHO

promotion practices necessary for effective and efficient recovery environment.

- Effective hygiene promotion practices will depend and sustain in PHC facilities on the basis of a number of WASH related different requirements, including:-
    - Water supply (with water quality, quantity and access);
    - Safe excreta disposal and maintaining clean toilets;
    - Appropriate drainage system;
    - Healthcare waste management;
    - Cleaning and laundry;
    - Control of vector-borne disease;
    - Infection control measures;
    - Health care package for disabled people;
    - Hygiene promotion (including food hygiene);
    - Extensive use of IEC materials for awareness creation
    - Cleaning of maternity wards;
    - Menstrual hygiene management.

*****

4. LEVEL OF RISKS AND REQUIRED WASH INTERVENTIONS IN PHC AND OTHER HEALTH FACILITIES:

- The minimum WASH standards[6] are intended for use in all PHC and other health-care facilities. It includes:

#	Type of health care facilities	Scope	Level of Risks	Required WASH interventions
1.	**Central and other hospitals**	Range of outpatient and in-patient care;	Disease transmission risks are substantial, given the presence of infectious patients and extended contact with other patients, staff and carers;	Full range of WASH interventions needed;
2.	**PHC facilities**	Range of outpatient care and outreach activities. Less inpatient care;	Disease transmission risks are lower than in hospitals;	Full range of WASH interventions needed;
3.	**Temporary clinics or refugee/IDP clinics**	range of outpatient care and PHC activities;	Disease transmission risks may be higher due to overcrowding and a lack of adequate water, sanitation and shelter;	Full range of WASH interventions needed;
4.	**Cholera treatment centres/units (CTC/CTU);**	Range of inpatient care activities for patients with cholera;	Disease transmission risks are very high;	Full requirements for WASH interventions needed;
5.	**Mobile clinics (in tents, under plastic sheeting, or inside temporary buildings);**	Provide outpatient care and outreach activities including primary health-care;	These are emergency settings, thus infection risks are high;	Relevant requirements for WASH facilities and services needs to be provided to the same level as if the facilities were permanent structures;
6.	**Therapeutic feeding centres;**	Provide in-patient medical care for patients (generally children) those are	Disease transmission risks are high;	Full requirements for WASH interventions needed;

[6] Adopted from WASH in health-care facilities in emergencies, WHO 2012

		severely malnourished;		
7.	**Isolation wards /areas;**	Provide emergency treatment of patients during outbreaks of infectious diseases such as cholera and viral hemorrhagic fevers;	Disease transmission risks are very high;	Full requirements for WASH interventions needed;

*****

5. ACCESS TO WASH SERVICES IN PHC FACILITIES IN NIGERIA

- In Nigeria, access to improved WASH services in most public health facilities has been estimated to be grossly inadequate. This is often due to various reasons, among which are: –

  (a) Inadequate plans by policy makers and other stakeholders to allocate sufficient resources to provide WASH services in various health facilities, especially for out-patients and visitors;

  (b) Inadequate funding for maintenance of WASH services;

  (c) Inadequate training of staff on maintenance, importance and necessity of WASH, including hand hygiene;

  (d) Lack of awareness/education among various stakeholders about the linkages between poor sanitation/hygiene and poor health.

- WASH services, especially toilets, in most PHC facilities are not adequate and not meeting the recommended standards of toilet to patients' ratio, which has been put by the World Health Organisation (WHO) in 2012 as 1: 20, that is one latrine/toilet to 20 users. Thus, in order to have a functional PHC facility, the minimum WASH requirements should be met in such facilities. It is also necessary that all WASH services should be well maintained and easily accessible for PHC staff, patients, caregivers and visitors.

- Lack of adequate WASH access in PHC facilities is one of the major contributory factors for un-hygiene practices, thereby increasing the risk of 'hospital acquired infections' (nosocomial risk). WASH related needs in PHC facilities include the following:

  - ❖ Adequate safe water, preferably, uninterrupted running water in toilets, washrooms and sinks through over head water tanks is needed for:
    - Hand washing with soap at critical times by staff, patients and visitors;
    - Cleaning of floor, wards, linen, medical equipment;
    - Cleaning of toilets;
    - Food preparation;
    - Cleaning of maternity wards.
  - ❖ Adequate sanitation is needed for:
    - Safe disposal of excreta in order to prevent outbreaks of diseases;
    - Adequate sanitation infrastructure for special needs of various groups (disabled, pregnant women, elderly).

- ❖ Hygiene is required for:
  - Hand hygiene for protection of patients, visitors and PHC staff from infections;
  - Ensure cleanliness of surfaces, environment, equipment and staff.

5.1 Advantage of WASH in PHC facilities

The following advantages can be obtained from the properly implemented WASH interventions in any PHC project:

- *Effective recovery:* Patients, visitors and staff generally in healthy PHC environments are healed more effectively.
- *Consistent usage of PHC:* Provision and usage of WASH services in PHC facilities will encourage patients in many settings to use such facilities, especially hand washing with soap at critical times.
- *Patient rights:* Healthy and happy life is assured as patient right; good WASH services being the right of patients, visitors and staff.
- *Gender equity*: There can be greater gender equity in access to PHC facilities and meeting WASH-related needs
- *Reduced diseases and worm infestations:* Improved WASH services and good hygiene practices will prevent infections and infestation, thereby reducing disease burden among patients, visitors, staff and their families.
- *Reaching household and community*: Patients, visitors and staff are able to introduce and reinforce hygienic behaviours in household and communities.
- *Environmental cleanliness:* Properly used hygiene facilities will prevent pollution of the environment and limit health hazards for the community at large.
- *WASH sustainability*: Patients, visitors and staff can learn and practice life-long positive hygiene behaviours and also promote safe environments at homes and in the communities.

*****

6. ROLE OF STAKEHOLDERS FOR WASH SERVICES AND HYGIENE PROMOTION AT PHC FACILITIES IN NIGERIA

- Hygiene Promotion in PHC facilities is not possible without adequate access to WASH services. 'Hardware and Software' aspects of WASH services facilitate sustainable measures to reduce health facility acquired infections by visitors, patients and health staff. Besides, it helps to motivate members of catchment communities to adopt good hygienic behaviours. Thus, there is a need to develop partnership among various stakeholders from national level to the community and PHC facilities. Partnership includes among:-

  i. National Task Group for Sanitation (NTGS) - State Sanitation Task Groups (STGSs);

  ii. Federal Ministry of Water Resources – State governments, RUWASSA, LGA WASH Team;

  iii. Federal Ministry of Health – National Primary Health Care Development Agency of Nigeria (NPHCDA), Community Health Officers' Registration Board of Nigeria (CHORBN), State governments, LGA's health coordinator/deputy coordinator, Basic Health Clinics (BHCs), Primary Health Centres (PHCs), Comprehensive Health Centres (CHCs), CHOs, CHEWs and Midwives;

  iv. Federal Ministry of Environment - Environment Health Officers (EHOs) posted in PHC facilities;

  v. Village Development Committees (VDCs), WASHCOMs, CHCOMs and School based hygiene promotion pupil groups attached to EHCs;

  vi. Donor agencies (Multilateral and bilateral) – DFID, EU and others;

  vii. International organization - UNICEF, WHO, WATERAID, WSSCC and others;

  viii. National level training institutes (for CHOs, CHEWs and Midwives) and research institutions; (in order to incorporate extensive lessons for hygiene promotion "in and through PHC facilities)";

- A strong partnership among various stakeholders will help for operative hygiene promotion interventions through participatory approaches. The effective partnership at various levels will facilitate the sustainability of the programme.

- The strong partnership among stakeholders will pave the way for an enabling environment through FGN policies and committed political will at national, state and LGA levels, with adequate funding from donors and International organization for construction of WASH facilities (water, sanitation, sinks) in

health centres. This will also help to accelerate the processes for adopting the good hygiene behaviours by the catchment community members in Nigeria.

- National Primary Health Care Development Agency create infrastructure for PHC facilities in Nigeria, under the overall supervision of FMoH, and take support from state RUWASSA under the FMWR for providing WASH facilities. Thus maintenance of WASH facilities within the premises remains with LGAs health coordinator but LGAs WASH coordinator remains the in-charge of providing hygiene promotion IEC materials to PHC facilities and also facilitating hygiene promotion through PHC facilities in catchment communities and schools. Thus at national level both FMoH and FMWR will own the programme of hygiene promotion through technical support from UNICEF and WHO.

- The partners at national level must look at the UNICEF-WHO recommended "Global health initiatives requiring wash services in health care facilities" to ensure the better health of a new born and early childhood disease prevention. **(See Annexure – II)**

- Once the partnership developed then an action plan must be developed to organize and implement on following themes:-

    a) Policies and standards;

    b) Coverage targets;

    c) Improving WASH services; and

    d) Operational research.

    a) <u>Policies and standards</u>: National policy and standards for Nigeria on WASH in PHC facilities along with hygiene promotion must be accompanied by strategies that identify adequate funding, human resources, capacity building of health worker/ staff and institutional arrangements to ensure that standards are implemented. Implementation of national standards may benefit from a 'laddered' approach that allows health care facilities to make incremental progress towards, and eventually beyond, a basic level of service.

    b) <u>Coverage targets</u>: On the basis of political will and resource allocations (matching matching share from states) coverage targets can be set on yearly basis. To ensure realistic target setting, detailed needs assessments shall be required that prioritize the most vulnerable (e.g. areas with high maternal and newborn mortality rates, cholera outbreaks, etc.) and that take into account human, financial and technological capabilities.

    c) <u>Improving WASH services</u>: To improve and maintain WASH services on regular basis in PHC facilities - training and sufficient staffing shall be needed, both on hardware and software (hygiene

practices) aspects. Training manuals on WASH must be developed and delivered with training on infection prevention and control. There should be regularly trained individuals for ensuring that water and sanitation facilities are properly operated and maintained and that essential services such as safe disposal of health care waste are available.

The training needs to be supported by appropriate IEC tools (e.g. posters, leaflets, and pocket booklets), refresher courses and incentives to enable the ongoing practices and delivery of messages by health care workers. When such support is provided, long-term, sustained improvements are possible.

d) **<u>Operational research</u>:** Periodic operational research on both hardware and software aspects of WASH interventions at health facilities shall be able to help to gauge progress on time bound manner, especially for installing WASH facilities at PHC facilities. The operational research on software aspects, e.g hygiene practices by care givers and care seekers will be helpful to determine the outcome of WASH intervention in a particular area/ward or at the catchment communities on the basis of indicators. Operation research will have to define the indicators and planning for specific interventions. The operational research is also important for informing effective implementation and further understanding the links between WASH services in health care facilities and health outcomes.

******

7. IMPLEMENTATION OF HYGIENE PROMOTION "*IN AND THROUGH PHC FACILITIES*" IN NIGERIA:

- Sufficient availability of WASH access, impact recovery process in PHC facilities, while inadequate WASH services contribute significantly to low support of PHC facilities in Nigeria. **Hygiene promotion and good sanitation in PHC centres are essential**, because they offer an important point of entry for raising the profile of hygiene and sanitation, as well as improving the environmental health conditions in the catchment communities and schools. Visitors and staff of PHC facilities could prove to be effective change agents when they learn and get inspired to perform good WASH behaviour such as always washing their hands with soap at critical times, using toilets properly, and drinking safe water. Moreover, those who adopt good hygiene practices at PHC facilities, they not only work as peer advocates but also become health conscious, thereby transferring the knowledge, skills and practices to the rest of their families.

- For good **synergy of hygiene promotion efforts**, the linkages need to be established between communities, schools and PHC facilities within a ward of a LGA. So that, a positive environment, in favour of processes to adopt good hygiene practices by each member of all communities within a ward is initiated and established. The focus, needs to be on involvement of all relevant health professional and other stakeholders to make people understand relationship between 'good hygiene and good health', by explaining that how lack of hygiene and sanitation at health facilities may lead to spread of infection among patients, pregnant women, new born babies, visitors and health workers themselves. Similarly, lack of sanitation and hygiene at public places may lead to spread of diseases/infections to the large population.

- As per **technical guidelines of FGN for WASH access** in each of the PHC facilities, adequate provision of water points, toilets/urinals (20:1 ratio, separate for male and female and disabled) and sufficient sinks must be constructed mandatory in health centers. Besides, an area demarcated for medical waste disposal. Defunct and broken WASH facilities must be repaired or replaced with working facilities in health centers, by the competent authorities or by VDCs and WASHCOMs through financial support from community members.

- The **LGA Health Coordinator** with support from LGA WASH Coordinator must take initiative to rehabilitate WASH services in existing PHC facilities. The LGA Health Coordinator must ensure following:-

a) Assess the quantitative and qualitative WASH needs in PHC facilities at each ward level;

b) On the basis of field reports and data, plan and implement control measures; (clear implementation plan of control measures in terms of Who, What, Where, When and How. At each facility)

c) Monitor the routine maintenance of WASH facilities;

d) Establish synergy with hygiene promotion programme in Schools, Community, Public Places and Health facilities;

e) Keep tab on daily footfall and daily requirement of water in each of the health centres at each ward level;

f) Involve in all other operational monitoring related with WASH and hygiene promotion;

g) Periodically analyse, prioritise and re-plan for better results and impact.

7.1 HYGIENE PROMOTION "*IN PHC FACILITIES*":-

- As stipulated in National Hygiene Promotion Strategy of Nigeria (2015), high visibility of hygiene promotion activities leads to motivation for more behavioural change, thus attempt to be made to make hygiene promotion activities more visible in PHC facilities. Besides, the strategy also stipulated phase-wise implementation of domains of hygiene.

- As per Hygiene Promotion strategy **phase – I** of implementation of hygiene promotion must emphasis on following three areas:-
  (a) Hand washing with soap;
  (b) Safe disposal of excreta including child's excreta;
  (c) Safe handling and consumption of drinking water.

  During the **phase – II**, the strategy emphasis on following areas, besides areas covered under phase-I (in some cases both phase – I and phase – II can overlap each other):-
  (a) Food and home hygiene
  (b) Solid and liquid waste disposal
  (c) Environmental hygiene
  (d) Personal hygiene related other issues including mandatory use of footwear by all children.

- While addressing WASH along with hygiene promotion interventions in Phase – I and II during implementation of hygiene promotion "in PHC" facilities, the LGA Health Coordinator and in-charge of a PHC facilities, must comply all obligation necessary for stopping the spread of infection with-in the PHC centre environment and as well

as from the PHC facility to the neighbouring catchment communities. On each aspect of hygiene domain the head of every PHC facility must ensure following:-.

1) **Hand washing:** Provide functional hand washing stations with water, soap and safe waste water disposal within the PHC premises, where health-care is provided (wards, consulting rooms, delivery rooms, operation theatres, etc.) in addition to all service areas (kitchen, laundry, showers, toilets, sterilization, laboratory, waste zone and mortuary). This may be carried out using simple equipment, such as a bucket of water, a basin and soap. If available, waterless, alcohol-based hand rubs may be used for rapid, repeated decontamination of clean hands. However in all scenarios soap and water should be available for cleaning of soiled hands.

   Clinical hand washing: Ensure that staff carry out clinical hand washing before and after every shift, directly before and after every patient contact (even if wearing gloves), directly after handling infectious materials, and when entering and leaving high risk areas such as delivery rooms, surgeries, isolation areas. (See annexure –I *Hand Hygiene*)

2) **Excreta disposal:** Ensure that there are sufficient numbers of adequate, accessible, appropriate and safe toilets for staff, patients and visitors that do not contaminate the health-care setting or water supplies (one functional toilet per 20 users). This can be as basic as providing pit latrines with reasonable privacy.

3) **Water quality and quantity:** Ensure that water for drinking, cooking, personal hygiene, medical activities, cleaning and laundry is treated and safe. Chlorine can be used as disinfectant for drinking-water in emergencies. Overall, water quality in line with Nigeria water quality standard must be maintained. Also ensure that adequate quantity of water is available for infection control activities, in addition to laundry, bathing, hand washing, drinking and medical procedures.

   Water access and facilities: If there is no provision of overhead storage water tank or running water system, then ensure that there are sufficient numbers and coverage of appropriate and functional water collection points. If the health-care facility has inpatients, then ensure that there is access to sufficient numbers of appropriate laundering, drying and bathing facilities (one functional shower cubicle per 40 users).

4) **Health-care waste management:** Ensure safe segregation, collection, transport, treatment and disposal of health-care waste. This can be done by providing adequate numbers of durable and colour-coded containers in all rooms where wastes are generated. Install a dedicated and fenced waste disposal zone, and ensure staff have appropriate Personal Protective Equipment (PPE) and are trained in waste management. Usually dumping of waste is seen at many PHC facilities on the compound (especially behind the building). The waste included needles, drip sets, medicine wrappers and sanitary napkins. Due to attitude of health staff , such practices are observed even when the PHC facilities have the correct infrastructure and sufficient staff.

Menstrual Hygiene Management (MHM): All PHC facilities must have provision for safe disposal of sanitary pads, privacy for changing of pads and sufficient safe water for cleaning and washing. The health staff must do advocacy and awareness creation with visiting women from the community for the need and benefits of adopting MHM by shedding age old taboos and cultural barriers.

5) **Wastewater disposal:** Ensure that wastewater from hand washing, bathing, cleaning, or laundering is disposed rapidly and safely without contaminating the health-care setting, water supplies or surrounding communities. This can be done by construction of appropriate number of soakage pits.

6) **Storm water management:** Ensure that storm water does not enter any areas where health-care is delivered, and does not carry potentially infectious material away from the health-care setting into the community. The drainage channels must exist, and ensure that they are not blocked and functional (all discarded/used polythene bags from the drainage must be removed on periodic basis).

7) **Cleaning and disinfecting:** Ensure that the health-care facility has sufficient materials (detergent, mops, buckets, disinfectants and chlorine) and staff to routinely clean and disinfect environmental surfaces. This can be as done by training cleaning staff in infection control measures. Separate cleaning equipment should be provided for each room. A cleaning schedule should be established so that all areas of the health-care facility are cleaned and disinfected routinely and directly after spills. The same broom, mop, or cloth must not be used to clean the toilet and wards, thereby transferring infections from one place to another, rendering cleaning ineffective.

8) **Cleaning of Maternity wards:** All maternity rooms must be kept clean and well-equipped without any rusty labour tables and unclean floors. Also ensure that room toilets are not locked or used for storage. Those toilets are meant for patients, so they must get easy access to toilets. Ensure that tray with clots and bloodied cotton should not be piled on the side of the toilet or rubber sheets used over the maternity table(s) were not washed in the toilet. Usually, the staff is unaware how these 'unrelated' situations could be connected to high morbidity and mortality among mothers and newborns. In these circumstances the probability of infection transfer within the wards is always high due to the lack of rules or guidelines to clean the hospital. Thus there must be a clear instructions and supervision that how often the ward, maternity room, or other parts of the hospital should be cleaned. The focus should aim to prevent the newborn baby and the mother from acquiring infections while being admitted in the hospital in the pretext of receiving skilled delivery support.

9) **Food safety:** Ensure all food that is stored, prepared, and consumed by patients and staff is safe. This can be done by ensuring that raw and cooked foods are kept separate at appropriate storage temperatures, food handling is carried out with utmost cleanliness, food is thoroughly cooked, and safe, treated water is used in food preparation.

10) **Overcrowding control:** Ensure that wards are not overcrowded and there is at least one-two meter distance between beds to reduce droplet and contact based transmission risks. In emergencies this may require working with the health-care facility management to identify and establish new nearby locations for temporary wards.

11) **Disease vector control:** Ensure patients, staff and visitors are protected from disease vectors. This can be as simple as removing vector breeding sites, ensuring kitchen and health-care wastes are properly disposed, installing window and door barriers, installing rodent traps, installing window and door screens, and installing insecticide treated mosquito nets in inpatient wards.

12) **Infection control training and PPE:** Ensure that all staff are correctly trained, are regularly updated in the infection control standard precautions, are properly vaccinated, and have sufficient and adequate PPE for the tasks they are carrying out (e.g. disposable gloves, single use plastic aprons, single use face masks, eye glasses, boots, thick gloves, gowns).

13) **Isolation areas:** Ensure that isolation areas (e.g. for Cholera, Viral Hemorrhagic Fever, Ebola, Avian Flu, Swine Flu or Zika fever outbreaks) are fenced and have their own dedicated, functional and safe toilets, showers, laundry, changing area, and healthcare waste disposal facilities. Ideally, the isolation area should be located away from the rest of the health-care facility.

14) **Isolation area entrances and exits:** Ensure that entrances and exits of isolation areas have functional foot baths or sprayers with chlorine, hand washing stations and permanent guards. Number of people entering the isolation area must be controlled, in addition to ensuring everyone entering and leaving, must disinfects their hands and feet.

15) **Disinfection of isolation area wastes:** Ensure that all infectious wastes, excreta and body fluids generated in the isolation area are disinfected with chlorine solution and disposed safely within the isolation area. Ensure that no potentially infectious wastewater flows out of the isolation area and no potential pathogenic reservoir including wastes, food, food containers, or soiled clothing is carried out of the area.

16) **Hygiene promotion:** (i) Ensure that patients, staff and visitors are informed of essential hygiene behaviours repeatedly. (ii) Ensure weekly 100% visual inspection of all hand washing stations with availability of soap and water. (iii) Display hygiene promotion posters, especially related with hand washing with soap, safe excreta disposal, safe handling of drinking water. (iv) distribute brochures, leaflets, small booklets to visitors and patients on various domain of hygiene promotion, including what to do in case of diarrhoea, cholera outbreak.

7.2 HYGIENE PROMOTION "*THROGH PHC FACILITIES*":-

- The LGA Health Coordinator, along with LGA WASH Coordinator and in consultation with in-charge of PHC facilities, must chalk out monthly plan of action to implement hygiene promotion in catchment communities "through PHC facilities".

- PHC facilities have a task to improve the environmental health conditions in the catchment communities and schools. The CHEWs, Midwives along with Environmental Health Officer (EHO) can play an important role (as change agents) to make community members aware about:-
    a) Benefits of good hygiene practices;
    b) Relationship between good hygiene and good health;
    c) Importance of hand washing with soap at critical times;
    d) Need for the safe disposal of excreta including child's excreta;
    e) Need and importance of safe handling of drinking water;
    f) Importance of personal hygiene;
    g) Need for the covering of cooked food and safe handling;
    h) Why to have safe disposal of liquid and solid waste;
    i) Importance of environmental sanitation and hygiene;
    j) Importance of Menstrual Hygiene Management (MHM).

- Interventions "through PHC facilities" will be part of an overall synergy of hygiene promotion efforts and linkages between communities, schools and PHC facilities within a ward of a LGA. The linkages between VDCs, Community Health Committees (CHCOMs), WASHCOMs, VHPs, hygiene promotion trained teachers of catchment schools, various groups of pupil from schools and PHC staff will pave a way for accelerated implementation of hygiene promotion components and stimulate the members of the catchment communities to adopt good hygiene behaviours. In this process, the health facility can become resource center for hygiene promotion on systematic way among community members.

- Hygiene Promotion by CHEWs can be an entry point for the poor communities to understand the economic benefit of consumption of safe water, use of improved sanitation and practicing of hygiene behaviours, which can lead to reduction of disease load on families. CHEWs can be very useful link wherever WASHCOM has not been established or CLTS programme has not been introduced. CHEWs can talk to community members and prepare them to adopt good hygienic behaviours on the five domain of hygiene promotion.

- CHEWs may be needed a comprehensive training on five domains of hygiene promotion as well on other tools required for making entry related to introduction of hygiene promotion in a community.

****

8. MONITORING:

- Usually, it is observed that health centre staff lean to shift the blame on the public by saying they dirtied the health facility, did not follow rules in the premises, and generally created nuisance. The senior staff held cleaning staff responsible for un-hygienic conditions in the health centre, yet they only supervised cleanliness at their facility by making morning rounds. In majority of PHC facilities no standard operating procedures or checklists are used to assess the cleanliness of the facility. Problems occurred due to absence of clearly defined policies for infection control or adequate training for the cleaning and sanitation of the facilities in infection control.

- The existing monitoring measures in PHC facilities in Nigeria do not emphasised on the status of infection control, review of the enabling factors (infrastructure, staff, equipment, policies), and the overall maintenance of hygiene to ensure patients safety. In most of the facilities, there is no point person who is responsible for infection control in health care facilities thus that burden remains with in-charge of the facility, who is already busy with so many other vital responsibilities.

- Often, materials like detergent, mops, disinfectants and chlorine go out of stock in many facilities and surfaces, floors, are not disinfected as moped by water only. As a result the safety of the environment and patients against Hospital Acquired Infection (HAI) is compromised. Supervision is needed with a focus on the actual hygiene and sanitation situation in the facilities and not just if targets are reached. HAI should be added as a performance indicator.

- Shortage of staff affected the functioning of the PHC facilities and left little time and resources dedicated to sanitation and infection control at a health centre. On daily basis the staff struggles to complete the provisions of mandatory services, as a result they tend to leave out those which they did not value much or did not need to send reports for, leaving out these tasks caused insufficient hygiene and sanitation interventions.

- Lack of knowledge and awareness about importance of WASH create gaps in hygiene and sanitation related correct procedures and safety measures. As a result, one can observe in majority of PHC facilities that there is no ownership for WASH interventions along with callous and indifference attitude of staff towards safety of patients, and an approach towards reaching targets rather than a good WASH interventions.

- **Establish operational monitoring programmes:** It is necessary to identify control measures, which needs to be monitored on daily basis or on weekly/monthly basis. Operational monitoring procedures should be established for each newly identified or

existing control measure. Thus, monitoring plans should address the following questions:

a) What will be monitored?
b) How will it be monitored?
c) Where will it be monitored?
d) How often will it be monitored?
e) Who will do the monitoring?
f) Who will receive the results and where?
g) Who will implement any remedial responses?

- Operational monitoring at the PHC facility level does not necessarily need to be complex and time-consuming. One staff needs to be designated for it, who should take the form of a planned sequence of inspections of observable features such as checking that--

,

a) Health-care waste containers are not overflowing;
b) Toilet facilities are clean, toilets are not locked, water availability in the toilets;
c) Soap availability in all hand washing stations;
d) There is no open defecation or health-care waste in the grounds;
e) Floors are disinfected and mopped daily;
f) Maternity wards are clean and disinfected;
g) Container or bag availability for disposal of sanitary pads;
h) Overall environmental cleanliness in the premises.

- If any staff, patients or visitor complaints about unhygienic or unsanitary conditions than that should be taken on positive note and as signals to be checked by the designated staff, leading to ad hoc monitoring.

- The LGA Health Coordinator, must ask all PHC facilities to provide with frequent (weekly, bi-monthly, monthly – depending on the nature of the control measures) reports on key WASH indicators so that the progress of the overall WASH interventions in health-care facilities can be tracked and if necessary then course correction can be planned.

****

9. HYGIENE PROMOTION AT PUBLIC PLACES:

- In Nigeria, rural markets or various market places or often very dirty, unhygienic and without any reliable structure for defecation, urination and bathing. Many rural markets have privately owned community sanitation facilities, which are operational on Use-and-Pay basis. People usually pay Naira 20 for urination, Naira 30 for defecation and Naira 50 for bathing. There are separate facilities for men and women. But, unfortunately many of these facilities do not provide soap for washing hands, thus people just wash their hands with water only. Often these facilities have shortage of water, or broken/damaged doors, ugly look of over-flowing drains and so on. Thus, to avoid unhygienic conditions in community sanitation facilities, many in the crowded rural markets prefer to go to bushes to ease themselves, rather than availing the Use –and- Pay services.

- Besides, rural markets, other market place such as health facilities, oil pumps, and religious places also have facilities for defecation and hand washing, but often it has been seen that, those facilities have been badly misused and as a result they have become breeding ground for diseases. As after defecation many people do not flush toilets, often water is not there to flush excreta, and similarly no water is available for washing hands after defecation. Some of these facilities are so dirty and unhygienic that even entry to those facilities are impossible as often entire floor is littered with dry excreta and room/enclosure is full of foul smell.

- In view of the pathetic situation, it is suggested to set-up an institutional approach for creating water and sanitation facilities at market place, so that they are properly used and maintained in a hygienic manner.

- The most important part is availability of soap and clean water for washing hands after defecation. Those who are currently operating the community toilet and bathing systems must be sensitized for make available soap all the time.

- Other places, where such systems are not available, it is necessary that state governments/LGAs, must encourage people to build and maintain community toilets. For that the land must be provided by the local government and operator may do construction on it and then recover money in a few years by charging money from the users.

- Besides, creating awareness about hygiene practices, it is necessary that IEC materials in the form of posters, leaflets must be used, besides, some public discourses by local/religious leaders can be arranged.

- Market committees also must be sensitized on importance of adopting hygiene behaviours and keeping the market place clean and hygienic.

******

Annexure -I

Hand Hygiene: Why, How & When?[7]

WHY?

- Thousands of people die every day around the world from infections acquired while receiving health care.
- Hands are the main pathways of germ transmission during health care.
- Hand hygiene is therefore the most important measure to avoid the transmission of harmful germs and prevent health care-associated infections.

WHO?

- Any health-care worker, caregiver or person involved in direct or indirect patient care needs to be concerned about hand hygiene and should be able to perform it correctly and at the right time.

HOW?

- Clean hands by **rubbing them with an alcohol-based formulation**, as the preferred mean for routine hygienic hand antisepsis if hands are not visibly soiled. It is faster, more effective, and better tolerated by hands than washing with soap and water.

Wash hands with soap and water

- When hands are visibly dirty or visibly soiled with blood or other body fluids or after using the toilet.

- If exposure to potential spore-forming pathogens is strongly suspected or proven, including outbreaks of *Clostridium difficile*, hand washing with soap and water is the preferred means.

FIVE MOMENTS FOR HAND HYGIENE

1. **Before touching a patient**

   WHY? To protect the patient against colonization and, in some cases, against exogenous infection, by harmful germs carried on your hands.

   WHEN? Clean hands before touching a patient when approaching him/her.

   Situations when Moment 1 applies:

   a) Before shaking hands, before stroking a child's forehead;

[7] World Health Organization

b) Before assisting a patient in personal care activities: to move, to take a bath, to eat, to get dressed, etc;
c) Before delivering care and other non-invasive treatment: applying oxygen mask, giving a massage;
d) Before performing a physical non-invasive examination: taking pulse, blood pressure, chest auscultation, recording ECG.

2. Before clean / aseptic procedure

WHY? To protect the patient against infection with harmful germs, including his/her own germs, entering his/her body.

WHEN? Clean hands immediately before accessing a critical site with infectious risk for the patient (e.g. a mucous membrane, non-intact skin, an invasive medical device)

Situations when Moment 2 applies:

a) Before brushing the patient's teeth, instilling eye drops, performing a digital vaginal or rectal examination, examining mouth, nose, ear with or without an instrument, inserting a suppository / pessary, suctioning mucous;
b) Before dressing a wound with or without instrument, applying ointment on vesicle, making a percutaneous injection / puncture;
c) Before inserting an invasive medical device (nasal cannula, nasogastric tube, endotracheal tube, urinary probe, percutaneous catheter, drainage), disrupting / opening any circuit of an invasive medical device (for food, medication, draining, suctioning, monitoring purposes);
d) Before preparing food, medications, pharmaceutical products, sterile material.

3. After body fluid exposure risk

WHY? To protect you from colonization or infection with patient's harmful germs and to protect the health-care environment from germ spread.
WHEN? Clean hands as soon as the task involving an exposure risk to body fluids has ended (and after glove removal).

Situations when Moment 3 applies:

a) When the contact with a mucous membrane and with non-intact skin ends
b) After a percutaneous injection or puncture; after inserting an invasive medical device (vascular access, catheter, tube, drain, etc); after disrupting and opening an invasive circuit
c) After removing an invasive medical device
d) After removing any form of material offering protection (napkin, dressing, gauze, sanitary towel, etc)

e) After handling a sample containing organic matter, after clearing excreta and any other body fluid, after cleaning any contaminated surface and soiled material (soiled bed linen, dentures, instruments, urinal, bedpan, lavatories, etc)

4. After touching a patient

WHY? To protect you from colonization with patient germs and to protect the health-care environment from germ spread.

WHEN? Clean your hands when leaving the patient's side, after having touched the patient.

Situations when Moment 4 applies, if they correspond to the last contact with the patient before leaving him / her:

a) After shaking hands, stroking a child's forehead;
b) After you have assisted the patient in personal care activities: to move, to bath, to eat, to dress, etc;
c) After delivering care and other non-invasive treatment: changing bed linen as the patient is in, applying oxygen mask, giving a massage;
d) After performing a physical non-invasive examination: taking pulse, blood pressure, chest auscultation, recording ECG.

5. After touching patient surroundings

WHY? To protect you from colonization with patient germs that may be present on surfaces / objects in patient surroundings and to protect the health-care environment against germ spread.

WHEN? Clean your hands after touching any object or furniture when living the patient surroundings, without having touched the patient.

This Moment 5 applies in the following situations if they correspond to the last contact with the patient surroundings, without having touched the patient:

a) After an activity involving physical contact with the patients immediate environment: changing bed linen with the patient out of the bed, holding a bed trail, clearing a bedside table;
b) After a care activity: adjusting perfusion speed, clearing a monitoring alarm;
c) After other contacts with surfaces or inanimate objects (note – ideally try to avoid these unnecessary activities): leaning against a bed, leaning against a night table / bedside table. germs should be transmitted.

- **Hand hygiene must be performed in all indications described regardless of whether gloves are used or not.**
- **The use of gloves does not replace the need for cleaning your hands.**

******

Annexure -II

GLOBAL HEALTH INITIATIVES REQUIRING WASH SERVICES IN HEALTH CARE FACILITIES[8]

- **Improving quality of care at birth:** This is a global effort to ensure quality of care at birth, at a time when both women and infants are particularly at risk for infection and other complications. As part of this effort WHO and others are working to certify the quality of facilities, including ensuring that all delivery rooms have sufficient and safe water, and sanitation facilities are available for mothers and staff.

- **Global Action Plan to Eliminate Childhood Pneumonia and Diarrhoea (GAPPD):** WASH is an important component of the three-pronged GAPPD approach (protection, prevention and treatment) to eliminate childhood pneumonia and diarrhoea. Universal access indicators to WASH in health care facilities are included in this plan.

- **Global Task Force on Cholera Control (GTFCC):** The purpose of the GTFCC is to support increased implementation of evidence-based strategies to prevent and control cholera through strengthened collaboration and coordination among WHO, Member States and stakeholders active in cholera-related activities. To this effect, one of the objectives of the GTFCC is to integrate all cholera activities (e.g. detection, surveillance, patient care, vaccination, WASH, advocacy and social mobilization) to ensure long-term disease reductions. This includes improving WASH in health care facilities in cholera hot spot areas which serve the populations most at risk of the disease.

- **Greening the Health Sector:** seeks to advance environmental sustainability in health care to improve health and enhance health systems performance. Focus areas include the promotion of safe and environmentally sound health care waste management and leveraging of clean energy technologies (e.g. solar power) to enhance quality, accessibility and safety of health care services.

- **Energy for Women's and Children's Health:** Co-led by WHO, UN Women and the UN Foundation, this initiative (implemented under the umbrella of the UN Secretary General's 'Sustainable Energy for All') seeks to improve the health of women and children by increasing access to reliable electricity in health care facilities. Particular focus is given to health care facilities in resource constrained settings. A 2013 review of energy access in health care facilities in 11 African countries found that only 28% have access to reliable power and 26% have no power at all (Adair-Rohani et al., 2014). Addressing WASH in tandem with

[8] UNICEF,WHO -2015 WASH in Health facilities

energy, provides “whole” facility solutions, especially to facilities that may be “off the grid” and have to supply power to pump their own water supplies.

- **Clean Care is Safer Care:** The goal of Clean Care is Safer Care is to ensure that infection control is acknowledged universally as a solid and essential basis towards patient safety and supports the reduction of health care associated infections and their consequences. Basic WASH services are fundamental to this goal and greater collaboration between WASH and infection control efforts in health care facilities will result in a myriad of benefits.

- **Universal health coverage:** Ensuring that all individuals can obtain health services without suffering financial hardship when paying for them is a major priority for WHO, the World Bank, and national governments and is supported by various international commitments, including the 2012 UN Resolution 67/L.36. An estimated 1 billion people suffer each year because they cannot obtain the health services they need (WHO, 2014). The ability to provide quality and sustainable health services necessitates provision of WASH in all health care facilities and staff that are sufficiently trained in WASH practices and delivering hygiene behaviour change messaging.

- **UN human right to water and sanitation:** In 2002, the UN Committee on Economic Social and Cultural Rights adopted General Comment No. 15: the right to water, defined as the right of everyone to sufficient, safe, acceptable and physically accessible and affordable water (UN, 2002). Later, in 2010, through Resolution 64/292, the United Nations General Assembly recognized the human right to water and sanitation and acknowledged that clean drinking-water and sanitation are essential to the realization of all human rights (UN, 2010). The Resolution defines five normative criteria (availability, quality/safety, acceptability, accessibility and affordability) which provide an important basis for comprehensively addressing WASH needs in health care facilities. It also provides legal tools and outlines obligations for State and non-State actors to progressively respect, protect and fulfil this right.

*****