MAKING HEALTH A RIGHT FOR ALL:
Universal Health Coverage and Water, Sanitation and Hygiene
Action for Global Health (AfGH) and WaterAid are both engaged in discussions on how the post-2015 framework can best deliver improved health outcomes around the world. WaterAid is an international Non-Governmental Organisation (NGO) with a focus on Water, Sanitation and Hygiene (WASH), whilst AfGH works across the whole health sector and promotes Universal Health Coverage (UHC) as a key instrument to achieving the universal right to health.

This discussion paper explores why Water, Sanitation and Hygiene (WASH) must be included in a comprehensive definition of Universal Health Coverage (UHC) and how this can be done.

It demonstrates the way in which UHC can improve WASH conditions and the positive impact this can have on health outcomes.

Water and sanitation are human rights that play a vital role in attaining the right to the highest standard of health for all (hereafter the ‘right to health’).

Health and WASH are intrinsically related and must be recognised as both preconditions for and outcomes of sustainable development.

Lack of joint action on WASH and health in the last few decades has resulted in poor progress on agreed international targets, including those on maternal, newborn and child health. The ability of countries and the international community to address these ongoing challenges will be significantly strengthened if this deficit is adequately addressed.
The impact of WASH on health

The importance of WASH for human health and well-being has been recognised for some time. More than 150 years ago, the assumed link between contaminated water and cholera outbreaks led to massive investment in legislation and infrastructure. This was to safely separate people from human faeces and the diseases they carry. Despite the knowledge and understanding of the importance of WASH, access to the basic services that underpin development and modernisation in the world’s leading economies remains woefully inadequate.

Two and a half billion people do not have access to basic sanitation worldwide, while over one billion people rely on open defecation and 768 million do not have access to improved sources of drinking water.1

The impact of this is staggering. Despite being easily preventable, diarrhoea remains a leading cause of childhood mortality. Repeated diarrhoeal episodes in childhood are responsible for one quarter of stunting cases.2 This in turn can have a lasting impact on health and well-being throughout life.

Pneumonia, the leading childhood killer globally, can be reduced by better hygiene practices, and repeated episodes of diarrhoea have been linked to increased susceptibility to pneumonia in under-nourished children. The impact of the lack of WASH extends far beyond child mortality. WASH-related infections, such as soil transmitted helminths, lymphatic filariasis, schistosomiasis and trachoma, can lead to chronic disease and disability.3

Meanwhile, diseases such as cholera and dengue, caused or exacerbated by lack of faecal and solid waste management and poor waste- and surface-water management, pose a growing threat to public health.4

When we consider that health is a ‘state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’,5 the impact is even greater. Several factors have a profound impact on poverty and well-being and disproportionately affect women, children, and poor and vulnerable groups. They include the need to fetch water into households, the cost of drinking water, the absence of safe toilets that maintain privacy and dignity, and the cost to households incurred by WASH-related sickness and subsequent care for family members who are sick.

“Achieving UHC requires solutions beyond the health sector – including investments in people, like education and social protection, but also things like roads, water and sanitation, and information technology.”

Dr. Jim Yong Kim, President of the World Bank.*

The cost to the health system is significant. The latest available estimate shows that people with WASH-related diseases fill half of hospital beds in developing countries.6 The burden on health systems globally is growing. At the same time there is an increased focus on value-for-money and cost-effectiveness. In this context, including UHC in the post-2015 framework and the subsequent implementation of UHC policies, presents an important opportunity for better integration of health and WASH.

The purpose of this paper is to help reach a better understanding of how this integration could be achieved through interventions to improve WASH conditions as a core part of effective UHC reforms to maximise the health dividend of UHC.

While we do not address it here, we recognise that the provision of water and sanitation facilities must be done in the context of sustainable, integrated water resource management.

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UNIVERSAL HEALTH COVERAGE

Universal Health Coverage (UHC) can be defined as ensuring that all people have access to health information and services (promotive, preventive, curative and rehabilitative) of sufficient quality to cover the variety of their needs, and at the same time that they do not suffer financial hardship by paying for these services. Health needs include for example Sexual and Reproductive Health and Rights (SRHR), HIV, TB and malaria.

Towards universal coverage

To attain UHC we must ensure health services are:

- **Available** – Facilities and skilled health workers need to be available in sufficient quantity;
- **Accessible** – Equity of access needs to ensure services are accessible for those who need them and not only those who can pay for them;
- **Acceptable** – Services must respect medical ethics and be culturally appropriate;
- **Affordable** – The cost of using services must not put people at risk of financial hardship; and
- **Of Quality** – Services must be of sufficient quality to improve the health of those who use them.

Institutional barriers to addressing WASH as a health determinant

The UK’s Public Health Acts of the 19th century on water and sanitation were implemented largely as public health measures. But the past few decades have seen a shift which has meant they have been subsumed into a distinct sector. This has often been under the leadership of ministries of water, environment or public works.

Drinking water, sanitation and individual hygiene behaviours are in general inadequately addressed within health programming, policy and planning. Water, in particular, is viewed as an infrastructure-based, investment-heavy sub-sector. Government responsibility for sanitation is often fragmented among various ministries and agencies, leading to a lack of accountability, under-prioritisation and under-resourcing.

While the Ministry of Health may be responsible for setting policy on sanitation and hygiene, the responsibility for the delivery of sanitation infrastructure is often neglected. Households are expected to carry the costs of on-site sanitation while little is done to ensure that sanitation standards in public environments such as schools and healthcare facilities are adhered to. The sanitation needs of inhabitants of unplanned settlements as well as itinerant population groups are often completely neglected. The promotion of hygiene practices such as hand-washing with soap at critical times is a particularly neglected area, with little invested in hygiene promotion and a failure to embed hygiene in relevant health programmes. This results in missed opportunities for generating behaviour change.

Overall the WASH sector suffers from chronic under-investment and political neglect, despite high-level commitments to the contrary.
WHAT IS WASH?

WASH is a broad term used in reference to water, sanitation and hygiene. More specifically, it is usually understood as a reference to drinking water, household or public toilet facilities (and the absence of open defecation), and hand-washing with soap.

The following definitions provided by the WHO/UNICEF Joint Monitoring Programme apply:*

- **Open defecation:** defecation in which excreta of adults or children are deposited (directly or after being covered by a layer of earth) in the bush, a field, a beach or other open area; are discharged into a drainage channel, river, sea, or other water body, or are wrapped in temporary material and discarded.

- **Drinking water:** water used, or intended to be available for use by humans for drinking, cooking, food preparation, personal hygiene or similar purposes.

- **Improved drinking water source:** an improved drinking water source is defined as one that, by nature of its construction or through active intervention, is protected from outside contamination, in particular from contamination with faecal matter.

- **Sanitation:** sanitation is the provision of facilities and services for the safe disposal of human urine and faeces.

- **Improved sanitation facilities:** for MDG monitoring, an improved sanitation facility is defined as one that hygienically separates human excreta from human contact.

- **Excreta:** human faeces and urine.

- **Hygiene:** personal and household practices that serve to prevent infection and keep people and environments clean. Examples of hygiene practices include hand-washing, bathing, and management of stored water in the home, all of which aim to preserve cleanliness and health.** Hygiene promotion programmes most often emphasise hand-washing with soap at critical times (mainly before handling food and after using the toilet). The World Health Organisation (WHO) defines hygiene as ‘the conditions and practices that help to maintain health and prevent the spread of diseases.’***


WASH IN HEALTHCARE SETTINGS

In healthcare settings such as hospitals, health centres, clinics, dental surgeries and general practitioner facilities, WASH needs extend beyond the above to include provision pertaining to quality of patient care and infection prevention and control.

The following guidelines have been defined by WHO:*

- **Water quality:** water for drinking, cooking, personal hygiene, medical activities, cleaning and laundry is safe for the purpose intended.

- **Water quantity:** sufficient water is available at all times for drinking, food preparation, personal hygiene, medical activities, cleaning and laundry.

- **Water facilities and access to water:** sufficient water collection points and water use facilities are available in the healthcare setting to allow convenient access to and use of water for medical activities, drinking, personal hygiene, food preparation, laundry and cleaning.

- **Excreta disposal:** adequate, accessible and appropriate toilets are provided for patients, staff and carers.

- **Waste water disposal:** waste water is disposed of rapidly and safely.

- **Healthcare waste disposal:** healthcare waste is segregated, collected, transported, treated and disposed of safely.

- **Cleaning and laundry:** laundry and surfaces in the healthcare environment are kept clean.

- **Food storage and preparation:** food for patients, staff and carers is stored and prepared in a way that minimises the risk of disease transmission.

- **Building design, construction and management:** buildings are designed, constructed and managed to provide a healthy and comfortable environment for patients, staff and carers.

- **Control of vector-borne disease:** patients, staff and carers are protected from disease vectors.

- **Information and hygiene promotion:** Correct use of water, sanitation and waste facilities is encouraged by hygiene promotion and by management of staff, patients and carers.

Situating WASH within UHC

UHC includes a mix of promotive, preventive, curative and rehabilitative services. WASH plays an important part in the provision and quality of these services.

1. PROMOTIVE

The promotion of hygiene practices, such as hand-washing with soap and safe food preparation and feeding practices, is a crucial element of primary healthcare for prevention of infections such as pneumonia and diarrhoea, as well as other infections.

This has also been identified as the most cost-effective intervention for high-burden diseases in low- and middle-income countries. Community-based and primary healthcare offer important opportunities for embedding hygiene promotion in relevant health programmes.

Relevant community-based programmes include (but are not limited to) community health clubs and village health teams, community-level health promoter and volunteer schemes, and community-level mothers’ groups.

Furthermore, Integrated Management of Childhood Illness (IMCI) programmes for example link hand-washing promotion to breastfeeding and other nutrition promotion activities, and embed counselling on hygiene promotion in the treatment protocol for diarrhoea cases at the health facility level.

Such efforts to embed the promotion of personal and environmental hygiene and sanitation practices into healthcare delivery maximise opportunities for disease prevention. These practices include (but are not limited to) stopping open defecation and hand-washing with soap at critical times. They also reinforce the role of healthcare services and staff in setting norms and standards among the population, by acting as role models for good hygiene practices.

As UHC reforms expand health service coverage throughout an entire country, the opportunities to extend the positive effects of good sanitation and hygiene behaviours increase. This is particularly relevant for populations currently unreached or under-served by healthcare services.

At the same time, the expansion of health services can also help relieve the burden on existing systems and thereby help ensure that healthcare systems give greater priority to promotive services to balance the existing emphasis given to curative services.

2. PREVENTIVE

Delivery of WASH services acts as a primary barrier to disease transmission. The recently launched Integrated Global Action Plan on Pneumonia and Diarrhoea (GAPPD) clearly sets out the importance of WASH provision alongside other life-saving interventions, as demonstrated in the graphic opposite.

WASH can also play an important role in other preventive aspects. For example, there is increasing recognition that vaccine response can be weakened if the child receiving the vaccine is experiencing enteric (relating to or occurring in the intestine) infections, including diarrhoea and environmental enteropathy.

It can be argued that not only is WASH important for the sustainability and effectiveness of immunisation programmes, but that immunisation programmes also present a potentially important platform for raising public awareness of good hygiene practices.

Information on coverage of water and sanitation infrastructure and its use provides important data for early-warning systems, in particular for outbreak preparedness (cholera, Hepatitis E etc). Furthermore, in the absence of high quality epidemiological data, it can help health systems identify areas at high risk of other WASH-related diseases, such as trachoma, schistosomiasis, dengue and other neglected tropical diseases.
A recent review of available survey data from 40 countries found that only 46% of healthcare facilities have drinking water services. This does not reflect whether or not these services provide sufficient quantity, quality, or are reliable, nor does it provide information about sanitation and hygiene aspects.

Limited water supply not only reduces the likelihood of healthcare facilities remaining hygienic, the lack of clean cups and drinking water in healthcare facilities can also reduce individuals’ ability to safely take their medicines.

Those attending healthcare facilities are often particularly susceptible to disease and infection. A systematic review of Healthcare-Associated Infections (HAIs), infections contracted in the healthcare setting that were not present at the time of admission, was carried out in Africa in 2011. It found HAI infection rates as high as 45.6% in some countries. HAI rates are closely linked to WASH and hygiene in healthcare facilities is fundamental to infection prevention and control. This is of critical importance in high-volume facilities where infections can spread most rapidly.

It should also be considered in terms of health issues for which the main strategy is to increase healthcare services utilisation. For example, encouraging women to give birth in healthcare facilities is one of the key strategies for reducing maternal mortality. Globally, 8% of maternal mortality is caused by sepsis. The absence of sufficient infection prevention and control measures in healthcare facilities should therefore be of particular concern to those attempting to redress the slow progress to reduce maternal mortality globally.

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The promotion of hand-washing with soap, like at this maternity ward in Uganda, reduces the number of deaths caused by waterborne diseases by an average of 65% (WHO), and helps to prevent infections such as pneumonia and diarrhoea. The absence of adequate infection prevention has led to high maternal mortality rates.
4. REHABILITATIVE AND PALLIATIVE

WASH plays an important part in the provision of good quality care and the management of disease and disability, both in terms of care provided in healthcare facilities and care and self-care at home. Health services have a key role to play in bringing about healthy and rehabilitative behaviours related to WASH as part of an overall care package or treatment plan.

- People living with leprosy, for example, need to be able to practice good hygiene to manage the disease and must take their medicine with safe water. Both the physical disabilities and social exclusion that result from leprosy can limit access to water and sanitation, negatively affecting an individual’s ability to care for themselves.

- In the case of lymphatic filariasis, a highly debilitating and incurable condition, WASH must form part of a basic minimum package for self-care. This includes washing affected body parts with soap and clean water, exercise, elevation and inspection and treatment of skin lesions. Evidence shows that there is a significant decrease in the frequency of acute attacks following the introduction of basic minimum care.15

- WASH is essential for ensuring that people living with HIV/AIDS live healthy and productive lives. People living with HIV/AIDS are six times more likely than people without HIV to acquire a diarrhoeal disease.16 In addition, babies born to mothers living with HIV are three times more likely to have diarrhoea.17 People living with HIV/AIDS need two and a half times the amount of water needed by people without HIV, as well as improved hygiene and sanitation to help prevent opportunistic infections.18 An adequate supply of water is essential for home-based care of people living with HIV/AIDS. Furthermore, Anti-Retroviral drugs (ARVs) are essential to enable people living with HIV/AIDS to lead healthy and productive lives. Their consumption requires approximately 1.5 litres of safe water every day.19 The physical burden of fetching water is also a strain for people living with HIV/AIDS when they experience reduced energy levels, side-effects from HIV medication and/or symptoms of opportunistic infections.

The number of people without access to safe water is expected to nearly double to 2 billion by 2025. The burden on global health systems as a result of WASH-related illness is increasing. As one of the biggest donors to WASH, the EU needs to ensure that basic sanitation is promoted both publicly, and at a household level.
WASH in relation to health services

To reach UHC we must ensure that services are available, accessible, acceptable, affordable, and of sufficient quality.

Available
Health leaders such as Ministers and other decision-makers should champion the provision and adoption of sanitation and hygiene facilities and practices across the population, both in the public domain as well as at the household level. While some healthcare facilities may be built with water and sanitation provision, lack of good management and resourcing for maintenance can cause such facilities to fall into disrepair. All countries should adopt, resource and monitor adequate WASH standards in all healthcare facilities, ensuring staff are sufficiently trained in hygiene practices, and management structures exist to maintain oversight of facilities.

Affordable
UHC aims to ensure that the cost of care does not put people at risk of financial hardship. In healthcare facilities where water is not readily available, additional non-medical costs may be incurred by patients. For example, patients may be forced to bring their own drinking water and/or pay for water for washing or laundry. In some cases, women giving birth must buy their own ‘clean birth kit’ which includes a plastic sheet and gloves to compensate for the lack of adequate hygiene provision in maternity units. These costs must be considered as part of overall efforts to reduce the cost of accessing healthcare services.

Accessible
UHC breaks down the barriers to accessing health services. It can also provide patients with greater access to hygienic conditions for healthcare; safe water for drinking and for taking medicines, and positive environments that protect health and encourage healthy and hygienic behaviours. Water sanitation and hygiene facilities must be accessible to all staff, patients and carers. They should include separate toilets for men and women, as well as toilets, drinking water and hygiene facilities that are accessible to people with disabilities, children, older people and the sick.

Quality
The quality of health services should be sufficient to improve the health of those receiving them. Consequently, a main priority should be to ensure that healthcare users are not exposed to increased risk as a result of attending healthcare services due to a lack of infection prevention and control measures. The control of HAIs should be a key service quality indicator. At the same time, a lack of WASH provision in facilities may have less tangible effects on service quality, by affecting staff motivation, as well as the trust of healthcare users in the quality of the services provided. This is particularly relevant in the case of birth services, where women can make choices about whether or not to give birth in a healthcare facility. WASH provision that is fully functional at all times must therefore be part of the sets of indicators on service quality, alongside other measures such as availability of medical inputs and staffing levels.

Nearly 800 million people still do not have access to an improved source of drinking water protected from outside contamination. A lack of understanding over water hygiene habits can be countered through awareness-raising in schools and communities, implementing a multi-sectoral approach, and improving access to safe drinking water.
CASE STUDY: COORDINATION IN GHANA

The Ghana Trachoma Control Programme, part of a joint programme targeting trachoma, Guinea-worm and cholera, reduced the prevalence of active trachoma from 9.7 – 16.1% to less than 3% in endemic districts between 2000 and 2010. The initiative contributed to better collaboration between the WASH and health and education sectors. The addition of cholera and Guinea-worm elements to the trachoma programme resulted in an increase in boreholes and latrines provided. Leadership played a key role in this success, and the formation of a joint task force facilitated collaboration instead of competition, while allowing the Ministry of Health to fulfil its coordination and leadership role.

This success provides valuable lessons on coordinated approaches to disease prevention. The programme brought together government, donor, multilateral and international and local NGO actors, to ensure the full implementation of the preventive aspects of the Surgery, Antibiotics, Facial cleanliness, and Environmental change (SAFE) strategy alongside treatment elements. Interventions included water and schools latrine provision, sanitation promotion using the Community-Led Total Sanitation approach, and hygiene promotion by community health workers, volunteers and mass media broadcasting. A school health education programme was also designed to ensure that the SAFE strategy was added to the national curriculum. In endemic areas, booklets for children were developed and distributed, and teaching materials were also developed. The implementation of a full and robust SAFE strategy through this partnership has embedded preventive elements alongside treatment components and ensured that the gains in decreasing trachoma prevalence are sustained in the long run.

Boreholes, like the one pictured above, significantly enhance the lives of those in developing communities. Provision of water must be done in the context of sustainable, integrated water resource management. Lack of sufficient water treatment systems and child-friendly toilets increases the risk of transmitting diseases, such as cholera.
Going beyond the boundaries of healthcare delivery

UHC is an integral component of realising the right to health for all. But the inter-relationship between WASH and the health sector illustrates that a broad, multi-sectoral approach is needed to achieve this goal. Addressing the social and environmental determinants of health is essential to improving the health profile of a country as well as challenging inequity in health outcomes.

Water and sanitation provision is the responsibility of a range of actors, including government ministries and agencies, private sector actors, donor agencies and households. Many others play a leading role in the provision of water and sanitation infrastructure, as well as hygiene and maintenance practices. Such areas include water provision for drinking, household and productive uses (such as industry and farming), household sanitation, sewerage infrastructure, soap manufacturing and distribution, and inputs for water treatment in urban systems and in emergencies.

The health system has a leading role to play in ensuring policy coherence amongst government departments and that the provision and use of water and sanitation infrastructure is carried out in a way that promotes and protects health. This should be done by a health system leading cross-sectoral action on WASH as an inseparable part of its overall efforts to improve public health.

Also, given the health sector’s stewardship role for safeguarding public health, the health system plays an important part in championing the need for water and sanitation, setting social norms and practices on good hygiene behaviour, and undertaking public information and education campaigns to promote good sanitation and hygiene practices.

It should be ensured that WASH is included in healthcare management and accountability frameworks, in terms of service delivery indicators, operation and maintenance, training of healthcare staff and ensuring adequate human resources, and performance management. All these aspects must be factored into the financial systems of the healthcare sector, and adequately resourced.

KEY MESSAGES

- WASH underpins human health and must be considered as a key aspect of UHC; failure to do so will result in poor progress on public health targets, as well as an undue financial burden on health systems.

- WASH is often neglected in terms of political priority and investment; UHC efforts offer an opportunity to redress this neglect and embed WASH into key functions of the health system.

- Given its stewardship role of safeguarding public health, the health system plays an important role in championing the need for water and sanitation, setting social norms and practices on good hygiene behaviour, and undertaking public information and education campaigns to promote good sanitation and hygiene practices.

- A broad, multi-sectoral approach is needed to realise the right to health. The health system has a leading role to play in ensuring policy coherence as well as leading cross-sectoral action on WASH as an inseparable part of its overall efforts to improve population health.
Endnotes


14 World Health Organisation, forthcoming. Landscape report on the status of water, sanitation, and hygiene and environmental conditions in healthcare facilities.


22 Community-Led Total Sanitation (CLTS) mobilises communities to eliminate open defecation. Communities conduct their own appraisal and analysis and take action to become ‘open defecation-free’ (adapted from Institute of Development Studies Community-Led Total Sanitation website (http://www.communityledtotalsanitation.org/page/clts-approach), accessed 5 March 2013.