TIME TO DELIVER

Born without water

The crisis in our delivery rooms

Miatta Kromah, ten months pregnant at Diah Clinic, Grand Cape Mount, Liberia. January 2026.

WaterAid

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Foreword

Every two seconds, a woman gives birth in a healthcare facility without clean water, safe sanitation or adequate hygiene. This exposes women and girls to health risks that they should simply not have to face. This is not because solutions are unknown, technologies unavailable, or costs insurmountable. It is because, all too often, the basics have not been prioritised.

In an era of remarkable medical progress, it is easy to assume that giving birth in a healthcare facility ensures the safest care possible for mothers and their babies. Yet for millions of women and babies, the absence of clean water for things like washing hands, going to the toilet, cleaning and drinking actually puts their lives at risk. Infections frequently spread when even basic hygiene cannot be maintained. Health workers are forced to support women without the essential tools they know are necessary to protect women and their children. Mothers and newborns face dangers that are entirely avoidable.

Discussions about global development and human rights can sometimes feel abstract or distant, particularly at a time when resources are stretched and competing crises dominate attention. But this issue is neither abstract nor unattainable. Clean water, decent toilets and handwashing facilities are among the most practical and cost-effective investments health systems can make. Women and health workers are demanding it. Our governments have the choice to act on women's demands, and we have the power to make them notice.

This report brings together compelling new evidence from 16 countries across Sub-Saharan Africa and the Asia-Pacific region, revealing the scale of a crisis that remains too often overlooked. Each year, more than 13.5 million women give birth in facilities where delivery rooms are deemed unsafe. Maternal sepsis continues to be one of the leading causes of maternal death. Basic measures such as access to clean water can help to prevent sepsis and are far cheaper than treatment. These simple, affordable essentials like clean water, toilets and handwashing could cut maternal infections and deaths by at least 50%.

Behind the statistics in the report are the women, families and health workers facing huge risks, that can be avoided. Their powerful voices are captured in this report. Their testimonies lay bare the unacceptable conditions that so many give birth and recover in. Their demands are clear: women speak not only about clinical care, but about dignity – about feeling safe, respected and protected at one of the most vulnerable moments of their lives. Health workers describe the frustration of trying to provide quality care without the most basic resources. Their messages are not abstract demands; they are practical calls for improvements that are entirely within reach.

Throughout my own work on gender equality and international development, including as Country Director for WaterAid Ethiopia, and later as a trustee, I have seen how transformative the combination of clean water, sanitation and hygiene can be. This is especially true when women are central in the planning and decision-making processes. This applies in all spheres, from homes, to schools and health clinics. In healthcare, water, sanitation and hygiene is immediately life-saving. It protects families at one of their most critical moments, strengthens health systems and supports frontline staff. Ensuring every healthcare facility can guarantee clean water, decent toilets and good hygiene is not an ambitious technological leap; it is a matter of political will and coordinated investment.

Governments and world leaders have an opportunity to turn long-recognised commitments into measurable progress. They have a chance to hear what women are demanding, and recognise the simple, affordable solution that sits in front of them. Every woman has the right to survive pregnancy and childbirth. It is time for governments to deliver.

Dr Helen Pankhurst CBE
British women's rights activist

Clare Newton FRSA

Executive summary

This report delivers a clear call to action: the failure to provide universal basic water, sanitation and hygiene (WASH) in healthcare facilities is costing women's lives.

Every two seconds, a woman gives birth in a healthcare facility without clean water, decent toilets and good hygiene, putting her life and her baby's life at risk from infections. Those infections can cause sepsis – a severe and life-threatening response to infections that causes the body to attack its own organs.

In the 16 countries studied in this report, more than 3,800 women's lives could be saved every year from sepsis alone through the simple, affordable and well-evidenced provision of clean water, decent toilets and good hygiene in healthcare facilities. The cost of saving those lives is around $1 per capita based on data from 46 least-developed countries.

Across the 16 countries studied in this report:

- **76.1% of births in Africa** and **64.5% of births in Asia** occur in healthcare facilities without basic water, sanitation and hygiene.
- Mothers with sepsis in **Sub-Saharan Africa have a 144 times greater** chance of dying than mothers in Western Europe and North America.
- **One in nine births in Africa result in maternal sepsis** from infections linked to poor hygiene during birth.
- At a **cost of $1 per capita** – which is cheaper than treatment – **sepsis prevention could avert 1.7 million cases and 3,800 maternal sepsis deaths annually across the 16 focus countries,** and up to 9.5 million cases and 8,580 maternal sepsis deaths globally.

WaterAid/Tariq Hawari

Jenitha, 21, gives her baby Regina water from one of the new community taps in their coastal community in East Sepik, Papua New Guinea, April 2024.

Every woman has the right to give birth in safety and dignity. Despite nearly 200 years of evidence linking hygiene to safe birth and widespread political commitments to maternal health, this is not always the case. WASH remains marginal in policy, planning and financing. Standards exist, but high-level political prioritisation and sustained investment do not.

Women's testimonies lay bare the human consequences. Women describe labouring without water to wash themselves or their newborns, toilets that are locked, blocked or unusable, and handwashing stations that are broken or empty. These conditions strip women of dignity and push families towards unsafe home births far from skilled attendants. They also deepen gender inequality by exposing women to avoidable infection and the burden of unpaid care, which they are often expected to carry when others become infected in healthcare facilities. Healthcare workers – of whom 70% are women – also suffer: the absence of basic WASH in healthcare facilities heavily affects their working conditions.

Yet this is entirely unnecessary. Universal basic WASH in healthcare facilities is affordable, quick to implement and highly cost-effective, with strong evidence of health and economic returns. Investing in WASH is one of the fastest and most practical ways to accelerate stalled progress on gender equality. It reduces maternal and child mortality, strengthens health systems, limits antimicrobial resistance and boosts economic productivity. All this while delivering on existing global resolutions and promises to women and girls and protecting their right to health.

The message of this report is clear: WASH in healthcare facilities is not an optional add-on to maternal health; it is the bedrock of safe care, gender equality and resilient health systems. The solutions are proven. Governments have the evidence, now what is needed is decisive action. Women are demanding WASH in healthcare facilities; it is their right.


WaterAid/Cianeh Kpukuyou

Miatta Kromah holding the hand of her baby girl after delivering her at Diah Clinic, Grand Cape Mount, Liberia. January 2026.

Governments must treat WASH in healthcare facilities as a non-negotiable foundation of quality maternal and newborn care by funding, delivering and designing facilities to fulfil women's right to a safe birth and equal access to healthcare. Development partners must match this ambition by backing national leadership with real financing, putting WASH at the heart of maternal health programmes, and standing with women – especially those living in poverty who face the greatest economic and social barriers to demanding safe, respectful and dignified care – to demand safe, respectful and dignified care.

It's time to deliver clean water for every woman and every birth. Change starts with water.

WaterAid/Sophie Harris-Taylor

Gloria Zimba holds her baby at a healthcare facility in Kasungu District, Central region, Malawi. January 2026.

Calls to action

National governments

- **Make WASH in healthcare facilities a political and policy priority and requirement:** Prioritise gender-responsive WASH services and behaviours in national strategies, standards and monitoring frameworks and embed them as a core component of the essential package for all maternity and newborn care.
- **Finance WASH for women:** Increase dedicated health budgets for gender-responsive WASH in healthcare facilities, supported by costed national plans and roadmaps.
- **Ensure respectful, safe and inclusive care for women, in all their diversity, by putting them at the centre:** Invest in clean water, decent toilets and good hygiene in healthcare facilities, train and equip health workers, and create systems where women's voices guide services and hold providers accountable.

Development partners

- **Development partners need to follow suit and support national leadership, strategies and systems** to treat WASH as foundational to maternal health.
- **Make WASH in healthcare facilities central to maternal and newborn health** programmes and results frameworks.
- **Increase dedicated financing for WASH in healthcare facilities,** systems strengthening and cross-sector coordination.
- **Champion and support women's leadership across the health system.** Ensure their rights as patients and health workers are upheld. Enable women from all backgrounds – particularly those living in poverty who face the greatest economic and social barriers to demanding safe, respectful and dignified care – to participate meaningfully in decision-making and leadership roles that hold the system to account.

WaterAid/Sophie Harris-Taylor

Women at a healthcare facility in Kasungu District, Central region, Malawi. January 2026.

Medical equipment is cleaned following a delivery at Diah Clinic in Grand Cape Mount County, Liberia. January 2026.

WaterAid/Cianeh Kpukuyou

Gender-responsive WASH in healthcare facilities that promote safe, respectful and inclusive care

Gender-responsive WASH in healthcare facilities that fulfil women's right to a safe, dignified birth and quality care means:

- Women (and all users) have clean water, toilets and handwashing facilities in the appropriate locations that are available, safe, accessible, private and easy to use for patients, health workers and caregivers.
- Health workers are equipped and enabled to practice the behaviours required to provide safe, quality and respectful care with the right training, systems and supplies to deliver gender-responsive WASH and infection prevention and control. Dedicated staff are available to deliver relevant services, such as environmental cleaning and staff attitudes support diverse patient groups.
- Women have a decisive role in determining how facilities are designed, managed, monitored and improved.
- Budget is allocated for delivery of gender-responsive WASH infrastructure, services and behaviours.

Women must be involved in facility design, as male designers and engineers may otherwise overlook practical issues, such as how difficult it can be for heavily pregnant women to use toilets that are too small or require squatting. Practical examples include ensuring:

- Women patients and staff have access to secure and single-sex toilets designed to support menstrual health and hygiene.
- Maternity wards are prioritised for adequate water, cleaning and sanitation – including toilets, handwashing and bathing facilities.
- All staff are trained and there are prominent reminders on how to provide safe, inclusive and respectful care – from handwashing, environmental cleaning and waste management practices.
- Facilities are accessible for those with limited mobility or different disabilities.
- An increase in both the number and seniority of women in leadership and decision-making roles within healthcare facilities.

Delivering this requires the health, WASH and finance sectors to work together, so improvements are sustainable.

WaterAid/Dennis Lupenga

Women in Malawi often stay at a residential guardian shelter, next to a health centre, in advance of their due date, so they don't have to travel during labour. Estely Banda recalls the poor conditions at one health centre and guardian shelter. Estely stayed at the guardian shelter for over two weeks before giving birth at the health centre. She was referred to the district hospital after giving birth, where she stayed for a week while she recovered. November 2025.

'I was spared from the harsh environment of the health centre since soon after giving birth, I was referred to the district hospital. What women at the guardian shelter have to experience after giving birth [in the health centre] is not hygienic. The bathrooms and toilets these women use after giving birth had blood stains all over. It wasn't a good sight to endure.'

'Even before women give birth, there is a lack of hygiene at the guardian shelter. Women would throw bloody fabrics and other items inside the bathroom. As they were all sleeping on the floor and in the dark, some women would walk around while leaving a trail of blood. This was dangerous as we could easily contract diseases in that tightly-shared space.'

'The toilets were very bad and accessing them was a nightmare. I felt degraded as a woman as I had to pee while pregnant, right in an open space with other people looking at me. I felt ashamed and less of a human. I had no choice but to go there.'

'I wouldn't be happy at all to go back there.'

'Having clean water helps women to take a bath, wash their clothes and prepare their food in good time. I wish we had such privileges especially when a woman has just delivered a baby. There is a need for better services.'

Estely Banda and her baby at Chikho hotel, Mponela, Dowa, Malawi, November 2025.

Introduction

WaterAid/Tracy Keza

Nurse Joyce Nsinde washes her hands after seeing a patient at the Research Station Health Centre in Mazabuka, Zambia. September 2025.

Imagine going to a clinic to give birth and finding there is no water, or the water is brown. Imagine giving birth in a clinic where the toilets are blocked, locked or otherwise unusable. Imagine the wards can't be cleaned, and midwives and health workers can't wash their hands. Imagine worrying about whether you will have any water to drink during and after labour to help your body recover and support milk supply. For millions of women, this is the reality of giving birth.

Every woman has the right to give birth in safety and dignity.[i] Yet around the world, millions of women give birth in healthcare facilities where there is no clean water, toilets are unusable or unsafe, basic hygiene[ii] and cleaning requirements are not met. This means that worldwide, over half a million mothers and babies die each year from preventable infections acquired during childbirth.

This doesn't only affect patients. It also impacts health workers who can't do their job effectively without the means to keep themselves and their patients clean. Like patients, health workers often have nowhere safe to go to the toilet while working long shifts. It's common that healthcare facilities have to choose between staff and water when it comes to dealing with limited budgets.

i. Although no treaty explicitly recognises a standalone 'right to a safe birth', international human rights law establishes states' obligations to ensure safe, respectful and dignified childbirth through the right to life (Arts. 2 and 6) under the International Covenant on Civil and Political Rights, the right to the highest attainable standard of health, including maternal health (Art. 12), under the International Covenant on Economic, Social and Cultural Rights, and women's rights to non-discrimination and appropriate maternity care under the Convention on the Elimination of All Forms of Discrimination Against Women, all of which are grounded in the inherent dignity of the human person.

ii. A basic hygiene service requires facilities, such as handwashing points and running water, and their maintenance, as well as the availability of consumables, such as soap and antibacterial hand rub.

This report shares women's stories of what it is like to give birth – and care for those giving birth – in circumstances where you can't rely on having enough water to keep wards clean and where hand hygiene can't be effectively practised. All this, alongside the additional discomfort of worrying about where you can go to the toilet and whether it will be clean, or whether you will have enough water to drink.

This report reinforces the message to governments and their partners that it is time to deliver on universal basic WASH in healthcare facilities as a straightforward, known and affordable solution. As our new data illustrates very clearly, failing to do so is costing tens of thousands of lives every year.

WASH in healthcare facilities, particularly in delivery rooms and maternity wards, is pivotal in avoiding preventable infections and sepsis. Clean water is essential for handwashing, cleaning delivery rooms and equipment, and enabling women to wash themselves and their babies. Safe[iii], private toilets and washing facilities are central to dignity, recovery and wellbeing. Effective hand hygiene, cleaning and waste management protect women, newborns and health workers from infection. Rehydration is fundamental to recovery and support for breastfeeding.

This report examines the relationship between women's health, maternal mortality and the availability of basic gender-responsive WASH in healthcare facilities, but it goes well beyond the data. It brings women's voices to the forefront, demonstrating the significance of inadequate WASH to their experiences of childbirth and healthcare. This report makes a clear case: the progress already made in seeing more women and their babies have healthy, safe pregnancies and births can't be sustained without clean, safe and dignified healthcare environments. Basic WASH that prioritises women and girls as the majority of users of healthcare facilities, particularly their safety during birth, is not an optional add-on. It is foundational to saving lives, advancing gender equality and realising women's rights.

Over the past two decades, global efforts to reduce maternal mortality have focused on increasing access to skilled birth attendants and encouraging women to give birth in healthcare facilities. These investments have contributed to important reductions in maternal mortality. However, progress has slowed, and preventable infections remain a major cause of death and illness for women and newborns. Improving WASH in healthcare facilities is critical to accelerating progress, and this must directly respond to the requirements of women staff and patients.

What is WASH in healthcare facilities?

In this report, 'WASH in healthcare facilities' refers to the availability of clean water, decent toilets, good hygiene, environmental cleaning and waste management services, and associated behaviours within healthcare facilities at all levels of the health system, meeting, at a minimum, the indicators defined by the WHO/UNICEF Joint Monitoring Programme for WASH in healthcare facilities.[1]

iii. Toilets should: be safe and private; cater for menstrual and other hygiene requirements; be accessible to all users; be available and affordable when needed; be well maintained and managed; meet the requirements of caregivers and parents. UNICEF, WaterAid and WSUP (2018). Female-friendly public and community toilets: a guide for planners and decision makers. WaterAid: London, UK. Available at https://washmatters.wateraid.org/publications/female-friendly-public-and-community-toilets-a-guide-for-planners-and-decision-makers

Methodology

Several research streams fed into this report:

- A new **review of data and literature** focusing on 16 African and Asian countries,[iv] creating brand new findings that quantify how many births take place in low-income countries in healthcare facilities without adequate WASH, and the related risks of sepsis infection. For the first time, this research has calculated the potential number of lives saved and sepsis cases prevented by improving WASH in healthcare facilities and the monetary costs of doing so.[v]
- A **listening exercise** involving interviews with and surveys of over 1,000 participants across 4 regions in Uganda[vi] and 800 participants across 25 facilities in 5 districts in Malawi.[vii] White Ribbon Alliance in Kenya, Uganda and Malawi, in partnership with WaterAid Malawi and WaterAid Uganda, used its Ask Listen Act methodology to capture authentic voices from women and frontline health workers on the state and impact of WASH in healthcare facilities. In the case of Uganda, responses were analysed thematically to identify women's priorities, the systemic barriers they face, and the practical changes they want to see. The quotes and stories in this report come from those listening exercises. They are supplemented by others from WaterAid's programmes to highlight that women in different countries are going through similar experiences.
- A **review of policy documents** relating to health, WASH and maternity services in 13 of those countries.[viii] We assessed whether these countries prioritise reducing maternal mortality through ensuring basic WASH in healthcare facilities that ensure clean, safe births. We also analysed whether these commitments are supported by guidance, resourcing and implementation mechanisms, with countries scored against a common set of criteria.
- The **development of case studies based on the work of WaterAid Country Programmes** in Cambodia, Ghana, Tanzania and Zambia, identifying lessons learned from efforts to improve WASH in healthcare facilities in those countries.

> **Water, sanitation and hygiene is very poor in the facility where I work. We always have congestion because the mothers and their accompanying attendants as well as healthcare workers do not have enough facilities like toilets and bathrooms.**
>
> Jennifer Lucky, midwife, Mbale District, Eastern Uganda – listening exercise participant

iv. The 16 countries are Bangladesh, Cambodia, Ghana, Liberia, Malawi, Mali, Mozambique, Nigeria, Nepal, Pakistan, Papua New Guinea, Rwanda, Tanzania, Timor-Leste, Uganda and Zambia.
v. Full methodology for the data and literature review can be found at https://washmatters.wateraid.org/publications/births-without-water
vi. Central, Eastern, Western and Northern.
vii. Chitipa, Kasungu, Ntchisi, Mangochi and Balaka.
viii. These 13 countries are Cambodia, Ghana, Liberia, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Tanzania, Uganda and Zambia.

WaterAid/Cianeh Kpukuyou

Haratu Kiewen describes her experience giving birth in Diah Community, Grand Cape Mount, Liberia, January 2026.

'The water that was used on me was the water from the creek. They put it in a barrel, and that was what was used on me when I gave birth. I remember after I gave birth, the midwife cleaned me up, cleaned my baby, wrapped my baby up and then gave me the baby in my arms. To clean the baby, they put a towel in the water from the barrel, and they wet my baby with the towel.'

Haratu Kiewen, nine month pregnant, at Diah Community, Grand Cape Mount, Liberia. January 2026.

Stark new data reveals deadly yet preventable maternal sepsis crisis across low-income countries

WaterAid research across Africa and Asia, including a deep dive into 16 countries, shows in the starkest terms that a lack of clean water, decent toilets, good hygiene and waste management and cleaning services in maternity services is a systemic barrier to safe, respectful and inclusive care.

> **There are no sinks for mothers to wash their hands. We need washing facilities around the wards. For the toilets, we need enough for the mothers we serve. If possible, build separate facilities for attendants.**
>
> Jennifer Lucky, midwife, Mbale District, Eastern Uganda – listening exercise participant

Unsafe delivery rooms

Across the countries analysed, more than 15.4 million births take place each year in facilities without basic sanitation. This is exposing mothers, newborns and health workers to heightened risk of infection – around three in four births (76.1%) in the African countries studied, and nearly two in three births (64.5%) in the Asian countries studied.[ix]

Figure 1 shows water, sanitation and hygiene gaps in maternity wards across six countries in Asia, and Figure 2 across ten countries in Africa.

ix. The literature and data review for this report was conducted by Guy Hutton at Innate Values. Full methodology for the data and literature review can be found at https://washmatters.wateraid.org/publications/births-without-water

Figure 1: Unsafe delivery rooms: Water, sanitation and hygiene gaps in maternity wards across Asia.[x]

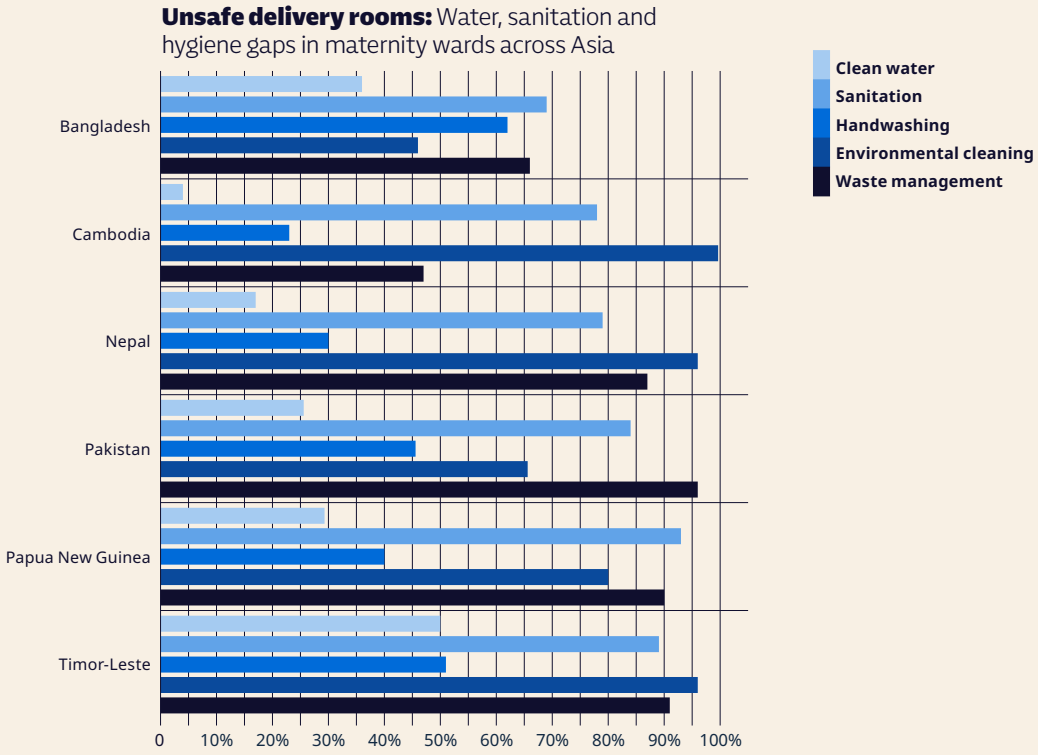
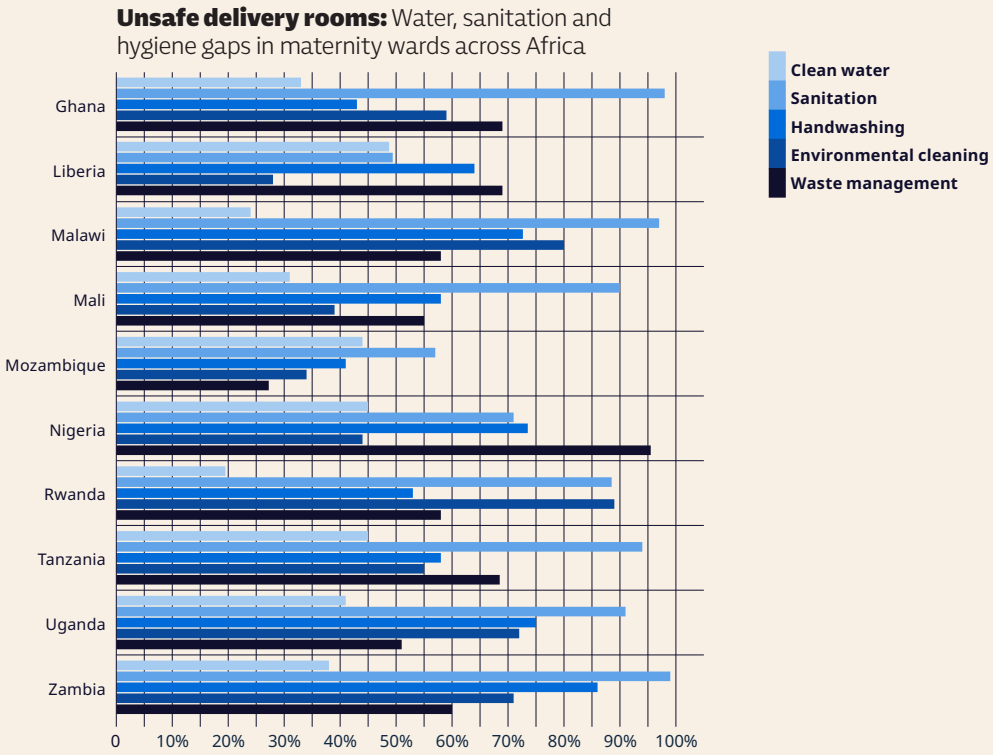
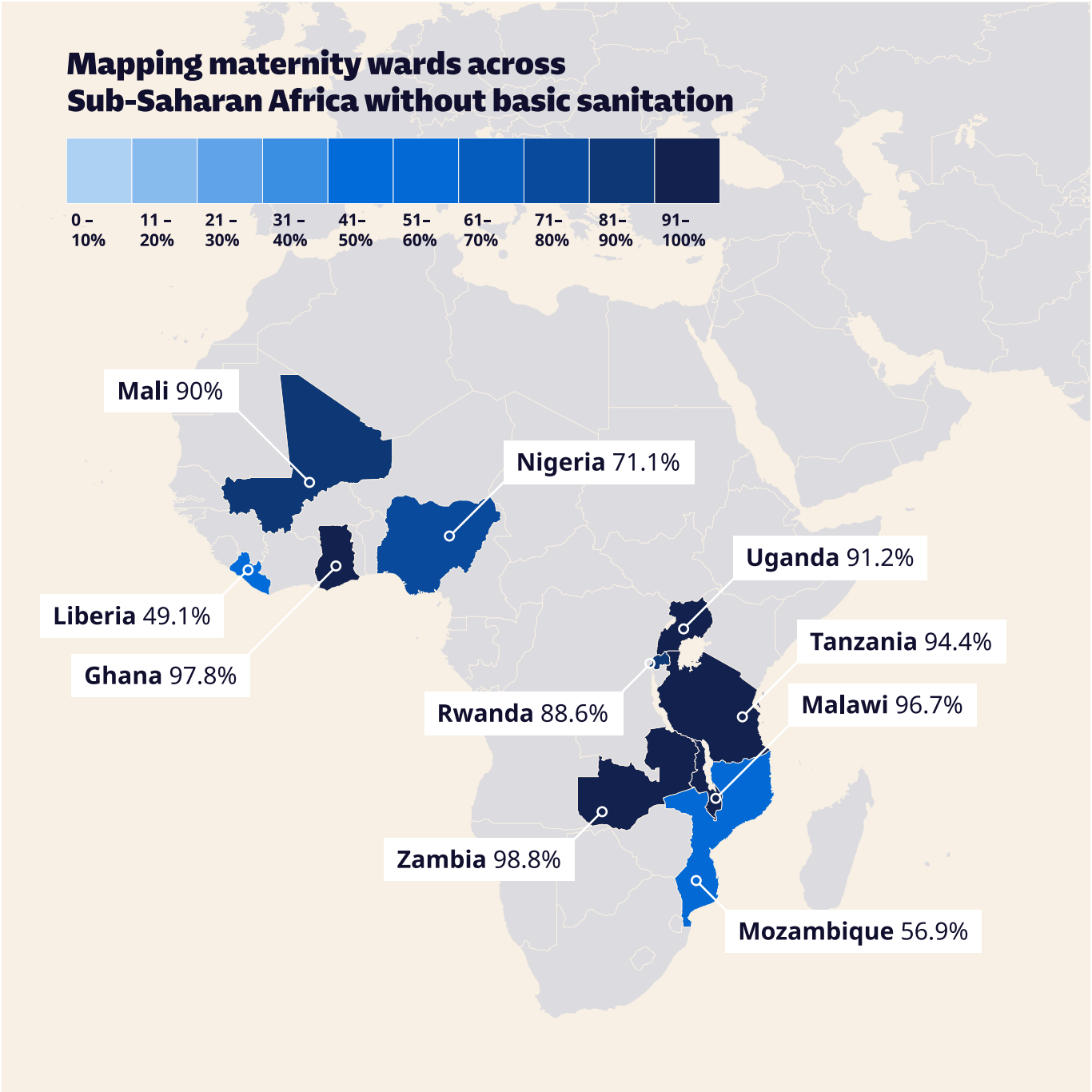


Figure 2: Unsafe delivery rooms: Water, sanitation and hygiene gaps in maternity wards across Africa.[xi]



x. Annual institutional births without basic level of service (WHO).
xi. Annual institutional births without basic level of service (WHO).

Figure 3: Unsafe delivery rooms: Water, sanitation and hygiene gaps in maternity wards across Africa.[xii]



These gaps help explain why maternal mortality remains unacceptably high. Across the 16 focus countries, around 112,000 women die each year from pregnancy-related causes. Maternal sepsis – caused by infections acquired in unhygienic birth conditions – accounts for 5–12% of deaths and infections and ranks as the third or fourth leading cause of maternal death, depending on the region.

xii. Annual institutional births without basic sanitation, like decent toilets.

Global maternal sepsis rates

In Sub-Saharan Africa alone, an estimated 4.7 million cases of maternal sepsis occur each year out of 41.2 million births – 1 in 9 births.

Globally, there is around one sepsis-related death for every 1,100 cases. In Africa, the risk is far higher, with one death for every 350 cases – around 3 times higher than the global average and more than six times higher than in Asia, where there is one death for every 2,230 cases.

Shockingly, mothers with sepsis in Sub-Saharan Africa have a 144 times greater chance of dying than mothers in Western Europe and North America.

In Africa, there is one sepsis-related death for every 350 cases – around three times higher than the global average.

The research demonstrates that improving the quality of care for mothers and newborns – including clean birth practices, such as handwashing by birth attendants, sterile equipment, clean surfaces and clean umbilical cord care – could help avert 9.7 million cases of maternal sepsis and 8,580 maternal sepsis deaths every year globally.

In addition, it could prevent 3,800 maternal sepsis deaths and 1.7 million cases of maternal sepsis every year in our 16 sample countries alone (Figures 4 and 5).

Improving WASH in healthcare facilities could help avoid more than 8,580 maternal sepsis deaths and 9.7 million cases of maternal sepsis every year globally.

Figure 4: Maternal sepsis: The effect of water, sanitation and hygiene in preventing cases and deaths in Asia.

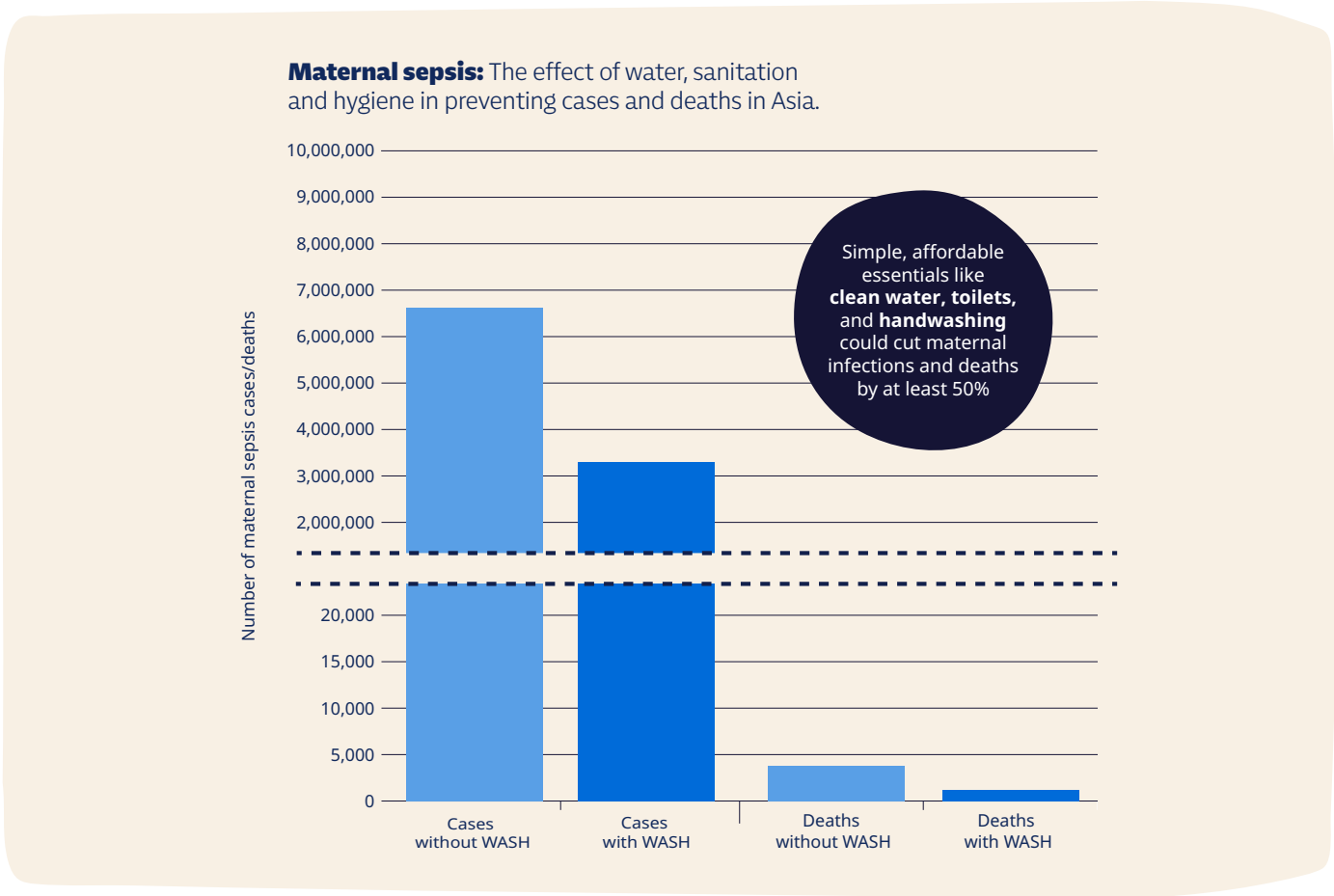
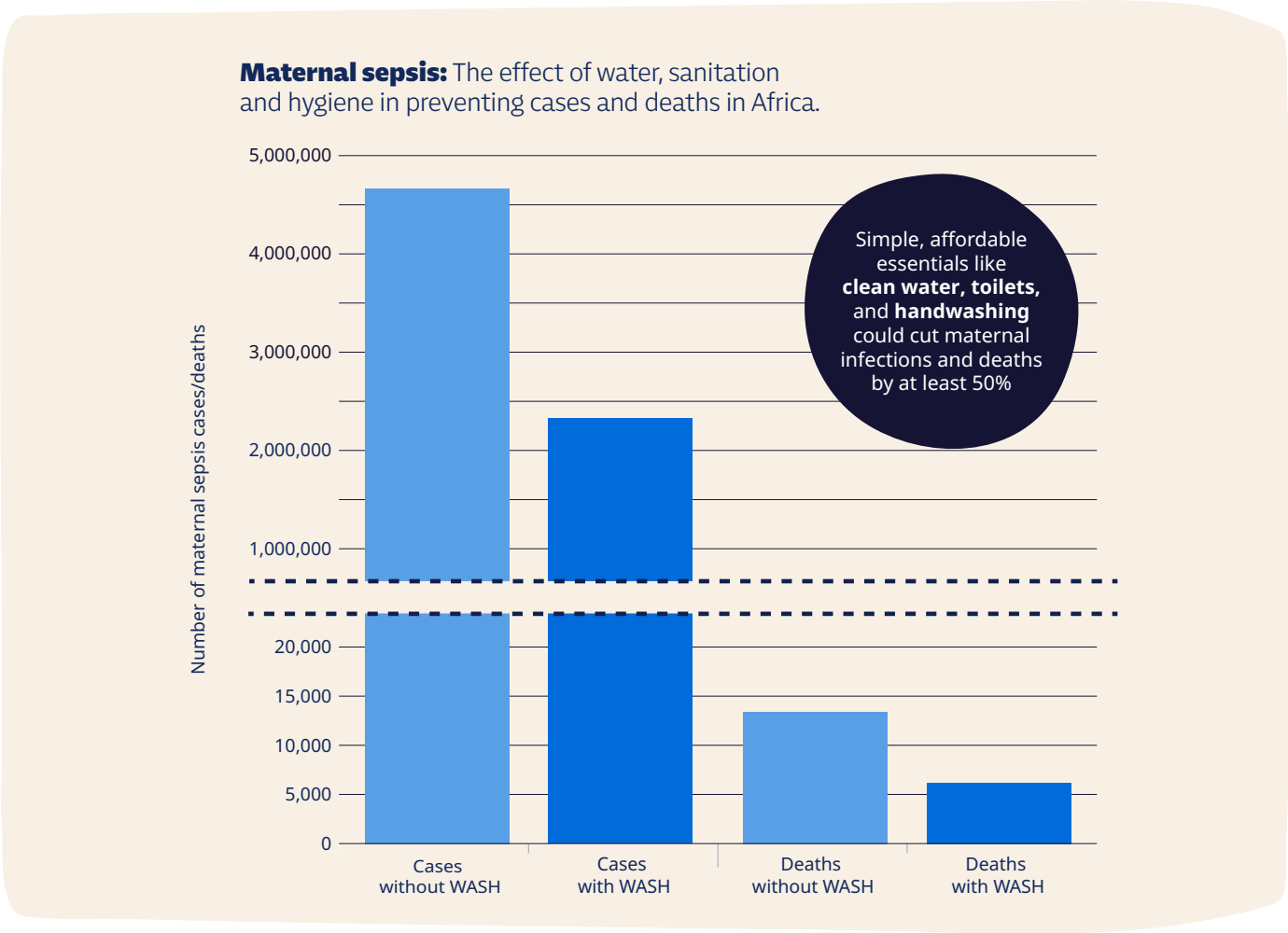


Figure 5: Maternal sepsis: The effect of water, sanitation and hygiene in preventing cases and deaths in Africa.



The toilets [in the hospital] were not clean. At times, over 20 people would be waiting to use one toilet. They were not functional, and were not safe.

Evelyn Akampurira, Mbarara, Western Uganda – listening exercise participant

Access to WASH in healthcare facilities

In some regions, fewer than 30% of delivery rooms have access to water.

Without basic WASH, the hazards go beyond maternal infections and sepsis and include postpartum complications, urinary tract infections and increased vulnerability during procedures such as caesarean sections.

A study of rural hospitals in Rwanda found that interruptions in water supply for a day or more were linked to a 2.6 times higher likelihood of surgical site infections following a caesarean.[2]

As we will see in the following sections, WASH is also central to women's experience of care. Dirty, overcrowded or unsafe environments cause fear, shame and distress and erode trust in health systems, leading women to delay or avoid seeking care. If women delay too long in getting to a facility or decide to give birth at home because of the poor state of WASH facilities, the risk of death rises. Statistics indicate that a one percentage point rise in home deliveries will contribute to one additional maternal death per 400 live births.[3]

Inadequate WASH in healthcare facilities has wider implications for efforts to reduce maternal mortality through increasing births in facilities. It also has wider implications for women's health in general. Healthcare-associated infections (HAIs), including urinary tract infections, disproportionately affect women. Women and children account for around three out of five (60.6%) HAIs, nearly two-thirds (64%) of the 9.5 million HAI-related deaths each year, and more than three out of four (77%) of the healthy life years lost globally.

Even small repairs take too long. It takes one to two weeks to fix a broken tap.

Jennifer Lucky, midwife, Mbale District, Eastern Uganda – listening exercise participant

On top of this, women overwhelmingly perform unpaid caregiving responsibilities, such as looking after relatives who have become sick from HAIs. This means that HAIs damage women's livelihoods indirectly[xiii] and, in turn, affect economic productivity.[4]

Women and children account for nearly two-thirds of the 9.5 million deaths related to HAIs each year.

xiii. Annual institutional births without basic sanitation, like decent toilets.

Impacts on healthcare workers

The impact also goes beyond patients: over two-thirds (70%) of health workers are women.[5] Inadequate WASH in healthcare facilities has a negative impact on their work conditions and morale and makes them vulnerable to infections, leading to increased absenteeism.[6]

In 2022, the White Ribbon Alliance surveyed over 56,000 midwives across 101 countries and found that supplies and functional facilities were one of their top demands. Midwives want to work in an environment with clean water and decent toilets so they can uphold quality and safety for the women in their care.[7]

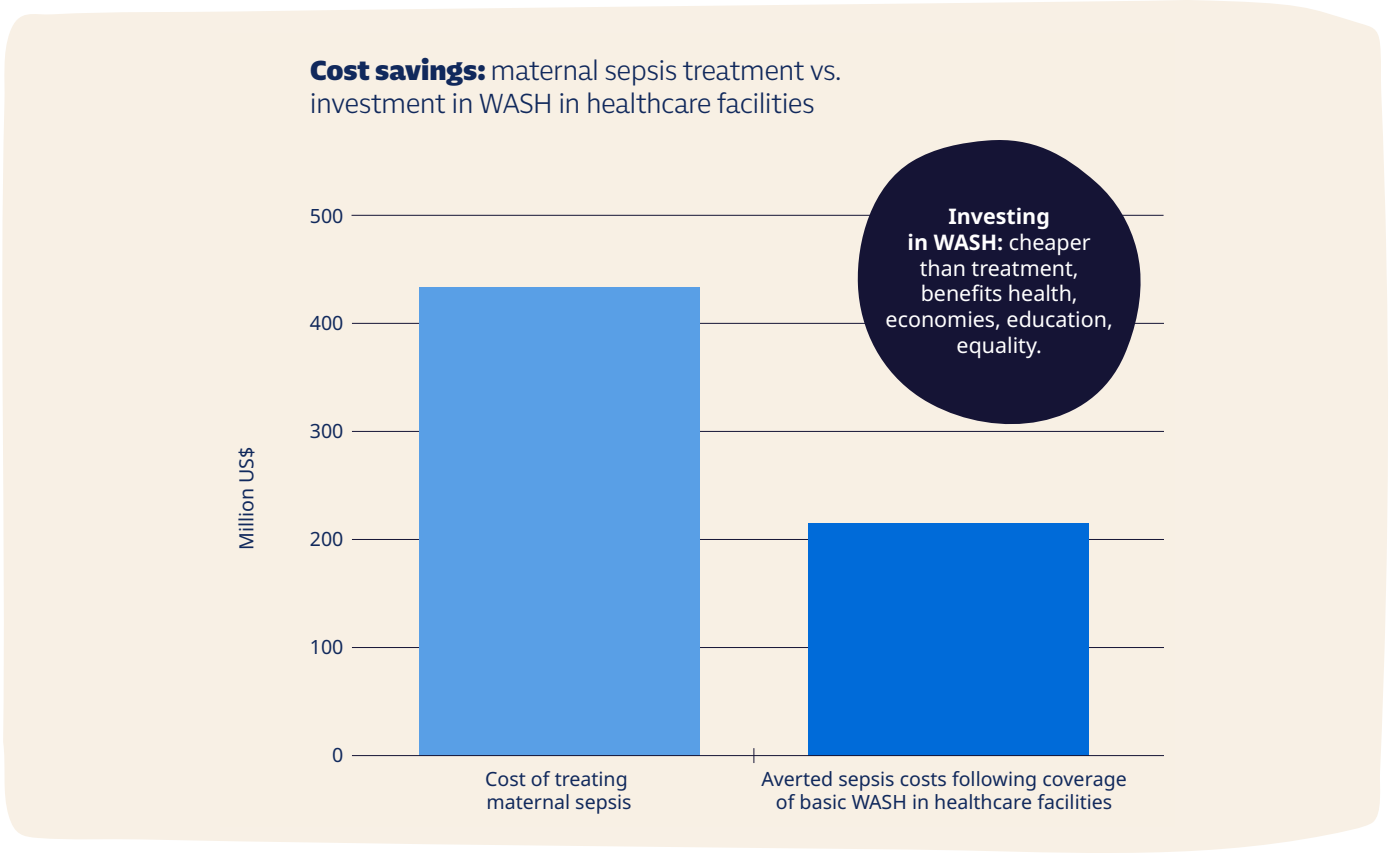
Over two-thirds of health workers are women.

The solution is, however, both achievable and affordable. The research shows that universal basic WASH in healthcare facilities can be delivered for $0.52–1.04 per capita per year in low and middle-income countries. This cost is less than the treatment costs which would be saved from halving the numbers of maternal sepsis cases (Figure 6).[8]

This modest investment promises to not only halve maternal sepsis infections and deaths and the other negative impacts of inadequate WASH in healthcare facilities on women's health, but it also meets women's demands for better care.

The costs of delivering basic WASH in healthcare facilities are less than the costs saved from treating fewer sepsis cases.[xiv]

Figure 6: Cost savings: maternal sepsis treatment vs. investment in WASH in healthcare facilities.[xv]



xiv. Costs of maternal sepsis and WASH investment in sample countries, total and relative to health spending and GDP.
xv. Medical costs averted from fewer cases of maternal sepsis following universal coverage of basic WASH in healthcare facilities in the 16 sample countries.

Zelifa Mzoma, a nurse midwife, explains the difference WASH intervention made at Mkhuzi Health Centre, Ntchisi, Malawi, December 2022.

Before WASH intervention:

'When I first got here, a year and three months ago, there were a lot of challenges regarding WASH. We did not have a reliable water supply. We depended on the guardians who come here to fend for their relatives to fetch water for us, from a borehole which is far away from this health facility.

'Some clients we have require immediate need to take medicine on the spot, like Fansidar* tablets, due to the severity of their illnesses. It was difficult for us and weird to ask the client to fend for themselves with water so that they could take the medicine.'

After WASH intervention:

'We have seen a huge drop in sepsis cases. For the past four months, we have not registered any case of sepsis. This can be attributed to the availability of clean water, decent sanitation and good hygiene, including healthy talks which encourage our clients to emulate the same good hygiene behaviours they experience here to their respective homes.'

'[Also] with clean hands, I can ably handle my job and keep babies and other clients safe from infection. This is the positive impact of having clean water in our health facility. We are grateful and happy.'

Zelifa Mzoma, 39, Nurse Midwife, holding a baby, Mkhuzi Health Centre, Ntchisi, December 2022.

* Fansidar is used for treatment and prevention of malaria.

Findings and analysis from the listening exercise

The above evidence only serves to confirm what most women and health workers already know: unclean births are dangerous. As women and health workers in Malawi and Uganda told us, clean water, safe sanitation and hygiene in healthcare facilities – particularly maternity wards – are what make dignified, respectful childbirth possible.

> **Listening to the voices of women and girls will help us reduce maternal and infant deaths.**
>
> Scovia Angom, women's advocate, White Ribbon Alliance, Uganda – listening exercise participant

Eunice Chilenga bathing her baby, Bale, Chitipa district, Malawi, June 2025.

WaterAid/Dennis Lupenga

The listening exercises across Malawi and Uganda gathered women's voices, but the Uganda report also quantified and ranked priorities. Therefore, the following are drawn from those findings, but they are largely supported by the views of women in Malawi, particularly the availability of safe and reliable water as the top priority.

From the Uganda listening exercise report, the following priorities were ranked as most important:

1. **Clean, safe and reliable water:** The 'first guarantee of safety and dignity.' This should be enough for drinking, bathing and washing newborns, and medical procedures such as cleaning instruments and delivery beds. There should be continuous running water both day and night, and backup tanks to cushion against shortages. Reliable water supply, women said, is 'the first sign that their health and lives are valued.' Health workers pointed out that infection prevention is impossible without water.[9]

2. **Clean, accessible toilets:** The 'most visible marker of dignity.'[10] Women demanded clean, dry and regularly maintained toilets with no smell or flies; flushable, with running water, tissue and lockable doors for privacy; close to maternity wards, well-lit at night and separate for women; accessible by wheelchairs with ramps and support rails.

3. **Well-equipped handwashing facilities:** 'Seen as the simplest yet most powerful act of protection, and its absence, one of the greatest risks',[9] such as at all points of care, ward entrances, delivery rooms, toilets and postnatal units; with soap, clean water and sanitiser/hand rub.

4. **Health information on WASH practices:** 'Information is as vital as infrastructure.'[11] Women complained of no guidance on hygiene after childbirth and wanted advice and visible reminders for all on safe hygiene routines.

5. **Clean and properly maintained maternity units:** Across Uganda, women agreed that cleanliness is fundamental to their experience of care. This means well-aerated, regularly cleaned maternity units, adequate and trained cleaning staff, disinfectants and a reliable water supply.

6. **Dignity in WASH delivery:** Childbirth and its immediate aftermath is a deeply vulnerable time for women. Adequate, safe and accessible gender-responsive WASH is a fundamental part of ensuring that their experiences are positive and not traumatic.

7. **Proper management and disposal of sanitary and medical waste:** The proper disposal of waste is seen as a vital signal of how trustworthy the health system is for women.

8. **Responsive and accountable WASH systems:** A clear mechanism for reporting issues and faults with rapid action to deal with them and regular monitoring of facilities.

80% of women's WASH demands centred on just three essentials: clean water, dignified toilets and functional handwashing facilities – the foundations of safe, respectful and inclusive childbirth.

Women in Malawi and Uganda spoke powerfully about dignity, safety and respectful care and the significance of water, toilets, hygiene, cleanliness as well as accountability to decision makers to make improvements to services based on their demands. They prioritised clean, reliable water; safe, accessible toilets; well-equipped handwashing facilities; clean and well-maintained maternity wards; clear information on hygiene; proper waste management; and health systems that change and improve to address their concerns and demands.

I had to stand on my toes to reach and wash my hands. Hanging my clothes before bathing was also difficult because I could not reach. Even washing from a basin was hard because I was told to place it on a higher surface.

Nagawa Annette, Mukono District, Central Uganda – listening exercise participant living with dwarfism

Despite global and often national standards setting minimum requirements for WASH in healthcare facilities, accounts from women patients and health workers demonstrate the unacceptable gap between those standards and what is available, and the impact that has on women's experience of healthcare and childbirth.

Women in both countries spoke of frequent and prolonged water outages, dependence on unprotected boreholes, long queues at single taps, contamination in storage tanks and having to share water sources with communities and local businesses. All of which hampered cleaning and increased risks of infection. Sometimes, women patients and health workers had to buy water from or use the toilets in nearby homes, or often the bush.

Often there was no usable toilet because it was locked, blocked or without doors. When there was, it often did not meet the standard of being clean, accessible, well-lit and private. In both countries, women and health workers called for functioning handwashing stations; many were reported to be not working, with no soap and bucket systems that regularly ran dry.

'The bedsheets we had were personal. We came with them from home. The hospital was not clean at all. The beds had stains and bed bugs all over. It was not safe at all for me and those I was with.'

Deborah Nambezo, Mbale District, Eastern Uganda – listening exercise participant

WaterAid/Ernest Randriarimalala

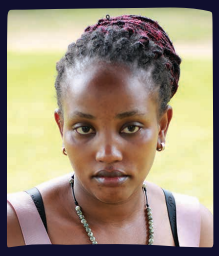
Miza, 24, and her youngest child, Mariella, 19 months, Taranty Bas, Madagascar. June 2025.

Issues around waste management, raised strongly in Uganda as a symbol of neglect, were echoed in Malawi. Women described overflowing pits, blocked drains, stagnant wastewater and bloody water in drains outside maternity wings.

Findings from Malawi add a further dimension to these challenges. Women highlighted the extremely poor conditions in shelters for expectant mothers and their 'guardians' – family caregivers, mainly women, who provide vital support during and after childbirth. In many countries, women and their guardians travel to health facilities a week or more before delivery because of the long distances involved. Women in Malawi – both mothers and guardians – reported that these shelters were overcrowded and unhygienic, and frequently lacked safe, private toilets and bathing facilities.

Guardians routinely absorb the consequences of WASH failures in healthcare facilities, collecting water from unsafe sources and washing sheets and clothes post-birth, while having to bathe or use the toilet in open or insecure spaces. This reliance on unpaid labour by women exposes how inadequate, gender-responsive WASH in healthcare facilities shifts risk, burden and responsibility onto those least able to bear it.

> **There was no privacy. Hygiene was difficult because of congestion. The experience was traumatising for me as a first-time mother.**
>
> Evelyn Akampurira, Mbarara, Western Uganda – listening exercise participant



In Malawi, in particular, women referenced staff shortages. This means that staff are not available, for example, to clean areas to the required standards or are pulled into other work, which prevents them from cleaning. These constraints are exacerbated by having to collect water from elsewhere because it is not always available in the facility. Staff complain of a lack of supplies for cleaning and other critical hygiene behaviours.

Women in both countries spoke of the need for, but absence of, reporting and accountability mechanisms. They also spoke of the need for facility management committees to have a clear role in ensuring standards are met and for women's complaints to be acted upon.

Kol Sotheary, 32, looks over at her newborn baby at Cheung Prey Referral Hospital, Kampong Cham District, Cambodia. February 2023.

WaterAid/Tariq Hawari

Improving hand hygiene to protect women and newborns in Cambodia

In Cambodia, the Changing Hygiene Around Maternal Priorities (CHAMP) research project has developed and tested a new approach to a critical but often overlooked part of safe, high-quality maternal and newborn care: improving hand hygiene during childbirth. Implemented in Kampong Chhnang Province, the project focused on strengthening handwashing practices in healthcare facilities and supporting safer behaviours that extend into the home during the postnatal period.

Although midwives and birth attendants in Cambodia generally have strong knowledge of when handwashing is required during labour and delivery, CHAMP found that persistent and context-specific barriers prevent these practices from being carried out consistently. For example, postnatal care wards didn't have functioning handwashing facilities and the risk of infection for newborns was often underestimated. This gap is particularly concerning given that five out of six births in Cambodia (83%) take place in healthcare facilities. Yet hand hygiene compliance remains low, and weaknesses in infection prevention and control continue to expose mothers and newborns to avoidable risk. Infections are the country's third leading cause of neonatal mortality and accounted for 16% of neonatal deaths in 2018.

Working in partnership with the National Maternal and Child Health Centre within the Ministry of Health, the National Institute of Public Health, the London School of Hygiene and Tropical Medicine and WaterAid, CHAMP designed and tested a multimodal, behaviour change intervention. The intervention linked antenatal care, labour and delivery, and postnatal care, and was delivered through practical, on-site, low-dose and high-frequency training to strengthen skills and confidence among midwives and caregivers. Strategically placed nudges and reminders, such as hand hygiene icon stickers at key points in the room, were used to support midwives and caregivers to sustain behaviours.

The results were striking. Hand hygiene practices during labour and delivery improved significantly, with a 4.7-fold increase among midwives and a 9.2-fold increase among mothers, fathers and other caregivers. The project also reduced the number of birth attendants initiating deliveries using incorrect sterilising techniques. At a national level, evidence from CHAMP has informed stronger guidelines, improved training and better resourcing across antenatal care, labour and delivery and postnatal care units, reinforcing hand hygiene as a foundation for safer births and better maternal and newborn outcomes.

Advancing Gender-responsive WASH for Women's Health in Ghana

The Sexual Health and Reproductive Education (SHARE) Project is working across four districts in Ghana to advance gender equality. It does this by improving access to comprehensive sexual and reproductive health education and gender-responsive care for young people aged 10–24.

SHARE is a collaborative project with local communities and is supported by a consortium of partners: WaterAid Ghana and Right To Play, in partnership with Forum for African Women Educationalists (FAWE) and FHI 360 with funding from Global Affairs Canada.

The project used data on high rates of early childbearing and early marriage to identify more than 15 healthcare facilities to work with.

Women's voices shaped the project from the outset:

- Consultations with families and community members identified drivers of adolescent Sexual Reproductive Health and Rights (SRHR) challenges – poverty, early marriage, and school drop-out. These insights informed interventions, including SRHR education delivered by female nurses and midwives, and strengthened links to clean and safe births and contraceptive services.
- Regular meetings and community scorecards enabled women and adolescents to articulate their demands directly to district health directorates, district assemblies, and school health programme officials. This also embedded clear accountability processes from the start. Women and girls highlighted WASH facilities in schools and health centres and stronger integration of WASH with SRHR services as their top demands. These demands were fed directly into district health quarterly management meetings to address emerging issues such as funding for WASH and infection prevention control activities, ensuring rapid response to fix broken water systems and improving waste disposal.

The SHARE project provides a compelling example of how gender-responsive WASH interventions in healthcare facilities can enable clean, safe births and strengthen women's health outcomes. Embedding women's voices in WASH decision-making improves maternal health outcomes as well as building accountability and investment pathways. This is essential to uphold women's right to health and ensure safe, inclusive and dignified births.

Bukari Manayaa, nine months pregnant mother, check-up at Adaboya's maternal health ward. Ghana.

WaterAid/Apag Studios

Are health systems set up for women?

How to create gender-responsive facilities

As reflected in women's testimonies and demands in Uganda and Malawi, gender-responsive WASH in healthcare facilities ensures that healthcare is accessible and safe for all women across their healthcare needs throughout their lives.

Both health workers and mothers deserve better. Water, sanitation and hygiene are not charity; it is a right. Prioritise it, and we all win.

Walter Omoko, healthcare provider, Department of Maternal and Child Health, Lira District, Northern Uganda – listening exercise participant

An approach that guarantees this level of provision and quality of service requires inclusive and accessible WASH infrastructure that meets women's needs. This means meeting the diverse needs of women and girls with disabilities or limited mobility due to disability, pregnancy, the aftermath of giving birth or illness. This includes well-lit, lockable and gender-segregated toilets that support menstrual health, sinks at appropriate heights, ramps and handrails. Maternity wards should have bathing and washing facilities located close by – and there should be training and guidance for staff on behaviours that promote WASH and infection prevention in healthcare services. These service and design standards are set out in the World Health Organization (WHO) and UNICEF Water and Sanitation for Health Facility Improvement Tool (WASH FIT).[12] The WHO *Quality of Care for Maternal and Newborn Health* monitoring framework[13] sets standards for WASH provision and related behaviours specifically for maternity areas – including accessibility of washing and bathing areas for maternity patients.

As these standards make clear, gender-responsive WASH in healthcare facilities can't be achieved without staff training; systems that promote safe behaviours, by staff and patients; and the supplies, such as soap and antibacterial hand rub, that enable this.

I felt dishonoured. Everything was challenging for me to use… I would like to see facilities specially designed for us, and easy to use. Bathrooms at our height, handwashing stations we can reach, hooks to hang clothes and towels and hospital beds that are easy for us to climb onto.

Nagawa Annette, a person living with dwarfism, Mukono District, Central Uganda – listening exercise participant

> **If they set up enough toilets, ensure there is enough water, and provide washing stations with soap, then people will wash their hands before attending to their babies. Infections will reduce among pregnant women.**
>
> Evelyn Akampurira, Mbarara, Western Uganda – listening exercise participant

It can only be sustained through strong accountability and maintenance systems. This includes routine monitoring, timely repairs, required budget for operation and maintenance, transparent oversight and channels for women to raise concerns that lead to action. It also requires multisectoral collaboration, adequate financing and integration with infection prevention, maternal and newborn health and quality-of-care frameworks. All of this requires recognition of the fact that women and girls, as the majority of users and staff, should shape WASH design, delivery and governance.

Despite constituting over two-thirds of staff, women only occupy 20% of leadership positions in healthcare. Facilities that are designed without the involvement of women, without understanding different needs based on gender, phases of life, socio-economic status and disability, are likely to miss critical features that they need. For example, the challenges of using cramped toilets that require squatting when heavily pregnant.

Underpinning all of this is the need for national policies, plans and budgets that prioritise the provision of reliable gender-responsive WASH infrastructure in all facilities and recognise the critical importance of clean births in reducing maternal mortality.

WaterAid/Ernest Randriarimalala

Gazetee, 29, walking to collect water, Taranty Bas, Madagascar. June 2025.

Overall, there is considerable overlap in what women want in Uganda and Malawi, and the standards outlined in the UNICEF/WHO WASH FIT and quality of care guidelines for maternity services:

- **Reliable, clean water:** Women prioritise continuous access to sufficient, safe water for drinking, washing, cleaning and care during childbirth. This is aligned with global standards that require uninterrupted supply, adequate storage and water points close to maternity wards.
- **Clean, safe and accessible toilets:** Women consistently call for toilets that are clean, private, lockable, well-lit and close to maternity wards. Including for women with disabilities, mirroring international requirements for safe, gender-segregated and accessible sanitation with nearby handwashing.

- **Handwashing for infection prevention:** Functioning handwashing stations with water, soap and/or alcohol-based hand rub at all critical points are seen by women as essential protection, fully aligned with global standards that require hand hygiene facilities at every point of care and toilets and routine hand hygiene by staff.
- **Clean maternity wards:** Women associate cleanliness with care and safety, highlighting the need for regular cleaning, adequate supplies and sufficient staff. This is in line with standards that require routine environmental cleaning and hygienic clinical areas at all times.
- **Dignity, respect, privacy and safety:** Women emphasise privacy, empathy and inclusion, particularly for women with disabilities. This reflects global expectations that WASH facilities and maternity environments are designed to be safe, private and respectful throughout labour and postnatal care.
- **Safe waste management:** Poor waste disposal is viewed by women as a visible sign of neglect and risk. This reinforces the standards that require safe segregation, disposal and drainage systems to prevent contamination and infection.
- **Accountability and rapid response:** Women want clear mechanisms to report problems and see visible action taken, consistent with global guidance calling for ongoing monitoring, timely repairs and continuous quality improvement.

Harunatu T. Kamara cleans medical equipment at Diah Clinic, Grand Cape Mount, Liberia. January 2026.

Shenette Khaula Shamu, a midwife at Diah Clinic in Grand Cape Mount, Liberia, explains how a lack of water can be a barrier to safe, respectful and inclusive care, January 2026.

'If the patient is brought here in labour, the time it takes me to go and look for water, she might deliver and she would need my attention immediately. But I'm not around because I am looking for water. That could cause significant harm to either the mom or the baby. She might have postpartum haemorrhaging in the process, and I am looking for water, so she could even bleed to death.'

WaterAid/Clareh Kpukuyou

Policy analysis in a selection of countries

Hajah Massaquoi, nine months pregnant, in Diah Community, Grand Cape Mount, Liberia. January 2026.

WaterAid/Cianeh Kpukuyou

With these priorities and criteria in mind, we reviewed a range of policies across 13 countries.[xvi] Our analysis focused on top-level national health, maternal and women's health policies, alongside strategies, plans and guidelines for WASH in healthcare facilities and, where available, guidelines and standards for maternal and newborn care. We assessed the extent to which governments recognise the link between WASH in healthcare facilities and women's and maternal health. We also assessed how far they are taking concrete steps to ensure gender-responsive WASH is available in the facilities women rely on.

No national high-level health policies, strategies or plans reviewed prioritised WASH in healthcare facilities as a means of reducing maternal mortality.

> **When we do not have water, we tend to touch one mother to another without doing some form of hand sanitising or handwashing. The infection from one mother transmits to the next.**
>
> Jennifer Lucky, midwife, Mbale District, Eastern Uganda – listening exercise participant

xvi. Cambodia, Ghana, Liberia, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Tanzania, Uganda and Zambia.

Our review found:

- ✓ Almost all high-level national health strategies, policies and plans prioritise reducing maternal mortality in their priorities and indicators – often it is their top priority.
- ✓ Some national health policies include general commitments to WASH in healthcare facilities, but none prioritise it as a core intervention to reduce maternal mortality. Where WASH in healthcare facilities is featured in national policies it is usually in passing or only in detailed targets. As these high-level policies shape national planning and resource allocation, this omission means that political attention and financial support are unlikely to be focused on this area in a way that is likely to ensure safe, respectful and inclusive care.
- ✓ Where plans and guidance on WASH in healthcare facilities do exist, they often address many of the fundamental elements recognised as significant in achieving gender-responsive WASH. In line with WASH FIT, most address areas such as separate, accessible and secure toilets for women, minimum water requirements for labour wards, and defined standards for handwashing stations across the facility.
- ✓ A small number of countries go further, for example, in Nigeria, where national standards explicitly call for prioritising women and other vulnerable groups in resource allocation.
- ✗ Many countries that have developed standards for WASH in healthcare facilities don't have the costed roadmaps, financing pathways or systems-level actions needed to deliver them.
- ✗ Across most countries, national reproductive, maternal, newborn and child health policies give limited attention to the WASH services that directly shape women's experience of care.
- ✓ Some countries issue guidance for quality of care in maternity services that fully adopt Standard 8 of WHO *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities*[14], which prioritises and sets standards for WASH provision in maternity wards and services.

The strongest-performing countries in our analysis are those that tick multiple boxes by referencing WASH in healthcare facilities within their national strategies. This includes publishing standards and guidelines for WASH in healthcare facilities that cover WASH FIT standards relating to gender-responsive WASH; reinforcing it with detailed guidance for maternity services that align with WHO *Quality of Care for Maternal and Newborn Health* monitoring framework; and having costed roadmaps for WASH in healthcare facilities that refer to the delivery of gender-responsive elements.

A small number of countries – Cambodia, Liberia, Nigeria and Zambia – tick several of these boxes, yet even they stop short of linking maternal mortality reduction with the provision of gender-responsive WASH in healthcare facilities. None provides a dedicated budget line for improving WASH in healthcare facilities. As a result, no country achieves 'full marks'. Not one fully connects their stated ambition to reduce maternal mortality with the critical need to transform WASH in healthcare facilities and prioritise women's rights and needs in doing so.

As a result, commitments to improving WASH for women often remain aspirational. Good as it is to see international standards so consistently reflected in most WASH in healthcare facilities policies and guidelines, better gender-responsive WASH will not be delivered if higher-level national policies don't prioritise it and if there are no clear plans or budgets for improvements. Without these, these are just standards that will remain unmet.

Women leading change for safe, dignified healthcare in Tanzania

In Hanang District, WaterAid and the Tanzania Gender Networking Programme (TGNP) have supported 60 women to understand and demand their rights to WASH, to use leadership roles within village councils to advocate for change and, ultimately, influence decisions on WASH in healthcare facilities at district and national levels.

In 2024, WaterAid supported the government of Tanzania to develop national standards and guidelines on WASH in healthcare facilities. With these standards in place, the government committed to rapidly improving access to WASH in healthcare facilities and investing in safer, higher-quality services for women. This commitment was backed by national investment and a World Bank health loan, enabling a significant scale-up of WASH services and improvements in over 2,000 healthcare facilities to meet women's demands for safer care.

> **This workshop changed my confidence level. I now feel equipped to challenge WASH issues in our meetings.**
>
> Veronica Samson, Balang'dalalu Village, Gehandu Ward

At the community level, WaterAid and TGNP supported women to understand their WASH rights and build advocacy skills. Following the training, many women were inspired to stand for elected positions, with one-third successfully securing seats on their village councils.

Despite this progress, some women continue to face resistance rooted in social and cultural norms, including needing spousal permission to attend meetings or facing criticism for speaking out. To support system-wide change, TGNP also trained district management teams on how to integrate women's specific needs into WASH and health planning, and on responding to women's demands for improved services.

In Tanzania, service planning begins with village committees, whose priorities shape district plans and ultimately inform national decision-making. In their new council roles, women championed WASH in healthcare facilities and built support for local investment.

By influencing district-level planning and budgets, women helped shape national-level decisions to invest in WASH in healthcare facilities and prioritise menstrual health and hygiene, including access to sanitary pads.

Yusra, 18, with her baby, Karim, at Msanga Health Centre, Kisarawe District, Pwani Region, Tanzania, August 2024.

WaterAid/James Kiyimba

Broader case for investment in WASH in healthcare facilities

Improving WASH in healthcare facilities is not only essential for safe childbirth – it is a foundational investment for stronger health systems, resilient economies and gender equality. Ensuring every facility has a reliable supply of clean water, decent toilets, environmental cleaning, waste management and the means to maintain good hygiene is one of the most cost-effective ways to protect health, save lives and strengthen primary healthcare.[15]

Investing in WASH reduces the burden on overstretched facilities, improves staff morale and strengthens the quality and safety of essential services from immunisation to chronic disease management. It also reduces HAIs, which cost African economies more than 1.14% of GDP and 5.6% of total healthcare expenditure through longer hospital stays, higher treatment costs and the lost productivity – particularly of women – who, as outlined above, are disproportionately vulnerable to HAIs and responsible for the unpaid care of others ill with HAIs.[16]

WASH in healthcare facilities is also critical for tackling antimicrobial resistance (AMR) – one of the greatest threats to global health and prosperity. In 2019, 4.95 million deaths were associated with drug-resistant bacterial infections, including 1.27 million directly caused by AMR.[17] Almost one-third of the approximately 690,000 neonatal deaths each year from sepsis can be attributed to resistant pathogens.[18] Modelling shows that improving hand hygiene, antimicrobial stewardship and environmental hygiene could reduce overall AMR by up to 85%.[19] Between 1990 and 2019, improvements in infection prevention and control, healthcare quality and sepsis management – including measures influenced by WASH – are estimated to have averted more than three million deaths associated with AMR.[14]

Improving hand hygiene, antimicrobial stewardship and environmental hygiene could reduce overall AMR by up to 85%.

> **My appeal is for the number of cleaners to be increased, for more handwashing stations to be set up, and for proper toilets and bathrooms inside the ward, clean water, soap and mosquito nets.**
>
> Deborah Nambezo, Mbale District, Eastern Uganda – listening exercise participant

Chifuniro, 19, washes her son, Ernest, 2, Namizimbe, Malawi. June 2024.

WaterAid/Sophie Harris-Taylor

These health gains translate directly into economic returns. The global healthcare costs of AMR already reach $66 billion annually and are projected to rise to $159 billion by 2050 if current trends continue. Wider economic losses could reach $1–3.4 trillion per year by 2030.[19]

WASH is one of the few interventions that reduces these costs immediately. WaterAid's analysis shows that basic WASH in healthcare facilities can be achieved for less than $0.65 per capita per year in least-developed countries, and every $1 invested returns more than $8.60 per capita in health and economic benefits.[16]

Every $1 invested in WASH in healthcare facilities returns more than $8.60 per capita in health and economic benefits.

For health workers, most of whom are women, WASH is fundamental to safety, wellbeing and professional dignity. Midwives surveyed across 101 countries identified clean water, sanitation and functional facilities as among their top needs for delivering quality care.[6] Poor WASH contributes to occupational hazards, low morale and absenteeism, costing an estimated 2% of total health spending in some systems.[20]

Ensuring safe working environments is therefore essential not only for staff wellbeing but also for patient outcomes and health system performance.

Women leading change for safe, dignified motherhood in Zambia

Safe Motherhood Action Groups (SMAGs) work to reduce the critical delays that prevent women from accessing life-saving maternal healthcare by mobilising communities, promoting health awareness and demanding accountability. In partnership with SMAGs, WaterAid Zambia is supporting women to speak out about what they need most for safe childbirth – clean water, decent sanitation and hygiene – and to use their voices to drive change in healthcare facilities.

Through capacity building and social accountability processes, women have strengthened their role in local decision-making. Women now make up half of WASH and neighbourhood health committees, giving them real influence over how healthcare facilities are designed and managed, and ensuring that WASH is placed at the centre of safe and dignified care.

Women have successfully advocated for permanent, gender-responsive toilets and washing facilities connected to a water supply and maternity annexes that meet hygiene and privacy standards. These demands were raised through structured dialogue with local authorities, including Ward Development Committees, where WASH is now recognised as a priority for maternal health.

The results are visible in the community. At the facility level, inclusive WASH infrastructure has improved access to water, hygiene and sanitation, particularly during childbirth, and increased awareness of the importance of care that prioritises and meets women and girls' needs. At the subnational level, local authorities and health partners have adopted inclusive facility and maternity annexe designs that embed WASH priorities.

Sange Mbilishi, 34, nurse midwife at Matero level 1 hospital, Matero, Lusaka, Zambia, November 2024.

Nationally, evidence from the project is informing the development of Zambia's WASH in healthcare facilities roadmap and influencing health policy. By amplifying women's voices and strengthening accountability, WaterAid Zambia has shown that inclusive WASH is not an optional extra, but a foundation for quality, safe and respectful healthcare and for lasting systems change.

Conclusion

In conclusion, gender-responsive WASH in healthcare facilities, particularly during childbirth, has the potential to make a decisive contribution to reducing maternal mortality globally and accelerating progress towards gender equality overall. Without improvements in many parts of the world, a lack of basic gender-responsive WASH in healthcare facilities will continue to contribute to maternal and child mortality.

It will also continue to be responsible for women's negative experiences of giving birth in healthcare facilities – depriving them of the right they have to safe, respectful and inclusive care and adding the extra burden of additional care responsibilities onto women's already long list of unpaid care work.

We've known about the link between hygiene and safe births for almost 200 years. However, governments in low and middle-income countries, their partners and the international community have yet to give it the prominence and resources WASH in healthcare facilities deserves in plans to reduce maternal mortality.

WASH in healthcare facilities is a strategic investment: it protects women and families, strengthens health systems, reduces AMR, enhances economic productivity and delivers rapid, sustained returns. Governments that invest in WASH in healthcare facilities are not only safeguarding maternal and newborn health – they are building more just, fairer, more resilient and more prosperous societies.

WaterAid/Cynthia Matonhodze

Elizabeth at Sikachapa in Kazungula District, Zambia, May 2022.

Women's voices

Elizabeth Nyanga explaining the importance of WASH for women, Kazungula District, Zambia, May 2022.

'If I met our president, I would tell him about the trouble we have of lack of water at a healthcare facility. I will tell him of how much women are suffering, how they walk a distance to access water and how they sleep on the cold floor. I will ask him to immediately do something about it.'

Recommendations

National governments

- **Make WASH in healthcare facilities a political and policy priority:** Governments must urgently prioritise and deliver inclusive, climate-resilient,[xvii] gender-responsive WASH in healthcare facilities to reduce preventable maternal and newborn deaths and provide safe, respectful and inclusive care. As this report shows in the starkest terms, without adequate WASH in healthcare facilities, women's lives are at risk, particularly during childbirth. Leaders must act now to fulfil the global commitments set out in the World Health Assembly's and UN resolutions on WASH in healthcare facilities,[xviii] treating WASH as an essential component of care in all maternity and newborn units. This requires hard-wiring WASH in healthcare facilities into national maternal and newborn health strategies, policies and accountability frameworks, including the development and mainstreaming of gender-responsive WASH standards and indicators across national health systems.

- **Deliver improvements with planning and finance:** Governments must increase and ring-fence health budget allocations for WASH in healthcare facilities, particularly in the 47 least-developed countries. Despite its proven cost-effectiveness in preventing HAIs and improving maternal outcomes, WASH in healthcare facilities remains chronically underfunded. To address this, governments should develop, adopt and deliver costed national plans and roadmaps for WASH in healthcare facilities, explicitly linked to reducing maternal mortality and ensuring gender-responsive WASH in healthcare facilities. This should include a systematic review of funding gaps, identification of priority investment areas across national and subnational budgets, and the inclusion of WASH in healthcare facilities within external financing business cases.

xvii. Climate-resilient WASH refers to water, sanitation and hygiene services and behaviours that continue to function, or can be quickly restored, as the climate changes and climate-related hazards occur. Robust, sustainable WASH systems help communities cope better with the impacts of climate change.

xviii. The United Nations Secretary-General's global call to action on WASH in health care facilities in 2018 brought new awareness of the issue among Member States, UN agencies and partners. The subsequent World Health Assembly resolution, passed in 2019, further elevated the issue, with all Member States committing to work towards achieving universal access by 2030. See more: https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health-(wash)/health-care-facilities/wash-in-health-care-facilities

- **Ensure respectful, safe care for women by putting them at the centre of decision-making:** Governments must guarantee safe and dignified healthcare for women and newborns. They can do this by institutionalising health service delivery that prioritises and meets women's rights and needs. They must also champion women's leadership in decision-making, recognising women as experts in their own needs as health workers, patients and caregivers. This requires operationalising WHO/UNICEF WASH FIT and the WHO *Quality of Care for Maternal and Newborn Health* monitoring framework, treating minimum standards as a starting point rather than the ceiling, and integrating WASH indicators into health management information systems alongside transparent, women-responsive accountability mechanisms. Governments must also invest in health workers and cleaners through regular training on infection prevention and control, inclusive service delivery and behaviours, waste management and respectful maternity care, supported by reliable WASH infrastructure and practices, supplies and maintenance.

> **When government listens to what women demand, policy changes. When policy changes, lives are saved.**
>
> Scovia Angom, women's advocate, White Ribbon Alliance, Uganda – listening exercise participant

Midwife Shenette Khaula Shamu comforts Miatta Kromah during her labour at Diah Clinic, Grand Cape Mount, Liberia. January 2026.

WaterAid/Cianeh Kpukuyou

Development partners

Development partners must support and reinforce national leadership by treating WASH as foundational to maternal and newborn health, dignity and gender equality.

- **Make WASH in healthcare facilities central to maternal and newborn health programmes**: Embed WASH in all maternal and newborn health programmes, results frameworks and accountability systems. Review existing health investments to assess WASH coverage and prioritise the integration of WASH FIT and WASH indicators into maternal and newborn health delivery and monitoring.

A clean mother is a safe mother. When we have clean water, we protect the mother and ourselves… I call for continuous water systems; reliable municipal supply or sustainable alternatives like boreholes and rainwater harvesting.

Walter Omoko, healthcare provider, Department of Maternal and Child Health, Lira District, Northern Uganda – listening exercise participant

- **Increase dedicated financing and coordination for WASH in healthcare facilities**: Increase and ring-fence financing for WASH infrastructure, systems strengthening, behaviour change and cross-sectoral coordination. Create incentives for collaboration between health and WASH actors through national investment cases and compacts and align financing with national WASH in healthcare facilities roadmaps.
- **Put women's voices and equity at the centre of accountability**: Invest in national and subnational accountability approaches so that women's groups, health committees and civil society organisations can track WASH performance and demand accountability. Prioritise WASH in healthcare facilities as a means of addressing entrenched inequalities faced by adolescents, women with disabilities, those in rural areas and communities who don't have the WASH in healthcare facilities that they need. Champion implementation of the Lusaka Agenda[xix] by aligning donor efforts to country-led priorities, strengthening coordination across global health initiatives, and establishing mutual accountability mechanisms.

xix. The Lusaka Agenda is a country-led commitment by governments, global health initiatives and donors to better coordinate, align and harmonise health financing and support behind national health strategies, reducing fragmentation and strengthening country ownership and accountability.

WaterAid/Tariq Hawari

Dr Paulo Simas, 35, treats a child at the health post in Vatuboro, Liquica. July 2022.

> **I would like to see more water sources put in place. I would like more toilets to be constructed in my health facility. I would like more cleaning resources to be bought and more cleaners recruited.**
>
> Winfred Ikiring, Mbale, Uganda – listening exercise participant

> **I expect to find free water and soap for washing hands. I expect to find free toilets near labour room.**
>
> Alice Apio, Mbale, Uganda – listening exercise participant

> **What matters to me most is the toilet to clean and open always.**
>
> Justine Biryeri, Mbale, Uganda – listening exercise participant

> **Every health facility must have accessible toilets, bathrooms and water points that women with disabilities can use without difficulty.**
>
> Scovia Angom, women's advocate, White Ribbon Alliance, Uganda – listening exercise participant

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