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HEALTH CENTER RENOVATION
PROJECT

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Health Center Assessment and
Renovation Findings in Ethiopia
(October 2006 to April 2008)

Submitted to:
James Browder
Cognizant Technical officer
USAID/Ethiopia
Addis Ababa, Ethiopia
jbrowder@usaid.gov

Submitted by:
Project Staff
Dabi Building, 5th Floor
Addis Ababa, Ethiopia
enmcintosh@comcast.net

Crown Agents USA, Inc.
Addis Ababa, Ethiopia

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BACKGROUND

The Federal Government of Ethiopia (FGOE) has set very ambitious targets for scaling up HIV/AIDS services.¹ The scale and complexity of implementing the full range of services, especially at the health center (HC) level, has exerted huge pressure on an already fragile healthcare system. As such, establishing and maintaining minimum standards for safe and quality delivery primary healthcare services as well as a full range of HIV/AIDS and associated co-infection services is a top priority.

Previously, a limited assessment of HCs compiled by Family Health International (FHI) in 2006 identified infrastructure deficiencies as a major obstacle impeding sustained progress in achieving ART targets (1). Subsequently, these findings were confirmed by Crown Agents' Health Center Renovation (HCR) project based on preliminary assessments of 12 HCs located in Amhara, Oromia and SNNP regions (2). In particular it was found that nearly all HCs have physical and/or essential functions problems (e.g., lack of water, blocked waste water disposal lines, overflowing dry pit latrines) as well as space limitations that compromise patient care and the safety of healthy clients and healthcare providers.² Moreover, recent efforts to upgrade some of these HCs by a number of USG and non-USG organizations often were not well planned (or designed), further complicating clinic (patient and staff) flow patterns and space use within the HC compound.

METHODOLOGY

Purpose of the Report

The **purpose** of this report is to update and expand the preliminary findings from the March 2007 report as well as to describe the challenges encountered in the renovation of the first 23 HCs.

The two HCR project results that specifically relate to the findings in this report are:

1. To provide technical assistance on HC renovations to the Federal Ministry of Health's Regional Health Bureaus (FMOH/RHBs) including technical design, engineering, procurement and logistics support
2. To provide direct renovation support of 50 selected HCs to support chronic disease management, including HIV/AIDS

¹ PEPFAR COP07. Services include: VCT, CT and PMTCT; adult, young child and infant ART and OIs; mother support group (MSG), ART adherence and prescription-based distribution; laboratory; ARV pharmacy and dispensary; and ARV and OI drug stores.

² Healthy clients are those adults, children and infants coming to the HC for preventive services such as family planning, immunizations and well baby care.

Report Structure

Unlike the preliminary report that had four sections – methodology, observations, implications and recommendations; the present report is organized around a set of six specific objectives.

Selection of Health Centers to be Assessed

Data in the preliminary report were based on assessments conducted at 12 HCs located in three regions of the Ethiopia (Amhara, Oromia and SNNP). In the current report, data are based on HC assessments conducted at 81 HCs located in these three regions as well as Tigray region and the capital city, Addis Ababa.

In each region, HCs were selected from the January 11, 2007 PEPFAR (COP06) priority list that includes HCs scheduled to initiate (or have initiated) ART and chronic disease services (3). As a result of the adjustment in the HIV prevalence (from 3.5 to 2.1%) in April 2007, the PEPFAR strategy shifted from being countrywide to a targeted (urban and peri-urban) approach focusing on those cities and regions where the ART case load is highest. Thus, beginning in July 2007 it was necessary to revise the list of HCs to be assessed and renovated by the HCR project in order to reflect this change. Because a number of the HCs remaining on the PEPFAR priority list for COP06 had few patients on ART and were located in rural areas, eleven were replaced with HCs from the USAID FY 2006 priority list. These 11 HCs are located in-and-around Addis Ababa where the ART case load is high (up to 800 in some HCs).

The HC assessments were conducted during March 2007 to April 2008 by members of the HCR project team with assistance RHB engineers (where available) and supplemented by technical consultants from a private A&E firm with subdivisions throughout Ethiopia.

Twenty-three HCs were renovated within 103 days on average by/before October 2007. An additional 22 HCs currently are being renovated.

Objectives

In order to appreciate the circumstances under which the HC assessments were conducted and findings generated as well as the effect of funding constraints that limited the extent of renovation works, the **objectives** of this report are to:

1. Describe the HC assessment process
2. Present the demographic characteristics of the HCs assessed (e.g., location, population served, size, age, type of building construction and available utilities)
3. Describe the findings based on HCs assessed in the four regions and Addis Ababa targeted for intensive HIV/AIDS service intervention;
4. Present data on the estimates required to upgrade HCs to a level that provides a safe environment for patients and staff;

5. Describe the type and extent of renovation works provided based on available funds;
6. Discuss the urgent need for a small preventive maintenance management budget and a mechanism for provision of routine maintenance by HC staff

In the following sections, each objective is presented in considerable detail.

HEALTH CENTER ASSESSMENT PROCESS

The **purpose** of the conducting a HC assessment, which consists of both engineering and health services components, is to gain an overview of the HC from both a physical and functional perspective by:

- assessing the condition of the HC buildings;
- estimating if the HC is over- or under-utilized;
- determining if the utilities and sanitation system are functioning and adequate for the needs of the HC;
- ensuring the availability of adequate space and facilities for primary healthcare services as well as a full range of HIV/AIDS and co-infection services;
- assessing if patient care is compromised by space limitations, inappropriate use of existing space and/or a combination of the two; and
- assessing if clinical (patient and staff) flow patterns, hygiene practices and environmental health control measures are sufficient to ensure provision of safe and quality health care.

Engineering Assessment Approach

The first step in conducting the engineering assessment is to tour the facility with HC in-charge.³ During this initial walkthrough a preliminary sketch (“as built” or “is built” drawing) of the HC layout is made and the function/use of each room noted. In addition, the general structure of the buildings, including the roof and guttering, is assessed to determine their condition as well as the functional condition of the utilities (water supply and electrical system) and sanitation system (waste water disposal, toilets, pit latrines and septic tank(s)).⁴

Subsequently, the assessment team and RHB engineer, if available, inspects each building and room/space in the HC in greater detail, measures it, and takes detailed notes in order to identify items that are damaged, not functioning or missing (e.g., plugged sink drains or damaged/missing handwash basins in designated examination

³ On the initial tour, the assessment team consisted of the HCR project’s engineering, architectural and medical staff and, where available, an RHB engineer.

⁴ At each HC, two water samples are taken from an outlet closest to entry point to the facility or the water storage tank (reservoir); one sample is used to test for bacterial contamination (48 hours) and the second to test for lead levels (10 minutes).

or treatment rooms).⁵ In addition, digital photos (40-60) are taken using a camera with a wide-angle lens to document the observations. Items identified for repair or replacement also are noted as well as any structure(s) deemed unsuitable for renovation (e.g., a partially burned out building or an unused mud hut). Finally, where expansion of existing rooms or service areas is required, comparison with the FMOH's HC construction standards is used as the guide.

Health Services Assessment Approach

To gain a better understanding of how the HC functions, an assessment of where and how health services are provided is done. As the initial step in this process, the HC in-charge is asked to:

- describe the services currently provided,
- discuss any concerns or limitations, and
- make suggestions for improving any services.

Then, when available (and appropriate), provision of various types of health services is observed, staff and patient interactions noted, and patient and staff flow patterns observed. In addition, basic hygiene and environmental health control practices are assessed (e.g., is there adequate cross ventilation in examination and treatment rooms). The guidelines for the assessing the quality of health services provided are based on the promotive, preventive and curative healthcare service standards defined in the FMOH/HSD draft manual, **Standards of Care for Health Centers (4)** and other FMOH documents (**5** and **6**).

DEMOGRAPHIC CHARACTERISTICS OF HEALTH CENTERS ASSESSED

Based on guidance from USAID/Ethiopia, the HCs selected for assessment were taken primarily from the PEPFAR COP06 Priority list published in January 2007 (**3**). Although the PEPFAR list contained 100 sites, only 89 are located in the four most populous regions (Amhara, Oromia, SNNP and Tigray) and Addis Ababa where the HCR project is mandated to work. Thus, additional HCs were drawn from the USAID/Ethiopia's FY2006 list of 267 HCs that had been developed in conjunction with the RHBs in each of the four regions and Addis Ababa. In all cases, final selection of the HCs to be assessed was made with the full knowledge and support of RHB Head or Deputy Head and the RHB/Program and Planning Department (PPD).

To date, 81 HCs have been assessed. In **Appendix 2**, each of the 100 HCs listed to be assessed during the two-year HCR project (October 2006 to September 2008) is identified by region and name and, where known, the ART referral hospital to which the HC is linked. Eighty-two HCs on this list were taken from the COP06 PEPFAR priority list and the remaining 18 from the USAID priority list. (See above, **page 3**, for details.)

⁵ For each HC assessed, a **Health Center Assessment and Renovation Works Summary Report Form** is completed on site and filed in the HCR Project Office within one week of the assessment being conducted (see **APPENDIX 1**)

The demographic characteristics of the 81 HCs assessed to date are presented in **Table 1**. As documented, these HCs are not typical of the 670 FMOH HCs in Ethiopia. In general, they:

- are almost all located on major roads (truck and bus routes) in fairly large towns and serve large populations (> than 200,000 population);
- are large (HC compound has more than 10 buildings);
- most have undergone intense HIV/AIDS attention (training and new services initiated) during the past 1-2 years; and
- all potentially have electricity (on the grid) and access to safe water from deep wells.

Table 1. Demographic Characteristics of HCs Assessed to Date (N =81)

Variable	Rate		Variable	Rate
LOCATION			BUILDINGS	
Urban/Peri-urban	88%		<10 Units	34%
Rural	12%		>10 Units	66%
POPULATION SERVED			CONSTRUCTION	
<100,000	21%		Concrete hollow block	32%
100-200,000	47%		Mud-walled	0%
>200,000	32%		Mixed	78%
AGE OF HC			UTILITIES	
< 10 years	24%		Water (piped city well)	98%
10-30 years	53%		Electricity (on the grid)	100%
> 30 years	23%		DEDICATED STORES	0%

As such, the extent of assessments and the range of damages and deficiencies identified are considerably greater than would be expected if the assessments were conducted on the more typical, small, rural or remote HCs. This difference is particularly true in Addis Ababa where some of the HCs are larger than rural district hospitals and provide more clinical (curative services), especially those that are invasive, than HCs located outside Addis.

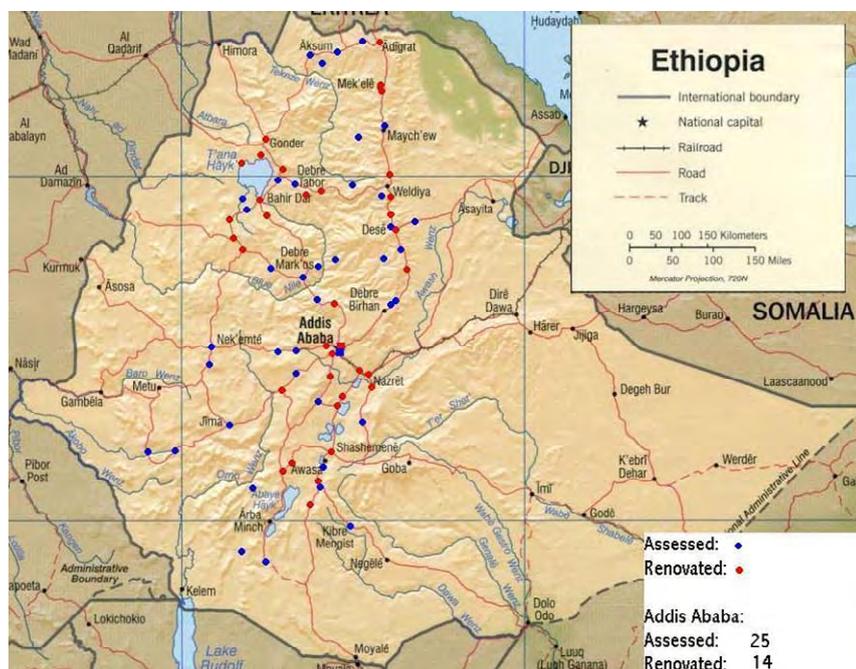
The location of the 100 HCs to be assessed and 50 HCs to be renovated during the two-year LOP is illustrated in **Figure 1 (next page)**.

GENERAL AND SPECIFIC FINDINGS AT HEALTH CENTERS RENOVATED

The 50 HCs assessed and subsequently renovated (23 in the first year and 27 in the second) are listed in **Appendix 3** by region, name and, where known, the ART referral hospital. The type and extent of problems identified in the first 23 HCs assessed and subsequently renovated during FY 2007 is extensive (see **Table 2, page 8**). Damage or deficiencies in all four components of basic systems (access to water, waste water disposal, sanitation and electrical) ranged from a low of 74% requiring

repair of the electrical system to 96% needing repair of the waste water disposal system).

Figure 1. Location of Health Centers to be Assessed and Renovated from 2006 to 2008



In addition, despite previous efforts of other donors to prepare HCs to implement HIV/AIDS and associated chronic disease services, as shown in this table, 87% (19/23) required additional improvements, primarily involving adding water (plumbing and sinks for handwashing) and windows for cross ventilation to examination and treatment rooms. The situation with lack of running water to all or a majority of areas of the HC where it is needed (e.g., labor and delivery areas or examination and treatment rooms) is distressing. At 21/23 (91%) of HCs, the reason in all cases was not lack of safe, piped water from the city wells, but lack of access within the HC. A few of the observed/reported reasons were:

- water storage tank was broken or too small to supply the HC;
- electrical motor to pump water to elevated storage tank was inoperative;
- water pipes to delivery rooms, examination rooms, laboratory or toilets were plugged or damaged; and finally
- the water had been turned off because the HC could not pay the water bill!

This finding is particularly discouraging because of the 81 HCs assessed to date, only two potentially did not have access to safe, piped city well water.⁶ At both of these HCs, water was being drawn from what was thought to be the source of a natural

⁶ At each HC, water from one or two taps, located closest to entry point of the HC, was tested for bacteria and lead levels. The coliform count of the water tested on site was less than 100 colonies per ml (clean water level/EPA) at 63 of 65 HCs, and the lead concentration was negligible (below EPA action level) at all HCs.

spring, but in fact was a highly contaminated stream that went underground for approximately 500 meters before surfacing adjacent to the HC compound.

Table 2. Damages and Deficiencies Identified in HCs Renovated in 2007 (N = 23)

Region and HC Name	Water Supply System	Waste Water System	Septic System ¹	Electric System ²	HC ³	Services ⁴					
						HIV & CD	CH	EC	FP	MH	WA
AMHARA											
Bure	X	X		X		X	X	X		X	X
Dangla	X	X	X	X	X	X	X	X	X	X	X
Injebura	X	X	X	X		X	X	X	X		
Adet	X	X	X		X	X	X	X		X	X
Addis Zemen	X	X	X	X	X	X	X	X	X	X	X
Bahidar	X	X	X		X	X	X	X	X	X	X
OROMIA											
Shashemene	X	X	X	X	X	X	X	X	X	X	X
Zeway	X	X	X	X	X	X	X	X	X	X	X
Adama	X	X	X	X	X	X	X	X	X	X	X
Fitche	X	X	X	X	X	X				X	
Holeta	X	X	X	X	X	X	X	X	x	X	X
SNNP											
Sodo	X	X	X	X	X	X	X	X	X	X	
Yirgalem	X	X	X	X	X	X	X	X	X	X	X
Buee	X	X	X	X	X	X	X	X		X	X
Yirgacheffe	X	X	X	X	X	X	X	X	X	X	X
Wolkite	X	X	X	X	X	X	X	X		X	X
Boditi	X	X	X	X	X	X	X	X	X	X	
TIGRAY											
Mekele	X	X	X	X	X	X	X	X	X	X	
Semen	X	X	X	X	X	X	X	X	X	X	X
Adigrat	X	X	X	X	X	X	X	X	X	X	X
ADDIS ABBA											
Kazanchis	X	X	X	X	X	X	X	X	X	x	x
Lideta	X	X	X	X	X		X	X		X	
Bole Woreda 17	X	X	X	X	X					X	X
RESULTS	21(91%)	22(96%)	20(87%)	17(74%)	21(91%)	19(87%)	15	15	11	20	10

¹ Septic System: includes septic tank(s), sewage lines, dry pit latrine, toilets and placental pit

² Electric System: includes condition of wiring, conductors, safety

³ HC: repair or expansion of an existing unit or block

⁴ HIV & CD (VCT, PMTCT, ART, and TB Rx); CH (EPI and under 5); EC (emergency care); FP (family planning); MH (labor, delivery, and immediate postpartum); WA (waiting area)

COST ESTIMATE TO RENOVATE HEALTH CENTERS

Based on the HC assessment findings (see above, **page 6**), successful transfer of HIV/AIDS and chronic disease services from hospitals to HCs requires bringing these HCs up to a minimum performance standard if safe and quality delivery of these services is to be sustainable. To accomplish this requires:

- repair of major physical problems;
- improvements in essential functions (water supply, waste water disposal, sanitation and electrical systems);
- more effective use of existing space to facilitate patient care and safety;
- provision of basic hygiene and environmental controls measures to prevent transmission of TB and other serious co-infections to patients and healthcare providers;
- upgrading maternity and newborn units to support PMTCT services as well as the care and treatment of HIV/AIDS infected mothers, infants and young children;
- replacement of destroyed or non-repairable furniture and fittings; and
- construction of dedicated drug, equipment and supplies stores (100 to 200 m² per HC) in all targeted HCs.

The latter is necessary because **no** HC has dedicated space for general and specific drugs, equipment and supplies storage. (Currently, as much as 20-25% of available space in HC is used for these purposes as well as storage of out-dated drugs and non-repairable equipment and furnishings.)

As summarized in **Table 3 (next page)**, to upgrade each HC to a performance level consistent with the most recent FMOH standards and PEPFAR guidelines, it is estimated average cost per HC is over USD 39,000.⁷ This estimate, however, does not include the cost of building dedicated stores space (about \$30,000 to \$60,000 depending on the size).⁸

Based on data from the first 23 HCs renovated (**Table 2, see above**), the extent of damages to basic systems (e.g., lack, or limited supply, of water; blocked sinks and toilets, etc.) and cost to repair them exceeded available renovation works funds by over 90%. With just over \$ 20,000 per HC for renovation (amount available for renovation in FY 2007), only the most serious problems (e.g., provide clean water and/or waste water disposal to part of the HC, such as the maternity unit and/or HIV/AIDS service areas) can be addressed – and then only partially. As a consequence, in FY 2007 none of the 23 HCs were renovated to a performance level consistent with FMOH standards or PEPFAR guidelines.

⁷ **Health Sector Strategic Plan (HSDP-III: 2005 - 2009/10)**. Planning and Programming Department, 2005. The average cost (\$39,351) was determined by costing those problems and deficiencies identified in each HC assessment that directly relate to the requirements for the safe delivery of the promotive, preventive and curative services stipulated in the (**HSDP-III: 2005 -2009/10; Standards of Care for Health Centers** (draft), Health Services Department, July 2007) and the requirements to implement ART and chronic disease services in the **Recommendations from the First Emergency Plan for AIDS Relief USG and Partners ART Consultation in Ethiopia** (August 1-10, 2005), which are expanded on in PEPFAR COP06 and COP07 (5 -9).

⁸ At the request of FMOH, several modular designs for HC stores have been prepared, costed and in 2008, a model stores complex built at the Modjo HC (Oromia Region) in collaboration with RPM Plus and the FMOH Implementation Support Team..

Table 3. Extent of Health Center Renovation Based on Available Funds

System or Service to be Upgraded¹	Renovation Cost (\$20,000 per HC)	Renovation Cost (\$39,000 per HC)
1. Physical Problems	1 or 2	All major problems corrected
2. Essential Systems (access to water, waste water disposal, electrical and sanitation systems)²	1-2	All operational
3. Additional Space (rooms)	1	2 or 3
4. HIV (CT/VCT)³	Limited	Yes
5. ART and TB (Adult) Area (improved ventilation, water and wash basins)	Partial	Yes
6. MCH (ANC, PMTCT, MSG, PBF, FP, EPI and Under 5)	Limited	As above #3
7. ART and TB (Infant and Child) Area	No	Yes
8. Clinical Services		
- Labor, Delivery & Postpartum	Only 1 ⁴	Yes
- Emergency Care/Injections	Only 1 ⁴	Yes
9. Waiting Area	No	Limited improvements
10. Single Chamber Fire Box (incinerator)⁵	No	Repair only
11. Stores (general and specialty)⁶	No	No
12. Support Areas (laundry, administration, records, registration, etc.)	No	Limited improvements

¹ Excluded are laboratories, pharmacies, pharmacy stores that are being upgraded by RPM+; VCT and PMTCT (space and furnishings provided by other USG-implementing partners) and general medical services (OPD).

² Sanitation includes pit latrines, toilets, septic tank systems, and placenta pits.

³ Furnishing provided by FHI (HCs).

⁴ Only 1 of 2 clinical areas can be upgraded.

⁵ PEPFAR funds can not be used to build a new incinerator (**Technical Considerations for FY 2008 COP**, page 38) (10). The Making Medical Injections Safer is responsible for repairing 23 incinerators (fireboxes) in COP07.

⁶ HCs have no dedicated stores (i.e., space for storing drugs, equipment and supplies).

In FY 2008, additional resources (about \$28,000 per HC) are available to renovate 27 HCs (22 currently are being renovated with renovation to start on the remaining five in May 2008). This additional funding will enable repairs to be made on all essential functions and utilities. In addition, it should be possible to repair the most serious physical problems (e.g., replace sections of a damaged roof or gutters) as well as to:

- renovate existing space for 1 or 2 new HIV/AIDS services being added, or planned to be added in the near future, such as mothers support groups and pediatric ART; and
- upgrade both the obstetrical units (labor, delivery and postpartum) and injection/trauma treatment area.

In addition, more extensive changes in space use should be possible (i.e., where specific services, such as DOTS for TB and administrative functions, are provided) than was possible in 2007.⁹

In **summary**, while the average renovation cost per HC is considerable as determined in this review, it is less than one tenth the cost of building a new HC to the 1998 FMOH standard. As such, even at this cost, HC renovation represents excellent value in the short- and long-term, especially if it is linked with a modest maintenance management budget and regularly implemented self-maintenance system.

NEED FOR HEALTH CENTER MAINTENANCE MANAGEMENT

In Ethiopia, there appears to be no easily accessible budget for repair or maintenance of the HC, its equipment or furnishings. As a consequence, with few exceptions routine maintenance is not done (e.g., even basic inspection of blocked handwash basins or sinks that often can be unblocked easily). Other findings observed during HC assessment site visits include:

- There are no records or drawings available on-site detailing the location of buried water and waste water pipe lines.
- Broken and damaged equipment and furnishings, which are repairable, often are stored in rooms intended for provision of health services, thereby taking up valuable space rather than being repaired and put back in use.
- Existing drug storage space is limited and often the rooms are so crowded with boxes and cartons of drugs lying on the floor and tables that stock rotation (first in/first out) is difficult. In addition, because shelving is rarely available at most HCs, this makes it even more difficult to have a stock rotation system.
- In some HCs, one or more rooms intended for provision of services are allocated for storage of expired drugs awaiting disposal.

Because the importance of preventive maintenance can not be overestimated, a small budget should be available at each HC for this purpose. It should include sufficient funds for:

- repair of minor damage to the HC buildings (routine maintenance and making simple repairs can extend the life of buildings and their fittings);

⁹ The details of how to improve space use are based on the “patient first” concept (e.g., zoning by type of service and changing clinic flow patterns). Employing these techniques, it is possible to improve patient access to services and to provide a safer environment for patients, healthy clients and healthcare workers.

- repair of broken and damaged equipment or furnishing or replacement if not repairable;
- upkeep of basic utilities, including handwash basins/sinks and taps/faucets, S-traps for showers, waste water manholes and water supply valves;
- removal of expired drugs to reduce the requirement for storage at HCs; and
- disposal of unusable (broken and not repairable) furniture, equipment and other items according to FMOH policy (these items should not be stored in valuable HC service delivery rooms).

In lieu of funds for preventive maintenance of the HC, in the short term a simple, self-administered maintenance checklist has been developed for use by HC staff (**Appendix 4**). A copy is included as an attachment to the MOU signed by both parties (the implementing agency representative and HC in-charge) prior to starting renovation works. By signing the MOU, the HC in-charge accepts her/his responsibility for providing the agreed on routine maintenance for the entire HC, not just for the elements of work included within the MOU.

The effort required to implement the routine maintenance activities detailed in the checklist is very little. It does, however, require a change in attitude by HC staff regarding upkeep of equipment and maintenance of the HC in general. In addition, depending on the management capabilities of the HC in-charge, assistance may be required to help her/him to a) convert the maintenance schedule into a routine inspection process as detailed in the checklist, and b) allocate the work to appropriate staff members.

In **summary**, the importance of preventive and routine maintenance can not be overestimated. Without benefit of a maintenance management system, improvements to the water supply, waste water disposal, sanitation and electrical systems will be lost in short time (sinks and drains are again plugged and latrines overflowing). Without a maintenance budget that staff can easily access, capital investment in a HC will be continually degraded, requiring continued support from the government, community or external agencies. The need for preventive and routine maintenance as well as a maintenance budget applies to new HC construction as well.

REFERENCES REVIEWED

1. **PEPFAR: Ethiopia Country Operational Plan (COP06)**. April 2006
2. **Preliminary Health Center Assessment Findings from Three Regions of Ethiopia**. Health Center Renovation Project, March 12, 2007
3. **Standards of Care for Health Centers**. FMOH/Health Services Department July 2007
4. **ART Sites at Health Centers: Proposed Support from PEPFAR Ethiopia under COP06**. 11 January 2007
5. **Health Sector Plan for 1998**. FMOH/PPD
6. **Health Sector Plan (HSDP-III): 2005-2009/10**. FMOH/PPD
7. **Recommendations from the First Emergency Plan for AIDS Relief USG and Partners ART Consultation in Ethiopia**. August 1-10, 2005
8. **Review of Standards of Care for Health Centers**. USAID/HCR Project September 2007

9. **PEPFAR: Ethiopia Country Operational Plan (COP07).** April 2007
10. **PEPFAR: Technical Considerations for FY 2008.** July 2007

APPENDIX

1. Health Center Assessment and Renovation Works Summary Report Form
2. List of 100 Health Centers Assessed to Be Assessed (2007/08)
3. List of 50 Health Centers to Be Renovated (2007/08)
4. Health Center Maintenance Checklist

Appendix 1

HEALTH CENTER ASSESSMENT AND RENOVATION WORKS SUMMARY REPORT FORM

NAME(S):

NAME OF HEALTH CENTER:

REGION:

CONTACT PERSON(S):

Phone:

Email:

DATES OF TRIP:

DATE SUBMITTED:

PURPOSE

The **purpose** of the site visit was to:

- _____ Conduct an engineering assessment
- _____ Conduct a HC renovation supervision visit
- _____ Conduct a HC renovation completed and approval visit
- _____ Other (specify):

PROGRESS IN ACHIEVING PROJECT RESULTS

Result 3. Contribute to the number of health centers renovated (20 in PY1 and 30 in PY2)

- _____ 3.1. Engineering and Health Services assessment conducted (Date:
 - _____ 3.1.a. Renovation required
 - _____ 3.1.b. No Renovation required
 - _____ 3.1.c. Renovation deferred (specify):
- _____ 3.2. HC construction on-going
- _____ 3.3. HC renovation completed and approved (Date:

At initial visit: Questions to be asked/answered

1. What is the estimated size of the population served by the HC? _____
The catchment area? _____(longest travel distance in kms)
2. Is the health center providing HIV/AIDS counseling and testing (BCT or PICT)?
 - _____ NO
 - _____ YES (name of agency providing training or equipment or supplies):
 - _____ FHI _____ IntraHealth _____ Pathfinder _____ Care and Support
 - _____ Other (name):

3. Is the health center providing antiretroviral treatment (ART)? NO
 YES (name of agency providing training or equipment or supplies):
 FHI IntraHealth Pathfinder Other (name):
4. Is the HC providing prevention of maternal to child transmission (PMTCT) counseling and testing? NO
 YES (name of agency providing training or equipment or supplies):
 FHI IntraHealth Pathfinder Other (name):
5. Other services provided at HC:
 Emergency care and injections
 Family planning
 Immunization and under five children
 Labor, delivery and postpartum (If checked, estimated number of deliveries/month)
 OPD (general medical)
 Pediatric ART services
6. Is the HC providing mother-to-mother support group (MSG) services?
 No Yes (specify if space is sufficient) _____
7. Will additional room/space be needed if the health center starts pediatric ART services? No Yes
8. Does HC compound have space for general stores (new building or extension)?
 No
 YES 100 m² 200 m² (please identify potential site location[s] in sketches)

Results of water tests

1. Lead:

A. Time start:	Time end:	Result:
B. Time start:	Time end:	Result:

2. Bacteria

A. Date and time start:	Result:
Date and time end (48hours):	
B. Date and time start:	Result:
Date and time end (48hours):	

General Comments

Constraints or Limitations

Appendix 2

List of 100 Health Centers to Be Assessed (2007/08)

Hospital		Health Center	PEPFAR Priority		USAID Priority	
			Assessed (FY 2007)	Assessed (FY 2008)	Assessed (FY 2007)	Assessed (FY 2008)
AMHARA						
Woldiya	1	Kobo HC	x			
	2	Mersa HC	x			
Debreberhan	3	Shoarobit HC	x			
	4	Ataye HC	x			
Felegehiwot	5	Durbete HC	x			
	6	Dangla HC	x			
	7	Adet HC	x			
	8	Bahir Dar HC	x			
	9	Merhawi HC		x		
	10	D/Sina HC		x		x
	11	Wogel Tena HC		x		x
	12	Sekota HC		x		x
	13	Lalibela HC		x		x
DebreMarkos	14	Debre Markos HC			x	
	15	Dejen HC			x	
Finote Selam	16	Burie HC	x			
	17	Injabura HC	x			
Dessie	18	Dessie HC	x			
	19	Bati HC	x			
	20	Kemissie HC	x			
	21	Kombolcha HC	x			
	22	Haik HC	x			
Debretabor	23	Addis Zemen HC	x			
	24	Debretabor HC			x	
	25	Nefas Mewcha HC			x	
	26	Este HC	x		x	
	27	Wereta HC	x			
Akesta	28	Wereilu HC	x			
	29	Mechaneselam HC	x			
Gondar University	30	Gondar HC	x			
	31	Koladiba HC	x			
	32	Delgie HC	x			
OROMIA						
Ambo	33	Ginche HC		x		
	34	Holeta HC	x			
	35	Wolinchit HC				x
Fichie	36	Fichie HC	x			
	37	Kuyu HC		x		
	38	Dera HC		x		
Chiro						
Goba						
Asela	39	Asela HC	x			
Adama	40	Adama HC	x			
	41	Modjo HC	x			
	42	Meki HC	x			
	43	De'era HC	x			
	44	Adola HC				x
Nekempt	45	Nekemte HC		x		
	46	Jimma Arjo HC		x		
Jimma	47	Jimma HC		x		
Blue Hora						
Saint Luke	48	Woliso HC	x			
Shashemene	49	Shashemene HC	x			
	50	Arsi Negele HC	x			
	51	Zeway HC	x			
Alert	52	Sebeta HC	x			

Appendix 2 (continued)

Hospital		Health Center	PEPFAR Priority		USAID Priority	
			Assessed (FY 2007)	Assessed (FY 2008)	Assessed (FY 2007)	Assessed (FY 2008)
SNNP						
Yirgalem	53	Yirgalem HC			x	
Sodo	54	Sodo HC	x			
	55	Boditti HC				
Attat	56	Wolkete HC	x			
Mizan	57	Teppi HC		x		
Bonga	58	Sheshinda HC		x		
Butajira	59	Worabe HC		x		
	60	Buee HC	x			
	61	Bushulo HC			x	
Gidol	62	Karate HC		x		
	63	Keyafer HC		x		
Dilla	64	Yirgcheffe HC		x		
Sawla	65	Sawala HC				x
	66	Aleta Wondo HC				x
TIGRAY						
Adigrat	67	Adigrat HC	x			
Axum	68	Entico HC		x		
	69	Axum HC		x		
	70	Adet HC		x		
Michew	71	Mehoni HC		x		
Shire	72	Shire HC		x		
Mekele	73	Mekele HC	x			
	74	Semen HC	x			
ADDIS ABABA						
Saint Peter	75	Addis Ketema HC		x		
	76	Woreda 7 HC	x			
Zewditu	77	Kirkos HC		x		
	78	Kazanchis HC	x			
	79	Meshualekia HC	x			
	80	Akaki HC	x			
	81	Kaliti (Woreda 4) HC	x			
Black Lion	82	Lideta HC	x			
	83	Teklehaimanot HC		x		
	84	Bole Wereda 17 HC	x			
	85	Woreda 4 HC		x		
	86	Woreda 25 HC		x		
Alert	87	Nefasilk 1 (No.19 HC)		x		
	88	Kolfe HC		x		
	89	Nefasilk 2 (No.23) HC)		x		
	90	Woreda 24 HC		x		
Yakatit	91	Arada HC	x			
	92	Gulllele HC	x			
Saint Paulos	93	Selam (Woreda 8) HC		x		
	94	Shromeda HC	x			
Minilik II	95	Entoto No. 1 HC		x		
	96	Kotebe HC	x			
	97	Yeka HC		x		
	98	Woreda 13 HC				x
	99	Kebena HC				x
	100	Woreda 5 HC				x

Appendix 3

List of 50 Health Centers to Be Renovated (2007/08)

Hospital		Health Center
AMHARA		
Woldiya	1	Kobo HC
	2	Mersa HC
Debreberhan	4	Ataye HC
Felegehiwot	5	Dangla HC (No.1)
	6	Dangla HC (No. 2)
	7	Adet HC
	8	Bahir Dar HC
Finote Selam	9	Burie HC
	10	Injabura HC
Dessie	11	Kombolcha HC
	12	Haik HC
Debretabor	13	Addis Zemen HC
	14	Nefas Mewcha HC
	15	Este HC
Gondar University	16	Gondar HC
	17	Koladiba HC
	18	Delgie HC
OROMIA		
Ambo	19	Holeta HC
Fichie	20	Fichie HC
Adama	21	Adama HC
	22	Modjo HC
	23	Meki HC
	24	De'era HC
Shashemene	25	Shashemene HC
	26	Zeway HC
Alert	27	Sebeta HC
SNNP		
Yirgalem	28	Yirgalem HC
Sodo	29	Sodo
	30	Boditi
Attat	31	Wolkete HC
	32	Buee HC
Dilla	33	Yirgacheffe HC
TIGRAY		
Adigrat	34	Adigrat HC
Mekele	35	Mekele HC
	36	Semen HC
ADDIS ABABA		
Saint Peter	37	Addis Ketema HC
Zewditu	38	Kazanchis HC
	39	Meshualekia HC
	40	Akaki HC
Black Lion	41	Lideta HC
	42	Bole Wereda 17 HC
Alert	43	Nefasilk 1 (No.19 HC)
	44	Kolfe HC
	45	Nefasilk 2 (No.23) HC)
	46	Woreda 24 HC
Yakatit	47	Gullillele HC
Saint Paulos	48	Selam (Woreda 8) HC
	49	Shromeda HC
Minilik II	50	Kotebe HC

Appendix 4

Health Center Maintenance Checklist

DAILY (or after use)

- _____ Sweep walks and pick up litter on ground daily to prevent dirt being tracked into buildings
- _____ Dust and put benches and chairs in place in waiting areas
- _____ Sweep corridors and common areas
- _____ Clean delivery, treatment and examination tables daily and after use
- _____ Clean and change beds in labor room and female and male wards after use with soap and disinfectant
- _____ Wash floor in labor and delivery, emergency care and sluice rooms daily with soap and disinfectant
- _____ Clean toilets, showers and latrines
- _____ Check that sharps disposal containers (needles and syringes) are not full; replace when $\frac{3}{4}$ full

WEEKLY (or as needed)

- _____ Check water faucets for leaks and report if broken or damaged
- _____ Check sinks and drains and open if clogged (remove trap and clean)
- _____ Wash walls in labor and delivery room, emergency care and sluice rooms
- _____ Wash walls in toilets, showers and latrines

MONTHLY

- _____ Check water reservoir for leaks (tanks, pipes and connections)
- _____ If present, check water in holding tanks, that pump is working and cover is in place and locked
- _____ Check that cover on placenta pit is in place and locked
- _____ Check that pit latrine is not full (drop stone – time delay 1 second or longer)
- _____ Check incinerator and ash pit and clean debris around area
- _____ Check and replace dead/broken bulbs, electric socket outlets and switches
- _____ Wash floors and walls in male and female wards, corridors and public areas

SEMI-ANNUALLY

- _____ Check incinerator for damage and repair
- _____ Check manholes for functioning, especially for kitchen and sluice rooms
- _____ Check roof for leakage and put glue or putty on possible holes
- _____ Check doors, hinges and locks – repair or oil as needed
- _____ Check windows and replace broken glass as needed
- _____ Clean gutters and down pipes; tighten any loose connections
- _____ Check electrical system for shorts (whole HC)

YEARLY (or as needed)

- _____ Check storm water drainage and remove debris blocking system
- _____ Check that septic tanks not blocked
- _____ Check metal surfaces, especially in wet areas, and paint (every other year)
- _____ Check common areas and corridors and paint every other year