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IMPROVING INFECTION PREVENTION AND CONTROL IN ETHIOPIA THROUGH SUPPORTIVE SUPERVISION OF HEALTH FACILITIES

2013

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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AIDS Support and Technical Assistance Resources Project

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ACRONYMS

ART	antiretroviral therapy
BCC	behavior change communication
FMOH	Federal Ministry of Health
HBV	hepatitis B virus
HCV	hepatitis C virus
HCWM	health care waste management
HIV	human immunodeficiency virus
IS	injection safety
IP	infection prevention
IPC	infection prevention control
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counseling
PMTCT	prevention of mother-to-child transmission
PPE	personal protective equipment
RHB	regional health bureau
USAID	U.S. Agency for International Development
WASH	water, sanitation, and hygiene

BACKGROUND

Health care-associated infections lead to death, disability, and excess medical costs. Infection prevention and control measures maximize patient outcomes and are essential to providing effective, efficient, and quality health care services.

Since 2004, John Snow, Inc. (JSI) has provided technical assistance to the Government of Ethiopia (GOE) related to injection safety (IS) and health care waste management (HCWM) interventions and trainings. Between 2004 and 2009, this technical assistance was provided through the U.S. Agency for International Development (USAID)-funded Making Medical Injections Safer (MMIS) Project. Its goal was to prevent the medical transmission of HIV and other blood-borne pathogens by reducing unsafe and unnecessary injections and ensuring the proper disposal of health care waste in health care settings.

When MMIS ended in September 2009, USAID/Ethiopia provided field support funding for 12 months to further sustain IS and HCWM efforts through the AIDSTAR-One Project, which is funded by PEPFAR through USAID. Since October 2010, AIDSTAR-One has continued to provide technical assistance related to IS, HCWM, as well as infection prevention control (IPC) to the GOE. The goal of the project is to facilitate the sustainability of these interventions through the integration of IS and HCWM into the wider IPC framework.

APPROACH

Supportive supervision aims to ensure and improve the quality, effectiveness, and efficiency of services provided at the facility level. This method of supervision also enhances competencies and job satisfaction for staff engaged in activities at all levels of care delivery.

Many institutions respond to poor performance by providing on-the-job (i.e., “in-service”) training. Long-term staff capacity building takes time and planning. It should include a needs assessment, in-service training based on results of the assessment, supervision, and continuing education. Supervision is an excellent opportunity to provide follow-up training, improve performance, and solve other systemic problems that contribute to poor program performance. There are many examples and case studies that show supportive supervision helps improve health worker performance and service coverage, however, long-term and sustainable results have not been thoroughly documented.

Supportive supervision has been defined as “expand[ing] the scope of supervision methods by incorporating self-assessment and peer assessment, as well as community input. Supportive supervision shifts the locus of supervisory activity from a single official to the broader workforce ... [and] promotes quality outcomes by strengthening communication, focusing on problem-solving, facilitating teamwork, and providing leadership and support to empower health providers to monitor and improve their own performance” (Marquez and Kean 2002). Supportive supervision is a process that promotes quality at all levels of the health system. It strengthens relationships within the system, focuses on the identification and resolution of problems, and helps optimize the allocation of resources, promoting high standards, teamwork, and better two-way communication (Program for Appropriate Technology in Health [PATH] 2003).

A cornerstone of supportive supervision is working with health staff to establish goals, monitor performance, identify and correct problems, and proactively improve the quality of service. Together, the supervisor and health workers identify and address weaknesses on the spot, thus preventing poor practices from becoming routine. Supervisory visits are also an opportunity to recognize good practices and help health workers maintain their high-level performance (PATH 2003).

Supportive supervision fosters a collaborative approach to strengthen health worker performance and quality of services. It has been an effective tool for improving performance for many organizations (Marquez and Kean 2002). Field experience in Kenya has shown that properly trained and supported external and on-site supervisors can support local health teams’ performance in district hospitals and health centers (Lynam and Takuom 2005).

Supportive supervision and self-assessment can reinforce communication and counseling, reflection, and learning—especially among inexperienced health workers—helping them to improve their communication skills (Kim et al. 2002).

Supervision of health services and programs is not a new phenomenon in Ethiopia’s health care system. However, the existing supervisory practices are often ineffective in supporting management to improve staff performance. Research and application of supportive supervision in several countries has shown that the supportive supervision approach is superior to existing practices and significantly improves the performance of health systems (USAID 2008).

AIDSTAR-One’s supportive supervision consists of observation, discussion, support, and guidance on IPC program management, standard practices, and equipment, supplies, and infrastructure. To ensure long-term sustainability of the program, AIDSTAR-One staff developed a set of criteria for facility “graduation” from supportive supervision. The strategy includes follow-up steps to ensure that zones, *woredas*, and health facilities have appropriate capacity to plan, implement, monitor, and manage IPC programs independently.

AIDSTAR-One/Ethiopia conducted supportive supervision visits in 54 facilities in FY 2013 in Amhara and Tigray regions with the following goals:

- To enable health care workers to practice new skills in infection prevention and control following formal trainings.
- To guide and coach health care facility staff to improve their performance in order to meet recommended IPC and HCWM standards.
- To improve the supervisory skills of woreda and zonal supervisors for independent program monitoring.
- To integrate IPC and HCWM into the routine health care supervision system.
- To monitor the changes in program performance as a result of the above mentioned activities.

PROCESS

Based on the national IPC guidelines in Ethiopia, a standard supportive supervision checklist that addresses a comprehensive IPC program was developed and used for data collection (See Annex I).

A purposive sampling technique was used to select facilities from the regional health bureaus’ (RHBs) list of health centers in both regions. The criteria used to select the health centers included: a high patient load, the presence of HIV medical services (antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), and provider-initiated HIV testing and counseling [PITC]), proximity to major roads for easy access, and health

centers that were not included in previous supervision visits. A total of 54 health centers (18 from Tigray and 46 from Amhara regions) were targeted for supportive supervision.

All of the supportive supervision visits followed AIDSTAR-One/Ethiopia's supervision protocol to ensure uniformity in the data collection procedures. The AIDSTAR-One supportive supervision team conducted three rounds of supportive supervisions at four- to six-week post-training intervals at each of the 54 facilities over a seven-month period from April to October 2013.

The supportive supervision team for each region included an AIDSTAR-One regional training coordinator, a trained woreda supervisor, and the head of the health center/representative. The third visit was done independently by a trained woreda/zone supervisor and the health facility head (without the AIDSTAR-One regional technical officer) to ensure sustainability. This handover of the supervision work was to woreda/zone supervisors.

The team visited the internal and external environments of each facility. They interviewed health facility heads, observed injection and laboratory units, observed and interviewed medical equipment processing personnel, observed storage and stock of supplies, and interviewed pharmacy staff. They also observed and interviewed waste handlers, laundry and housekeeping staff. Before concluding each visit, the supervision team held meetings with the IPC committee and discussed findings and major gaps.

The team identified interventions and action points for monitoring changes. All completed checklists were approved by official seal of the facility and readied for data entry before leaving the health center.

Team members double-checked, cleaned, and entered data into Microsoft Excel and analyzed by category. They summarized and displayed results using frequency tables and graphs to show changes by comparing the levels at baseline (first visit) with the levels at the third visit.

A summary of the results of the supportive supervision was also shared with donors, RHBs, zones, woredas, and other relevant stakeholders after completing the third visit. The results can be used to monitor implementation of the program, to sustain the observed good practices in the absence of the AIDSTAR-One project, as well as for decision making at the local level.

DEFINITIONS OF OUTCOMES

Using the standard supportive supervision checklist that was developed based on the national infection prevention guidelines, data were collected on the following variables:

IPC PROGRAM MANAGEMENT

- Availability of IPC/HCWM guidelines

- Availability and functionality of an IPC committee that meets regularly (at least every six weeks), takes meeting minutes, provides mentorship within the facility, takes actions on identified gaps, and provides training for waste handlers and other staff to make the IPC program sustainable
- Budget allocation for IPC commodities and supplies and IPC infrastructure maintenance
Supportive supervision on IPC by internal or external supervisors in the previous year with written feedback
- Behavior change communication (BCC) materials posted to reinforce IPC practices and job aids for a quick reference in the health facility

STANDARD PRACTICES

- Hand hygiene practiced by the health care providers at critical times, an essential measure in reducing infections in health care settings
- Use of personal protective equipment (PPE) by health care providers to avoid direct contact with blood/body fluids
- Safe work practices, including proper needle and syringe usage and disposal, and a reporting/tracking mechanism for needle-stick injuries and HIV post-exposure prophylaxis (PEP)
- Safe housekeeping practices, including use of PPE by waste handlers when cleaning the service delivery rooms, practice of wet mopping, and use of 0.5% chlorine solution for cleaning blood/body fluids
- Health care waste management, including segregation at point-of-generation using the three-bin system (infectious, non-infectious, and sharps) using color coded/labeled waste bins. Collection, storage, and transportation of wastes by waste handlers using PPE without mixing infectious and non-infectious wastes, and use of appropriate disposal facilities
- Appropriate decontamination, cleaning, and storage of instruments as well as appropriate collection and transportation of soiled linens to be sorted and cleaned outside of patient care areas by laundry staff using PPE

EQUIPMENT, SUPPLIES, AND INFRASTRUCTURE

- Stock of supplies: PPE and cleaning supplies (e.g., gloves, soap, towels, linens, alcohol)
- Availability of functioning handwashing facilities and toilets
- Availability of functioning incinerator and other waste disposal equipment
- Availability of drinking water for clients

RESULTS

OVERALL SUMMARY

Overall, the supportive supervision results showed improvement on IPC knowledge, attitudes, and practices of health care workers and supporting staff at the facility level. This improvement can be attributed to IPC training and on-site mentoring during supportive supervision visits. All 54 targeted health centers were visited in three rounds during the seven months, generating a total of 324 observations and 162 interviews.

To analyze results, every variable in the checklist (n=56) was assigned a value of 1. Health facilities received a score between 0 and 56 based on performance. This performance score was then categorized as good (≥ 35), average (21-34), or poor (<21).

The number of facilities that scored “good” increased from 24 to 49 over the seven-month period. The number of facilities that scored “poor” decreased from 1 to 0 at the final visit (Table 1).

Table 1. Facility Progress Scores: AIDSTAR-One/Ethiopia, November 2013

	Good (≥ 35)	Average (21-34)	Poor (<21)
Round 1	24	29	1
Round 2	47	7	0
Round 3	49	5	0
Total	120	41	1

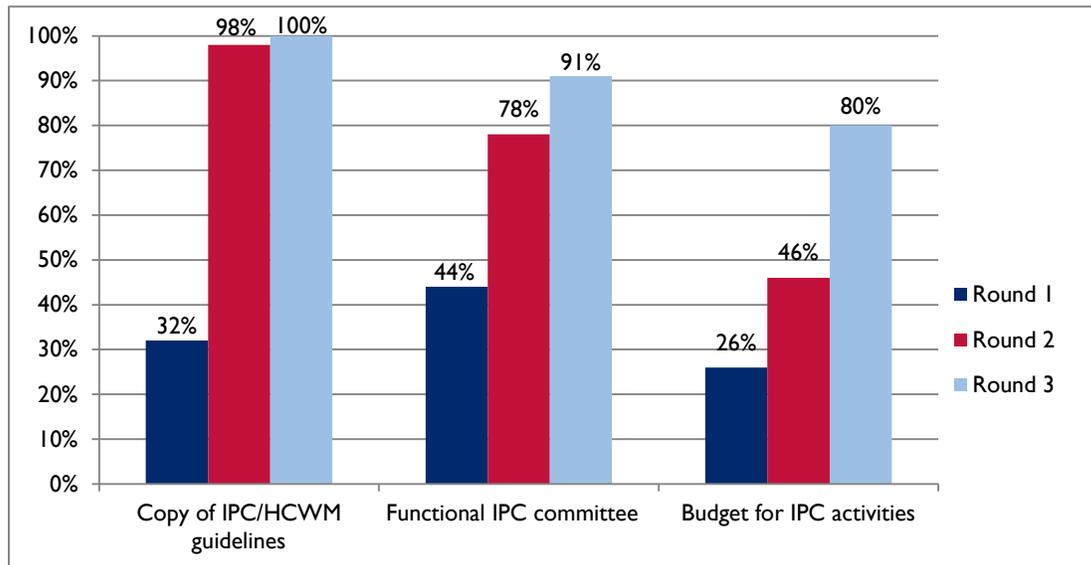
INFECTION PREVENTION AND CONTROL PROGRAM MANAGEMENT

The results show that the proportion of facilities with IPC guidelines, functional IPC committees, behavior change communication (BCC) materials and job aids, and a budget for an IPC program significantly improved over baseline (first visit). This suggests a positive correlation between regular and sustained supportive supervision visits and improvement in IPC program management by health facilities.

The visits were good opportunities to establish IPC committees and increase their involvement in the planning and follow-up of the IPC program, distribute policy documents, educate and advocate for PEP services for staff safety, and to mobilize a budget for the program.

The availability of a trained and committed IPC committee is vital to implementing and sustaining the recommended IPC practices at the facility level. Only 44 percent of the 54 facilities had functional IPC committees during the first visit, but this increased to 91 percent by the third visit (Figure 1).

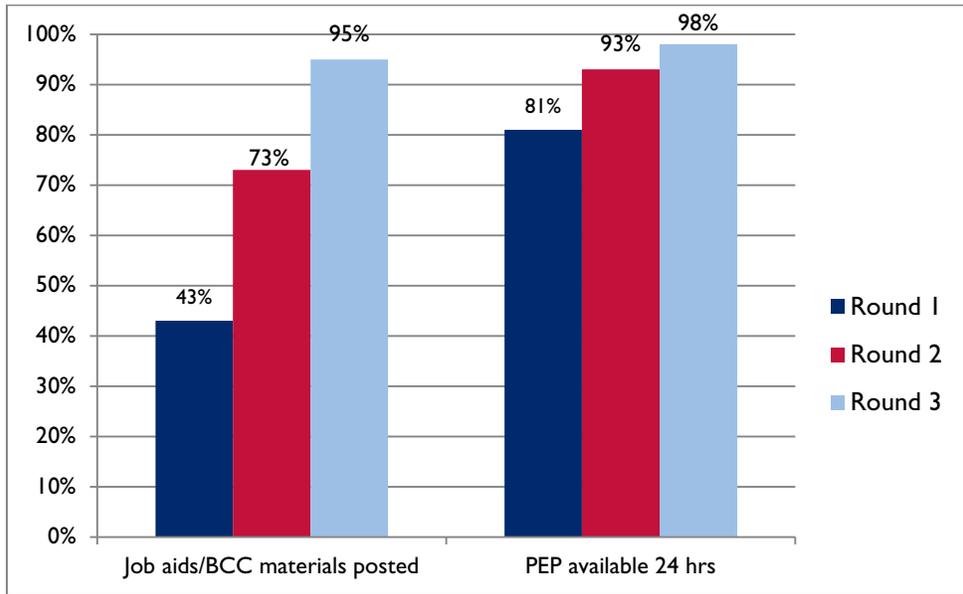
Figure 1. IPC Policy and Guidelines



Avoiding occupational exposure to blood and body fluid is the primary way to prevent HIV, hepatitis B (HBV), and hepatitis C (HCV) in the health care setting. The HBV vaccine and appropriate post-exposure management are integral components of a program to prevent infection following exposure. Evidence supports the recommendation that PEP drugs be started for exposed persons as early as possible, but preferably within two hours of exposure. Giving PEP drugs after 72 hours of exposure is not generally recommended. Therefore, it is important to have 24-hour availability of PEP services (including weekends and holidays) in health care facilities and to orient staff on the procedures and the reporting system to follow when an incident happens. As a result of the supervision visits, the proportion of facilities that offered PEP services 24 hours a day increased from 81 percent to 98 percent.

Posted BCC materials and availability of job aids can reinforce IPC practices and serve as a quick reference for staff and clients. At the first visit, however, more than half of the health facilities (57 percent) did not have BCC or information, education, and communication (IEC) materials and job aids posted. This significantly increased by the third visit (95 percent), because of materials and awareness of their importance provided by AIDSTAR-One at each supportive supervision visit (Figure 2).

Figure 2. IPC BCC and PEP Availability

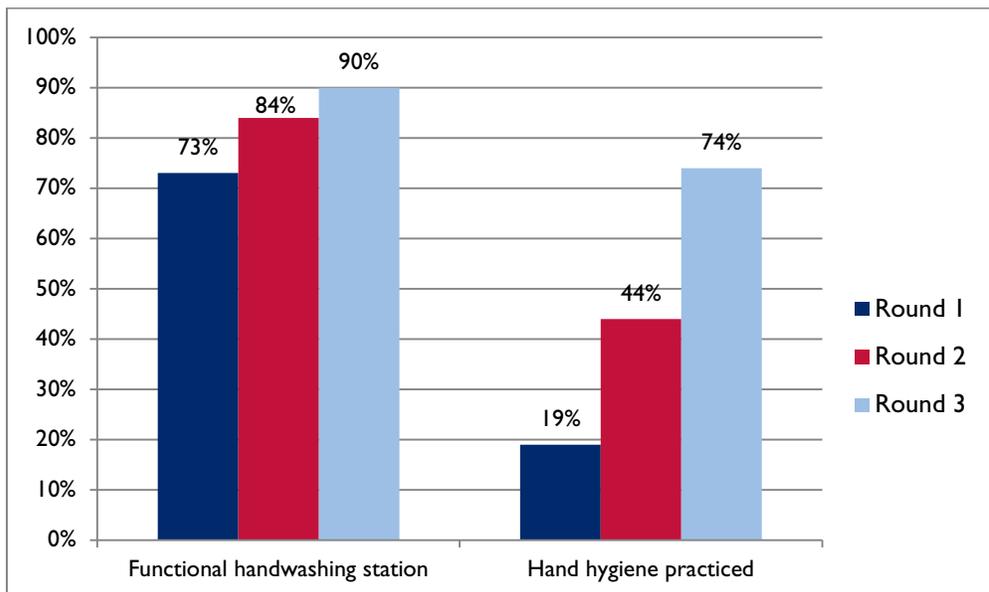


STANDARD PRACTICES

HANDWASHING

Improved handwashing practices significantly reduce the number of potentially infectious microorganisms on the hands, reducing infections spread in the health care facility and the associated risk. The results showed the practice of provider handwashing with soap and running water, or alcohol-based hand sanitizer, between procedures was very low, but improved from the first to the third visit (19 percent to 74 percent) (Figure 3).

Figure 3. Handwashing Practices

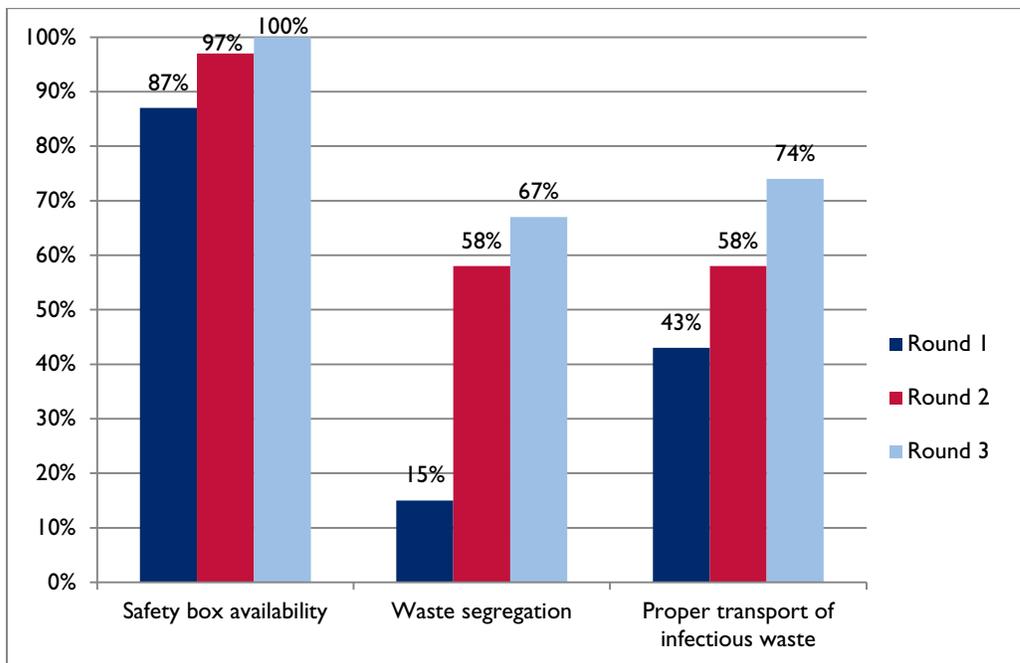


HEALTH CARE WASTE MANAGEMENT

Most health care waste is non-infectious, like paper, cardboard, and food scraps. But when waste that carries harmful germs or dangerous chemicals is mixed with ordinary waste, the mixed waste can pose a health risk for the health workers, patients, and the surrounding community. By the third supportive supervision visit, all facilities (100 percent) had safety boxes available in injection rooms, treatment rooms, operating theaters, labor and delivery rooms, and laboratories, an increase from 87 percent at the first visit. Waste segregation practices significantly improved from the first to the third visit (15 percent to 67 percent) and the waste containers were emptied in a timely manner (Figure 4).

Ethiopia’s IPC guidelines recommend that waste should be transported in a way that does not pose risk and the waste containers should also be emptied frequently. The results demonstrated improvement (from 43 to 74 percent). Reasons cited for not following guidelines included the shortage of proper waste transportation materials (wheelbarrow) and poor road access to the disposal site (incinerator). (Figure 4).

Figure 4. Health Care Waste Management

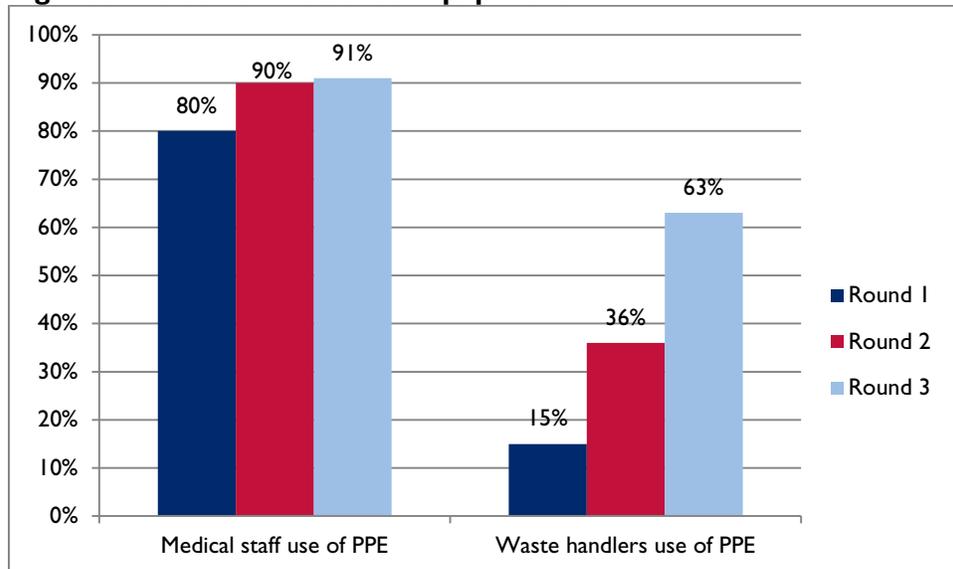


PERSONAL PROTECTIVE EQUIPMENT

The appropriate use of PPE by health care providers is important in the prevention and control of infections acquired in the health care setting. PPE provides a physical barrier and protects the health workers from direct contact with infectious agents. Staff awareness of the necessary PPE to protect against exposure to blood/body fluid reduces the risk of accidental injury. However, some medical staff did not use PPE (at minimum, disposable gloves) consistently or appropriately. Reasons mentioned included shortage of PPE, discomfort

(e.g., due to the quality or the size), and lack of awareness about the risks of non-use. Proper use of PPE by medical staff increased from the first to the third supervision visit (80 to 91 percent) (Figure 5).

Figure 5. Personal Protective Equipment



Most facilities have faced shortages of PPE for waste handlers and laundry workers due to unavailability in the local market. Supportive supervision increased waste handlers' awareness on proper use of PPE (e.g., utility gloves, aprons, face shield, and boots) when handling medical waste and when cleaning. The PPE rate of use by waste handlers (at least utility gloves and gown) improved between the first and third round visits (15 percent to 63 percent) but continues to be low after the third round of visits.

In addition to the PPE shortages, other reasons that the waste handlers and laundry workers were not using PPE included discomfort due to poor quality or incorrect sizing, and lack of awareness about the risks if not worn. Their awareness increased through training, mentoring, and instruction on the proper use of the safety box by health workers and proper use of the available PPE by waste handlers. The reported incidence of needle-stick injury decreased from 2 percent to 0 percent during the six-month supportive supervision period.

CLEANING/STERILIZATION

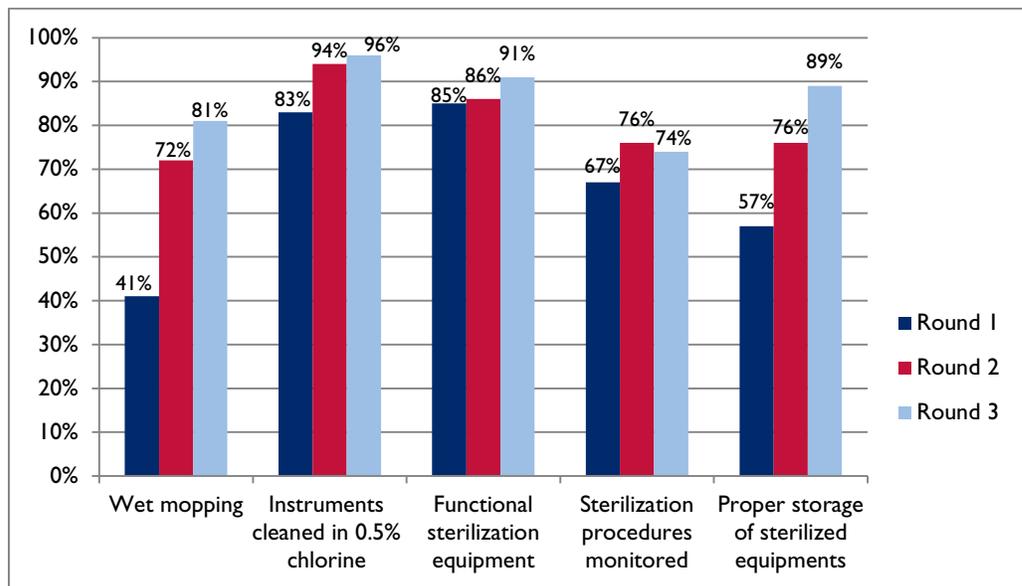
The practice of wet mopping by waste handlers improved between the first and third visits (41 percent to 81 percent). Use of 0.5% chlorine solution for cleaning blood and body fluid spills increased (85 to 96 percent) as well.

The majority of the visited facilities (91 percent) had functional sterilization equipment at the third visit. However, the percentage of facilities that monitor equipment sterilization procedures decreased between the second and the third visit (76 to 74 percent) (Figure 6). Specific time, temperature, and pressure requirements are necessary for effective steam sterilization.

Autoclaves (steam sterilizers) and dry-heat ovens must be properly maintained to achieve required sterilization. Routine maintenance of sterilization equipment should be standard procedure, and a responsible staff member should be assigned. However, in almost all facilities, sterilization equipment was not regularly or properly maintained and there was no responsible staff member to accomplish the task.

All sterile instruments and other items should be stored in an environment that is free of dust, dirt, and insects. Sterilized instruments storage practice improved from the first to the third supportive supervision visit (57 percent to 89 percent) (Figure 6). Facility personnel were trained to store wrapped instruments and other items in a closed cabinet, and store unwrapped instruments and other items covered in a sterile container. Some of the visited facilities prepared closed cabinets for storage of sterile instruments.

Figure 6. Cleaning and Sterilization



EQUIPMENT, SUPPLIES, AND INFRASTRUCTURE

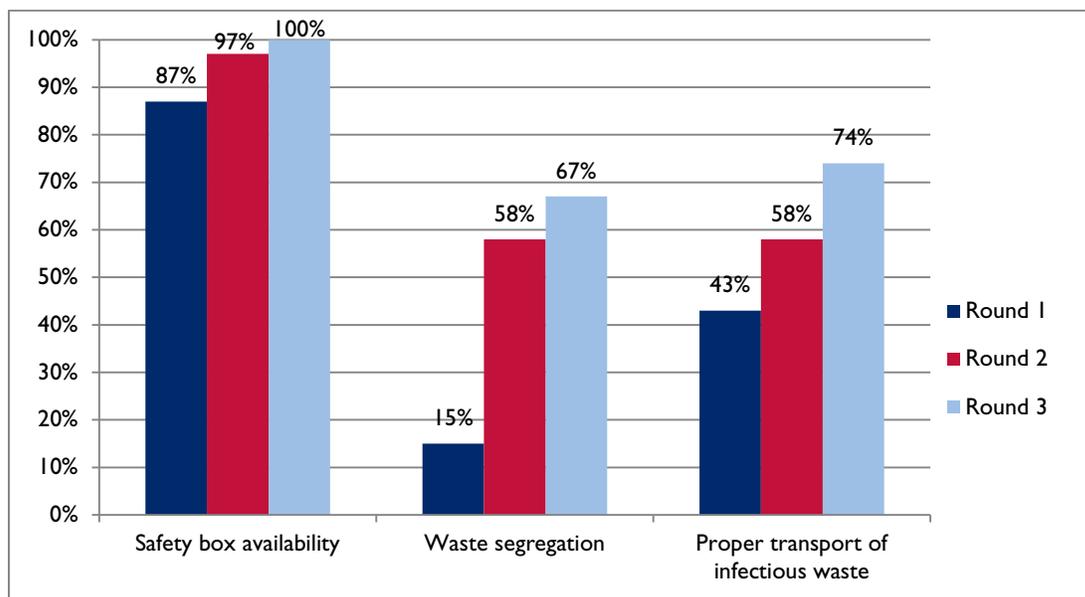
In facilities where running water is not available or not functional, it is possible to prepare and use locally-made tippy taps for handwashing. A tippy tap is a handwashing facility made of locally-available material—such as clay, metal, or plastic—and is a good alternative for handwashing in a resource-limited environment. In areas where there is a shortage of water for handwashing, an alcohol-based hand sanitizer can be prepared and used.

The results showed that the number of functioning handwashing facilities for staff increased (73 percent to 90 percent) (Figure 3). Some of the health facilities repaired non-functional sinks and created locally-made tippy taps. Most facilities with non-functional sinks provided alcohol-based hand sanitizer as a substitute for handwashing with soap and water.

Availability of functional incinerators also increased (85 to 96 percent). During supportive supervision, non-functional incinerators were identified and AIDSTAR-One/Ethiopia provided technical assistance to the facility management to determine how to make the repairs.

Training for waste handlers and follow-up supervision by the health facility’s IPC committee contributed to proper incinerator use in the majority of the target facilities. Similarly, functional placenta pit availability increased (83 percent to 96 percent) during the mentoring period. Waste disposal pit availability showed slight improvement (87 to 89 percent) (Figure 7). To prevent access by children and animals, fencing was installed around incinerators, placental pits, and waste disposal pits. Health facilities prepared waste disposal pits and made other improvements from their internal budgets.

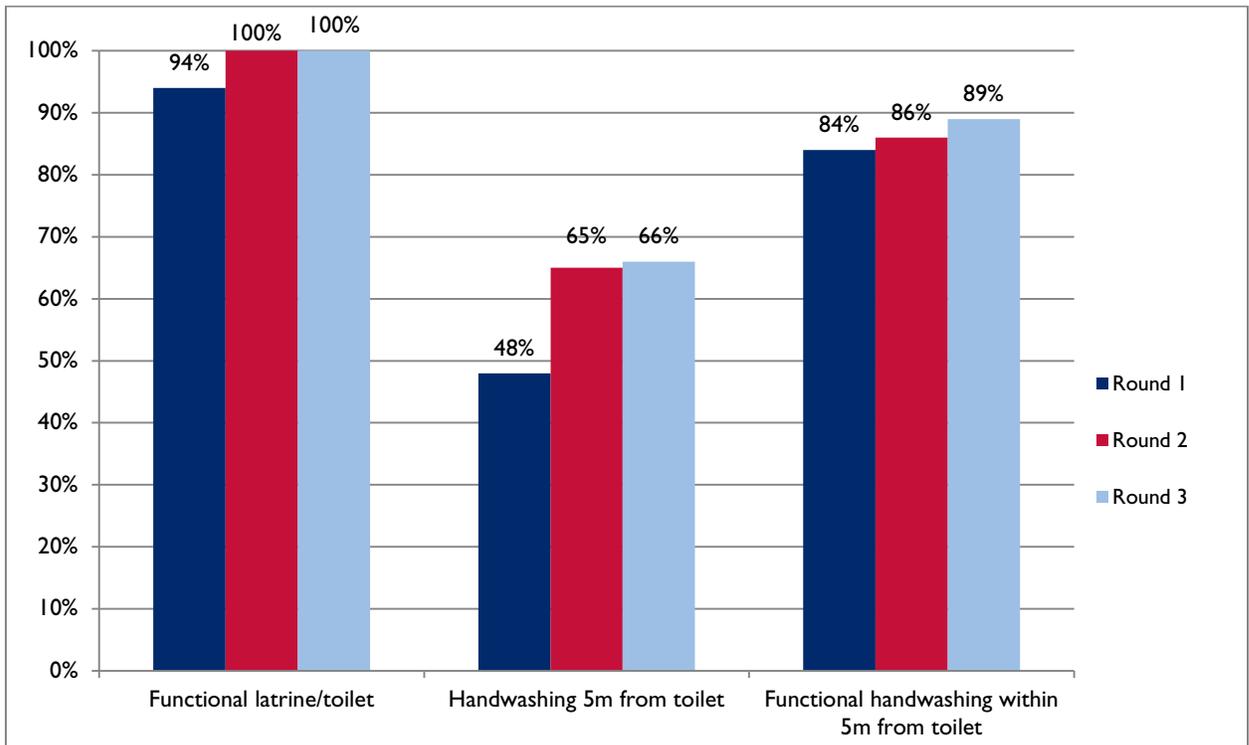
Figure 7. HCWM Disposal Availability



Nosocomial diarrhea is a common problem in health care settings. Nosocomial transmission of fecal organisms by contaminated water can be reduced considerably by supplying quality drinking water in health care facilities. *Clostridium difficile* is the most frequent etiologic agent for diarrhea associated with health care facilities. In one hospital, 30 percent of adults who developed health care–associated diarrhea were positive for *C. difficile*. Availability of drinking water for clients and facility/service delivery room staff improved (70 to 85 percent) between the first and third visit.

All of the facilities (100 percent) had a functional latrine for staff and clients by the third visit. Supportive supervision focused on latrine sanitation and on availability of a handwashing facility near the latrine, for which there was improvement (from 48 to 66 percent). Of the available handwashing facilities near the client latrines, 89 percent were functional at the third supervision visit (Figure 8).

Figure 8. Latrines and Handwashing



CONCLUSION

Health care-associated infections lead to death, disability, and excess medical costs. IPC interventions maximize patient outcomes and are an essential part of providing effective, efficient, and quality health care services. To successfully implement and maintain appropriate IPC practices at health care facilities, basic IPC training can improve knowledge and skills. Training also improves creativity and effective management skills through experience sharing among health care workers. Once IPC awareness has been created through training, regular monitoring and supervision of the facilities help health care workers improve their IPC practices. Establishing and strengthening the facility-level IPC committee and building the independent supervisory capacity of their members are essential to sustain the improved IPC practices.

Overall, the supportive supervision results showed strong improvements in IPC knowledge and practices of health care workers and supporting staff at the facility level. This improvement can be attributed to IPC training during supportive supervision visits. Improvements were especially made in creating functional IPC committees, facility-level budget increases for IPC programs, safety box use, PPE use by health workers, availability of PEP, and proper medical instrument processing and storage practices.

The team observed encouraging progress on handwashing, waste segregation, instrument sterilization monitoring practices, PPE use, and proper waste transportation practices by waste handlers. But knowledge and skill gaps can be further improved and strengthened through onsite training and scheduled supportive supervision by IPC committees and woreda supervisors.

The findings demonstrate that supportive supervision can lead to behavior change among health care workers and supporting staff by improving knowledge and practices related to IPC.

Handover was done at the catchment area review meetings for the RHB, zonal health department, woreda health offices, and facility-level IP committees. They were debriefed on current strengths, gaps, and recommendations for each health facility, especially health facilities that need additional visits by the woreda/zone experts.

CHALLENGES

- IPC staff turnover (especially among the facility heads) in some of the visited health facilities has made sustainability a challenge.
- There is a shortage of PPE for waste handlers and laundry workers (not available in the local market). Written supervision feedback is not properly documented in some of the facilities. Introduction of a logbook helped address this situation.
- In some facilities, there is a lack of commitment by the IPC committee members and head of the facility.
- Some facilities were constructed without an incinerator or placenta pit, especially facilities that were upgraded from clinics.
- There is a water shortage during the entire year as well as malfunctioning sewers, pipes, sinks, and other sanitary fittings in some of the visited facilities.
- Non-functional instrument sterilizers were found in some of the visited facilities. This is because instrument sterilizers are frequently not bundled with spare parts or manuals, staff has little knowledge or skill to operate and repair them, no maintenance training has been given, and some facilities have no power supply to use their sterilizers.
- Sterilized medical equipment was not stored appropriately by some staff in certain facilities.
- There are no clear-cut written policies or procedures for the treatment and disposal of expired drugs in facilities.

RECOMMENDATIONS

PARTNERS

Partners should continue to provide technical and financial support at each level (Federal Ministry of Health, regions, zones, woredas, and health facilities) on the proper implementation of IPC and HCWM activities. This should include a sustainable supply of IPC commodities, staff training, and capacity building of biomedical equipment maintenance personnel.

FEDERAL MINISTRY OF HEALTH (FMOH)

- The Federal Ministry of Health of Ethiopia should ensure the availability of IPC commodities and supplies in the local market by working with local manufacturers and technical and vocational training colleges, enabling them to produce IPC supplies locally.
- Provide all health facilities with IPC and HCWM guidelines. The FMOH should distribute these guidelines to RHBs, who should further distribute them to health facilities.
- Provide hard and soft copies of educational materials, job aids, and video clips to all targeted health facilities. The FMOH and the health education center should collect and distribute IPC-related IEC/BCC materials and job aids developed by partners to the RHBs on a regular basis.
- Ensure regular funding to purchase IPC commodities and IPC and water, sanitation and hygiene (WASH) facilities maintenance work. Prioritize IPC commodities during regular budget allocation, raise funds centrally, and purchase enough supplies of IPC commodities for the country.
- Replicate these supportive supervision experiences for other public facilities to improve their IPC practices. Work with partners to document best IPC practices (such as training followed by supportive supervision) and scale up those best practices in other regions.
- Support regions, woredas, and health facilities on medical equipment maintenance activities. The FMOH should, in collaboration with partner organizations, arrange training and capacity building activities on medical equipment maintenance for the regional, zonal, woreda, and facility-level biomedical equipment technicians, so they can repair and maintain medical equipment in their respective areas.

REGIONAL HEALTH BUREAUS

- The Regional Health Bureau (RHB) should ensure the availability of IPC commodities and supplies in the local market by working with local manufacturers and technical and vocational training colleges, enabling them to produce IPC supplies locally.
- Provide all health facilities with IPC and HCWM guidelines. The FMOH should distribute these guidelines to RHBs who should further distribute them to health facilities.
- Provide hard and soft copies of educational materials, job aids, and video clips to all targeted health facilities. The FMOH and the health education center should collect and distribute IPC related IEC/BCC materials and job aids developed by partners to the RHBs on a regular basis.
- Build the independent supervision capacity of the woreda experts and health facility level IPC committees. The RHBs, with partner organizations, should provide training on supportive supervision skills and arrange joint supportive supervision visits with zonal and woreda experts to build capacity.
- Ensure regular funding for IPC commodities and IPC and WASH facilities maintenance work. The RHBs should prioritize the IPC program during budget allocation and secure funds from donors and other sources to locally purchase IPC commodities and distribute to health facilities.
- Support zones, woredas, and health facilities in medical equipment maintenance activities. The RHBs should deploy trained medical equipment maintenance technicians to repair and maintain medical equipment in their surrounding facilities.
- Replicate these supportive supervision experiences for other public facilities to improve their IPC practices. Work with partners to document best IPC practices and scale up those best practices (such as training followed by supportive supervision) in other regions.
- Organize refresher training to health care workers on IPC practices, especially on handwashing and waste segregation practices.

ZONAL HEALTH DEPARTMENT/WOREDA HEALTH OFFICE

- Establish/strengthen the health facilities' IPC committees through joint supportive supervision, so that the committee regularly supervises the implementation of IPC practices by staff, identifies gaps, and explores possible solutions.
- Prioritize the IPC program during budget allocation and increase budgets for it.
- Support woredas and health facilities in medical equipment maintenance activities.

HEALTH FACILITIES

- The health facility IPC committee should conduct regular meetings, internal facility supervision, gap identification, action plan preparation and implementation, and staff sensitization.
- Secure funds for the IPC program locally through sensitization of the local community and local NGOs working on health activities.
- IPC committees should regularly conduct staff and waste handler orientation on handwashing, waste segregation, and medical instrument processing practices.
- When the waste disposal pit is filled, a new pit should be prepared immediately. Staff should also ensure the incinerator is regularly maintained and kept clean.
- In areas where there is no running water for handwashing, tippy taps should be constructed using locally available materials.
- Health facilities should purchase and make available PPE for health workers and waste handlers from their internal budget. The facility IPC committee should insure proper use.

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ANNEX I.

RESULTS

Table 1. IPC management, by region

Variables	Regions								
	Amhara			Tigray			Total		
	R1	R2	R3	R1	R2	R3	R1	R2	R3
Health facilities with copy of IPC/HCWM guidelines	36 (8) 27%	36 (35) 97%	36 (36) 100%	18 (9) 50%	18 (18) 100%	18 (18) 100%	54 (17) 32%	54 (53) 98%	54 (54) 100%
Health facilities with functional infection prevention committee	36 (7) 23%	36 (25) 69%	36 (32) 89 %	18 (14) 78%	18 (17) 94%	18 (16) 94%	54 (21) 44%	54 (42) 78%	54 (48) 91%
Health facilities with budget for IPC activities	36 (13) 37%	36 (22) 61%	36 (33) 92%	18 (1) 6%	18 (3) 17%	18 (10) 56%	54 (14) 26%	54 (25) 46%	54 (43) 80%
Post-exposure prophylaxis service available 24 hrs	36 (27) 75%	36 (32) 89%	36 (35) 97 %	18 (17) 94%	18 (18) 100%	18 (18) 100%	54 (44) 81%	54 (50) 93%	54 (53) 98%

Table 2. Service delivery units, by region

Variables	Regions								
	Amhara			Tigray			Total		
	R1	R2	R3	R1	R2	R3	R1	R2	R3
Safety box at each injection area	71 (57) 80%	72 (69) 96%	72 (72) 100%	36 (36) 100%	35 (35) 100%	36 (36) 100%	107 (93) 87%	107 (104) 97%	108 (108) 100%

Needle & syringe taken from sterile/unopened package	71 (71) 100%	72 (72) 100%	72 (72) 100%	36 (36) 100%	35 (35) 100%	36 (36) 100%	107 (107) 100%	107 (107) 100%	108 (108) 100%
Provider immediately disposes used needles and syringes in an appropriate sharps container	71 (66) 93%	72 (67) 93%	72 (70) 100%	36 (36) 100%	35 (35) 100%	36 (36) 100%	107 (102) 95%	107 (102) 95%	108 (106) 100%
Functional handwashing facility	71 (38) 78%	72 (52) 93%	72 (58) 94%	36 (23) 66%	35 (24) 71%	36 (28) 82%	107 (61) 73%	107 (76) 84%	108 (86) 90%
Provider washes hands	71 (3) 7%	72 (33) 43%	72 (36) 72%	36 (11) 33%	35 (13) 37%	36 (28) 78%	107 (14) 19%	107 (46) 44%	108 (64) 74%
Staff wears the necessary PPE when exposure to blood/body fluid is anticipated	72 (33) 66%	72 (47) 89%	72 (52) 91%	36 (36) 100%	35 (34) 97%	36 (35) 97%	107 (69) 80%	107 (81) 92%	108 (87) 94%
Proper waste segregation practice	71 (10) 14%	72 (46) 64%	72 (50) 69%	36 (6) 17%	35 (16) 46%	36 (22) 61%	107 (16) 15%	107 (62) 58%	108 (72) 67%
Availability of BCC materials & job aids	71 (35) 49%	72 (60) 83%	72 (69) 96%	36 (11) 31%	35 (18) 51%	36 (34) 94%	107 (46) 43%	107 (78) 73%	108 (103) 95%

Table 3. Medical equipment processing, by region

Variables	Regions								
	Amhara			Tigray			Total		
	R1	R2	R3	R1	R2	R3	R1	R2	R3
Used medical instruments decontaminated with 0.5% chemical	36 (33) 92%	36 (36) 100%	36 (36) 100%	18 (12) 67%	18 (15) 83%	18 (18) 100%	54 (45) 83%	54 (51) 94%	54 (54) 100%
Functional sterilization equipment available	36 (27) 90%	36 (26) 79%	36 (31) 89%	18 (14) 78%	18 (18) 100%	18 (17) 94%	54 (41) 85%	54 (44) 86%	54 (48) 91%
Monitors sterilization procedures	36 (23) 68%	36 (24) 67%	36 (22) 63%	18 (11) 65%	18 (17) 94%	18 (17) 94%	54 (34) 67%	54 (41) 76%	54 (39) 74%
Storage for sterilized instruments and other items	36 (21) 58%	36 (27) 75%	36 (32) 89%	18 (10) 56%	18 (14) 78%	18 (16) 89%	54 (31) 57%	54 (41) 76%	54 (48) 89%

Table 4. Waste handlers/laundry workers, by region

Variables	Regions								
	Amhara			Tigray			Total		
	R1	R2	R3	R1	R2	R3	R1	R2	R3
Waste handlers/laundry workers wear PPE according to the standard	36 (5) 23%	36 (9) 43%	36 (16) 64%	18 (1) 6%	18 (5) 28%	18 (11) 61%	54 (6) 15%	54 (14) 36%	54 (27) 63%
0.5% chlorine solution used when cleaning blood/body fluids	36 (28) 78%	36 (35) 97%	36 (36) 100%	18 (18) 100%	18 (17) 94%	18 (18) 100%	54 (46) 85%	54 (52) 96%	54 (54) 100%
Needle stick injury in the past six months	36 (0) 0%	36 (1) 3%	36 (0) 0%	18 (1) 6%	18 (0) 0%	18 (0) 0%	54 (1) 2%	54 (1) 2%	54 (0) 0%

Transportation of waste practiced in a way that does not pose risk	36 (23) 64%	36 (26) 76%	36 (27) 75%	18 (0) 0%	18 (4) 22%	18 (13) 72%	54 (23) 43%	54 (30) 58%	54 (40) 74%
Wet mopping used for cleaning	36 (22) 61%	36 (34) 94%	36 (34) 94%	18 (0) 0%	18 (5) 28%	18 (12) 67%	54 (22) 41%	54 (39) 72%	54 (46) 85%

Table 5. Facility waste treatment and disposal and WASH infrastructure, by region

Variables	Regions								
	Amhara			Tigray			Total		
	R1	R2	R3	R1	R2	R3	R1	R2	R3
Functional incinerator	36 (23) 77%	36 (26) 87%	36 (30) 94%	18 (18) 100%	18 (17) 94%	18 (16) 100%	54 (41) 85%	54 (43) 90%	54 (46) 96%
Functional placental pit	36 (29) 81%	36 (34) 94%	36 (35) 97%	18 (16) 89%	18 (17) 94%	18 (17) 94%	54 (45) 83%	54 (52) 94%	54 (52) 96%
Availability of waste disposal pit	32 (31) 86%	36 (31) 86%	36 (33) 92%	18 (16) 89%	18 (17) 94%	18 (15) 83%	54 (47) 87%	54 (48) 89%	54 (48) 89%
Functional toilet for clients	36 (34) 94%	36 (36) 100%	36 (36) 100%	18 (17) 94%	18 (18) 100%	18 (17) 100%	54 (51) 94%	54 (54) 100%	54 (54) 100%
Handwashing facility within 5m of toilet	36 (14) 41%	36 (22) 61%	36 (22) 61%	18 (11) 61%	18 (13) 72%	18 (13) 72%	54 (25) 48%	54 (35) 65%	54 (35) 65%
Functional handwashing facility for clients within 5m of toilet	36 (11) 79%	36 (20) 91%	36 (19) 86%	18 (10) 91%	18 (10) 77%	18 (12) 92%	54 (21) 84%	54 (30) 86%	54 (31) 89%

ANNEX 2.

AIDSTAR-ONE SUPPORTIVE SUPERVISION CHECKLIST FOR INJECTION SAFETY AND INFECTION PREVENTION

Section 1: Identification

Region: _____ Zone _____

Woreda _____

Name of health center _____

Circle the type of facility: Government / NGO / Private

Date of last visit _____

Date of current visit _____

Section 2: Follow-up Issues from Previous Supervision

Key issues from the last visit:

1. _____
2. _____
3. _____
4. _____
5. _____

Circle Yes or No for each question below in each of the sites visited. If you are unable to observe an item, circle NA/No. If respondent does not know the answer, circle don't know.

All questions should be answered. If a question has two parts and the answer to part A is No, mark NA for part B.

For each question below, if you observe an unsafe injection, practice, or situation, discuss what the health worker should do differently and why it is important. Please record your additional relevant observations in the column entitled "Comments."

If you mark “not observed” explain the reason for no observation in the comments column.

Explain the purpose of the visit to the head of the facility/representative. Inform this person that you would like to ask a few questions about infection prevention. Ask to look around the facility to observe infection prevention (IP) and waste management practices.

Section 3: Questions

No	Question or Observation	Response	Intervention	Comments
INTERVIEW WITH THE HEALTH FACILITY DIRECTOR or person in charge of the unit, as appropriate.				
1	In this facility, do you have a copy of IPC/HCWM guidelines?	1/Yes 2/No 3/Don't know	If no, provide a copy.	
2A	Is there an infection prevention committee in this facility?	1/Yes 2/No 3/Don't know	If no, discuss importance with health facility head and next steps for committee organization.	
2B	If yes, is it functional? (meets at least once a month, check plan and minutes)	1/Yes 2/No 3/Don't know 4/NA		
3	Did this facility allocate budget for IPC activities? (such as for IP commodities and facility maintenance)	1/Yes 2/No 3/Don't know		
4	Is a needle stick injury recording and reporting system available in this facility?	1/Yes 2/No 3/Don't know	If yes, ask to see the registration and check for proper use. Ensure that staff knows how to report injury and how to access VCT services. If no, discuss importance of creating a reporting system with facility head & IP committee.	
5	Is post-exposure prophylaxis (PEP) service available at all times (24	1/Yes 2/No 3/Don't Know	If no, discuss the importance of 24-hour PEP with	

	hours) in this facility?		management and IP committee.	
6	Have you ever conducted internal IS/IP supportive supervision in this facility?	1/Yes 2/No, 3/ Don't know	If yes, ask to review identified gaps noted in follow up, if any.	
7A	Did your facility receive supervision on IS/IP practices by external supervisors during the previous year (12 months)?	1/Yes 2/No 3/Don't know	If yes, record who supervised the facility.	
7B	If yes, did the facility receive supervision feedback from external supervisors? If no supervision in previous year, mark NA.	1/ Yes 2/ No 3/ Don't know 4/NA	If yes, ask for major feedback.	

OBSERVATIONS OF SERVICE DELIVERY UNITS (Injection and Laboratory units)
Instructions: Observe two different providers (observation 2 should take place in the lab, if the facility has one). If no provider is available for the second observation, select “not observed” for observation 2.

		Observation 1	Observation 2	Interventions	Comments
8	For each injection observed, were the needle and syringe taken from unopened package? If not observed, explain why in comments. (This question applies to standard disposable syringes and syringes with reuse and/or needle stick prevention features. Code sterilizable syringes as “no.”) NOTE: Intervene tactfully to interrupt any unsafe injection or reconstitution as needed.	1/Yes 2/No 3/Not observed	1/Yes 2/No 3/Not observed		
9	After observed	1/Yes	1/Yes	If no, ask the	

	injection, did the provider immediately dispose of the used needles and syringes in an appropriate sharps container/safety box? If not observed, explain why in comments. (Include the needles and syringes used for reconstitution and for injection in answering this.)	2/No 3/Not observed	2/No 3/Not observed	reason why they are not using a sharps container or not using it immediately. Discuss the importance of proper disposal of used sharps and the dangers improper disposal to other health workers and the community. Seek solutions.	
10	Did the provider use a pair of gloves? If not observed, explain why in comment column	1/Yes 2/No 3/Not observed	1/Yes 2/No 3/Not observed		

INTERVIEW WITH THE INJECTION PROVIDER

11A	Ask injection provider: Have you had any needle-stick injuries in the last 6 months?	1/Yes 2/No 3/Don't know	1/Yes 2/No 3/Don't know	If yes, find out how the injury occurred and discuss ways of preventing such injuries. Discuss any constraints the person faces in reporting/ being tested and the MOH policy. Answer any questions on PEP.	
11B	If yes, did you report the incidence?	1/Yes 2/No 3/NA	1/Yes 2/No 3/NA		

OBSERVATION OF THE FACILITY

12	Is there a safety box in all observed injection areas?	1/Yes 2/No	1/Yes 2/No	If no, discuss why safety boxes are not available and discuss obtaining them with the head of the facility and making them available in all	
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				injection areas.	
13A	Is there a handwashing facility in observed injection area?	1/Yes 2/No	1/Yes 2/No	If no, discuss its importance and discuss next steps with the IP committee.	
13B	If yes, is it functioning? If no handwashing station, mark NA	1/Yes 2/No 3/NA	1/Yes 2/No 3/NA	If no, ask the reason why not functioning and discuss possible solution and next steps with the IP committee.	
14	Did the service provider wash his/her hands between procedures? If yes, indicate the technique used (soap and water, alcohol based sanitizer) on the comment column	1/Yes 2/No 3/Not observed	1/Yes 2/No 3/Not observed	If no, discuss the importance of handwashing. If possible, demonstrate the right technique.	
15	Is waste being properly segregated (using 3 bin system)?	1/Yes 2/No	1/Yes 2/No	At minimum, a safety box for sharps and at least two different waste bins for infectious and non-infectious wastes should be available in each injection area (3 bin system).	
16	Are job aids/ BCC materials posted that promote safe IS/IP practices?	1/Yes 2/No	1/Yes 2/No	If not, encourage posting in order to promote safe IS/IP. practice	

INTERVIEW WITH THE HEALTH FACILITY, MEDICAL EQUIPMENT PROCESSING PERSONNEL, OR PERSON IN CHARGE

17	Are used medical instruments first decontaminated with 0.5% chemical, then cleaned and sterilized before reuse?	1/Yes 2/No 3/Don't know	If no, ask the reason and provide technical support on how to prepare the solution. For equipment processing unit and/or all service	
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			delivery units.	
18A	Is sterilization equipment available in the facility?	1/Yes 2/No 3/Don't know	For equipment processing unit and/or all service delivery units.	
18B	If yes, is it functioning?	1/Yes 2/No 3/Don't know 4/NA	If no, ask the reasons and discuss maintenance issues with management and IP committee.	
19	Do you monitor sterilization procedures? If yes, describe how in comment section	1/Yes 2/No 3/Don't know		
20	Are sterilized instruments stored in a closed cabinet that limits the risk of contamination?	1/Yes 2/No 3/Don't know	If no, provide technical assistance on proper storage of sterile instrument.	

INTERVIEW WITH THE HEALTH FACILITY STORE MAN OR PERSON IN CHARGE

21	Have 5 ml syringes been out of stock in the last 6 months?	1/Yes 2/No 3/Don't know 4/NA	If yes, discuss why with facility management.	
22	Has there been a stockout of safety boxes in the last 6 months?	1/Yes 2/No 3/Don't know 4/NA	If yes, discuss why with facility management.	
23	Has there been a stockout of disposable gloves in the last 6 months?	1/Yes 2/No 3/Don't know 4/NA	If yes, discuss why with facility management	
24	Has there been a stockout of chemicals (e.g., chlorine) in the last 6 months?	1/Yes 2/No 3/Don't know	If yes, discuss why with facility management	
25	Is personal protective equipment available for waste handlers? If heavy duty gloves and boots are available, mark yes.	1/Yes 2/No 3/Don't know 4/NA	Discuss with the store man what equipment is available, what additional needs they may have, and possible strategies to meet those needs.	Circle all that are available: 1. Face mask 2. Goggles 3. Heavy duty gloves 4. Plastic apron 5. Clothes that cover the body 6. Heavy duty

				boots, other protective equipment.
OBSERVATION OF THE FACILITY				
26A	Is there a stock/bin card for 5 ml syringes?	1/Yes 2/No 3/NA	If yes, record the balance. If no, count and record the balance; suggest use of stock/bin card. Check for different types of gloves.	
26B	If yes, is it updated? If no stock/bin card, mark NA.	1/Yes 2/No 3/NA	At least updated for the last one month	
27A	Is there a stock/ bin card for disposable gloves?	1/Yes 2/No 3/NA	If yes, record the balance. If no, count and record the balance; suggest use of stock/bin card.	
27B	If yes, is it updated? If no stock/bin card, mark NA	1/Yes 2/No 3/NA	At least updated for the last one month.	
INTERVIEW WITH WASTE HANDLER AND/OR LAUNDRY STAFF				
28	Does staff practice wet mopping for cleaning?	1/Yes 2/No 3/Don't know	If staff practices dry mopping, discuss the risk of disease transmission and suggest wet mopping	
29	When cleaning blood/body fluid spills from surface/floors, is a 0.5% chemical solution used?	1/Yes 2/No 3/Don't know	If no, discuss the risk of disease transmission and prepare method for 0.5% solution.	
30A	Ask waste handler: Have you had any needle-stick injuries in the last 6 months?	1/Yes 2/No 3/Don't know	If yes, discuss how the injury occurred and ways of preventing injury in the future. Discuss any constraints faced in reporting/being tested and the MOH policy. Answer any questions on PEP.	
30B	If yes, did you report	1/Yes		

	the incidence? If no needle stick in the last 6 months, mark NA	2/No 3/NA		
31	Is transportation of infectious medical waste being practiced in a way that does not pose risk of infection?	1/Yes 2/No 3/Don't know	“Not pose risk” during transportation means: Using carts for infectious and non-infectious wastes transportation or waste bin with cover and handle & for sharps with the necessary precaution, to avoid risk of needle-stick injury.	

INTERVIEW WITH LAUNDRY WORKER

32	Is used linen sorted in a non- patient care area?	1/Yes 2/No 3/Don't know 4/NA	If sorting takes place in patient care area, discuss the risk of disease transmission and suggest sorting used linen in the laundry area.	
33	Are clean and used linens transported using different carts?	1/Yes 2/No 3/Don't know 4/NA	If using the same carts without cleaning, discuss the risk of cross- contamination and suggest use of separate carts or provide technical assistance on how to clean before use.	
34	Is there a storage place/area for used/soiled separate from clean linen?	1/ Yes 2/ No 3/Don't know 4/NA	If no, discuss the risk of cross-contamination and suggest separate storage.	
35A	Ask laundry staff: Have you had any needle-stick injuries in the last 6 months?	1/Yes 2/No 3/Don't know	If yes, find out how the injury occurred and discuss ways of preventing such injuries in the future. Discuss any constraints the person faced in reporting / being tested and the MOH policy.	

			Answer any questions on PEP.	
35B	If yes, did you report the incidents? If no needle stick, mark NA	1/Yes 2/No 3/NA		

OBSERVATION OF WASTE HANDLER AND LAUNDRY WORKERS

36	During each observation, did all waste handlers wear PPE according to the standard (while engaged in activities)? If not observed, explain why in comments.	1/Yes 2/No 3/Not observed 4/NA	PPE according to the standard: utility gloves, mask, and boots. If no, ask the reason for not wearing. Discuss the importance of PPE with waste handlers and IP committee, and how to get if not available.	
37	During each observation, did all laundry worker wear PPE according to the standard (while engaged in activities)?	1/Yes 2/No 3/Not observed 4/NA	PPE according to the standard: utility gloves, apron, boots. If no, ask the reason for not wearing. Discuss the importance of PPE with the workers and IP committee, and how to get if not available	

OBSERVATION OF FACILITY WASTE TREATMENT & DISPOSAL and WASH infrastructure

38A	Is an incinerator available?	1/Yes 2/No		
38B	If yes, is incinerator functional? If no incinerator is available, mark NA.	1/Yes 2/No 3/ NA	If maintenance is needed for the incinerator to function, discuss needs and next steps with facility head and IP committee.	
39	Is a waste disposal pit available? If waste disposal pit is full, mark NO and explain in comments section.	1/Yes 2/No	If no, discuss the importance with management and IP committee and discuss next steps.	
40	Is a placental pit available?	1/Yes 2/No	If no, discuss importance and	

	If placenta pit is full, mark No and explain in comments section		next steps (maintenance or construction).	
41	Is clean drinking water available for clients?	1/Yes 2/No		
42A	Is a latrine/toilet available for clients?	1/Yes 2/No		
42B	If latrine/ toilet is available, is it functional? If No latrine available, mark NA.	1/Yes 2/No 3/ NA	If not functional, discuss why and next steps with the management and IP committee.	
42C	If latrine/toilet is functional (yes to 42B), is it clean (no visible feces or urine)? If no functional latrine, mark NA.	1/Yes 2/No 3/ NA	If no, discuss importance of keeping latrine clean with IP committee.	
43A	If latrine/toilet is functional (yes to 42B), is there a handwashing facility available within 5 meters of the latrine? If no functional latrine, mark NA.	1/Yes 2/No 3/ NA	If no, discuss the necessity of a handwashing facility near latrine/toilet with the management and IP committee, and next steps for construction.	
43B	If handwashing facility is available within 5 meters of latrine (yes in 43 A, is it functional)? If no functional latrine, mark NA. If no handwashing, mark NA	1/Yes 2/No 3/ NA	If no, discuss why with the management and the IP committee and next steps for maintenance.	
43C	If functional handwashing facility is available (yes in 43 B), is soap/ash available at each facility? If no functional latrine available, mark NA. If no functional	1/Yes 2/No 3/ NA	If no, discuss importance of availability of soap/ash with the management and IP committee and next steps for its	

	handwashing facility, mark NA.		provision.	
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N.B: Make sure that any IPC commodities and supplies that are available in the facility store are being used, if there is a need.

3.3 Major Strengths and Weaknesses

Strengths

1. _____

2. _____

3. _____

4. _____

Observed gaps

1. _____

2. _____

3. _____

4. _____

5. _____

3.4 Additional comments and concerns for future revision

1. _____

2. _____

3. _____

4. _____

5. _____

Supervision Team:

1. Name _____ Position _____
Signature _____ Date _____

2. Name _____ Position _____
Signature _____ Date _____

3. Name _____ Position _____
Signature _____ Date _____

4. Name _____ Position _____
Signature _____ Date _____

For more information, please visit aidstar-one.com.

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