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MINISTRY OF HEALTH - ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

HEALTH EXTENSION PROGRAM OPTIMIZATION: COMPREHENSIVE HEALTH POST REFORM IMPLEMENTATION GUIDELINE

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CONTENTS

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ACRONYMS

AMC	Average monthly consumption
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
AYH	Adolescent and youth Health
BHP	Basic Health Posts
CASH	Clean and Safe Health Facilities
CDC	U.S. Centers for Disease Control
CHIS	Community health information system
CHP	Comprehensive Health Post
CSC	Community scorecard
CSS	Client Satisfaction Survey
DHIS2	District Health Information System
DM	Diabetes Mellitus
EHPRIG	Ethiopian Health Post Reform Implementation Guideline
EHSP	Essential Health Services Packages
FMOH	Federal Ministry of Health
HBV	Hepatitis B virus
HC	Health Center
HCAI	Health care acquired infection
HCP	Healthcare personnel
HCV	Hepatitis C virus
HCW	Healthcare waste
HCWM	Healthcare waste management
HEP	Health Extension Program
HEPA	High efficiency particulate air
HEPO	Health Extension Program Optimization
HIS	Health Information System
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
HP	Health Post
HPRIG	Health Post Reform Implementation Guideline
HR	Human Resources
HRM	Human Resources Management
ITN	Insecticide Treated Net
IMAI	Integrated Management of Adolescent and Adult Illness
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IPLS	Integrated Pharmaceutical and Logistic Supply
IUCD	Intrauterine contraceptive device
IP	Infection prevention
IP&PS	Infection Prevention and Patient Safety

IPC	Infection Prevention and Control
LQAS	Lot quality assurance sampling
M&E	Monitoring and Evaluation
MDT	Multidisciplinary team
MFI	Mater Family Index
MHP	Merged Health Posts
MOS	Months of stock
NCD	Non Communicable Diseases
NTD	Neglected Tropical Diseases
PEP	Post-exposure prophylaxis
PHC	Primary healthcare
PITC	Provider-initiated HIV testing and counseling
PMT	Performance Monitoring Team
PPE	Personal protective equipment
PRM	Performance review meeting
PVC	Polyvinyl chloride
STI	Sexually transmitted infection
TB	Tuberculosis
VEN	Vital, Essential and Necessary
VHL	Village-level Health Leaders
WDG/A	Women's Development Group/Army
WorHO	Woreda Health Office

FOREWORD

The recent roadmap, which is intended to guide the implementation of Health Extension Program Optimization (HEPO) for the coming 15 years, has identified key transformative strategic objectives to address the challenges identified by the HEP assessment. These objectives include the stratification of HPs into three categories, redefining the health service packages, changing the professional mix, rethinking community engagement strategies, using innovative methods to ensure sustained financing, and ensuring the resilience of the HEP and ability to maintain essential service delivery during public health emergencies.

The Health Post Reform Implementation Guideline (HPRIG) builds on the HEPO roadmap and HEPO Implementation Manual to set minimum management standards for the Health Posts (HP). The HPRIG focuses on selected management and PHC service functions, such as HP leadership, governance and resource management, HP essential service packages, pharmacy services, infrastructure, Infection Prevention and Control (IPC), Clean and Safe Health Facilities (CASH), community engagement, community health information, and monitoring and evaluation.

This guideline was primarily developed based on the requirements for the comprehensive HP. It is expected, however, that the HPRIG will be customized to meet the needs of basic HPs as needed. On the other hand, the guideline must be revised in a timely manner to accommodate emerging developments and concerns.

We hope this guideline provides an important resource for effectively managing HPs. Therefore, frontline health staff must properly make use of this guideline.

CONTEXT

In Ethiopia, the Health Extension Program (HEP) has been a flagship platform for the provision of primary healthcare (PHC) services to all, notably the rural communities with limited access to health care services. As a result, promising results have been achieved for the last 15 years in terms of ensuring access to basic primary health care services at the community level.

A recent HEP evaluation revealed, however, persistent health system challenges related to leadership and governance, human resources, HEP financing, logistics, community health information system (CHIS), and service delivery, all of which have contributed to the HEP's stagnation in recent years.

To overcome such challenges, the Federal Ministry of Health (FMOH) has developed a long-term envisioning roadmap to transform the HEP in the next 15 years (2020–2035). Several new initiatives are included in this roadmap, including restructuring service delivery modalities, advancing HR allocations and quality, upgrading and modernizing infrastructure, and expanding essential health service packages. In addition, the roadmap has recommended the revitalization of governance structures, HEP financing, and community engagement functions, as well as the establishment of proper management standards for the HPs as part of implementing HP reform.

These sets of standards will serve as tools to improve performance quality as well as create consistency or uniformity across the Health Posts in the country. Moreover, the implementation of management standards can help managers identify areas for improvement and the proper allocation of resources.

INTRODUCTION TO THE GUIDELINE

This guideline is organized into six chapters:

- Health Post Leadership, Governance, and Resource Management;
- Health Post Health Services;
- Pharmacy Services;
- Human Resources
- IPC and CASH;
- Community Engagement;
- Health Information System and Performance Monitoring.

Each chapter provides a minimum set of performance standards to be implemented at the HP level, with detailed guidance on how to implement those standards. For every chapter, there is an embedded checklist to track the application of the standards. This provides an opportunity for the HP to do self-assessment as part of retaining accountability.

Health Post leadership, governance, and resource management: Based on the HEP Optimization roadmap (2020–2035) recommendation, Health Posts (HPs) are classified in three categories: Comprehensive Health Posts (CHPs), Basic Health Posts (BHPs), and Merged Health Posts (MHPs). CHPs are required to provide more comprehensive health services to the community, with limited access to HCs and HPs. This type of HP should be led by a public health officer or Family Health Professional. Each HP is accountable to and governed by the HC. The kebele's administration can be part of the management body using a matrix management principle. Accordingly, the head of the CHP is responsible for coordinating technical, material, and resource support, while the inter-sectoral team of each kebele is responsible for the management of all essential community-, institution-, and household-level health services.

HP health services: HEP Services are packages of promotive, preventive, curative, and rehabilitative services that are categorized under four major headings (Family Health; Disease Prevention and Control; Hygiene and Environmental Health, and Health Education and Promotion). These packages cover a range of interventions to be provided at HPs, in households, in the community, at school, or through outreach and mobile posts based on the revised Ethiopian Essential Health Services Packages (EHSP).[2] The type and number of these services and interventions vary depending on the category of the HP (whether a comprehensive HP [CHP] or basic HP [BHP]), as outlined in the HEPO roadmap.[3] The CHP is designated to provide all basic HEP service packages and additional services like delivery services, PMTCT, and the treatment of common adolescent and adult illnesses, including emergency and referral services. In addition, the CHP can provide minimal pharmaceutical services

Human Resources Management: The most important asset of a HP is the people who work there. A well-performing health workforce is one that works in ways that are responsive, fair, and efficient to achieve the best health outcomes possible, given the available resources and circumstances. The main objective of the Human Resources Management (HRM) function is to ensure that the facility attracts, develops, retains, and motivates employees, who are critical to achieving the organization's objectives of delivering high-quality and safe patient care.

Infection Prevention and Control (IPC) and Clean and Safe Health Facilities (CASH): The potential for the transmission of infections in the health care setting is high. Both those receiving and providing care in an HP are at risk of acquiring and transmitting infections through exposure to blood, body fluids, or contaminated materials. Establishing an infection prevention and patient safety program with the aim of stopping the transmission of infectious agents is the only way to reduce the occurrence of Healthcare Acquired Infections (HCAIs).

Community engagement: Community engagement (CE) entails involving communities in planning, design, governing, delivering services, and making decisions, enabling them to increase their control over their lives. Empowering families and communities to produce their health outcomes has been the driving philosophy of the Ethiopian community health system, the HEP. This is achieved through engaging individuals, families, and communities. Therefore, to apply well-planned community engagement as part of a community and primary health care system across the country, a set of operational standards, monitoring checklists, and implementation guidelines have been prepared.

Health information system: The Health Information System (HIS) is where health data are recorded, stored, retrieved, and processed to improve decision-making. Ethiopia has introduced different health information system reform agendas to improve the use of quality data production for performance improvement and evidence-based practices at the HP level, such as the community health information system (CHIS), electronic CHIS, data-quality assurance, and information use culture.

Performance monitoring: Performance monitoring is a system that helps track and follows up on priority routine information about a program and its expected results. Performance monitoring in the implementation of HPRIG will provide information to the ongoing process that focuses on reinforcing high performance or improving substandard performance.

OBJECTIVES OF THE HEALTH POST REFORM IMPLEMENTATION GUIDELINE

The Health Post Reform Implementation Guideline (HPRIG) has the following objectives:

- Set minimum standards for HPs;
- Provide guidance on the implementation of complementary standards;
- Ensure accountability for the actors;
- Help health workers provide quality health services to their clients;
- Help program managers monitor the progress of HP reforms.

GUIDELINE DEVELOPMENT PROCESSES

The HPRIG has been developed in tandem with the revision of the Health Center Reform Implementation Guideline (HCRIG). Doing so helped the developers align the chapters and sub-topics of HPRIG with those of the HCRIG and thus avoid redundancies, discrepancies, and fragmentations. The design of the HPRIG was primarily embarked upon by the TWGs at the national level. In the process, however, key stakeholders were engaged: partners, Regional Health Bureaus (RHBs), Woreda/Town Health Offices (WorHOs/THOs), HCs, and HPs.

Health Post Reform CHAPTERS

Chapter 1

LEADERSHIP, GOVERNANCE, AND RESOURCE MANAGEMENT

OPERATIONAL STANDARDS

1. The head of the Health Post participates actively in the inter-sectoral Kebele steering committee/Cabinet
2. The Health Post has annual, quarterly, and monthly plans approved by the kebele council and supervising Health Center.
3. The performance of the Health Post is reviewed regularly.
4. The Health Post assesses the satisfaction of the community members quarterly.
5. The Health Post practices a standard financial management system at the HP level.
6. The Health Post has key job-aids to guide its daily activities.
7. The Health Post practices a standard asset management system and avails itself of the necessary furniture, including chairs, tables, shelves, push-pin boards, and tablets.

IMPLEMENTATION GUIDANCE

Inter-sectoral collaboration: The kebele, the smallest administrative structure, is led by a team of inter-sectoral bodies called the kebele cabinet. The main sectors available at the community level are: agriculture, education, youth association, women's association, and religious leaders. The kebele cabinets are mandated to provide guidance to health professionals and community members, mobilize resources, mobilize community structures, and promote institutional health. The kebele administration must participate actively in the planning in the planning process of the HP. This includes examining the HP's strengths, weaknesses, opportunities, and challenges. In addition, it is expected to approve the annual plans and report of the HP and ensure that the community's health priorities are part of the kebele plan.

THE MAJOR ROLE AND RESPONSIBILITIES OF THE KEBELE COUNCIL INCLUDE BUT ARE NOT LIMITED TO:

- Actively participating in and providing overall guidance to the annual plan's development process.
- Facilitating the implementation of social-accountability tools, a community scorecard, and the measurement and use of information generated from focus group discussions.
- Conducting community discussion forums that encourage households to seek basic health services and implement HEP packages at the household level.
- Organizing health bazaars and arrange open house event to improve health literature
- Mobilizing resources useful for, e.g., constructing health workers' residences, running maternity waiting homes, and constructing fences and latrines.
- Facilitating the availability of a model HEP packages corridor in, e.g., school health, water supply,

and hand washing facilities.

- Mobilizing communities to enroll in community-based health insurance (CBHI) schemes and encouraging their timely renewal.

Managing CHPs: HPs should be overseen by a PHCU management committee and have a coordinator/head who leads and directs its day-to-day operations; this person will be assigned by the PHCU director in consultation with the WorHO.

Some of the duties and responsibilities of the CHP Director are:

- Establishing strong relations and linkages with the HC;
- Liaising between the CHP and HC and community structures;
- Ensuring the application of CHP standards;
- Managing the human, financial, and other resources of the HP;
- Coordinating and providing directions to staff;
- Facilitating the annual plan's development activity;
- Preparing and submitting facility report on a weekly, monthly, and quarterly basis;
- Facilitating the linkage and work with the kebele steering committee/cabinet;
- Organizing monthly, quarterly, and annual review meetings and capacity-enhancement workshops;
- Arranging community–facility discussion forums.

Financial management: The current arrangement of HPs demands the provision of a user fee for non-exempted essential health services. In addition, HPs are expected to serve CBHI members as one point of services delivery for HC. Therefore, the HC should delegate financial management to the HP staff, who will support the HP.

The following major responsibilities should discharge by HP staff:

- Collecting service fee using official receipt and closely working with the supervising HC;
- Providing credit services for active CBHI members;
- Summarizing a detailed list of credit service beneficiaries with associated costs that should be submitted to HCs monthly;
- Facilitating and providing the necessary documents for auditing services.

Asset management: A fixed asset is "a tangible asset costing 1000 Ethiopian Birr or more that is in operational use and has a useful economic life of more than one year, such as furniture, computers, equipment, vehicles, buildings." Supplies include all other items owned by the government, such as stationery and cleaning supplies. The management of assets includes their procurement, inventory,

storage, maintenance, and disposal. The following asset-management activities should be executed at the HP level:

- Establishing a fixed-assets register and providing unique condes for each identified asset;
- Conducting an annual physical count and reconciling it with the register;
- Using goods-received and issuing memos (Models 19, 20, 21, and 22).

Client satisfaction: The HP may undertake a Client Satisfaction Survey (CSS) on a regular basis (at least every quarter) to rate the satisfaction/confidence of the users (i.e., community members) with the quality of the services being provided at the facility and community levels. This helps the governing bodies identify problems as early as possible and tackle them accordingly. A standard CSS tool can be used for this purpose by customizing from the HC.

VERIFICATION CHECKLIST

Table 1 can be used as a tool to record whether the HP has implemented the main operational standards outlined above.

Table 1: Leadership, governance, and resource-management standards implementation checklist

SN	Implementation standards	Verification criteria	Yes (√) / No (X)	Met = 1 / Not met = 0	Remarks
1	The head of the Comprehensive Health Post participates actively in the inter-sectoral kebele committee.	There is evidence that the position of head of the HP is officially assigned to a member of the kebele steering committee			Letter of assignment from kebele steering committee/ cabintet
		There is evidence of that the head of the HP attends regular kebele committee meetings and health issue discussed regularly			▪ Check whether it is documented in meeting minutes ▪ Check the health and /or multi-sectoral issues discussed in the last months
2	The Health Post has annual, quarterly, and monthly plans approved by the kebele steering committee and supervising Health Center	There are comprehensive annual, quarterly and monthly HP plans			Check the availability of the plan and its contents
		There is a separate multi-sectoral plan to which key sectors agreed			Check the availability of the plan and its content is comprehensive
3	The performance of the Comprehensive Health Post is reviewed regularly	There is an established management committee			Check the meeting minutes
		The management committee reviews the performance of the HP weekly			Check the meeting minutes
		The performance of the health sector has been presented and reviewed at the regular (at least quarterly) kebele steering committee/cabinet meeting			Check the meeting minutes

4	The Comprehensive Health Post assesses the satisfaction of the community members quarterly.	A developed checklist is available			Check the availability of the checklist
		A community satisfaction assessment report exists			Check the report
		There is a developed quality or performance improvement plan			Check the plan
5	The Health Post practices a standard financial management system at the Health Post level.	A list of essential health services, along with their costs, is posted for users using local languages			Check the information consisting of a list of services with time to complete each activity, cost, exemption, and advice to clients/ patients to collect receipts for all payments
		The Health Post uses legal receipts to collect all payments			Check the document
		There is in place an auditing system (at least annually)			Check the audit report
6	The Comprehensive Health Post has key job-aids/tools to guide its daily activities.	The following job-aids/tools are available: ▪ HEP optimization implementation manual ▪ HP standard ▪ Referral protocol & sheet ▪ Family health card ▪ HPRIG ▪ Community engagement guideline			Make inventory based on the pre-prepared checklist
7	The Health Post practices a standard asset-management system and uses the necessary furniture including chairs, tables, shelves, push-pin boards, and tablets.	Necessary furniture, including chairs, tables, shelves, push-pin boards, and tablets, are available			Observe the availability of the listed items
		A fixed-assets register with unique codes for each identified asset has been established			Check the annual report and memos (models)
		An annual physical count is conducted and reconciled with the register			
		Goods-received and issuing memos are used (Model 19, 20, 21 & 22)			

Chapter 2

HEALTH POST HEALTH SERVICES

OPERATIONAL STANDARDS

1. The HP provides health services at facility, household, community-outreach, schools, mobile posts and other work places
2. The HP provides routine services on weekdays regularly and emergency services twenty-four hours a day, seven days a week
3. The Health Post provides maternal health services and interventions
4. The Health Post provides Essential new-born care and child health services and interventions
5. The Health Post provides FP and AYH services and interventions
6. The Health Post provides nutrition services and interventions
7. The Health Post provides communicable disease prevention and control health services
8. The Health Post provides Non-communicable disease prevention and control health services and emergency and first aid
9. The Health Post provides NTDs prevention and control health services
10. The HP conducts community-based surveillance regularly
11. The Health Post has functional referral and emergency services
12. The Health Post provides comprehensive hygiene and environmental health service
13. The HP provides comprehensive health education for communities/clients using standard materials/ tools

IMPLEMENTATION GUIDANCE

HEP service delivery outlets: The Health Extension service packages are delivered through different service delivery outlets, such as households, in the community, at schools, and at HPs. Staff are expected to use several job-aids and tools while providing services at these outlets. The head of the HP should review the HEP implementation manual to rearrange services and interventions in accordance with the service delivery outlets.

Household-level services: Almost all kinds of service packages can be provided at the household level, notably family health services. This ensures access to essential health services and enhances individual and family health service-seeking behavior. Health promotion, disease prevention, and rehabilitative services are widely exercised at the household level based on the health needs of the family. Such interventions require committed and passionate health workers.

Community-level services: The HP staff are expected to facilitate the training of community health agents, organize community conferences and dialogues, and provide community-level services, such as immunization, family planning, growth monitoring, mass drug demonstrations, community-based disease surveillance, and campaign-based environmental health activities. The HEP is also provided at workplaces, schools, and religious institutions.

School services: As a great majority of young people spend a considerable amount of their time in school, this could be a good opportunity to create and cultivate healthy and productive generations by engaging and working with school communities (e.g., school clubs and school teachers). Therefore, HP staff should implement the school health packages as indicated in the HEP-optimization implementation manual.

Mobile service delivery mechanisms: In geographic areas where access to health facilities (HPs and HCs) is limited, notably in pastoralist settings/regions, a mobile service delivery modality will be institutionalized. The mobile team will comprise a health officer, nurse, midwife, Health Extension Worker, and local community health workers/volunteers.

Health Post-level services: In the current categorization of Health Posts, there are comprehensive and basic Health Posts (CHPs and BHPs). The types and number of health services entirely depend on the category of the HP and the availability of the required number and professional mix of the staff. The CHPs are meant to provide some outpatient clinical and emergency services, including FANC, delivery, and ENBC, in addition to the second-generation basic health services outlined in the HEPO implementation manual.

Core PHC packages: A core package of PHC includes promotive, preventive, curative, palliative, and rehabilitative services. The actual content of the services varies by place and over time, depending on the local situation. There remains, however, an essential set of services that should constitute the core of PHC. Box 1 defines the core PHC services relevant to all communities in Ethiopia.

Box 1: A proposed set of core primary healthcare services for communities in the Ethiopian context

Core Preventive Services

- Immunizations and micronutrient supplementation
- Focused Antenatal care (FANC)
- Detection of hypertension, DM, breast and cervical cancers, and cataracts in adults
- Screening for HIV, STIs, and tuberculosis
- Distribution of Insecticides Treated Net (ITN) in malaria-endemic areas and intermittent preventive treatment of malaria in pregnant women and children
- Promotion of good dental health

Core Promotive Services

- Promotion of good nutrition during pregnancy and postnatal periods (exclusive breastfeeding during the first six months of life, appropriate complementary feeding after six months of age, and so forth)
- Promotion of handwashing and access to clean water and sanitation facilities
- Promotion of healthy household behaviors for good maternal and child health (promotion of importance of birth spacing, household cleanliness, danger signs of pregnancy and in newborns, serious childhood illnesses for which care should be sought)
- Promotion of a healthy lifestyle (smoking cessation, weight reduction for those who are obese, and physical activity for those who are sedentary)

Core "Curative"[1] Services

- Diagnosis and treatment of common ailments and conditions (e.g., eye and skin infections, acute respiratory infection, and diarrhea) and pain management
- Management of serious childhood illness
- Management of serious mental illness
- Initial management of obstetrical complications (removal of retained placenta, management of preeclampsia, initial management of eclampsia, obstructed labor, postpartum hemorrhage, and puerperal sepsis)
- Provision of first-line family-planning services (oral birth control pills, condoms, injectable contraceptives, contraceptive implants, and intrauterine contraceptive devices [IUCDs])
- Recognition of and referral of life-threatening conditions to a higher-level facility
- Continued treatment and management of conditions of patients referred down from a higher-level facility for ongoing follow-up care

Core Rehabilitative Services

- Physical therapy for those recovering from injury
- Assistance to those with long-term disabilities (e.g., blindness, deafness, limb loss, mental retardation, and congenital deformities) and their families

[1]Not all conditions will be curable—such as HIV infection, hypertension, and some forms of mental illness.

Adapted from Achieving Health for All: Primary Health Care in Action. Johns Hopkins University Press, 2020.

Essential Health Extension service packages and interventions: Essential Health Extension service packages include four major packages and eighteen sub-packages based on the type of the HP with a total of about 305 interventions in BHP and more than 405 interventions in CHP. See Table 3.

Table 2: Essential Health Extension service packages

Major package	Sub-packages	No. of interventions[1]	Common SD outlet	Remarks
Family Health	· Maternal and newborn care, including FANC and delivery services · Child health · FP and AYH services · EPI · Nutrition	190	· HP · Household · Outreach · School	FANC, delivery, and ENBC services are not provided at BHPs
Disease Prevention and Control	· Prevention and control of malaria · Prevention and control of TB and leprosy · Prevention and control of HIV/AIDS and STIs · Prevention and control of NTDs · Prevention and control of Major NCDs · Mental health services · Emergency and first aid · Treatment of common adult and adolescent illnesses	50	· HP · Household · Outreach · School	Refill of medications for chronic communicable and non-communicable diseases, with adherence. Monitoring can be done at CHP only
		105	HP	These services are provided at CHP with the support of pharmacy and non-microscopic laboratory services
Hygiene and Environmental Health	· Healthy housing · Food and water sanitation · Institutional hygiene · Personal hygiene · Solid and liquid waste management and disposal	19	· Household · Community · School	Multi-sectoral and community engagement is vital to effectively providing such services. The involvement of private organizations is equally important
Health Education and Promotion	Health Education and Communication	52	· HP · Household · Community · School	

1 The number of interventions has been calculated based on Ethiopian Essential Health Services Packages, 2019: List of service interventions for the HP. Treatment of common adulthood and adolescent illnesses in CHPs is customized from HC clinical services, most of which require no microscopic laboratory diagnosis.

Health Post-Level Service Delivery Arrangements

Outpatient Service Layout

- Outpatient service consists of patient registration, and comprehensive health care, including curative, preventive, promotive, and rehabilitative services;
- Outpatient layout should be organized in a manner that reduces the length of time that it might take a patient to travel from one service area to another. Outpatient departments comprise the following service areas:
  - Waiting area;
  - Reception and recording area/desk;
  - Dedicated patient examination rooms for adult and under-5s;
  - Room for minor procedures (wound care & other);
  - Emergency room;
  - Storage place for sterile supplies;
  - Utility room for cleaning and storing used equipment;
  - Staff room (for minor office work).

Outpatient Service Activity

- The clinical service in Out Patient Department (OPD) shall have and use the Ethiopian Primary Health Care Clinical Guideline (EPHCG) for the management of communicable and non-communicable diseases for both adults and children above 5 years of age. The ICCM/IMNCI chart booklet will be applied in the management of common childhood illnesses.
- The patient examination chart shall be filled based on EPHCG requirements.
- Both the results of any investigations and treatment options should be explained and discussed with the patient and clearly documented on the patient card.
- If medication is required, the patient should be directed to the pharmacy dispensing unit to obtain the necessary drugs and appropriate counseling.
- Any minor procedures required (such as dressing changes or injections) should be carried out in the dressing/injection room of the outpatient department.
- If the patient needs to be referred to other health facility, s/he should be guided to the referral focal person for referral arrangement (see "Emergency and Referral Services" below).
- The emergency and delivery services should be provided at outpatient level and open 24 hours a day, 7 days a week
- The HP should provide minor surgical services for common surgical conditions with clear

protocols, including patient consent for minor surgical procedures to be done at the outpatient level: e.g., circumcisions, lipoma excisions, abscess drainages, suturing of soft tissue injuries, external immobilization of closed and open fractures, and other minor interventions.

- The HP should provide other RMNCH, EPI, and nutrition services as part of the outpatient services offered based on the RMNCH standards, guidelines, and protocols. (A package of such job aids and tools shall be provided to each HP.)
- Regular pharmacy service should remain open for working hours on weekdays, but all required emergency items should be available for those emergency and labor services provided after working hours.
- The HP–OPD should be led by a health officer/family health professional. Outpatient services can be provided by a team of professionals (health officer/family health professional, midwife, nurse/level 4 HEW, and pharmacy technician).
- Each service room should be equipped with equipment and supplies needed to provide care. (See HEPO Implementation Manual and CHP standard for the list of suggested items.)
- Waiting area of the HP should be located closest to the reception and should incorporate:
  - Sitting area for the patients and those accompanying them;
  - Sanitation facilities;
  - Natural or mechanical ventilator;
  - Natural or artificial light sources;
  - Audio-visual corner with TV for educating patients and their family members.

Referral and Emergency Services

Referral service: Referral is a two-way process and ensures that a continuum of care is maintained for patients or clients. Referral is done from the community to the primary care health service, to hospitals, within hospitals, and vice versa. The referral process begins with the referring health professional communicating with the receiving health professional, who then shares with the referring health professional information and a plan for a continuum of care, thereby completing the referral process.

The essential elements of a referral system are:

- Designated referral focal persons at each HP;
- A directory of services and organizations within a defined territory;
- A standardized referral format;
- A feedback loop to track referral;
- Documentation of the referral.

Reasons for referral: The criteria for referral should be medical, objective, and in the best interest of the patient or client. The following are considered good reasons for referral:

- A patient needs advanced care, as determined by the attending health professional;
- Technical examination is required that is not available at the HP;
- Intervention is required that is beyond the capabilities of the facility;
- A patient requires inpatient care that cannot be given at the referring facility.

Management of Referrals

Roles and responsibilities of the referring health professional and referring facility:

- Assign to the referral coordinator clear roles and responsibilities;
- Know what, whom, when, and where to refer;
- Fill out the referral form with all the necessary information and attach the relevant documents;
- Explain to the patient the rationale, reasons for choice of doctor or facility, preparation, expected cost, and possible outcome of referral;
- Be available to answer queries from the referral coordinator or receiving facility about the referral if necessary;
- Ensure the availability of a continuous supply of standardized referral forms;
- Keep a directory of health services and facilities in the defined geographic area;
- Ensure the proper recording of all referral activities;
- Facilitate ambulance/transportation in emergency conditions.

Roles and responsibilities of the referral coordinator:

- Refer out and receive referrals;
- Facilitate scheduling based on the level of priority for consultation: i.e., emergency, urgent, or routine cases;
- Use the following communication methods: letter, telephone, email, photocopied report, personal contacts;
- Ensure the availability of service or professionals at the receiving health facility before referral;
- Facilitate transportation for emergency cases.

Roles and responsibilities of receiving health professional and receiving facility:

- Respond promptly to consultation requests;
- Report in detail all pertinent findings and recommendations to the referring health worker and outline opinion to the patient (feedback with all required information and recommendation);
- Communicate with the patient or family;
- Refrain from, by word or deed, undermining the role of the referring health worker;
- Assign to the referral coordinator clear roles and responsibilities;
- Ensure that staff at points of entry clearly understand the referral process;
- Provide continuing education about the referral process to staff and the community;
- Ensure that referred patients are seen by appropriate professionals;
- Ensure that all prescheduled referrals are attended to without undue delay.

Basic emergency service: The emergency unit may be situated in HP–OPD rooms. A duty professional in the OPD will be responsible for the organization and function of the emergency service. The emergency unit shall serve as the basic care area/facility and equipped and staffed to provide rapid and varied emergency care to all people with life-threatening conditions based on the basic emergency protocol.

Health professionals in the emergency room will receive, support, and direct patients arriving for emergency care and ensure the proper handover of patients. The health professional(s) assigned to the emergency room should be trained in patient moving and handling, basic life support, communication skills, and infection prevention and control procedures. There should be patient-support devices in the emergency patient reception area, including wheelchairs and stretchers.

VERIFICATION CHECKLIST

Table 3: HEP service operational standards and verification checklist

SN	Implementation standards	Verification criteria	Yes (√) No (x)	Met = 1 Not Met = 0	Remark
1	The HP provides health services at facility, household, community-outreach, schools, mobile posts and other work places	Services are provided at facility (HP) level without any Services are provided at facility (HP) level without any interruption			Check the availability of the schedule and activity report
		Services are provided at Household and community-outreach			Check the weekly records of assigned professionals
		Services are provided at schools			Check the availability of the schedule and activity report
		Customized service delevery approaches are employed (mobile clinic, outreach..) for mobile pastoralist communities			Check the availability of the schedule and activity report
2	The HP provides routine services on weekdays regularly and emergency services twenty-four hours a day, seven days a week	The HP should provide routine services on all weekdays regularly			1) Observe activity schedules and daily service records 2) Randomly interview clients or surrounding communities weather the HPs are open all the weekdays and working hours
		The HP provides emergency services twenty-four hours a day, seven days a week			
3	The Health Post provides maternal health services and interventions Note: Please refer the HP optimization implementation manual for the details for each interventions	ANC supported by essential lab tests (if the lab service is available)			Check Registration books, Family folders, forms, tally sheets and referral records and other relevant documents
		Post natal care (facility and home based)			
		Delivery services			
		Perinatal and maternal death surveillance and response, Identification of Fistula, utirine prolapse and cervical cancer identification and referal service			

4	The Health Post provides Essential new-born care and child health services and interventions	Essential new-born care			Check Registration books, Family folders, forms, tally sheets and referral records and other relevant documents
		Child health iCMNCI/CBNC)			
		EPI (all atigene)			
5	The Health Post provides FP and AYH services and interventions	All FP methods except permanent			Check Registration books, Family folders, forms, tally sheets and referral records and other relevant documents
		AYH services (Adolescent sexual and reproductive health including adolescent friendly FP, Prevention of teen age pregnancy, Comprehensive health education about GBV..)			
		Comprehensive abortion care, referral and post-abortion follow-up			
6	The Health Post provides nutrition services and interventions	Nutrition promotion-growth monitoring, beast feeding and screening (maternal and childeren nutrition problems)			Check Registration books, Family folders, forms, tally sheets and referral records and other relevant documents
		Management of MAM and SAM			
		Suplementation and de-warming			
7	The Health Post provides communicable disease prevention and control health services Note: Please refer the HP optimization implementation manual for the details for each interventions	Prevention and control of Malaria-promotion, prevention and treatment			Check Registration books, Family folders, forms, tally sheets and referral records and other relevant documents
		Prevention and control of TB and leprosy (DOTs, referal, health promotion)			
		Prevention and control of HIV/AIDS and STIs- health promotion, prevention, counseling, testing and ART refilling			

8	The Health Post provides Non-communicable disease prevention and control health services and emergency and first aid Note: Please refer the HP optimization implementation manual for the details for each interventions	Health promotion and prevention HPTN including screening, referal and refilling of medications			Check Registration books, Family folders, forms, tally sheets and referral records and other relevant documents
		Health promotion and prevention of Diabetus including screening and referal, monitoring and refilling of medications			
		Health promotion, screening and referal services of cancers including clinical examination of breast cancer			
		Screening, referal, health promotion and control of mental illness and neurological substance use disorders [MNSD] including emergency management of poisining			
		Emergency and first aid			
9	The Health Post provides NTDs prevention and control health services	Health promotion and prevention (SBCC) on common NTDs			Check Registration books, Family folders, forms, tally sheets and referral records and other relevant documents
		Mass drug administration			
10	The HP conducts Community-based surveillance reguraly	Community surveillance is conducted by actively using community level structures			Check reports
		Disease under surveillance notified/reported regularly			
11	The Health Post has functional referral and emergency services	Check availability of a directory of services and organizations within a defined territory;			▪ Check if a feedback loop in placed to track referral; ▪Check documentation of all referrals.
		Check availability of a standardized referral format			

12	The Health Post provides comprehensive hygiene and environmental health service	Promotion of Food and water sanitation			Check registration books, Family Folders, reports and other relevant documents
		Promotion of Healthy housing			
		Promotion of Institutional hygiene			
		Promotion of Personal hygiene			
		Promotion of Solid and liquid waste management and disposal			
13	The HP provides comprehensive health education for communities/clients using standard materials/ tools	Check materials availability and application for health education materials/tools such as FHG and other digital tools			Check registration books, Family Folders, reports and other relevant documents

Chapter Three

PHARMACY SERVICES

OPERATIONAL STANDARDS

1. The HP has a separate dispensary and medical store directed by a Health Post coordinator.
2. The HP has a health-facility-specific list of medicines and medical equipment as outlined in the HEPO Implementation Manual and classified by Vital, Essential and Necessary (VEN). The list is reviewed and updated annually.
3. The HP has a supply- and inventory-management system for drugs, medical supplies, and equipment as approved by their respective Health Center pharmacy departments.
4. The HP conducts a physical inventory of all drugs, medical supplies, and consumable equipment in the store and/or dispensing unit at least yearly.
5. The HP ensures the proper and safe disposal of pharmaceutical wastes and expired drugs in consultation with Health Center's pharmacy department.
6. The HP has and uses stock-management tools: at least a bin card, Facility Combined–Reporting and Requisition Form, Stock Status Analysis Chart, and Store Inventory Form

IMPLEMENTATION GUIDANCE

Organization and Management of Pharmaceutical Services

Pharmacy Organization: Pharmacy services in CHPs should have a separate unit for storage with standard shelf in the unit. Pharmacy service should be provided by a pharmacy professional.

Dispensing and Medication Use Counseling Services: The dispensing of prescription drugs involves both the interpretation of the prescriber's instructions and the technical knowledge required to carry out these instructions accurately and safely to the patient.

Emergency Pharmacy Service: It is required in CHPs that emergency services be provided 24 hours a day. So, the CHP`s OPD with emergency dispensary should be on standby 24 hours a day, 7 days a week.

Comprehensive Health Post: Specific Drugs List: The CHP should have a drug list that contains all drugs, medical supplies, medical instruments, and test kits that can be used in the facility. The list should be reviewed and updated at least annually based on the DTC requirements and schedule. The focal person at the CHP, in consultation with pharmacy department of the HC, should prepare the draft of CHP drug list based on the proposed drug list in the *HEP Optimization Implementation Manual Disease Pattern*'s Essential Health Service package.

Supply Management: Effective drug supply management ensures the uninterrupted availability of quality, registered, safe, and effective pharmaceuticals. Drug supply management involves six basic functions: selection, quantification, procurement, storage, distribution, and use.

Selection: All CHPs should have a facility drug list that lists all drugs, medical supplies, and consumable equipment that can be used in the CHP.

Quantification: After each product is selected, the quantity required by the CHP for a given period of time should be determined (Box 2).

Box 2: Quantification steps using the consumption method

Step 1: Prepare the list of pharmaceuticals to be quantified.
Step 2: Determine the period to be reviewed for consumption.
Step 3: Enter the consumption data for each pharmaceutical.
Step 4: Calculate the average monthly consumption.
Step 5: Calculate the quantity of each drug required.
Step 6: Adjust for expected changes in consumption patterns.
Step 7: Adjust for safety stock requirements and estimated losses.
Step 8: Perform stock analysis.
Step 9: Adjust for safety stock requirements, estimated losses, and expiration.
Step 10: Estimate the costs for each pharmaceutical and total costs.
Step 11: Compare the total costs with the budget and make adjustments.

Procuring and Receiving Pharmaceuticals: The supervising HC should be responsible for the purchase of all required pharmaceutical products for the HC, including the CHP. At the end of each month, the pharmacist in the CHP should bring the Facility Combined Report and Requisition Form (FC-RRF) (Appendix E) to the HC for re-supply. Using the information contained in the report and the *"Completed by Health Post"* part of the form, the HC staff (pharmacist) should determine the re-supply quantities and issue pharmaceuticals to the CHP. All pharmaceuticals and supplies will be re-supplied to the Maximum Stock Level (two months of stock) each month.

The following activities should be conducted when receiving medicines:

- Check that the quantity issued corresponds to the quantity indicated on the issue voucher (Model 22).
- Check that all original boxes, tins, or bottles are unopened and in good condition.
- Check the labels and ensure that there are no expired drugs. Any drugs that have already expired or are not in good condition should not be received.
- Sign copies of the issue voucher if the above procedures have been completed.
- Take one copy of the signed issue voucher (Model 22).
- Put all drugs in suitable and appropriately labeled containers to maintain their potency and quality and avoid damage to the medicines and their packages during transportation.
- Transfer the medicines received to the dedicated storage location at the HP as soon as you arrive at the facility.
- Record the new stock on the respective bin cards and appropriate forms.
- Properly arrange the medicines in the storage area. Place drugs with shorter expiration dates at the front of the shelf so that they can be reached and used first.

Storage: Storage is the safekeeping of pharmaceuticals to protect their shelf life and avoid damage (by sunlight, flammable chemicals, polluting chemicals and dust, oxygen, moisture, extreme temperatures, or physical pressures like sharps, insects, and rodents), expiry, and theft (see Table 5).

The pharmacist services as the focal person responsible for the overall management of pharmaceuticals in the CHP.

Table 4: Guidelines for the storage of pharmaceuticals

	Activities	Justification
1.	Store pharmaceuticals in a dry, well lit, well ventilated storeroom—away from direct sunlight. Temperatures in the storeroom should not exceed 25°C.	Extreme heat and exposure to direct sunlight can degrade pharmaceuticals and dramatically shorten their shelf life. Direct sunlight raises the temperature of the product and can reduce its shelf life or may damage the product by other mechanisms.
2.	Clean and disinfect the storeroom regularly. Keep food and drink out of the storeroom.	Pests are less attracted to the storeroom if it is regularly cleaned and disinfected. The outside of the store should also be kept clean, and any garbage should be stored in covered containers. Water should not be allowed to stagnate near the building. Wood should be varnished or painted to discourage pests. If possible, a regular schedule for extermination will also help eliminate pests.
3.	Protect the storeroom from water and moisture.	Moisture can destroy both supplies and their packaging. If the packaging is damaged, the product is still unacceptable to the patient even when the pharmaceutical is not damaged.
4.	Keep fire safety equipment available, accessible, and functional and train employees to use it.	Stopping a fire before it spreads can save expensive supplies and the storage facility. The right equipment should be available; water can put out paper fires but is ineffective on electrical and chemical fires. Place well maintained fire extinguishers in suitable positions in the storeroom. If a fire extinguisher is not available, keep sand or soil in a bucket nearby.
5.	Store latex products away from electric motors and fluorescent lights.	Latex products can be damaged if they are directly exposed to fluorescent lights and electric motors, which create ozone, a chemical that can rapidly deteriorate latex products. Keep latex products in paper boxes and cartons.
6.	Maintain cold storage, including a cold chain, as required.	Cold storage (2–8°C or 36–46°F) is essential for maintaining the shelf life of certain pharmaceuticals, including vaccines. These items are irrevocably damaged if the cold chain is broken. If electricity is unreliable, the use of cylindered gas or kerosene-powered refrigeration is recommended. Many drugs require storage below 25°C. There may also be products that should be stored at a temperature below 0°C; hence, the required storage conditions should be maintained for these products.

	Activities	Justification
7.	Limit storage area access to authorized personnel. Drugs that need an access-controlled environment, such as narcotics or psychotropics, should be stored under lock and key separate from the rest of stock, preferably in a locked wire cage within the storage facility or a lockable cabinet.	To prevent theft and pilferage, lock the storeroom and/or limit access to personnel other than authorized staff and track the movement of pharmaceuticals.
8.	Stack cartons at least 10 cm off the floor, 30 cm away from the wall and other stacks, and no more than 2.5 m high for heavy cartons.	Pallets keep the products off the floor so that they are less susceptible to damage from pests, water, and dirt. Stack pallets 30 cm away from the walls and each other to promote air circulation and to ease movement of stock, cleaning, and inspection. Do not stack cartons more than 2.5 m high, as the weight of the products may crush the cartons at the bottom. This will reduce potential injury to warehouse personnel. If cartons are particularly heavy, stack cartons less than 2.5 m. Where feasible, strong, well organized shelving is preferred.
9.	Store medical supplies away from insecticides, chemicals, old files, office supplies, and other materials.	Exposure to insecticides and other chemicals may shorten the shelf life of pharmaceuticals. Old files and office supplies may get in the way and reduce space for medical supplies or make them less accessible. “De-junking” the storeroom regularly makes more space for storage.
10.	Store flammable products separately from other products. Take appropriate safety precautions. Storage areas and cabinets should be clearly marked to indicate that they contain highly flammable liquids and should display the international hazard symbol. Corrosive or oxidant products, laboratory chemicals, and reagents should be stored away from flammables, ideally in a separate steel cabinet to prevent leakage.	Some medical procedures use flammable products, such as alcohol, cylindered gas, or mineral spirits. Such products should be stored in the coolest possible place, away from electrical appliances and other products, and near a fire extinguisher.
11.	Store pharmaceuticals to facilitate FEFO procedures and stock management.	FEFO (First Expiry, First Out) is a method of managing drugs in a storage facility where the drugs are managed by their expiry date. Drugs that will expire first are issued first, regardless of when they were received at the health facility.

	Activities	Justification
12.	Store drugs in their original shipping cartons. Arrange cartons with arrows pointing up and with identification labels, expiry dates, and manufacturing dates clearly visible.	Drugs should not be opened to repackage them. Store supplies in their original shipping cartons. Items should be stored according to manufacturer's instructions on the cartons; this includes paying attention to the direction of the arrows. Identification labels make it easier to follow FEFO and select the right product.
13.	Separate unusable pharmaceuticals from usable pharmaceuticals and dispose of damaged or expired products without delay.	Do not dispense expired drugs to the patients. Designate a separate part of the storeroom for damaged and expired goods.

Orderly Arrangement of Essential Medicines

Medical stores must have a system for classifying or organizing medicines and must ensure that all employees know the system being used. Some common systems for arranging medicines include:

Alphabetical order by generic name: Often seen in both large and small facilities. When using this system, the labeling must be changed when the Essential Medicines List is revised or updated.

Therapeutic or pharmacologic category: Most useful in small storerooms or dispensaries where the storekeeper is very knowledgeable about pharmacology.

Dosage form: Medicines come in different forms, such as tablets, syrups, injectables, and external-use products, such as ointments and creams. In this system, medicines are categorized according to their dosage form. Within the area for each form, a fixed, fluid, or semi-fluid system is used to store items. Any of the other methods of categorizing can be used to organize the items more precisely.

Frequency of use: Frequently used products that move quickly or often through the store should be placed in the front of the room or closest to the staging area. This system should be used in combination with another system.

Inventory-Control System

The purpose of an inventory-control system is to maintain appropriate stock levels to meet the needs of patients. A well-designed inventory control system tells personnel when and how much of a pharmaceutical to order and helps reduce shortages, oversupply, and expiry of drugs and medical supplies.

Maximum/Minimum Inventory Control System

The **maximum months of stock** is the largest amount of each pharmaceutical a facility should hold at any one time; the minimum **months of stock** is the level of stock at which actions to replenish inventory should occur under normal conditions.

The **emergency order point** is the level where the risk of stocking out is likely, and an emergency order should be placed immediately. If the stock on hand for any product at a facility falls below a set emergency-order point before the end of the reporting period, an emergency order should be placed.

Using a Maximum/Minimum (Max/Min) inventory-control system will help the CHP prevent both over-stocking (which leads to wasted pharmaceutical products) and shortages or stockouts of the products. A Max/Min system ensures that the amount of stock on hand is always between established maximum and minimum levels. In this system, each organizational level of the program is assigned a maximum and minimum level for its supplies.

Maximum and minimum levels are expressed as a number of months of supply. For example, according to IPLS, a CHP is required to keep a minimum of one month and a maximum of two months' worth of supplies on hand of all products; a HC will have a minimum of two months and maximum of four (see Table 6).

To determine the maximum and minimum quantities for each product, multiply the level by that product's Average Monthly Consumption (AMC), which is equivalent to one month's supply. It is usually the monthly average of the quantity of that product that has been dispensed to users during the past three months. (Information on the quantities dispensed is taken from the Bin card or summary reports of dispensed-to-user data.)

AMC = Quantity dispensed in 3 months ÷ 3

+	Amount dispensed 3 months ago	
	Amount dispensed 2 months ago	
	Amount dispensed last month	
=	Total dispensed during the past 3 months	÷ 3 = AMC (3-Month Average)

Table 5: Max/Min stock level

Level	Review Period	Maximum Months of Stock	Minimum Months of Stock	Emergency Order Point
Health Centers and Hospitals	Every other month	4 months	2 months	0.5 months (= 2 weeks)
Health Posts	Monthly	2 months	1 months	0.25 months (= 1 week)

For most essential pharmaceuticals, the CHP should adopt the national system for pharmaceutical inventory management and transaction systems (e.g., forms, recording, reporting, ordering, inventory control procedures, delivery schedules) in consultation with the nearby HC.

Records and Reports Used in Managing Pharmaceuticals

Recording: Recording is one of the major logistics activities of CHP staff. Recording in the CHP should be done carefully daily and updated regularly because logistics information in the CHP is solely dependent on the data obtained from bin cards.

***Bin card*:** Each pharmaceutical product on the shelf should have a Bin Card. This card provides essential information on the quantities of stock on hand of that product, any losses or adjustments to the inventory, and lead time. It is sometimes called an Inventory Control Card or, when kept with

the supplies, a Bin Card. The Bin Card is used at all health facilities (CHPs, HCs, and hospitals). The Stock Record Card is also used for recording purpose—but only at HCs and hospitals. (See Appendixes B and C for a sample Bin Card and Stock Card, respectively.)

The purpose of the Bin Card is to provide an up-to-date record of all transactions (the quantities of that product that have been received and issued or otherwise disposed of) and the amount currently in stock.

Use the Bin Card in the following situations:

- *Every time stock is added to the shelf or removed from the shelf*: enter the date and amount on the Bin Card and calculate the new balance on hand.
- *Whenever a physical inventory is conducted:* write the quantity found during the inventory on the Bin Card. Any difference between the physical count and the calculated balance should be noted in the Loss/Adjustment column and explained in the Remarks column.
- *Whenever supplies are lost* (such as due to damage or expiration) or there are any other adjustments to the stock quantity, such as samples taken to test the quality.

Reporting and Ordering

Reporting by Comprehensive Health Posts: CHPs should complete one part of the Health Post Monthly FC-RRF every month and submit it to the HC, which uses the information found on the FC-RRF to complete the form and calculate the quantity of pharmaceuticals needed by the CHP. Each month, the HC will issue enough stock to bring the CHP up to its maximum stock level of 2 months' stock for each product.

Assessing **s**upply **s**tatus**:** To ensure supplies are adequate, do the following calculation for each of your CHP pharmaceutical supplies**:**

Stock on Hand ÷ AMC = months of supply on hand

This calculation shows how long the current supply will last if consumption stays at the current rate. If the months of supply on hand are less than the time remaining before your next delivery of supplies, then the Health Officer may need to arrange for an emergency delivery.

The following is an example of months of supply on hand for four contraceptive products (see also Stock Status Analysis Chart (Appendix D) for more information).

Table 6: Months of supply of various family-planning methods

Product	Stock on Hand	÷ AMC	Months of Supply
Lo-Femenal® Combined Orals	470 cycles	180	2.6
Ovrette® Progestin- Only Orals	320 cycles	45	7.1
Blue & Gold Condoms	1200 condoms	420	2.9
Depo-Provera	520 vials	92	5.7

Conducting a Physical Count: A physical count (also called a *Physical Inventory*) is an actual count of the quantity of each supply at any given time. It is one of the most frequent pharmaceutical-management activities in health facilities.

A physical count of the products is done to verify that the stock balance found on the *Bin Card* shows the correct number of usable pharmaceuticals available on the shelf. If the quantity on the *Bin Card* does not match the quantity on the shelf, the *Bin Card* should be updated and an adjustment entered.

Physical counts should be performed at least every quarter at the CHP level and at least twice a year at the HC/hospital level. It can be done any time if there is any suspicion that products have been lost.

Prior to a Physical Count, the following tasks should be completed:

- Set a date for the physical count.
- Do not issue pharmaceuticals during the physical count or count receipts on the day of the physical count,
- Make sure that the *Bin Cards* health supplies are updated to the day of the physical count. If the *Bin Cards are* not completed, complete them.
- Prepare the store, ensuring that all items are neatly stacked and partial cartons are clearly visible.
- Reorganize products by FEFO before counting. Mark expiry dates clearly, with large, dark numbers on each Item or carton. This step should have been taken during routine receipt and management of supplies.
- Visually inspect pharmaceuticals as you organize them for counting.
- Separate any expired or damaged supplies.
- Be sure to have the *Bin Cards* for the pharmaceuticals to be counted.
- Make sure you have completed the Store Inventory Form (SIF). (See Appendix F for a sample SIF).

Pharmaceutical Waste Management

The FMHACA Pharmaceutical Waste Disposal Guideline should be taken into account for every activity in relation to pharmaceutical waste management in CHP.

Pharmaceuticals eligible for disposal include the following:

- All expired/damaged pharmaceuticals;
- All syrups or eye drops (expired or unexpired) found unsealed when received from supplier or in the store;

- All cold chain products not stored per appropriate storage guidelines or manufacturers' recommendations (e.g., insulin, hormones, gamma globulins, and vaccines);
- All bulk or loose tablets and capsules with containers that are unsealed, improperly labeled, or in a broken blister pack.;
- All unsealed or damaged tubes of creams, ointments, lotions, and related products;
- Any counterfeit pharmaceuticals.

Each CHP should establish a pharmaceutical waste-disposal committee comprising representatives from the HC's pharmacy, finance/audit, and sanitation services departments to ensure the proper disposal of pharmaceutical wastes in accordance with the FMHACA directives.

N.B. Each CHP should adopt the HC`s SOP for the management of pharmaceutical waste. Disposal of pharmaceutical wastes should be supported by proper documentation, including the price of the products for audit and other legal requirements and may require the presence of a representative of concerned regulatory body at the place and time of disposal.

Disposal of pharmaceutical wastes: The basic steps to be adhered to for the disposal of pharmaceutical wastes are:

- **Step 1:** Pharmaceuticals that are expired/damaged or unfit for use should be counted, recorded, and placed separately from the other pharmaceuticals in the HC.
- **Step 2:** The list of pharmaceuticals expired or unfit for use should be submitted to the responsible body for disposal and should be reported to the regulatory body.
- **Step 3:** The pharmaceuticals should be sorted based on the pharmaceutical dosage form and chosen disposal method.
- **Step 4:** The pharmaceuticals should be disposed of via the appropriate method and in the presence of delegates from the responsible body.
- **Step 5:** A signed and stamped certificate of disposal should be issued by the authorized body entitled to oversee the proper disposal of the pharmaceuticals.
- **Step 6:** Adjustments for each disposed pharmaceutical waste should be made in the available inventory management system.

VERIFICATION CHECKLIST

Table 7: Pharmacy standards and verification checklist

SN	Implementation standards	Verification criteria	Yes (√) No (x)	Met = 1 Not Met = 0	Remarks
1	The HP has a separate dispensary and medical store directed by an HP coordinator	The HP has a separate medical store and a dispensary corner.			
		The Health Post employs a pharmacy professional.			
2	The Health Post has a health-facility-specific list of medicines and medical equipment as outlined in the HEPO Implementation Manual and classified by VEN. The list is reviewed and updated annually.	The HP has a facility-specific drug list as outlined in HEPO Implementation Manual.			
		The list is updated annually.			
3	The Health Post has a supply- and inventory-management system for drugs, medical supplies, and equipment, as approved by their respective Health Center pharmacy departments.	The HP uses stock status analysis to avoid drug expiry (<2%), overstock, and stockouts.			
		The HP has updated bin card/ stock cards.			check
		All the HP's essential drugs are available at any time.			
4	The Health Post conducts a physical inventory of all drugs, medical supplies, and consumable equipment in the store and/or dispensing unit at least yearly.	The HP conducts a physical inventory at least twice a year.			
		The HP uses the report of the physical count of drugs for financial reconciliation/auditing and decisions.			
5	The HP ensures the proper and safe disposal of pharmaceutical wastes and expired drugs in consultation with the Health Center's pharmacy department.	The HP disposes expired and unusable drugs in accordance to guideline under the guidance of HC pharmacy Department.			
6	The HP has and uses stock-management tools:: at least a bin card, Facility Combined–Reporting and Requisition Form (FC-RRF), Stock Status Analysis Chart (SSAC), and Store Inventory Form (SIF).	The Comprehensive Health Post has available and uses: o Bin Cards o FC-RRF o SSAC o SIF.			

In addition, the following indicators may be monitored on a regular basis to assess the effectiveness/ outcomes of implementation of the recommendations provided in this chapter.

Table 8: Pharmacy service indicators

S/N	Indicators	Formula	Frequency	Comments
	Percentage availability of national tracer drugs at HP	$\frac{\sum \text{tracer drugs } x \sum \text{months available}}{\sum \text{tracer drugs } x \sum \text{total number of months in time period}} x100$	Quarterly	HMIS
	Average stockout duration for national tracer drugs at HP	∑ of stock out days of tracer drugs throughout reporting period/total number of tracer drugs	Quarterly	HMIS
	a) % of expired and damaged drug in value (%ED)	(% ED) = (monetary value of total expired drugs) ÷ (monetary value of total drugs available in that physical year) * 100 Note: it should be less than 2%	Quarterly	

Chapter Four

HUMAN RESOURCES MANAGEMENT

OPERATIONAL STANDARDS FOR HUMAN RESOURCES MANAGEMENT

1. The Health Post properly maintains personnel file for every employee
2. The Health Post has a Human Resources Development plan that addresses staff numbers, skills mix, and staff training and development
3. The Health Post has all the required workforces as per the standard
4. The Health Post has a performance management process in which all employees are formally evaluated at least twice a year.
5. The Health Post has an employee policy and procedure related to Human Resources Management and code of conduct that is known, and adhered to, by all staff.
6. The Health Post has an occupational health and safety guideline to identify and address health and safety risks to staff.

IMPLEMENTATION GUIDANCE

Human Resource Development Plan: Human resource development planning enables the CHP to forecast its human-resources needs, acquire human resources in the right number and type or skill mix, and develop and take best advantage of the available resources. The HP should have a short- and long-term HRD plan based on the HEPO Roadmap and HP standard, which can be form the foundation for the recruitment, training, and promotion of staff. The HP's HRD plan should be submitted to the respective HC and WorHO concerned officials when requesting new recruitment or making transfers. The HRD plan should be made by critically considering the available resources versus the services provided in the HP based on the standards of HR mix/type and number as clearly outlined in the HEPO roadmap. The HRD and budget plan should be approved by the HP/HC management committee/governing body and updated annually.

Human Resource Development Plan: Human resource development planning enables the CHP to forecast its human-resources needs, acquire human resources in the right number and type or skill mix, and develop and take best advantage of the available resources. Therefore, the focal person should have a short- and long-term HRD plan based on the HEPO Roadmap and HP standard, which can be form the foundation for the recruitment, training, and promotion of staff. The HP's HRD plan should be submitted to the respective HC and WorHO concerned officials when requesting new recruitment or making transfers. The HRD plan should be made by critically considering the available resources versus the services provided in the HP based on the standards of HR mix/type and number as clearly outlined in the HEPO roadmap. The HRD and budget plan should be approved by the HP/HC management committee/governing body and updated annually.

Human Resource Management Policies, Procedures, and Code of Conduct: HPs should ensure the availability of all civil service proclamations and procedures of the country or region, with explanations and briefing on employee activities and employee/employer relationships, including work schedules, hiring and placement procedures, employee behavior and code of conduct, remuneration, benefits, performance-evaluation procedures, disciplinary and grievance procedures, education and training, recognition/award schemes, and termination of employment. Once these legal frameworks are

available in the HPs the HRM focal person and management committee are responsible for ensuring that employees' activities and employee/employer relations are managed according to the established procedures. The proclamation/procedures should be communicated to all employees to acquit them with their rights and obligations when working in governmental organizations.

Dress Code and Identification: The HP should ensure guidelines that clearly and strictly define dress codes for all employees. Such guidelines should explicitly list each article of clothing, its color, and the acceptable condition for it in HP settings. The HP should have a color-coded system that clearly and easily allows patients/users to distinguish between staff. The HP should also have a ***protocol*** to ensure that all staff wear their identification badges at all times in pre-defined workplaces.

Employee Job Description: Job descriptions are short statements that include information about an employee's assigned duties or responsibilities and obligations. A job description also defines the type of employee desired for the position and what is expected from them. The job description should be detailed with the overall position's objectives and explained to all new employees when they commence employment; they should sign the job description to indicate their understanding of and agreement with the duties and responsibilities therein. The job description should be kept under review and amended if the need arises based on the template job descriptions from the FMOH or RHB of each profession. If an employee is promoted or transferred to another position, then a new job description should be signed for the new position.

Job descriptions should contain at least the following information:

- Job title,
- Supervisor reported to,
- Department/case team,
- Employment type,
- Job summary,
- Responsibilities,
- Qualifications,
- Licenses,
- Experience and other required skills,
- Physical demands,
- Description of job site and work environment,
- Occupational exposure,
- Salary and benefits,
- Date, employee name and signature.

Recruitment, Hiring, and Orientation: The HP receives already recruited or assigned staff from the concerned body and is not expected to recruit on its own.

The head of the HP should organize an orientation session for the newly assigned employee. The orientation provides information about the HP's mission, vision and values—and helps build the

employee's sense of identification with the organization. The orientation should also include an overview of the job expectations and performance skills needed to perform the job and an explanation of the reporting structures and mechanisms. The Employee Code of Conduct and Statement of Employee Rights and Responsibilities should be introduced to the employee at this stage as well.

Performance Management: Performance management is an ongoing process focused on reinforcing high performance or improving substandard performance to enhance the knowledge, skills, and behavior of all employees to achieve organizational goals. The HPs should improve the performance of the staff through supervisions and mentorship support and timely and regular performance evaluation and improvement:

Supportive supervision is a continuous and participatory process wherein a supervisor or leader accepts shared responsibility for an employee's professional development in order to get the best possible performance from the employee.

Performance-based evaluation (PBE) is the practice of periodic review and evaluation of an individual's or team's performance against specified goals or expectations. The evaluation should be conducted using the "Balanced Score Card" (BSC) framework.

The Performance Improvement Process (PIP) is designed to identify, communicate, and intervene when job performance is below the expected standards. Performance improvement interventions should be initiated as soon as it becomes apparent that an employee is not meeting the expected performance standards. Supervisors should not wait until the end of the review period to communicate the need to improve performance if the need is identified earlier in the period. The HPs should use PIP to improve an employee's performance through coaching and counseling. In all cases of poor performance, the supervisor should consult with the HRM focal person and other relevant bodies as necessary for advice and decision-making about any potential action.

N.B. All PBE results and any performance improvement measures should be documented in the employee's personnel file for follow-up and future reference.

Training and development: It is the default that all public health cadres, including HP employees, are entitled to training to improve their capability or prepare for increased responsibilities as part of continuous career development interventions. Staff training includes both short- and long-term training and educational opportunities. Clear selection criteria should be set transparently to ensure equity in the distribution of trainings among the staff. As part of staff development, each HP should have a core set of trainings that are provided to all staffs on a regular basis; e.g., fire safety, a major incident plan, occupational health and safety, and infection-prevention practices.

Discipline management: The HP should take disciplinary actions in cases where an employee demonstrates behavior that is unacceptable or in conflict with the Code of Conduct of civil servant or where an employee persistently performs poorly despite performance-improvement opportunities. The overall aims of disciplinary actions should be to influence the employee positively to learn from his/her mistakes. The HP should demonstrate good leadership and governance endeavors by making the right decisions at the right time.

Disciplinary actions should be taken consistent with the rule and regulations of civil service management.

Grievance management: A grievance is a concern or complaint that an employee has about his/her job: e.g., his/her employment terms and conditions, work environment, contractual or statutory rights, or treatment at work. Grievances can often be avoided by good communication between employees and senior managers so that problems are identified and corrective action taken at an early stage. Grievances are more likely when employees feel that their views are not being heard or their concerns are not being addressed. Grievances are more likely to be settled when employees perceive that the process is transparent, fair, and without retribution for the employee. The HPs should handle grievance based on the proclamation as early as possible to prevent further crises.

Personnel records: For organizational and legal purposes, HPs should maintain and regularly update a file on each employee that includes information like credentials for hiring, ongoing performance evaluations, and any documentation concerning performance improvement action. Employee files are also the repository of documents defining the mutual understanding between the employee and the employer concerning workplace policies and performance expectations.

The HP may choose to install a computerized database (optional) to manage selected human resource information where it provides easy retrieval of information for audit and planning purposes. The HP should ensure that employee records are private and confidential.

Occupational Health and Safety (OHS): Occupational health and safety addresses the overall working environment's suitability for employees to increase the HP's efficiency and effectiveness. Maintaining a safe work environment for employees is essential for the provision of quality care and the promotion of staff satisfaction. The HP physical standard should ensure that a work premise is safe and not hazardous to the staff. The employees, on the other hand, must use safety devices and materials properly and report any problems with or defects in materials/equipment as early as possible. Any potential hazard situations should be reported in a timely way as well. The HP's governing body should have workplace hazard reporting mechanisms both within the HP and in the external environment. This body must also assess the potential risks that might occur in the workplace through scheduled workplace inspections on regular basis. These risks may include slippery floors and grounds, violence and aggression (from patients and/or other staff), hazardous substances (e.g., chemicals, drugs), harassment (from patients and/or other staff), looting and robbery at outreach sites, rape/sexual assault, intimidation or terror, accidents during fieldwork, and stress, among others.

IMPLEMENTATION CHECKLIST

Table 9: Health Post Human Resources Management checklist

SN	Implementation standards	Verification criteria	Yes (√) No (x)	Met=1 Not Met=0	Remarks
1	The Health Post Properly maintains personnel file for every employee	There is an officially assigned focal person or the head of the HP manage the HR related activities.			Identify designated staff members for HRM and check the official letter given to them or check the HR related activities included in the HP head's annual plan.
		Personnel file maintained for every employee.			Take a random sample of 5 personnel files from the archive and ensure that they contain at least: personal contact information, an appointment letter, an employee job description, a medical certificate, and performance evaluation.
		The HRM Focal Person is a member of the HP/HC management committee (this apply if the HP assigned HRM focal person).			Obtain a list of HP management committee members and confirm that the HP-HRM Focal person is a member.
2	The HP has a Human Resource Development plan that addresses staff numbers, skills mix, and staff training and development.	There is updated HRD plan.			Review a copy of the HRD plan.
		The plan addresses staff numbers, skills mix, and staff training and development.			
3	The Health Post has all the required workforces as per the standard	Health officer, MW and Nurse deployed in the HP			
		Two HEWs are deployed in the HP			
		Guard and cleaner recruited for the HP			
4	The Health Post has a performance management process in which all employees are formally evaluated at least twice a year.	All staff are evaluated as per the procedure and protocol at least bi-annually.			Confirm that the five randomly sampled files contain a performance evaluation conducted within the past year (apart from new employees currently in their probation period).

	The Health Post has an employee policy and procedure related to Human Resources Management and code of conduct that is known, and adhered to, by all staff.	All staff adhere to a known code of conduct.			Obtain a copy of the employee code of conduct. Interview 3 staff members of the HP, ask whether they are familiar with the code of conduct, and have each describe (in general terms) the areas it covers.
		ID badges and appropriate uniforms are worn by employees at all times in the workplace and during outreach activities.			Observation. Confirm that each staff member interviewed or observed during the assessment is wearing an ID badge and uniform.
	The Health Post has an occupational health and safety guideline to identify and address health and safety risks to staff.	There are occupational health and safety policies and procedures.			Obtain a copy of the occupational health and safety policies and procedures and discuss its implementation with the staff.

Chapter Five

INFECTION PREVENTION AND CONTROL AND CLEAN AND SAFE HEALTH FACILITIES

OPERATIONAL STANDARDS FOR INFECTION PREVENTION AND CONTROL (IPC) AND CLEAN AND SAFE HEALTH FACILITIES (CASH)

1. The health post should have functional IPC/CASH committee
2. All the necessary personal protective equipment, commodities, and supplies for IPC/CASH are routinely available and used in the designated service areas.
3. Hand hygiene is practiced by all healthcare providers before and after contact with a patient/client regardless of their health status.
4. Safe injection practices and safety box use are implemented to minimize risk.
5. The Health Post practices standardized healthcare waste management as per the national IPC/CASH guidelines.
6. The Health Post ensures housekeeping activities and green areas.
7. The Health Post ensures the availability of adequate and functional toilets, and showers.
8. All reusable medical equipment/material is processed as per the national IPC/CASH guidelines.
9. All Health Post staff are trained using standard infection-prevention and patient-safety training materials.
10. The Health Post provides health education to patients/clients and caregivers
11. The health post ensures availability basic amenities

IMPLEMENTATION GUIDANCE

IPC–CASH plan

- Standard precautions; healthcare waste management, hand hygiene, instrument reprocessing….
- Transmission-based precautions;
- Equipment and supplies for IPC/CASH activities, including personal protective equipment (PPE);
- Monitoring and evaluation of IPC/CASH activities;
- IPC/CASH training.

Standard Precautions

Standard precautions are a set of recommendations to minimize the spread of infections in a healthcare setting. Healthcare workers should apply the principles of standard precautions with each encounter with a patient and consider every person, whether patient or staff, as potentially infectious or susceptible to infection.

Most HCAIs can be prevented through readily available and relatively inexpensive strategies. The elements of standard precautions include implementation of recommended practices regarding:

- Hand hygiene;
- Use of PPE;
- Safe work practices (e.g., safe injection practice, safe practices in the procedure room);
- Safe housekeeping;
- Healthcare waste management;
- Processing of instruments and linens.

Hand Hygiene: Hand hygiene is one of the most important measures for infection prevention. Hand hygiene generally refers to hand washing, hand antisepsis (alcohol-based hand rub and surgical hand scrub). Hand hygiene should be practiced by all healthcare providers before and after contact with a patient/client regardless of their health status. The steps of hand hygiene should be posted. To achieve the greatest compliance in hand hygiene, all staff should be trained or correctly oriented on proper hand hygiene techniques as part of an infection prevention training program. Hand hygiene facilities, such as functioning sinks, soap, and water should be in place in all patient care areas. The HP should provide a consistent supply of clean water for all patient care areas. This can be achieved by the short-term provision of water using containers with improvised sinks (faucets fixed to buckets) and/or temporary storage tankers or the long-term provision of water from a reliable supply designed for the HP.

Personal Protective Equipment: Personal protective equipment (PPE) can be defined as "specialized clothing or equipment worn by an employee for protection against infection/chemical materials." PPE protects the healthcare worker by creating a barrier between them and any potentially infectious substance. PPE includes gloves, gowns, aprons, masks/respirators, protective eyewear (e.g., face shield, goggles), caps, and protective shoes. Synthetic long-sleeved aprons, goggles, and masks should be provided to all staff involved in conducting invasive procedures. Each piece of PPE has a different use and application.

Table 10. Personal protective equipment: types

Personal Protective Equipment	Type
Gloves	Heavy-duty gloves
	Surgical gloves
	Examination gloves (latex or nitrile)
Protective Eyewear	Goggles
	Visors
Masks	Dust mask
	Surgical
	Respirators
Aprons	Plastic apron
	Protective gown
Protective shoes	Boots
	Nurse shoes
Caps	
Face shield	

Table 11. Personal protective equipment: uses

Type of PPE	What is Protected?	When PPE should be worn
Gloves Surgical (normal and elbow length) Examination Nitrile Latex Heavy-duty	Hands	When there is direct contact with exposed wounds, blood, body fluids, or any type of lesion. When drawing blood or handling medical instruments involved with invasive procedures (e.g., catheters, IV insertion, probes). During surgical procedures. When handling waste items or other contaminated surfaces. When cleaning patient areas.
Protective eyewear	Eyes	When the splattering of blood or body fluids to the face is possible. When handling bio-hazardous or soiled linens. When performing waste collection for hazardous or non-hazardous waste.
Masks Surgical masks	Mouth and nose	To protect mucous membranes of mouth and nose when the splattering of blood, body fluids, secretions, or excretions is possible.
Particulate respirators	Mouth and nose	When entering the room of airborne infectious agents, such as TB.
Face shields	Face, mouth, nose, and eyes	To protect the mucous membranes of eyes when the splattering of blood, body fluids, secretions or excretions is likely
Plastic aprons Gowns	Skin and clothes	To protect skin and clothing when the splattering of blood, body fluids, secretions, or excretions is likely.
Protective shoes	Feet and shoes	To protect feet when the splattering of blood, body fluids, secretions, or excretions is likely. To protect from sharps injuries.
Caps	Hair	To protect hair when the splattering of blood, body fluids, secretions, or excretions is likely. To reduce the spread of microorganisms from healthcare personnel to patients or food.

Table 12: Personal protective equipment: decontamination, cleaning, and HLD/sterilization or disposal

ITEM	DECONTAMINATION	CLEANING	HIGH-LEVEL DISINFECTION	STERILIZATIC
Protective eyewear (plastic goggles and face shields)	Wipe with 0.5% chlorine solution. Rinse with clean water. After each procedure or when is visibly soiled.	Wash with liquid soap and water. Rinse with clean water, then air or towel dry.[2] After each procedure or when visibly soiled.	Not necessary	Not necessary
Linens (caps, masks, scrubsuits or covergowns)	Not necessary. (Laundry staff should wear plastic aprons, gloves, and protective foot and eyewear when handling soiled items.)	Wash with liquid soap and water, removing all dirt particles. Rinse with clean water, air or machine dry.[2] Air-dried attire can be ironed before use.	Not necessary	Not necessary
Aprons (heavy plastic or rubber)	Wipe with 0.5% chlorine solution. Rinse with clean water. Between each procedure or each time they are taken off.	Wash with liquid soap and water. Rinse with clean water, air or towel dry at the end of the day or when visibly soiled.[2]	Not necessary	Not necessary
Footwear (rubber shoes or boots)	Wipe with 0.5% chlorine solution. Rinse with clean water. At the end of the day or when visibly soiled.	Wash with liquid soap and water. Rinse with clean water, air or towel dry at the end of the day or when visibly soiled.[2]	Not necessary	Not necessary
Surgical gowns, linen drapes and wrappers	Not necessary. (Laundry staff should wear plastic aprons, gloves and protective foot and eyewear when handling soiled items.)	Wash with liquid soap and water, removing all particles. Rinse with clean water, air or machine dry.[2]	Not practical	Preferred
Paper or disposable plastic items	Place in plastic bag or leakproof, covered waste container for disposal.			

ENVIRONMENTAL HYGIENE

Waste Management

Improper disposal of special healthcare wastes, including open dumping and uncontrolled burning, increases the risk of spreading infections and of exposure to toxic emissions from incomplete combustion. Proper management of healthcare wastes through an integrated, effective waste-management system can minimize the risks both within and outside healthcare facilities.

Waste management procedures: Waste management is a multi-step process involving:

- Waste minimization;
- Segregation;
- Handling;
- Collection;
- Storage (not applicable at HP level);
- Transportation;
- Treatment and disposal.

Waste minimization: In a proper HCW management system, the first step is waste reduction or minimization. This helps to ensure good sanitation of the health facility and the safety of workers and communities by reducing the quantity of waste generated.

Segregation denotes the separation of waste into a range of classes according to its character. Waste separation reduces the quantity of waste that requires specialized treatment and care. Generally, health-facility waste is classified into 3 categories of waste: non-infectious, sharps waste, and infectious waste.

Non-infectious waste is waste that is non-hazardous and that under normal circumstances poses no health risk: e.g., paper, packaging, left-over foods, boxes, glass, and plastic.

Sharps waste includes sharp materials and equipment that is disposed of after being used: e.g., used syringes, needles, lancets, blades, scalpels, and broken glass.

Infectious waste is waste material that has, in part or in whole, been in contact with blood and/or body fluids. Due to the presence of blood and body fluids, such wastes are regarded to be infectious waste and can potentially transmit microorganisms to susceptible people. It includes contaminated gauze, dressings, used gloves, placenta, tissues and the like.

Segregation must:

- Take place immediately and at the source where the waste is generated; waste must never be re-sorted.
- Ensure that proper segregation techniques are used and that infectious HCW is not mixed with non-infectious waste.

Table 13: Categories of HCW to be segregated into color-coded containers

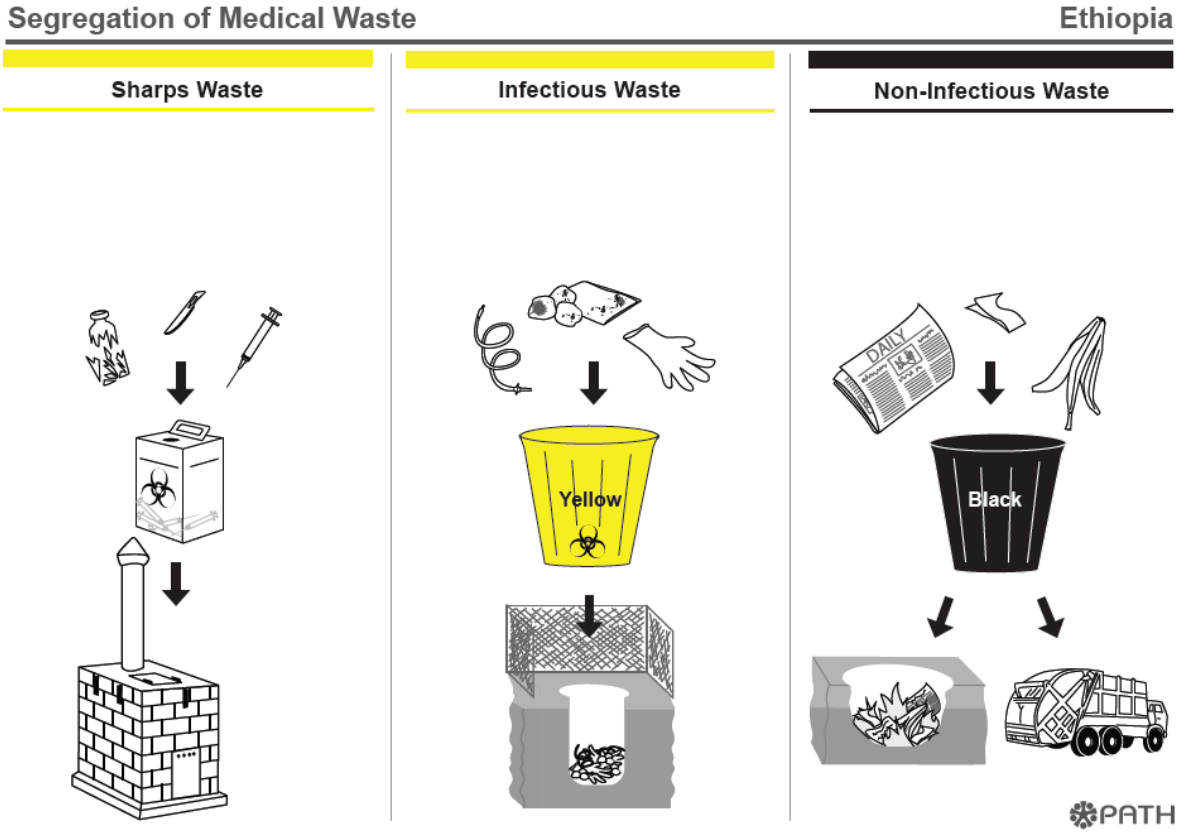
Segregation Category	Color-coded container	Non-color-coded bins
Non-infectious waste/ General waste	Black bin	Bins should be labeled "Non-Risk Waste."
Infectious waste	Yellow bin	Bins should be labeled "Infectious Waste."
Sharp waste	Yellow safety box	Box should be labeled "Biohazard Waste."

Note that, in the absence of color-coded bins, it is possible to create a waste segregation system using labeled waste bins labeled with infectious and non-infectious symbols or text. Such bins should not, however, be used for liquid waste.

To maximize efficiency and safety, these three waste categories must be handled and disposed of separately throughout the main steps of: segregation, collection, handling, storage, transport, treatment, and disposal.

Location of segregation containers

- Safety boxes
  - A safety box should always be located within arm's reach of any place where an injection is given.
  - Don't place containers on the floor or anywhere where they could be knocked over or easily reached by children.
- Infectious waste bins.
  - Yellow infectious waste bins should be located in all rooms where infectious waste is generated.
  - Infectious waste bins should not be located in public areas.
- Non-infectious waste garbage bins
  - Black garbage bins should be located in all sites where waste may be generated and in all public areas.



Source: Path, 2005.

Figure 1: Segregation of healthcare waste by type

Handling

When handling waste, waste-management staff should always wear protective clothing. Wearing PPE reduces the risk from sharps and protects against exposure to blood, other bodily fluids, and splashes from chemicals. PPE that is recommended to be worn when handling waste includes:

- Dust mask
- Face shield
- Heavy duty, gloves
- Plastic apron
- Clothes that cover the body
- Head cover
- Goggles

N.B. See Box 3 for an illustration.

Handling sharps

- Place the syringe in a safety box immediately after use.
- Do not recap, bend, or remove needles from syringes.

Handling safety boxes

- Safety boxes must be fully and properly assembled before use.
- Safety boxes must be sealed and collected when ¾ full.
- Safety boxes must never be emptied or opened.
- Put sharps containers as close to the point of use as possible and practical, ideally within arm's reach.
- Mark or label safety boxes so that people will not unknowingly use them as a garbage container or for discarding other items.
- Don't shake a safety box to settle its contents and make room for more sharps.

Handling infectious-waste bins

- Infectious-waste bins should be covered before collection.
- Bins should be cleaned and disinfected by using a 0.5% chlorine solution for 10 minutes after emptying.

Collection

Schedule:

- Infectious-waste bins should be collected at least each day.
- Safety boxes should be collected when ¾ full or daily.
- Garbage bins should be collected daily.
- No infectious bag or bin should be collected unless it is labeled with its point of production and content.

Transport:

- A trolley, bin, or wheelbarrow may be used to transport safety boxes and bins.
- Containers should be covered with lids during storage and transport.
- Carts should be used for transporting bags of infectious waste within the facility.

Disposal: Options in decreasing order of preference include:

- Sharps waste:
  - Incineration using either properly built brick incinerator or another incinerator
  - On-site burial
- Infectious waste:
  - On-site burial
  - On-site incineration, provided that the incinerator is a standard incinerator and capable of destroying such wastes
- Non-risk waste:
  - Collection by municipal truck for landfill disposal
  - On-site secured burning

Incineration: All incinerators should be inspected and maintained by an environmental health professional regularly, and inspection reports should be provided to HP management.

Staff must wear protective equipment when loading and operating the incinerator. Proper equipment includes heavy-duty gloves, boots, aprons, and goggles. Protective equipment should be made of materials that do not easily burn or melt.

Burial of infectious waste: Burial pits must be properly constructed and protected. Pits must be above the water table (the bottom of the pit should at least be 1.5 meters away from the groundwater table) and fenced to prevent access by animals and the community. Non-risk waste must not be dumped into infectious-waste burial pits.

Waste Spills

Despite the implementation of preventive measures, waste spills can occur. Outlined below are procedures to manage waste spills according to type.

All those managing waste spills should wear PPE, such as protective gloves, goggles, and masks.

A) Infectious waste spills

A bleach (sodium hypochlorite) solution should be poured over waste and allowed to stand for 15 minutes. Next, use a dustpan and broom to brush it carefully off the ground and into an infectious-waste bag or bin. Ensure that no waste remains in the broom. After the waste has been removed, cover the area with a bleach solution.

B) Sharps waste spills

A bleach (sodium hypochlorite) solution should be poured over waste and allowed to stand for 15 minutes. Next, use a dustpan and broom to brush it carefully off the ground and into a puncture-proof container. Do not allow hands to contact sharps. Ensure that no sharps fragments remain in the broom. After the waste has been removed, cover the area with a bleach solution.

C) Spills of broken thermometers and blood-pressure equipment

Those handling spills of broken thermometers and blood-pressure equipment should wear examination gloves on both hands. All droplets of mercury should be collected with a spoon (or similar utensil), and placed in a small, closed container for disposal or reuse. Wash or clean the area with a bleach (chlorine) solution. When this process is complete, the examination gloves that were used should be removed carefully and hands washed properly.

Housekeeping

Maintaining a clean environment is essential to providing quality care for patients. Proper cleaning will reduce the number of microorganisms in patient-care areas and help minimize the risk of exposure to infectious agents by patients, families, caregivers, visitors, and HP staff.

Work plan: The HP should develop operating procedures or a work plan on the cleaning process and schedule for each room.

Supplies: The HP should have a regular supply of all necessary cleaning materials. At a minimum, each HP should provide:

- Disinfectants and detergents, bleach, and powder detergents (e.g., Omo)
- Mops, cloths for dusting, brooms, soaps, and buckets
- PPE for cleaning staff and alcohol for hand-rub preparation

The head of the department should plan for and request supplies to meet the HP's monthly consumption needs.

Procedures: Administrative and office areas with no patient contact require normal domestic cleaning, including sweeping, dusting, and washing floors and windows with detergent.

All patient-care areas should be cleaned by wet-mopping, scrubbing, dusting, and/or scrubbing using disinfectant cleaning solutions. The cleaning solution should be prepared according to the guidance outlined in the Infection prevention and patient safety reference manual for healthcare providers and healthcare managers in Ethiopia. Staff should be trained on how to prepare cleaning solutions, and procedures for preparing the solution should be posted in an area visible to the cleaning staff

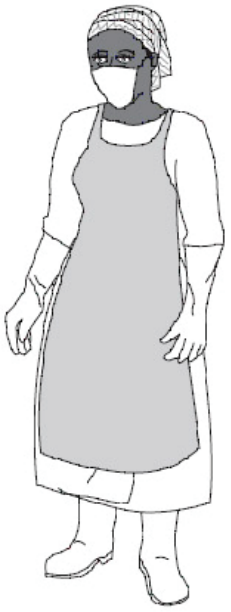
Safety: The staff should wear PPE appropriate for the work. For example, during cleaning, staff should wear plastic aprons, heavy-duty gloves, masks, and protective shoes. Staff likely to be exposed to substances that may splash or splatter should wear goggles. Other protective equipment should be provided as necessary.

Box 3. Personal protective equipment during cleaning

Wearing PPE reduces risk from sharp, germs, exposure to blood and other bodily fluids, and splashes from chemicals.
Staff handling waste should wear:

- Dust mask
- Face shield
- Heavy-duty gloves
- Plastic apron
- Clothes that cover the body
- Head cover

Other cleaning staff should wear PPE as appropriate to their exposure.



Instrument processing**:** There are four main steps in instrument processing, as outlined in Figure 2 below: decontamination, cleaning, sterilization or high-level disinfection, and storage.

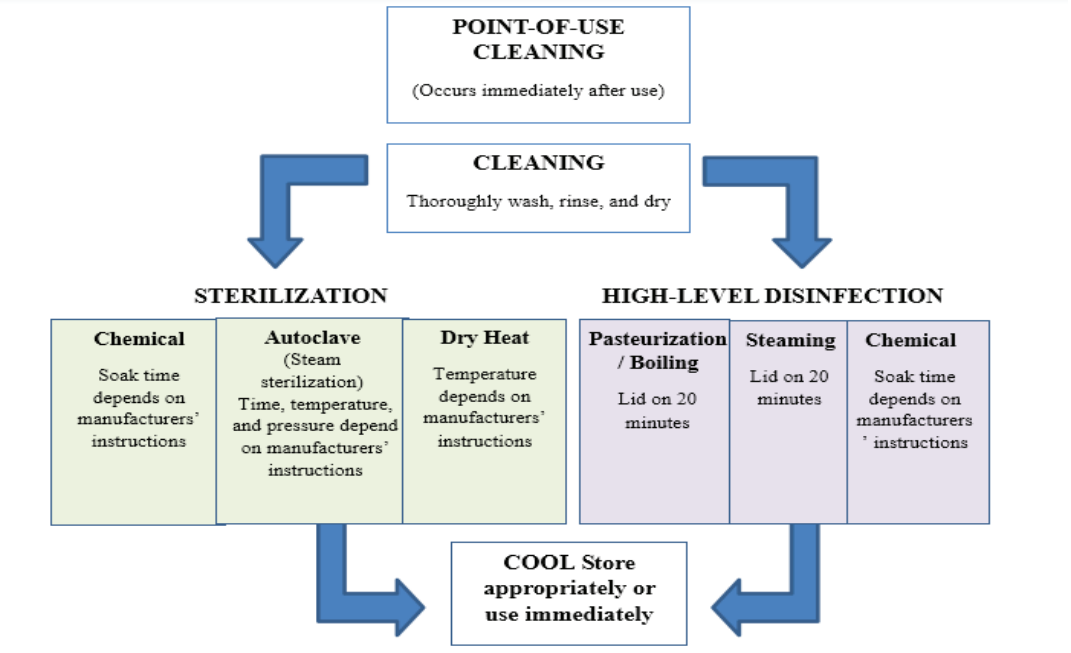


Figure 2: Instrument-processing steps

Cleaning: During cleaning, the number of microorganisms and infectious agents, especially endospores and other organic matters, should be physically removed and mechanically reduced. Cleaning though the use of detergent or soaps and brushing must be done for effective sterilization and high-level disinfection. Liquid soap is good for effective cleaning. Cleaned instruments should be dried, packed or wrapped if necessary, and labeled before being sterilized.

Sterilization: The HP should have functioning autoclaves and dry-heat ovens for the sterilization of medical equipment. There should also be a supply of 2–4% glutaraldehyde or 8% formaldehyde for the chemical sterilization of plastic items. Proper packing should be applied before following the procedure. In the case of chemical sterilization, objects must be removed from the solution with sterile forceps, all surfaces must be rinsed three times with sterile water, and the object must be air-dried. Mechanical, chemical, and biological indicators can be used to control the functioning of the process. Mechanical indicators are used most often. This would include checking adherence to the recommended time, temperature, and pressure. Chemical indicators are often used as a supplement to mechanical indicators.

High-level disinfection: HLD can only be used when there is no sterilization system. Steamer pans and boilers should be in place for high-level disinfection purposes. Steaming, boiling, and chemical HLD can be applied. Instructions on how to perform HLD should be posted in the procedure rooms and staff instructed to follow the outlined procedures.

Storage of sterilized equipment: All sterile items should be stored in an area and manner to protect the packs or containers from contaminants like dust, dirt, moisture, animals, and insects. The storage area for sterile items for the HP is best located next to or connected to the area where sterilization occurs. This space should be in an area separate, enclosed, and with limited access and should be used only to store sterile and patient-care supplies. Sterilized instruments should be re-sterilized if anything happens to the package before 30 days.

- Soaking of instruments in disinfectant prior to cleaning: According to the WHO and PHAO, soaking of instruments in 0.5% chlorine solution or any other disinfectant prior to cleaning is not recommended for the following reasons:

- It may damage/corrode the instruments

- The disinfectant may be inactivated by blood and body fluids, which could become a source of microbial contamination and formation of biofilm 146

- Transportation of contaminated items soaked in chemical disinfectant to the decontamination area may pose a risk to health care workers and result in inappropriate handling and accidental damage May contribute to the development of antimicrobial resistance to disinfectants.

Worker Safety

In addition to the procedures outlined above, HPs should ensure that mechanisms are in place to identify and address occupational health and safety risks to staff. HPs should also ensure that staff can access services if they are exposed to infectious agents.

Injection safety: The use of injection materials in the HP setting exposes healthcare personnel to needle-stick injuries and potentially to infectious materials.

Injection safety includes:

- Needle and syringe usage and disposal:
  - Every injection is given using a single sterile syringe and needle combination
  - Syringes are not reused
  - Used needles are not recapped, manually detached, or manipulated
  - After each use, the needle and syringe are safely disposed of in a puncture-proof container
- Needle-stick injuries:
  - There is a reporting and tracking mechanism for needle-stick injuries
  - There is an HIV post-exposure prophylaxis plan (see below)

HIV post-exposure prophylaxis: The risk of HIV infection after a needle-stick injury or other exposure to HIV-infected blood is estimated to be 0.3% (3 in 1000 or 1 in 300). Still, several cases of seroconversion among healthcare workers exposed to HIV via mucous membrane or non-intact skin have been documented. Implementation of standard precautions will significantly reduce the occupational exposure of HP staff (both healthcare workers and support staff) to HIV and other blood-borne pathogens. If healthcare personnel (HCP) are exposed, HP staff should immediately contact the nearest HC to identify and assess the staff's need for PEP and provide care and treatment.

N.B. The following guidelines address only the management of occupational exposure among healthcare workers. In addition to PEP for occupational exposures, HPs should link clients to the nearby HC, which provides PEP services for non-occupational exposure to HIV, such as sexual assault. The recommendations provided in this section are based on the national PEP protocol.

PEP Procedures

If an occupational exposure occurs, the following procedures for PEP should be followed:

Step 1. Treat exposure:

- Use soap and water to wash the areas exposed to potentially infectious fluids as soon as possible
- Flush exposed mucous membranes with water
- Flush exposed eyes with water or saline solution

Step 2 . Report exposure:

- Report and document the exposure. Report the incident to the healthcare personnel's immediate supervisor and nearby HC.

Personal Protective Equipment, Commodities, and Supplies

The HP staff should ensure the availability of:

- PPE cleaning supplies, such as gloves, soap, towels, linens, and alcohol
- Functional sinks and toilets
- Functional incinerator and other waste-disposal equipment
- Water supply

Educating patients, caregivers, and other visitors regarding IPC/CASH guidelines

Family members/caregivers are integral in the health delivery process, as they may assist in the care of the patient. Therefore, it is critical that family members and other caregivers are informed and educated on IP&PS guidelines.

Educate patients and visitors on IPC/CASH guidelines using illustrative pamphlets. The HP staff is responsible for educating patients and visitors about IPC/CASH practices within the HP.

The staff can educate patients and visitors on either a group or individual basis. The HP should have pamphlets and/or brochures that highlight the IPC/CASH practices by which patients, caregivers and visitors are expected to abide. For example, educational pamphlets should address hand-hygiene procedures. Brochures, pamphlets, or other educational materials should be illustrative in nature. This enables all visitors and patients—regardless of education or literacy level—to grasp the concepts of the IPC/CASH guidelines quickly. Wherever possible, posters detailing IPC/CASH practices also should be posted in patient client care areas.

Health Post infrastructure

There should be a separate room for each service provided in the HP. The room should be in line with the respective standards set with adequate ventilation. The arrangement of service rooms should be considered with regard to the flow of service provision in the HP.

Furthermore, the homes or living area of professionals working in the HP or any other kebele personnel should not be near the HP service areas.

Electricity: There should be a reliable source of electricity for every HP. If the source is either a generator or solar panels, there should be dedicated personnel overseeing the maintenance and function of these appliances through arrangements with their woreda/HC.

Water supply: All HPs should have access to a safe and reliable water supply. Water in HPs must be:

- Free of disease-causing organisms and any other hazardous substances,
- Clear, colorless, odorless, and tasteless,
- Not too highly concentrated with calcium, magnesium, manganese, iron, or carbonates,
- Free of corrosive substances, and
- At a relatively low temperature.

A backup water supply, such as water tanks, a reservoir, or a dedicated well, should be available in case the main supply is interrupted. Water tanks should hold enough water to supply the HP for at least three days. Backup supplies should be cleaned regularly and the water checked to ensure the quality and safety of the water being brought to the HP. A mesh filter can be used to prevent large debris from entering the water supply. Filters must be cleaned regularly, as they tend to get clogged with dirt or mud.

Pest and rodent control: Rodents and insects can spread disease and cause damage to buildings and equipment. The presence of pests and rodents can be minimized by keeping the facility clean and free of waste materials.

Inspections should be performed quarterly to detect the presence of rats, rodents, or other pests, paying particular attention to storerooms. Proper extermination methods should be undertaken when pests are suspected. Extermination techniques should be performed in accordance with local rules. Patients and staff should be temporarily removed from areas if there is a risk of exposure to toxic chemicals or substances.

Health Post security and safety: Security for the staff, patients, property, and information in the HP is essential. Security personnel play a vital role in ensuring that the HP is welcoming and accessible but also a safe environment for patients, visitors, and staff. Security personnel need a thorough knowledge of the premises in order to protect buildings and valuable equipment.

The HP should have a policy to control access to it, addressing all relevant areas. Access to the HP should be limited to staff, patients, caregivers, and visitors with legitimate access. HP staff must wear badges at all times in the HP.

Fire safety: A fire in a health facility risks the safety, health, and lives of patients and providers. A fire extinguisher should be available in the HP in a location of which all staff are aware. All staff should be trained on the prevention and response to fire incidents.

CHECKLIST

Table 14: **IPC-CASH checklist**

SN	Implementation standards	Verification criteria	Yes (√) No (x)	Met = 1 Not Met = 0
1	The health post should have functional IPC/CASH committee	▪ FP and members assignment letter ▪ Check TOR ▪ Check meeting minutes ▪ Check if baseline assessment is conducted ▪ Obtain updated IPC/CASH operational plan		
2	All the necessary personal protective equipment, commodities, and supplies for IPC/CASH are routinely available and used in the designated service areas.	▪ Check PPE acquisition plan ▪ Check store availability of supplies ▪ Use PPE during patient handling, housekeeping, and waste handling		
3	Hand hygiene is practiced by all healthcare providers before and after contact with a patient/client regardless of their health status.	▪ Check the presence of hand washing facilities (at minimum with soap, water and functional faucets) at different service outlets ▪ Check availability of continuous water supply at point of use with backup ▪ Check whether hand washing posters are posted at a visible location ▪ Randomly spot-check 2–3 staff from different service points regarding hand washing		
4	Safe injection practices and safety box use are implemented to minimize risk.	▪ Check that safety boxes are available in the right area ▪ Check timely disposal ▪ Verify through spot checks or interviews whether recapping of used syringes is practiced		
5	The Health Post practices standardized healthcare waste management as per the national IPC/CASH guidelines.	▪ Verify presence of color-coded bins ▪ Verify practice of waste segregation, ▪ Verify presence and proper use of well-designed functional incinerator with ash pit ▪ Verify presence of fenced and ventilated placenta pit with tight-fitting cover (if applicable) ▪ Check/interview personnel about whether safety boxes are disposed safely during the incineration. ▪ Verify proper disposal of liquid wastes: check presence of septic tank/absence of leakage of the sewerage system (waste should not be discharged without treatment)		

6	The Health Post ensures housekeeping activities and green areas.	▪ Check/observe the Health Post compound cleanliness ▪ Check/observe that service areas are visibly clean, lack bad odor, and are well ventilated ▪ Check availability of green areas		
7	The Health Post ensures the availability of adequate and functional toilets, and showers.	▪ Verify that there are functional showers in the Health Post (if applicable) ▪ Verify presence of adequate toilets (1 seat per 40 patients/clients) with hand washing facility ▪ Verify cleanliness of toilets (inside and outside)		
8	All reusable medical equipment/material is processed as per the national IPC/CASH guidelines.	▪ Check Presence of SOPs based on revised 2019 IPC manual ▪ Check functionality and how personnel operate autoclave and dry-heat oven or chemicals for sterilization (if applicable) ▪ Check whether proper high-level disinfection procedures are in place (if applicable) ▪ Check whether processed items are properly stored (if applicable)		
9	All Health Post staff are trained using standard infection-prevention and patient-safety training materials.	▪ Verify by checking staff training database from the respective HC or check if certificate/letter of participation is issued		
10	The Health Post provides health education to patients/ clients and caregivers	▪ Verify the presence of a client education schedule ▪ Check IPC/CASH is included as a title ▪ Verify availability of educational materials and supplies ▪ Observe health education logbook		
11	The health post ensures availability basic amenities	▪ Check presence of 24/7 water supply ▪ Check presence of 24/7 electric supply		

Chapter Six

COMMUNITY ENGAGEMENT

OPERATIONAL STANDARDS

1. The kebele has functional community health volunteers (women's group, men's group, village health leaders, youth groups, and other local social structures).
2. The Health Post staff work closely with other sectors to strengthen community engagement strategies in health.
3. The Health Post staff establish regular forums with community health volunteers at the kebele and gote levels every quarter.
4. The Health Post implements school health packages in all schools in the kebele.
5. The Health Post staff organize community forums every quarter.
6. The kebele regularly implements a community scorecard system.

IMPLEMENTATION GUIDE

Enhance community engagement strategies: Comprehensive community engagement strategies will be implemented in all kebeles. This requires the active engagement of health sectors and mobilization of local administration and other sectors. The community engagement strategies identified for implementation at the kebele and community levels include:

- Introducing Village Health Leaders (VHLs) to link Women's Development Groups/Armies (WDG/As) and communities with the HEP;
- Optimizing the WDG/A strategy;
- Appending men and youth engagement strategies;
- Using existing treasured and trusted social platforms;
- Designing and implementing tailored motivation mechanisms.

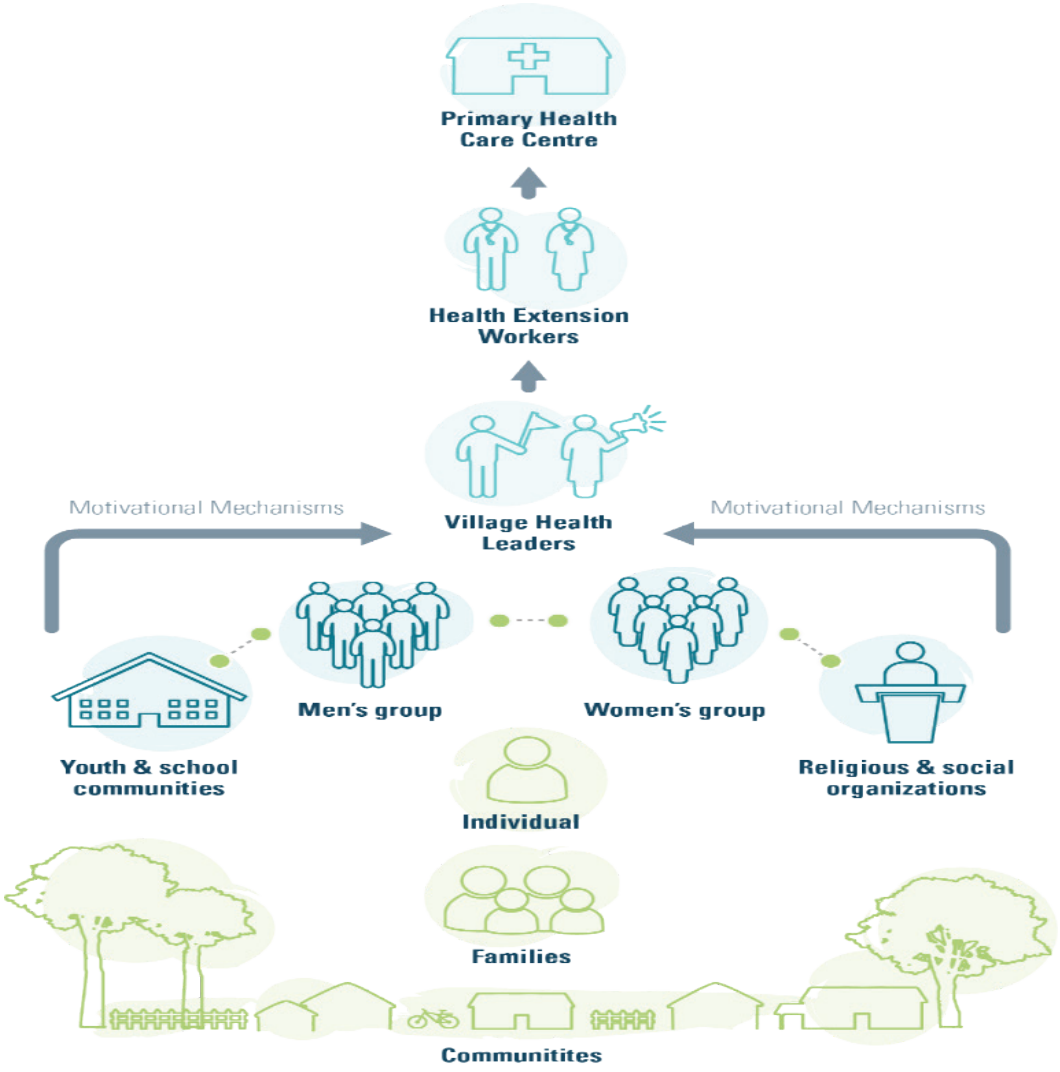


Figure 3: Community engagement strategies and their relationships

Building the capacity of community health volunteers: Once all required community-based structures are established and deployed, building the knowledge and skills of those recruited community volunteer health cadres is essential to reaching every individual, family, and community and improving health and health system literacy. The HP staff in the HC are responsible for building the capacities of these community health cadres. Key activities include but are not limited to:

- In collaboration with kebele administration and the HC, recruit active community health volunteers;
- Provide capacity-building training for recruited community volunteers;
- Set up regular performance review and learning platforms at the kebele and sub-kebele/gote level as per the national guideline;
- Provide community-level mentorship/coaching to community volunteers in their catchment areas;
- In collaboration with the local administration and the HC, implement motivation mechanisms for volunteer community health cadres.

Engage other sectors: Working relationship with kebele and sub-kebele structures is essential to fostering local political ownership and ensuring multi-sectoral engagement to improve the community engagement strategies and promote health. As health sector is a member of the kebele cabinet, there is an opportunity to advocate and share the performance of community engagement in health in the regular meetings. The major activities to strengthen community engagements in health include but are not limited to:

- Actively working with other sectors, such as Education, Water, Women, Youth and Children's Affairs, Agriculture, and others to recruit, train, deploy, and monitor community health volunteers;
- Regularly discussing successes and bottlenecks with kebele leadership and other key stakeholders to implement local solutions;
- Working with community representatives to ensure accountability and ownership of community and primary health care systems by implementing a community scorecard.

IMPLEMENTATION CHECKLIST

Table 15: Community engagement implementation checklist

SN	Implementation standards	Verification criteria	Yes (√) / No (x)	Met = 1 / Not Met = 0	Remarks
1	The kebele has functional community health volunteers (women's group, men's group, village health leaders, youth groups, and other local social structures).	Village-level Health Leaders are recruited, trained, and deployed in the kebele as per the guideline			Number and gender mix from list of VHLs at HP from the report
		At least 80% of Village Health Leaders attend meetings and trainings and supervise other community groups at least once in on quarterly basis			Observe VHL registers and meeting attendance
		At least 80% of Women's Development Group/Armies report to and attend meetings and trainings with Village Health Leaders/Health Extension Workers quarterly			Observe WDG/A registers
		At least 80% of men's groups are actively participating in health activities (e.g., they report to and attend meetings and trainings with Village Health Leaders/Health Extension Workers at least quarterly)			Observe register, reports, and minute book
		Youth groups are actively participate in health activities (e.g., they report to and attend meetings and trainings with Village Health Leaders/Health Extension Workers at least quarterly)			Observe register, reports, and minute book
		Other local social structures (e.g., idir) are identified and actively participating in health activities (e.g., they report to and attend meetings and trainings with Village Health Leaders/Health Extension Workers at least quarterly)			Observe register, reports, and minute book

2	The Health Post staff work closely with other sectors to strengthen community engagement strategies in health.	There is a joint annual plan on which key sectors have agreed to strengthen the community engagement strategies			Observe a joint plan signed by all stakeholders
		The performances of community engagement has been reviewed on a regular basis (at least quarterly) in the presence of kebele leaders and other sectors			Observe HP reports and meeting minutes
		Joint action points have prepared and implemented based on reviews findings			Observe the action points included in the quarterly/ monthly plan
3	The Health Post staff establish regular forums with community health volunteers at the kebele and gote levels every quarter.	HP staff have schedules/plan to train and regularly review the performance of volunteer community health groups			Observe schedules
		The HP staff provide training and/or review performance of Village-level Health Leaders, Women's Development Armies, men's groups, and youth groups on at least a quarterly basis			Observe minute book and reports
4	The Health Post implements school health packages in all schools in the kebele.	A school health work plan is prepared included in their annual, monthly, and weekly work plan			Observe work plan
		School health packages are implemented in all schools in the kebele			Observe school health reports
5	The Health Post staff organize community forums every quarterQ.	Community forums are conducted on quarterly basis			Observe minute book
		Action points have been prepared and implemented based on feedback from the community			Observe an action plan
6	The kebele regularly implements a community scorecard system.	Community scorecard implementation guide is available			Observe guideline
		A community scorecard committee has been established in the kebele			Observe list of CSC committee
		The community scorecard committee implements the community scorecard in the kebele on a quarterly basis			Observe minute book and reports

INDICATORS

Table 16: Community engagement indicators

S.N	Indicator	Formula	Frequency	Remarks
1	Proportion of active/functional Village-level Health Leaders Note: Active/functional Village-level Health Leaders are Village-level Health Leaders who actively work with Women's Development Armies and other structures, attending meetings with Health Extension Workers at least quarterly and regularly reporting their performance	Number of active/functional VHLs in the kebele ÷ total number of VHLs in the kebele	Quarterly	Admin report
2	Proportion of active/functional Women's Development Armies Note: Active/functional Women's Development Armies are Women's Development Armies who actively work with their members and conduct home visits, attend meetings with Village-level Health Leaders regularly, and report their performance	Number of active in the kebele/ functional WDAs ÷ total number of WDAs in a kebele	Quarterly	Admin report
3	Proportion of active/functional men's groups Note: Active/functional Men's groups are Men's groups who actively participate in health activities (i.e. report to and attend meeting and training with Village-level Health Leaders/Health Extension Workers at least quarterly)	Number of active men's groups in the kebele ÷ total number of men's groups in the kebele	Quarterly	
4	Proportion of schools where school health packages have been implemented	Number of schools implementing school health packages in the kebele ÷ total number of schools in the kebele	Quarterly	Admin report

Chapter Seven

HEALTH INFORMATION SYSTEM AND PERFORMANCE MONITORING

OPERATIONAL STANDARDS

1. The Health Post prepares annual, quarterly, and monthly plans.
2. The Health Post has a functional Monitoring and Evaluation (M&E) system.
3. The Health Post has implemented a Community Health Information System/Family Folder system.
4. The Health Post has implemented a data-quality audit on selected priority problems.
5. The Health Post has updated display charts.
6. The Health Post has a functional electronic Community Health Information System.

IMPLEMENTATION GUIDE

Health Information System

Community Health Information System (CHIS)

The Community Health Information System uses the Family Folder, which is a tool or package designed for data collection and documentation to meet the necessary information needs for providing family-focused promotive, preventive, and environmental health services at the community level. Complementing the Family Folder is a simple HIS record-keeping and reporting procedure that feeds community-level health information.

Family Folder: This is a family-centered tool designed for the HEW to manage and monitor her work in educating households and delivering an integrated package of promotive, preventive, and basic curative health service to families. The Family Folder is a pouch provided to each family. Information on household identification, data on family members and household characteristics in terms of environmental sanitation (latrine, handwashing facilities, waste disposal, and drinking water source) and malaria prevention (LLITN) is recorded on the cover side of the Family Folder.

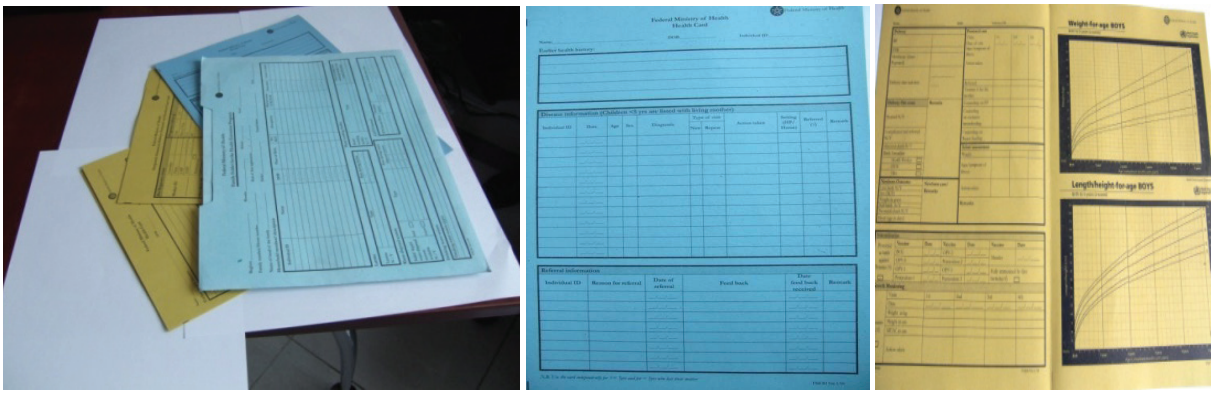


Figure 4: Sample Family Folder

These standardized Family Folder or CHIS recording forms are developed according to international standards through consultation with technical programs and care providers. Below is the list of

basic forms/instruments used in the record-keeping process at the HP/community level: A) kebele profiling forms; B) family/household health information recording instruments; C) tallies, and D) reporting forms.

Kebele profiling forms: Kebele profiling forms serve as tools for collecting data on the kebele population, health resources available within the kebele, the status of environmental health, and basic health indicators. This information serves to help plan health activities and as baseline data to calculate coverage indicators and assess changes in the health status of the population. The kebele profiling forms are:

Kebele demographic profile: This form is for compiling the demographic data of the kebele. Once the household registration is complete and the cover pages of the Family Folders have been filled out, the following data are compiled from these cover pages. The information is updated annually based on the updated data from the Family Folders.

Table 17: Kebele demographic information

	Kebele Demographic Information	Number
1.1	Total population	
1.2	Female population	
1.3	Male population	
1.4	Total number of households	
1.5	Total number of under 6 months of age infants	
1.6	Total number under 1 year of age infants	
1.7	Total number of under 3 years of age children	
1.8	Total number under 5 years of age children	
1.9	Total number of reproductive age (15-49 yrs) women	
1.10	Total number of live births in the previous year	
1.11	Total number of deaths in the previous year	

Kebele resource mapping: This is a form for compiling data on potential resources within the kebele that can be useful in promoting health-related activities: e.g., schools, religious institutions, teachers, agriculture department agents, trained traditional birth attendants, and community health workers (or graduate model households) within the kebele. Data on slaughterhouses and marketplaces are also compiled to target health-promotion activities.

N.B. The data for kebele resource mapping are collected from the office of the kebele administration and updated yearly. This information is also used to draw the map of the kebele with its main key descriptions, like HPs, mediation places, market areas, main roads, and rivers.

Table18: Kebele resource mapping

2	Kebele Resource Data	Number
2.1	Total number of schools in the Kebele	
2.2	Total number of teachers in the Kebele	
2.3	Total number Agricultural Development Agent	
2.4	Total number of Community Health Worker (Innovators)	
2.5	Total number of trained Traditional Birth Attendants	
2.6	Total number of churches	
2.7	Total number of mosques	
2.8	Total number of other meditation places	
2.9	Total number of market places	
2.10	Total number of slaughter sites	
2.11	Total number of communal latrines in the kebele	

Kebele household environmental sanitation profile: This is for compiling data on the household-level environmental sanitation profile of the kebele. Once the household registration is complete and the cover pages of the Family Folders have been filled out, the following data are compiled from these cover pages. The information is updated annually based on the updated data from the Family Folders.

Table 19. Kebele environmental sanitation information compilation form

3	Kebele Environmental Sanitation Information	Number
3.1	Total number of household with latrine	
3.2	Total number of households with solid waste disposal sites	
3.3	Total number of households with liquid waste disposal sites	
3.4	Total number of households with protected solid waste disposal sites	
3.5	Total number of households using wells as source of drinking water	
3.6	Total number of households using spring water as source of drinking water	
3.7	Total number of households using tap water as source of drinking water	
3.8	Total number of households with any hand washing facility but **without** soap/ash	
3.9	Total number of households with secure hand washing facility **with** soap/ash	
3.10	Total number of households with at least one LLITN available in the house	

N.B. The initial kebele profiling will be done at the time of household registration, when all the households in each gote (sub-kebele) of the kebele are numbered and the families are issued Family Folders. Subsequently, the kebele profile will be updated annually based on updated data recorded in the Family Folders.

Family Folder: The Family Folder is a pouch issued to every household in the kebele. It contains information about the household that will help the HEW identify the health (preventive, promotive, and environmental) service needs of the family or household and provide the service or counsel

them accordingly. During the initial household registration, every household in a gote is issued a unique identifier number consisting of a 2-digit gote code followed by 3-digit household number (XX. XXX). The HEW, in consultation with the kebele administration, will assign the gote code to each gote in the catchment kebele. Subsequently, when a new household is created in a gote, the last available serial number for the Gote will be assigned to that new household.

The Family Folder pouch has five basic parts:

- Identification;
- Household description;
- Household characteristics;
- HEP package training status;
- Household implementation status of the HEW packages.

Tickler boxes/reminder file system: The tickler/reminder file system comprises 12 boxes arranged serially, with each box representing a month of the year that helps identify the clients who should have received follow-up services in a certain month but have defaulted. Figure 5 provides more details.

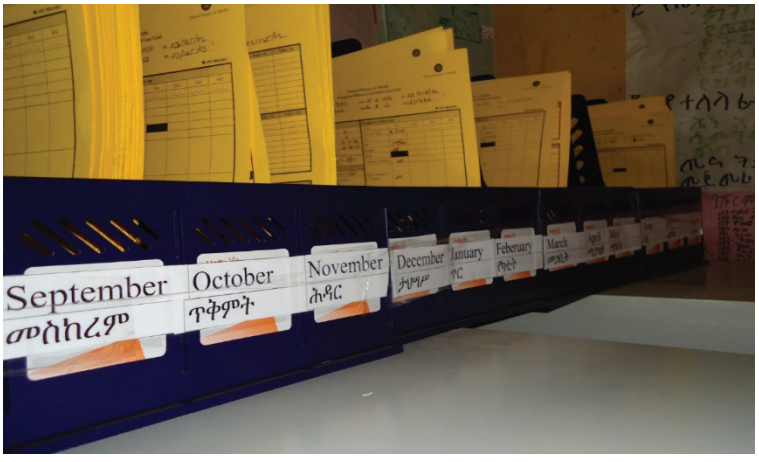


Figure 5: Tickler/reminder file system

Health card: The health card comes in two colors, with identical content to identify the sex of the household member. Blue is assigned to male members and yellow for female members. Every household member older than five years has his/her own health card, and every child under five years of age has a health card associated with his/her mother's yellow card. When the child reaches five years old, he/she is issued a new health card based on his or her sex. A child who has lost his/her mother or whose mother for some reason does not have a yellow health card, uses his/her own health card based on his or her sex. The health card has ten parts:

1. Identification;
2. Earlier health history;
3. Disease information;
4. Referral information;
5. HIV/AIDS:
    a. ART follow-up;
    b. Home-based care and support for PLWHA;
6. Tuberculosis;

7. Family planning;
8. History of Immunization;
9. Height and weight status;
10. Orphan support.

Integrated Maternal and Child Care Card: Every woman in a household who is pregnant and delivers a baby has her own integrated maternal and childcare card. The card is a folded, yellow, A4-sized card with the front used for recoding pre-pregnancy status and pregnancy follow-up information. The inside is used to recode delivery, postnatal care, immunization, and a growth monitoring chart for boys. The back side contains growth charts for girls. The content of the integrated maternal and childcare card contains:

- Identification;
- General condition;
- Obstetric history;
- Current pregnancy;
- Pregnancy follow-up.

Master family index (MFI): The MFI is an index to record the name, father's name, and grandfather's name for each household in alphabetic order by gote. For every letter, use one or more pages, as necessary, and start a new page for the next letter. Separate lists are maintained for each gote. For recording household information, use one row for each household's record. In the first column write the name of the head of the household. In the next columns, write the household head's father's and grandfather's names. Put the household number in the last column.

Table 20: Master Family Index (MFI)

Name of Gote _____ Alphabet _____

Household Head			Household number
Name	Father	Grand Father	

Field Book: The Field Book has five columns. For every client served for whom the Family Folder is not available to the HEW, enter the date of the visit, name of the client, and the service provided. Services are recorded in the third column. For recording the service, note the specific service provided. For example, for Family Planning services, record the type of commodity or service provided; for disease, write the diagnosis. In the fourth column, note the name of the household head or the household number, if available, and in the fifth column note the name of the gote to which the client belongs.

Table 21: Field book

Date of visit	Name of the client	Service provided	Household number/ name	Gote

Tallies and reporting forms: Tally sheets are tools used to count service items provided to individuals or any observation units. There are four kinds of tally sheets: service delivery, disease information, tracer drug availability, and family-planning method dispensed.

The HIS reporting forms collect and transfer the data required to calculate the indicators used in performance monitoring. The data are gathered from family/household health information records, using tally sheets, and entered into the reporting forms both manually and electronically. The quarterly and annual reporting forms for each level, along with the definition for each data item reported, and the registered items and tally source for each data item are included in the updated HIS/CHIS manual.

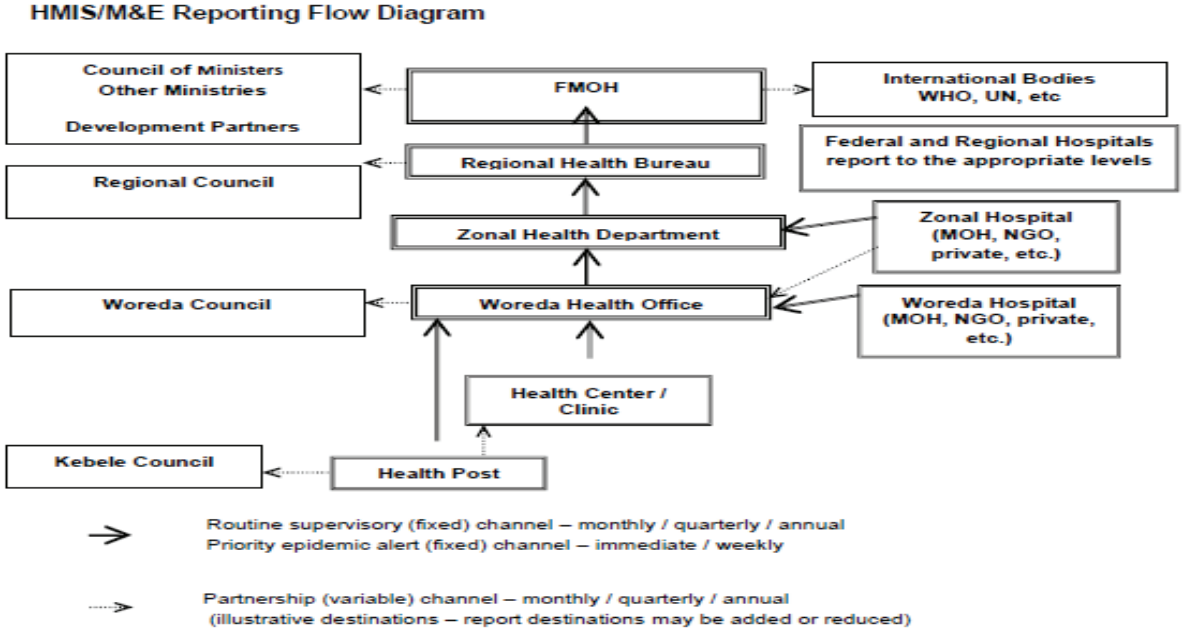


Figure 6: HMIS/M&E reporting flow

Reports flow into and out of the Health Extension Program through the head of the HP, who disseminates the information compiled to the responsible officers. These officers review and may provide feedback or additional processing.

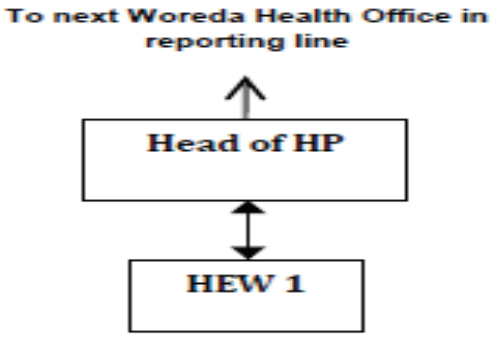


Figure 7: CHIS data flow

Electronic Community Health Information System (eCHIS): This is used for electronic and comprehensive data collection, documentation, analysis, reporting, and use of the information by HEWs to meet the necessary information for providing family-centered health services at the community level. There are 3 mobile applications in eCHIS system:

- **[Primary] Health Extension Worker application**: It supports the HEWs in Family Folder (Pouch) management and prioritizes RMNCH service delivery and follow-up;
- **Health Center referral application**: It supports the HC workers to confirm referrals and provide referral feedback to HEWs;
- **Focal person application:** It supports the supervisor (focal persons) in providing technical and programmatic support to the HEWs.

The eCHIS mobile application system

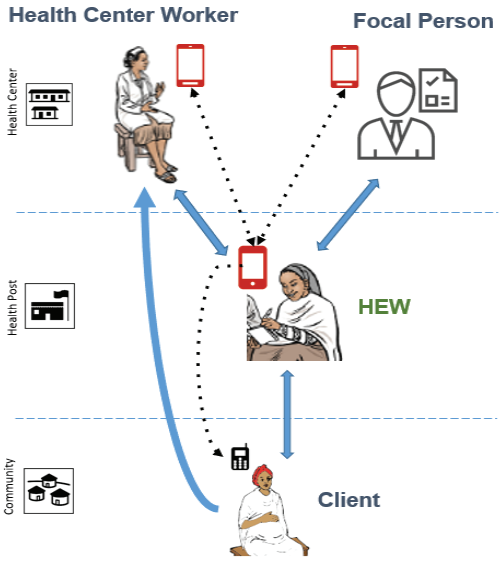


Figure 8: eCHIS mobile application system

Data Quality

Data quality is often defined as "fitness for use." Good-quality health is dependent on the access to and use of good quality data. It is a starting point for healthcare information, whether maintained

manually or electronically. The availability of quality data lies at the heart of functioning evidence-based decision-making in the health sector. It is widely recognized that quality data lead to better clinical and health administrative decisions that result in better health outcomes for the country. Data quality is important for service users, for healthcare organizations, and for researchers.

Symptoms of data-quality problems:

- Different people supply different answers to the same question.
- Data are not collected in a standardized way or objectively measured.
- Staff suspect that the information is unreliable, but they have no way of proving this.
- There are parallel data systems to collect the same indicator.
- Data-management operational processes are not documented.
- Data-collection and reporting tools are not standardized; different groups have their own forms.
- Too many resources (money, time, and effort) are allocated to investigate and correct faults after the fact.
- Mistakes are spotted by external stakeholders (during audits).

Possible solutions to problems of data quality: Guidelines and recording and reporting forms should be standardized and simplified across the health system:

- Integration and institutionalization of health data;
- Build the capacity of the health work force, from data generation to information use;
- Staffing of health institutions with necessary skilled human power to support the HIS;
- Strengthen the Performance Monitoring Team (PMT) at each level of the health system;
- Enhance the culture of information use at each level of the health system.

Data quality assurance: Data quality assessments help improve data quality by uncovering hidden problems in data collection, aggregation, and transmission of priority indicators/data. Knowing about these problems allows health professionals and managers to develop a data-quality improvement plan. Different techniques are used at the facility and administrative levels to determine the level of data quality and take corrective measures.

Techniques of data quality assurance: The following methodology shall be applied to assure data quality at the service delivery and intermediate health administration units. A desk review can be performed of the data that have been reported to the national level, whereas the quality of the aggregate reported data for the recommended program indicators can be examined using standardized data-quality metrics.

Health Post Assessment

Data quality checks using the lot quality assurance sampling (LQAS) method: Other Health Post assessments can be performed to conduct data verification and evaluate the adequacy of the information system to produce quality data (system assessment).

Lot quality assurance sampling: LQAS is a technique useful for assessing whether the desired level of data accuracy has been achieved by comparing data in relevant record forms (e.g., registers or tallies) and the CHIS reports at the Health Post level.

Basic Principles of LQAS

1. A method for testing hypothesis, e.g. desired level of HMIS data quality is achieved (or not)
2. Small random sample for a lot/supervisory area is used
   - The optimal sample size is 19
   - A sample size of 12 also serves well, particularly if it is consistently used over time for studying the same supervisory area
   - Testing only two possibilities i.e. Yes or No; Present or Absent
3. If the number of sampled items not meeting the standard exceeds a pre-determined criterion (decision rule), then the lot is rejected or considered not achieving the desired level of pre-set standard
4. "Decision rule" table is used for determining whether the pre-set criterion is met or not
5. Aggregating LQAS data from multiple supervisory areas can give us mathematical percentage of the level of achievement.
6. Comparing LQAS results over time can also indicate if there is any change or not."

Information use culture: The term *data/information use* refers to the use of data in the decision-making process. A decision-maker uses information if he/she is aware of the decision to be made or question to be answered and relevant information is explicitly considered in the decision-making process, even if the quality of the data is suboptimal.

Culture of information use: The perceived value of individuals and organizations on the role of information for informed decision making.

Information use at the Health Post level: Facilities need information on the coverage or amount and quality of services, resources availability including human resources, patients' satisfaction with the service etc. These kinds of data inform facilities in planning and managing health services, program's performance, and resources.

Information use at the administrative level: For this, information is needed on, e.g., service coverage, burden of disease, disease occurrences, staff performance, and resource availability for planning, policy formulation, performance measurement and improvement, designing interventions, developing strategies, and formulating policies.

Major platforms and forums for information: The major platforms in the health sector for use of information are the woreda-based annual planning, regular performance monitoring meetings, and participatory review meetings. These platforms use information to monitor progress vis-à-vis performance targets set at the time of strategic planning-Health sector Transformation Plan (HSTP) and the woreda-based annual planning. Within this performance improvement framework, results are achieved through a process that considers the institutional context, describes the desired performance, identifies gaps between the desired and actual performance, identifies root causes, selects interventions to close the gaps, and measures changes in performance.

Performance Monitoring

Performance management is an ongoing process focused on reinforcing high performance or improving substandard performance to enhance the knowledge, skills, and behaviors of all employees to achieve organizational goals. HPs should improve the implementation of CHIS/Family Folders through supervisions and mentorship for community and HP staff.

- **Supportive supervision**: This is a continuous and participatory process in which Health Post staff share responsibility for the community to improve community performance using data verification and support the community to obtain the best possible performance from the HPs.
- **Performance Review Meeting (PRM):** This is the practice of periodic review and evaluation of the HPs' performance with the community leaders against specified goals or expectations.

Monitoring and Evaluation

Planning in BSCs: This Ethiopian Health Post Reform Implementation Guideline (EHPRIG) is a comprehensive set of standards for the newly reorganized Health Posts (both Basic and Comprehensive Health Posts); these standards cover the HEP service packages and administration activities in Health Posts. A balanced scorecard (BSC) is a management system that enables organizations to translate the vision and strategy into action. BSC also enhances and encourages accountability to the planning system. Nationally, the BSC is used as the main planning tool in in the health system (FMOH, health bureaus, and health facilities). EHPRIG implementation should be included in BSC planning by all stakeholders of the program. Comprehensive Health Posts should include the implementation of EHPRIG standards in their main BSC plan. EHPRIG standards should be cascaded to the Health Post staff at the individual level. The Health Post staff should also review the performance of the implementation of the standards regularly.

Analysis: Health Post staff should have a discussion session regarding the performance of the Health Post. The Health Post coordinator—probably the health officer and other staff—shall focus on the gaps in the review and develop action and an intervention plan to enhance the performance. Finally, the action plan must be discussed with all stakeholders and approved by the catchment the HP staff.

Performance Monitoring Team (Comprehensive HPs only): In Comprehensive HPs, the Performance Monitoring Team is a team comprising a multidisciplinary health workforce that is primarily responsible for improving data quality and using information regularly to monitor progress and improve performance at all levels. Ensuring data quality and the continuous use of information will result in improvement in the access to, use of, coverage of, and quality of health services. The Performance Review Team is formed at the HP level.

- The HP head or delegate will be the chairperson for the HP–PMT;
- All HP staff will be team members;
- The reporting focal person will serve as secretary and be responsible for:
  - Ensuring the data accuracy, timeliness, and completeness of reports
  - Supporting the case team coordinators to review and interpret the data analyzed to help them decide and take action;
  - Ensuring the recording of the meeting minutes, archiving the minutes, and circulating them to all concerned in a timely manner.
- The PMT will evaluate the overall performance accordingly.

Data analysis and reporting using DHIS2 application (Comprehensive HPs only): To address the growing need for timely, complete, and accurate reporting across the various health networks, the FMOH developed the District Health Information System (DHIS 2), a health information system that supports local governments at various levels (Federal, Region, Zone, Woreda, health facility) to efficiently carry out three core categories of health information management activities:

- Collecting, capturing, validating, and forwarding raw health data;
- Processing data, which entails analysis, extraction, form manipulation, production, and dissemination of statistics, reports, graphs, maps, and similar health information;
- Using data/information for daily management, budget allocations, and long-term planning, which have traditionally been done to a very limited extent by most managers and decision-makers.

DHIS 2 is a secure, web-based information system that enables health facilities, Woreda Health Offices (WorHOs), Zonal Health Departments (ZHD), and RHBs to electronically compile data on weekly and immediately reportable diseases, outpatient department (OPD), inpatient department (IPD), and service delivery for Public Health Emergency Data and electronically receive and submit them to the next level. Reports are submitted and received electronically through DHIS 2, working in both offline and online modalities. The data and data elements also can also be exported via removable media, such as USB flash drives, and CD/DVD, where internet/network connectivity is not available.

Data-quality checks using the DHIS2 application

Ensuring data quality is a key concern in building an effective CHIS. Data quality has different dimensions, including:

- **Correctness:** Data should be within the normal range for data collected at that facility. There should be no gross discrepancies when compared with data from related data elements.
- **Completeness:** Data for all data elements for all health facilities should have been submitted.
- **Consistency:** Data should be consistent with data entered during earlier months and years while allowing for changes with, e.g., reorganization, increased workload, and consistent with similar facilities.
- **Timeliness:** All data from all reporting organizational units should be submitted at the appointed time.
- **Data quality checks:** Data quality checking can be done through various means, including:
  - At the point of data entry, the software checks the data entered to see whether it falls within the min–max ranges for that data element (based on all previous data registered);
  - Defining various validation rules, which can be run once the user has finished data entry.
  - The user can also check the entered data for a particular period and organizational unit(s) against the validation rules and display the violations for these validation rules.
  - Analysis of data sets: i.e., examining gaps in data.
  - Data triangulation: comparing the same data or indicators from different sources.

IMPLEMENTATION CHECKLIST

Table 22: Health Information System and monitoring implementation checklist

SN	Standard	Verification criteria	Yes (√) No (×)	Met = 1 Unmet = 0	Remarks
1	The Health Post prepares annual, quarterly, and monthly plans.	Has an annual plan using BSC			
		Has a cascaded quarterly plan from the annual plan using BSC			
		Has a cascaded monthly plan from the annual plan using BSC			
2	The Health Post has a functional M&E system.	Monthly, quarterly, and annual reports prepared			
		Review Health Post performance monthly, quarterly, and annually			
		Performance plan vs. performance by PMT			Check whether PMT is established
		Perform root-cause analysis			
		Action plan developed			
3	The Health Post has implemented a community health information system/Family Folder system.	Has used a standards registry and field book			
		Has used a standard tally and CHIS reporting tools			
		Has used Family Folder /HH register			
		Has secured enough registry, tallies, and CHIS reporting tools for three months			
		Has willow/tickler boxes: Unique FF numbers given to all households (If applicable) Data registration has a tickler box for the tracing system for EPI, ANC, and FP services			
		Every individual Family Folder is registered with the electronic-based records system. **A paper-based registration** system should have an updated Family Folder **Note:** Review the use of forms: 10 Family Folders to MPI: check the completeness of the Family Folder Pouch; Health Card; Integrated Maternal & Child Care Card, and field book			
		Separate shelve for storing medical records.			
		Have adequate furniture's (at least 4 tables with drawers, 2 cap board 10 chairs, 5 and accessories) and office materials			

SN	Standard	Verification criteria	Yes (√) No (×)	Met = 1 Unmet = 0	Remarks
4	The Health Post has implemented a data-quality audit on selected priority problems.	Self-assessments of Health Post performance conducted using LQAS (Lot Quality Assurance Sampling)			
		Check completeness (content & representative) and timeliness (on time reporting)			
		Major indicators selected for follow up where the Health Post has poor performance			
		Develop action plan			
5	The Health Post has updated display charts.	Perform data cleaning, and analysis Display plan VS performance by using standard minimum display charts			
		Plan VS performance Map of catchment area Catchment Population Profile Ten Top Causes of Morbidity (Males & Females) Top Five Causes of Morbidity In < 5 Children Functionality of WDG/A/s Reproductive Health (ANC) Immunization Monitoring For < 1 Children (Penta3, PCV, Measles) Kebele resource profile Sanitation profile Outreach Locations and Schedule Malaria Monitoring Chart			
6	The Health Post has a functional electronic community health information system.	Have functional tablets with updated eCHIS application.			Review the utilization electronic CHIS (Randomly sample 10 individual Family Folders seen in the previous quarters, and confirm that all data elements were entered in electronic CHIS (demographic data, clinical and administrative data)
		Have updated community data in electronic Community Health Information System (eCHIS)			

INDICATORS

Table 23: Health Information System and monitoring implementation checklist

	Standard	Formula	Period	Remarks
1	% of timely reporting sent to Health Center	Total # of reports sent on time to Health Centers × 100% Total expected report	Quarterly/ biannual/ annual	
2	% of complete reporting sent to Health Center	Total # of complete reports sent to Health Centers × 100% Total expected report	Quarterly/ biannual/ annual	

References

1. HEP Optimization Roadmap, 2020
2. HEP Optimization Roadmap Implementation Manual, 2021
3. Ethiopia's Essential Health Service Package, 2019
4. Federal Ministry of Health (2010), Community Health Information System User's Manual for Data Recording and Reporting, October 2010
5. Federal Ministry of Health (2018), eCHIS End User Training for HEWs, November 2018
6. Federal Ministry of Health (2018), Health Data Quality Facilitator Manual, July 16, 2018
7. World Health Organization. (2010). Western Pacific Country Health Information Profiles, 2010, revision 2.
8. A Guideline on Referral System, 2010
9. Ethiopian IPLS
10. HCRIG

Appendices

APPENDIX A: SAMPLE BIN CARD

Name of health facility .....
Product name, strength, and dosage form .....
Unit of issue .....

Date	Doc. No. (receiving or issuing)	Received from or issued to	Quantity				Batch No.	Expiry Date	Remarks
			Received	Issued	Loss/Adj.	Balance			

APPENDIX B: SAMPLE STOCK CARD

Name of health facility .....
Maximum stock Level .....
Product name, strength, and dosage form .....
Reorder Level ....
Unit of issue ..... **Bin Location** .....
Minimum stock level/ Emergency order point .....
Average Monthly /last month consumption if regular increase/ .....

Date	Doc. No. (receiving or issuing)	Received from or issued to	Quantity				Price		Expiry Date	Remarks
							Unit Price			
			Received	Issued	Loss/ Adj.	Balance	Birr	Cent		

APPENDIX C: STOCK STATUS ANALYSIS CHART

Ser. No.	Description: Name of drug, dosage form, Strength, brand (if any)	Units	Total stock on hand & ordered	Expiry Date	Average monthly or last month's consumption (if increasing)	Months of stock (MOS) Stock could be enough for ___ months	Until expiry, the amount of stock that could be consumed	Overstock (will expire unless measures are taken)	Additional stock needed for the next 4 months	
									Amount of stock in unit	Months
			A	B	C	D	E	F	G	H
Key: A = Stock Dispensing Units + Other Service Units + Pharmacy Store +SO		C = Quarterly consumption 3 – DOS in months		D = A ÷ C	E = (C x Shelf life in month), or = (A) when no overstock Note: *S.L			F = A – E	G = (C x 4) – DC	

Note:- If column **G** is a negative number, then divide that number by column **C**; the result is the amount of stock available that can be used for extra months (more than 4 months), months beyond the 4^{th} month are indicated as negative **H**, and out-of-stock months before the 4^{th} month are indicated as positive **H**. When calculating **D,** the shelf life of a drug is very much important. *S.L. stands for "shelf **life"** of a drug should be considered in calculating consumption ". SO=stock ordered, DOS=days out of stock in months. When ABC/VEN analysis is performed and when **A** class items are in discrepancy with VEN, then **A** class should be subjected to Stock Status Analysis. When a drug is near expiry, it should be analyzed with this Stock Status Analysis Form.

APPENDIX D: FACILITY COMBINED–REPORT AND REQUISITION FORM (FC–RRF)

Health Facility ..... **Region** ..... **Zone** ..... **Woreda** .....
Reporting period: From ..... **to** .....
(Month/day/year) (Month/day/year)

SN	Item Code	Item Description	Unit of Issue	Report Part						Requisition Part	
				Beginning Balance in Store	Quantity Received	Losses/ Adjustments	Ending Balance in Store	Days Out of Stock	Calculated Consumption	Maximum Stock Quantity	Quantity Ordered
				A	B	C	D	E	F=A+B+/-C–D	G = F * 2	H = G – D

Remarks:

Completed by: ..... signature: ..... date: .....

Approved by: ..... signature: ..... date: .....

APPENDIX E: SAMPLE STORE INVENTORY FORM (SIF)

Name of Health facility ..... Section (unit) store Page number ..... Date .....

SN	To be Filled before Physical Inventory						To be Filled during Physical Inventory		To be Filled after Physical Inventory			Remarks
	Drug code	Description (drug name, dosage form, strength, and brand)	Unit	Batch No.	Expiry date	Unit cost	Physical Qty	Stock card Balance	Total cost		Discrepancy	
								Sum Total				

Inventory Registered by Name ..... Counted by Name ..... Recounted by Name .....

Signature ..... Signature ..... Signature .....

Responsible Persons

Name .....

Signature's .....

APPENDIX F: SUGGESTED CLEANING GUIDELINES FOR HEALTH POST ENVIRONMENTS

Item/Area	Method	Minimum Frequency
Waiting area	Use clean cloths and change frequently during cleaning; disinfectant solution preferred (follow contact time). Wet-mop floor (detergent is adequate).	Daily; pay attention to chairs, tables, and other surfaces in frequent contact with hands.
Exam room/area	Use clean cloths for each room; change cloths frequently when cleaning a large area; disinfectant solution preferred (follow contact time). Wet-mop floor (detergent is adequate unless contaminated with blood or body fluids, then use a disinfectant).	Between patients unless surfaces are covered (then daily) or immediately when contaminated with blood/body fluids. Pay attention to exam table, chairs, and tables.
Hand washing sinks	Use disinfectant to clean sink, water tap, and faucet handles. Re-supply soap and clean towels.	Daily
Bathrooms	Use dilute bleach or other disinfectant to clean toilet, sink, water tap, faucet handles, and doorknobs. Wet mop floor with a disinfectant solution. Re-supply soap, clean towels.	Daily; more often as needed
Corridors	Wet-mop floors; detergent/water solution is adequate. Change bucket solution and mop head frequently.	Daily
Trash	Empty daily, more often as needed.	

APPENDIX G: SAMPLE VACANCY NOTICE FORM

Reference No: ..... Date: .....

1. Name of agency .....
2. Vacant position
   a. Title .....
   b. Grade .....
   c. Salary .....
   d. Number of posts available .....

3. Minimum requirements to quality for the position: .....
4. Additional requirements for the position:
   a. Knowledge .....
   b. Skills .....
   c. Competence .....
   d. Other essential qualification traits .....

5. Supporting documents that must be submitted with application Form:

.....

6. Description of position: .....
   .....
7. Salary and benefits:: .....
   .....
8. Place of registration: : .....
   .....
9. Registration closing date: : .....
   .....

Applications must be submitted on a Standardized Application Form. Copies of the Application Form and further details about the position, including a copy of the job description can be obtained from:

Name: ..... Tel: ..... email: .....

APPENDIX H: REFERRAL FORM (SAMPLE)

Patient referral form						
From (referring facility)						
Address of health facility						
Arrangements made	Yes	No	Tel No.	Fax No.	Case No.	
To (receiving facility) Receiving health professional				Date		
Patent's Name address	Date of birth ..... Age			Sex	M	F
History						
Findings						
Treatment given						
Reason for referral						
Name of referring health professional (and telephone number)			Signature Reg. No.			
On completion of management of patients, please fill in and detach the referral back slip below and send with patient, fax, or post						

Tear off .....

From		Tel No.	Fax No.	
Reply from (name)			Date	
To referring person				
Address of health facility				
Patent's Name				
Identity No	Address	Age	Sex	M F
This patent was seen by			on	
Patent History				
Physical Findings				
Special Investigations				
Diagnosis				
Treatment/Operation				
Medicines prescribed				
Please continue with (meds, Rx, F/u, care) Refer back to	on			
Name of doctor, signature and Reg. No.				

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MINISTRY OF HEALTH - ETHIOPIA
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Health Extension Program Optimization:

Comprehensive Health Post Reform Implementation Guideline