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

Scientific Group Discussion on The National I-CARE Program

I C A R E

Day One Afternoon

Time	Activity	Presenter	Moderator
1:30 PM	Introduction of Agenda, Objective and Outputs	Dr Abraham Endeshaw, Chairperson ARM-I-CARE Panel Discussion	Esayas M, Senior Adviser, MSGD/FMoH
1:35 PM	I-CARE Documentary Film	PRCD-FMoH	Esayas M, Senior Adviser, MSGD/FMoH
1:45 PM	General Overview of National I-CARE Program	Yakob Seman, Director General for Medical Services, FMoH (Panelist)	Esayas M, Senior Adviser, MSGD/FMoH
2:10 PM	Innovative Hospital Financing	Dr Girmaye Deye, Health Economist, PCD/FMoH (Panelist)	Esayas M, Senior Adviser, MSGD/FMoH
2:35 PM	Culture of Hospital Amenities Management	Mebratu Masebo, Senior Adviser, EHIA, (Panelist)	Esayas M, Senior Adviser, MSGD/FMoH
3:00 PM	Standardization of ME and Laboratory Service	Sufian Abdulber, Senior Adviser, PMED/FMoH, (Panelist)	Esayas M, Senior Adviser, MSGD/FMoH
3:25 PM	Introducing Health Professional Dressing Code	Helen Teklebirhan, Senior Expert, CSD/FMoH, (Panelist)	Esayas M, Senior Adviser, MSGD/FMoH
3:50 PM	Health Break		ARM-Organizers
4:10 PM	General Discussion: Q&A	Participants	Dr Abraham E. Chairperson and all panelists
6:00 PM	Day one summary and next day briefing	Dr Abraham E. Chairperson	Esayas M, Senior Adviser, MSGD/FMoH

Day Two

Time	Activity	Presenter	Moderator
8:30 AM	Short overview on National CATCH-IT Initiative	Kasu Tolla, Senior Expert, CSD/FMoH	Esayas M, Senior Adviser, MSGD/FMoH
9:00 AM	Short overview on National IPC Initiative	Molla Godif, Senior Expert, CSD/FMoH	Esayas M, Senior Adviser, MSGD/FMoH
9:30 AM	Short overview on National AMR	Ednekachew Degefaw, National AMR Coordinator	Esayas M, Senior Adviser, MSGD/FMoH
10:00 AM	Short overview on National Patient Safety	Dr Desalegn Bekele, Senior Expert, HSQD/FMoH	Esayas M, Senior Adviser, MSGD/FMoH
10:30 AM	Short overview on National Major City Initiative, MIS-Project	Dr Alegnita G, Director for ECCD/FMoH	Yakob S. Director General
11:00	Health Break		ARM-Organizers
11:30 AM	General Discussion	Dr Abraham E. Chairperson and all presenters	Esayas M, Senior Adviser, MSGD/FMoH
12:30 PM	Lunch		ARM-Organizers
1:30 PM	Hospital specific I-CARE implementation plan development	All I-CARE implementing hospitals	Esayas M, Senior Adviser, MSGD/FMoH
3:30 PM	Health Break		
4:00 PM	Hospital specific I-CARE implementation plan development	All I-CARE implementing hospitals	Esayas M, Senior Adviser, MSGD/FMoH
5:30 PM	Summary of the two days discussion and closure of the panel	Dr Abraham E. Chairperson and Yakob S. Director General	Esayas M, Senior Adviser, MSGD/FMoH

I-CARE

Objectives of the Panel Discussion

:

- Introduce the concept of I-CARE
- Enrich the concept of I-CARE
- Discuss Implementation strategy and roles and responsibilities
- Introduce selected I-CARE initiatives
- Discuss Implementation Challenges and outline Key next steps

Approach of the Panel

Panelists will briefly make presentations on identified areas:

- Concept ,expected outcome and implementation strategy I-CARE
- Hospitals Financing
- Hospital Amenities Services Management
- Access to Essential Medical Devices

Expected Outcome of the Panel:
Common consensus and clear implementation next steps on **I-CARE**

I C A R E

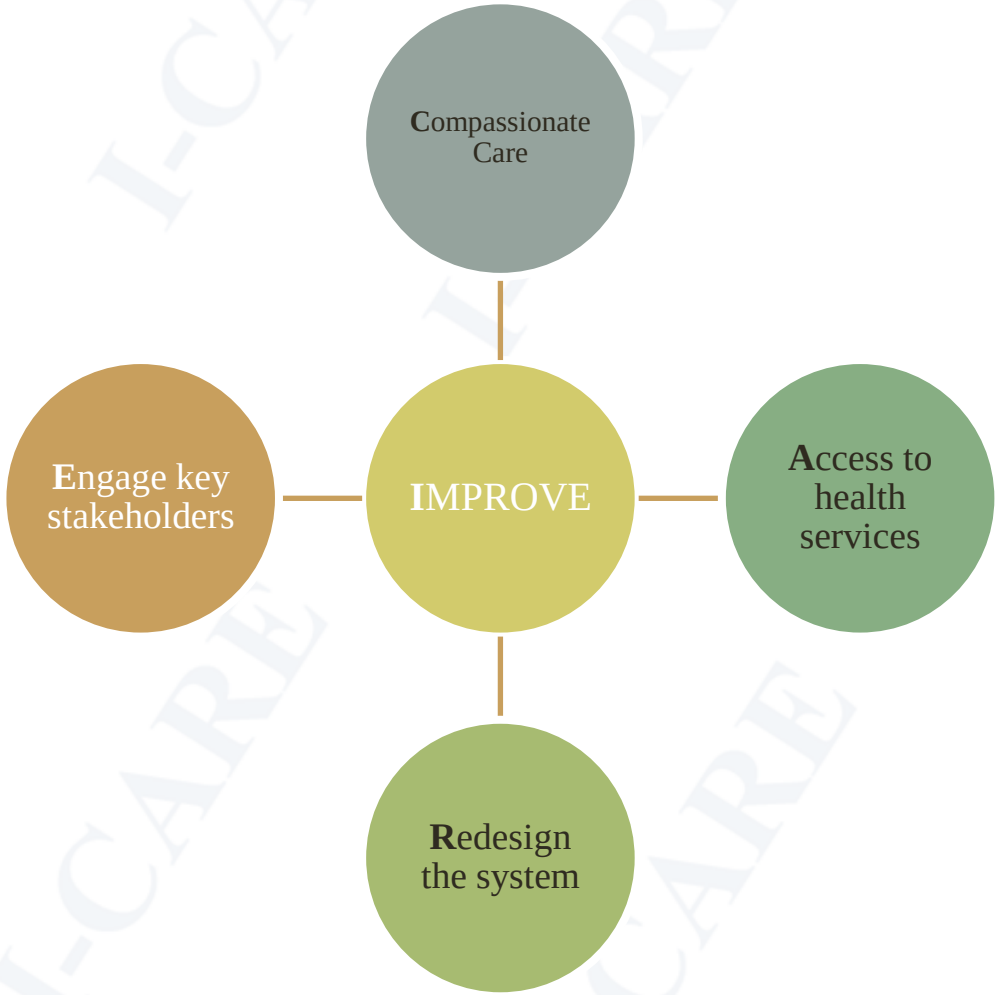
I-CARE… basket of solutions for the challenges of our time in provision of hospital's services

Overview of The National I-CARE Program

Yakob S
Medical Services, Director General
Yakob.seman@moh.gov.et

Introduction and Pillars

- **I**MPROVE
  - **C**ompassionate Care
  - **A**ccess to health services
  - **R**edesign the system
  - **E**ngage key stakeholders



Key Measures and Targets for I-CARE

- Reduce hospital waiting time
  - Outpatient waiting time to treatment
  - Average length of stay
  - Emergency stay greater than 24 HRs
  - Delay for elective surgical admission
- Improve Surgical Volume
  - National backlog clearance
  - Reduce cancelation
  - Operation theater efficiency
- Improve Client Experience
- Improve Staff Engagement
- Improve Revenue retention and utilization
  - Proportion of revenue collected
  - Proportion of revenue utilized

I-CARE Interventions for Selected 24 Hospitals

Compassionate Care

- **Scope Based Clinical Practice**
  - Develop scope of practice for all professionals and level of care
  - Design Implementation strategies and build capability
  - Integrate scope of practice with pre-service training
- **Pain Free Health Facility**
  - Create pain free culture
  - Capability building on Pain management
  - Design stock management system for pain management drugs

Compassionate Care

- **Standardization of care**
  - Implement EHSTG standards
  - Implement HSTQ clinical standards
  - Implement national clinical audit guideline
- **Caring Health workforce development**
  - Establish Patient council
  - Establishment of health and health system literacy unit in the hospitals
  - Establish Volunteer service coordination office
  - Opening of legal offices and protect health professionals in all hospitals

Access to Health Services

- **Access to basic surgical service /SALTS:**
  - Introduce Surgical Backlog Clearance campaign
  - Equip and make OR blocks functional
  - Create alliance between primary and university hospitals to improve efficiency

- Introduce Day care surgery
- Improve Operation theatre efficiency
  - Maximal time utilization
  - Temporary and permanent leadership – OR director
  - Resource sharing for OR table
  - Standardizing preoperative preparation protocols
  - Revisiting preoperative and postoperative stay
  - Data driven system for productivity – open days
  - Reduce cancelation

Access to Health Services

- **Access to specialty and sub-specialty care**
  - Finalize and launch tertiary care roadmap
  - Develop public private partnership model for tertiary care
  - Establish centre of excellence for tertiary care based on facility mission and vision

- **Access to basic emergency, trauma and intensive care**
  - Pre-hospital emergency care with ambulance management
  - Establish 60 standardized emergency units in the country
  - Establishment of need based advanced trauma centers and ICUs
  - Creating surge capacity to handle mass casualty incident and disasters advocacy and mobilization
  - Mass training of BLS for formal and informal sectors

Access to Health Services

- **Access to diagnostic service**
  - Putting all the hospitals on laboratory framework agreement
  - Introduce PPP model
  - Tele-consultation

- **Access to essential drugs**
  - Access to essential drugs and ME availability
  - Expansion of Model Community Pharmacy
  - Clinical pharmacy service
  - Rational use of drugs and AMR
  - APTS Automation

Redesign the System

- **Major city medical service improvement project(MIS-Project)**
  - Create integration modality between RHB, Regional hospital and university hospital
  - Regular evaluation of major city medical service status using set indicators
  - Improve pre-hospital emergency care
  - Redesign Referral communication and network
- **EHIAQ implementation**
  - Initiate regional EHAQ and EPAQ
  - Set a priority intervention area, clear measurement and evaluation method
  - Recognition of high performing PHCU and hospitals based on the alliance performance

Redesign the System

- **Teaching Hospitals Improvement Project(THIP)**
  - Finalize teaching hospitals leadership and governance structure
  - Integrate mandatory clinical audit and quality improvement for medical students
  - Clinical Service, research and Academic Integration
  - Implement scope based practice
- **Redesign pharmaceuticals procurement system**
  - EPSA Reform
  - Framework agreement of non EPSA items
  - Implement Service Level Agreement for high tech equipments

Engage key Stakeholders

- **Team transformation at point of care**
  - Clients and clients engagement during care provisions
  - Improve client privacy
  - Team building trainings and LIP
- **Engage senior physicians in system design**
  - Establish senior physician engagement campaign for ICARE implementation
  - Training of selected senior physicians on health care leadership
  - Funding opportunity for QI projects
  - Create linkage with quality journals or Establish national HCQJ

Engage Key Stakeholders

- **Engage Health Professional Associations**
  - Establish professional council
  - One plan, one budget and one report concept revitalization
  - Joint supervision, review meetings and reward
- **Engage medias and media houses to build health and health system literacy**
  - Health programs in all TV and radio stations
  - Films and drams to build a resilient health system
  - Media forums establishment
  - Medical journalism

National Priorities for 2012 E.C

National Priorities

- **P1: Redesign Hospitals financing**
  - Approval of the new fee revision document and launch the implementation
  - Finalize and approve internal revenue collection and utilization guideline
  - Show case the implementation in selected health facilities
- **P2: Engagement of private for profit organizations**
  - **P2.1: Standardize professionals uniform and textile products in the hospitals**
  - Approval of the dressing guideline and launch the implementation
  - Support regions to adapt and implement the guideline
  - Establish framework agreement system with selected garments

National Priorities

- **P2.2. Standardization of Hospitals food service**
  - Develop national hospital food management guideline and Hospital food menu
  - Support regions to adapt and implement the guideline
  - Establish framework agreement system with selected hotels
- **P3: Engagement of private for non-profit**
  - Hospital renovations by philanthropy investors
  - Equip hospitals

National Priorities

- **P4: Improve Laboratory Services**
  - Placement lab equipment in selected facilities
  - Framework procurement of reagent
  - Improve test availability by 85%

Governance

- MoH will take the leadership role for the 24 hospitals
- During the pilot these 24 hospital will be under one leadership
- Agreement been reached between regions and federal to implement the initiative in 24 hospitals
- Working guide will be finalized and shared to the hospitals
- Hospital specific plan will be developed and shared
- Costing will be done by the national team in collaboration with RHB team

Roles of MoH

- Describe the initiative with key interventions
- Reach consense with regions
- Develop hospital selection criterion
- Mobilize resource
- Take the national leadership of the initiative
- Integrate the initiative with in the current structure to follow its implementation

Roles of RHB

- Customize the initiative with key interventions
- Reach consensus with regional government
- Select pilot hospitals
- Mobilize resource for matching
- Take the regional leadership of the initiative
- Integrate the initiative with in the current structure to follow its implementation
- Make regular report to the federal ministry of health

BFR Model for I-CARE

- Model of robust performance management
- 8-steps approach that is radical & transformational.
- Practical Delivery Units, Reform Teams and Performance Management
- Transparency and accountability are central pieces
- Creates and apply accountability
- Works for any business
- Robust planning, implementation, monitoring and evaluation process
- No room for unnecessary and uncalculated assumptions

BFR Model for I-CARE

Strategic Direction **(Step-1)**	• Delivering basic hospital's level changes • Capturing low hanging fruits • Focusing on what matters most for both patients and hospital
Lab sessions **(Step-2)**	Lab sessions are composed of all relevant experts and decision makers from the hospital. It should also include key representatives from hospital's external stakeholders who have high influences and contributions during hospital's I-CARE plan development, implementation, monitoring and performance evaluation

BFR Model for I-CARE

Open days **(Step-3)**	• Publicly displaying all the proposed detail I-CARE Implementation plan • A kind of formal forum by which the hospital engages all other internal and external stakeholders to collect possible constructive comments for further enrichment of hospital's I-CARE plan
Detailed Roadmaps **(Step-4)**	• Robust exercise to detail all the required Hospital's I-CARE implementation activities including the "what, why, how parts of the plan" which are ultimately to be shared with all relevant stakeholders • A meticulous detailed roadmaps are created for each implementation periods such as yearly, monthly and weekly

BFR Model for I-CARE

KPIs and Targets **(Step-5)**	This step of BFR Model refers to: • Setting measurable and traceable KPIs to clearly monitor performances of hospital's approved I-CARE implantation major activities or interventions • This step creates clear accountable and performance monitoring framework for all relevant stakeholders to be aware and confident enough at all stages of I-CARE implementation period
Implementation activities **(Step-6)**	This step of BFR Model refers to: • Based on step-5, the hospital will clearly and meticulously describe everything necessary to make sure all I-CARE implementation phases are monitored and controlled based on the agreed yearly, monthly and weekly expected implementation outcomes • This step clearly informs the detail roles and responsibilities of all individuals and organizations. • It also shows all models of collaborations, level of stakeholders' engagements

BFR Model for I-CARE

Performance Validation **(Step-7)**	There is no room for false report Strict Data capturing Approving all types of reports at all levels Plan Vs Report Validation, Reports Vs Registries Validation Continuous Validation System Cultivate Trust-ship among team work Full engagement and empowerment
Performance Monitoring and Review **(Step-8)**	This step clearly informs to all stakeholders on what the hospital has delivered or achieved finally after implementing all the agreed major I-CARE implementation activities or interventions • This step is the place where the hospital will clearly tell to its all stakeholders on how it will evaluate what it has delivered after completion of I-CARE implementation periods

Thank you

Hospital financing reform in Ethiopia

Girmaye D. Dinsa, PhD

Outline

- Current hospital financing
- The need for reforming hospital financing
- Costing hospital services
- Innovative financing

How are Hospitals Financed Currently?

Government

- Probably the largest hospital financer
- Inefficiencies – shortages/wastages

Patient

- Pays highly subsidized or no fees – eligibility issue
- Don’t know actual cost of services

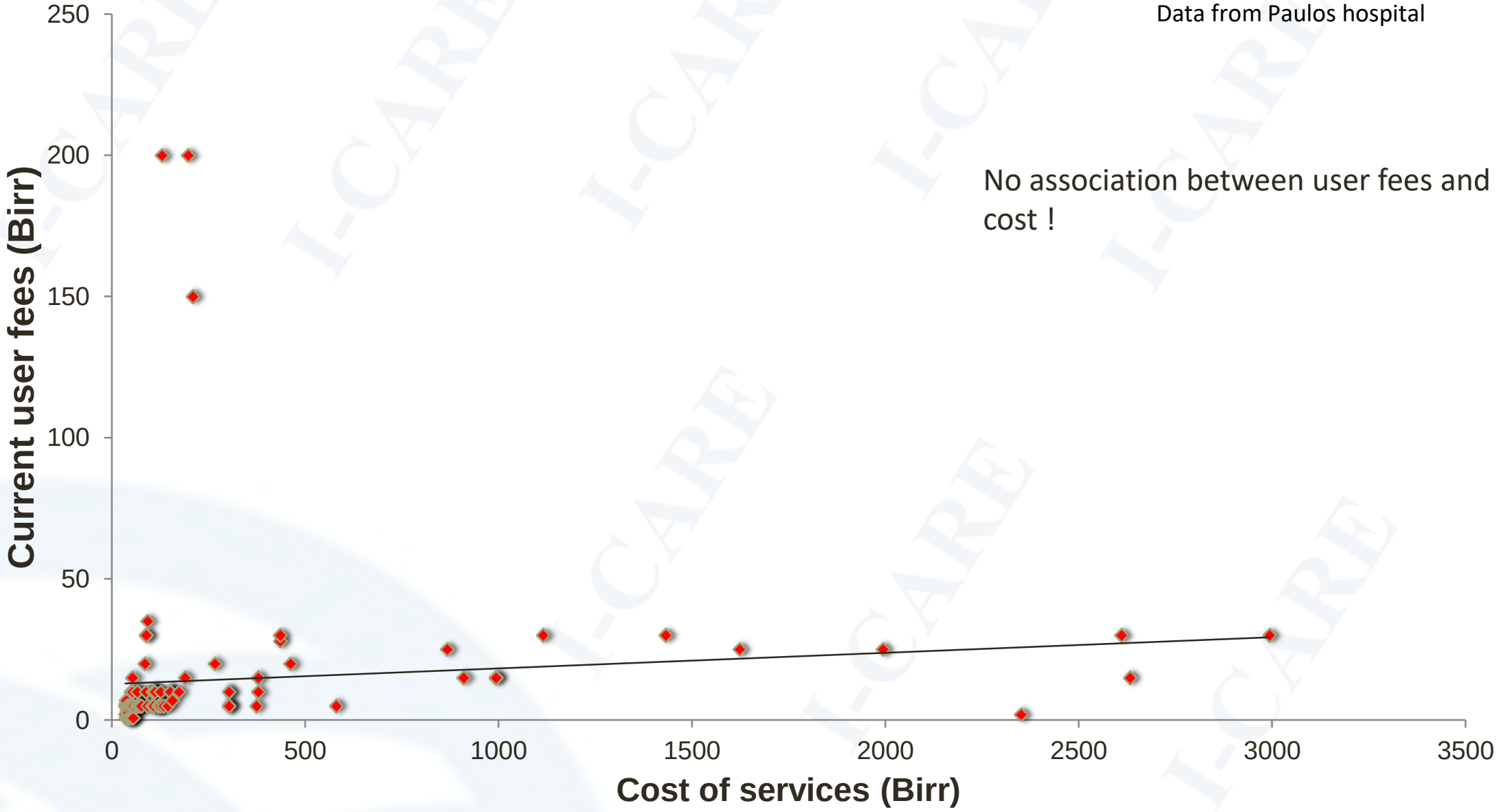
Insurance

- Not everyone is covered
- Limited capacity to pay for services

Inefficient and underfinanced hospitals

Relationship Between User Fees and Cost of Services

Data from Paulos hospital



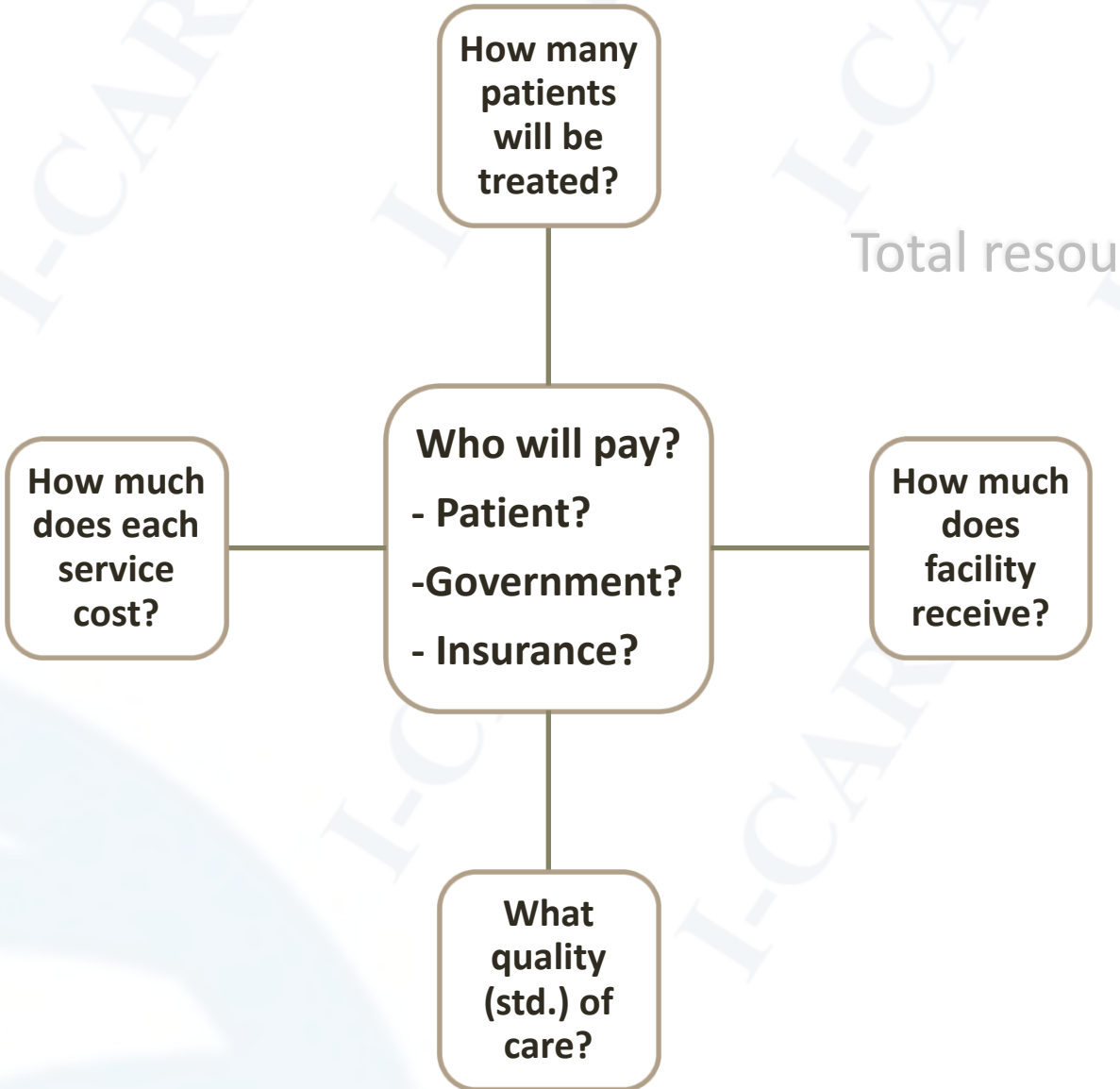
No association between user fees and cost !

How Should Hospitals be Financed?

Fees ≥ Cost

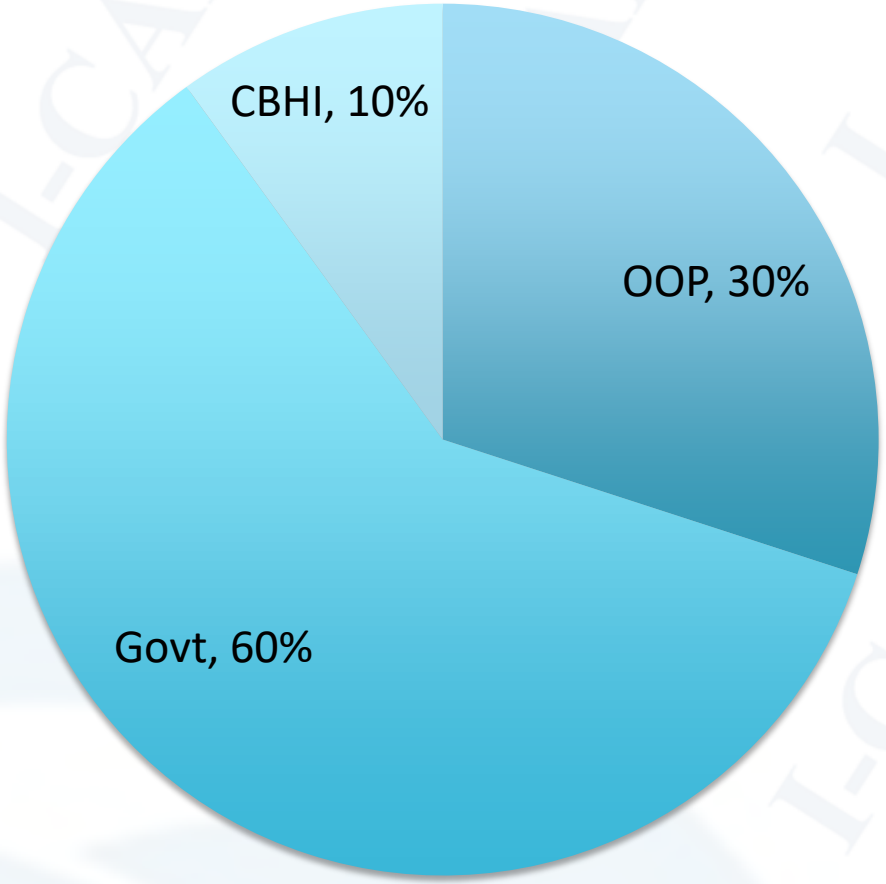
Sustainable and Quality Hospital Services

Components of Hospital Financing Reform

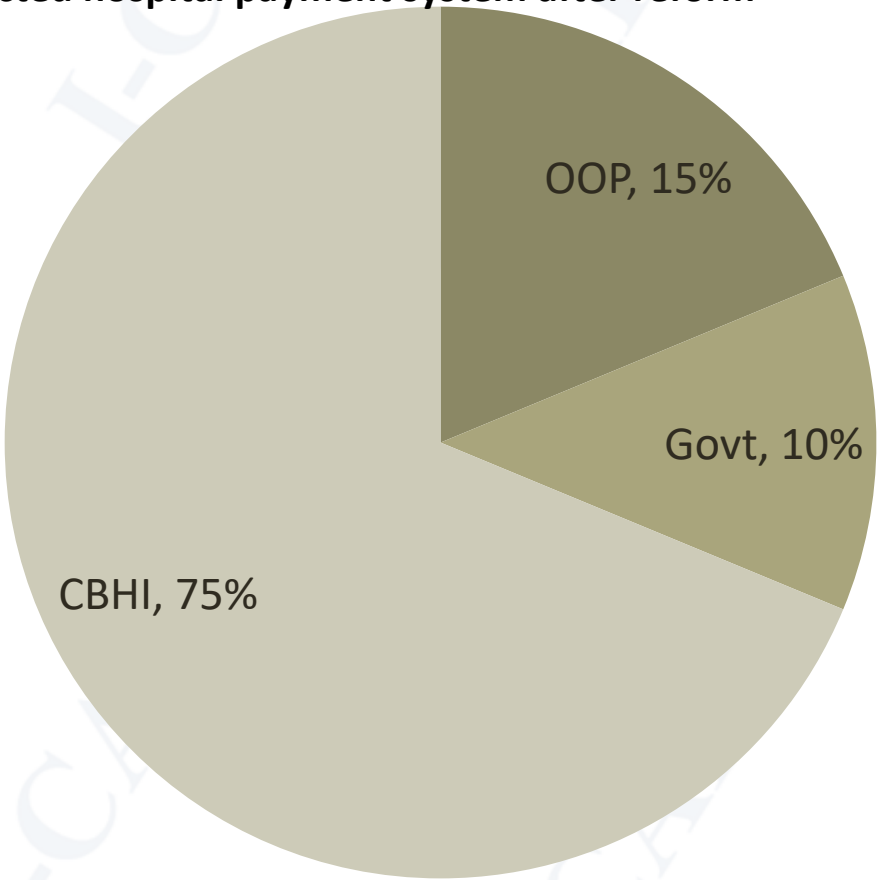


How are Hospitals Financed Currently?

Current hospital payment system



Expected hospital payment system after reform



Innovative hospital financing?

Rationale for Hospitals Financing Reform?

- To move away from input-based to output-based financing
- To improve service availability and quality of care
- To separate service seller and purchaser as well as regulator
- To ensure hospitals are financed sufficiently and sustainably

New Hospital Costing and User Fees

Outline:

- Methods
- Results
- Implications

Method (1)

$$Csd = SSsd + EQUIPsd + HRsd + INDIRs + DRUGs$$

Where:

- Csd = cost of service *s* in department *d*
- SS*sd* = Cost of supplies (consumables) required to provide service *s* in department *d*
- EQUIPsd = Depreciation cost of equipment (non-consumables) for service s in department d
- HRsd = remunerations for health workers' time for providing service *s* in department *d*
- INDIRs = indirect cost (overhead cost) in the hospital allocated to service *s*
- DRUGs = cost of drugs provided for service *s*
- *Note: cost of infrastructure (building) not accounted for*

Methods (2)

- Supplies (consumables)
- Equipment
- Human Resources
- Indirect cost
- Drugs

Methods (2) - Supplies

- **Unit/quantity** of supplies multiplied by **unit cost** of supplies required for providing specific service
- Type and quantity of supplies required for each service determined and validated by experts from respective specialties (based on current clinical practice)
- Cost of supplies collected from EPSA and unit cost calculated by research team

Methods (3) - Equipment

- **Time** equipment is used **(in minutes)** for providing specific service multiplied by **depreciation rate (per minute)** of that equipment

- Type and duration of equipment used for each service was determined by experts gathered from respective specialties (based on current clinical practice)

- Cost of equipment collected from EPSA and depreciation rate calculated by research team

Methods (4) – Human Resources

- **Clinical staff time (in minutes)** of relevant type multiplied by **remuneration (per minute)** of clinical staff required for providing specific service.

- Type and duration of staff time (in minutes) required for each service determined by experts gathered from respective specialties/departments based on current clinical practice

- Cost of staff time collected from Human Resources Administration and compensation per minute calculated by research team

Methods (5) – Indirect Cost

- **Indirect expenditure** data collected from 3 Federal/University hospitals in Addis Ababa and 3 in regions for 2009/10 EFY.
- Calculated proportion of indirect cost out of total expenditure of these hospitals – this came to 10 to 20% of total spending
- Increased cost of each service by averaging indirect cost (15%)

Methods (5) – Indirect Cost

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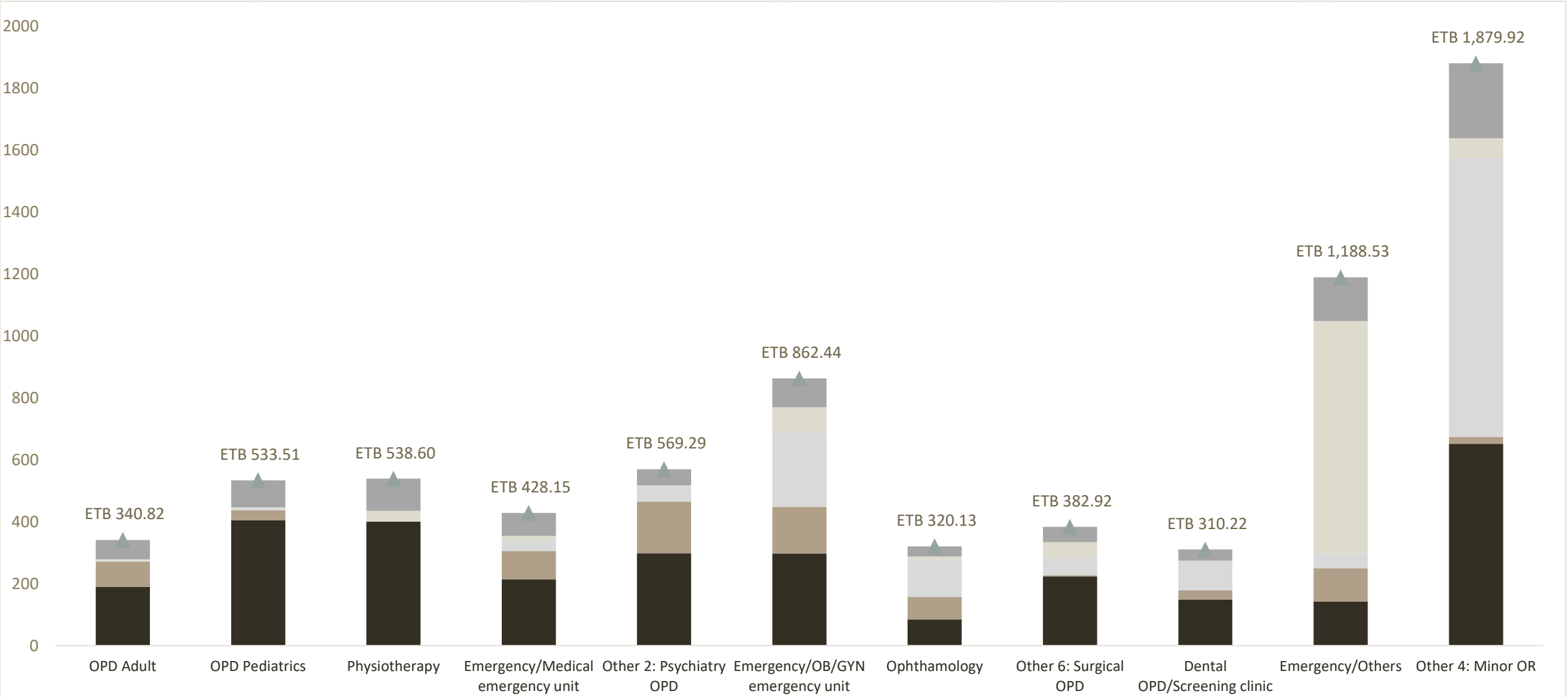
- Increased cost of each service by averaging indirect cost (15%)

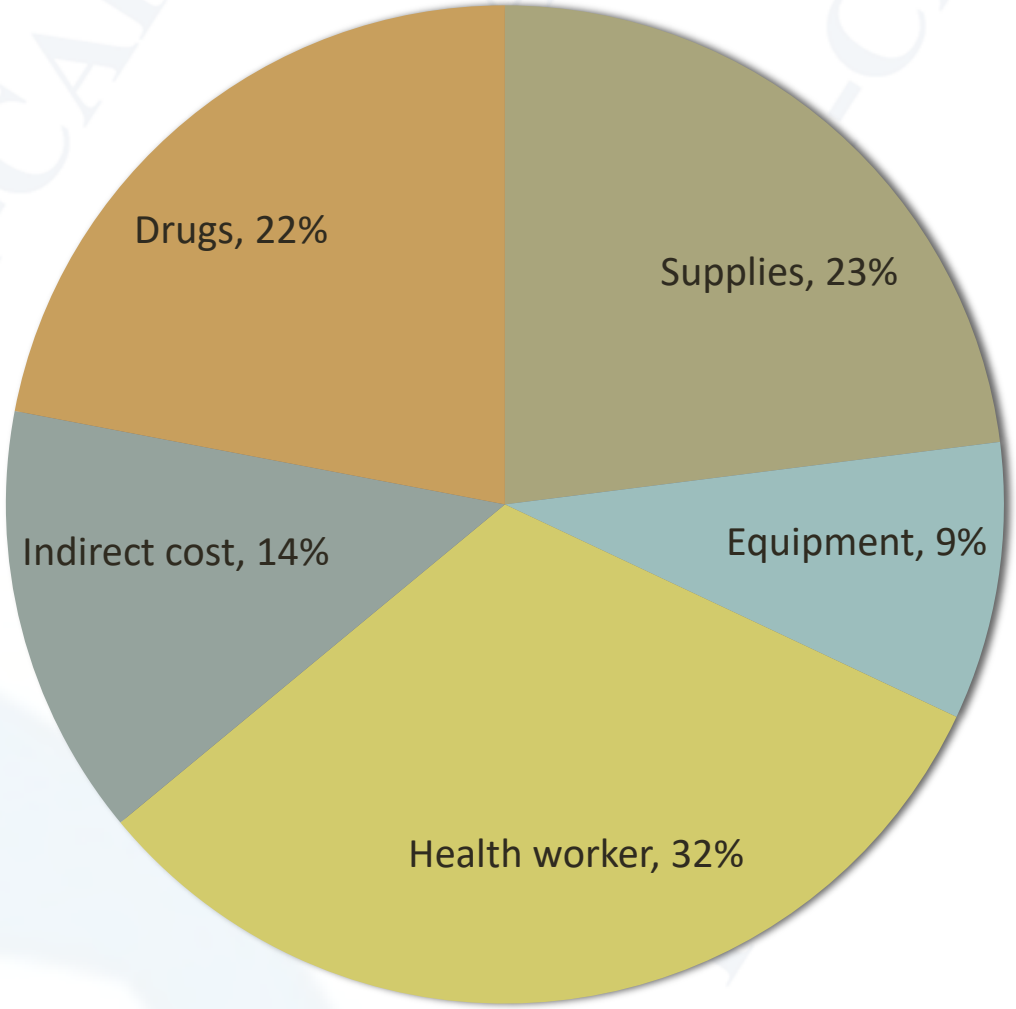
Results (1)

Department	No. of service
Initial list of services	1,672
Initial grouping (by clinical relationship)	180
Further grouping (by department)	50
Standard OPD	16
Specialized OPD	11
Standard IPD	4
Specialized IPD	6
Intermediates	9

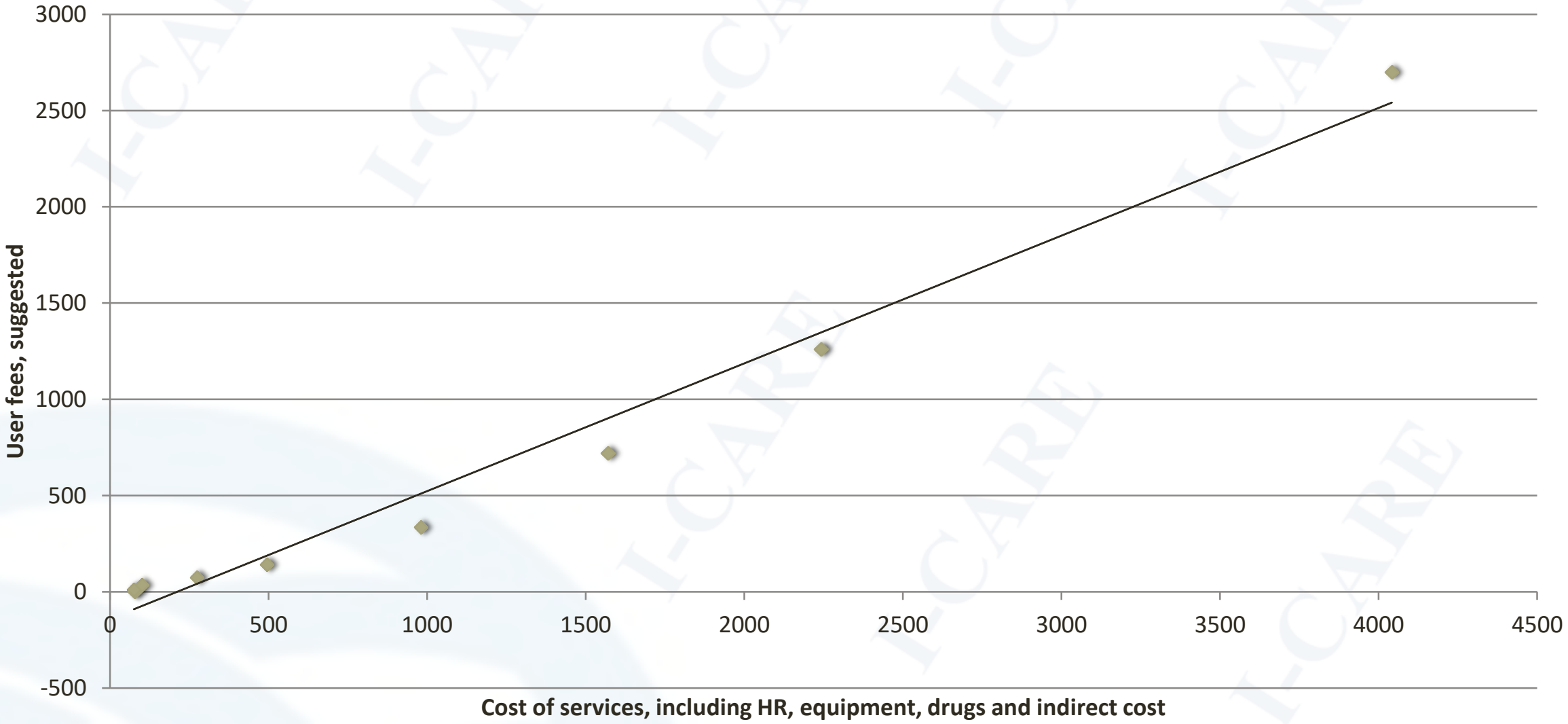
Results (2)– Example of calculated cost



Results (2)– Share of cost by input type



Results – Expected association between cost and new user fees



Thank you

Amenity Services Management in Public Health Facilities in Ethiopia
[Lessons and Way Forward]

Mebratu M.

Outline

1. An overview
2. Context of amenity management in Ethiopian healthcare
3. Describing amenity management across hospitals
4. Key drivers of amenity service management
5. Implications for government and hospitals

Context of amenity service management in Ethiopia

Context of Public Hospitals

- Typically, hospitals were headed by a CEO/CED
- These directors and senior staff had limited training and experience in overall hospital management, .
- Unclean facilities, lack of beds, and poor/non-existent meal service
- Hospital tried to make internal administrative improvements, weak output monitoring and poor accountability impeded the desired change.
- Wasting physicians' time on administrative issues
- Management practice is strongly related to:

Clinical outcomes, Patient satisfaction & Hospital financial performance

The operational amenities slice is comprised of a wide variety of support services—including engineering, facilities management, distribution, landscape services, linens, dietary, courier service, security, IT, and others

Results Expected

- Lowers **operating costs**
- Standardizes **delivery quality** and **timing**
- Allows facilities management to **track delivery volume and timing** for process improvement
- **Minimizes damage** to facilities and employees from **in secure** movement
- Improves **infection control** measures and **facility cleanliness**
- Increases **productivity and patent satisfactions**

I C A R E

Let me explain this in plain terms…

Good amenity management is correlated with better clinical and financial performance

Case in points for amenity management:

UK Hospitals

- 6.5% reduction in risk adjusted 30 days mortality rates
- 33% increase in income per bed
- 20% increase in the probability that the hospital is above average in terms of patients satisfaction

US Hospitals

- 7% reduction in risk adjusted 30 days mortality rates[1]
- 14% increase in income per bed
- 8 % increase in the percentage of people that would recommend the hospital

For Amenity management to succeed, certain key requirements need to be fulfilled

- Political will and consensus as to the needs of the health sector and the benefits of engaging in the hospital amenities
- A clear legal framework and standards that governs the roles of the public Hospitals in priority 24 hospitals
- A unit within the Hospital whose responsibility is to monitor facility amenity/contract management
- Capacity of both public and private sector
- Fiscal space with ability to finance similar initiatives
- A transparent and competitive bidding and evaluation process

Following I-Care initiative, MoH will support in setting guidelines and the overall initiatives

- 6 priority service delivery areas have been identified

- Specifically MoH aims to achieve the following:
  - **Catering, cleaning, security, gardening:** To ensure continued availability of quality services and create a system to prevent interruption of services in public centers, on top of other benefits.
  - **Incinerations and Laundry:** To maximize efficiency by aggregating the demand for these services across facilities, leveraging economies of scale at strategically located centers
  - Government could aims to offer infrastructure and utilities to the private providers that can enable significant reduction in contracting prices

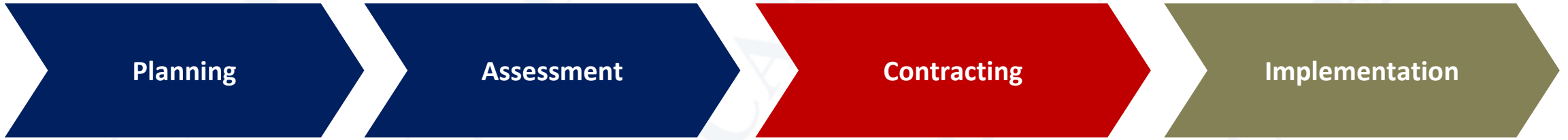
Results and key challenges

- Improved partnership between private venders and public Hospital
- Increase the proportion of blue-collar employees share of white collar employees,
- Improving the status of manager;
- Reduced costs and increased efficiency; and Focus on core competencies (the specialized nature of a hospital's competitive advantage).

Key Challenges

- Conflict regarding the quality of non-clinical services provided, partly because of poor specification in the management .
- Managing price variations over the life of years & contract agreement; increases in input prices frequently increased the cost of the service.
- Absence of competitive vendors, especially in remote, rural areas.
- Weak recordkeeping and data management by hospitals;
- Limited internal capacity to prepare technically feasible and managing all-binding contracts.

The initiative will occur on a number of steps



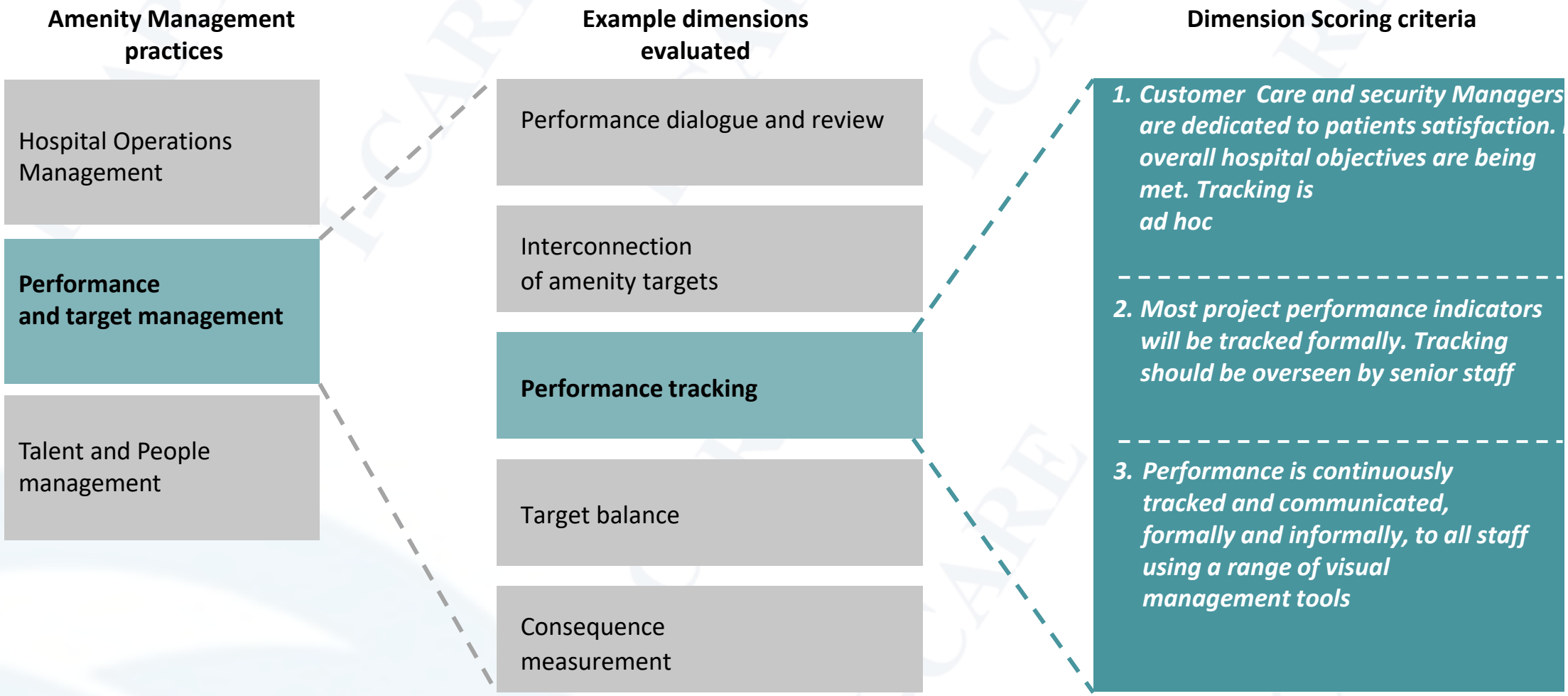
- Identification of needs
- Establish working group
- Prioritization of departments and services

- Deep dive Gap assessment
- Quantifying of needs and service volumes
- Assessing capacity and expectation of out sourcing providers
- Assess the legal framework
- Economic analysis
- Developing application documents
- Providers consultative workshop

- Further feasibility study
- Develop tendering document and contracting tools
- Solicitation of Expression of Interests
- Negotiation with providers
- Evaluation and contracting of providers

- Implementation of support
- Contract management
- Monitoring and evaluation
- Quality control
- Develop scale up plan

Role of pilot hospitals – level assessment to evaluate amenity management practices



There is an estimated huge resource gap to realize amenities service outsourcing

I C A R E

Agendas for discussion (1/2)

1) How can we best fit amenity management in the I-care initiative
2) What is your reflection on the current and planned capacity of local private providers to carryout outsourcing improving institutions capability
3) What are the outsourcing modalities for each of the service categories under consideration
4) Anticipated challenges and mitigation measures for implementing the initiative

Agendas for discussion (2/2)

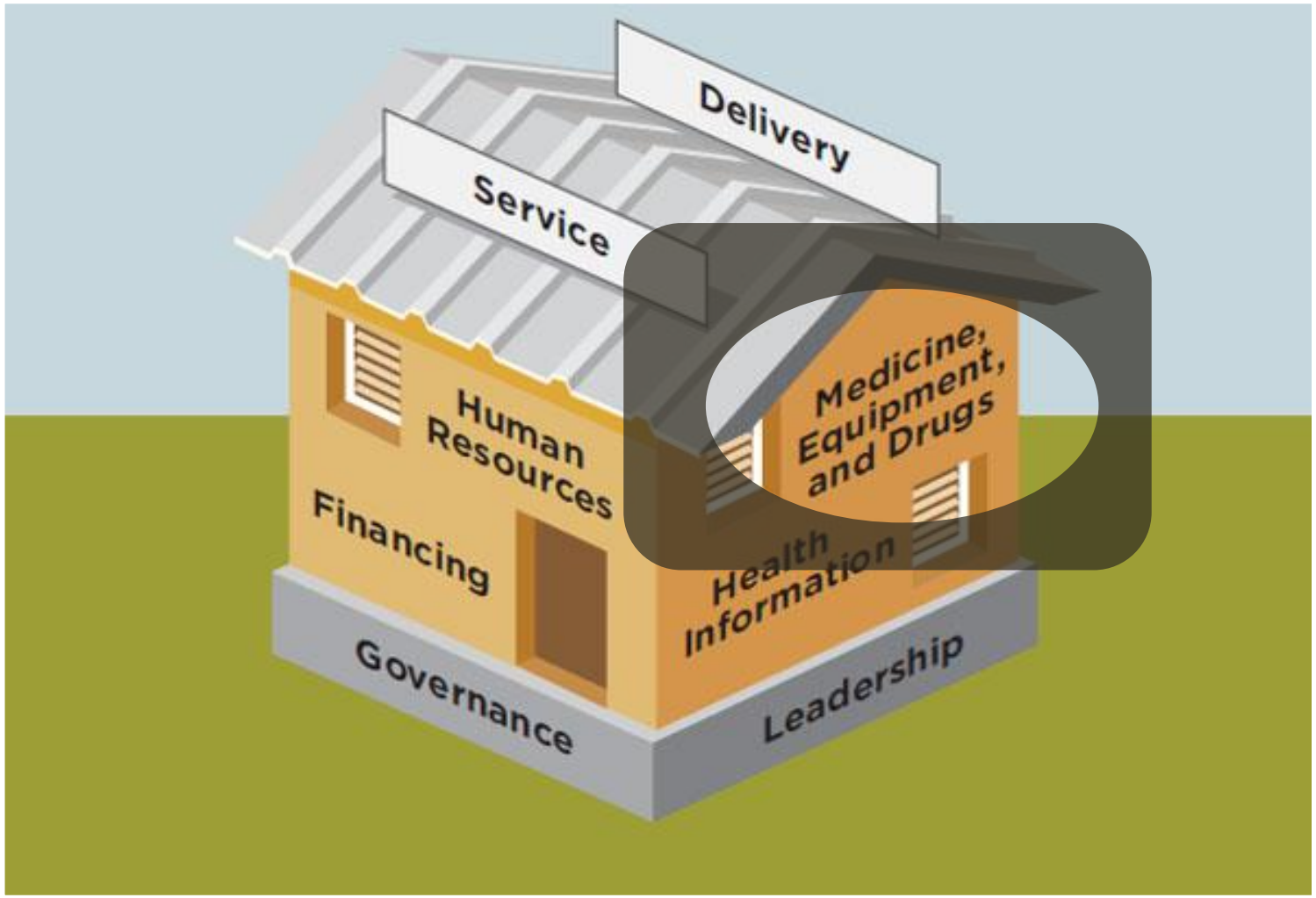
- 5) What are your thoughts on
  a) Platforms that could be leveraged towards the success of the outsourcing
  b) Subsidy from government to make costs affordable
  c) Appropriate provider payment mechanisms
  d) Potential approaches and areas for local providers to increase their involvement in the amenity management
  e) Monitoring systems that should be put in place for implementation

Thank you

I-CARE:

Access to Essential Medical Devices

Medical Devices: WHO Health System Building Block



EHSTG:

- Medical Equipment Maintenance Workshop
- Medical Equipment Inventory
  - Equipment Risk Classification
  - Spare Parts Inventory
- Equipment History File

EHSTG:

- Model Medical Equipment List
- Acceptance Testing and Installation
- Medical Equipment Incident Reporting
- ETC.

I-CARE: Actual Access to basic services

- Access to basic emergency surgical service /SALTS
- Access to basic emergency and intensive care
- Access to basic laboratory service
- Access to tertiary care
- Access to essential drugs and supplies
- Access to basic primary health care

Current Situation – Challenges:

- Need baseness of procured medical devices
- Availability of medical devices as per national standards
- Specifications setting and quality of medical devices
- Focus given to reagents and spare parts during planning

Challenges…

- Information & data management system at all levels
- Procurement:
  - Time taking - as long as more than 2 years,
  - not knowing ahead of time for which facilities medical devices are being procured,
  - poor evaluation and acceptance system at central level,
  - procuring unlimited brands for same devices,
  - Packaged items procured separately

Challenges…

- Distribution related:
  - lack of acceptance protocol at HFs
    - accepting medical devices without proper checking
  - incomplete delivery of accessories or parts,
  - distribution without checking site readiness,

Challenges…

- Installation taking very long time
  - Medical devices not installed at HFs
- Poor maintenance capacity and system
- Poor (unavailability of) medical devices decommissioning/disposal system
- etc.

Solutions

- Focus for medical devices management more than ever… FMOH
- HTA
- Specifications database (FMOH, EPSA)
  - Standardization of medical devices by level

Solutions…

- Focused PPL
  - capital and non-capital medical devices
- Introducing quality components
  - Global standards,
  - Suppliers' prequalification
- Framework procurement modality
- Package procurement of medical devices

Solutions…

- Placement of laboratory and diagnostic equipment (Medical devices leasing)
- Strategies to ensure sustainable availability of reagents
- Crossdocking of medical devices to HFs
- Contract management guidelines
  - Team reorganization

Solutions…

- MEMIS
- Facility level mentorship and facility readiness assessments

Thank you

የኢትዮጵያ ጤና ባለሙያዎች የአለባበስ ስርዓት መመሪያ

መግቢያ

- አግባብ ያለው የጤና ባለሙያዎች **የአለባበስ እና ባጅ አጠቀቀም ስርዓት** በጤና ተቋማት ላይ መዘርጋት አስፈላጊ ሁኖ በመገኘቱ፡-

- በጤናው ሴክተር የትራንስፎርሜሽን ዕቅድ ላይ ትኩረት ተሰጥቷቸው ከተቀመጡ አጀንዳዎች አንዱ የሆነው **ሩህሩህ ተገልጋይን አክባሪ ተንከባካቢ (CRC)** እና ሙያዊ ስነ ምግባር የተላበሱ ጤና ባለሙያዎችን ለማፍራት የሚደረገውን ንቅናቄ ለማጠናከር፡-

- የጤና ባለሙያዎችን የአለባበስ ስርዓት በጤና ተቋማት ውስጥ **ወጥ ለማድረግ፣**

መግቢያ...

- ተገልጋዩ ማህበረሰብ አገልግሎት የሚሰጠውን **ባለሙያ ማንነት በቀላሉ እንዲያውቅና** የጤና አገልግሎት አሰጣጡ ላይ **ግልፅና ተጠያቂነት** ያለው አሰራር ለመዘርጋት

- በጤና ተቋማት የሚያገለግሉ ባለሙያዎች እንዲሁም ተገልጋዮች **ከተላላፊ በሽታዎች ለመከላከልና ለመቆጣጠር** ንፅህናውን የጠበቀና ስርዓት ያለው ሙያዊ አለባበስ መፍጠር እንዲያስችል ፡-

መግቢያ...

- የጤና ባለሙያዎች የአለባበስ ስርዓት **የባለሙያውን ሙያዊ ገፅታ በመገንባትና ሙያዊ ክብር እንዲሰማው** ከማድረጉም ባሻገር ተገልጋዩ ማሕበረሰብ በሚገለገልበት ተቋም እና በሚያገለግለው ባለሙያ **አመኔታ** ለማሳደር

- የኢፌድሪ ጤና ሚኒስቴር ይህንን የኢትዮጵያ የጤና ባለሙያዎች የአለባበስ ስርዓት መመሪያ አውጥቷል።

የመመሪያው ዓላማ

1. ጤና ባለሙያውን እና ተገልጋዩን ማህበረሰብ ከተላላፊ በሽታዎች እና ጉዳቶች መከላከል

2. ጤና ባለሙያው በሙያው እንዲኮራ እና ሙያዊ ፍቅር እንዲያጎለብት ማገዝ

3. ተገልጋዩ ማህበረሰብ የሚያገለግሉትን ጤና ባለሙያዎች በቀላሉ መለየት እና መግባባት እንዲችል ማድረግ

የመመሪያው አላማ...

4. ተገልጋዮ ማህበረሰብ በጤና ተቋማቱ እና አገልግሎቱን በሚሰጠው ባለሙያ እምነት እንዲኖረው ማስቻል

5. በጤና ተቋማትና በባለሙያዎች ዘንድ ተጠያቂነት እና ግልፀኝነት መፍጠር

6. የጤና ባለሙያዎችን የአለባበስ ስርዓት በጤና ተቋማት ውስጥ **ወጥ ለማድረግ፣**

ጠቅላለ

1. አውጪው ባለስልጣን

በኢትዮጵያ ፌደራላዊ ዲሞክራሲያዊ ሪፐብሊክ የጤና ሚኒስቴር የጤና ተቋማት ሀገር አቀፍ የጤና ባለሙያዎች የአለባበስ ስርዓት ውጥ በሆነ መልኩ ለመዘርጋት በአሰፈፃሚ አካላት ስልጣን እና ተግባር አወሳሰን አዋጅ ቁጥር 1097/2011 አንቀፅ 27(1) እና አዋጅ ቁጥር 661/2009 አንቀፅ 55/1መሰረት ይህ መመሪያው አውጥቷል።

ትርጓሜ...

1. **“የጤና ባለሙያ የአለባበስ ስርአት”**፡- ማለት በጤና ተቋም ውስጥ የሚሰሩ የጤና ባለሙያዎች በስራ ቦታቸው **የደንብ ልብስ፣ መለያ ባጅ፤ የጸጉር እና የጥፍር አያያዝ፣ የጌጣጌጥ** እና **የመዋቢያ እቃዎች፣ የግል ኤሌክትሮኒክስ መገልገያዎች** አጠቃቀም እና **የግል ንጽህናን** የሚያጠቃልል ነው።

ትርጓሜ...

2. ሙሉ የደንብ ልብስ፡ ማለት ማንኛውም የጤና ባለሙያ የሙያ ስራውን ሲያከናውን የሚለብሰው ደረጃውን የጠበቀ የልብስ አይነት ነው።

ይህም ሲባል፡-

- **ወንድ/ሴት** የጤና ባለሙያ በዚህ መመሪያ የተዘረዘሩትን የተለያዩ ቀለማትን ያገናዘበ ከላይ አላባሽ **አንገቱ (y)** ወይም **(v)** ቅርፅ የሆነ እጅጌው **ከክርን በላይ፣ ሱሪ ወገቡ ማሰሪያ ያለዉ** እና ዶክተር ጫማ ሲሆን ቀሚስ ወይም ጉርድ ለሚለብሱ ተመሳሳይ y ወይም v ቅርፅ ሆኖ ከጉልበት በላይ ማጠር የለበትም።

የተፈጻሚት ወሰን

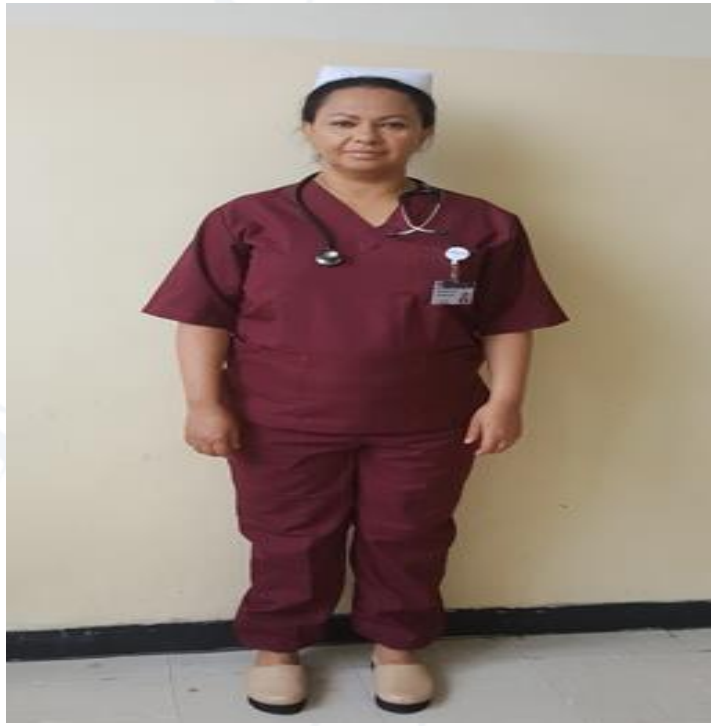
- በኢትዮጵያ በሚገኙ በሁሉም **የመንግስት፣ የግል** እና **የግብረሰናይ** ጤና ተቋማት ውስጥ በሚሰሩ ጤና ባለሙያዎች እና ተማሪዎች ላይ ተፈጻሚ ይሆናል።

የተለያዩ የሥራ ክፍሎች የደንብ ልብስ አይነት እና ቀለም

1. ማንኛውም የጤና ባለሙያ በኦፕራሲዮን ክፍልና በፅኑ ህሙማን ክፍል በሚያገለግልበት ጊዜ ፈዛዛ አረንዴ (light green) ሙሉ የደንብ ልብሱን መልበስ አለበት።

የተለያዩ የሥራ ክፍሎች የደንብ ልብስ አይነት እና ቀለም

2.ማንኛውም የጤና ባለሙያ በድንገተኛ ክፍል በሚያገለግልበት ጊዜ በርገንዲ ቀለም (Burgendi) ሙሉ የደንብ ልብስ መልበስ አለበት።



የባለሙያዎች የደንብ ልብስ አይነት እና ቀለም...

- ማንኛውም ጤና ባለሙያ ከላይ በስም ከተጠቀሱት ክፍሎች ውጭ በሚያገለግልበት ጊዜ

3. ሀኪም **እርሳስ ከለር (light silver)** እና ነጭ ጋዋን መልበስ አለበት፡



የባለሙያዎች የደንብ ልብስ አይነት እና ቀለም...

4. ነርስ ፈዛዛ ሰማያዊ (light blue) ሙሉ የደንብ ልብስ መልበስ አለበት።

የተለያዩ የሥራ ክፍሎች የደንብ ልብስ አይነት እና ቀለም...

5. ሚድዋይፍ ፈዛዛ ሀምራዊ (light purple) ሙሉ የደንብ ልብሱን መልበስ አለበት።

የተለያዩ የሥራ ክፍሎች የደንብ ልብስ አይነት እና ቀለም...

6. ከላይ ከተጠቀሰው የስራ ክፍልና ሙያ ዉጪ የሆኑ ሁሉም ባለሙያዎች(ላብራቶሪ፤ ፋርማሲ፤ኢሜጂንግ፤ ፈዚዮቴራፒ፤ ወዘተ... **ጥቁር ሰማያዊ (blue black)** ሙሉ የደንብ ልብስ

የተለያዩ የሥራ ክፍሎች የደንብ ልብስ አይነት እና ቀለም...

የተለያዩ የሥራ ክፍሎች የደንብ ልብስ አይነት እና ቀለም...

የተለያዩ የሥራ ክፍሎች የደንብ ልብስ አይነት እና ቀለም...

7. ማንኛውም የጤና ባለሙያ በህፃናት ክፍልና የስነ አእምሮ ህክምና ክፍል በሚያገለግልበት ጊዜ የደንብ ልብሱ የታካሚውን ስነ ልቦና ይረብሻል ተብሎ ከታመነበት ያለደንብ ልብስ አገልግሎቱን ሊሰጥ ይችላል።

የተለያዩ የሥራ ክፍሎች የደንብ ልብስ አይነት እና ቀለም...

8. ማንኛውም የጤና ሳይንስ ተማሪ በጤና ተቋማት ውስጥ ልምምድ በሚያደርግበት ጊዜ በኮሌታው ዙሪያ ነጭ መለያ/ stripe / ያለበት ሆኖ ሲመረቅ የሚኖረውን ሙያ ሙሉ የደንብ ልብስ መልበስ አለበት ።

እንዲሁም የሚኖረው ነጭ መለያ (stripe) ብዛት እንደ ተማሪው የትምህርት ዘመን ይወሰናል።

ማለትም አንደኛ አመት ተማሪ አንድ መለያ ሲኖረው እንደ ተማሪው የትምህርት ዘመን መለያው እየጨመረ ይሄዳል።

- የትምህርት ዘመን መለያው የእጀጌው ጫፍ ላይ የሚደረግ ይሆናል።

የደንብ ልብስ ይዘት እና ዲዛይን

- የደንብ ልብሱ የጨርቅ አይነት አንደኛ ደረጃ ቴትራን 6000 ሆኖ በፋብሪካ ደረጃ ተመርቶ በቀላሉ በሬድሜድ መልኩ የተዘጋጀ መሆን አለበት።
- የደንብ ልብሱ የወገብ ማሰሪያ/መመጠኛ የገመድ ወይም ባለላስቲክ መሆን ይችላል።
- የደንብ ልብሱ የላይ አላባሽ በጎን በኩል መከፍት የሚችል መሆን አለበት።

ዲዛይን

የባለድርሻ አካላት ተግባር እና ሀላፊነት...

የጤና ሚኒስቴር ተግባር እና ሀላፊነት

- የጤና ባለሙያዎች የአለባበስ መመሪያ ማውጣት
- በፌደራል ጤና ተቋማት መመሪያ እንዲተገበር ማድረግ
- መመሪያዉ ለክልሎች ማስተዋወቅ
- የመመሪያዉን ተፈጻሚነት ማገዝ ፣ መከታተል እና ማረጋገጥ፤
- እንደ ሀገር ይህን መመሪያ መሰረት አድርገው የደንብ ልብስ ማቅረብ የሚችሉ ጋርመንቶችን መለየት
- መመሪያ ከመተላለፍ ጋር ተያይዘው ለሚነሱ ቅሬታዎች መፍትሔ መስጠት
- መመሪያውን እንደ አስፈላጊነቱ መከለስ፣

የባለድርሻ አካላት ተግባር እና ሀላፊነት...

- **የክልል ጤና ቢሮ ተግባር እና ሀላፊነት**
  - በፌደራል ደረጃ የወጣውን የጤና ባለሙያዎች የአለባበስ መመሪያ ለክልሉ ጤና ተቋማት ማስተዋወቅ፤
  - የመመሪያዉን ተፈጻሚነት ማገዝ ፣ መከታተል እና ማረጋገጥ፤
  - መመሪያ ከመተላለፍ ጋር ተያይዘው ለሚነሱ ቅሬታዎች መፍትሄ መስጠት፤
  - እንደ ክልል ይህን መመሪያ መሰረት አድርገው የደንብ ልብስ ማቅረብ የሚችሉ ጋርመንቶች ይለያል እገዛ ያደርጋል
  - በክልሉ የሰው ሀይል ልማት ላይ የአለባበስ ሥርዓት እንደ አንድ መስፈርት አድርጎ መውሰድ፤
  - በክልል ደረጃ ጋርመንቶችን በመለየት ውል ማሰር
  - በየ ዓመቱ ለጤና ተቃማት ለደንብ ልብስ በቂ በጀት መመደብ

የጤና ተቋማት ተግባር እና ሀላፊነት

- በየአመቱ በጤና ተቋማት ዉስጥ ለሚገኙት የጤና ባለሙያዎች የደንብ ልብስ በጀት መመደብ፤
- የጤና ተቋማት ማኔጅመንት ጥራቱን የጠበቀ ሁለት የደንብ ልብስ በአመት መስጠት
- ይህ የደንብ ልብስ በአግባቡ በተቀመጠው መስፈርት መሰረት መሆኑን ማረጋገጥ፤
- የተሰጠዉ የደንብ ልብስ በአግባቡ መለበሱን በየጊዜዉ ይቆጣጠራል፤ ይከታተላል።

የጤና ተቋማት ተግባር እና ሀላፊነት...

- ከጤና ባለሙያው የሚነሳውን ሀሳብና ቅሬታ መፍታት እንዲሁም ለበላይ አካል ማስተላለፍ፤
- ደንበኞች ጤና ባለሙያዎችን በቀላሉ መለየት እንዲችሉ የአለባበስ ስርዓቱን ማስተዋወቅ
- የጤና ባለሙያ ተማሪዎች ከመንግስትም ሆነ ከግል የትምህርት ተቋማት ወደ ሆስፒታሎች ለተግባር ልምምድ ሲመጡ ይህን መመሪያ እንዲተገብሩና በውል ስምምነታቸው(MOU) ውስጥ አካተው በመግባባት ተግባራዊ እንዲያደርጉ ማድረግ፤

የጤና ባለሙያዎች አለባበስ ስርዓት ኮሚቴ መመስረት እና ተግባር እና ሀላፊነት

- የጤና ባለሙያ የአለባበስ ስርዓት አስፈፃሚ ኮሚቴ ከተመላላሽ ህክምና የስራ ሂደት፣ ከተኝቶ ህክምና የስራ ሂደት፣ ከድንገተኛ ህክምና የስራ ሂደት፣ ከሜትረን ቢሮ፣ ከሰው ሀብት ልማት ክፍል፣ ከግዢ ክፍል እና ከኪሊቲ ኦፊሰር የተውጣጡ ባለሙያዎች ያቀፈ እና ብዛታቸው **ከሰባት(7)** ያላነሰ ይሆናል።

- ኮሚቴው **በሜትረን** እየተመራ የጥራት ክፍል እንደ ፀሓፊ ሆኖ ያገለግላል።

መመሪያው ስለመተላለፍ

- አንድ ባለሙያ በወር ውስጥ ሁለት ግዜ የአለባበስ ስርዓቱን ተከትሎ ሳይለብስ ቢቀር በኮሚቴው የቃል ማስጠንቀቂያ ይሰጠዋል
- አንድ ባለሙያ በወር ውስጥ ሶስት ግዜ የአለባበስ ስርዓቱን ተከትሎ ሳይለብስ ቢቀር በኮሚቴው የፅሁፍ ማስጠንቀቂያ ይሰጠዋል
- አንድ ባለሙያ በወር ውስጥ አምስት ግዜ የአለባበስ ስርዓቱን ተከትሎ ሳይለብስ ቢቀር በኮሚቴው ወደ ህክምና ክፍል ገብቶ እንዳይሰራ ታግዶ ወደ ሆስፒታሉ ዲሲፕሊን ኮሚቴ ይላካል

መመሪያው የሚፀናበት ጊዜ

- መመሪያው በሚኒስቴር መስሪያ ቤቱ የበላይ ሀላፊ ከተፈረመበት ቀን አንስቶ የፀና ይሆናል።

የአለባበስ ስርዓት መመሪያ ተግበራዊ ለማድረግ በ2011ዓ.ም የተያዙ ዋናዋና ተግባራት

- የአለባበስ ስርዓት መመሪያው በሚንስትር ደረጃ ማስፀደቅ
- የፀደቀው መመሪያ በየደረጃው ለሆስፒታሎች ለክልሎች ለሙያ ማህበራት ማስተዋወቅ
- በተመረጡ ሆስፒታሎች የደምብ ልብስ ፍላጎትና ፍጆታ ጥናት ማድረግና መለየት
- አዲሱን አገር አቀፍ የጤና ባለሙያዎች የአለባበስ ስርዓት መመሪያ ኢትዮጵያ ውስጥ ላሉ የጨርቃ ጨርቅ ኣምራች ድርጅቶችን ማስተዋወቅ

የአለባበስ ስርዓት መመሪያ ተግበራዊ ለማድረግ በ2011ዓ.ም የተያዙ ዋናዋና ተግባራት

- የረጅም ግዜ **የግዢ የስምምነት ማዕቀፍ** ዙርያ ላይ ለመወያየት
- በመመሪያው መሰረት የጤና ባለሙያዎች የዩኒፎርም አቅርቦት (Ready Made) ማድረግ በሚቻልበት ሁኔታ ላይ መነጋገር እና መስማማት
- በመመሪያው ያልተጠቀሱ እንደ **የኦፕሬሽን ድሬፕ፣ አንሶላ፣ ብርድልብስ፣ የአስታማሚ ጋዎን** የመሳሰሉ ምርቶችና አቅርቦት ላይ ስታንዳርዳይዝድ የማድረግ ስራ መስራት

አመሰግናለሁ!!!

CATCH-IT As part of I-CARE

Kasu Tolla

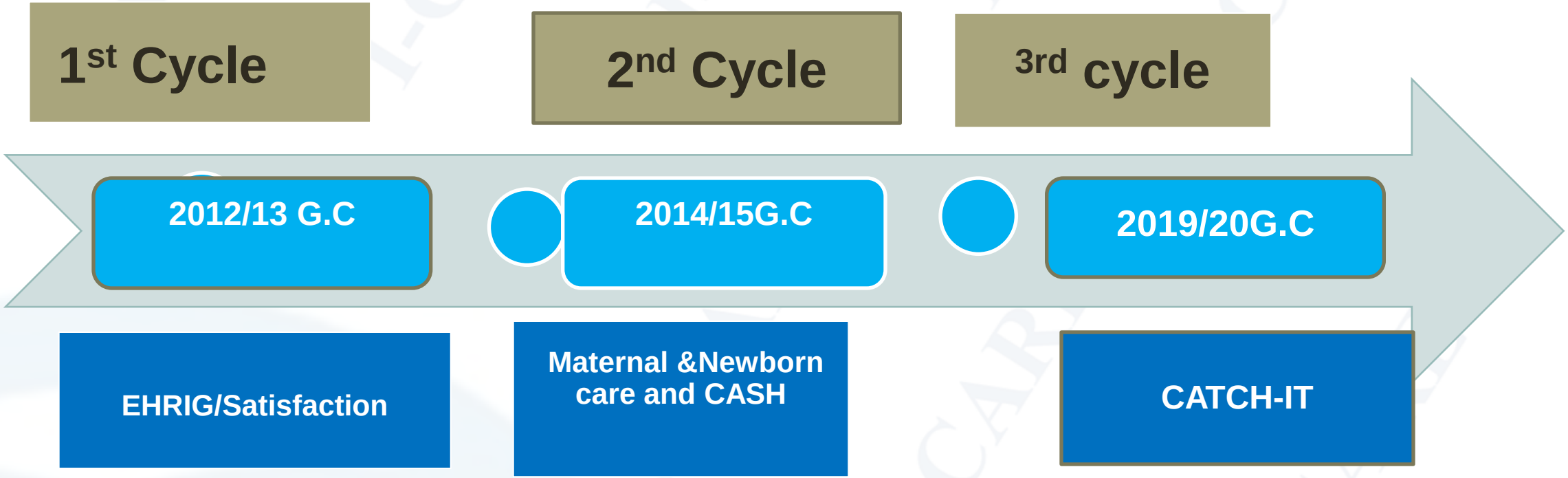
Outlines

1. Introduction
2. Objective
3. CATCH-IT principles
4. CATCH-IT key interventions
5. CATCH-IT project implementation phases
6. M &E frameworks

1.Introduction---EHAQ cycles

1.1.EHAQ cycles

EHAQ : learning collaborative network



Redesign the system

- Initiate and revitalize EHAQ platform.
- Set a priority intervention area, clear measurement and evaluation method.
- Recognition of high performing hospitals and clusters based on the alliance performance.
- Designed to improve timeliness and cleanness of care

3. Objective

General objective:

- ✓ To **transform the quality of services** in hospital through **clean and timely care** improvement.

Specific Objectives:

- ✓To strengthen **cleanliness of care** practice in hospital service.
- ✓To **reduce waiting time** in hospital services for the provision of timely care.
- ✓To **revitalize** the existing initiatives.
- ✓To **identify best practices and scale up** rapidly through the collaborative learning.

4.Principles of CATCH-IT

4.1.Principle of Cleanliness

- Cleanliness is **everybody's responsibility.**
- Clean Care is **Safer Care.**
- Cleanliness is all about **Attitude** than Resource.

4.Principles of CATCH-IT……

4.2.Principle of Timeliness

- Timeliness of care is at the **HEART** of everything in health care settings demonstrating:
- **H**ospitality
- **E**nthusiasm
- **A**ttitude and
- **R**espect to patients

- Timely care is **saving lives** of the diseased.

5.CATCH-IT key interventions

5.1.Cleanliness interventions:

- Monthly **cleaning Day**
- Regular **recognition** of clean wards
- Implement **kaizen 5S**
- Conduct standardized regular internal and external **cleaning audit**
- Assign **ward master** to sustain cleaning practice

5.CATCH-IT key interventions

5.2.Timeliness interventions:

- Digitalization of liaison offices.
- Central/Regional surgical backlog management.
- expected date of discharge introduction during patient admission.
- Bank queue system for medical record rooms.
- Early initiation of clinics and late working of clinics.

5.CATCH-IT key interventions ……

5.3.Transformation of the institution Intervention:

- Pain free Hospital Initiative /PFHI/
- Ethiopian Hospital Service Transformational Guidelines implementation /EHSTG/
- Data quality and data use (DHIS2 implementation)
- SaLTS implementation

6.CATCH-IT project phases

- Phase One: Preparation
- Phase Two: Implementation
- Phase Three: Evaluation and Reward

6.CATCH-IT project phases

6.1.Preparation phase:

- Initiative description, development and approval
- Key intervention selection and prioritization
- Implementation methods and strategies development
- Monitoring and evaluation tool development

6.CATCH-IT project phases

6.2.Implementation phase

- National launching
- Regional launching
- Hospitals introduction and implementation of key interventions
- Integrated supportive supervision and focused mentorship
- Regional review meeting
- National review meeting

6.CATCH-IT project phases

6.3.Evaluation and reward phase

- Evaluation of the initiative
- Regional recognition of hospitals
- National Champion Hospital recognition
- **Monitoring and Evaluation frameworks**
- Timeliness of care measures
- Cleanness of care measures
- Transformation measures

Thank you !!

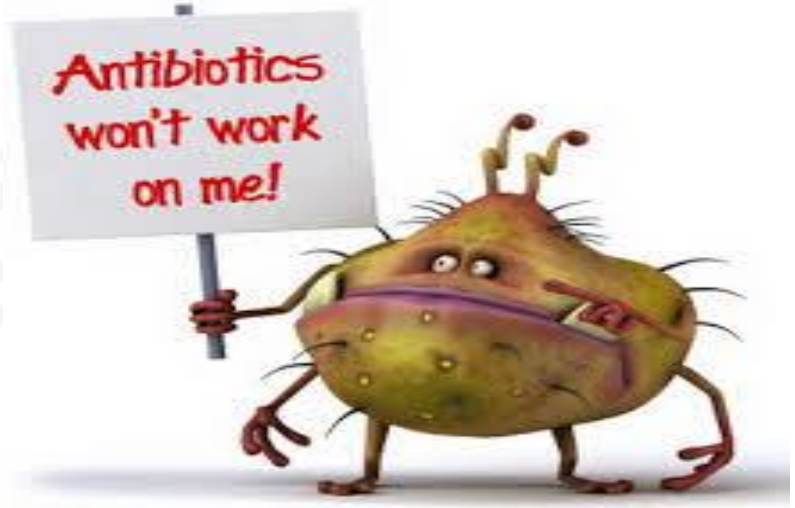
Antimicrobial Resistance (AMR)

October, 2019

Addis Ababa

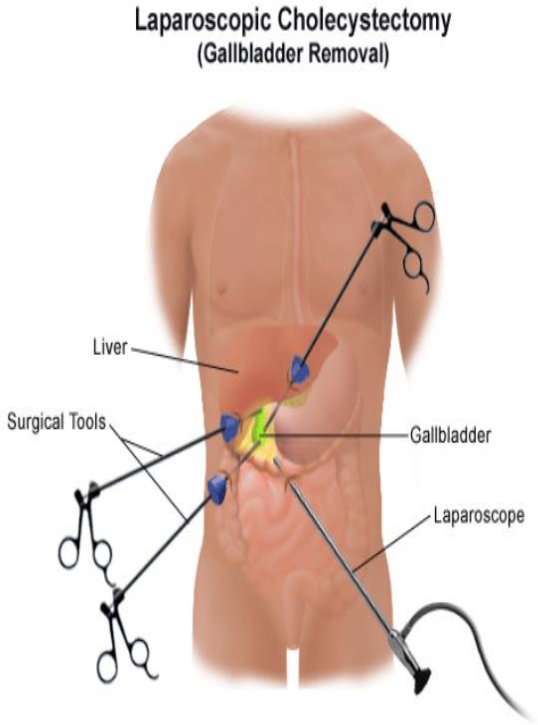
Outline

- Introduction
- Global responses to AMR
- National responses to AMR
- Way forwards



68 year old gentleman

- A sixty eight year old gentleman was admitted to a large private hospital in India
- The admission was for surgical removal of gall bladder due to stones
- The surgery was **uneventful** and patient was apparently **improving well**
- Signs of chest infection from **second day onwards**
- He was started on antibiotics and nebulization, but the chest infection was worsening

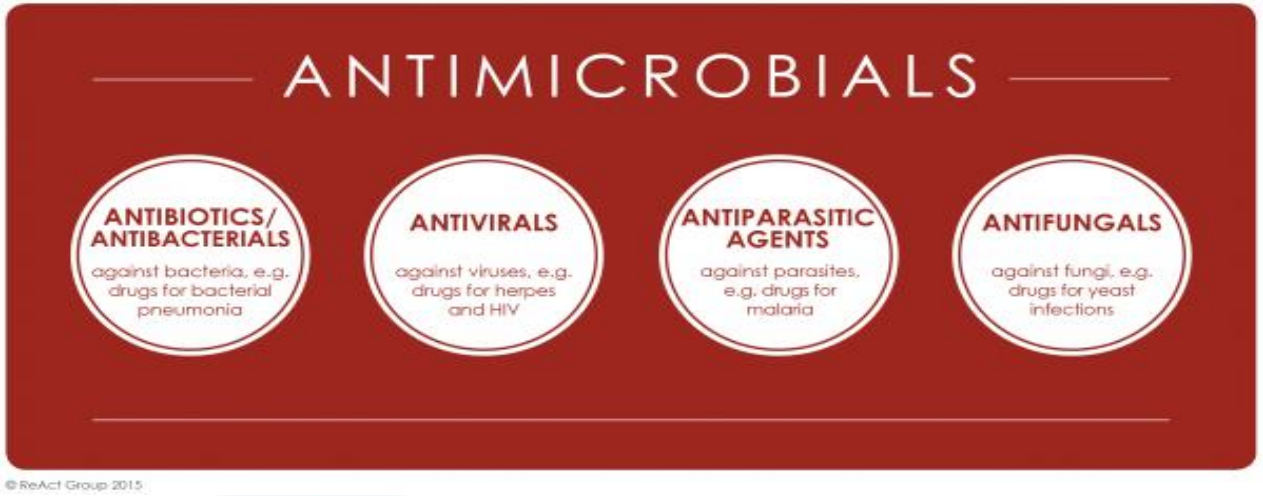


68 year old gentleman

- He was shifted to the **ICU** and started on oxygen.
- A chest X-ray showed signs of pneumonia
- His sputum culture meanwhile grew **Klebsiella**
- The antibiotic sensitivity testing showed that it was a **resistant form of Klebsiella,** which may not respond to routine antibiotics
- He was given **Meropenam** (a very expensive antibiotic) and **Colistin** (a very toxic antibiotic which can damage the kidneys) in view of his worsening condition and the resistant bug.
- **Despite all efforts, he died on the 4th day of ICU admission.**

Introduction

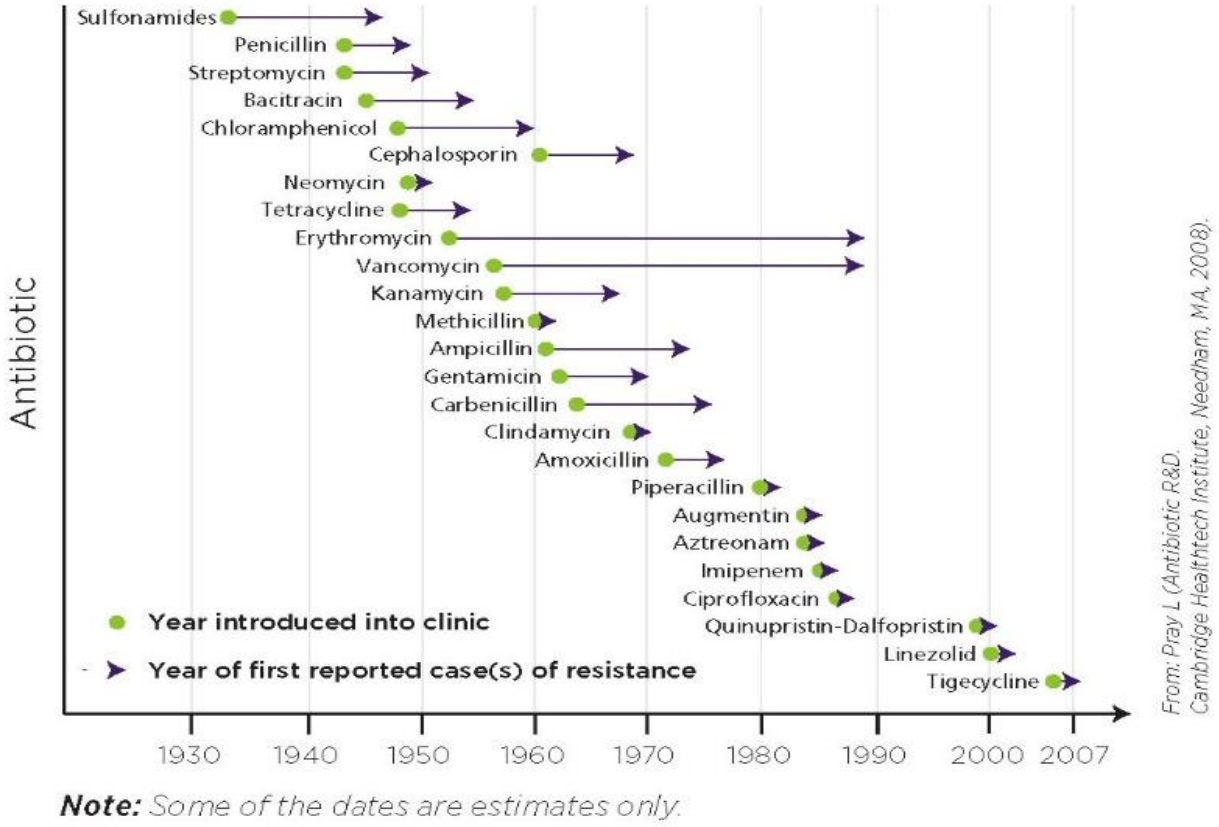
Antimicrobial resistance (AMR) is the ability of microbes to grow in the presence of a class of drugs known as antimicrobials that would normally kill microbes or limit microbial growth.



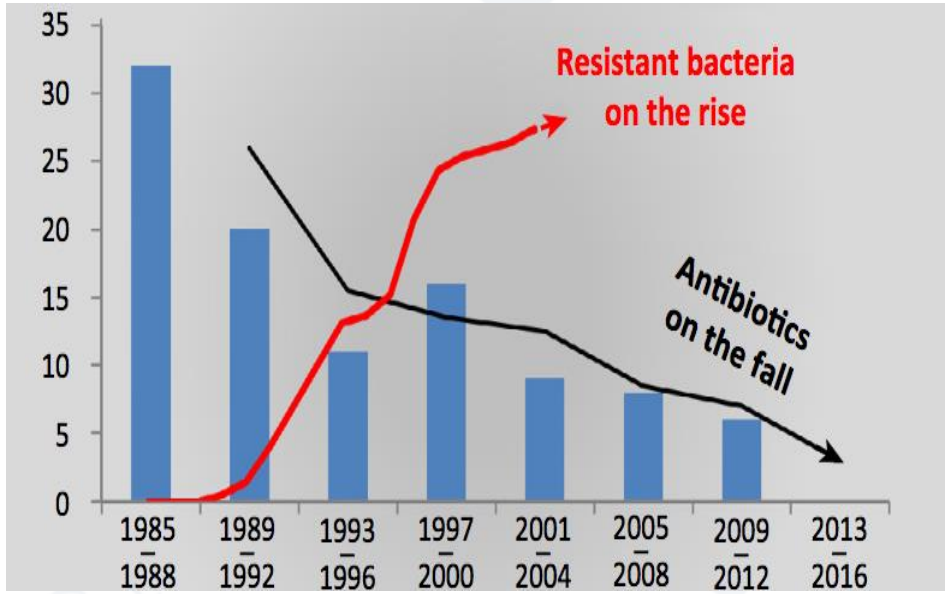
Introduction. . .Cont'd

- AMR is both global and national health threat.
- Silent Tsunami
- Demands Strong Collaboration and coordination in *One health* approach

Introduction. . .Cont'd

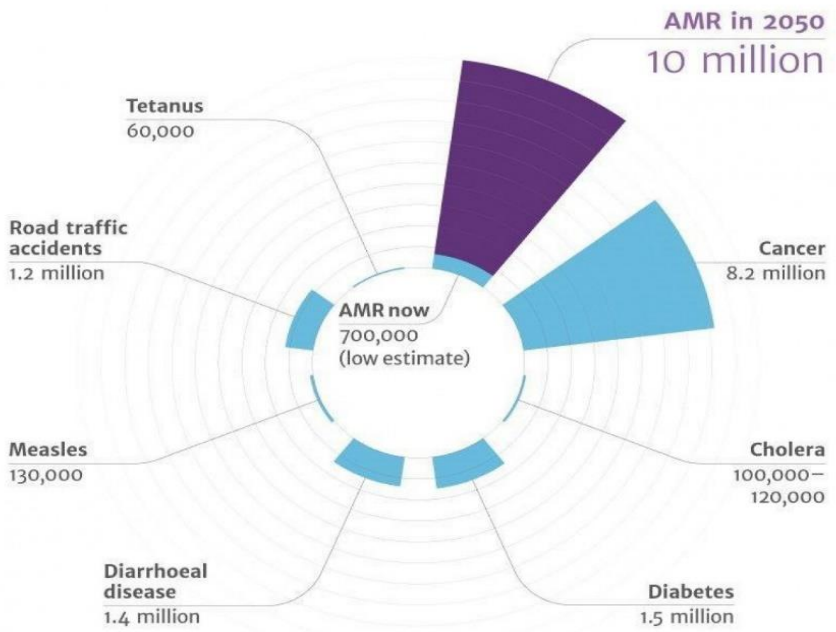


It's not a question of "if" but rather "when"

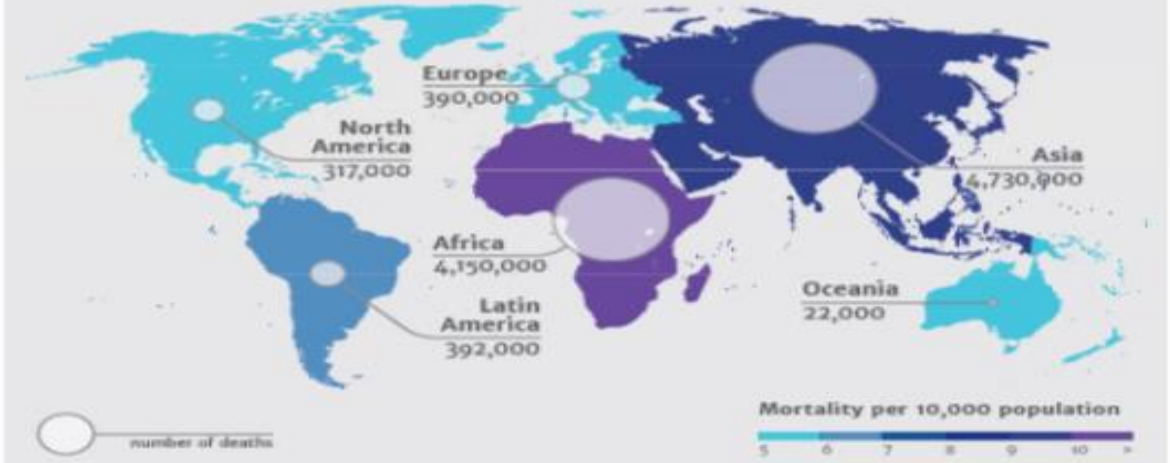


I C A R E

Introduction. . .Cont'd



Timeline	Deaths/Year	Deaths/Min
Present	700,000	1
2050	10,000,000	19



Economic burden 1 trillion USD

I C A R E

Introduction. . .Cont'd

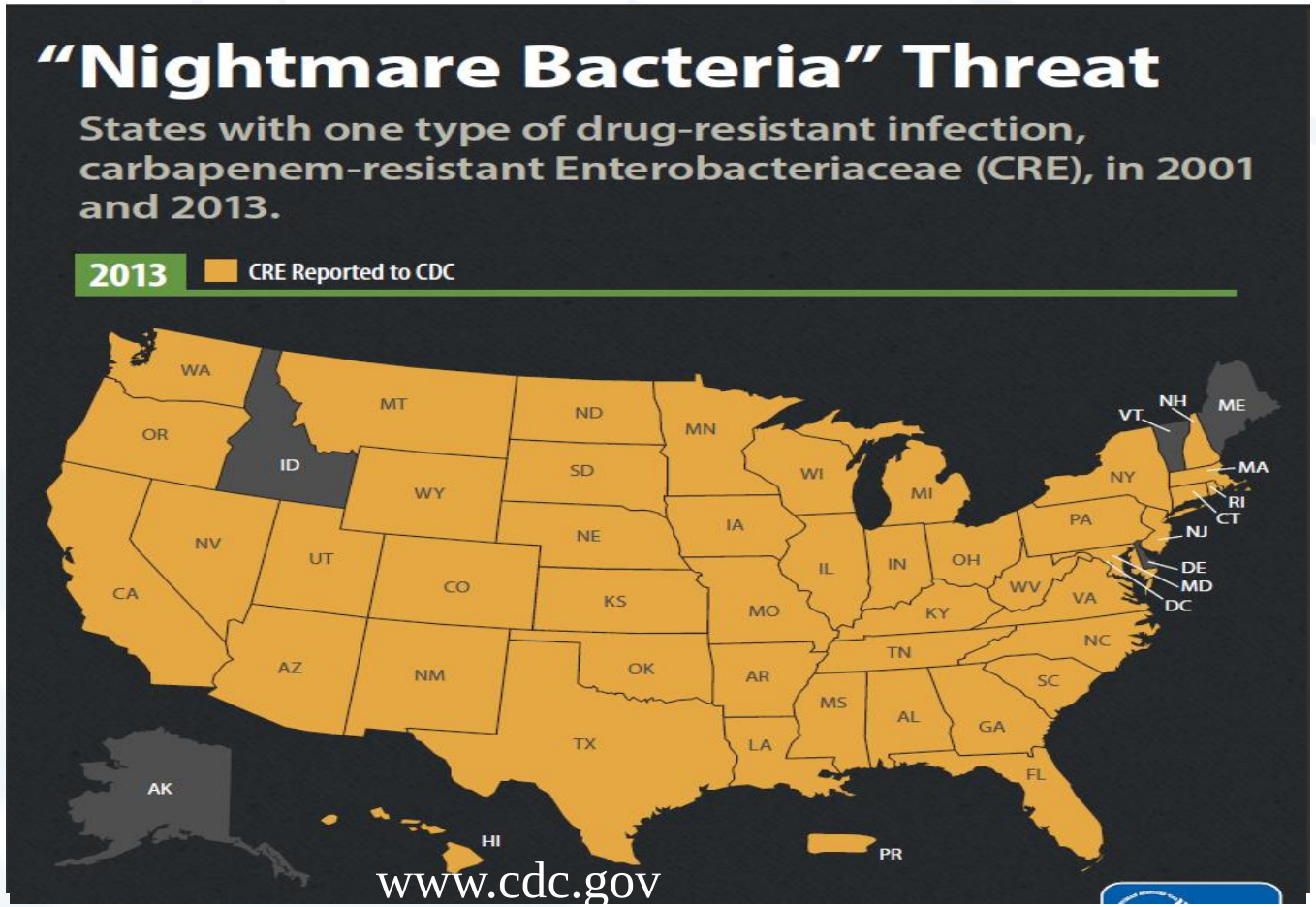
- Furthermore without action, by 2050
  - The global economy may lose more than 100 trillion USD annually
  - between 1.1% and 3.8% of global GDP could be lost due to antimicrobial resistance
    - climate change are predicted to cause a drop of 1.0% to 3.3% in global GDP by 2060
- Without action, by 2030
  - 24 million people could fall into extreme poverty
  - low-income countries lose more than 5% of their Gross Domestic Product (GDP)

Introduction. . .Cont'd

'If we fail [to address antibiotic resistance], we will pay for it through our wallets, but the poor will pay for it with their lives'

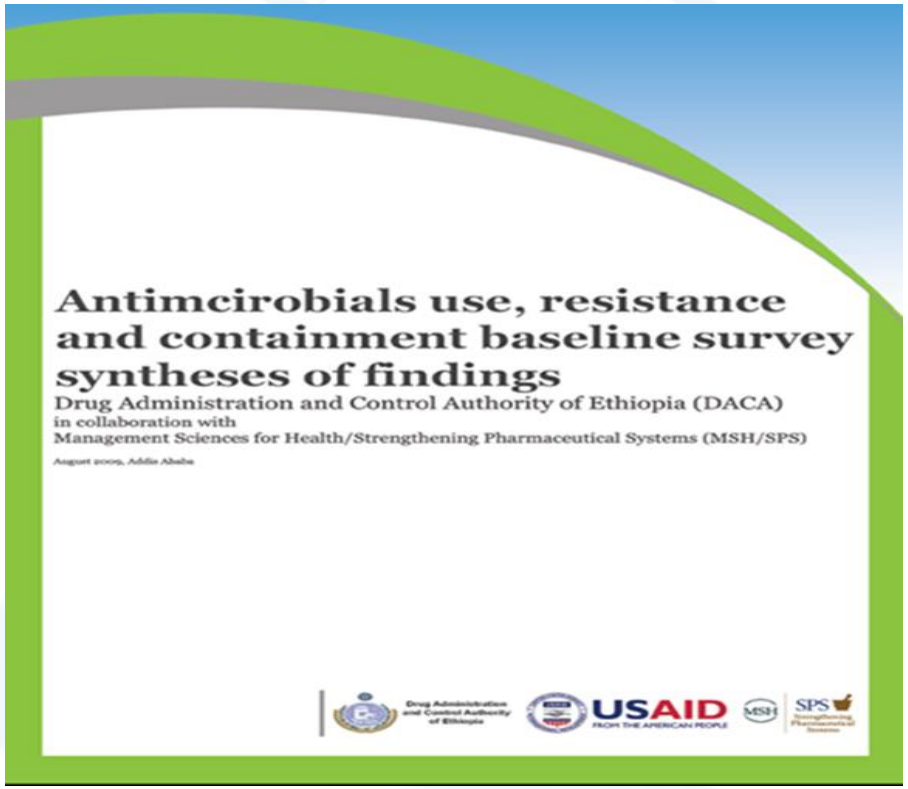
Participant speaking on antibiotic resistance at the World Health Organization's Primary Healthcare Meeting (Alma Ata 2.0, 25-26 October 2018 - Astana, Kazakhstan)

Introduction…Cont'd



www.cdc.gov

Introduction. . .Cont'd



- AMR is real and high in magnitude in this country.
- Majority of broad-spectrum antibiotics show resistance
- AMR is not advocated as a real challenge.

Global responses to AMR

- The World Health Organization (WHO) released the Global Action Plan on Antimicrobial Resistance

- This action plan underscores the **need for an effective "one health" approach** involving coordination among numerous international sectors and actors, including human and veterinary medicine, agriculture, finance, environment, and well- informed consumers.

International partnership to address human-animal-environment health risks gets a boost

Standing from left to right:Dr Tedros Adhanom Ghebreyesus, Director-General of WHO, Dr Monique Eloit, Director General of the OIE and Mr Jose Graziano da Silva, FAO Director General after signature of the MOU

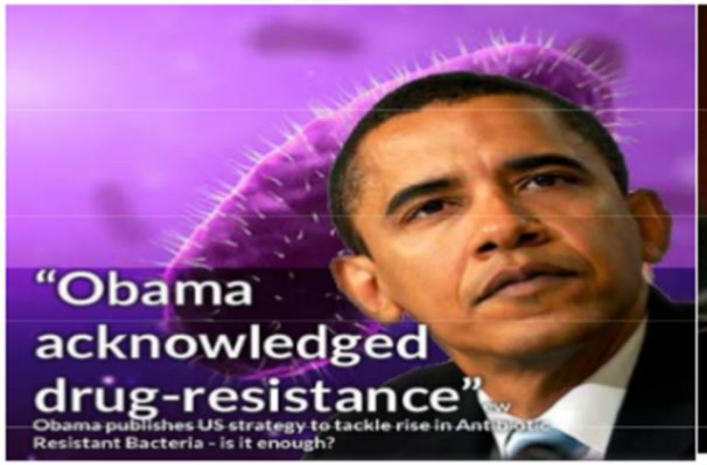
THE FAO-OIE-WHO
Tripartite Coordination

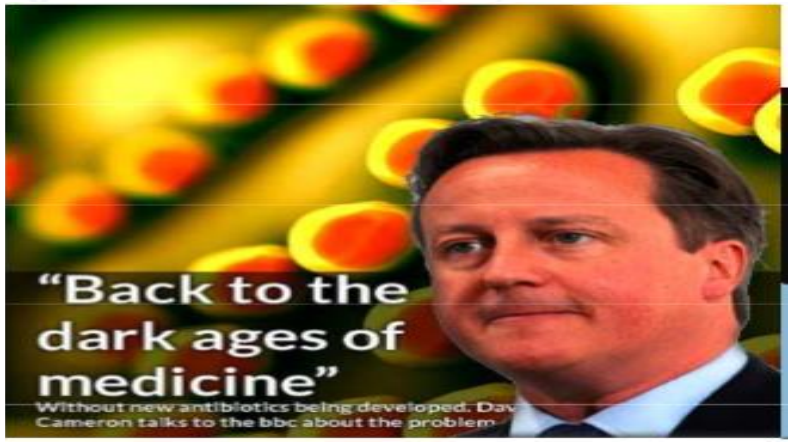
Global leader for food and agriculture	Global leader for animal health and welfare standards	Global leader for human health

The FAO-OIE-WHO Tripartite applies "One Health" approaches by **combining their respective expertise** to reduce the risks to health at the human-animal-ecosystems interface.

Flagship topics: Influenza, rabies and **AMR**

Global responses to AMR



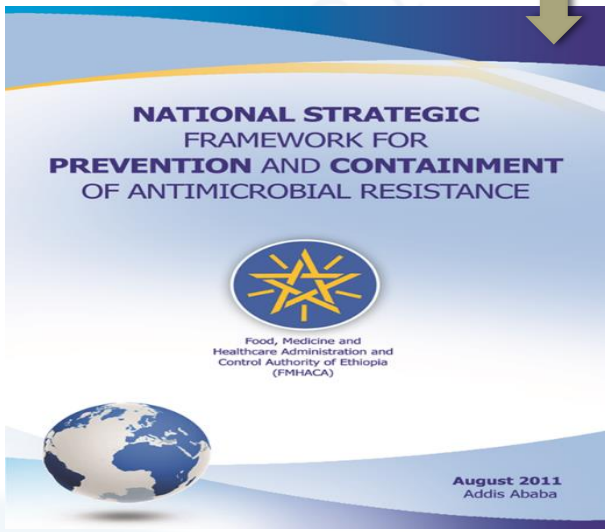


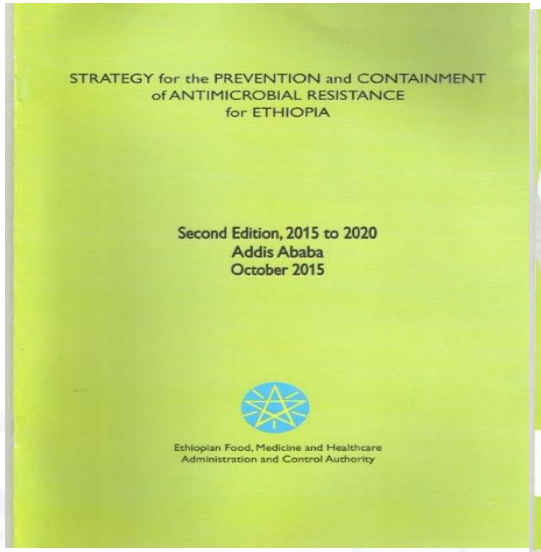
G7 GERMANY
2015 | Gesundheitsministertreffen

The leaders confirmed that the G7 will coordinate its responses to antimicrobial resistance (AMR).

I C A R E

National policy responses to AMR

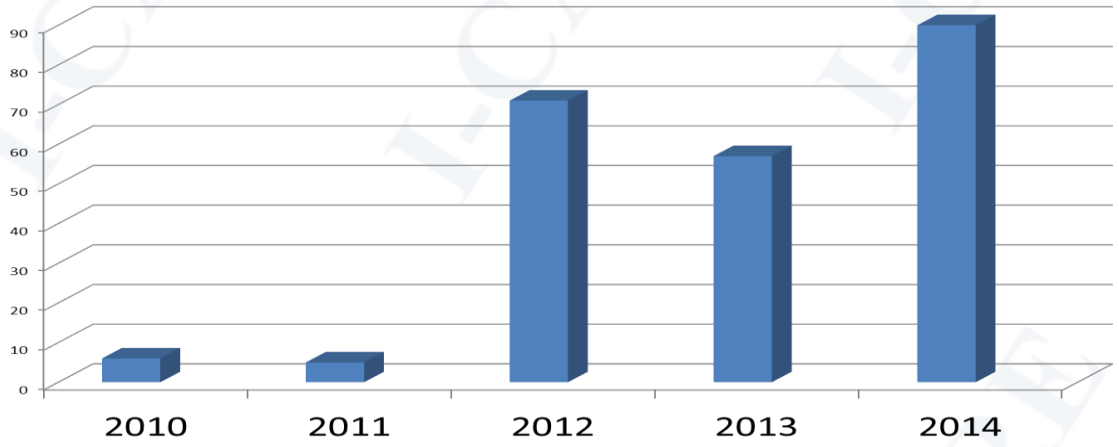


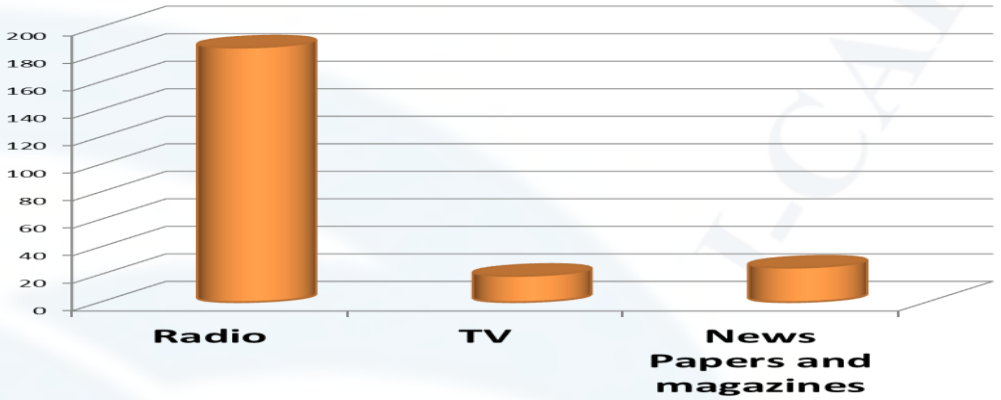


20 priority areas and 186 priority actions

I C A R E

Interventions – Advocacy





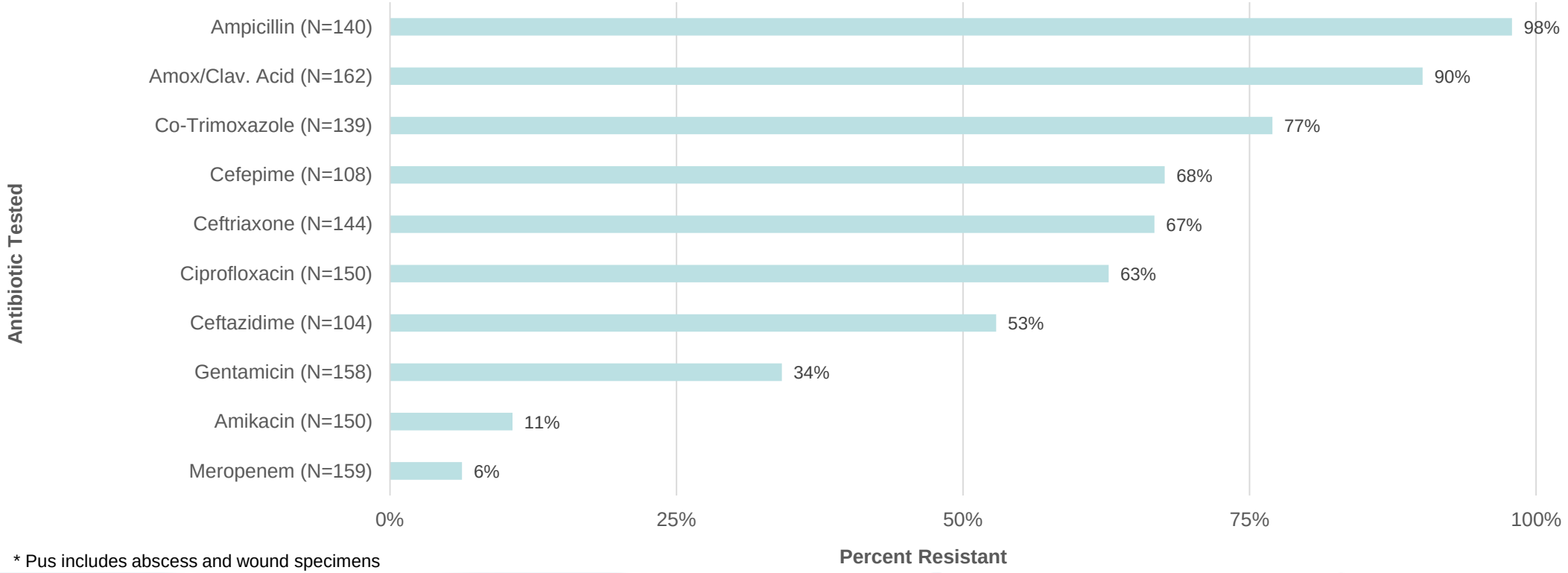
Interventions – Surveillance

Findings from Tikur Anbessa Specialized hospital

- 1716 urine &323 pus, abscess, and wound specimen collected(Sept-July 2018).
- Escherichia coli is the most common pathogen isolated from urine and the second most common pathogen from pus.
- The majority of the isolates **showed resistance to broad-spectrum antibiotics.**

Surveillance Findings

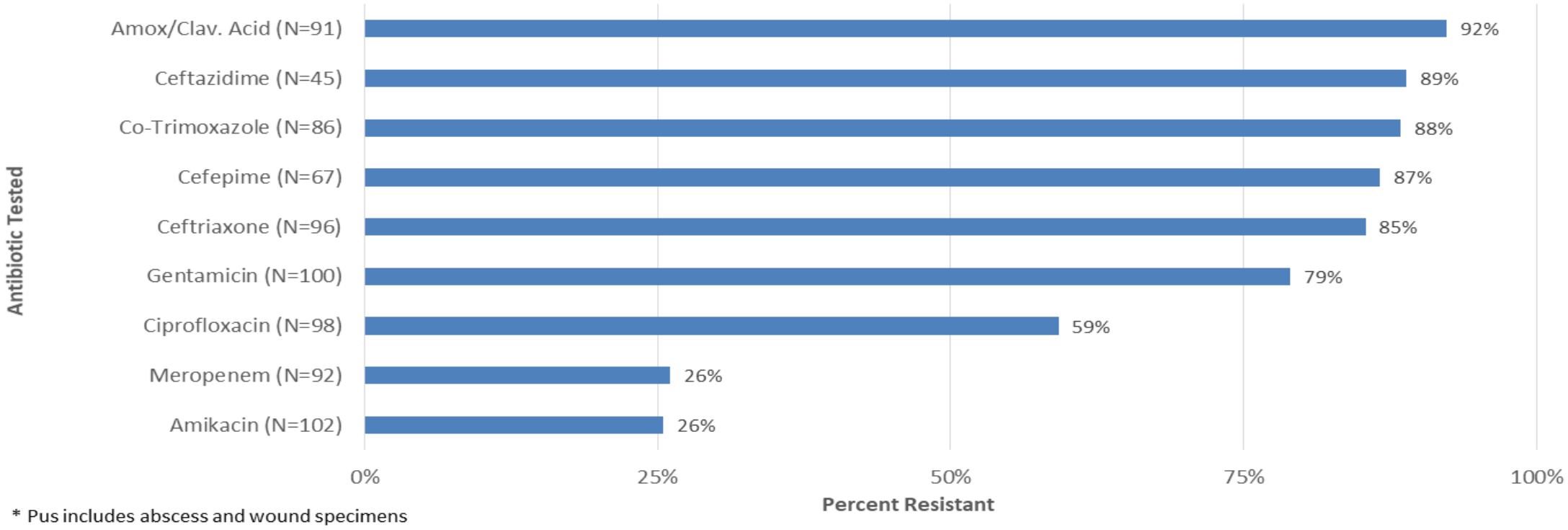
Figure 2. Proportion of *E. coli* Isolates (N=184) from Urine and Pus* Showing Resistance by Antibiotic



* Pus includes abscess and wound specimens

ICARE

Surveillance Findings

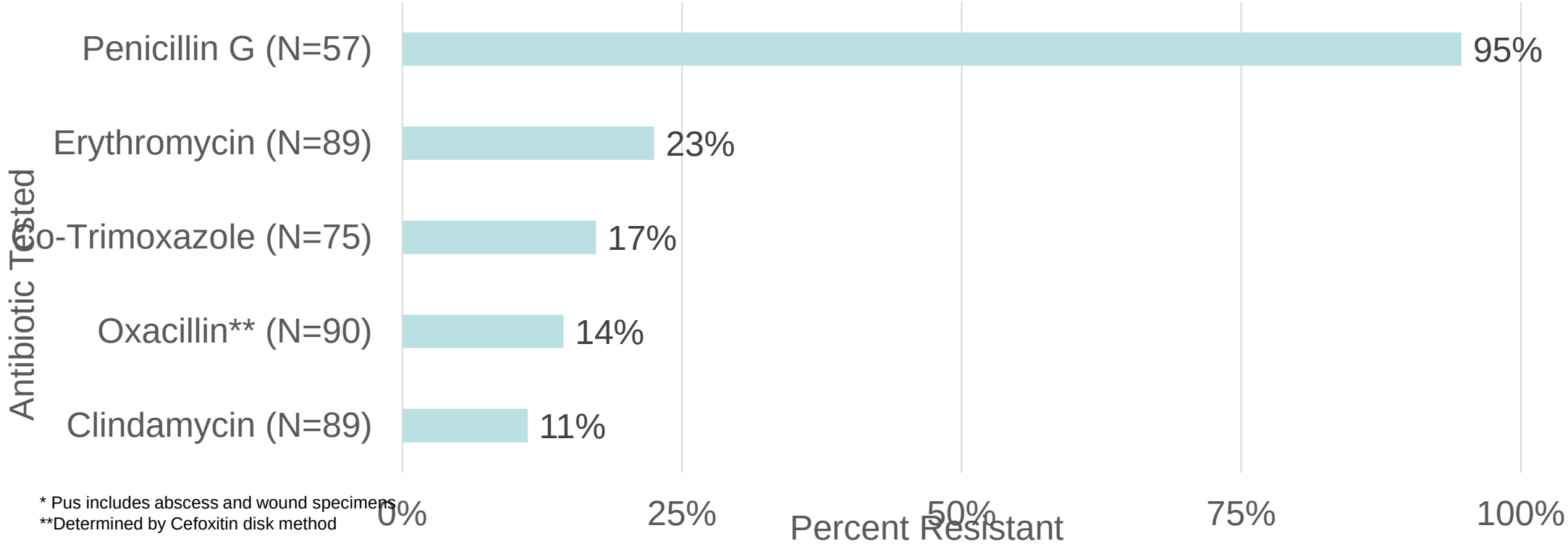


* Pus includes abscess and wound specimens

I C A R E

Surveillance Findings

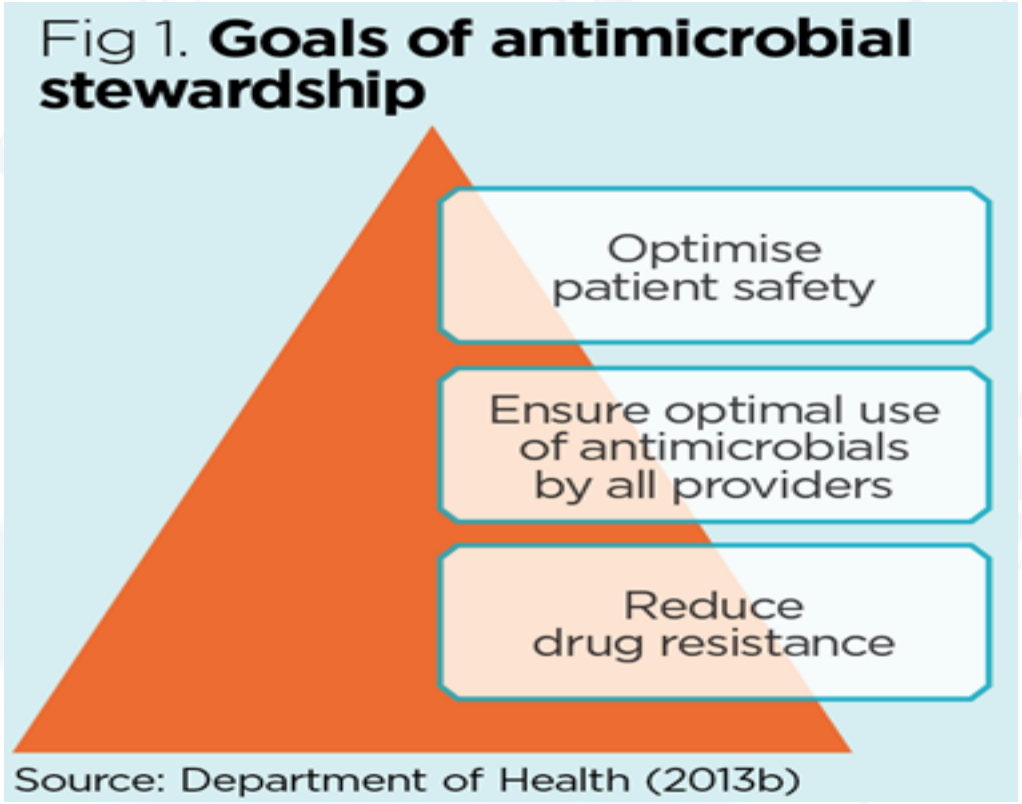
Figure 4. Proportion of *Staphylococcus aureus* Isolates (N=95) from Urine and Pus* Showing Resistance by Antibiotic Tested,

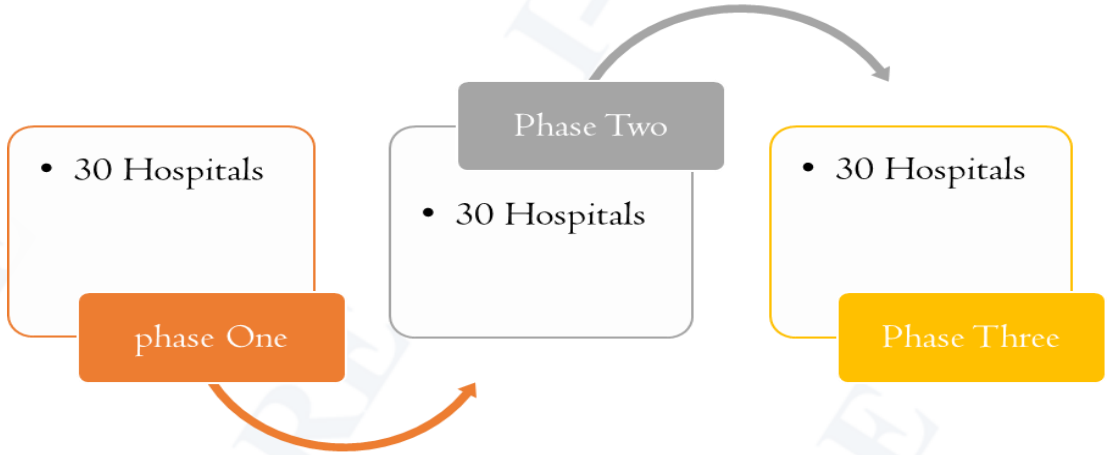


* Pus includes abscess and wound specimens
**Determined by Cefoxitin disk method

I C A R E

Interventions–Antimicrobial Stewardship Program





I C A R E

Way forwards

- AMR is one of the components of I-CARE
- AMR at the high level policy
- Implementing Antimicrobial Stewardship program
- Strengthening IPC Program at health facilities (ABHR)
- Awareness to the public and health care provider
- Multisectoral/department collaboration
- Research mapping & prioritization

Thank you

Let us Save Antimicrobials
for Our Children!

Patient Safety

Desalegn Bekele Taye (MD)

Coordinator, Health Service Quality Improvement Team

National Patient safety Focal

Outline

- Objective
- Patient safety
- **I-CARE** for Patient Safety focus areas,

Objective

- To discuss patient safety improvement initiatives in the perspective of I-CARE for HSTP targets program

Patient Safety

- *“The absence of preventable harm to a patient during the process of health care*
- *and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.” WHO.*

I-CARE for Patient Safety: Focus areas

1. Medication errors,
2. Health care-associated infections
3. Unsafe surgical care procedures
4. Diagnostic errors
5. Radiation errors
6. Unsafe injection practices
7. Unsafe transfusion practices
8. Venous thromboembolism
9. Unsafe care in mental health setting

Medication errors,

- Scope based practice,
- Standardizing clinical pharmacy services,
- Standardizing nursing care (medication Administration)
- Establishing high ALERT and polypharmacy medications protocols,
- Ensuring good communication at the transition of care,
- Maintaining/establishing psychological safety

Health care-associated infections

- Implementing CATCH IT
- Implementing standard precautions (hand Hygiene)
- Improving reporting and surveillance

Unsafe surgical care procedures

- Prevention of Surgical Site Infection
- Safe Anesthesia
- Safe Surgical Teams
- Safe surgery Checklist utilization

Unsafe injections practices

- Injection protocols
- Ensuring adequate supply
- Training the staff
- Strengthening the hospitals transfusion committe

Diagnostic errors

- Scope Based practice,
- Transforming health workforce
- Availing essential diagnostic modalities
- Combating provider Burnout

Unsafe transfusion practices

- Implementing blood Safety,
- Transfusion protocols
- Improving reporting of transfusion reaction

Radiation errors

- Standardizing Radiation services
- Patient engagement

Venous Thromboembolism

- Standardizing the Inpatient and ICU services
- Optimize Nursing Care
- Availing essential drugs

Unsafe care in the mental health setting

- Implementing CATCH IT
- Standardizing psychiatric care
- Ensuring scope based practice
- Availing the essential drugs for psychiatric care

Speak up for patient safety!

Thank you so much!

Does Infection prevention and Control (IPC) program deserve top priority ?

What is IPC ?

- A practical and proven set of organizational and technical approaches and measures to prevent the spread avoidable infections and Antimicrobial Resistance (AMR) within both community and health care settings .

Background of IPC and opportunities In Ethiopia.

- MOH has been has implementing Infection prevention and Patient safety program since 2005
- In complement of the IPPS program, clean and safe health care facilities (CASH) program has been implemented since 2014/2015
- CATCH –IT initiative under the big program I-CARE has been introduced 2019

IPC Plays a critical Role in Meeting national Health priorities

- Quality of Universal Health Coverage
- Anti-Microbial Resistance(**AMR**)
- Health security
- Maternal and neonatal health
- Others

Reasons to invest on IPC

- Directly improves health outcome
- Reduces health care costs and out of pocket expenses
- Monitors and tracks quality
- Consists proven strategies supported by implementation aids
- Is scalable to local context

Quick Action Points

- Consider how IPC is relevant to Global and national Health priorities (AMR, WASH, International health regulations, Sepsis and Patient safety).
- Make sure you have strong IPC program at all levels inline with WHO guideline on cc of IPC and interlinked with Quality ,AMR, Emergencies and other programs.
- Make sure that you grow IPC expert and all health workers know basic IPC
- Check a system is in place to track the frequency of infection and AMR in your health care facilities
- Make sure that your health facility has utilities, staff and equipment
- Check IPC indicators, show progress and act to correct Gaps
- Be a champion in IPC

The way forward Cont……
The 8 WHO's Core components of IPC

1. IPC programmes
2. Evidence-based guidelines
3. Education and training
4. Health care-associated infection (HAI) surveillance
5. Multimodal strategies
6. Monitoring and audit of IPC practices and feedback
7. Workload, staffing and bed occupancy (facility level)
8. Built environment, materials and equipment for IPC (facility level)