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

National Infection Prevention and Control Strategy and Roadmap

2021/22-2025/26

National Infection Prevention and Control Strategy and Roadmap

2021/22-2025/26

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Foreword

Infections that originate within health care facilities have always presented a major problem in delivering health care. Health care-associated infections (HAIs), which can be blood-borne, airborne, or transmitted directly through physical contact, endanger the safety of anyone who enters the health care setting: patients and their families, clients, health care workers (HCWs), and support staff.

These infections can lead to prolonged hospital stays, long-term disabilities, financial burdens for health care facilities, additional costs for patients and their families, and often-avoidable deaths.

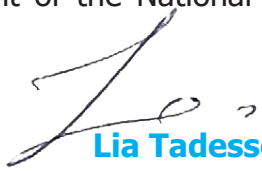
The ongoing world globalization, extensive travels between countries, changing pattern of infections and the emergence/re-emergence of viral disease pandemics and bacteria that are resistant to multiple antibiotics; have only exacerbated this problem in recent years.

Infection prevention and control (IPC) initiatives should therefore be a high priority for all health care facilities. Good IPC practices can make health care safer by protecting patients, clients, and HCWs from HAIs. All HCWs must understand and adhere to evidence- based IPC practices in order to provide high-quality health care services and to prevent unnecessary illnesses, expenses, and deaths.

The Ministry of Health (MoH) recognizes the critical role that IPC plays in preventing HAIs. To this effect, the Ministry in collaboration with all relevant stakeholders; in line with internationally acclaimed standardized recommendations has developed this National Infection Prevention and Control Strategy and Strategy Road Map for Health Care Services to assist HCWs and other IPC stakeholders in the design, implementation, monitoring, and evaluation of IPC programs in Ethiopia. The Ministry remains firm that these efforts will improve health care delivery, lead to a reduction in infections, and move the country towards the achievement of the broader goals of the Ethiopian Healthy Policy.

The Strategy and Strategy Roadmap is to be used in conjunction with other relevant documents, such as the National IPC Policy and the National IPC Guidelines for Health Care Services in Ethiopia, and all other IPC related guidelines in the country.

Finally, I wish to extend my heartfelt gratitude to all individuals and institutions that have contributed to the development of the National IPC Strategy and Strategy Roadmap documents.



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Acknowledgment

The Ministry of Health acknowledges the commitment and technical support of the National Infection Prevention and Control Advisory Technical Working Group members and other key contributors along with their organizations who made the development of this IPC Strategy and Strategy Roadmap documents possible.

The Ministry of Health would like to specially thank ICAP Ethiopia, WHO and EPHI for their technical support in the national IPC strategy and national IPC Strategy roadmap development by delivering their expertise in the national Core Group for the development of IPC related documents.

Furthermore, the Ministry would like to extend its gratitude to ICAP-Ethiopia for providing financial support to conduct series of consultative workshops during the development of the strategy and roadmap documents.

The Ministry of Health acknowledges the persons and organizations listed below who were actively engaged from inception to the final writeup of the above-mentioned national documents.

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Acronyms

CASH	Clean and Safe Healthcare Facility
CATCH-IT	Clean and Timely Care for Institutional Transformation
CRC	Compassionate, Respectful and Caring
CRPD	Convention on the rights of persons with disabilities
EHRIG	Ethiopian Hospital Reform Implementation Guideline
EHSTG	Ethiopian Hospital Service Transformation Guideline
GoE	Government of Ethiopia
HAIs	Healthcare-facility Acquired Infections
HCFs	Healthcare Facilities
HCWs	Healthcare Workers
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HSTQ	Health Service Transformation in Quality
HR	Human Resource
HSTP- II	Health Sector Transformation Plan Two
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IPCU	Infection Prevention and Control Unit
MoH	Ethiopian Ministry of Health
OHS	Occupational Health and Safety
PEP	Post Exposure Prophylaxis
PPP	Public Private Partnership
STIs	Sexually Transmitted Infections
TOR	Terms of Reference
WaSH	Water, Sanitation and Hygiene

SECTION 1

Infection Prevention and Control Strategy

1. Background

Recent and current threats posed by epidemics such as Ebola, Cholera, Influenza, and the ongoing COVID-19 pandemics on the one hand and growing antimicrobial resistance (AMR) on the other have become increasingly evident as ongoing universal challenges to public health. These challenges have been given top priority for action on the global health agenda along with patient safety and Water, Sanitation and Hygiene (WASH) in health facilities.

Effective infection prevention and control (IPC) program is the cornerstone for combating healthcare-associated infections (HAIs) and AMR. IPC is unique in the field of patient safety and quality universal health coverage (UHC) since it affects the safety of health workers and patients.

The United Nations Sustainable Development Goals (SDGs) came into effect in January 2016. SDG 3 (good health and wellbeing, SDG 3.8) and SDG 6 (clean water and sanitation) reinforce the importance of IPC as a contributor to safe, effective high-quality health service delivery, in particular to those related to WASH, quality of care and UHC.

There is also a renewed focus on the International Health Regulations (IHR) positioning IPC as a pivotal strategy for dealing with public health threats of international concern. In Ethiopia, the National Health Policy prescribes that everyone must have access to the best possible quality health care in an equitable manner.

Ethiopia began to implement targeted infection prevention and control activities since 2005 in response to the HIV/AIDS epidemics and TB in collaboration with International Partners. Furthermore, Ministry of Health has been implementing initiatives like clean and safe healthcare facilities (CASH), clean and timely care for institutional transformation (CATCH-IT) to complement and strengthen the IPC activities.

These infection prevention and control activities are now crowned by the development of national IPC Policy and this IPC national strategy is intended to guide the implementation of the National IPC Policy.

While the 2016 WHO core components are based on systematic reviews and robust evidence gleaned mainly from high-income countries, these core com-

ponents apply equally to low to middle- income countries including Ethiopia.

- WHO defines eight core components for IPC, the first six are specifically aimed at national level IPC programs and last two are aimed at health facility level programs. This Ethiopian National IPC Strategy is structured around these 8 WHO IPC core components:
- National IPC program.
- National and health facility level IPC guidelines.
- IPC education and training.
- HAI surveillance.
- Multimodal improvement strategies (MMIS) for implementing IPC activities.
- Monitoring, evaluation, and feedback.
- Workload, staffing and bed occupancy at the health facility level and
- Built environment, materials, and equipment for IPC at the health facility level.

1.1 Rationale

During the past few years, the Ministry of Health has invested a lot of efforts in scaling-up infection prevention activities in health care facilities. Accordingly, several promising gains have been achieved. However, there are still several components of IPC such as surveillance for HAIs, implementation of multimodal strategies, addressing IPC practices in educational curricula as well as prevention of antimicrobial resistance have not yet been adequately addressed.

Moreover, the growing threat of emergence of pandemic disease including the one that the country is facing now that is the COVID-19 pandemic subject the country to owning an organized and standardized IPC approach that will effectively prevent and control HAIs and decrease AMR.

Therefore, the rationale for having this national IPC strategy and the subsequent strategy roadmap is to guide and outline the strategic interventions required to prevent, reduce and control the development of HAIs and AMR, ultimately improving patient safety and health outcomes. The strategic inter-

ventions are aligned with the Ethiopian HSTP 2 guidance.

1.2 Scope

The National IPC strategy will be applicable to all federal and teaching hospitals, general/referral and primary hospitals, health centers, health posts and as well as all private, NGOs, and other health care facilities providing health care and health care related services. In addition, all healthcare and healthcare related facility managers and staffs should use these strategies to improve their IPC practices.

1.3 Relevance of the Strategy

The legislative and strategic mandates that bear relevance to the development and implementation of this strategy are set out in Table 1 below.

Table 1. Relevance of the Strategy

INTERNATIONAL	
Sustainable Development Goals	SDG 3 (good health and wellbeing) and SDG 6 (clean water and sanitation) reinforce the importance of IPC as a contributor to safe, effective high-quality health service delivery.
International Health Regulations, 2005, third edition (published 2016)	The purpose of the IHR is to protect against the international spread of disease. The Ministry of Health must oversee the implementation of the IHR. Health facilities are in the front-line of containment and response strategies that requires facilities to have IPC systems in place.
NATIONAL	
Ethiopian Constitution	The Constitution of Ethiopia has policy provisions related to air pollution, occupational safety and health (OSH), and climate change and health. Proclamation No. 300/2002 on Environmental Pollution Control specifies ambient air quality standards and allowable emissions
National Health Policy	The policy in its article 3 states: Development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources.

Proclamation no. 200/2000 public health proclamation	Proclaims that the issuance of public health law is believed to be an important step for the promotion of the health of the society and for the creation of healthy environment for the future generation thereby enabling it to assume its responsibility.
Proclamation no.1112/2019 a proclamation to provide for food and medicine administration	Proclaims that it is necessary to adopt a national legal framework that enables to establish a coordinated food, medicine, medical device, cosmetics, and tobacco products regulatory system.
Proclamation no.553/2007 on Establishment of the drug fund and the pharmaceutical supply agency	The proclamation advocates that it is appropriate to design a system of mobilizing funds from different sources to ensure uninterrupted and sustainable supply of pharmaceuticals to all public health facilities and thereby serve the public in an equitable manner.
Proclamation 3/2020	A State of Emergency Proclamation enacted to counter and control the spread of COVID-19 and mitigate its impact.
Council of Ministers regulation no.466 /2020	A regulation issued to implement the state of emergency proclamation no. 3/2020 enacted to counter and control the spread of COVID-19 and mitigate its impact.
National IPC Policy	The policy aims to establish and institutionalize high standards of IPC to reduce the risk of HAIs, improve the safety of patients, health care workers, and the public, and attain the highest quality of health care across all levels of the Ethiopian health care system.

1.4 Strategy Harmonization

The Medical Services General Directorate at the MOH will oversee that the different strategies developed by Directorates under its jurisdiction are harmonized leading to results greater than what would have been produced had each directorate acted on its own. Synergies must be harnessed in ways that contribute to sustainable scale-up rather than increasing fragmentation and duplication between different short-term initiatives/activities. In line with this IPC strategy is fully harmonized with the strategies prepared by the 1. Clinical Service Directorate 2. Pharmacetical and Medical Equipment Directorate 3. Emergency and Critical care Directorate 4. Health Service Quality Directorate 5. Hygiene and Environmental Health Directorate and other directorate in the

Ministry.

1.5 Rights of Persons with Disabilities

The national IPC strategy fully embraces the resolutions, principles, and protocols of the 2006/2007 UN convention on the rights of persons with disabilities (CRPD) with special emphasis on Article 26 of the convention under which signatory states and parties are urged to organize, strengthen and extend comprehensive habilitation and rehabilitation services and programs, particularly in the areas of health, employment, education and social services. Accordingly, this strategy calls for complete compliance with the international recommendations of the CRPD in designing and implementing IPC practices

2. SWOT Analysis

The strength, weakness, opportunity, and threat are analyzed by assessing both internal and external factors using IPC core components that are used as guidance for effective implementation of Infection Prevention and Control which helps to clarify the current situation. The aim of this assessment is to build on strengths, resolve weaknesses, exploit opportunities and avoid threats. The SWOT analysis was made through desk reviewing reports of several supervision and assessment conducted by the Ministry and through consulting experts with years of experience in the implementation of IPC in the country starting from early the beginning.

Table 2: SWOT Analysis

1. IPC Program Management and Institutional Coordination Structure		
Internal factors	**Strength** • Presence of IPC focal person at national level under medical service directorate coordinating the program • Inclusion of IPC as a cross cutting issues in the emergency management and surveillance program at national level • At national level IPC become priority in complementary initiatives and in ensuing quality of health services • Presence of expression of senior leadership at MoH commitment for IPC at national level using complementary priority initiatives (CATCH-IT, CASH, WASH, AMR etc.). • The existence of health extension program	**Weakness** • Absence of enforcing mechanism to ensure implementation of the IPC program • Weak coordination among stakeholders involved in the IPC program • Confrontation in considering IPC as a priority and cross cutting important program at all levels • Lack of structural governance and stand-alone national and regional IPC program with clearly defined objectives, functions and activities. • Poor linkage with other relevant national programs and professional associations. • Insufficient budget allocation of IPC program at all levels • Low score in the WHO global survey • Resource limitation
External factors	**Opportunity** • IPC has become concern of higher officials across other sectors • Existence of partners that supports the program • Demand of IPC due to pandemics • IPC policy and strategy	**Threats** • Emerging and remerging infectious disease outbreaks and AMR may compromise the implementation of comprehensive IPC interventions • Presence of competitive health service programs which may inhibit IPC to become a priority

2. National Infection Prevention and Control Standards and Guidelines		
Internal factors	**Strength** • Presence of updated and contextualized national reference manual • Presence of final draft comprehensive IPC monitoring and evaluation tools • IPC monitoring indicators included in DHIS2	**Weakness** • Poor implementation and adherence of health care workers on the recommended IPC practices • The revised National IPC reference manual is not widely disseminated • Lack of SOPs and Pocket guide/job aids at facility level • Lack of IPC monitoring and evaluation system (such as; performance review meeting, supportive supervision, and audit) • Absence of national IPC strategy and strategy roadmap • Lack of required supplies and infrastructures to ensure IPC guideline implementation • Poor engagement of higher-level professionals • Absence of comprehensive IPC program monitoring indicators
External factors	**Opportunity** • Presence of supporting partners in the development of required IPC documents and capacity building • Inclusion of IPC requirements into Ethiopian health care facility standards • IPC practice happening as a cross cutting guide in all health care services	**Threats** • Academic institutions with the national IPC guidelines • Lack of sufficient budget to properly implement the IPC strategies • Availability of quality and appropriate technology supplies and infrastructures to ensure the standard implementations of IPC • Lack of commitment and integration of other sectors (example, Water and Sewerage Authority, Environmental Protection Agency etc.)

3. National Infection Prevention and Control Education and Training		
Internal factors	**Strength** • Presence of IPC training package • Presence of a pool of IPC trainers at all administrative levels	**Weakness** • Lack of cascading the IPC training by Regional Health Bureaus and thus in-service training opportunity is low • Shortage of well skilled and dedicated master/lead trainers • Lack of proper organization of training (trainer selection, supplies for demonstration, training site selection etc.) • Absence of nationally indorsed IPC related videos in the national IPC training package • Shortage of dedicated and properly trained team of health care workers at facility level and • Lack of uniformity and standardization of the IPC training package among the stakeholders • Lack of IPC knowledge, skill and attitude among health care workers. • Absence of attitudinal change mechanism in the IPC training package
External factors	**Opportunity** • Supporting partners increased interest in capacity building for IPC • The increment of training centers at national and regional level • The occurrence of life-threatening disease outbreaks magnified the importance of IPC	**Threats** • Turn-over of IPC trained health care professional at all levels • Pre-service education curriculum not containing comprehensive IPC knowledge and practice • Limited higher professionals' involvement in the IPC training • Insufficient budget allocation

4. Surveillance of HAI's		
Internal factors	**Strength** • Presence of research and surveillance coordinating body at national and regional level which can support facility level HAI's surveillance • The existence of preliminary works and establishment of IDSR in hospitals	**Weakness** • Absence of HAIs' surveillance plan, monitory, and reporting and handling mechanism at all health system • Poor understanding of the importance, capacity (human, laboratory and supplies) to perform and commitment of facility managers to do periodic HAI's surveillance and AMR stewardship • Lack of HAI's process and outcome indicators at national, regional and hospital level
External factors	**Opportunity** • Presence of partner showing interest in promoting and implementing AMR • Presence of existing routine data collection mechanism (DHIS2) • Established health emergency and surveillance department at all health system level	**Threats** • Emerging and remerging infectious disease outbreaks • Limited budget and capacity to do periodic HAI's surveillance •

5. Multimodal Strategy		
Internal factors	**Strength** • The implementation of CASH program through multi modal approach such as; **I.** National and regional launching of the initiative by higher officials and advocacy campaign **II.** Appropriate governance structure national, regional and facility level **III.** The development of CASH audit tool for monitoring and evaluation format **IV.** Champions selections as part of EHAQ platform **V.** CASH has training tools **VI.** Involvement of all staff and leadership within the healthcare facility	**Weakness** • There is no clear policy for the implementation of IPC practice through multimodal approach • Lack of sustainability in creation of champions in IPC practice • Lack of successful linkage of IPC to quality improvement initiatives at national levels • Inadequate implementation of a IPC multi modal bundle of care at facilities • Unable to create a culture and system change in IPC practice
External factors	**Opportunity** • Quality and Safety strategy development and focus on patient safety • Increased attention of the leadership due to frequent appearance of infectious pandemic • Presence of multiple partners can support IPC program • National and sub-national hand hygiene campaigns implemented as part of CATH-IT initiative and COVID-19 pandemic response	**Threats** • Limited resource • High attrition rate of well-trained professionals

6. Monitoring/Audit of IPC Practices and Feedback		
Internal factors	**Strength** • Development of CASH audit tool and integrated to DHIS2 reporting format • Presence of some IPC out-come indicators in national DHIS 2 indicators	**Weaknesses** • There is no clear IPC M&E framework • Lack of comprehensive and representative IPC indicators • Lack of regular monitoring/auditing of IPC practices • There is no regular audit and feedback mechanism of health care practices according to IPC standards • Lack of accountability for both reporting and performance improvement • Lack of structure and dedicated staff for IPC M&E at all levels • The progress and impact of national program are not monitored
External factors	**Opportunity** • Presence of DHIS2 platform • Presence of partner who support supportive supervisions and monitoring of IPC practices	**Threats** There is no flexible budget allocation mechanism for staff recruitment based on the workload

7. Workload, Staffing and Bed Occupancy		
Internal factors	**Strength** • Some hospital conduct quality improvement on workflow • Nurse work force plan included in the nursing care guideline • Presence of Liaison's office at health care facilities	**Weakness** • Shortage of staff mix with population ratio and the health workers dealing with high client volume • Shortage of trained staff on IPC • There is no standardized staffing based on the workload • There is no surge plan for staffing in healthcare facilities • Overcrowding • Poor bed management
External factors	**Opportunity** • Expansions of health facilities • Increasing number of health facilities and repurposing of the service • Presence of standard patient flow guideline and Health facility design	**Threats** • Turn-over rate of IPC trained health care professional at all levels • Lack of integration of IPC in the pre-service education curriculum • Limited higher professionals' involvement in the IPC training • Insufficient budget allocation

8. Built Environment, Materials and Equipment for IPC		
Internal factors	**Strength** • There are standards for health facility design and construction • Existence of IPC commodities production in the health facilities of IDSR in hospitals	**Weakness** • Infrastructure (WaSH components, buildings, electricity, and road) of healthcare in most health facilities are not convenient to fulfill IPC standards • Unavailability and expensiveness of some products of IPC materials • Lack of maintenance and proper utilization of IPC materials
External factors	**Opportunity** • Existence of one WaSH program • Behavioral change towards hand hygiene due to COVID 19 pandemic. • Introduction of innovative technologies	**Threats** • Unavailability and expensiveness of some products of IPC material in the market • Natural disasters destroying WaSH infrastructures • Inadequate implementation of National WaSH Program at health care facilities

3. Stakeholder Analysis

The involvement of all stakeholders is necessary for the successful implementation of this strategy. Partners need to work together to achieve the objectives of this roadmap by information sharing, adopting innovative approaches, avoiding conflict of interest and duplication of efforts to maximize the use of available resources. MoH and its' agencies, RHBs, Health Facilities, Line Ministries, Non-Governmental organizations, and professional associations including clients share responsibilities for the prevention and reduction of HAIs through the achievement of this strategy.

Table 3: Stakeholder Analysis

Stakeholder	Role	Anticipated Challenges	Institutional response /Strategic Implication/
MoH	• Establish national coordinating body • Policy and guidelines development • Resource mobilization and funding • Coordination • Training and capacity building • Surveillance		• Strong stewardship of IPC program at all levels • Lobby for resources & allocate budget • Integrate IPC with other programs as cross cutting issue • Promote PPP
Regions	• Establish governance & leadership structures • Resource mobilization and funding • Coordination • Supervision of health facilities • Training and capacity building	• Establishing appropriate structure • Budget allocation • Weak coordination, monitoring & follow up	• Appropriate stewardship of IPC • Leadership support • Enhance existing M&E integrating IPC • Collaboration • Advocacy

Health Facilities	• Front-line implementer • Establish strong IPC structure • Resource mobilization and budget allocation • Engagement of all staff, client & community	• Considering IPC as low priority • Leadership engagement • Budget allocation • Fragmented implementation	• Strong stewardship & advocacy • Strengthen management capacity • Enhance M&E framework • Accountability • Integration of program intervention with quality of care
EFDA	• Integrate IPC standards in health facility regulatory requirements	• Mandate • Capacity	• Shared responsibility and accountability • Leadership support
EPSA	• Provision of supplies and commodities	• Not part of priority list equipment • Access to foreign currency	
EPHI	• Research • Technical support in Surveillance system establishment & strengthening	• Organizational focus and priority	

Line Ministries (MOSHE, MoWIE)	• Integration of IPC in educational curricula • Consider priority conditions in adequate water supply to health facilities • Quality control & surveillance of water supply	• Consider IPC as low priority for medical & other health education • Curricula revision • Priority for adequate water supply	• Strong communication and information • Shared responsibility & common understanding • Collaboration • Advocacy
Federal Civil Service Commission	• Collaborative engagement in structure establishment • Ratification of HR related directives	• Delay in decision making	
Partners (WHO, Splash-Ethiopia, ICAP, CDC, MSH, MTaPs)	• Provision of technical support & capacity building • Funding and resource allocation to government priorities	• Fragmentation • Dissatisfaction • Limited funding • Withdrawal (project termination)	• Strong government leadership • Harmonization and alignment • Transparence & advocacy • Efficient resource use • Enhance engagement in planning, implementation and M&E
In-service Training Centers	• Ensure the development of appropriate & standard training materials • Ensure provision of standard training (including knowledge & skill) • Include IPC as one of licensing & accreditation course	• Standardizing training methodology • Curricula designing	• Technical support and capacity building • Improved M&E and certification

Professional Associations	• Provision of technical advice & support • Capacity building • Research	• Setting pre-requisite • Mixing with one's association priority	• Enhance mechanism for collaborative roles • Motive and support to engage on CPD program
Clients and Attendants	• Participation, engagement & ownership	• Role and mandate • Participation	• Advocacy and promotion of their role on HAIs prevention • Put in place enabling platform for engagement

4. Mission and Vision

4.1 Mission

"To promote and guide high standards of IPC practice in order to prevent and reduce the risks of HAIs, AMR and respond & manage outbreaks for the wellbeing of clients, HCWs and the community at large."

4.2 Vision

"To create healthcare delivery settings free from preventable harm."

5. Strategic Objectives

From the in-depth SWOT analysis undertaken, the strategy identified seven major strategic objectives as priority areas for focus where each incorporates key interventions to deliver the IPC program at all levels of the health care system. These strategic objectives are aligned with the IPC core components and will be implemented in line with the next five-year health sector strategic plan (HSTP-II).

The strategic objectives include:

Strategic objective 1: Ensure strong program management, governance and leadership at all levels to oversee IPC program implementation

Description

This objective refers that the development and maintenance of a national IPC program is the foundation for the implementation of all other core components. Developing and establishing an IPC program ensures that national leadership and the right technical expertise is in place to support all IPC activities. It is essential to have an active, stand-alone, national IPC program with clearly defined objectives, functions, and activities for the purpose of preventing HAI and combating AMR through IPC good practices. National IPC program needs to be linked with other relevant national programs and professional organizations. A strong, effective, and sustained IPC program ultimately strengthens health systems and supports the delivery of high quality, people-centered and integrated

health services that are a prerequisite to achieve universal health coverage and SDGs.

Result 1: Strong, functional, and sustainable IPC governance structures in place at all levels of the health system.

Key Interventions

1. Advocate for IPC program nationally as a flagship initiative
2. Establish IPC coordinating body/units/focal at national, regional and facility levels with necessary resources accordingly
3. Establish strong partnership among sectors and partners working on WaSH and IPC at all levels.
4. Establish and monitor the functionality of multidisciplinary IPC Committee at each facility.
5. Health managers regularly monitor the progress status of implementation of planned activities.

Strategic objective 2: IPC education and training for all health care providers working in healthcare facilities

Description

This objective refers to the need that the national IPC program support education and training of the health workforce as one of its core functions. Support of IPC education and training for the health workforce is recommended as a key function of national IPC program. It also refers that the aim of education is to have a skilled and knowledgeable health workforce, including a front-line workforce with IPC basic competencies and IPC specialists with advanced knowledge and mentorship and implementation skills. It affirms that health worker training has been found to be an essential component for effective IPC guideline implementation, contributing to the ultimate prevention of HAIs and AMR and provision of high-quality health service delivery.

Result 2: Knowledgeable, skilled, caring, and compassionate healthcare workers implementing IPC program activities.

Key Interventions

1. Standardize and endorse the national IPC training package with involvement of all relevant stake holders.

2. Integrate IPC in the pre-service education curriculum of health sciences and medical disciplines.
3. Develop/Review and disseminate evidence-based, ministry-approved IPC guidelines.
4. Develop/Review evidence based, Standardized, IPC Procedures, SOPs, and Patient flow charts, based on the national IPC guidelines for health-care facility level use
5. Map resources and identify implementing partners for in- service IPC basic & TOT trainings.
6. Provide IPC Specific in-service trainings for HCWs.
7. Train a pool of well qualified and skilled IPC trainers.

Strategic objective 3: Establish robust HAI surveillance system at all levels

Description

This objective refers to the need to develop level specific mechanisms to capture critical information on the incidence and prevalence of HAIs and AMR, assess trends over time, geographically or across high risk populations, detect clusters or outbreaks of importance and take public health actions. Timely obtaining critical information will assist decision-makers and the IPC national team to identify priorities for IPC and develop targeted evidence-based standards and policies as well as enable them assesses the impact and effectiveness of interventions.

Result 3: Improved HAIs surveillance practice and data use for decision making and action

Key Interventions

1. Develop Standardized HAIs Surveillance guidelines
2. Establish HAI prevention leadership through the integration of HAIs Surveillance in multidisciplinary IPC Committee activities
3. Provide Training on HAIs Surveillance for healthcare workers.

Strategic objective 4: Promote the use of multimodal approach in implementation of IPC programs

Description

This objective refers to following multimodal strategy while practicing IPC interventions. The multimodal strategy comprises of five components These include: (i) system change (availability of the appropriate infrastructure and supplies to enable IPC good practices); (ii) education and training of health care workers and key players (for example, managers); (iii) monitoring of infrastructures, practices, processes, outcomes and providing data feedback; (iv) reminders in the workplace/ communications; and (v) culture change within the establishment or the strengthening of a safety climate.

Result 4: IPC practice as cultural change instituted in the health system.

Key interventions

1. Promote the utilization of multi modal approach/strategy in IPC practices through development and dissemination of thematized sample bundle frameworks.
2. Create and advocate a system for champion selection at national, regional and facility level in specific IPC practices.
3. Health facilities need to organize and conduct IPC Quality improvement projects and ensure CQI in IPC practice.
4. Map and engage partners and relevant stakeholder in the implementation of multimodal strategies.

Strategic objective 5: Establish and implement strong Monitoring and Evaluation framework for IPC program

Description

This objective describes that monitoring and evaluation allow assessing the extent to which standards are being met, goals accomplished, activities performed according to requirements, and to identify aspects that may need improvement. This includes the regular evaluation of facility compliance with regulations and IPC best practices and standards, and identification of actions that need reinforcement or a change in strategies, as well as successful experienc-

es. Doing this helps to create a "monitoring and learning" culture. Monitoring and evaluation also provide a systematic method to document the impact of national programs using defined indicators

Result 5: Effective IPC program performance and M&E system in place.

Key interventions

1. Develop clear IPC program monitoring and evaluation framework.
2. Develop comprehensive IPC program implementation recording and reporting tools.
3. Develop comprehensive IPC program M and E Indicators and integrate to DHIS2 reporting platform.
4. Strengthen regular provision of feedback on IPC program implementation at all levels.

Strategic objective 6: Ensure and standardize the management of workload, staffing and bed occupancy in healthcare facilities

Description

This objective refers to the fact that in order to reduce the risk of HAI and the spread of AMR, the following should be addressed: (1) bed occupancy should not exceed the standard capacity of the facility; (2) health care worker staffing levels should be adequately assigned according to patient workload.

Result 6: Improved standardized workload, staffing and bed occupancy practice in health care facilities in place

Key interventions

1. Ensure the practice of facility based standardized work force assignment proportional to workload.
2. Develop facilities-based emergency preparedness and response plan for health emergency.
3. Monitor and evaluate the management of bed occupancy and spacing in healthcare facilities.

Strategic objective 7: Improve the management and investment on infrastructure, equipment, and supplies in IPC programs

Description

This objective assert that at the facility level, patient care activities should be undertaken in a clean and/or hygienic environment that facilitates practices related to the prevention and control of HAI, as well as AMR, including all elements around the WASH infrastructure and services and the availability of appropriate IPC materials and equipment. At the facility level, materials, and equipment to perform appropriate hand hygiene should be readily available at the point of care.WASH in health care facilities focus on the provision of water, sanitation, health care waste management, hygiene and environmental cleaning infrastructure and services across all parts of a facility.

Result 7: Improved infrastructure, equipment & supplies for IPC program.

Key interventions

1. Advocate, support and monitor adherence of health facilities to National regulatory standard on IPC infrastructure.
2. Advocate and support healthcare facilities to develop procedures for IPC commodities forecast and stock management.
3. Promote and support local marketers in production of IPC Commodities and supplies.
4. Advocate for innovative technologies towards IPC programs.
5. Improve and support facility-based IPC equipment maintenance and proper utilization.

6. Management and Coordination

The focus of this section is to show the coordination mechanism for effective IPC implementation of the program at all levels. It deals on system, physical structure and the role of all government body who will have part on national IPC programs. There shall be a coordinating body at all levels such as; at the national, regional and facility/community level.

As this is the coordination, integration, and harmonization of the efforts at all

levels, units and departments to provide unity of action for pursuing common goals. The managing bodies shall use their optimum coordination and facilitation capacity to allocate adequate resource, the relevant human resources and equipment and supplies. These will help to effectively implement IPC strategies and for efficient use of resources.

The following section of this strategy document details the roles and responsibilities at each level of the hierarchy of IPC structure. The need for having IPC programs nationally and at the facility level is clearly reinforced within the IPC policy.

6.1 Role and Responsibility

6.1.1 National IPC Coordinating Body

There will be a coordinating body established to govern the implementation of the IPC policy at national level. This coordinating body will be embedded at the MoH under the Clinical Service Directorate and will have the following roles and responsibilities:

- Develop and maintain written infection prevention policies and procedures appropriate for the services provided by the facility and based on evidence-based guidelines, regulations, or standards.
- Enhancing national IPC implementation through provision of technical advice and rapid development and dissemination of relevant recommendations/documents and by providing evidence-based IPC recommendations to contain HAIs, AMR, and outbreaks as well as contributing to emerging diseases' management.
- Contributing to define the national health and research agenda for IPC including in the context of quality universal health coverage, as well as the most effective ways of working together to promote and implement them.
- The coordinating body shall facilitate and mobilize resources for the IPC programs.
- The coordinating body will work to create a network between all stakeholders that have interest in IPC; the stakeholder includes but not limited to the health facilities, the regional health bureaus, IPC related equipment suppliers, Partners etc.
- The coordinating body shall plan IPC related country level capacity-build-

ing.

- The national IPC coordinating body shall work on the establishment of the steering committee and the technical working group who oversees the IPC implementations at the national level.
- These committees and technical working groups are not an independent legal entity but a collaborative mechanism between the interested parties.

6.1.2 National IPC Steering Committee

Chaired by a state Minister at MOH-E, the NIPCSC shall be responsible for steering IPC efforts, resource mobilization and prioritization of IPC interventions, reception of National level IPC performance reports and the crafting of evidence-based improvement interventions.

6.1.3 National IPC Technical Working Group

The NIPCTWG the members of which can be drawn from the MoH's Directorates, Health Facilities, Universities, Health Agencies, other sectors and or private institutions at the discretion of the CSD shall be responsible for providing technical support and advise on making high-level technical decisions on IPC issues and convenes as deemed necessary by the CSD.

6.1.4 Regional IPC Coordinating Body

- All regions shall establish their IPC coordinating body in their regional health bureau for effective management and coordination of the IPC programs.
- The IPC coordinating body shall develop and maintain written IPC policies and procedures appropriate for the services provided by the health facilities and based on evidence-based guidelines, regulations, or standards.
- The regional health bureaus must support the zonal health departments and the woreda health offices.
- The regional IPC coordinating body shall align expertise and planning to effectively support development, dissemination and implementation of IPC recommendations, technical documents, campaign promotional messages and supporting resources, and training materials and tools.
- The regional IPC coordinating body shall contribute to and oversee the design and institution of HAI surveillance systems in the health facilities and region wide and will also track performance of surveillance activities.

6.1.5 Health Facility Level Implementation Arrangement

6.1.5.1 Health facility IPC units

a. University and Federal Hospitals

Each University and Federal Hospital will establish an IPC unit/case team. The units will have a coordinator who will be mandated to coordinate the overall IPC and health care facility WaSH Program in the facility. This unit may have the necessary staff comprised of clinical professionals, environmental and hygiene experts, behavioural and education experts, Laboratory experts and epidemiologists.

b. General and primary hospitals

General and primary hospitals may resources permitting, have an IPC unit/case team and have a coordinator who will be mandated to coordinate the overall IPC and health care facility WaSH Program in the facility. This unit may have the necessary staff comprised of clinical professionals, environment and hygiene experts, behavioural and education experts, Laboratory experts and epidemiologists.

When short of resources, the hospitals may have only an IPC focal person to lead and coordinate facility IPC practices.

c. PHCU IPC Focal Person

The PHCU IPC Focal Person is responsible for coordinating, implementing the national IPC program activities and procedures at designated PHCUs. The PHCU IPC focal person will report progress and issues to the IPC unit at facility level. The IPC focal person at PHCU will report progress and issues to the higher level.

6.1.5.2 Health Facility IPC Committees

- All health facilities must establish IPC committee comprises, the clinician (Surgery, OR staff), Environmental health professional, Laboratory experts, Nurses and Support staff (Finance personnel, Facility management/general service Purchaser, Janitor etc).
- Develop and maintain written infection prevention policies and procedures appropriate for the services provided by the facility and shall be based on

evidence-based guidelines, regulations, or standards.

- The committee has to prepare facility level IPC implementation guideline and work plan.
- The guideline should include but not limited to the following areas; Hand hygiene, Prevention of surgical site infections, IPC to combat antimicrobial resistances, Injection safety, Burden of health care-associated infections, Emergency response and recovery, IPC facility capacity-building, Prevention of sepsis and bloodstream infections, and Prevention of urinary tract infections.
- The infection prevention and control focal person should ensure that equipment and supplies (e.g., hand hygiene products, safer devices to reduce percutaneous injuries, and personal protective equipment) are available and should maintain communication with all staff members to address specific issues or concerns related to infection prevention.
- In addition, all health care settings should have system and protocols for early detection and management of potentially infectious persons at initial points of patient encounter.

7. Financing & Resource Mobilization

The core functions of health financing are collecting revenue, pooling resources and purchasing medical services. On this regard, even though resource mobilization and financing for the health care system is multi directional for the achievement of this strategy MoH together with its partners will nationally strategize so as to achieve an increased funding allocation internally from government resources and externally from other innovative initiatives.

MoH:

- Budgetary allocation for the IPC Unit at national level.
- Sensitize regions and facilities to include IPC budget line during planning and budgeting process.
- Nationally mobilize resource and support regions and facilities to strengthen existing system with regard to HCWs capacity building, improvement project implementation & motivate IPC Program implementation.
- Design and implement mechanism for improved key stakeholder's engagement to ensure sustainable availability and provision of resources, supplies

and commodities essential for IPC program including personal protective equipment and WaSH infrastructure & related supplies.

- Engage private sector through PPP (including the manufacturing & production of IPC commodities and supplies).
- Mobilize and coordinate local and international partners working in the area of IPC for unified and integrated financial and logistic support to enhance efficiency.

Regions:

- Budgetary allocation for the IPC unit at regional level
- Sensitize and support facilities to include IPC budget
- Coordinate partners working in the area of IPC in the region & integrated financial support mechanism to enhance resource optimization
- Mobilize local resource and support facilities to strengthen & improving IPC program implementation

Facilities:

- Budgetary allocation for IPC implementation during planning & budgeting
- Engage the Governing board and local community in resource mapping and utilization for enhanced implementation of IPC

8. Monitoring and Evaluation

Monitoring IPC activities in hospitals based on evidence synthesized using high-quality data should guide the implementation process in the right direction and attain the national policy objectives. Information gathered from routine documentation, surveillance and audits should be feed back to the relevant authorities at the national, regional, zonal, and facility levels. Timely feedback given on IPC practices during patient/client care is crucial for improvement, including the concerted efforts of healthcare facility management and staff working together as a team.

WHO recommends the practices of regular monitoring and evaluation for documentation of progress and impact of programs. The Standards and Regulations applicable to different levels of health care facilities should be used to monitor progress as set out in strategic objectives 1-7. Health facilities should monitor compliance to the implementation of, and adherence to, infection prevention

and control standards set out in major national guidelines and manuals such as CASH audit tool, IPC reference manual, EHSTG, HSTQ, and EHCRIG. This would ultimately result in effective prevention and reduction of HAIs. The National IPC strategic framework shall be reviewed every five years, with mid-term (third year) and end-term evaluations of the policy.

8.1 Monitoring of IPC activities

The major components of the monitoring mechanism for the national IPC activities are:

8.1.1 Indicators for Monitoring and Evaluation of the National IPC strategy

These indicators should be routinely collected to be used for decision making and also should be reported to concerned higher bodies.

Table 4: Key Performance Indicators

S.N	Indicators	Indicator type	Baseline	Progress to goals achievement in YEARS					Data sources	Reporting frequency /remark
				1	2	3	4	5		
1	Surgical site infection rate	Outcome							HMIS registry	Monthly
2	Hospital acquired infection rate	Outcome							HAI Survey	Quarterly
3	Proportion of IPC Audit score	Outcome							IPC Audit tool	Quarterly
4	Hand hygiene compliance among healthcare professionals at healthcare facilities	Outcome							Audit reports	Biannual

5	Proportion of hospitals producing alcohol-based hand rub locally	Process							Survey	Quarterly
6	Proportion of facilities with functional HAI surveillance system	Process							Survey	Quarterly

8.2 Conducting National and Regional IPC Specific Review Meetings

The national infection prevention and control policy recommends establishing IPC as a standalone program with national and regional coordination bodies and case teams/focal persons and IPC committees at the level of healthcare facilities. To learn and share experiences of regions and healthcare facilities regarding IPC, national and regional level review meetings are recommended on a minimum of a quarterly basis. The agenda of the meetings could vary based on the level of the review meetings. It could still focus on reviewing the national or regional level IPC specific indicators, the performance of healthcare facilities on CASH and other related audit results, and best experience sharing regarding IPC in general, CASH/WASH, supply chain management IPC equipment and materials, etc. The review meeting participants shall include concerned IPC personnel from FMOH, RHBs, healthcare facilities (hospitals, health centers), public and private, and other stakeholders such as non-governmental organizations working on IPC. And as necessary, the review meeting's duration could last from a day to two or three days.

8.3 Supportive Supervision

At both national and regional level, having a technical working group to supportive the health facilities by providing Up-to-date practices and recommendation as well as technical guidance has been a practice in different programs. The effectiveness of supportive supervisions and mentorship activities depends on the technical and leadership experience of team, which should be strengthen by necessary capacity building prior to visit it facilities.

8.4 Mid-term and End-term Evaluation

To get initial lessons and a glimpse of an implementation's outcomes, mid-term evaluation is recommended for policy interventions such as the national IPC policy. Mid-term evaluation can potentially indicate the direction the implementation is heading in terms of efficacy and effectiveness. This can help policymakers and all relevant stakeholders to take appropriate action before the implementation ends up in failure. Hence, the policy will be reviewed at the end of the third period. The final evaluation is mainly intended to assess whether the aims and the goals set in the policy document are met. The implementing body will set up an evaluation team, and tools will be developed for an onsite assessment.

SECTION 2

Infection Prevention and Control Strategy Roadmap

9. National IPC Strategy Roadmap

The roadmap is designed to visualize the elements to be considered when making a given strategy actionable. The roadmap details the direction how the national IPC strategy implementation evolves and the work that is required to get there. It also allows assessing new requests for functionality against planned work in view of available resources

The goals of the national IPC strategy indicated in the previous section of the document are listed below.

1. Strong, functional and sustainable IPC governance structures in place at all levels of the health system.
2. Knowledgeable, skilled and caring and compassionate healthcare workers implementing IPC program activities
3. Presence of available data and information for decision and action
4. IPC practice as cultural change instituted in the health system.
5. Presence of effective tracking progresses of IPC practices, outputs and outcomes
6. Implement facility based standardized workload, staffing and bed occupancy in healthcare facilities
7. Availability of essential investment, infrastructure, equipment & supply to effectively coordinate and manage IPC program.

The following roadmap depicts the activities to be undertaken in order to achieve the above goals.

10. Timeline

The activities in the strategy roadmap below shall be implemented during the next 5 years period 2021-2025 in harmony with the National Health Sector Transformation Plan II.

11. Important Milestone & Deliverables

The following major deliverables will be used for reference as milestone throughout the implementation of the national IPC Program:

- Advocate for IPC program nationally as a flagship initiative

- Establish IPC coordinating body/units/focal at national, regional and facility levels
- Establish functional multidisciplinary IPC Committee at each facility
- Allocated sufficient budget to implement planned IPC activities throughout the strategy timeframe
- Trained HCWs in specific IPC topics (in-service training)
- Integrate IPC in the pre-service education curriculum
- Develop/Review and disseminate evidence-based, ministry-approved IPC guidelines
- Develop/Review evidence based, Standardized, IPC Procedures, SOPs, and Patient flow charts, based on the national IPC guidelines for healthcare facility level use
- Training of trainers and basic training of IPC for qualified health professionals
- Create and advocate a system for champion selection at national, regional and facility level in specific IPC practices
- Clear IPC program monitoring and evaluation framework
- Comprehensive IPC program implementation recording and reporting tools
- Emergency preparedness plan in terms of professional assignment during emergencies
- Procured basic IP materials and PPEs

12. Strategy Roadmap

Table 5: Stakeholder Analysis

Strategic objective & Goal	Key interventions / Activities	Timeline					Responsible	Remark
		Year 1	Year 2	Year 3	Year 4	Year 5		
Strategic Objective 1: Ensure strong program management, governance and leadership at all levels to oversees IPC program implementation								
Result: 1 Strong, functional and sustainable IPC governance structures in place at all levels of the health system.	**Activity 1.1:** Advocate for IPC program nationally as a flagship initiative						• MOH • ICAP • CDC • EPHI	
	Activity 1.2: Establish IPC coordinating body/units/focal at national, regional and facility levels with necessary resources accordingly						• MOH, RHB, Zonal Health Office & HCF • Partners	
	Activity 1.3: Establish strong partnership among sectors and partners working on WaSH and IPC at all levels.						• MOH, RHB, Zonal Health Office & HCF • Partners	
	Activity 1.4: Establish and monitor the functionality of multidisciplinary IPC Committee at each facility.						• MOH, RHB, Zonal Health Office & HCF • Partners	

	Activity 1.5: Health managers regularly monitor the progress status of implementation of planned activities.						• MOH, RHB, Zonal Health Office & HCF • Partners	
Strategic objective 2: IPC education and training for all health care providers working in healthcare facilities								
Result 2: Knowledgeable, skilled and caring and compassionate healthcare workers implementing IPC program activities.	**Activity 2.1:** Standardize and endorse the national IPC training package with involvement of all relevant stake holders.						• RHB, Zonal Health Office & HC • Training Centers • Professional associations • Partners	
	Activity 2.2: Integrate IPC in the pre-service education curriculum of health sciences and medical disciplines						• RHB, Zonal Health Office & HCF • Training Centers • Professional associations • Partners	

	Activity 2.3: Develop/ Review and disseminate evidence-based, ministry-approved IPC guidelines						• RHB, Zonal Health Office & HCF • Training Centers • Professional associations • Partners	
	Activity 2.4: Develop/Review evidence-based, Standardized, IPC Procedures, SOPs, and Patient flow charts, based on the national IPC guidelines for healthcare facility level use						• RHB, Zonal Health Office & HCFTraining Centers • Professional associations • Partners	
	Activity 2.5: Map resources and identify implementing partners for in- service IPC basic & TOT trainings.						• RHB, Zonal Health Office & HCF • Training Centers • Professional associations • Partners	

	Activity 2.6: Provide IPC Specific in-service trainings for HCWs.						• RHB, Zonal Health Office & HCF • Training Centers • Professional associations • Partners	
	Activity 2.7: Train a pool of well qualified and skilled IPC trainers.							
Strategic objective 3: Establish robust HAI surveillance system at all levels								
Result 3: Improved HAIs Surveillance Practice and data use decision and action	**Activity 3.1:** Develop Standardized HAIs Surveillance guidelines						• MOH • Professional associations • UN partners • ICAP • CDC • MSH	
	Activity 3.2: Establish HAI prevention leadership through the integration of HAIs Surveillance in multi-disciplinary IPC Committee activities						• MOH • Professional associations • UN partners • ICAP • CDC • MSH	

	Activity 3.3: Provide Training on HAIs Surveillance for healthcare workers.						• MOH • Professional associations • UN partners • ICAP	
Strategic objective 4: Promote the use of multimodal approach in implementation IPC								
Result 4: IPC practice cultural change instituted in the health system	**Activity 4.1:** Promote the utilization of multi modal approach/strategy in IPC practices through development and dissemination of thematized sample bundle frameworks.						• MOH • RHBs • ICAP • MSH • CDC • UN partners	

	Activity 4.2: Create and advocate a system for champion selection at national, regional and facility level in specific IPC practices **Sub-activity 4.2.1:** Develop national, regional and facility level IPC champion selection criteria **Sub-activity 4.2.2:** Conduct supportive supervision and assessment using prepared tools **Sub-activity 4.2.3:** Prepare National, Regional and facility level champion rewarding events						• MOH • RHBs • ICAP • MSH • CDC • UN partners • Clients • MoSHE • Civil service Commission	
	Activity 4.3: Health facilities need to organize and conduct IPC Quality improvement projects and ensure CQI in IPC practice						• MOH • RHBs • ICAP • MSH • CDC • UN partners	

	Activity 4.4: Map and engage partners and relevant stakeholder in the implementation of multimodal strategies.						• MOH • RHBs • ICAP • MSH • CDC • UN partners • Clients	
Strategic objective 5: Establish and implements strong Monitoring and Evaluation framework for IPC program								
Result 5: Effective IPC program performance M&E system in place.	**Activity 5.1**: Develop clear IPC program monitoring and evaluation framework						• MOH • RHBs • ICAP • MSH • CDC • UN partners	
	Activity 5.2: Develop comprehensive IPC program implementation recording and reporting tools						• MOH • RHBs • ICAP • MSH	
	Activity 5.3: Develop comprehensive IPC program M and E Indicators and integrate to DHIS2 reporting platform						• MOH • RHBs • ICAP • MSH • CDC • UN partners • Clients	

	Activity 5.4: Strengthen regular provision of feed-back on IPC program imple-mentation at all levels						• MOH • RHBs • ICAP • MSH • CDC • UN partners • Clients	
Strategic objective 6: Ensure and standardize the management of workload, staffing and bed occupancy in healthcare facilities								
Result 6: Improved standardized work-load, staffing and bed occupancy practice in healthcare facilities in place	**Activity 6.1:** Ensure the practice of facility based standardized work force assignment proportional to workload						• MOH • RHBs • ICAP • Professional associations • Federal Civil service com-mission	
	Activity 6.2: Develop facilities-based emergency preparedness and response plan for health emergency						• MOH • RHBs • Professional associations • Federal Civil service	

	Activity 6.3: Monitor and evaluate the management of bed occupancy and spacing in healthcare facilities						• MOH • RHBs • Professional associations • Federal Civil service commission • ICAP/CDC	
Strategic objective 7: Improve the management and Investment on infrastructure, equipment, and supplies in IPC programs								
Result 7: Improved infrastructure, equipment and supplies for IPC programs	**Activity 7.1:** Advocate, support and monitor adherence of health facilities to National regulatory standard on IPC infrastructure.						• MOH • RHBs • Professional associations • ICAP/CDC • EFDA	
	Activity 7.2: Advocate and support healthcare facilities to develop procedures for IPC commodities forecast and stock management						• MOH • RHBs • Professional associations • MoWIE • ICAP/CDC • Ministry of Urban development	

	Activity 7.3: Promote and support local marketers in production of IPC Commodities and supplies						• MOH • RHBs • Professional associations • MoWIE • ICAP/CDC • Ministry of Trade	
	Activity 7.4: Advocate for innovative technologies towards IPC programs						• MOH • RHBs • Professional associations • MoWIE • ICAP/CDC • Ministry of Trade	
	Activity 7.5: Improve and support facility-based IPC equipment maintenance and proper utilization						• MOH • RHBs • ICAP/CDC • MSH	December 2024

13. National IPC Strategy Budget Costing

Table 6: National IPC Strategy Budget Costing, Eth. Birr

Strategic Results	Activities	Year 1	Year 2	Year 3	Year 4	Year 5
Result 1: Strong, functional and sustainable IPC governance structures in place at all levels of the health system.		**20,003,700.00**	**20,416,440.00**	**24,091,399.20**	**27,705,109.08**	**31,306,773.26**
	Activity 1.1: Advocate for IPC program nationally as a flagship initiative	16,670,500.00	20,004,600.00	23,605,428.00	27,146,242.20	30,675,253.69
	Activity 1.2: Establish IPC coordinating body/units/focal at national, regional and facility levels with necessary resources accordingly.	3,146,000.00	187,200.00	220,896.00	254,030.40	287,054.35
	Activity 1.3: Establish strong partnership among sectors and partners working on WaSH and IPC at all levels.	187,200.00	224,640.00	265,075.20	304,836.48	344,465.22

	Activity 1.4: Establish and monitor the functionality of multidisciplinary IPC Committee at each facility.	-	-	-	-	-
	Activity 1.5: Health managers regularly monitor the progress status of implementation of planned activities.	-	-	-	-	-
Result 2: Knowledgeable, skilled and caring and compassionate healthcare workers implementing IPC program activities.		**511,100,000.00**	**636,304,200.00**	**722,160,000.00**	**830,484,000.00**	**938,446,920.00**
	Activity 2.1: Standardize and endorse the national IPC training package with involvement of all relevant stake holders.	343,750.00	-	-	-	-
	Activity 2.2: Integrate IPC in the pre-service education curriculum of health sciences and medical disciplines	343,750.00	-	-	-	-
	Activity 2.3: Develop/Review and disseminate evidence-based, ministry-approved IPC guidelines	-	4,860,000.00	-	-	-

	Activity 2.4: Develop/Review evidence based, Standardized, IPC Procedures, SOPs, and Patient flow charts, based on the national IPC guidelines for healthcare facility level use	412,500.00	12,495,000.00	-	-	-
	Activity 2.5: Map resources and identify implementing partners for in- service IPC basic & TOT trainings.	-	-	-	-	-
	Activity 2.6: Provide IPC Specific in-service trainings for HCWs.	-	960,000.00	-	-	-
	Activity 2.7: Train a pool of well qualified and skilled IPC trainers.	510,000,000.00	617,989,200.00	722,160,000.00	830,484,000.00	938,446,920.00
Result 3: Improved HAIs surveillance Practice data use decision and action		-	**2,655,000.00**	**584,100.00**	-	-
	Activity 3.1: Develop Standardized HAIs Surveillance guidelines	-	2,655,000.00	584,100.00	-	-
	Activity 3.2: Establish HAI prevention leadership through the integration of HAIs Surveillance in multidisciplinary IPC Committee activities	-	-	-	-	-

	Activity 3.3: Provide Training on HAIs Surveillance for health-care workers.	-	-	-	-	-
Result 4: IPC practice cultural change instituted in the health system		**21,250,000.00**	**-**	**-**	**-**	**-**
	Activity 4.1: Promote the utilization of multi modal approach/ strategy in IPC practices through development and dissemination of thematized sample bundle frameworks	-	-	-	-	-
	Activity 4.2: Create and advocate a system for champion selection at national, regional and facility level in specific IPC practices					
	Sub-activity 4.2.1: Develop national, regional and facility level IPC champion selection criteria	-	-	-	-	-
	Sub-activity 4.2.2: Conduct supportive supervision and assessment using prepared tools	-	-	-	-	-

	Sub-activity 4.2.3: Prepare National, Regional and facility level champion rewarding events	-	-	-	-	-
	Activity 4.3: Health facilities need to organize and conduct IPC Quality improvement projects and ensure CQI in IPC practice.	21,250,000.00	-	-	-	-
	Activity 4.4: Map and engage partners and relevant stakeholder in the implementation of multimodal strategies.	-	-	-	-	-
Result 5: Effective IPC program performance M&E system in place.		**8,331,000.00**	**10,409,700.00**	**11,796,696.00**	**14,125,962.90**	**15,329,806.45**
	Activity 5.1: Develop clear IPC program monitoring and evaluation framework	-	412,500.00	-	559,762.50	-
	Activity 5.2: Develop comprehensive IPC program implementation recording and reporting tools	-	-	-	-	-

	Activity 5.3: Develop comprehensive IPC program M and E Indicators and integrate to DHIS2 reporting platform	-	-	-	-	-
	Activity 5.4: Strengthen regular provision of feedback on IPC program implementation at all levels	8,331,000.00	9,997,200.00	11,796,696.00	13,566,200.40	15,329,806.45
Result 6: Improved standardized workload, staffing and bed occupancy practice in healthcare facilities in place		-	-	-	-	-
	Activity 6.1: Ensure the practice of facility based standardized work force assignment proportional to workload	-	-	-	-	-
	Activity 6.2: Develop facilities-based emergency preparedness and response plan for health emergency	-	-	-	-	-
	Activity 6.3: Monitor and evaluate the management of bed occupancy and spacing in healthcare facilities	-	-	-	-	-

Result 7: Improved infrastructure, equipment and supplies for IPC programs		**4,540,000.00**	**5,274,000.00**	**6,428,640.00**	**7,156,818.00**	**7,820,391.00**
	Activity 7.1: Advocate, support and monitor adherence of health facilities to National regulatory standard on IPC infrastructure.	145,000.00	-	-	-	-
	Activity 7.2: Advocate and support healthcare facilities to develop procedures for IPC commodities forecast and stock management	-	174,000.00	-	236,118.00	-
	Activity 7.3: Promote and support local marketers in production of IPC Commodities and supplies	145,000.00	-	205,320.00	-	-
	Activity 7.4: Advocate for innovative technologies towards IPC programs	4,250,000.00	5,100,000.00	6,223,320.00	6,920,700.00	7,820,391.00
	Activity 7.5: Improve and support facility-based IPC equipment maintenance and proper utilization	-	-	-	-	-

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The development and printing of this document was supported by ICAP in Ethiopia with funding from U.S. CDC and CDC Foundation.

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