

IDI CDC WASH Project in Moroto District

Handover Report



June 2021- Sept 2023

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Acronyms

CDC	Centers for Disease Control and Prevention
FGD	Focus Group Discussion
HCWs	Health care workers
IDI	Infectious Diseases Institute
IPC	Infection Prevention and Control
KII	Key Informant interview
POE	Point of Entry
PopCAB	Population Connectivity Across borders
ABHR	Alcohol Based Hand Rub
MGHWS	Management Guidelines for Hand Washing Stations
MOH	Ministry of Health

Message from Program Manager



Practicing appropriate hand hygiene (HH) through handwashing with soap and water or using alcohol-based hand rub (ABHR) is a key prevention measure recommended to reduce the disease burden worldwide. Hand hygiene adherence (HHA) among healthcare workers (HCWs) is particularly important to reduce disease transmission in healthcare settings.

Health facilities in low and middle-income countries (LMICs) often lack the necessary funds to purchase commercial Alcohol Based Hand Rub (ABHR) and local production may be a more economical option. The WHO developed a protocol for local production of ABHR to guide the production procedure within

health facilities.

The Infectious Diseases Institute (IDI) received funding from the Centres for Diseases Control and Prevention (CDC) under the Strengthening Partnerships for Preparedness and Response project to scale up handwashing and Alcohol Based Hand-Rub (ABHR) use in priority health facilities in six districts in Uganda (Kabarole, Kasese, Amuru, Tororo, Moroto and Kotido). This included setting up ABHR production units, training producers, and establishing distribution structures as well as hand hygiene mentorship and impact evaluation. This report provides an account of project activities in Moroto district from inception in August 2021 to September 2023.

We extend our sincere thanks to the Ministry of Health Environmental Department (EHD) for the project above-site oversight and continuous technical support throughout the implementation. Special thanks to the Moroto District Local Government for leading the implementation through the office of the District Health Officer, in charges of supported health facilities and community locations as well as the producers and quality assurance team for ABHR in the district and the stores personnel.

Finally, as a project, we thank the IDI project staff who have provided technical support in the implementation of the project especially Mr. Herbert Isabirye, who successfully coordinated the district-level activities throughout the implementation period with enthusiasm and diligence.

As we hand over the project to the district, we are confident that the capacity that has been built, complimented by the structures and supportive environment, the project will continue to thrive, and IDI will continue to provide technical assistance whenever there is a need.



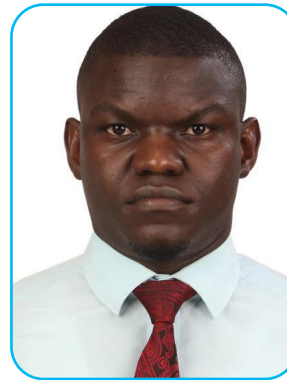
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Strengthening Partnerships for Preparedness and Response in Uganda Project

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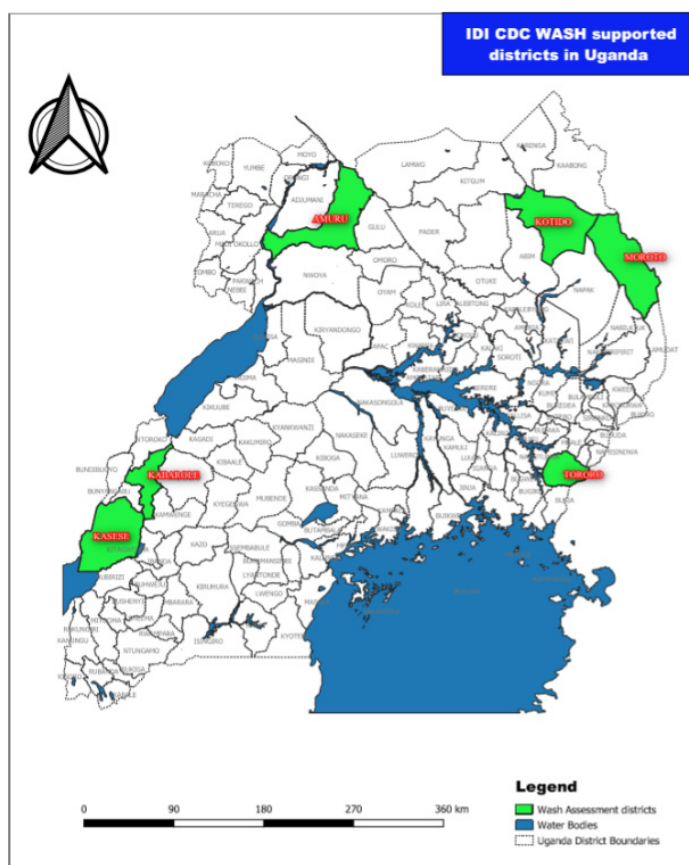


John Twesige
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Districts

Background



The World Health Organization (WHO), regards the alcohol-based hand rubs (ABHRs) as a “gold standard” for hand disinfection in healthcare facilities because of its excellent antimicrobial activity and good antiviral activity against enveloped viruses (including SARS-CoV-2), easy availability at the point of care, and general acceptability to health professionals. Despite the range of sanitizers in the global market, the cost of ABHR has been relatively expensive and unaffordable by most health facilities. WHO identified formulations for its local preparation to ease availability and affordability in low- and middle-income countries (LMICs).

In 2018, Infectious Diseases Institute with funding from the CDC WASH Implemented local production of ABHR in Kabarole District as a pilot. The project adopted a district led model with districts providing production space and district staff to be trained by IDI WASH team, led completely by the district with technical oversight support from IDI. Following the outputs, the project, the project was extended to Kasese district during the Ebola outbreak that spilled over from Congo to Uganda in 2019.

A production unit was set up at the Kasese District Health Office to produce and distribute ABHR to 125 health facilities for a year.

In the first phase of COVID-19 outbreak, Uganda COVID-19 cases increased with majority being imported by truck drivers from the neighboring countries their major points of entry. A study based on truck driver movement from the point of entry to their destination informed a selection of sites as one of the interventions to support the Ministry of health to flatten the curve. The ABHR project was scaled up to border districts to improve hand hygiene compliance. This intervention targeted priority POEs, truck route community locations and health facilities within

Inlieue of the above the project was initiated and later extended to the hard to reach districts of Moroto in northern Uganda utilizing a district led approach. At this facility, ABHR is being manufactured and distributed to all government-supported healthcare facilities within the region. In a concerted effort to ensure quality and safety, district staff, with a preference for laboratory technicians and pharmacists, along with district Infection Prevention and Control (IPC) focal persons, underwent comprehensive training in ABHR production methodologies and stringent quality control measures.

This concerted effort underscores the project's commitment to promoting hand hygiene and providing essential resources to safeguard the health and well-being of both healthcare workers and the communities they serve in Uganda.

1.1 Methods

Moroto District Health Office generously allocated space for the establishment of the production unit. The IDI technical staff conducted a rigorous training for the district staff on the local production of Alcohol-Based Hand Rub (ABHR) and were subsequently equipped with the necessary ABHR supplies.

In parallel, a series of three assessments on hand hygiene practices were carried out in 20 healthcare facilities, employing both the Kobo Collect tool and hard copy for observational purposes. Following the second (Midpoint) assessment, a noticeable decline in hand hygiene compliance became evident. In response, an on-site hand hygiene mentorship program was initiated to identify challenges and devise effective mitigation strategies.

Furthermore, in July and August 2023, Moroto District conducted assessments and provided training on the proper cleaning and disinfection procedures for ABHR bottles. This initiative aimed to enhance the quality and safety of ABHR usage within healthcare facilities. Quantitative data was meticulously collected from all 20 healthcare facilities, leveraging the Kobo Collect tool. Additionally, comprehensive materials, including Standard Operating Procedures (SOPs), job aids, and Information, Education, and Communication (IEC) materials, were furnished post-training to support effective cleaning and disinfection practices.

These combined efforts reflect the dedication of Moroto District and IDI in fostering improved hand hygiene compliance and ensuring the safe and efficient use of ABHR within healthcare settings.

1.2 Results

The IDI WASH project officer, with support of the District Stores Officer and the District Production Unit officer, supported the initial distribution of alcohol-based hand rub (ABHR) to 20 healthcare facilities. A significant quantity of 5,520 liters of ABHR was produced, with a commendable distribution of 4,840 liters to the designated health facilities.

These concerted efforts produced concrete and discernible outcomes, most notably improving timely production, distribution to facilities and subsequently improving hand hygiene practices

among health workers. It is noteworthy that a significant and substantial improvement was clearly evident across the different years of implementation. Initially documented at 32.7% during the baseline assessment, there was a subsequent reduction noted, with hand hygiene compliance registering at 20% during the midpoint assessment and xx end term. However, it is particularly heartening to highlight that as we progressed to the end-line assessment, hand hygiene compliance exhibited a remarkable resurgence, ascending to elevated levels beyond our initial expectations.

In conclusion, the implementation of Water, Sanitation, and Hygiene (WASH) activities in Moroto has been resoundingly successful. This success is evidenced by the sustained production and utilization of ABHR, the consistent enhancement of hand hygiene practices among healthcare personnel, and the notable reduction in the risk of disease outbreaks and their subsequent transmission through improved hand hygiene practices.

1.3 Goal/Main Objective

To improve access and use of alcohol-based hand-rub in 21 facilities in Moroto district in the Karamoja region

2.2 Specific Objectives

- i. To Support the district, establish an Alcohol-Based Hand Rub (ABHR) production unit and commence production
- ii. To Strengthen external quality control measures for Alcohol-Based Hand Rub (ABHR).
- iii. Support Initial distribution of ABHR to priority sites.

WASH I 2022/2023

2.1 Baseline Assessment In selected HCFs in Moroto

2.1.1 Sampling of facilities: All the healthcare facilities were selected for assessment. Assessments included: Hand hygiene compliance of healthcare workers with patient interaction, HH after latrine usage and HH practices at entrances and exists at healthcare facilities.

2.1.2 Quantitative Data Collection: Open Data Kit and Survey CTO were used to collect data as well as hand hygiene observation forms.

2.1.3 Qualitative data collection: KII and Interviews were recorded and transcribed, KIIs and FGDs: Purposively sampled to represent all categories. This was complimented by the district meetings before data collection.

The key issues raised here where 100% of Moroto HCF have ABHR on site, 64.2% of facilities reported that the amount of ABHR is insufficient, 2.9% of facilities reported most providers carried ABHR on themselves. The most common reason for insufficient ABHR was the stock running out before the next shipment.

During the Qualitative baseline assessment, the approach used focused Key informant interviews and focus group discussions that were used to collect data, 9 Key informants _ Health facility in charges (Moroto), 2 Focus group Discussions (FGDs) with male and female in charges each with four participants. The Sampling methodology was a purposive approach.

Participant category	Number of participants interviewed		
In charges/ Designees (MOROTO)	KII	FGD	Number of FGD Participants
Loputuk HC II	1		
Nadunget HC III	1		
Rupa HCII	1		
Nakapelemen HCII	1		
Kadonyo HCII	1		
Kosiroi HCII	1		
Moroto Prisons HC II	1		
St Pius_Kidepo HCIII	1	0	0
Moroto RRH	1	0	0
Total	9	0	0

2.1.4 The key finds presented included

It is mandatory for all individuals to diligently practice handwashing with soap and water before and after entering the facility, ensuring the highest standards of hygiene.

- Stringent requirements have been established for the provision of handwashing stations at entry points and gates, facilitating easy access to hand hygiene facilities for all.
- Staff members are expected to meticulously adhere to the Standard Operating Procedures (SOPs) by observing the crucial "5 moments of hand hygiene," underscoring the paramount importance of hand cleanliness.
- In cases where the hands of staff members are visibly soiled, they are obliged to engage in thorough handwashing with soap and running water, leaving no room for compromise on hygiene standards.
- It is imperative that all health workers engage in compulsory sanitization before commencing any work-related tasks, ensuring a safeguarded environment for all.
- Health workers are not only required but duty-bound to sanitize their hands before undertaking any work responsibilities. This practice includes instances where they come into contact with table surfaces, door handles, and after handling patient books or prescriptions, ensuring comprehensive infection prevention.
- Sanitizer dispensers have been strategically placed in all rooms and at every service point, ensuring convenient access to hand sanitization facilities.
- It is important to note that the use of hand sanitizer is restricted exclusively to staff members, with visitors encouraged to practice thorough handwashing with soap and water for their safety and the safety of others.
- Efforts are consistently made to ensure an uninterrupted supply of hand sanitizer, with stockouts being proactively managed to maintain a robust hand hygiene infrastructure.

2.2 Establishment of a Production unit for ABHR.

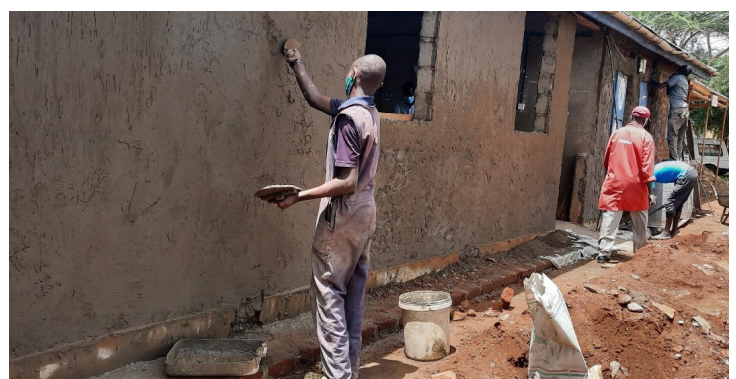
The district, provided dedicated production space at Nadunget HCIII, thereby facilitating the seamless operationalization of the production unit. A series of minor renovations were done by the installation of air conditioning systems, signifying our dedication to creating an optimal working environment.

Essential supplies were procured and promptly delivered, reinforcing our unwavering commitment to equipping the production unit. A thorough training of district staff, was conducted ensuring the sustainability of the production process. The selection process was guided by the Referral Hospital (RRH) and the District Health Officer (DHO), resulting in the identification and training of a select group of individuals, including two district producers, two district equipment quality controllers (EQC), two RRH producers, and two RRH EQC personnel, who were entrusted with the pivotal task of upholding our standards of excellence. The noble task of production was adeptly overseen by district staff, ably supported by the dedicated and expertly trained team from IDI, fostering collaboration and knowledge sharing.

IDI thoughtfully supplied all the requisite materials and ingredients essential for the production of Alcohol-Based Hand Rub (ABHR), and these resources were thoughtfully illustrated in pictorial form for easy identification and utilization.



Before



After

2.2.1 Training District Staff on Local Production of Alcohol-Based Hand-Rub (ABHR):

The training was conducted by the IDI technical officer over the course of five days, with three days dedicated to district producers and two days allocated for EQC officers. The training sessions combined both theoretical and practical approaches, ensuring a comprehensive learning experience.

The training was conducted at Nadunget Health Center III for both theoretical classroom sessions and hands-on practical training.

The training curriculum centered on the local production of Alcohol-Based Hand Rub (ABHR) and drew inspiration from the IDI training program titled 'Local Manufacture of Alcohol-Based Hand Rub (ABHR) to Sustain Hand Hygiene Programs.'

This curriculum, thoughtfully adapted from the WHO protocol on local ABHR production, served as the foundation for the training, equipping participants with the knowledge and skills required to produce ABHR locally and contribute to the sustainability of hand hygiene programs.

Natalina	Opuwa	Stores Personnel
Catherine	Lorot	Lab Tech
Suzan	Akiteg	Nurse
Justine	Kolobi	Lab Tech
Gabriel	Lowot	District focal Person
Philip	Lote	Nadunget In-charge
Akitegi	Suzan	Nurse
Kolobi	Josephine	Lab Tech
Lorot	Catherine	DLFP



Training of the Tororo district Local government team on ABHR production.

2.2.2 District Inception meetings and setting up the production Unit.

The team made visit to all main officers in the districts from the district health offices, Resident district commissioner to the Chief administrative officers' office. The visit was aimed at providing an entry to the district officials and also increase acceptability of the project to the district leaders.

During the District COVID-19 task force on 3rd of August 202, the IDI WASH team was given an opportunity to introduce the project to the district task force members. The project taking a district approach, a district team was to be trained on the ABHR production and IDI was to support supplies for the production

After the inception meetings, space was allocated by the district local government through the district health office at Nadunget Health Centre III. The IDI team was led to the production unit by the Assistant DHO in charge of maternal and child health through which we were introduced to the health facility in charge Mr. Philip Lotte. This helped us through most of the operations as we headed to visit the proposed site/ production room and assessments where made.

2.2.3 Moroto Stakeholder meeting

As the renovations where on going, the IDI team went on to prepare for the stakeholder meeting from which district stakeholders, Implementing and development partners were brought together to provide feedback from the baseline assessments and the progress of the works in Moroto. This was aimed at providing a baseline finding, discussing the sustainability aspect the production unit, partner engagement and commissioning the production Unit.

This meeting was held at Mt. Moroto on the 18th of August; Attendance varied from district officials, police force implementing partners from Save the children, World health Organization to health facility in charge from the targeted health facilities. During the meeting quantitative and qualitative findings were presented to the stakeholders; In the quantitative the methodology used was

2.3 ABHR Production

A total of 1,920 liters of ABHR was meticulously manufactured, with this production being organized into 21 distinct batches. The process was conducted ensuring adherence to quality standards. In terms of quality control, a comprehensive internal quality control (QC) was carried out by the ABHR producers and, external quality assurance (EQA) evaluations were conducted by district EQA focal persons. Notably, every batch of ABHR successfully passed the rigorous internal QC assessments, demonstrating an impressive average alcohol content of 80%.

These collective efforts and stringent quality control measures culminated in the successful production of ABHR that met the established quality benchmarks.

2.4 ABHR Distribution

The first cycle of distribution in Moroto was facilitated by IDI using hired vehicles. ABHR was distributed in 20 L jerrycan and each HCF received 1 L and 60 ml dispenser bottles as in Table2.



Signing of the MoU by the district leadership

WASH II 2022/2023

3.1 ABHR Produced and Distributed in 2022

3.2 IDI-CDC WASH Mid-point Assessment Across Healthcare Facilities in Moroto District

This intervention was accompanied by the distribution of soap and hand washing stations that preceded a baseline assessment in 2022.

3.2.1 Activity outcomes

3.2.2 Assessment of Healthcare Worker Hand Hygiene Compliance.

This assessment involved a meticulous examination of hand hygiene practices among healthcare workers. It encompassed the observation of the availability of hand hygiene materials at the point of care, monitoring healthcare workers during patient interactions, and documenting the specific type of hand hygiene they practiced. The assessment focused on two pivotal moments: before patient contact and after patient contact. Data collection was conducted utilizing a standardized paper form and subsequently transferred to Microsoft Excel for analysis.

3.2.3 Evaluation of Hand Hygiene Practices at Healthcare Facility Latrines and Entrances/Exits

Assessors employed a digital tool to assess hand hygiene practices at key locations within healthcare facilities, including latrines and entrances/exits. The evaluation encompassed an examination of hand hygiene infrastructure, the presence or absence of Information, Education, and Communication (IEC) materials, and the availability of hand hygiene attendants. Observations were made from a distance to assess the practices of participants at these locations. In instances where hand hygiene materials or participants were lacking, no observations were recorded.

3.2.4 Administration of a Comprehensive WASH Assessment Tool

Prior to administering the assessment, assessors diligently sought consent from the facility in charge or the Healthcare Facility Infection Prevention and Control (IPC) lead. The assessment tool focused on a range of crucial factors, including patient numbers, staffing levels, and the availability of sanitary supplies, among other pertinent aspects.

Data collected through this process was meticulously documented and subsequently uploaded to the server for further analysis.

3.2.5 Conducting Intercept Interviews for Hand Hygiene Behavioral Change Interventions.

Intercept interviews were thoughtfully conducted at healthcare facilities equipped with functional hand hygiene (HH) stations. These stations included handwashing facilities with water, chlorine, soap, and/or Alcohol-Based Hand Rub (ABHR). Participants above the age of 18 were engaged in these interviews, with a particular emphasis on entrances over exits. The primary objective of these intercept interviews was to identify the barriers and enablers of hand hygiene practices among patients, visitors, and caretakers at healthcare facilities. Data gathered through these interviews was efficiently uploaded to the server using the Kobo Collect digital tool.

These comprehensive assessments and interviews collectively contribute to our understanding of hand hygiene practices and provide valuable insights into potential behavioral change interventions within healthcare settings.

3.2.6 Hand Washing Stations distributed in Moroto district

A total of 30 hand washing stations of which 24 small size with the capacity of 50 liters and 056 large size with the capacity of 150 liters were distributed to the selected 22 health facilities.

WASH III 2022/2023

4.1 Inspection of the production Unit in Moroto by the EHD department

A team from the Environmental Health department Ministry of Health inspected Moroto Production Unit. This was part of the support supervision program of the project to ensure that quality standards are maintained at the production Unit. But as well to discuss with the district leadership and to support the continuity of the project at district level.

The Environmental health team was led by the principal Inspector of environment Mr. Mulabya Paul with Mr. Mbaha emery. The team was hosted by the WASH project officer. The office of the DHOs in both district where visited and discussion on sustainability and maintenance of the production unit where taken note of; The table below provides a summary of the discussions at each of the production Units.

District	Level of discussion	District officers met	Topic discussed	Recommendation
Moroto	Strategic level discussion	District Health officer; Tororo; Moroto: Dr. Hans Lokale	Human Resources; Currently IDI is supporting the team making the production with an SDA of 20,000 shs. And maintaining the cleaning	1) The district intends to incorporate some funds from the PHC fund for the production Unit to enable and motivate the production Unit. 2) Engagement of partners supporting WASH in the districts to support the production Unit.
			Distribution. Moroto Distribution is through the District Health stores. Uptake is however slow since many Ips have been supporting the facilities with ABHR.	There is need to a stakeholder meeting chaired by the DHO with all the ABHR beneficiaries to forge a sustainable mode of ABHR distribution to other sites other than health facilities.
	Operation level discussions	Moroto Ms.Natalina Opuwa Lonah, Mr. Nathan & Apaja Joseph	Production Unit arrangement;	The team guided that the production Unit should be organized in a unidirectional flow i.e from the production site, Raw Material and the ABHR stores site; This is to enable easy Movement during production. The immediate to use items such as laboratory Coats should be placed near to the production Unit as well as other protective gears; The production Unit should label all sites in the production Unit
			Biosafety & Security	The production Unit should have the 3 biohazard bins in their respective color codes.
				A fire extinguisher should be placed at the production unit with a sand bucket in case of a fire hazard.
				The Production Unit doors should open from the outside to enable Easy of exit in case of emergency

4.1.1 ABHR Produced and Distributed in 2022/23

Amount of ABHR produced in 2022 was 1160 liters and 1820 liters distributed in Moroto district. This was supported by the district staff.

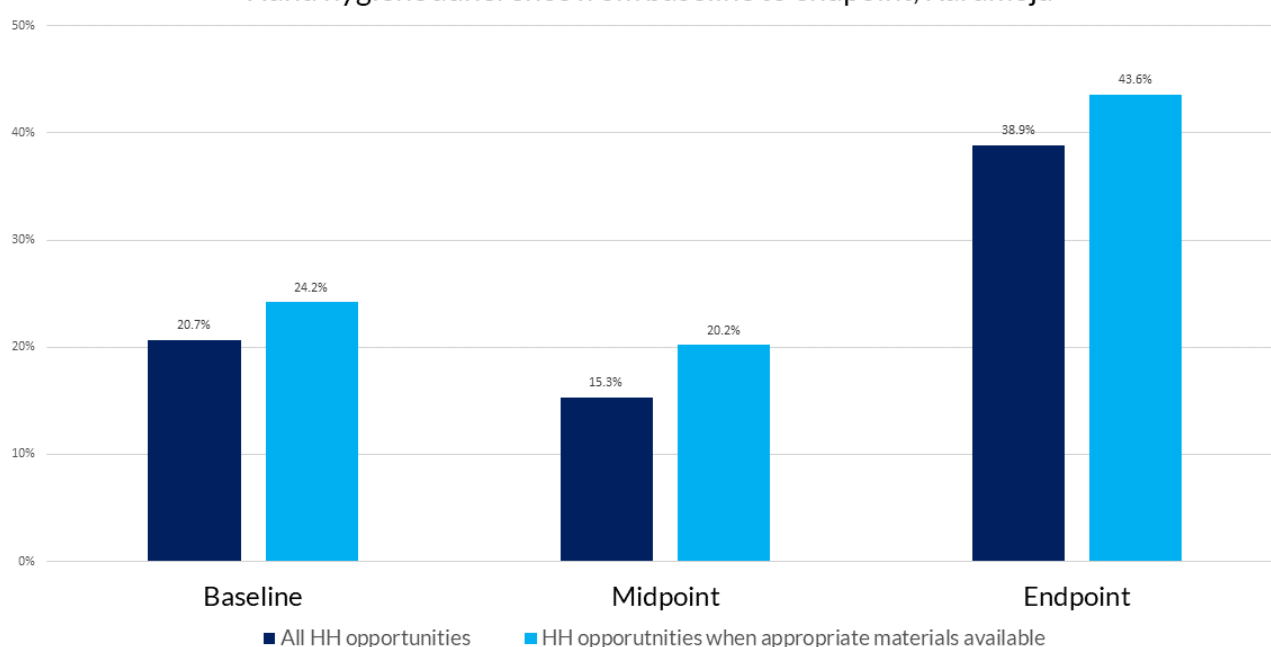
4.1.2 WASH End Line Assessment in Moroto District

IDI conducted end-point assessments in all IDI supported healthcare facilities within the district using Kobo Collect and hard copies of hand hygiene observation assessment tools. Assessments in all selected healthcare facilities in the district.

4.1.3 Hand Hygiene Assessments in Moroto. (base-line, mid-line and end-line)

Average Hand hygiene adherence at district level baseline was fairly performed with 32.7% which was associated to HH campaigns of covid-19 however at mid-line as covid-19 cases tended to continuously go down a noticeably reluctance was observed hence the score of and 21% The drop between baseline and midpoint necessitated an intervention before the endpoint (hand hygiene onsite mentorship) which caused a positive impact at end line assessment with 67%.

Hand hygiene adherence from baseline to endpoint, Karamoja



Type of Patient Contact and HH Behaviour (when appropriate materials available)

	Baseline			Midpoint			Endpoint		
	n	Total	%	n	Total	%	n	Total	%
HH Before									
New patient	38	212	17.9%	36	179	20.1%	77	206	37.4%
Same patient	9	48	18.5%	3	27	11.1%	16	52	30.8%
HH After									
New Patient	61	212	18.8%	38	179	21.2%	101	206	49.0%
Same patient	18	48	22.8%	6	27	22.2%	31	52	59.6%
HH All									
New patient	99	424	23.4%	74	358	20.7%	178	412	43.2%
Same patient	27	96	28.1%	9	54	13.1%	47	104	45.2%

HH Behavior by HCW Type (Where appropriate materials available)									
	Baseline			Midpoint			Endpoint		
	n performed HH	Total	%	n Performed HH	Total	%	n Performed HH	Total	%
HH Before									
Clinician	8	27	29.6%	4	28	14.3%	12	26	46.2%
Doctor	2	11	18%	7	15	47%	1	6	17%
Lab Tech	3	47	6.4%	2	55	3.6%	10	50	20.0%
Midwife	10	40	25.0%	11	21	52.4%	18	34	52.9%
Nurse	24	135	17.8%	15	87	17.2%	52	142	36.6%
HH After									
Clinician	14	27	51.9%	9	28	32.1%	17	26	65.4%
Doctor	0	0	0.0%	5	15	33.3%	5	6	83.3%
Lab Tech	9	47	19%	1	55	1.8%	15	50	30.0%
Midwife	11	40	27.5%	10	21	47.6%	19	34	55.9%
Nurse	45	135	33.3%	19	87	21.8%	76	142	53.5%
HH All									
Clinician	22	54	40.7%	13	56	23.2%	29	52	55.8%
Doctor	2	22	9.1%	12	30	40.0%	6	12	50.0%
Lab Tech	12	94	12.8%	3	110	2.7%	25	100	25.0%
Midwife	21	80	25.3%	21	42	50.0%	37	68	54.4%
Nurse	69	270	25.6%	34	174	19.5%	128	284	45.1%

Among the health workers observed, midwives were more adherent to hand hygiene followed by clinicians before patient contact. Majority of the doctors (83.3%) assessed adhered to hand hygiene after patient contact

4.1.4 Logistical support to Moroto

All essential logistics/supplies essential for the production of Alcohol-Based Hand Rub (ABHR) were procured and supplied to the Moroto ABHR Production Unit. A record, outlined in Table 1 below, encompasses all items received during the period spanning from August 2021 to February 2023. This comprehensive documentation serves as a testament to the unwavering commitment to ensuring the uninterrupted production of ABHR at the Moroto facility.

i. Supplies as of received in Moroto

The Tororo production Unit received stock from the WASH-CDC project and subsequently a donation of 98% ethanol to a total of 200 jerrycans from the Resolve IPC project

Supplies as of Received in Moroto			
Item	Unit of measure	Total Stock status	
		Tororo	
Absolute Ethanol	20 liters	7,880	
3% Hydrogen peroxide	200 ml	120,000	
98% Glycerol	5 liters	40	
Deionized water	20 liters	105	
Surgical masks	50 pieces	100	
Empty jerrycans of 20 liters	20 liters	124	
Dispenser bottles 1 liter	1 piece	60	
Dispenser bottles 60 ml	1 piece	164	
Liquid soap	20 Liters	120	
Sticker for 20 liters jerrycan	1 piece	200	
Sticker for 1 Litre spray bottles	1 piece	246	
Sticker for 60 ml spray bottles	1 piece	300	
Examination gloves	Boxes	2	

4.1.5 Key Lessons Learnt

1. HCWs can benefit from routine WASH mentorships.
2. IPC/WASH focal persons should regularly be trained and supported to implement their duties.
3. HCWs and the leadership of Moroto are open to receive, accept and implement innovative ideas that can have a positive impact to the health status.

4.1.6 Sustainability and continuity plan

Proposed ABHR Sustainability Plan

4.1.7 ABHR Raw Materials:

1. The procurement of ABHR raw materials will be efficiently managed through the utilization of the Primary Health Care (PHC) and National Medical Stores (NMS) order lines, ensuring a steady and reliable supply chain.
2. We will actively engage and lobby support from other implementing partners, seeking their collaboration in terms of providing ingredients, facilitating ABHR producers, and assisting with the maintenance and repair of the production unit. This collaborative effort will bolster sustainability.

5.0 Human Resource

1. The sustainability plan hinges on the utilization of the already trained district staff in ABHR production, optimizing their skills and expertise.
2. We will strategically incorporate facilitation for ABHR producers into the District Water, Sanitation, and Hygiene (WASH) work plan and budget, ensuring ongoing support and motivation.
3. The Assistant District Health Officer (ADHO) responsible for environmental health will be tasked with recommending interested staff for online ABHR training opportunities, thus expanding the pool of trained personnel.

6.0 ABHR Distribution

1. Existing logistical structures, such as National Medical Stores (NMS) trucks, will be efficiently utilized to distribute ABHR during their routine distribution cycles, minimizing additional resource requirements.
2. Healthcare facility in-charges (HCF I/Cs) will be empowered to collect ABHR from the district medicine store on-demand, aligning with their routine collection of other medical supplies.
3. We will leverage the activities of implementing partners within the district that target healthcare facilities (HCFs), effectively utilizing their existing networks and resources for ABHR transportation.
4. District vehicles, routinely deployed for support supervision at HCFs, will be employed for ABHR distribution, capitalizing on existing assets.

7.0 Existing Opportunities and Activities for Continuity:

1. Continuous monitoring of water quality and the installation of rainwater reservoirs will remain pivotal in improving WASH conditions both within HCFs and communities.
2. The integration of Water, Sanitation, and Hygiene (WASH) components into nutrition programs will continue to enhance the well-being of communities.
3. The sustained focus on community hygiene and environmental improvement is vital. In the unique context of Moroto, targeted and sustainable technical assistance from implementing partners and the government is essential to improve hygiene practices, especially water treatment, latrine coverage, and handwashing.
4. The promotion of hygiene to boost tourism in the Manyattas (traditional homesteads) is an exciting opportunity. Enhanced WASH facilities, hospitality, and small-scale art businesses within the Manyattas can attract both local and international tourists, boosting income for the communities.
5. The ongoing training of Health Assistants on WASH, initiated with support from UNICEF, will be perpetuated. Consistent emphasis on implementation will yield significant improvements in WASH practices at healthcare facilities.

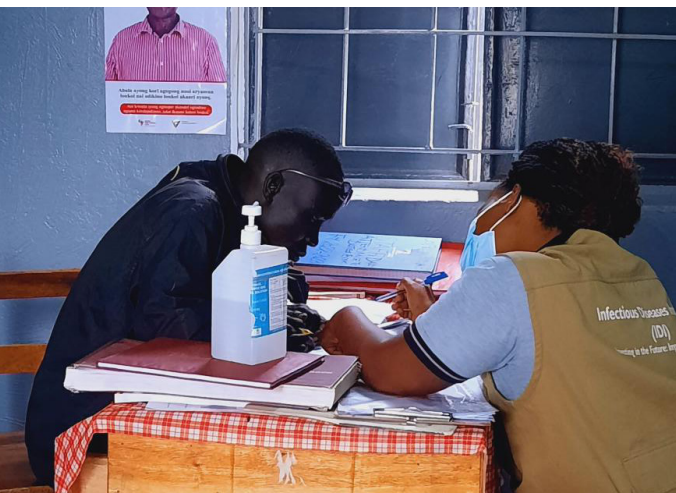
Conclusion

The imperative to enhance the Water, Sanitation, and Hygiene (WASH) standards within healthcare facilities (HCFs) in Moroto district necessitated the local production of Alcohol-Based Hand Rub (ABHR). The produced ABHR was distributed to all of the designated 20 healthcare facilities, thereby significantly mitigating the longstanding challenges posed by inadequate access to water and other essential supplies. This distribution effort effectively bridged the gap that had previously impeded robust adherence to hand hygiene protocols.

The comprehensive assessments conducted within Moroto district serve as irrefutable evidence that the compliance with hand hygiene protocols can indeed be markedly improved. The production and subsequent distribution of ABHR within the district, while requiring minimal resources, has yielded substantial and far-reaching impacts.

This existing intervention serves as a solid foundation upon which to build, activating various pre-existing structures and opportunities within the district. By doing so, we can usher in a cost-effective and timely transformation of the WASH standards within healthcare facilities, thus enhancing overall public health outcomes.

Pictorial







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