Clean Clinic Approach

To improve WASH at health facilities so patients want to seek care.

The Problem

Water, sanitation, hygiene (WASH) and environmental conditions in health care facilities remain a neglected area despite a high associated risk for morbidity and mortality. Data from the World Health Organization (2015), representing 66,101 facilities in 54 countries, showed that 38% of health care facilities do not have an improved water source, 19% do not have improved sanitation and 35% do not have water and soap for hand-washing.[1] The lack of WASH-safe services results in two primary consequences:

1. The facility becomes unable to provide appropriate, safe services (e.g. hygienic births that reduce sepsis, or infection), especially to mothers, neonates, and children:

Health Care Facilities?

Allegranzi et al. (2011) estimated that 15% of patients develop one or more infections during a hospital stay.

Infections associated with unsafe WASH in health facilities affect hundreds of millions of patients every year. An estimated 15% of patients develop one or more infections during a hospital stay.

Sepsis and other severe infections cause roughly 430,000 newborn deaths annually. It is estimated that sepsis in low-resource settings creates 34 times greater risk than in high-resource settings.[2]

2. Populations served by these facilities lose confidence in the institutions as safe places to seek health.

Improving WASH conditions can help establish trust in health services and influence pregnant women to seek prenatal care and facility-based delivery. Conversely, a lack of safe WASH in health facilities may discourage women from giving birth or cause delays in care-seeking.[3]

The challenge of improving the WASH environment in facilities is manifold: national standards may not exist or may be poorly implemented and monitored, funding may be limited, the "ideal can be the enemy of the better" as overarching barriers prevent incremental improvements, lack of trained personnel, lack of ownership or vision from responsible ministries, etc.

The Solution

The Maternal and Child Survival Program's Clean Clinic Approach (CCA) provides a programmatic tool that encourages health facilities to establish WASH goals and make incremental improvements towards the end goal of achieving "Clean Clinic" status, as defined with the national Ministry of Health.

The CCA recognizes that the biggest barrier to improving WASH at facilities is behavioral and managerial. While ideal WASH conditions at a health facility require increased funding, staff, training, and policy work, lesser improvements can make a difference – e.g. improving waste management processes, ensuring hand-washing stations are identified and designated, assigning roles for maintenance, etc. After assessing and prioritizing WASH needs at clinics in a target area, the CCA works with governments to establish "Clean Clinic" criteria and then works with clinics to develop action plans to work towards those criteria.

The overarching goals that drive the Clean Clinic Approach include:

- Develop self-sufficient health facilities that are clean, desirable, and well-attended.
- Embed ownership of health facility improvements within the Ministry of Health.
- Empower health facility staff (including management), teams, and communities to improve WASH at their facilities without outside assistance.
- Develop realistic goals for "cleanliness" (including water, sanitation, hygiene, and environment) with each targeted health facility.

The Approach

A Clean Clinic Approach deploys the following step-by-step model but maintains flexibility to adapt to local contexts, politics, and environments.

1. Assessment of target clinics.
2. Establishment and/or refinement of minimum standards for a clinics (with government), based on assessments. Illustrative criteria include:

1. http://www.who.int/water_sanitation_health/publications/wash-hcf-10things.pdf
2. http://www.who.int/water_sanitation_health/publications/qa-wash-hcf.pdf
3. ibid

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a. Improved waste management system in place and operational
b. Water quality assurance, including safe storage
c. Water quantity assurance
d. Adequate water storage
e. Appropriate toilet facilities (for staff, caregivers, and patients)
f. Dedicated hand-washing stations (for staff, caregivers and patients)
g. Appropriate laundry facilities for washing linens
h. General cleanliness (interior and exterior)
i. Dedicated staff for maintenance of facilities
j. Adequate IEC materials posted in critical places
k. Clearly-defined hygiene promotion program
l. Appropriate and safe structure
m. Staff protocols for better hygiene
n. Monitoring plan to ensure compliance with protocols

3. Development of CCA program parameters and overview documentation with government. Program documentation may include criteria, process, means for verification, and incentive/reward system.
4. Introduction of CCA program to targeted health facilities.
5. Establishment of action plans with target facilities to achieve "Clean Clinic" status.
6. Monitoring of target facilities progress towards achieving "Clean Clinic" status.
7. Verification of clinics reaching "Clean Clinic" status.
8. Delivery of reward to clinic/staff.

Action Plans and Ladders

Most WASH facility work has fallen under Infection Prevention and Control (IPC) programs and activities. While these programs can be effective, especially in well-resourced settings, they do not solve the problem of limited resources. What can be done in places where commodities and development monies do not reach?

The CCA promotes a ladder concept in developing action plans. As example, the waste management target may include installation and use of an incinerator with waste separation at the point of collection. In the many cases where facilities do not have access to incinerators or materials for waste separation, the CCA develops intermediate, achievable actions – e.g. enclosing an existing waste pit to avoid animal and human entry, assigning dedicated staff person to manage the waste, ensuring accountability for this function, etc. By steadily working up the ladder with incremental steps toward the end goal, health facilities take improvement into their own hands.

Incentivizing Change and Competition

The CCA recognizes that change, especially in low-resource settings, is challenging and that targeted incentives (monetary and non-monetary) act as catalysts for this change. The CCA develops incentive programs with local governments and Ministries of Health that may include: recognition at a national conference, preferential treatment, a cash prize, a specialized flag, etc. In target regions or zones, friendly competitions between health facilities are also used to incentivize collective action.

Enabling Environment

Water, sanitation, hygiene, and environmental conditions at health facilities are often plagued by a lack of ownership by one entity. The CCA works to ensure that all health facility improvements (both behavioral and infrastructure) are the responsibility of the Ministry of Health. Ensuring buy-in and ownership during the planning and development process is critical. Aligning WASH improvements with more specific health actions and agendas (e.g., Quality of Care) is also important.

The CCA works to create a financial, behavioral, and political environment where health facilities (and the communities they serve) are empowered to improve their own WASH and environment conditions.

The Maternal and Child Survival Program (MCSP) is a global, USAID Cooperative Agreement to introduce and support high-impact health interventions with a focus on 24 high-priority countries with the ultimate goal of ending preventable child and maternal deaths (EPCMD) within a generation.

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1. http://www.who.int/water_sanitation_health/publications/wash-hcf-10things.pdf
2. http://www.who.int/water_sanitation_health/publications/qa-wash-hcf.pdf
3. ibid