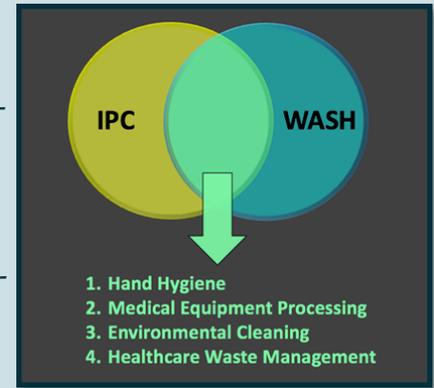


WASH Training for Healthcare Facilities: Taking Action

Background

Since 2004, The General Electric Foundation (GEF) has been working with various partners to design and install small-scale water treatment systems for healthcare facilities (HCF) in developing countries. As one of the first major philanthropic donors in the area of “safe water for healthcare”, GEF has steadily transformed its safe water program into a comprehensive, evidence-based intervention that ensures *sustainable* clean water provision in partner HCF. With assistance from public health researchers at the Center for Global Safe Water, Sanitation and Hygiene at Emory University, the safe water program has championed sustainable safe water provisions and appropriate capacity building that encourages ownership and maintenance of the donated water purification technology. One key area of capacity building was the training of healthcare facility staff in Cambodia on the importance of safe water, sanitation and hygiene (WASH) and the interdependent relationship between infection prevention and control (IPC) and WASH. Prior to this training development effort, no IPC training with a WASH emphasis had ever been conducted in Cambodia.



The relationship between IPC and WASH consists of four main components.

The following brief is the first in a two-part series describing the process of developing a unique WASH/IPC training program that highlights WASH as an essential element. This brief will highlight the efforts to engage government and health sector stakeholders in collaborative research to assess the knowledge, attitudes and practices of clinicians and cleaners in 18 healthcare facilities in Cambodia. Further, we highlight the steps taken to ensure that research design and implementation were co-managed and responsive to the needs of relevant partners.

Step One: Identifying Stakeholders and Developing a Working Group

Beginning in 2014, several organizations were focused on WASH in HCF programming in Cambodia. Emory partnered with WHO-Cambodia and WaterAid in a special working group focused on WASH in HCF within both the WASH and health development sectors. The goal of the working group was to advocate for the inclusion of WASH in relevant health sector program activities. In addition, the working group collaborated on facility-level activities that could be taken in the 18 HCF that were part of Emory and WHO WASH programs. Through discussion with the Ministry of Health, the working group identified healthcare staff training as a priority initiative for Cambodian HCF.



Members of the working group gathered to discuss WASH in HCF strategies.

In order to strengthen multi-sectoral partner relationships, several important steps were taken. First, several discussions with the MOH led to the assignment of all WASH in HCF activities, including the new training, to the Department of Hospital Services. In addition, it was agreed that the WASH in HCF working group and future WASH teams would convene at the MOH office to facilitate the participation of relevant MOH personnel. The MOH also collaborated with Emory to allow a Department of Hospital Services staff member to dedicate 30% of his time working on the development and implementation of the new WASH training program. Further, the working group and MOH agreed to use the technical content of the existing national IPC guidelines and curriculum to ensure consistency and accountability for trainees.

Step Two: Co-Creating the Training Needs Assessment

The training development began with Emory researchers conducting a literature review on IPC training needs assessments for healthcare workers, paying particular attention to studies based in Southeast Asia and those including hospital cleaning staff. The researchers also identified potential behavior change frameworks that could guide the development of the training after completion of the needs assessment.

Other formative data were collected from four healthcare experts in Cambodia who had conducted IPC and/or other types of healthcare trainings in Cambodian hospitals. These interviews revealed that there was no evidence of a needs assessment having been conducted prior to designing or implementing an IPC training in Cambodia. Also, the experts agreed that the training of trainers (ToT) model was ineffective as a training delivery method in Cambodian hospitals; the primary problem was that the much-needed IPC and/or health training information and materials were not always thoroughly disseminated to all levels of the healthcare team by the “trained trainer.” The ineffectiveness of this training model in the Cambodian context may partially explain why IPC has remained one of the lowest scoring domains on the national quality of care assessments.

After gathering the formative data, Emory and WHO-Cambodia formed an expert panel to advise and guide the process of developing the WASH training needs assessment and training curriculum. The panel consisted of the MOH, Cambodian healthcare providers, UNICEF, and NGOs such as WaterAid. Several of the experts had been involved in previous IPC trainings and evaluations conducted by the MOH between 2010 and 2014.

The expert panel members reviewed findings from the literature review and responses from the informal interviews, and agreed that the training needs assessment would take a mixed methods approach. The assessment would include observations of clinical and cleaning staff behavior, visual facility inspections, written surveys of clinicians’ knowledge and attitudes, and oral surveys of cleaners’ knowledge and attitudes. Panel members also recommended that written survey responses be phrased as “True/False,” as compared to a Likert scale, in order to be culturally appropriate. In terms of content, the needs assessment would include the four WASH topics related to IPC (hand hygiene, medical equipment processing, environmental cleaning and healthcare waste management) as well as universal precautions.



Step Three: Co-Implementing the Training Needs Assessment

To conduct the needs assessment, staff from the Department of Hospital Services, as well as recent midwife and nursing graduates, served as enumerators and visited each of the 18 HCF for two days. On the first day, enumerators visited key wards and followed clinicians during their morning rounds to observe their hand hygiene practices using the WHO’s five key handwashing moments framework. When possible, enumerators also observed techniques used for the sterilization of medical equipment. On the second day, all observations from the previous day were repeated, followed by the dissemination of knowledge and attitude surveys to the clinical staff during their morning meeting. The written surveys had 30 true/false questions that addressed topics such as disease transmission (e.g., “Most patients are infectious”) and hospital waste management (e.g., “Waste at a healthcare facility should be separated at the point at which it is generated”). All knowledge-based questions came directly from the national IPC guidelines, while attitude questions were derived from the relevant scientific literature on health worker attitudes regarding IPC. Cleaners were surveyed verbally with similar IPC knowledge and attitudes questions, as well as other questions related to their maintenance role.

Lessons Learned from the Collaboration Process

The collaborative process between Emory researchers, the WASH working group, the expert panel, and the MOH to develop a training needs assessment for a WASH-focused IPC training was the first of its kind in Cambodia. As such, there were many lessons learned. Strategic advocacy for improved WASH and IPC in healthcare facilities was vital to the success of the collaboration. Emory, WHO, and WaterAid worked with the MOH for nearly a year prior to have discussions about training to bring awareness to the issues related to WASH in HCF. Secondly, having adequate time for collaboration was central to the ability to integrate governmental, non-governmental, and academic goals into the research and training development process. It took approximately four months to gain consensus, ensure inclusiveness and secure ownership of the training by the MOH and other partners. The successful development of the training hinged upon strong relationships with all parties involved.