Ebola Pillar II Funds: Global Health Ebola Team

Guinea's Readiness Response to Ebola: Strengthening Data Availability and Use

June 2018

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MEASURE Evaluation

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Health information system (HIS) strengthening and the rollout of a national electronic platform are the result of collaborative efforts. We deeply appreciate all the district- and facility-based officials, implementing partners, and others who contributed their time and perspectives. We thank the stakeholders for sharing their technical expertise and providing the resources to roll out the DHIS 2 platform, the supportive supervision structure, and the data demand and use (DDU) method nationwide.

We thank all members of the technical working group and the implementing partners collaborating with the Ministry of Health's HIS strengthening efforts in Guinea.

MEASURE Evaluation's activities in Guinea were led by Mohamed Rahim Kebe, in Conakry, and the hard-working Conakry-based team: Jonas Sagno, Albert Camara, Abdoulaye Saikou Diallo, and Mamadou Diao Diallo. Continuous technical guidance and support were provided by M. Alimou Barry, Eric Geers, Romain Tohouri, and Jeanne Chauffour. Special thanks to Scott McKeown and Richard Gakuba, MEASURE Evaluation advisors embedded in Guinea from September through December 2015, for laying the groundwork for a successful follow-on project.

We thank MEASURE Evaluation's knowledge management team for editorial and production services.

Cover: DHIS 2 workshop in Kindia, Guinea, April 2016. Photo: Jonas Sagno, MEASURE Evaluation

CONTENTS

ABBREVIATIONS

BSD	*Bureau de Stratégie et de Développement*/Office of Strategy and Development, Ministry of Health
DDU	data demand and use
DHIS 2	District Health Information Software, version 2
DPS	*Direction Préfectorale de la Santé*/Prefectural Health Department
EPI	Expanded Program for Immunization
GHET	Global Health Ebola Team
HFR	health facility registry
HIS	health information system
IP	implementing partner
IT	information technology
MFL	master facility list
MOH	Ministry of Health
OP	operational plan
PRISM	Performance of Routine Information Systems Management
RHIS	routine health information system
SNIS	*Système National d'Information Sanitaire* (French)/National Health Information System
SOP	standard operating procedure
SP	strategic plan
TA	technical assistance
TOT	training of trainers
TWG	technical working group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

PROGRAMMATIC OVERVIEW

Background and Context for Interventions

A serious outbreak of Ebola virus disease in Guinea in 2014 resulted in 3,801 recorded Ebola cases and 2,533 recorded deaths—the highest mortality rate (66%) from Ebola in West Africa. Disruptions caused by the outbreak were inevitably felt throughout the healthcare system, leading the international community to call for investment to strengthen a weakened healthcare infrastructure. The urgency of the Ebola response challenge led to a heightened awareness of shortcomings in the nation's health information system (HIS) and accelerated the search for appropriate digital data platforms, including electronic and mobile data systems. It also led to consideration of the potential of digital technology to contribute to the restoration and long-term resilience of the health system. In September 2015, MEASURE Evaluation, funded by the United States Agency for International Development (USAID), embedded two senior advisors in the Ministry of Health (MOH) to begin developing an environment that would support creation of a health information strategy, work to strengthen health data collection in the routine health information system (RHIS), and support efforts to strengthen the organizational infrastructure within the MOH.

In January 2016, Guinea was a post-Ebola environment with no HIS electronic platform, no HIS strategic plan, and no operational plan. Data reporting was irregular, data quality was low, and the information generated was not used for decision making. The MOH had a weak coordination mechanism, a lack of HIS guidance documents, and the staff in charge of the RHIS system were too few and not well skilled in performing the required tasks.

Since 2016, however, Guinea's HIS has made great strides, thanks to top-level support at the MOH and to collaboration among many implementing partners (IPs). This concerted effort enabled the adoption and national rollout of a software platform for the HIS (in this case, DHIS 2) in less than one year.

MEASURE Evaluation provided consultation and support for the HIS technical working group (TWG) and technical and logistical support to the MOH to build a foundation for a stronger RHIS. An essential component of RHIS strengthening is fostering systematic and strategic engagement with individual government ministries and development partners, the integration of data streams and data warehousing in order to strengthen procedures, and data quality assurance for the systematic collection and management of health data at all levels of the RHIS. This was done through mentoring, supportive supervision, data verification, and the integration of data demand and use elements in RHIS policies, guidelines, and training.

The team continues to support RHIS strengthening through the integration of malaria information in the RHIS and DHIS 2 on a limited basis, continued efforts to improve the environment for data-informed decision making, and data packaging to meet the needs of decision makers.

By December 2017, Guinea's RHIS environment had these fundamental elements in place:

- A DHIS 2 platform established and functional nationwide down to districts and prefectural hospital levels (100%)
- A national five-year HIS strategic plan and a costed operational plan developed and updated
- RHIS guidance documents developed for national use (IPs then collaborated to disseminate them for use at lower levels throughout the country); MEASURE Evaluation led the technical assistance (TA) and paid for piloting and rollout of DHIS 2 (training, equipment, supervision visits, maintenance,

Internet fees, etc.) in more than half of the country (three regions: Conakry, Kindia, and Labé) and provided TA when possible to other regions that requested it.

- Data review meetings conducted at regional, district, and health facility levels; data dashboards and data visualizations developed at the district level; and national RHIS quarterly bulletins published

Start and End Dates: January 15, 2016–March 31, 2018

Funding for MEASURE Evaluation's TA with Ebola Pillar II Global Health Ebola Team (GHET) began on January 15, 2016, and ended on March 31, 2018.

Names of Subawardees In-Country

No subawardees in-country. The project worked directly with the government.

Table 1. Sample of the Ebola project's results framework (see Annex 2 for full report)

Indicators that Support the GHET Results Framework (On a Per-Country Basis)	Indicator Definition	Frequency of Data Collection	Source of Data	Baseline	Month/Year of Baseline	Life of Project Result	Comments
Percentage of hospitals in MEASURE Evaluation-supported zones that report data every month directly through DHIS 2	Hospitals that receive material or technical support through MEASURE Evaluation and that submit complete monthly reports through DHIS 2	Monthly	DHIS 2		May 2016	100%	See Annex
Percentage of districts (DPS/DCS) in MEASURE Evaluation-supported zones that report data every month directly through DHIS 2	Hospitals that receive material or technical support through MEASURE Evaluation and that submit complete monthly reports through DHIS 2	Monthly	DHIS 2		June 2016	100%	See Annex
Number of personnel trained in MEASURE Evaluation-supported training events	Participants who complete a training event[1] supported by MEASURE Evaluation	Quarterly	Training toolkits		N/A	523	See Annex

Objectives

The primary objective of this activity was to strengthen the institutional capacity of the Guinea MOH in HIS and health system strengthening, in general. In response to the Ebola epidemic, this project used Ebola Pillar II funding to complete the following objectives (with illustrative examples of achievements):

- Objective 1: Increase availability of health service delivery data in the RHIS, by establishing the foundation for a system upgrade, integration, and data warehousing
    - Achievement: Established the foundation for system integration and data warehousing, produced a master facility list (MFL), a health facility register, system guidelines and standards, and piloted and rolled out the DHIS 2 platform nationally.
- Objective 2: Enhance the quality of RHIS data on health services delivery, by strengthening systematic data collection and management and procedures for health information at all levels

[1]A training event is designed to improve knowledge or capacity and has explicit training objectives. Training events can include trainings of trainers (TOTs) and stepdown/cascade trainings. Workshops in which participants gather to develop, review, or update materials, but that do not have a specific knowledge-building component or training objectives, are not counted toward this indicator. MEASURE Evaluation-supported training events are funded by MEASURE Evaluation, through USAID. Training events that are facilitated by MEASURE Evaluation in whole or in part, but are not funded by MEASURE Evaluation, do not count toward this indicator.

    - Achievement: Strengthened procedures for the systematic collection and management of health data at all levels of the system and enhanced procedures for data quality assurance, through mentoring, supportive supervision, and data verification

- Objective 3: Institutionalize a culture of data-driven decision making, by strengthening collaborative efforts to create an enabling environment for the regular use of good-quality RHIS data in decision making at the MOH, and integrate DDU elements in RHIS policies, guidelines, and trainings
    - Achievement: Built on organizational support provided to the MOH to strengthen collaborative efforts to create a larger enabling environment for regular use of good-quality RHIS data for decision making

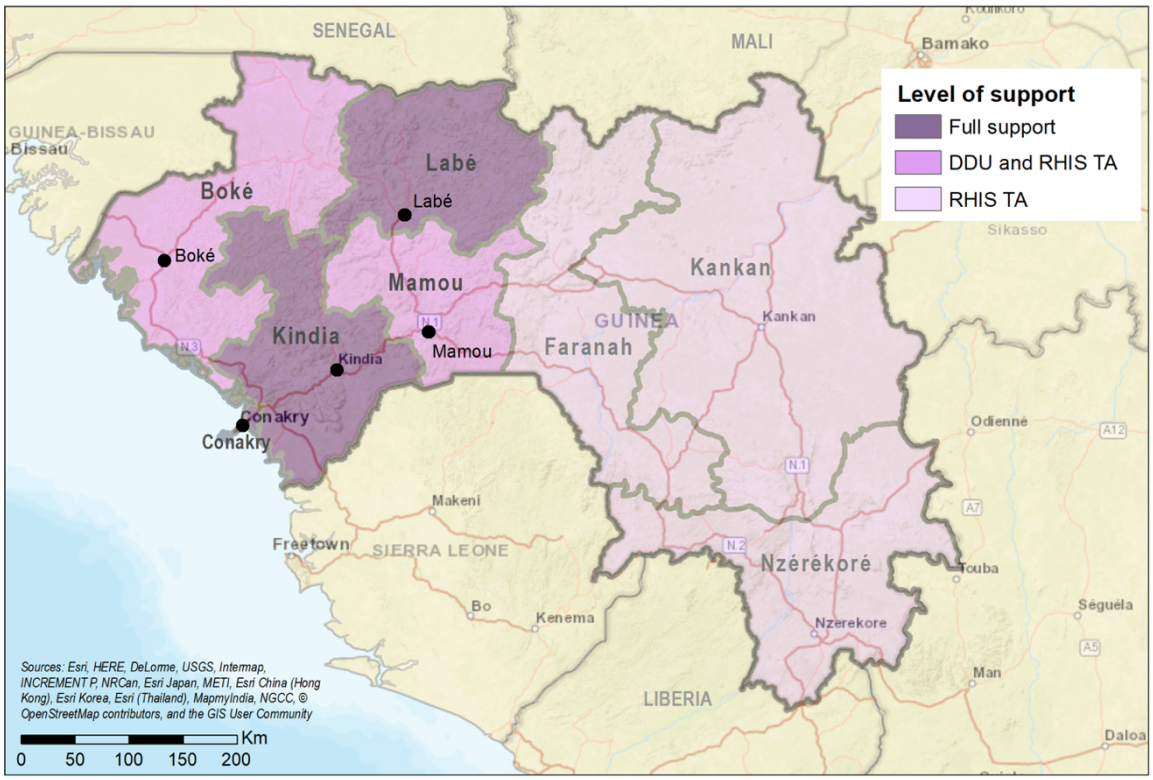
The project integrated capacity building in its work, through trainings and mentoring throughout implementation. Capacity building at the national level included strengthening at the individual, institutional, and systems levels. Management capacity for RHIS was improved through regular supervision visits, joint development of HIS guidance documents, data review meetings, coaching for data use, and the development of national and regional feedback bulletins for users and decision makers at all levels of government.

ACTIVITIES AND RESULTS

The GHET development objective is "Country is better equipped to sustain a 'Resilient Zero' of Ebola cases." MEASURE Evaluation's activities align with intermediate result 2—"Health system functions are improved to respond appropriately and adequately to future public health crises"—and specifically with sub-intermediate result 2.3—"Integration and effectiveness of monitoring systems are improved."

A fundamental activity was the joint development and subsequent approval of a national strategic plan to strengthen RHIS governance. The plan represented a strategic direction for RHIS that was agreed to by the Office of Strategy and Development (BSD) and its partners. It included a guiding framework for prioritizing and sharing information on activities and annual costed operational plans, to ensure efficient use of resources.

Figure 1. Regions supported by MEASURE Evaluation



MEASURE Evaluation supported regions and districts for the DHIS 2 implementation (three regions, 15 districts, two regional hospitals, eight prefectural hospitals, six municipality medical centers, and three national hospitals).

MEASURE Evaluation's geographic focus was at the national, regional, and district levels. At the national level, MEASURE Evaluation and the TWG for HIS finalized the HIS strategic plan through 2020—the drafting of a plan had begun with the 2015 embedment following the Ebola outbreak. MEASURE Evaluation's work to help enact the vision set forth in the plan focused on strengthening the RHIS and rolling out the DHIS 2.

MEASURE Evaluation facilitated the customized design of the DHIS 2 system and the TOT of central-level staff for cascade trainings for the national rollout. At the same time, the project supported the development of RHIS tools, an RHIS training curriculum, and development of an MFL linked with DHIS 2.

The project piloted the DHIS 2 system in all districts of Conakry and Kindia and then was in charge of the full DHIS 2 rollout in Labé. For leadership and DDU activities, the project also worked in Boké prefecture. MEASURE Evaluation provided TA to other groups in the country for DHIS 2 supervision and data review meetings.

In technical aspects of the work, MEASURE Evaluation's activities were organized in three major areas: increased availability of health service delivery data in the RHIS (Activity 4EBL-007), enhanced quality of RHIS data on health service delivery (Activity 4EBL-013), and institutionalization of a culture of data-driven decision making (Activity 4EBL-014).

Increased Availability of Health Service Delivery Data in the RHIS (4EBL-007)

Building on the work of MEASURE Evaluation's two-person technical team embedded in the MOH in 2015, the new team worked with the Guinea MOH and implementing partners to create a 16-member multidisciplinary DHIS 2 technical team to manage the DHIS 2 platform at the central level.

Activity Summary of Availability of Health Service Delivery Data

- Active MFL for public and private facilities with database and registry
- Final costed HIS operational plan
- Electronic data system/platform: Guinea MOH staff and IPs trained in DHIS 2; platform successfully rolled out in all districts, including hospitals, within six months
- Capacity building in MEASURE Evaluation areas, plus TA provided to other areas: statistics officers trained and supervised in Conakry, Kindia, and Labé
- Information technology (IT) support and security: secured hosting, backup system, standard operating procedures (SOPs) on IT maintenance and disaster recovery; selection and training of MOH staff

MEASURE Evaluation then led efforts to finalize a costed HIS operational plan, which was approved in March 2016. The first activity in that plan was to operationalize DHIS 2 to support the RHIS. MEASURE Evaluation trained the national DHIS 2 team to adapt and customize DHIS 2 for the Guinean context and worked with them to configure RHIS monthly reports for health centers and hospitals. TWG members refined the DHIS 2 guidance documents and supported the piloting of materials and equipment. National-level technicians and IP staff were trained as trainers, and statistics officers were trained and mentored. MEASURE Evaluation directly supported DHIS 2 piloting and rollout in 15 districts (representing one-third of the country) and corresponding hospitals (district, regional, municipal, and national). It also provided TA to stakeholders that were rolling out the system in the rest of the country. Working with the MOH, the BSD and regional and district teams deployed DHIS 2 in record time: just nine months.

Enhanced Quality of RHIS Data on Health Service Delivery (4EBL-013)

The RHIS is more than an electronic platform. The strategic plan and operational plan provide the framework for success and comprehensive training, coaching, and feedback for national and regional staff to build the required human skills. Those skills are data warehousing, equipment maintenance, DHIS 2 operation,

leadership, management, and data use. More than 417 people have been trained in this comprehensive skills-building approach.

Guinea has many RHIS partners supporting the MOH and the BSD. MEASURE Evaluation has demonstrated its commitment to technical excellence and sustainable approaches to RHIS strengthening. Sustainability is aided by MOH-led planning and joint implementation by the TWG to carry out RHIS activities and develop local capacity. Partnering with stakeholders and donors helps to establish the DHIS 2 applications and guidelines nationwide and promotes the collaboration that allows Guinea to leverage available funding in a way that corresponds to the established strategic plan and operational plan. One crucial step was configuring new tools in DHIS 2 to foster data collection from all programs and projects that affect the RHIS, thus reducing or even eliminating parallel data collection. MEASURE Evaluation supported this effort. See box below for other successful initiatives.

Activity Summary of Successful RHIS Quality improvement Initiatives

- RHIS data management and procedures manual developed, validated, and in use
- Joint development of RHIS guidance documents
- A set of three RHIS supervision tools developed, validated, and in use
- TOT for central and regional staff conducted on new RHIS tools and DHIS 2
- Cascade trainings conducted in MEASURE Evaluation-supported zones on new RHIS tools and DHIS 2 at individual, institutional, and systems levels
- Management capacity improved through supportive supervision conducted throughout and outside of MEASURE Evaluation-supported zones
- Data validation SOPs across all levels of the health system developed and validated
- Data management standards workshop conducted, weaknesses identified, and action steps now in development

Institutionalization of a Culture of Data-Driven Decision Making (4EBL-014)

Electronic systems require system integration and data warehousing, which in turn require an MFL for public and private facilities; a health facility register, which is a database containing all facility details, including geographic information system coordinates of government health facilities; system guidelines and standards; system piloting; and national rollout. The MFL framework (https://dhis2.sante.gov.gn/cartesanitaire) was created and can now be regularly updated by the MFL core team. The registry was finalized and the database in place by December 2017. MEASURE Evaluation expanded its workplan in 2016—when the contract for one IP ended—to provide IT support and security to the system. The team worked with MOH counterparts to secure hosting, install a good-quality backup system, and develop SOPs on IT maintenance and disaster recovery protocols. The project also provided TA to develop terms of reference that would allow recruitment of IT staff and training of MOH personnel on system maintenance.

Creating a culture of data use requires data and also people, tools, discussion, and dissemination of the data. Advocating a data-driven culture requires skilled people (leadership training) who build consensus on a way forward (selecting key health indicators, data review guidelines, and data review meetings) and the dissemination of data for discussion and action (in Guinea, through national and regional bulletins). This approach led to increased engagement with routine health data for decision making on health services and management of health programs.

Activity Summary of Improved Culture of Data Use

- Data review meetings and coaching of staff for data use
- National and regional quarterly feedback bulletins developed, piloted, and institutionalized
- Trained people at all levels of the system to lobby for a strong HIS, which fosters an improved culture of data use

Leadership training and skills building. A data use curriculum was created, based on a 2016 rapid assessment, and used to train a cadre of trainers who work with the national and district health levels to foster a culture of data use. Participants learned to apply leadership and management practices to problems they had identified with their data. The goals were to: (a) interpret routine data to understand service performance, (b) identify and overcome barriers to data use, and (c) achieve measurable results through data-informed decisions.

These participants then conducted coaching visits to health teams to support implementation of data-informed action plans. At the national and regional levels, qualified trainers from the MOH delivered the program and have expanded it to three additional regions (Boké, Labé, and Mamou). The BSD expressed interest in allocating resources to expand the program throughout the country and sought further support to reach this goal.

"Data use champions" were selected from among team members from the health districts of Kindia and Conakry regions. Their accomplishments were included in the advocacy and dissemination tool—the RHIS quarterly feedback bulletin—to demonstrate data use and to motivate other regions to use the RHIS to manage their health services. The training was repeated in 2017, allowing MEASURE Evaluation to reach health teams from 21 hospitals, 18 prefectural health departments (DPS), four regional health departments (DRS), two community health centers (CMC) in Conakry, and the Health Department of the City of Conakry.

Dissemination. The dissemination aspect of the data use leadership strategy is chiefly housed in the RHIS quarterly feedback bulletins, which also serve as advocacy tools. The national bulletin provides analysis and feedback to the regional level for reproductive health, malaria, tuberculosis, and vaccination program data from the DHIS 2. The bulletins were used in Conakry and Kindia to review and plan improvements to their health services. These regions then created a regional bulletin for the district health directorates in Conakry and Kindia to promote the use of data for health services management.

As a result, at both the national and regional levels, health staff have continued to update data analysis and interpretation and to disseminate national and regional feedback bulletins. The BSD and regional directorates are continuing to provide this routine feedback to promote data quality and use throughout the health system.

Data Use Champion: District Regional Salut Kindia

After the Ebola crisis, the community health worker program in Guinea's Kindia region was shut down. The Kindia health team, through the Leadership for Data Demand and Use program, worked with local partners to restart the community health worker program. They mobilized and trained 140 new health workers and, from November 2016 through May 2017, their data showed that malaria prevention, testing, and referral services doubled and under-five malaria referrals increased from 160 to 641.

Conclusions from the Three Activities

Guinea has made great progress in a short period toward reforming its RHIS. This has led to *establishing a functional and integrated health information system* likely to provide a solid basis for decision making while improving the quality of data to support such decisions.

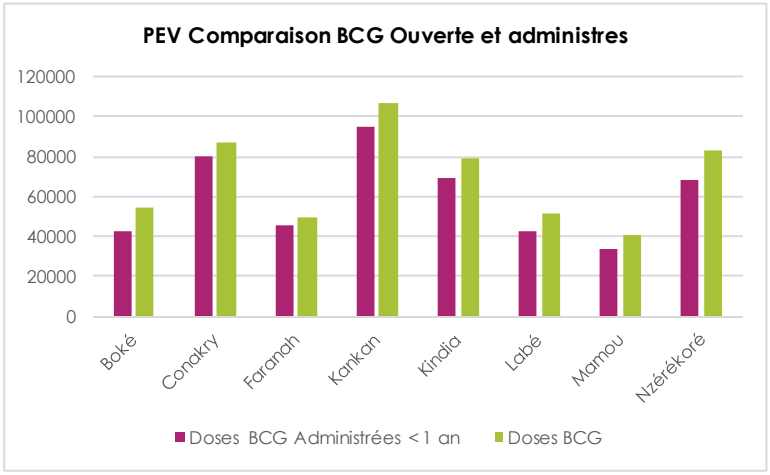
During the same period, the RHIS staff also received ongoing support—basic training, sharing of experience, supportive supervision visits, data review meetings, and development of RHIS guidance documents—that enabled them to perform basic RHIS tasks in a more standardized fashion.

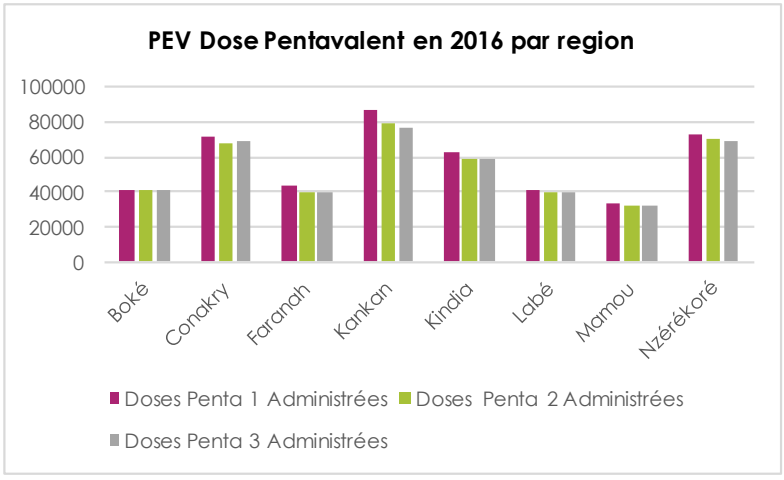
However, the support provided over the last two years should not be perceived as a guarantee of its sustainability. The MOH should be fully aware of the potential vulnerability of its young RHIS system, particularly when it comes to Internet connectivity and coverage, server maintenance, and staff skill. The MOH should work to strengthen gains by actively supporting supervision activities, providing continued capacity-building efforts (refresher trainings and trainings for new staff), and revising the RHIS guidance documents to build on experience gained through their continued use.

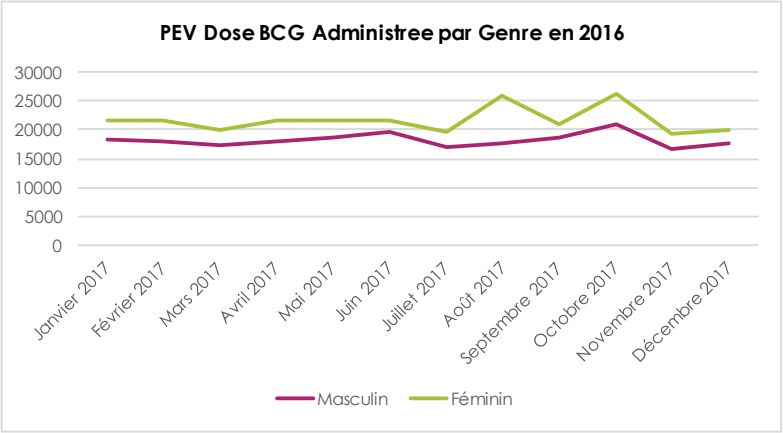
The introduction of data review meetings and the coaching of teams at the district, regional, and health facility levels to problem-solve is a good model. The approach used to roll out DHIS 2 at the district level could be applied at the health facility level, as long as time, budget, and connectivity exist. Continued joint planning and cooperation could mean that the program could be expanded to urban health facilities and provide a window for further scale-up.

Supporting Tables and Charts

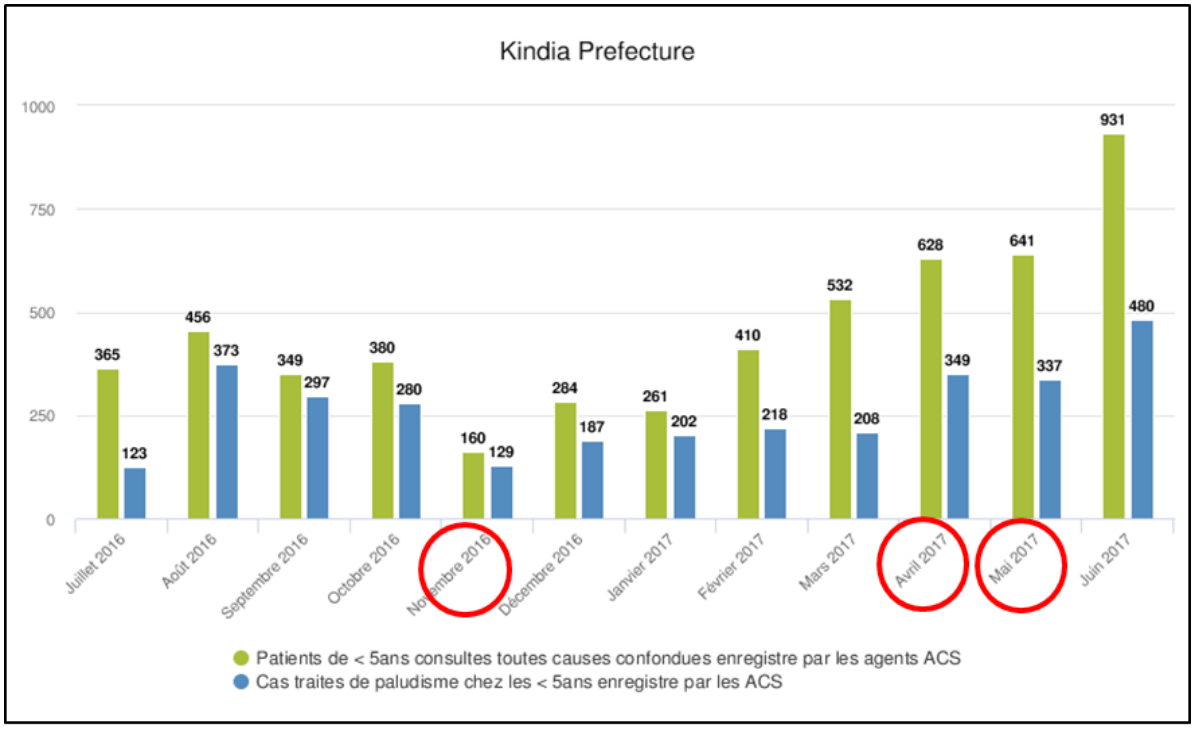
Figure 2. Examples of Expanded Program for Immunization (EPI) dashboards produced from the Guinea DHIS 2 platform

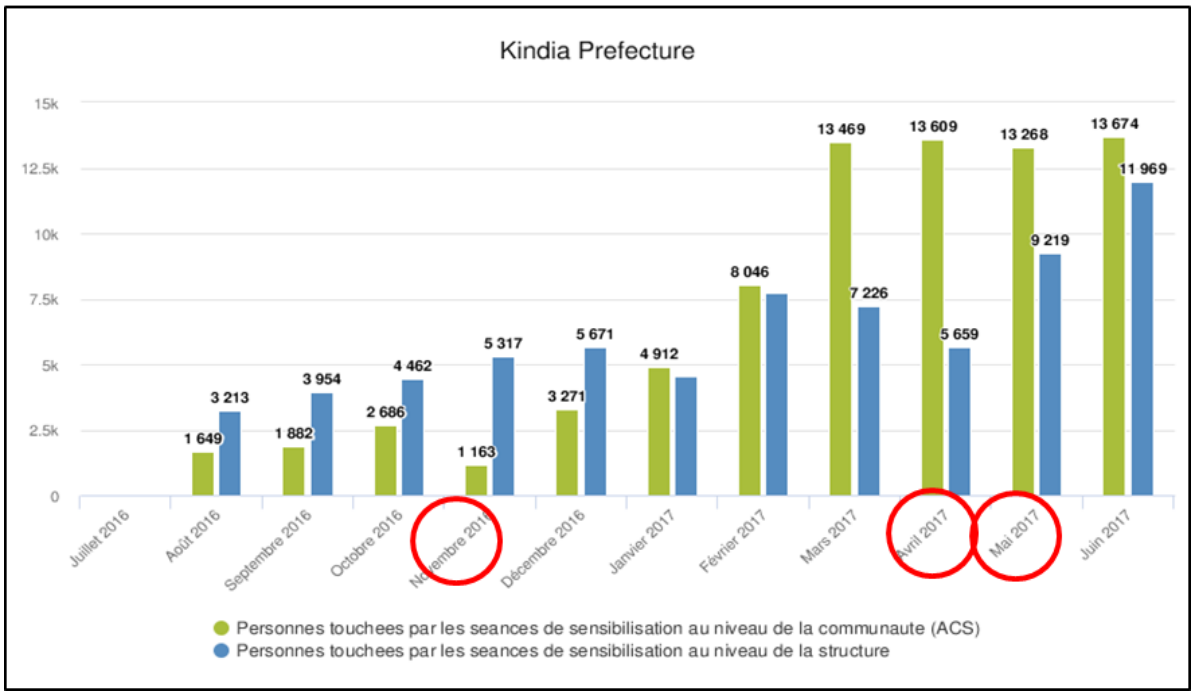






Figures 3 and 4. Outcome of the leadership for DDU program





The DDU champion in the Regional Health Department, Kindia, documented a reinforced community health system, with 140 newly trained community health workers. These figures show the increase in referrals following the addition of these trained health workers and compare the number of people reached by community health talks (green bars) and the number reached in the health services talks (blue bars)—both of which increased, too.

CHALLENGES

At the time of the Ebola crisis, an HIS that was underfunded and understaffed exacerbated Guinea's challenges. The outbreak suddenly introduced resources that could be deployed to meet increased demand for health data, ensure data quality, improve program partner coordination, establish a national electronic health data platform with the right indicators, and meet national program needs and service level management.

During the initial phases of project implementation, the MEASURE Evaluation team was able to coordinate partners around the HIS strategic plan, which was a large factor in the successful deployment of DHIS 2 across the country within one year.

However, as partners became more familiar with the DHIS 2 platform, individual work plans, driven by donors, began to have greater influence over HIS strengthening activities and the MOH at the central level was pulled in many directions. The dominance of donor-driven, duplicative work plans and the emphasis on short-term gains threatened the shared vision of the HIS strategic plan and led to some instances of duplicated effort.

At the regional level, health teams benefitted from the combination of well-analyzed and well-presented data with thoughtful interpretation from experienced service providers. Seeing the uses of good-quality data, local decision makers were eager to propose data-informed strategies to address their service delivery challenges.

However, the action plans and associated targets developed were often divorced from available resources. MEASURE Evaluation faced a challenge to facilitate data-informed action planning with the limited resources available.

- **Internet connectivity.** *Challenge*: Paying for this and having staff to maintain it. *Solution*: IP budgets will be dedicated to cover Internet connectivity in the short term while the MOH looks for a permanent solution.
- **Server maintenance and hosting**. *Challenge*: The MOH's lack of readiness to assume the related costs and maintain the contracts. *Solution*: IP budgets will be dedicated to cover server maintenance and hosting in the short term while the MOH looks for a permanent solution.
- **TWG revamping.** *Challenge*: The need for the TWG to be run by MOH staff. *Solution*: The MOH needs to be committed to address the TWG more effectively. The head of BSD will chair the committee and work to involve the partners.
- **Continued supervision visits**. *Challenge*: Budget to support travel and transport. *Solution*: IP budgets need to be adjusted to cover some of the cost.

The challenges noted were identified, and tentative solutions discussed, through a round table organized during the project half-day closeout event. Proposed solutions regarding short-term challenges were assigned to specific implementing RHIS partners and to the BSD, along with recommendations to address them more effectively.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons Learned

1. Joint planning and joint implementation will work if all partners are committed to achieving common goals, as was done through the TWG regular meetings.
2. Commitment to partner coordination from the government is key. In Guinea, the BSD senior management needs to be actively involved in the RHIS TWG.
3. The health sector needs to have partnerships with other sectors that can become advocates and whose activities and engagement can increase data use and stretch limited resources.
4. At the regional level, there should be more emphasis on linking data-informed action plans to the budget cycle.
5. TA is effective only when leadership is committed and supports it at the highest level.
6. Regular supervision visits are critical, especially with a young system. Supervisions help staff assess skills and jointly develop action plans to improve performance. While DHIS 2 does provide some data quality checks, people erroneously think that it resolves data quality issues.
7. The focus of data quality should be generating data that help to manage services, linking indicators to objectives and to realistic targets.
8. Subnational teams should be involved in information system integration. Data that meet the district health manager's needs will result in more active participation in the system.
9. The performance of local managers should be recognized through leadership programs—this would improve the environment for data use and application.

Recommendations

Building the HIS will take time. The system in Guinea has been rebuilt, but success depends on a long-term vision, national leadership, and adequate resources. Our effort had a limited mandate and resources. A long-term vision is needed if Guinea is to develop a strong system. The current strategic plan ends in 2020. With that in mind, we present these recommendations from MEASURE Evaluation:

Medium-Term Vision

1. Continue to support a fully-functioning HIS by using DHIS 2 to strengthen the RHIS and the RHIS tools (supervision tool and SOPs) across all levels of the health system. Improve the use of DHIS 2-produced data and information to inform decision making at the highest level.

2. Expand DHIS 2 implementation to improve patient-level management, indicator coverage, and antiretroviral quantification while reducing the data collection burden for health district staff. This can be done by:

a. Piloting service electronic registers (antenatal care and expanded program for immunization [EPI])
b. Introducing the DHIS 2 tracker system (HIV and tuberculosis programs)
c. Rolling out the DHIS 2 at urban health centers
d. Supporting the use of DHIS 2 mobile for data collection at the peripheral level

3. Provide support to the IT team at the MOH to build capacity to manage and administer the national DHIS 2 platform, ensure data security against emerging threats, and ensure continuity of service to DHIS 2 users nationwide. In addition, the data producers' and users' access to the server should be secured, and the MFL register and servers (production and backup) maintained, as appropriate.

4. Assess the current performance of the RHIS and develop action plans to address the findings, which would include findings of the Performance of Routine Information Systems Management (PRISM) and RHIS rapid assessments (data management standard).

5. Ensure interoperability of the DHIS 2 with other RHIS subsystems via the implementation of an interoperability layer and a facility registry application programming interface.

6. Support partner coordination around a common vision for a sustainable RHIS, including:

a. Tracking implementation of the RHIS National Strategic Plan 2016–2020

b. Tracking and regularly reporting to BSD and donors (USAID; The Global Fund to Fight AIDS, Tuberculosis and Malaria; European Union; United Nations Children's Fund [UNICEF], and WHO) regarding all partner activities around RHIS strengthening

c. Supporting BSD-led advocacy efforts for greater stakeholder engagement with RHIS strengthening

7. Promote use of DHIS 2 through capacity building in data analysis, visualization, interpretation, leadership, management, and advocacy skills by:

(a) Using government trainers and DDU champions to deliver the Leadership for DDU program in the rest of the country

(b) Promoting data review meetings at national, regional, and district levels

(c) Coaching and sharing expertise with struggling teams

8. Promote national and regional bulletins by:

a) Supporting further BSD and health program engagement (e.g., HIV/AIDS)

b) Standardizing DHIS 2 dashboards with indicator description and data interpretation applications

c) Experimenting with Internet-based social networks to promote their use in decision making (e.g., WhatsApp)

KNOWLEDGE MANAGEMENT

A knowledge management plan was developed with input from the communications staff supporting Guinea. The project generated materials for distribution (see below) and held a closeout event on March 21 that was covered on Google Hangout, allowing global participation. In addition, printed materials were made available in Guinea to stakeholders and are available electronically at the sites mentioned below.

We have asked to hold a brown-bag event in Washington, DC, and are awaiting confirmation of dates.

MEASURE Evaluation uses an iterative approach in its HIS work, continually building and improving. In terms of the materials created and lessons learned in Guinea, these learnings are being transferred to work in Mali and Burkina Faso, through additional support from Pillar IV GHSA funds.

Knowledge Management Materials

- Video: Big steps in a short time
- Posters: https://www.measureevaluation.org/resources/publications/gr-18-024
- https://www.measureevaluation.org/resources/publications/gr-18-23
- Data Champions in Kaloum: https://www.measureevaluation.org/resources/publications/gr-18-022
- Data Use in Kindia: https://www.measureevaluation.org/resources/publications/gr-18-021
- A standardized approach to strengthening the National Health Information System is the key to successful implementation: https://www.measureevaluation.org/resources/publications/gr-18-019
- Technical approaches to strengthening the management of Guinea's RHIS (in English and French):
  https://www.measureevaluation.org/resources/publications/gr-18-018
  https://www.measureevaluation.org/resources/publications/fs-17-251-fr
- Leadership for data demand and use (in French)
  https://www.measureevaluation.org/resources/publications/tr-18-244
- Further information at https://www.measureevaluation.org/countries/guinea

ANNEX 1. LOCATIONS OF OPERATION

Region	Capital and Districts	Area (km^2)	Population
Conakry	Conakry	450	1,667,864
Kindia	Kindia	28,873	1,561,374
	Coyah		264,164
	Dubréka		328,418
	Forécariah		244,649
	Kindia		438,315
	Télimélé		283,639
Labé	Labé	22,869	994,458
	Koubia district		101,171
	Labé district		318,633
Mamou	Mamou	17,074	731,188
	Dalaba district		136,320
	Mamou district		318,738
	Pita		277,059
Boké	Boké	11,124	449,405

Facilities

We did not work in specific facilities but created an MFL for the DHIS 2. This list can be found here: https://dhis2.sante.gov.gn/cartesanitaire.

ANNEX 2. PERFORMANCE INDICATOR REFERENCE SHEETS

MEASURE Evaluation Phase IV

Monitoring & Evaluation Plan
January 2017 – December 2017

Guinea

January 2017

Carolina Population Center
University of North Carolina at Chapel Hill
400 Meadowmont Village Circle, 3rd Floor
Chapel Hill, NC 27517 USA
TEL: 919-445-9350 FAX: 919-445-9353
http://www.cpc.unc.edu/measure

INTRODUCTION

Strong health systems are central to achieving better health outcomes, and strong health information systems (HIS) are the backbone of strong health systems. A properly functioning HIS gets the right information into the right hands at the right time, enabling policymakers, program managers, and individual service providers to make informed choices about everything from patient care to national budgets. Strong health information systems support greater transparency and accountability by increasing access to information.

In the aftermath of the 2014 Ebola epidemic, the Guinea Ministry of Health committed to transitioning a fragmented health information system to the open source district health information software (DHIS 2) platform. In order to accelerate country-led efforts to upgrade and strengthen Guinea's health information system, first the USAID Global Development Lab, and now the USAID GHET, in partnership with the Guinea Ministry of Health, supported MEASURE Evaluation to provide RHIS strengthening technical assistance. From October 2016 through September 2017, MEASURE Evaluation will continue to provide technical support to the Guinea Ministry of Health to increase the availability and quality of health service delivery data, support the implementation of the DHIS 2 operational platform, and support an enabling environment for data use.

This M&E plan describes the processes and systems in place to monitor the implementation of MEASURE Evaluation activities in Guinea, measure progress toward achieving proposed outcomes, and document the results achieved for the scope of work (SOW). This plan is intended to be a living document and will be reviewed and updated, as needed. This is particularly important when program decisions and funding adjustments are made annually, and changes to the SOW may occur within the work plan year.

PERFORMANCE INDICATORS

The indicators presented in Table 1 have been identified to capture achievements under MEASURE Evaluation's Guinea work plan for October 2016–September 2017. The indicators in the table below are crosscutting and are tracked within most activity codes.

Table 1. MEASURE Evaluation Guinea indicators

Indicator Number	MEASURE Evaluation Guinea Indicator	Corresponding Work Plan Activities
1	Percentage of hospitals in MEASURE Evaluation-supported zones that report data every month directly through the DHIS 2	4.1, 4. 2 5.1, 5.2, 5.3
2	Percentage of districts in MEASURE Evaluation-supported zones that report data every month directly through the DHIS 2	4.1, 4. 2 5.1, 5.2, 5.3
3	Number of technical working group meetings that are conducted with MEASURE Evaluation support	4.1.3 5.2.3 6.1.1, 6.1.4, 6.1.10, 6.1.13, 6.2.2, 6.2.4
4	Number of tools and resources created or updated by MEASURE Evaluation to address RHIS strengthening and data use	4.1.1, 4.1.2 5.1.3, 5.1.4, 5.2.1, 5.2.2, 5.2.3, 5.2.4 6.1.3, 6.1.5, 6.1.13, 6.2.1, 6.2.2, 6.2.3, 6.2.4
5	Number of personnel trained in MEASURE Evaluation-supported training events	4.1.5 5.1.1, 5.2.5, 5.2.6 6.1.6, 6.1.7, 6.1.8
6	Number of health regions and districts in MEASURE Evaluation-supported zones that received a supportive supervision visit on RHIS	5.3.1 6.1.9
7	Number of data use instances to improve services in MEASURE Evaluation-supported regions that are publicly highlighted and shared	6.2.5

PERFORMANCE INDICATOR TRACKING

The performance indicator tracking table (Table 2) details how and when data for each indicator are to be collected. It also outlines indicator targets for activities within the current work plan.

Table 2. Performance indicator tracking table

Indicator Number	MEASURE Evaluation Guinea Indicator	Corresponding Work Plan Activities	Targets					Data Sources	Data Collection Frequency	Reporting Frequency
			Q1	Q2	Q3	Q4	Annual			
1	Percentage of hospitals in MEASURE Evaluation-supported zones that report data every month directly through the DHIS 2	4.1, 4.2 5.1, 5.2, 5.3	75%	75%	100%	100%	100%	DHIS 2	Monthly	Annually
2	Percentage of districts (DPS/DCS) in MEASURE Evaluation-supported zones that report data every month directly through the DHIS 2	4.1, 4.2 5.1, 5.2, 5.3	75%	75%	100%	100%	100%	DHIS 2	Monthly	Annually
3	Number of technical working group meetings conducted with MEASURE Evaluation support	4.1.3, 5.2.3, 6.1.1, 6.1.4, 6.1.10, 6.1.13, 6.2.2, 6.2.4	9	9	9	9	36	Meeting minutes	Quarterly	Annually
4	Number of tools and resources created or updated by MEASURE Evaluation to address RHIS strengthening	4.1.1, 4.1.2 5.1.3, 5.1.4, 5.2.1, 5.2.2, 5.2.3, 5.2.4 6.1.3, 6.1.5, 6.1.13, 6.2.1,	1	4	5	1	11	Quarterly reports	Quarterly	Annually

Indicator Number	MEASURE Evaluation Guinea Indicator	Corresponding Work Plan Activities	Targets					Data Sources	Data Collection Frequency	Reporting Frequency
			Q1	Q2	Q3	Q4	Annual			
		6.2.2, 6.2.3, 6.2.4								
5	Number of personnel trained in MEASURE Evaluation-supported training events	4.1.5 5.1.1, 5.2.5, 5.2.6 6.1.6, 6.1.7, 6.1.8	50	45	0	5	100	Training toolkits	Quarterly	Annually
6	Number of districts in MEASURE Evaluation-supported zones that received a supportive supervision visit on RHIS	5.3.1 6.1.9	15	0	10	15	15	Supervision reports	Quarterly	Annually
7	Number of data use instances to improve services in MEASURE Evaluation-supported zones that are publicly highlighted and shared	6.2.5	0	0	0	2	2	Meeting minutes, activity reports, interviews, and/or emails	Annually	Annually

INDICATOR REFERENCE SHEETS

Indicator 1	Percentage of hospitals in MEASURE Evaluation-supported zones that report data every month directly through the DHIS 2
Corresponding work plan activities	4.1, 4.2 5.1, 5.2, 5.3
Precise definition	Hospitals that receive material or technical support through MEASURE Evaluation and that submit complete monthly reports through the DHIS 2
Annual targets	100% of hospitals in MEASURE Evaluation-supported zones are expected to report data every month directly through the DHIS 2.
Numerator	Number of hospitals in MEASURE Evaluation-supported zones that submit monthly reports through the DHIS 2
Denominator	Number of hospitals in MEASURE Evaluation-supported zones that have a mandate to submit monthly reports
Disaggregation	By district
Data collection tool and method	This indicator will be collected through the DHIS 2.
Data collection & reporting frequency	Data will be collected monthly and reported annually.
Person responsible	Romain Tohouri
Data quality considerations	It may be challenging to document completeness depending on the type of management system in place for receipt and management of reports. Because the number of hospitals supported by MEASURE Evaluation and those with the capacity to submit complete monthly reports on time will change over time, caution should be taken in interpreting the indicator.
Baseline data source (if applicable)	N/A
Other notes or comments	

Indicator 2	Percentage of districts in MEASURE Evaluation-supported zones that report data every month directly through the DHIS 2
Corresponding work plan activities	4.1, 4.2 5.1, 5.2, 5.3

Indicator 2	Percentage of districts in MEASURE Evaluation-supported zones that report data every month directly through the DHIS 2
Precise definition	Districts that receive material or technical support through MEASURE Evaluation and that submit complete monthly reports through the DHIS 2
Annual targets	100% of districts in MEASURE Evaluation-supported zones are expected to report data every month directly through the DHIS 2.
Numerator	Number of districts in MEASURE Evaluation-supported zones that submit monthly reports through the DHIS 2.
Denominator	Number of districts in MEASURE Evaluation-supported zones that have a mandate to submit monthly reports.
Disaggregation	By district
Data collection tool and method	This indicator will be collected through the DHIS 2.
Data collection & reporting frequency	Data will be collected monthly and reported annually.
Person responsible	Romain Tohouri
Data quality considerations	It may be challenging to document completeness depending on the type of management system in place for receipt and management of reports. Because the number of districts supported by MEASURE Evaluation and those with the capacity to submit complete monthly reports on time will change over time, caution should be taken in interpreting the indicator.
Baseline data source (if applicable)	N/A
Other notes or comments	

Indicator 3	Number of technical working group meetings that are conducted with MEASURE Evaluation support
Corresponding work plan activities	4.1.3 5.2.3 6.1.1. 6.1.4. 6.1.10, 6.1.13, 6.2.2, 6.2.4
Precise definition	Number of meetings convened for TWGs, TWG thematic groups, or subcommittees that are MOH-led or include MOH participants and are held with support or attendance from MEASURE Evaluation. Examples include the national HIS TWG and DHIS 2 Technical Team meetings.

Annual targets	36 TWG meetings are expected to be conducted with MEASURE Evaluation support. Individual TWG meetings may be jointly supported under activities 4GN-004, 4GN-005, and 4GN-006.
Numerator	Number of TWG meetings held
Denominator	N/A
Disaggregation	By TWG structure (e.g., HIS TWG)
Data collection tool and method	Meeting minutes
Data collection & reporting frequency	Data will be collected on an ongoing basis, aggregated each quarter, and reported annually.
Person responsible	Romain Tohouri Eric Geers
Data quality considerations	N/A
Baseline data source (if applicable)	N/A
Other notes or comments	

Indicator 4	Number of tools and resources created or updated by MEASURE Evaluation to address RHIS strengthening and data use
Corresponding work plan activities	4.1.1, 4.1.2 5.1.3, 5.1.4, 5.2.1, 5.2.2, 5.2.3, 5.2.4 6.1.3, 6.1.5, 6.1.13, 6.2.1, 6.2.2, 6.2.3, 6.2.4
Precise definition	Number of tools and resources. These may be paper based and/or electronic resources, including, but not limited to, data collection and management tools, training curricula, supervision tools, and tools that facilitate reporting and that have been created or updated with material and/or technical support from MEASURE Evaluation. Development or updates to tools designed to be applied at multiple levels (e.g., data collection tools for facilities, districts, and regions) will be counted as one tool. Tools and resources may be created with the support of TWGs. Tools should be validated, finalized, and approved by the MOH, as needed, before being counted toward this indicator. Specific examples of tools and resources include the RHIS data collection and supervision tools, data review guidelines, and the quarterly data feedback template for data review meetings.
Annual targets	Eleven tools and resources will be created or updated by MEASURE Evaluation to address RHIS strengthening and data use. Annual targets for individual activities are as follows: - 4GN-004: 1

Indicator 4	Number of tools and resources created or updated by MEASURE Evaluation to address RHIS strengthening and data use
	- 4GN-005: 6 - 4GN-006: 4
Numerator	Number of tools/resources
Denominator	N/A
Disaggregation	Type of tool/resource, whether updated or new, intended users
Data collection tool and method	This information should be tracked through usual monitoring methods and highlighted through routine reporting.
Data collection & reporting frequency	Data will be collected quarterly and reported annually.
Person responsible	Romain Tohouri Eric Geers
Data quality considerations	N/A
Baseline data source (if applicable)	N/A
Other notes or comments	

Indicator 5	Number of personnel trained in MEASURE Evaluation-supported training events
Corresponding work plan activities	4.1.5 5.1.1, 5.2.5, 5.2.6 6.1.6, 6.1.7, 6.1.8
Precise definition	Participants who complete a training event that is supported by MEASURE Evaluation. A training event is an event that is designed to improve knowledge or capacity and has explicit training objectives. Training events can include both TOTs and stepdown/cascade trainings. Workshops in which participants gather to develop, review, or update materials but that do not have a specific knowledge-building component or training objectives will not be counted toward this indicator. MEASURE Evaluation-supported training events are trainings that are funded by MEASURE Evaluation. Training events that are facilitated by MEASURE Evaluation in whole or in part, but are not funded by MEASURE Evaluation, will not count toward this indicator. Participants in MEASURE Evaluation-supported training events can include both government and IP staff. MEASURE Evaluation staff who are supported in trainings should not be counted within this indicator. Participants who are trained in TOTs and then facilitate stepdown/cascade trainings should only be counted as participants for the TOT event. Participants who complete multiple trainings in the same

Indicator 5	Number of personnel trained in MEASURE Evaluation-supported training events
	(e.g., refresher training) or different content areas will be counted under each individual training.
Annual targets	100 persons will be trained in MEASURE Evaluation supported training events. Annual targets for individual activities are as follows: - 4GN-004: 5 - 4GN-005: 75 - 4GN-006: 20
Numerator	Persons who complete a training event, supported by MEASURE Evaluation.
Denominator	N/A
Disaggregation	By training event, type of training, participant sex, organizational affiliation, level of employment (district/region/central)
Data collection tool and method	Collected at the time of each training event supported by MEASURE Evaluation, using the In Country Training Toolkit.
Data collection & reporting frequency	Data will be collected on an on-going basis, aggregated quarterly, and reported annually.
Person responsible	Romain Tohouri Eric Geers
Data quality considerations	For cascade trainings where MEASURE Evaluation staff are not directly leading the training, it may be challenging to gather all of the needed data. Participants who complete multiple trainings in the same (e.g., refresher training) or different content areas will be counted under each individual training, which may lead to double counting.
Baseline data source (if applicable)	N/A
Other notes or comments	In order to count event participants in this indicator, the event must be substantiated as a training. This can be done through completion of the agenda tab of the MEASURE Evaluation In-Country Training Toolkit or through submission of an agenda and training materials to identify training/learning objectives.

Indicator 6	Number of health districts in MEASURE Evaluation-supported zones that received a supportive supervision visit on RHIS
Corresponding work plan activities	5.3.1 6.1.9

Indicator 6	Number of health districts in MEASURE Evaluation-supported zones that received a supportive supervision visit on RHIS
Precise definition	Number of health districts supported by MEASURE Evaluation that receive at least one supportive supervision visit that is supported by MEASURE Evaluation.
Annual targets	Fifteen health districts in MEASURE Evaluation-supported zones will receive a supportive supervision visit on RHIS. Individual supervision visits may be jointly supported under activities 4GN-005 and 4GN-006.
Numerator	Health districts that are located within MEASURE Evaluation-supported zones and receive at least one supportive supervision visit that is supported by MEASURE Evaluation
Denominator	N/A
Disaggregation	By district, region
Data collection tool and method	Field visit reports
Data collection & reporting frequency	Data will be collected quarterly and reported annually.
Person responsible	Romain Tohouri Eric Geers
Data quality considerations	In order to maintain data quality, it will be important to maintain records in a way that will prevent double counting in the event that a district is visited more than once in a reporting period.
Baseline data source (if applicable)	N/A
Other notes or comments	

Indicator 7	Number of data use instances to improve services in MEASURE Evaluation-supported regions that are publicly highlighted and shared
Corresponding work plan activities	6.2.5
Precise definition	A data use instance is defined as a routine data-informed recommendation that is submitted to a decision maker with a request for action that will improve services. Public highlighting and/or sharing can occur through a data review meeting, a TWG meeting, or other meeting that is open to HIS stakeholders.
Annual targets	Two data use instances to improve services in MEASURE Evaluation-supported regions are expected to be publicly highlighted and shared.

Indicator 7	Number of data use instances to improve services in MEASURE Evaluation-supported regions that are publicly highlighted and shared
Numerator	Number of unique data-informed recommendations that are publicly submitted to a decision maker with a request for action that will improve services in a MEASURE Evaluation-supported region.
Denominator	N/A
Disaggregation	N/A
Data collection tool and method	Meeting minutes, activity reports. Follow-up interviews and/or informal correspondence (email) may be needed to confirm the recommendation and follow up on action steps.
Data collection & reporting frequency	Data will be collected on an ongoing basis and reported annually.
Person responsible	Eric Geers
Data quality considerations	Data use often goes unrecognized and unreported; therefore, we expect that there will be more instances of data use than are reported under this indicator and that are not publicly highlighted or shared. The action associated with data use may not occur immediately after the data-informed recommendation is submitted to decision makers and may occur after the MEASURE Evaluation activity is complete. Data use also goes beyond the control of the project and will be influenced by external factors that play a role in decision making, such as political factors and resource constraints.
Baseline data source (if applicable)	N/A
Other notes or comments	

Include any PIRS for each indicator if they were not included in the submitted M&E plan.

ANNEX 3. SUCCESS STORIES

Video: Peu de temps, longues foulées: https://vimeo.com/259734885

Posters :

Training health workers:

Data Use in Kindia: https://www.measureevaluation.org/resources/publications/gr-18-021

Succès de l'utilisation des données : La région de Kindia renforce les capacités des agents de santé communautaires dans la lutte contre le paludisme

L'équipe régionale de Kindia a utilisé les données du District Health Information Software–version 2 (DHIS 2) pour identifier le besoin de renforcer les capacités des agents de santé communautaires (ACS) dans la lutte contre le paludisme. Les membres de l'équipe ont réussi à engager les parties prenantes de leur région pour comprendre les problèmes et élaborer un plan d'action avec un large soutien. Leurs efforts collectifs ont abouti à l'expansion des services de paludisme pour les habitants de Kindia.

Le responsable de la planification, de la formation, et de la recherche, ainsi que le chargé de statistiques de la Direction Régionale de la Santé (DRS) de Kindia, le chargé de statistiques de la Direction Préfectorale de la Santé (DPS) de Kindia, et le surveillant général de l'hôpital régional de Kindia ont été formés suivant le programme du Leadership pour la Demande et l'Utilisation des Données (DUD) mené par MEASURE Evaluation en novembre 2016. Ce programme comprenait un module de formation, des visites de coaching, et un module de présentation des résultats. Le module de formation s'est concentré sur les aptitudes de leadership et de gestion pour la DUD, l'engagement des parties prenantes, la cartographie de l'utilisation de l'information, l'analyse et l'interprétation des données, l'évaluation des barrières à la DUD, l'analyse des causes profondes et la gestion du changement. Les équipes ont développé des plans d'action basés sur les problèmes identifiés en utilisant le DHIS 2 pour relier des données sanitaires de routine à des action concrètes. Les visites de coaching ont soutenu la mise en œuvre de ces plans d'action.

L'équipe de Kindia a choisi comme défi « Comment allons-nous améliorer (de 68% à 80%) la complétude et la promptitude des données des rapports des ASC sur le paludisme (les services de prévention, dépistage et références de patients) d'ici fin 2017 ? » L'équipe de Kindia a affiné son plan d'action en collaboration avec le responsable du service de santé à base communautaire de la DPS, le point focal du Programme National de la Lutte contre le Paludisme (PNLP), et le superviseur de l'organisation non-gouvernementale (ONG) Fédération Mounanfagny de Kindia (FMK). Ce plan d'action a été partagé avec neuf chefs de centres de santé (CS) pour obtenir leur soutien dans le renforcement des activités de paludisme des ACS.

Grâce à ce partenariat élargi, et avec l'appui technique de MEASURE Evaluation, l'équipe a identifié et adressé les causes profondes de la mauvaise performance de rapportage. Après l'épidémie de la maladie à virus Ebola en Guinée, la plupart des ACS étaient non-opérationnels. Suite à cette situation, un effort important a été fourni afin d'identifier 140 ACS à partir d'un ensemble de critères. Ces ACS ont été formés pour servir leurs communautés au cours de cinq séances distinctes. De plus, ils ont choisi des indicateurs clés pour suivre leurs activités et fournir la rétro information aux CS au sujet du travail sur le paludisme dans la communauté.

En mai 2017, l'équipe a remarqué une implication effective des ACS dans les activités du paludisme et le rapportage des cas de paludisme (graphiques 1 et 2). L'équipe s'est engagée à continuer de travailler pour renforcer encore plus ce partenariat avec des plans ciblés sur la distribution des kits de paludisme ainsi que sur des supervisions, des analyses mensuelles des rapports et un sondage communautaire sur l'utilisation des moustiquaires.

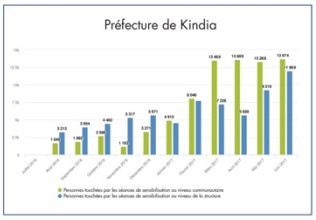
Ceci dit, il reste néanmoins des défis, qui incluent (1) le renforcement des relations entre les ACS et les CS, (2) les limitations des ressources financière, et (3) l'amélioration de la prise en charge des ACS. En vue des efforts fournis dans la mise en œuvre du plan d'action et de la mobilisation des parties prenantes dans la re-dynamisation des activités des ACS, le Bureau de Stratégie et de Développement (BSD) du Ministère de la Santé a choisi l'équipe de Kindia comme l'équipe championne en DUD dans la mise en œuvre de leur plan d'action. Cette équipe a été présentée comme un exemple à suivre pour les autres afin de promouvoir une culture des données pour la prise de décisions.

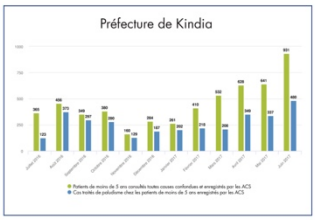
Résultats obtenus

- La formation des 140 ASC identifiés selon les critères de choix
- L'amélioration de la complétude et de la promptitude des rapports des ASC sur le paludisme dans le district sanitaire de Kindia
- La prise en compte des rapports des ASC par les chefs des CS dans la compilation et le rapportage des rapports SNIS au district
- La cartographie et les implications des parties prenantes dans les efforts de lutte contre le paludisme

Eléments de preuve

1. Rapport du premier module de la formation « Leadership pour la DUD »
2. Deux rapports des visites de coaching
3. Rapport des résultats des équipes du deuxième module de la formation « Leadership pour la DUD »
4. Présentations des équipes dans le deuxième module de la formation « Leadership pour la DUD »
5. Graphiques de données provenant du DHIS 2





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Improving vaccine coverage:

Data Champions in Kaloum: https://www.measureevaluation.org/resources/publications/gr-18-022

La DCS de Kaloum, Championne en DUD, contribute à la amélioration de la couverture vaccinale

Le taux d'abondon entre les antigènes BCG/VAR a réussi à être reduit

Une intervention essentielle pour la survie de l'enfant est la prévention de la maladie grace à l'adhésion au calendrier vaccinal. C'est la mission que de la Direction Communale de Santé (DCS) de Kaloum s'est fixée en vue de renforcer les capacités des centres de santé (CS) à fournir ce service important pour la survie de l'enfant.

L'équipe de la DCS de Kaloum a identifié que le niveau de mise en œuvre du service de vaccination était trop faible pour atteindre la couverture suffisante afin de protéger les enfants de la commune de Kaloum.

Après une analyse poussée des données du système national d'information sanitaire (SNIS), les membres de l'équipe de la DCS de Kaloum ont identifié ce problème de santé dans leur communauté et élaboré un plan d'action axé sur des activités pour promouvoir l'adhésion au calendrier vaccinal des enfants.

En janvier 2017, le directeur, le médecin chargé de la maladie et le chargé de statistiques de la DCS de Kaloum ont été formés par le programme du Leadership pour la Demande et l'Utilisation des Données (DUD) mené par MEASURE Evaluation. Ils ont ensuite développé des plans d'action basés sur les problèmes identifiés lors de l'utilisation des données du SNIS sur la plateforme DHIS 2 pour relier des données sanitaires de routine à des actions concrètes, puis ont choisi comme défi de « réduire le taux d'abandon entre la vaccination contre la tuberculose (BCG)—la porte d'entrée à la vaccination des enfants car administrée à la naissance—et la vaccination contre la varicelle (VAR), qui est la porte de sortie du calendrier vaccinal dans la commune de Kaloum ».

L'adhésion au calendrier vaccinal est un indicateur important pour le programme élargi de vaccination (PEV). En effet, si un enfant reçoit les deux doses d'un vaccin, il est considéré comme ayant complété ou adhéré au calendrier vaccinal du pays et est immunisé. Mais si l'enfant reçoit le premier vaccin mais pas le deuxième, il est considéré comme un cas « d'abandon » et il faut faire des efforts en sensibilisation et en communication pour assurer qu'il soit repêché lors des prochaines séances de vaccinations.

La performance de l'équipe a été mesurée par la réduction du taux d'abandon élevé à Kaloum.

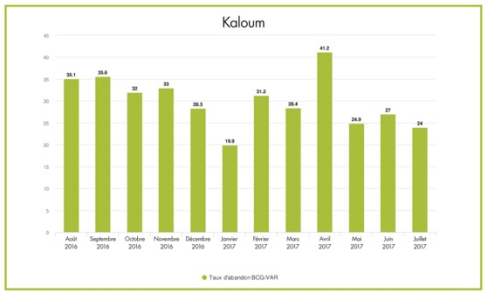
Stratégie de mise en œuvre

- Implication du directeur des ressources humaines de la DCS et le chef du CS de Kassa dans la mise en œuvre des activités centrées sur les cinq CS de Port, Kouléwondy, Boulbinet, Kassa, et Bernard Kouchner.
- Plaidoyer pour l'affectation d'un agent PEV au CS Bernard Kouchner pour assurer la vaccination et la formation d'agents supplémentaires
- Implication de l'UNICEF pour appuyer des activités de sensibilisation des femmes et des soignants sur la disponibilité et la gratuité des vaccins dans quatre quartiers de Coronthy entre janvier et juin 2017.
- Mise en place d'un système de parrainage des agents par quartiers.
- Réalisation de deux visites de supervision externe par l'équipe de la DCS de Kaloum visant les CS et 25 visites internes effectuées par les chefs des CS auprès des agents du PEV, le personnel de la vaccination et les agents communautaires.

Résultats

- Réduction du taux d'abandon qui variait normalement entre 30% et 40% par mois à environ 25% pendant trois mois consécutifs de mai à juillet 2017 (voir graphique 1).

Malgré cette performance, l'équipe s'est heurtée à plusieurs problèmes dans l'atteinte de ces objectifs: (1) le mouvement de population sur l'île de Kassa et le CS de Port, (2) le manque de motivation des agents du PEV, et (3) l'insuffisance de supervisions par les chefs des CS.



Vu les efforts consentis et les résultats obtenus par l'équipe de Kaloum, le Bureau de Stratégie et de Développement du Ministère de la Santé l'a choisie comme l'équipe championne dans le cadre du leadership pour la DUD, un bel exemple à suivre dans la promotion de la culture des données pour la prise de décisions.

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