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INKUNGA Y`ABANYAMERIKA

RWANDA INTEGRATED HEALTH SYSTEM STRENGTHENING PROJECT (IHSSP):

Quarterly Report Narrative

January – March 2010

This publication was produced for review by the United States Agency for International Development. It was prepared by Management Sciences for Health.

Rwanda IHSS Project:

Quarterly Report Narrative

January – March 2010

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Task Order No. GHH-I-03-07-00058-00

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About the Rwanda Integrated Health Systems Strengthening Project

The Government of Rwanda (GOR) has embarked on the next steps to strengthen its Health System and to reach its goals outlined in the Health Sector Strategic Plan II in order to accomplish the vision of the "*Rwandan population* having improved financial and geographic access to quality health services that are sustainable and efficiently managed by well trained *health sector staff* with clear functional responsibilities and of having Fully functional *districts* becoming the hub for managing health service delivery supported by actively engaged community and civil society organizations."

Management Sciences for Health has been awarded a contract by USAID to support the Rwandan Ministry of Health in 5 areas to reach the following results: 1) Improved Utilization of Data for Decision-Making and Policy Formulation across All Levels of the Health Sector, 2) Strengthened Health Financing Mechanisms and Financial Planning and Management for Sustainability,3) Improved Management, Quality, and Productivity of Human Resources for Health and Related Social Services, 4) Improved Quality of Health Services through Implementation of a Standardized Approach to Quality Improvement (QI), 5) Extended Decentralized Health and Social Services to the District Level and below.

Rwanda IHSS Project

Contract/Task order No. GHH-I-00-07-00058-02 / GHH-I-03-07-00058-00

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Acronyms

AIDS/SIDA	Acquired Immunodeficiency Syndrome
BDD	Base de Données/Database
BTC/CTB	Belgian Technical Cooperation/Coopération Technique Belge
CA	Collaborating Agency
CAAC	Cellule d'Appui a l'Approche Contractuelle; performance-based financing Department of the Rwandan Ministry of Health
CBHI	Community Based Health Insurance (Mutuelle)
CHW/ASC	Community Health Worker (Agent de Sante communautaire)
CHAI	Clinton Health and Aids Initiative
CTAMS	Cellule Technique d'Appui au Mutuelles de Sante; Mutuelle Technical Support Cell
CNLS	Commission National de Lutte contre le Sida
CPN	Consultation Prenatale/Antenatal Consultation
DHS	Demographic and Health Survey
DH	District Hospital
DRG	Diagnosis Related Group
ET	Extended team
GOR	Government of Rwanda
HC	Health Center
HDP *asdl*	Health Development & Performance, a newly created Rwandan NGO from remnants of the Cordaid Rwanda team
HIV/VIH	Human Immunodeficiency Virus
H(M)IS	Health (Management) Information System
HR	Human Resources
HSS	Health Systems Strengthening
IHSSP	Integrated Health Systems Strengthening Project
ICT	Information, Communication and Technology
ILO/BIT	International Labor Organization
IT	Information Technology
ITG/IMT/ITM	Instituut voor Tropische Geneeskunde, Antwerp/ Institut de Médecine Tropicale d'Anvers/Institute for Tropical Medicine, Antwerp
M&E	Monitoring & Evaluation
MIS	Management Information System
MCH	Maternal and Child Health
MOH	Ministry of Health

MSH	Management Sciences for Health
NGO	Non-governmental Organization
PBF/PBC	Performance-based Financing/Performance-based Contracting
PEPFAR	President's Emergency Plan for AIDS Relief
PHP	Hypertext Preprocessor
PMA	Paquet Minimum des Activités; Rwandan basic package of health services
PMTCT	Prevention of Mother-to-Child Transmission [of HIV]
P4P	Pay-for-Performance
PRISM	
QA	Quality Assurance
RBF	Result-Based Financing
SIS	Système d'Information Sanitaire (Health Information System)
SWAP	Sector Wide Approach
TA	Technical Assistance
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WB	World Bank

Executive Summary

The first quarter of 2010 has been marked by the complex and challenging task of developing a work plan for IHSSP that reflects USAID's ambition to implement a health systems strengthening project that can be a flagship program in Rwanda and a reference for other developing countries. Substantial technical input and leadership from USAID has been provided in the workplan development process to assure harmonization with its ideas. MSH has thus elaborated a work plan that looks at the long term horizon focusing on sustainable health systems while maintaining its support to ongoing successful interventions (i.e. areas of PBF, HMIS). It builds on past experiences with the Ministry of Health (MoH) recognizing the reality in the field and the need for close collaboration and support to the MoH.

A preliminary annual work plan that sets the direction of IHSSP for the next 5 years was partially approved by USAID in early April 2010 and discussions are ongoing on the remaining elements such as the strategic direction to be taken to support the districts (grants versus PBF) and to implement the data audit mechanisms for PBF and CBHI.

The team has been reinforced with 3 key staff while other positions are still pending. The health financing specialist, Pascal Kayobotsi, and the quality assurance advisor, Wiliam Twahirwa, started late March while the technical director, Bob de Wolfe, took post in early April.

Amidst the development of the work plan, MSH continued its involvement in the key areas the HIV/PBF project was focusing on; namely the revision of the framework for performance based financing at the hospital and health center levels, the roll out of the community PBF program, the technical assistance provided to CTAMS, the support on a variety of activities related to health management and information systems (HMIS) crucial for M&E and PBF-functioning and the validation of tools used in integrated supervision at all levels of clinical care.

Much of the staff time has also been directed to the development of a Health Systems Strengthening (HSS) strategic plan for the MoH. This plan should clarify the vision and strategic direction for health systems development over the next 5-10 years and will serve as a roadmap and strategy for future financers of HSS. It will guarantee as well greater coherency across sub-sector policies and improve coordination of partners supporting HSS. The plan is currently in the final stages of the first draft and requires substantial input (preferably through a 2-day workshop) from the different departments of the MoH.

The first quarter of 2010 has been marked by the complex and challenging task of developing a work plan for IHSSP that reflects USAID's ambitions to support a project for health system strengthening that can be a flagship and reference for other developing countries. Substantial technical input and leadership from USAID has been provided to assure harmonization with its ideas. With this in mind, MSH has elaborated a work plan that looks at the long term horizon focusing on sustainable health systems while maintaining as well its support to ongoing successful interventions (in the area of PBF, HMIS, …). It

builds on past experiences with the Ministry of Health (MoH) recognizing the reality on the field and the need for close collaboration and support to the MoH.

Much of the staff time has also been directed to the development of a Health Systems Strengthening Framework and Consolidated Strategic plan for the MoH. This plan should clarify the vision and strategic direction for health systems development over the next 5-10 years and will serve as a roadmap and strategy for future financers of HSS. It will guarantee as well greater coherency across sub-sector policies and improve coordination of partners supporting HSS. The plan is currently in the final stages of the first draft and requires substantial input (preferably through a 2-day workshop) from the different departments of the MoH.

Narrative Progress Report

IHSSP

Work plan development

A detailed work plan up to the end of the fiscal year 2009 (end September 2010) was submitted during the month of January. Based on feedback received from the COTR, a revised version has been submitted during March 2010 which received feedback mid April 2010.

> Major activities that were not approved included the PBF and CBHI audit mechanisms, the district PBF model, the CBHI PBF framework and the conditional cash transfer mechanisms for the community PBF model.
>
> Other activities planned for this fiscal year are deferred to fiscal year 2010, such as partnership with educational institutions (national or international) to support the strengthening of health economics and management expertise among health professionals, and the development of accreditation standards well adapted for district hospitals.

Currently the plan is again revised and more justification will be given in the second quarter of 2010.

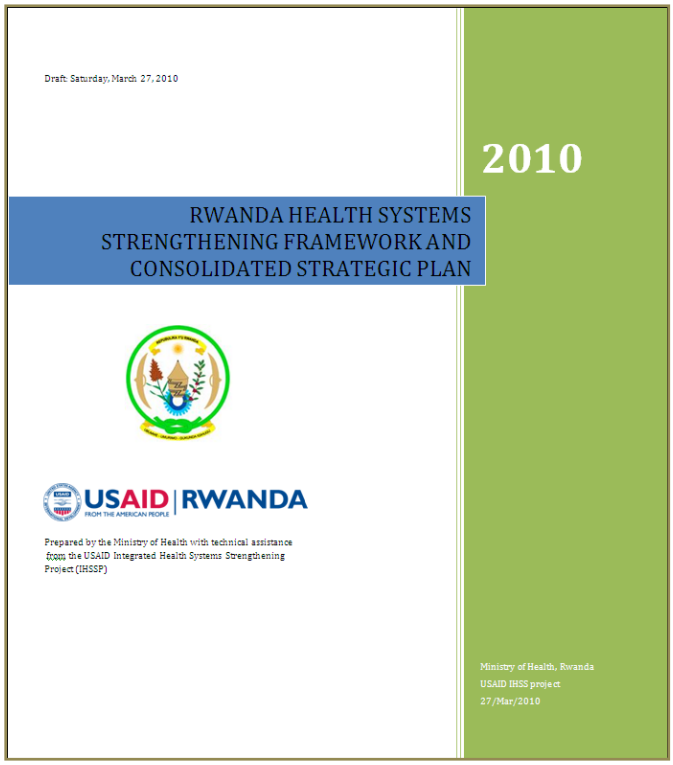
Recruitment

The team leaders and the project management staff recruited intensively in the reporting period. While a number of staff appointments are still pending USAID approval (M&E officer, project management support staff, IT specialist, Leadership and Management specialist, etc), the team has already been reinforced for crucial positions like Health Financing Specialist, Quality Assurance Advisor and the Technical Director.

HSS strategic plan

MSH was invited by USAID in mid-January 2010 to develop a health system strenghening strategic plan in collaboration with the Ministry of Health. This document will contain a clear vision and strategic direction for health systems development over the next 5-10 years and should serve as a roadmap and strategy for future financers of HSS. It will also provide greater coherency across sub-sector policies by reducing overlaps and inconsistencies and improving coordination of partners supporting HSS.

The first draft of this document has been prepared through a long series of consultations with USAID and the MoH. Policy and strategic documents have been reviewed, a situational and gap analysis of the 6 *WHO-building blocks* of a health system along the lines of HSSP-II (Health Sector Strategic Plan) has been conducted and new interventions to reach the goals specified in HSSP-II have been proposed.


Draft: Saturday, March 27, 2010

2010

RWANDA HEALTH SYSTEMS STRENGTHENING FRAMEWORK AND CONSOLIDATED STRATEGIC PLAN

USAID | RWANDA

Prepared by the Ministry of Health with technical assistance from the USAID Integrated Health Systems Strengthening Project (IHSSP)

Ministry of Health, Rwanda
USAID IHSS project
27/Mar/2010

Figure 1: HSS strategic plan first draft

All IHSSP teams were involved to some extent in the development of the draft document. The document needs further refinement and ultimate validation but this process requires considerable input from the MoH. A one to two-day workshop has been proposed to further discuss the status of the implemented plans and to assess possible funding gaps of new and exisiting/planned interventions. A copy of the draft of the agenda can be found in annex.

Data management and Data use

During much of this time period, the HMIS advisor had to step in as acting Technical Director for the IHSSP project as a result of the absence due to illness of the Chief of Party and the delay in arrival of the Technical Director. This resulted in considerable level of effort to support the important Health Systems Strengthening Framework development efforts, as well as the preparation and modification of the IHSSP workplan and budget. In addition, he managed the installation of a new network at the new MSH office, the transfer and upgrade of all voice and data server equipment and provided IT support to the entire MSH team while awaiting approval for the hiring of a new employee. This seriously reduced the amount of time that could be devoted to supporting the Ministry's HMIS team.

Progress was made in the following areas:

- **Community health worker information system:** the IHSSP team has been supporting the Community Health desk in a number of ways during this period.

  - Implementation and web-enabled database for Community HIS. Final changes were made to this system that enables district staff to enter the compiled monthly reports from every CHW cooperative. The software is hosted on the PBF server. A user manual was prepared in English and French, and a program has been initiated to train district data managers to enter the data.
  - Worked with Community Health desk and World Bank team to develop the community PBF impact evaluation design – focusing in particular on how data would be collected routinely through the Community HIS and PBF database on both indicators and quality assessments.
  - Helped the MOH negotiate a collaborative approach for the implementation of 2 cell-phone based reporting systems mUbuzima and RapidSMS. Prepared a joint action plan and budget that reflects the total cost of ownership of the system.
  - Worked with Voxiva/Phones 4 Health team to define system requirements for interoperability between CHW MIS and Community PBF web application.
  - Assisted CH desk staff to design computerized models to allocate community PBF funds during the startup period - until data are routinely available from the CHW SIS.
- **PBF database:**
  - Assisted the CAAC team with the processing of quarterly payments – introducing new payment tariffs for selected districts and redistributing payments for specific indicators across different donors.
  - Helped developed an action plan for enhancing the web application over the course of the next year.
  - Worked with PBF team at the CAAC to integrate portions of the Measure Data Quality Assessment Tool into the quarterly performance evaluations conducted in all health centers. This will enable the MOH to monitor the evolution of data quality more effectively down to the individual health center level.
- **HMIS:**
  - Implemented a web-based application for sharing the Ministry of Health's health facility database. http://www.pbfrwanda.org.rw/hf/index.php
  - Assisted with development of data interchange scripts between HMIS and the District Health System Strengthening tool.
  - Prepared draft functional requirements document for the MOH data warehouse and web-enabled dashboard.
  - Installed and tested a new business intelligence platform (JasperServer) that looks like it will meet the MOH requirements for web-enabled dashboards.
  - Worked with MOH information and communications technology (ICT) team to troubleshoot network issues on the MOH computer network.
  - Helped the HMIS team and Community Health Desk prepare a poster on the Community Health Worker MIS that was presented by Dr. Emilien at the HIS conference in Bangkok, Thailand in January.
  - Participated as a facilitator in the Routine Health Information Network (RHINO) conference in Guanajuato, Mexico. During the conference I facilitated 2 two-hour

sessions on PBF and Routine Health Information Systems that included an in-depth presentation of the Rwanda PBF case study. The conference was also an excellent opportunity for practical experience using the PRISM tools for assessing HMIS performance. We are planning to conduct a PRISM assessment in Rwanda next month.

- **PNLP (PMI):**
  - Assisted the PNLP staff obtain data and prepare analyses of malaria trends based upon HMIS data.
  - Helped PNLP staff design and implement a multi-user data entry application using Access to enter data from a data audit in 100 health facilities. Prepared initial analyses of data quality for presentation to a Global Fund team.
  - Provided an HMIS orientation and arranged for the new M&E officer at PNLP, Irenee Umulisa, to attend a blended learning course organized in Ghana.
- **eHealth:**
  - Assisted the national eHealth coordinator to plan for the creation of an eHealth Secretariat to be located with the CNLS office building. This included finalizing job descriptions for staff.
  - Supported discussions with the Nursing Council for the development of an eLearning curriculum for upgrading A1 nurses to A0 nurses.
  - Worked with the eHealth coordinator and the Clinton Health and Aids Initiative (CHAI) to develop the terms of reference for a national Health Information Systems helpdesk.

Health Financing

Community PBF

The PBF at the community level was defined and introduced in the districts of the country in 2009. To make the system operational, ensuring its effective implementation and establishment of an institutional framework, different actors were identified and trained during the past year: members of Steering Committees, the supervisors of community health workers and community health workers themselves. The overall objective of the community PBF program is to improve access to health services and to improve key maternal and child health indicators.

With the development of the impact evaluation intervention and the choice made by the Rwanda Ministry of Health to add 5 indicators to the monthly report of the CHWs cooperativesdesigned to improve maternal and infant health, the national model has been established. This study will be conducted in 200 sectors as follows:

• CHW Cooperative Incentives only (50 sectors): providing direct incentives to community health workers;
• Demand-side Incentives only (50 sectors): designed to encourage eligible women from rural areas to use the services of maternal and child health;
• CHW Cooperative Incentives + Demand-side only (50 sectors): the combination of the two models;

• Control only (50 sector)

During January to March 2010, preparations continued to introduce the national model of community Performance-Based Financing with the addition of the 5 indicators and the above defined models of the Impact evaluation.The community PBF Guide was revised and minor issues were corrected.

A workshop for extended team members was held in this quarter on community PBF. The goal of this workshop was to orient the members of the National PBF extended team on new changes in the model. In addition, the workshop aimed to explain the process of entering data through the PBF database (http://www.pbfrwanda.org.rw/siscom/).

These meetings revealed that implementation in the field proved to be challenging. It has been noted that the functioning of institutional structures, and specifically the ones for the PBF sector steering committee, are not yet effective. This has adverse consequences on coordination of the community health program and other activities associated with community PBF: (eg data entry into the community PBF database (SIS com), the payment of CHWs cooperatives, etc).
To bridge these gaps, decentralized coordination mechanisms will be strengthened. Coordination mechanisms will be formalized at the district level and a decentralized model of SOP for district actors will be produced.

Regional PBF-conference

Health actors in low-income countries are increasingly paying attention to PBF. PBF aims to improve the performance of health systems and to accelerate the achievement of the Millennium Development Goals in countries with low income.

In three countries of central Africa, PBF is today at the heart of the reform process of health systems. Rwanda, Burundi and the DRC have put in place large scale PBF-systems. These initiatives are not isolated: many other countries in the region (Cameroon, Burkina Faso, Madagascar, Sudan, Zambia, Tanzania, Kenya…) have initiated pilot projects or are planning to in the short term.
From 2nd to 5th February 2010 a regional conference on PBF took place in Burundi. The objective of the seminar was to bring together regional actors active in PBF and discuss technical issues that these actors are facing. Beyond the principles and theory, the seminar aimed to highlight the successes and limitations of regional dynamics, and analyzed the factors that contributed to these successes and failures. This seminar brought together professionals working in the PBF for health service. More specifically, the seminar aimed to:

- Identify lessons learned through various experiences in the region.
- Identify similarities in the difficulties, differences in research approaches and solutions.

Rwanda was represented by a number of actors from MoH and implementing partners. The seminar intended to identify specific technical issues, to present some experiences, and to start discussions around these topics. Feedback can be found on the following website:
http://performancebasedfinancing.wordpress.com/

Health Center and District Hospital Performance-based Financing

A four -day workshop on the revision of the framework was held in Musanze in early February, assembling MoH (CAAC) and all partners involved in the implementation of the PBF-mechanisms. This process started at the end of the HIV/PBF project but never arrived at its final stages. The revision is planned annually and tackles mainly the choice of quality and quantity indicators. Small changes were done in 2009 and after analysis of the data of the last 3 years and feedback from the field (during the end of project conference and extended team meetings) it was clear that major revisions were warranted. Outlined below are a set of issues that were addressed:

- The administrative model underwent minor modifications. Roles and responsibilities of different entities have been slightly expanded and the district PBF steering committee will now be called district health steering committee having a broader scope of work. It is supposed to discuss all district health related issues during its monthly meetings.
- The health centre PBF-model was mainly updated with respect to the quantity indicators abiding to the following principles:

    1. PBF should incentivize neglected area's and areas of huge Public Health importance
    2. PBF incentives should be more or less equally distributed over the different indicators (in the sense that they generate revenue across the whole PMA and HIV-care spectrum in a balanced way).
    3. Indicators should be easy to collect
    4. Indicators should be harmonized with HMIS and TRAC+-indicator formulation and reporting (equivalent definitions)
    5. Quality indicators should focus on ensuring procedures and protocols are well followed and quality of care is given to patient

In annex, the new PMA and HIV quantity indicators are described. Tariffs are modified in line with the above mentioned principles. Next steps before the new PBF-indicators are operational include official validation of these indicators, incorporation in the web based reporting system, adaptation of data collection tools and dissemination and training of the updated list and definitions of the new indicators.

The district hospital PBF-model was the most criticized and merited intensive scrutiny. It had been frequently noted that district hospital management staff forged documents and prepared themselves for the quarterly quality evaluations once the dates were known. The quality scores did not reflect either the real quality of the clinical care and the management of the hospital. Unannounced evaluation by the central level revealed these limitations last year and it was decided that this process should continue. It is not decided yet what would be the frequency of unannounced visits and what would be the exact PBF-budget allocated to these evaluations by central level. They would most likely still be alternated by peer evaluations to stimulate collaborative approaches and exchanging ideas among peers.

In addition, it was perceived as incorrect to include productivity of the hospitals in the calculation of the PBF revenues. The main task of the DH's should be to provide good quality of care to all referred patients and to give supportive supervision to the health centers. As such, attention should be guided away from rewarding quantity (productivity and towards quality. Care should be taken not to consider PBF and the quality evaluations as a panacea for resolving all inappropriate functioning of the hospital. It remains difficult to establish correct, objective verifiable indicators measuring the real quality of care. The quality measurement framework was used to identify new indicators and an example of the set of quality indicators is found in annex. To remedy the absence of any quantity indicator in the DH-PBF framework used to reward higher incentives for larger hospitals, a tailor made budget for each DH was calculated based on past productivity, number of staff, number of in-patients on average in 2009, weighted productivity on average for 2009, number of HC's supervised per DH and on an equity index. For this new evaluation by the central level, an extra component was added assessing the medical infrastructure. In total 61 composite indicators will be collected over 4 volets covering 460 data elements.

The previously used Infopath tool was replaced by a more user friendly protected excel-file. Advantages of Infopath are retained (protection of the file, only 1 version in use, revenues automatically calculated and immediate feedback to DH) while excel facilitates easier monitoring and analysis of the data and enhances future modifications.

CBHI/CTAMS

The new CBHI policy ,with as main change the "stratification" element whereby the population is subdivided in different categories each subject to a different subscription fee, has been drafted and transmitted to the Prime Minister's cabinet for approval. MSH'stechnical team helped develop the policy and gave comments on the latest version. Although the "capitation"system is not supported anymore, the policy remains ambiguous on that aspect. The MSH technical team still suggests that it would be a more feasible option to manage the CBHI.

One of the top priorities of CTAMS for 2010 is the improvement of the CBHI database. To respond to this, an editorial committee has been set up with support from MSH. Currently only one person is working for CTAMS (Dr. Hertilan, the coordinator of the unit) and much input is needed from the partners. CTAMS is recruiting additional staff to render the unit operational.

The main objectives of the committee are the management of the website (Publications management, Shared calendar ...) and the analysis of CBHI data (management of database)

During its first 2 meetings, the editorial committee has drafted its ToR to be submitted to the Technical Working Group for approval, and held a brainstorming about the improvement of the Database (Format and Content).

The technical aspects of the CBHI database and web application are supported by MSH/IHSSP.

The CTAMS and Partners Extended Team (ET) encountered challenges to go on functioning because of the closure of the TWUBAKANE project. This resulted in the disappearance of technical assistants for 16 districts, and in the reform of CTAMS, where the key members of the ET have been suspended.

The reform at the district level (with changes of persons in charge of CBHI) made data collection difficult for many of the districts. To overcome this challenge, IHSSP proposed to cover the districts without Focal Points (Technical Assistants) with MSH staff; this is an interim solution and will be completely resolved after the recruitment of CTAMS Staff and the identification by the MoH of the districts where IHSSP will be working.

Training in Database management & data collection for the new staff recruited at different districts is planned in May, 2010.

On request of the CTAMS/MOH, the project will propose a CBHI appropriate accounting system which will be in compliance with the national accounting system and will propose a mechanism to reinforce the organizational structures. For that purpose the project is conducting an assessment to identify gaps in administrative, financial and accounting management as well as in the functionality of organizational structures. The assessment is conducted in 4 districts chosen by CTAMS and is currently taking place. End date is foreseen for the end of April, 2010.

Decentralization

Activities conducted by Decentralization team:

- IHSSP work plan: Planning and budgeting of Decentralization component work plan has been done
- Recruitment of new staff: Developed job descriptions for District Capacity Development Coordinator, Community Mobilization specialist; interviews process for the two positions have been conducted.
- TA to the District: Assisted Districts/ PBF steering committee (Huye, Nyanza, Gicumbi and Musanze districts) in Health Center quantity and quality Evaluation for Q4 2009 and Q1 2010,
- Participated in PBF Framework review process (workshops)
- Technical assistance in preparation of PBF steering committee meetings for Huye, Nyanza, Gicumbi and Musanze districts
- Assisted MOH/CTAMS in M&E of Mutuelle de sante activities for Huye,Nyanza, Burera,Gicumbi and Musanze Districts
- Participated in District Hospital Evaluation for Q4 2009.
- TA to MOH:
    - District Health Facility supervisory workshop: decentralization team assisted the MOH/decentralization task force to conduct the District Health Facility supervisory workshop. This workshop aims to develop tools to be used in the health facility (= district

hospitals) integrated supervision approach. The decentralization was deeply involved in order to prepare the start-up of the planned activities being the TA needed for the District Health Steering Committee in establishing coordination mechanisms for a new integrated supervision approach.

- Community PBF: Decentralization team assisted MOH through District hospital to conduct training of staff in charge of Community PBF for Nyanza District/Southern Province. The decentralization team participated actively in Community PBF refresher sessions held in March 2010.
- Participated in the monthly extended team meeting of PBF and Mutuelle de santé

Human resources for Health

Activities conducted by Human Resource team:

- The main activity for this quarter consisted to design the HSS Framework for Human Resources for Health component. We also finalized our activity planning taking into account the feedback received from the COTR.
- We developed the job descriptions of persons to be hired for the HRH component and proceeded with the recruitment of a Leadership and Management Specialist.
- We participated in the review of the model and indicators of PBF from 9 to 12/01/2010.
- In collaboration with the Ministry of Health, WHO and the Human Resources for Health Technical Working Group, we have organized consultancy activities for a situational analysis for HRH.
  From 9 /03 to 18/03/2010, we assisted the consultant recruited by IHSSP for situational analysis of the HRH. The work of this consultant was focused on Human Resources Management while consultants hired by WHO assessed the Human Resource Information System aspect. We visited four district hospitals and 2 health centers and conducted interviews with hospital managers and HR managers to better understand the situation of human resources management. The report was submitted on 18/03/2010 at the Human Resources for the Health Technical Working Group during its meeting held on 18/03/2010.

Quality Improvement

The QI team participated in the workshop to review the DH PBF quarterly evaluation tool. Input was given with respect to concept of tool (removal of quantity indicators) and choice of indicators. Elements were added in some areas like finance, Human Resource and infrastructure management.

As part of the process to strengthen the supervisory system, a workshop, with as main objective the development of the supervision tool for district hospitals, was conducted. Input was sought from supervisors from the referral hospitals (CHUK, CHUB), from Kanombe military hospital and form partners involved in quality improvement. This took place at Nyandungu, 33 participants attended. Valuable contributions were given towards the development of a realistic, comprehensive and standardized supervision tool reflecting the objective of maintaining the concept of *formative* supervision. The workshop concluded with the recommendations that a task team composed of specialists from obstetrics, internal Medicine, pediatrics and surgical departments both from CHUB and CHUK should have extra work sessions to finalize the tool where after a 1-day validation workshop can be organized.

Next steps and challenges

Now that most of the activities have been approved, the project is moving towards full implementation of FY09 work plan. Highlights for next quarter will be:

- Continue to Assist the MOH with the development of a Health Systems Strengthening strategic plan
- Conduct PRISM assessment to identify current practice and barriers to data use
- Develop HMIS data use guidelines for community-based HMIS as well as for hospital and health centre HMIS
- Conduct trainings for community health workers on RapidSMS and mUbuzima community information systems
- Support computerization and rollout of Community Health Information System (SISCom), linking it with phone-based reporting system and PBF web application
- Assist the GoR in implementing the CBHI policy and the establishment of the organizational structures
- Provide TA to MoH to strengthen the national PBF model for HC, DH in all districts and National referral Hospitals
- Assist the GoR in strengthening PBF organizational structures
- Training on Data analysis & Use for PBF & CBHI extended team members
- Review and update the supervision tools to incorporate the feedback and input of MOH services and other stakeholders.
- Facilitate the dissemination and communication of MOH National Norms and Standards
- Develop a strategic framework for the accreditation program
- Propose accreditation structure to support accreditation program
- Organize an orientation meeting for the local government authorities on IHSSP interventions at national level
- Facilitate the organization of a meeting with MOH to clarify governance structures between central and decentralized units

- In collaboration with RALGA and other partners provide training of District authorities on planning, M&E and data use for health interventions in IMIHIGO elaboration process
- Development of RDT policy and guidelines, starting with an operational comparison of alternative RDTs at the community level, supervision of CHW

Annexes

Health System Strengthening strategic plan Workshop MoH: Draft Agenda

Time	Activities	Presenter/ Facilitator	Materials
8:30 – 9:00	1) Welcome, Workshop Objectives a) Why? b) Expected product (HSS strategic plan) c) Program for the day	Yogesh/Kathy	Ppt with objectives and program
9:00-9:15	2) Overview of document structure	Randy	Copy of Table of contents, LCD projection of document
9:15-10:00	3) Overview of issues a) Objective of HSS framework/revised framework b) How well do strategies relate to HSSP-II goals and objectives?	Randy/Yogesh	PPT
10:00-10:30	4) Plenary discussion topics: a) Prioritization: necessary and if yes, which criteria b)	Randy	Flip charts and markers
10:30-10:45	Coffee Break		
10:45-11:15	5) Small group work: Interactive facilitator overview (small ppt by each responsible of each building block) a) Which strategic plans and policies exist b) Context (situational analysis: progress and gaps) c) Vision of the building block d) Strategies and objectives	Team leaders	PPT by Building block Copies of relevant documents for each work group
11:15-13:00	6) Small Group work: Review strategic intervention table	Groups	Projector for each group

	a) Current status i) Budget gaps? ii) Implementation gaps: Barriers to progress/constraints iii) Timing: (1) According to time frame (on track?) (2) Timing realistic? (3) Sequencing of interventions? (4) Prioritization b) new interventions needed? (because missing or because new priorities) c) Alignment with HSSP-II? i) Code each strategic intervention with the appropriate HSSP-II objective which it supports ii) Note if any do not support HSPP-II		
1:00-2:00	Lunch break		
2:00-3:00	7) Plenary: a) Report back from groups		Flip charts, projector
3:00-4:00	b) Cross cutting themes: i) What is needed to operationalize your strategic plans? ii) Missing dependencies between plans? c) Next steps d) Closing remarks	Randy Randy Kathy/Yogesh	Flip charts and markers

Revised HIV-indicators for health center PBF-model

Indicateur	***Définition***	***Outil principal de Collecte des Données***	***Outil secondaire de Collecte des Données***
1. VCT : Nombre de clients testés pour le VIH	Nombre de personnes testées pour le VIH au cours du mois dans le cadre du service VCT. Le test VCT est fait dans une institution sanitaire avec les normes respectées.	**Outil principal**: Registre de conseiller VCT	**Outil secondaire** Registre de laboratoire
2. PIT : Nombre de clients testés pour le VIH à travers le PIT.	Nombre de cas testés pour le VIH au cours du mois dans le cadre des services PIT	**Outil principal**: Registre de PIT	**Outil secondaire:** Registre de laboratoire
3. PMTCT : Nombre de partenaires des femmes enceintes testés pour le VIH	Nombre de partenaires testés pour le VIH au cours du mois dans le cadre des services PMTCT ayant reçu le résultat.	**Outil principal**: Registre de conseiller PMTCT	**Outil secondaire:** Registre de laboratoire
4. PMTCT : Nombre de femmes[1] VIH+ recevant traitement ARV trithérapie	Nombre de femmes VIH+ traités à la prophylaxie ARV trithérapie au cours du mois selon le protocole national dans le cadre du service PMTCT.	**Outil principal**: Registre de conseiller PMTCT	**Outils secondaires:** Registre de suivi des femmes PMTCT Registre de suivi des enfants PMTCT
5. PMTCT: Nombre d'enfants exposés testés pour VIH à 6 semaines	Nombre d'enfants nés de mère VIH+ testés pour le VIH (au PCR à 6-8 semaines) ayant reçu le résultat au cours du mois.	**Outil principal**: Registre de suivi des enfants en PMTCT	**Outil secondaire:** Registre de laboratoire
6. PMTCT: Nombre d'enfants exposés testés VIH-négatif à18 mois	Nombre d'enfants nés de mère VIH+ testés VIH-négatif à18 mois au cours du mois.	**Outil principal**: Registre de suivi des enfants en PMTCT	**Outil secondaire:** Registre de laboratoire
7. ARV: Nombre de nouveaux patients adultes traités aux ARV	Nombre d'adultes VIH+ (≥ 15 ans) qui ont commencé un traitement ARV au cours du mois, **exclus transférés-in**	**Outil principal**: Registre ARV & Pre-ARV	**Outil secondaire:** Dossier individuel du patient

[1] Y inclus femmes des couples discordants

Indicateur	***Définition***	***Outil principal de Collecte des Données***	***Outil secondaire de Collecte des Données***
8. ARV: Nombre de nouveaux patients pédiatriques traités aux ARV	Nombre d'enfants VIH+ (< 15 ans) qui ont commencé un traitement ARV au cours du mois, **exclus transférés-in**		
9. ARV : Nombre de personnes sous ARV en vie après 12 mois	Nombre de personnes VIH+ sous ARV qui sont en vie 12 mois après début traitement ARV.	**Outil principal**: Registre des ARV	**Outil secondaire:** Dossier individuel du patient
10. ARV : Nombre de personnes sous ARV en vie après 24 mois	Nombre de personnes VIH+ sous ARV qui sont en vie 24 mois après début traitement ARV.		
11. VIH prévention: Nombre de femmes VIH+ qui utilisent la PF	Nombre de femmes VIH+ inscrites qui utilisent une méthode de planification familiale (pilule, injectable, DIU, implant, méthode des jours/collier*) au cours du mois	**Outil principal**: Registre de PF/PMTCT **Outil secondaire:** Registre général de PF (MINISANTE)	
12. VIH/TB: Nombre de patients VIH+ qui ont étés examinés pour TB	Nombre de personnes (enfant et adultes) VIH+ examinées pour le dépistage de la TB au cours du mois. NB: Preuve de résultats d'une série de trois crachats avec preuve de screening avec questionnaire TB.	***Si site ARV :*** **Outil principal**: Registre pré-ARV et ARV couplé au registre de laboratoire TB ***Si site Non ARV :*** **Outil principal**: Registre PT et registres de counseling couplés au registre TB de laboratoire	**Outil secondaire:** Questionnaire de screening TB **Outil secondaire:** Questionnaire de screening TB dans le dossier médical ou PT (preventif/therapeutic) du patient

Revised DH quality evaluation tool (by central level)

The next pages display the tool (first page of every *"volet"*) used for evaluation of district hospitals by central level. It will be updated for every evaluation while a certain set of basic key indicators will be retained for monitoring purposes.

CAAC

CELLULE D'APPUI A L'APPROCHE CONTRACTUELLE

GRILLE D'EVALUATION TRIMESTRIELLE DES HOPITAUX DE DISTRICT		
Nom Hôpital		
Période d'évaluation Année		
Période d'évaluation Trimestre		
Date d'évaluation		
EVALUATION TRIMESTRIELLE DES HOPITAUX DE DISTRICT: Score total de qualite		
VOLET I : FONCTIONNEMENT		Score de qualite
1.1. ACTIVITES DU COMITE DE GESTION		
1.2 GESTION DES RESSOURCES HUMAINES & RENFORCEMENTS DES CAPACITES		
1.3. GESTION DES MEDICAMENTS, CONSOMMABLES ET VACCINS		
1.4 GESTION DES EQUIPEMENTS & INFRASTRUCTURES		
1.5. ACTIVITES D'EVALUATION & ARCHIVAGE		
1.6 HYGIENE		
TOTAL		
Recommandations résumé		

VOLET II: 2.1 ENCADREMENT CENTRES DE SANTE	Score de qualite
Score total (2.1.1 - 2.1.9)	
Recommandations résumé	

VOLET IIIA: ACTIVITES CLINIQUES patient	Score de qualite
3.1. PRISE EN CHARGE DES PATIENTS SELON DOSSIER MEDICAL	
3.1.1 Consultations de référence par le médecin	
3.1.2 Consultations ordinaires	
3.1.3 Hospitalisations	
3.1.4 Maternité	
3.2. PRISE EN CHARGE DES PATIENTS SELON OBSERVATION DANS L'HOSPITALISATION	
3.2.1 Suivi paramedical du malade en hospitalisation	
3.2.2 Infection postopératoire	
3.2.3 Imagerie (Radiologie)	
VOLET IIIA : ACTIVITES CLINIQUES Patients: Score de qualité Total	
Recommandations résumé	

VOLET IIIB: ACTIVITES CLINIQUES infrastructure et plateau technique	Score de qualite
3.3 Infrastructure et plateau technique	
3.4 Imagerie, examens complémentaires et protocoles	
VOLET IIIA : ACTIVITES CLINIQUES infrastructure et plateau technique: Score de qualité Total	
Recommandations résumé	

	Budget disponible par trimestre pour hôpital concerné	**RWF -**	
	EVALUATION TRIMESTRIELLE DES HOPITAUX DE DISTRICT: Score total de Qualité		
Weight	**VOLET**	**Rwf**	**Score de Qualité**
30%	**Volet 1: Fonctionnement**		
20%	**Volet 2: Encadrement**		
50%	**Volet 3: Activités cliniques**		

REVENUE TOTAL CETTE TRIMESTRE		

Nom et function et Signature	**Date approuvé**

GRILLE D'EVALUATION TRIMESTRIELLE DES HOPITAUX DE DISTRICT

VOLET I : FONCTIONNEMENT

No	Code	Sujet	Indicateur	Critères de validation	Non=0 Oui=1 (M = mois)			Indication pour la cotation	Max.	Total de points	%
									200		
		1.1. ACTIVITES DU COMITE DE GESTION			**M1**	**M2**	**M3**		**58**		
1	1.1.1.	Evaluation de l'exécution des activités du plan trimestriel (y compris les activités d'encadrement envers les centres de santé et la communauté)	Rapport d'exécution du plan d'action trimestriel	(1) Existence du plan d'action trimestriel opérationnel transmis au conseil d'administration et respectant le canevas officiel				Rapport remplissant les 4 critères= 8 Même un critère non rempli =0	**8**		
				(2) Basé sur un plan d'action annuel							
				(3) au moins 80 % d'activités planifiées réalisées dans le délai prevu							
				(4) Moyens de vérification disponibles (tirer 3 activites realisees au hasard , regarder leur moyens de verification)							
2	1.1.2	Saisie des données SIS	Rapports mensuels de données SIS de l'hôpital et des centres de santé sous forme de fichier électronique saisies dans la base de données SIS.	Complétude des données SIS tel que fournie par le Ministère de la santé				Complétude à 100 % des toutes les Fosas à la fin de 2 premiers mois du trimestre évalué = 10 complétude Inferieure à 100% meme pour un CS =0	**10**		
3	1.1.3.	Analyse de données SIS	Rapports mensuels d'analyse de données SIS de l'hôpital	Rapports mensuels d'analyse des données SIS contenant:				1 rapport complet=5; Un élément du rapport manque =0	**15**		
				(1) une analyse de la qualité des données des rapports SIS des services de l'hôpital (Chaque analyse sous forme de graphique continu (courbe) des indicateurs sous mentionnés de l'année en cours affichés dans les services concernés):							
				(1)a) Pour chaque service d'hospitalisation: morbidité (pour les 5 premieres causes) et mortalité, occupation des lits, durée moyenne de séjour							
				(1)b) Distribution des cas (GBV violence sexuelle),bloc op, imagerie médicale, kinesithepie,dentisterie et labo)							
				(2) PV de réunion de discussions des données SIS							
				(2)(a) Commentaires/ conclusion pour chaque indicateur							
				(2)(b) stratégies/ recommandations si necessaires							
				(3) liste de présences signées							

VOLET II : ENCADREMENT DES CENTRES DE SANTE									295	
No	**Code**	**Sujet**	**Indicateur**	**Critères de validation**	**Non (=0); Oui (=1)**			**Indication pour la cotation**	**Max.**	**Total de points**
		2.1 ENCADREMENT CENTRES DE SANTE			**M1**	**M2**	**M3**		**%**	
23	2.1.1	Evaluation trimestrielle de la qualité	Promptitude de la transmission des resultats de l'évaluation	1) Accusé de réception de la lettre de transmission adressée au district des scores de qualité du trimestre précédent du trimestre évalué (sceau pour réception) endéans les 28 premiers jours du mois suivant le trimestre évalué				Transmission dans le délai et tableau synthétique annexe Un critère non rempli = 0	37	
				2) Annexer à la lettre de transmission le tableau synthétique des résultats trimestriels de la qualité des activités de chaque CS, signé par le Médecin Directeur de l'hôpital						
24	2.1.2	Evaluation trimestrielle de la qualité	Plan d'évaluation	1) Plan d'évaluation mensuelle de la qualité des CS transmis au district (avec accusé de réception, sceau pour réception du district) avant le 5 du mois en cours				Par plan remplissant critères = 4 points	12	
25	2.1.3	Evaluation trimestrielle de la qualité	Nombre de centres de santé évalués	Evaluations propres des CS: Les prochains critères doivent être remplis: (Mettez le % dans la case à coté (1) et (2)				Critères respectés pour 100% des services= 40 75-99% =30 50-74% =20 25-49% =10 <25% =0 N.B : Le denominateur est la somme des activites disponibles par CS pour critere (1) et (2)	40	
				1) Disponibilité de la copie de la grille trimestrielle de la qualité par CS (Mettez % dans la case à coté)						
				2) completement et correctement remplie pour les activites disponibles parmi les 14 (Mettez % dans la case à coté)						
26	2.1.4	Supervision des centres de santé	Planification et rapports de supervision des centres de santé	Les prochains critères doivent être remplis:				Proportion de rapports remplissant les 5 criteres pour 100% des supervisions identifiees = 52 75-99% =39 50-74% =26 25-49% =13 <25% = 0 NB:Le denominateur est le nombre des supervisions identifiees tel que decrit en (1) plan trimesteriel …	52	
				1) Plan trimestriel de supervision partant des recommandations pour supervision relevées lors des évaluations qualité du trimestre précédent et de l'analyse SIS						
				2) Rapport de supervision technique contenant: (Mettez % dans les cases (a)-(e) à coté)						
				(a) Justification de la supervision						
				(b) Methodologies ou techniques utilisees						
				(c) Etat de mise en execution des recommandations de la supervision precedente						
				(d) Description des actions menees ou constats durant la supervision avec identification des points forts et points faibles						
				(e) Recommandations						

VOLET III A : ACTIVITES CLINIQUES Patients					Remplissez avec 0 (=non) ou 1 (=oui)															
No	Code	Sujet/ source	Indicateur	Critères de validation	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total
				3.1. PRISE EN CHARGE DES PATIENTS SELON DOSSIER MEDICAL																
	3.1.1 CONSULTATIONS DE REFERENCE PAR LE MEDECIN **# de cas consideres pour echantillonage de 15 cas va concerner les indicateurs 32-33-34. Tirez au hasard (=chaque x-ième dossier; x est défini par total de prestations divisé par 15; point de départ est aléatoire) dans le registre concerné UN TOTAL DE 15 CAS**																			
32	3.1.1.1	Sujet: Consultations de référence de **femmes enceintes** Source: registre de consulation médicale de femmes enceintes où toutes les femmes référées sont identifiées	Proportion de consultations de réference prise en charge selon les normes	1) Fiche de consultation médicale contenant: a) Identification du patient (nom, prénom, âge, secteur, cellule																
				1b) Date de la consultation																
				1c) Nom et signature du médecin																
				1d) Anamnèse (plaintes et antécédents)																
				1e) Examen clinique: Signes vitaux (TA, pouls, T0, FR, poids, taille), inspection, examen clinique des systèmes affectés																
				1f) Diagnostic provisoire et différentiel																
				1g) Examens complémentaires avec résultats selon le diagnostic provisoire, différentiel et les protocoles																
				1h) Traitement selon le protocole ou référence																
				(2) Fiche de référence des femmes enceintes disponible																
				(3) Fiche de contre-référence signée par le médecin avec accusé de réception du CS (résultats/ observations significatifs, diagnostic, traitement reçu/interventions suivies, recommandations/ traitement à suivre)																
	total pour **femmes enceintes** (1 si chaque critère est respecté pour un dossier, 0 si déjà 1 des critères n'est pas respecté)																			
33	3.1.1.2	Sujet: **Planning familial chirurgical**	Proportion de ligatures tubaires et vasectomies selon les normes	(1) Protocole opératoire détaillé et bien décrit, signé par le médecin dans le dossier du patient																
				(2) Lettre de consentement signée conjointement par le couple																
	total pour **Planning familial chirurgical** (1 si chaque critère est respecté pour un dossier, 0 si déjà 1 des critères n'est pas respecté)																			
34	3.1.1.3	Sujet: Consultations des autres **cas référés** exclus les consultations de femmes enceintes Source: registre de consultation médicale où tous les cas référés sont identifiés	Proportion de consultations de référence prise en charge selon les normes	1) Fiche de consultation médicale contenant: a) Identification du patient (nom, prénom, âge, secteur, cellule																
				1b) Date de la consultation																
				1c) Nom et signature du médecin																
				1d) Anamnèse (plaintes et antécédents)																
				1e) Examen clinique: Signes vitaux (TA, pouls, T0, FR, poids, taille), inspection, examen clinique des systèmes affectés																
				1f) Diagnostic provisoire et différentiel																
				1g) Examens complémentaires avec résultats selon le diagnostic provisoire, différentiel et les protocoles																
				1h) Traitement selon le protocole ou référence																
				(2) Fiche de référence des cas référés disponible																
				(3) Fiche de contre-référence signée par le médecin avec accusé de réception du CS (résultats/ observations significatifs, diagnostic, traitement reçu/interventions suivies, recommandations/ traitement à suivre)																
	total pour **cas référés** (1 si chaque critère est respecté pour un dossier, 0 si déjà 1 des critères n'est pas respecté)																			
	3.1.1 TOTAL POUR REFERENCES par dossier																			

VOLET III B : ACTIVITES CLINIQUES Infrastructure et plateau technique

No	Code	Sujet/ source	Indicateur	Critères de validation	Non (=0); Oui (=1)	Indication pour la cotation	Max.	Total de points	%
				3.3 INFRASTRUCTURE ET PLATEAU TECHNIQUE			**60**		
53	3.3.1	Infrastructure	Salle d'urgence (existence et fonctionnement)	Existence de la salle d'urgence contenant:		Salle ayant tous les matériaux = 10 Même un matériel manque = 0	**10**		
				Obus d'oxygène					
				Aspirateur					
				Laryngoscope					
				Matériel d'intubation					
				Matériel de perfusion					
				Médicaments d'urgence (Diurétique, cardiotonique, corticoïdes, vaso-dilatants, matériel de pansement, insuline, broncho-dilateurs, infusion (glucose, ringer-lactate, physiologique, glycose hypertonique), adrenaline)					
				Médicaments d'urgence (voir liste)					
				Matériel de prélèvement					
				Sonde naso-gastrique					
				Sonde vésicale					
54	3.3.2	Infrastructure	Infrastructure bloc opératoire	(1) Existence de 2 blocs opératoires:		(1) 2 blocs = 3 points (2) Salle ayant tous les matériaux = 7 Même un matériel manque = 0	**10**		
				(2) Matériel suivant disponible et fonctionnel					
				Éclairage opératoire mobile					
				Éclairage opératoire plafonne					
				2 boites césariennes complètes selon les normes					
				2 boites laparotomies complètes selon les normes					
				1 appareil d'anesthésie en bon état et fonctionnel					
				1 aspirateur					
				Obus d'oxygène					
				Laryngoscope					
				Matériel d'intubation					
				Matériel de perfusion					
				Médicaments d'urgence (voir liste)					
				Matériel de prélèvement					
				Sonde naso-gastrique					
				Sonde vésicale					
55	3.3.3	Infrastructure	Infrastructure Imagerie	Infrastructure d'imagerie avec les éléments suivants:		Imagerie ayant tous les matériaux = 10 Même un matériel manque = 0	**10**		
				Jeu des cadres pour filmes RX selon les normes					
				Jeu des cassettes selon les normes					
				1 pair de gants en plombs					
				2 tabliers en plomb					
				1 paravent plombier					
				1 support mural pour tablier en plomb					
				1 négatoscope					
				1 salle noire pour développement du film					
				1 appareil de radiologie en bon état et fonctionnel					
				1 échographe en bon état et fonctionnel					
56	3.3.4	Infrastructure	Infrastructure Salle d'accouchement	Infrastructure de salle d'accouchement selon les normes contenant:		Salle d'accouchement ayant tous les matériaux = 10 Même un matériel manque = 0	**10**		
				ambu bébé					
				table de réanimation avec chauffage, lumière et chronomètre					
				aspirateur					
				sonde naso-gastrique					
				obus d'oxygène					
				manomètre					
				humidificateur					
				sonde oxygène					
57	3.3.5	Plateau technique	Plateau technique plannification familiale	Plateau technique plannification familiale complète		Chaque service PF disponible: 10 Un service manque: 0	**10**		
				vasectomie					
				ligature des trompes					
				diapositif intra-utérin					
58	3.3.6	Plateau technique	Plateau technique labo	Labo avec testes suivantes effectués:		Chaque service labo disponible: 10 Un service manque: 0 (Pour chaque teste, il faut avoir un résultat disponible au cours de la semaine passe (simule testes effectués) (a contrôler dans les registres de labo)	**10**		
				GE					
				crachat					
				Malaria Rapid Test					
				Malaria Smear (Microscope)					
				Gram Stain					
				HIV Rapid Test					
				VDRL or RPR pour Syphillis					
				TB Stains [Ziel-Nielson]					
				Dipstick pour Proteinurie					
				Hemoglobine					
				Blood Count [platelets, white blood cells/lymphocytes]					
				Blood Glucose Level					
				Teste hepatiques					
				Metabolic Panel [Creatinine, Blood Urea Nitrogen]					
				CD4 Count					
				3.4 IMAGERIE, EXAMENS COMPLEMENTAIRES et PROTOCOLES			**30**		
59	3.4.1	Contrôle de qualité de gouttes épaisses	% de concordance de la qualité de G.E. réalisées	Contrôle de qualité par le laboratoire national de référence effectué au cours du trimestre ≥ à 95% de résultats corrects (Mettez le % EXACT dans la case à coté)		Si contrôle ≥ 95%: 10 Si < 95%: 0	**10**		
60	3.4.2	Contrôle de qualité de crachats	% de concordance de la qualité d'examens de dépistage ou de contrôle TBC	Contrôle de qualité par le laboratoire national de référence effectué au cours du trimestre ≥ 95% de résultats corrects (Mettez le % EXACT dans la case à coté)		Si contrôle ≥ 95%: 10 Si < 95%: 0	**10**		
61	3.4.3	Documentation de la prise en charge	Disponibilite des protocoles et schémas thérapeutiques	Disponibilité de (1) Protocoles nationaux (paludisme, méningite, maladies diarrhéiques, TBC, réhabilitation nutritionnelle)		2 critères remplis: 10 1 critère manque: 0	**10**		
				(2) Schémas thérapeutiques avec référence là où il n'existe pas de protocole national (HTA, urgences médicales, fièvre typhoïde, pneumonie, diabète, choc, coma)					
				TOTAL Infrastructure et plateau technique			**90**		

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