



Health Systems Strengthening in Guinea: End of Project Report

01 March 2016 - 30 June 2018



Comprehensive Approach to Health Systems Management in Action: District Management Teams discuss management roles and responsibilities (left) and identify local resources for addressing priority problems (right)

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Jhpiego

The Maternal and Child Survival Program (MCSP) is a global, \$560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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Country Summary

Unveiling of the Gold Star for high quality services at the recognition ceremony for CSU Manquepas, Kindia



Coverage Area:

National level and 20 prefectures across four regions: Boke, Conakry, Kindia and Nzérékoré (plus Kissidougou prefecture)

Selected Health and Demographic Data for Guinea	
Population (1)	12,396,000
Live births/year (1)	447,000
Maternal Mortality Rate (per 100,000 live births) (2)	550
Newborn Mortality Rate (per 1,000 live births) (2)	20
Skilled attendance at birth (2)	62.7%
Contraceptive Prevalence Rate (modern and traditional methods) (2)	8.7%

Source: (1) 2016, Countdown to 2030 country profile, <http://profiles.countdown2030.org/#/cp/GIN>; (2) MICS 2016

Program Goal and Objectives

With the goal to strengthen health systems with a focus on the prefecture level to ensure the availability of sustainable and high-quality functioning of reproductive, maternal, newborn, and child health (RMNCH) services, MCSP worked to ensure:

- Key MOH policies and strategies are updated and disseminated
- Capacity of MOH coordination mechanisms to manage and guide health sector resources and functioning is increased
- Increased capacity of 20 prefectures to monitor and manage high impact interventions to reduce maternal, newborn and child mortality and morbidity
- Improved waste management at MOH facilities



Program Dates	March 1, 2016- June 30, 2018		
Funding	Total Mission Funding to Date		Total Core Funding to Date by Area
	NA		\$2.750,000 (Ebola response and recovery funding, Pillar 2)
Geographic Coverage	No. (%) of provinces	No. (%) of districts	No. (%) of facilities or communities
	4 of 8 regions (50%)	20 of 38 (53%)	NA
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Technical Interventions	  <p>PRIMARY: Health Systems Strengthening; Water, Sanitation, and Hygiene (IPC and Waste management) OTHER: Quality Improvement; Health Management Information Systems (Measurement and Data Use)</p>		

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Acronyms and Abbreviations

BSD	Office of Strategy and Development (<i>Bureau de santé et Développement</i> in French)
CA	Comprehensive Approach to Health System Strengthening (AIGSS in French)
CHS	Hygiene and Safety Committee (<i>Comité d'hygiène et de sécurité</i> in French)
COSAH	Community Health Committee (<i>Comité de santé et d'hygiène</i> in French)
CMC	Communal Medical center
CRS	Catholic Relief Services
CSR / CSU	Rural Health center / Urban health center (<i>Centres de santé rurale/ urbaines</i>)
CT/CTS	Technical Counselor/ Senior technical advisor (<i>Conseiller technique/Senior Conseiller technique</i>)
DCS	Communal health directorate (<i>direction communale de la santé</i>)
DHIS2	District health information system version 2
DMR	Director of micro realizations
DNEHS	National Directorate of Hospital and Healthcare Facilities
DPS	Prefectural health directorate
DRS/ DSVC _o	Regional Health Directorate / Health Directorate of the city of Conakry (<i>Direction regional de la santé/Direction regional de la santé de la ville de Conakry</i>)
ECD	District health management team (<i>Equipe cadre de district</i> in French)
EmONC	Emergency Obstetric and Neonatal Care
FP	Family Planning
GIZ	German development assistance program
HN/HR	National Hospital/ Regional Hospital (<i>Hôpital national/ hôpital régional</i>)
HSD	Health Service Delivery
HMIS	Health Management Information (<i>Système National d'Information Sanitaire, SNIS</i> , in French)
HSS	Health Systems Strengthening
IMC	International Medical Corps
IPC	Infection Prevention and Control
MCSP	Maternal and Child Survival Program
MOH	Ministry of Health
OFDA	USAID's Office of Foreign Disaster Assistance
PASA	European Union-funded Health Sector Support project (<i>Projet d'appui a la Santé</i>)
R4D	Results for Development
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBM R	Standards-based Management and Recognition
TDH	Terre des Hommes
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Acknowledgements

This report of the results of the USAID-funded MCSP / HSS project in Guinea, implemented from March 2016 to June 2018, is the result of a multidisciplinary collaboration between the Ministry of Health, the Ministry of Territorial Administration and Decentralization, and MCSP consortium partners Jhpiego and R4D.

We would like to thank the Ministry of Health, and particularly the Office of Strategy and Development (BSD), for its engagement and the excellent collaboration of the central administration, the health facility staff, and especially the district and regional management teams who have accepted to put themselves to the test for the improvement of the health system.

It is worth mentioning the particularly important contribution of the National Director of Hospitals and Health Service Hygiene, the Director of the BSD, and the Secretary General of the Ministry of Health, who provided their technical and management support.

We would also like to express our gratitude to the Jhpiego Guinea Country Director and her staff for hosting the MCSP Guinea / HSS project and for the countless efforts made to achieve the objectives of the project.

We cannot conclude without expressing our sincere thanks to the people and the American Government through USAID for their financial and technical support that allowed the implementation of the activities of the MCSP Guinea / HSS project aimed essentially at strengthening the Guinean health system.

Executive Summary

The Guinean health system is characterized by a lack of coordination of interventions and stakeholders, weakness in the mobilization of resources and insufficient monitoring and evaluation of the implementation process of activities in management and healthcare facilities. In addition, the waste management system and infrastructures are obsolete and are still not adapted to international standards; the lack of motivation of the staff often plays a role in the advent of serious adverse events related to the provision of care, which are some of the main causes of morbidity and mortality attributable to medical care. The Ebola Virus disease epidemic in 2014 and 2015 made these weaknesses even more apparent.

To overcome these shortcomings, the USAID-funded MCSP Guinea/HSS project supported the Ministry of Health in strengthening the healthcare system through strengthening health information management; improving the quality of services; introducing a comprehensive approach to health systems management; and reinforcing infection prevention and control in healthcare facilities across 20 prefectures in the regions of Boké, Conakry, Kindia and N'zérékoré.

The Maternal and Child Survival Program (MCSP) is a global program funded by USAID aiming to introduce and promote high-impact interventions in 25 priority countries. In response to the Ebola epidemic, MCSP was well placed to support the post-epidemic recovery in the affected countries. In Guinea, two complementary projects were implemented to support recovery of health services and systems: MCSP Restoration of Health Services (RHS) from June 2015 to December 2016 and MCSP Health System Strengthening (HSS) from March 2016 to December 2017, with an extension until June 2018. This report reviews the accomplishments of the MCSP Guinea HSS project.

Goal and Objectives:

The goal of the MCSP Guinea/HSS project was to strengthen the healthcare system specifically at the district level, with a focus on maternal, neonatal and infant health services in the four regions covered by the project (Boke, Kindia, N'zérékoré and the city of Conakry). The specific objectives to achieve this included:

- Increased coverage and utilization of high-impact reproductive, maternal, newborn, and child health (RMNCH) interventions and innovative new approaches
- Strengthen capacity of the MOH to manage and scale up high-impact RMNCH interventions
- Institutionalize and integrate Infection Prevention and Control (IPC) protocols into the routine RMNCH package

To accomplish this, the MCSP project focused on a set of activities at the national level that included policy development, improving coordination, and strengthening the health information system. These national level activities linked closely with another set of activities focused on the regional and prefectural level that focused on building management capacity and reinforcing the use of quality assurance methods and tools. Key accomplishments to realize this goal and objectives include:

Development/revision of IPC policy documents and their integration into RMNCH services

To continue the momentum regarding IPC that was created by the EVD epidemic and post epidemic recovery of services, MCSP Guinea/HSS supported printing costs and orientations sessions for the dissemination of IPC policy documents which included standards and procedures and a monitoring framework. To assist health schools to integrate the new IPC policy, the project supported the development of the IPC curriculum and detailed plans to integrate IPC into pre-service education of nurses, midwives and doctors. The project also successfully advocated for the integration of IPC specifications in the revised and validated reproductive health norms and protocols.

Under the auspices of the Ministry of Health, the MCSP Guinea/HSS project provided technical support to the IPC cluster (WHO, MCSP, Expertise France, CRS and others) in the development of an advocacy document for the Ministry of Health for the sustainability of the achievements made in IPC.

Implement the Comprehensive Approach to Health System Strengthening (AIGSS) at the health district level

A rapid situational analysis according to the six determinants of the healthcare system helped to identify strengths and limitations in order to tailor capacity building of health managers. This was followed by implementation of the Comprehensive Approach to Health Systems Strengthening (AIGSS) for 20 district health teams (ECDs) to identify and analyze challenges, their root causes, and local resources to leverage and the integration of corrective actions into district teams' annual work plans. Building on the districts' action plans, MCSP Guinea/HSS provided capacity building of 22 ECDs on stakeholder engagement, communication, and resource mobilization, resulting in 104 funding requests drafted, 84 submitted, and 43 funded across all districts.

MCSP Guinea/HSS achieved institutionalization of AIGSS through the integration of the tools into the national guidance for annual planning at all levels of the health system (national, regional, district, and facility). This was done at the request of and in close collaboration with the Bureau of Strategy and Development of the MOH (BSD).

Improvement of healthcare service quality through the Standards Based Management and Recognition (SBM-R) approach to quality improvement

Building on the MCSP Guinea/RHS project's work to reinvigorate this quality improvement approach in facilities, MCSP Guinea/HSS worked at the national and regional levels to reinvigorate the external monitoring components of SBM-R. Monitoring of 35 SBM-R sites in the focus regions along with nine validation assessments led to eight facilities successfully validated for recognition of good quality performance; including three earning a second recognition level developed by the project. Financial and technical support for six recognition ceremonies was provided; including obtaining donations from partners and communities. Overall, of 30 facilities assessed at the end of the project, 50% were performing at the minimum desired level according to the MOH (75-85% depending on domain).

Similar to the decline in performance in facilities during the EVD epidemic, the national SBM-R committee also was not functioning well by the end of the epidemic. MCSP Guinea/HSS advocated with MOH to reinvigorate the functioning of the national SBM-R committee, and also engaged at the national level on the review and prioritization of Quality Assurance methods and tools in use in Guinea. The issue of the national committee was not entirely resolved by the end of the project, but was an ongoing point of discussion with all partners engaged in QI/QA. Similarly, to reinvigorate regional and prefectural supervisors' use of SBM-R, 21 supervisors were trained on coaching and monitoring using SBM-R. These trainers/supervisors later went on to support the extension of SBM-R to new facilities under the new USAID bilateral, Health Service Delivery (HSD) project.

Support the initiatives of the national health management and information system (HMIS) to strengthen the collection and analysis of data

MCSP Guinea/HSS provided technical assistance to the BSD in collaboration with partners (MEASURE Evaluation, CRS) for the configuration of the new DHIS2 platform, including a data validation manual. MCSP contributed a service delivery level perspective to the revision of data collection tools and the development of training modules for dissemination of new indicators and tools. The project also supported the management and analysis of data through joint periodic supervision visits by the district management teams, and regional level data reviews. As a result of these efforts, data reporting rates were quite high for three of four quarters, but were beginning to slip at the end of the project while some new configuration

underway. Data accuracy assessments for the six prefectures of N’zérékoré saw good improvements in accuracy among the health centers in five of the six prefectures.

Introduction

The Maternal and Child Survival Program (MCSP) is the flagship global U.S. Agency for International Development (USAID) cooperative agreement to introduce and support high-impact health interventions in 25 priority countries with the ultimate goal of ending preventable maternal and child deaths within a generation. The Maternal and Child Survival Program engages governments, policymakers, private sector leaders, health care providers, civil society, faith-based organizations and communities in adopting and accelerating proven approaches to address the major causes of maternal, newborn and child mortality such as postpartum hemorrhage, birth asphyxia and diarrhea, respectively, and improve the quality of health services from household to hospital. The Program tackles these issues through approaches that also focus on health systems strengthening, household and community mobilization, gender integration and eHealth, among others. The Maternal and Child Survival Program carries forward the momentum and lessons learned from the USAID funded Maternal and Child Health Integrated Program (MCHIP), which has made significant progress in improving the health of women and children in over 50 developing countries throughout Africa, Asia, Latin America and the Caribbean.

The Ebola outbreak of 2014–15 had a devastating effect on routine health services in Guinea, especially those related to reproductive, maternal, newborn and child health (RMNCH). An already weak health system was at a near-standstill in Guinea due to a lack of regular monitoring and supervision, a devastating loss of health workers and fear by the community to seek services in health facilities. The MCSP mechanism provided an important opportunity to assist the Guinea MOH in efforts to respond to epidemic and as well as post-epidemic recovery, building on existing USAID-supported work under MCHIP. The Guinea Health System Strengthening Project (HSS) was the fourth and final project funded through MCSP and the second project with a focus specifically on post-epidemic recovery and building resilience to prevent the next potential epidemic. MCSP’s Guinea HSS program, which started in March 2016 with Pillar 2 Ebola Response and Recovery¹ funding, was designed to link the facility-level achievements of the earlier MCSP Guinea Restoration of Health Services (RHS, July 2015- December 2016) program with health systems-level efforts to sustain the management and coordination of improved RMNCH services. These two projects were planned and monitored in close coordination with the Global Health Ebola Team (GHET) tasked with overseeing the implementation of the health components of the Ebola Response and Recovery funding.

The goal of the Guinea/HSS project was to strengthen health systems with a focus on the prefecture level to ensure the availability of sustainable and high quality functioning of reproductive, maternal, newborn, and child health (RMNCH) services. Midway through the project, MCSP was requested to add activities focused on waste management to the HSS scope of work. The objectives to realize this goal included²:

- Increased coverage and utilization of high-impact reproductive, maternal, newborn, and child health (RMNCH) interventions and innovative new approaches
- Strengthen capacity of the MOH to manage and scale up high-impact RMNCH interventions

¹ In response to the epidemic, the United States Agency for International Development (USAID) developed a four-pillar strategy to address EVD: Pillar I – Control the outbreak; Pillar II – Recover from second-order impacts of EVD; Pillar III – Build coherent leadership and operations; and Pillar IV – Strengthen global health security in sub-Saharan Africa.

² The objectives were provided by USAID but as the project activities were developed, objective I did not become a focus. Objective I is largely unmeasurable by the project given the instruction to not include service delivery indicators, and the project did not intervene at the level of service provision. MCSP Guinea/HSS contribution to coverage and utilization is proximate based on the systems elements supported, such as IPC, Quality Assurance, HMIS and national level policy.

- Institutionalize and integrate Infection Prevention and Control (IPC) protocols into the routine RMNCH package

Project interventions focused on the following health systems elements:

- Key MOH policies and strategies are updated and disseminated
- Increased capacity of MOH coordination mechanisms to manage and guide health sector resources and functioning
- Increased capacity of 20 prefectures to monitor and manage high impact interventions to reduce maternal, newborn and child mortality and morbidity
- Improved waste management at MOH facilities

Interventions of the Guinea RHS and HSS projects were concentrated on geographic areas most impacted by the EVD epidemic. These impacts include high numbers of EVD cases and deaths, loss of healthcare workers to EVD, transfers and mobilization for the EVD response; and dramatic reductions in health service utilization for routine prevention and treatment such as antenatal and delivery care for pregnant women, family planning, treatment of diarrheal disease, malaria and other communicable diseases. Community based health information and services delivered by Community Health Workers (CHW) were also impacted by the mobilization of CHWs to support EVD surveillance, contact tracing and monitoring, and community awareness building.



HSS activities were designed to work closely with the prefectural health offices, and the regional offices that oversee their work, as well as at the central level to ensure that the national level policy, protocols and coordination are prepared to support the needs of the regions and prefectures. The Guinea/HSS project was implemented in two phases in order to assess needs prior to proposing specific interventions to build health management capacity, while continuously engaging at the national level on policy and coordination across several domains including Infection Prevention and Control (IPC), Quality Assurance (QA), RMNCH and Health Information Systems (HMIS). In addition, funding was added part way through the project to focus specifically on Waste Management.

Major Accomplishments

The following section is organized by the key technical areas of intervention in order to show the range of results realized across the central and sub-national level interventions to strengthen health systems.

Infection Prevention and Control and Waste Management

The weakness in healthcare waste management, a central aspect in the prevention of infection, became more apparent during the Ebola outbreak. There were alarming findings in healthcare facilities including the lack of incinerators, the poor condition of *De Montfort* incinerators and burn barrels; poorly maintained waste pits; improper sorting of waste in service provision areas, lack of elimination circuits for *waste assimilated to household waste (DAOM)*, lack of space to safely store waste; and poor availability and use of personal protective equipment (PPEs). USAID, through the MSCP Guinea/HSS project, supported the MOH to update policy and guidance based on learning from the Ebola epidemic and to make improvements of biomedical waste management in healthcare facilities.

Update health policies and protocols

Prior to the addition of activities specifically related to waste management during the second phase of the project, MCSP Guinea/HSS had already planned to facilitate the updating of the Infection Prevention and Control (IPC) normative documents, which serve as guides to the entire health system. MCSP succeeded on several levels:

- Following the development of IPC-specific policy and program documents (in process prior to the start of the HSS project³), MCSP Guinea/HSS supported regional and district managers with their validation and dissemination by providing technical assistance during orientation meetings and supporting printing costs. The IPC policy and program document was also accompanied by the standard and procedures' normative documents and the IPC program's monitoring and evaluation framework.
- To help health schools to integrate the new IPC policy, MCSP worked with the Faculty of Medicine, and the Ministry of Technical Education and Professional Training (which oversees nursing, midwifery, and nursing assistant programs) to develop the IPC curriculum and integration plans for the basic curricula of health schools.
- As part of the revision of reproductive health norms and protocols, MCSP Guinea/HSS successfully advocated for integration of specifications for water availability in service delivery locations for handwashing, as well as specifications by level of health care facility for availability of toilets and waste management measures.

Waste management assessment and improvements

Incinerators: MCSP, in collaboration with the other partners of the IPC cluster and the MOH, conducted a mapping of incinerators and their current functioning across the country. Of 63 incinerators identified primarily at hospitals and a few urban health centers, 31 or 49% were in good, working condition. This included seven that were donated and installed by the Office of Foreign Disaster Assistance (OFDA)-funded

³ The MCSP RHS project provided technical and financial support to the IPC policy development process as the need for this arose before the MCSP HSS project was in place. Two IPC capacity building projects funded by USAID and led by MCSP during the Ebola response phase also contributed learning that informed the policy process. An additional result of MCSP's work on IPC policy and implementation is that Jhpiego successfully leveraged funding from CDC to co-fund the development of supporting documents such as the IPC Norms and Procedure and IPC Monitoring Framework.

MCSP IPC 2 project. Among incinerators not functioning at the time of the assessment, some only had minor, repairable problems and/or lack of maintenance. Twelve incinerators donated by the Chinese Government during the Ebola epidemic were found at hospitals, but had never been installed or put into service. Using these findings, WHO led a program to repair non-functional incinerators with partner support. The MCSP Guinea/HSS project installed and made functional three incinerators at Mamou Regional Hospital, Labe Regional Hospital and the temporary annex to the Donka National Hospital at Camp Boiro in Conakry (Donka was closed for extensive renovations). Installation of the incinerators included creating the shelter, with smoke chimney, for the incinerator, digging and lining waste pits and fencing off the area for safety. The incinerator for Camp Boiro was actually transferred from the hospital where it was originally donated since that hospital had a functioning incinerator. Orientation was provided to two maintenance staff per site on the use and maintenance of these incinerators.

Autoclaves: To follow-up on autoclaves donated by previous MCSP projects, and others, MCSP Guinea/HSS provided on-site supervision visits to help improve the processing and sterilization of reusable instruments and equipment in accordance with IPC guidance. Donation alone is not sufficient, as many donated autoclaves were found still sitting in their boxes. Thirty-five *All American* brand autoclaves were made operational in 11 hospitals and 24 health centers (CS) through the orientation of 156 staff, clinicians and maintenance workers, on the use and routine, preventative maintenance of the autoclaves, along with review of correct instrument processing procedures. It is also important to note that MCSP had tailored the previous donations to the conditions of the facilities, providing electric autoclaves only to facilities with regular power while others received autoclaves that can be heated externally over a burner. MCSP identified that multiple smaller capacity units was often desirable even at high volume facilities because the electrical grid could not handle a large capacity unit.

Capacity Building of the Hygiene and Safety Committees

MCSP Guinea/HSS worked to revitalize 23 Hygiene and Safety Committees (CHS) in three regional hospitals, 14 prefectural hospitals, six Communal Medical Centers (CMC) including Ratoma, Matam, Miniere, Coleah, Flamboyant in Conakry and Sinko in Beyla. On average, 20 members per healthcare facility were oriented on their roles and responsibilities in overseeing IPC and developed action plans to implement routine monitoring and formulate corrective actions for performance gaps. A key tool for the CHS is the IPC checklist that served as a basis for IPC training, mentoring and supervision of healthcare providers in previous MCSP-led projects, and is part of the package of tools in the SBM-R quality improvement process used in Guinea. A fundamental role of the CHS is to ensure that the healthcare facilities perform regular self-evaluations to monitor IPC performance.

In N'zérékoré region, the increased attention of the CHS on IPC and waste management helped the regional (DRS) and prefectural (DPS) health management teams to identify major gaps in supplies for waste management at hospitals along with information available from health centers. The N'zérékoré DRS used these findings to request materials support from MCSP HSS. The project was able to donate a large lot of materials to support 87 health facilities in the six prefectures of N'zérékoré. Items included brooms, shovels, rakes, wheelbarrows, boots, buckets with tap, trashcans, and trash bags. These items help with hand washing, management of waste in service delivery areas and removal of waste to incinerators and burn pits, as well as cleaning of facility compounds. The donation was followed by joint supervision visits with the DRS and the DPS to review the availability of IPC inputs. The prefectures were responsible for distributing the items and the supervision visits found that the items were available in between 45-64% of healthcare facilities per prefecture. Implementation of the action plans of seven CHS was also reviewed. The average implementation was 81% of action items, with a range of 50-100%. The supervision team worked with the management teams and providers to develop solutions for persistent challenges and to problem solve issues with the distribution of the donated materials.

By the end of MCSP Guinea/HSS support, most CHS' were meeting regularly to review IPC performance and implementation of their actions plans. Key accomplishments include budgeting of actions that required

request for financial support; establishing IPC focal points in each service; monitoring of biomedical waste collection and incineration; organization of World Hand Washing Day activities; orientation of trainees on IPC procedures at the beginning of their practical sessions; and preparation of IPC procurement requests for different departments within the facility. Based on the work of the CHS, MCSP received requests to support the clean out of septic tanks at four hospitals in N'zérékoré region to render the toilet and waste water system functional again. MCSP HSS also provided orientations on water conservation and latrine maintenance (i.e. avoid putting non-biodegradable items in the latrine).

While supportive supervision was not intended to be a major focus of MCSP HSS, the project was able to respond to extraordinary needs that arose and requests for technical and financial support for supervision from MOH health managers. In addition to the IPC supervision in N'zérékoré described above, MCSP HSS helped to organize a joint mission to seven facilities in Conakry, including the two national hospitals. These facilities had experienced persistent problems with IPC performance and supply management under previous USAID supported projects and MCSP HSS was able to support an additional effort to highlight these challenges with local health authorities and identify corrective measures.

Coordination and Collaboration

Towards the end of the Ebola epidemic in December 2015, the IPC cluster, a committee that had been created as part of the emergency management by the National Ebola Coordination had ceased to function. MCSP initiated efforts in late 2016 to restore the IPC cluster under the auspices of the National Directorate of Hospital and Healthcare Facilities (DNEHS) to ensure coordination between IPC focal points in the MOH and partners. Following intermittent meetings, the IPC Cluster was reestablished in February 2017 and monthly meetings led to several major actions including:

- Revision of posters on six IPC topics and their distribution. Poster topics included waste sorting, injection safety, non-contaminated garbage disposal, and the disposal of infectious medical waste.
- The mapping of incinerators described above
- Planning and support for the organization of Global Hand Washing Day that was held on May 5th, 2018. MCSP supported printing of t-shirts, posters and distribution in 44 healthcare facilities in the 4 regions covered by MCSP Guinea/HSS (including two private facilities).

The partners engaged in the IPC Cluster (WHO, Expertise France, and Jhpiego (MCSP and HSD projects)) submitted a letter to the Ministry of Health in February 2018 advocating for continued attention to IPC in health facilities particularly given the challenges in sustaining good IPC practice. A written response was received from the Secretary General, Dr. Sekou Conde, formerly at DNEHS, acknowledging the ongoing challenges and expressing commitment of the MOH and appreciation for the support of technical and financial partners.

Comprehensive Approach to Health Systems Management

Given the complexity of the health system challenges and the low capacity to respond to problems, especially with the multiplicity of vertical programs in the country, MCSP recognized the importance of the functionality of peripheral health systems for post-Ebola recovery and rebuilding of the health system. To achieve the targeted objectives, the project implemented the *Comprehensive Approach to Health Systems Management* (CA, or AIGSS in French), a process that seeks to strengthen the health system and managerial capacities at the prefectural level to mobilize and coordinate health system resources to increase the coverage, use, quality, equity, and sustainability of health services. This approach provides technical support to prefectures so that they can identify, analyze and prioritize challenges that hinder the achievement of their goals in the health system. The implementation of the AIGSS in Guinea consisted of three activity areas: a

rapid assessment of the health system, strengthening capacities of prefectural teams, and the institutionalization of the approach in collaboration with the national level.

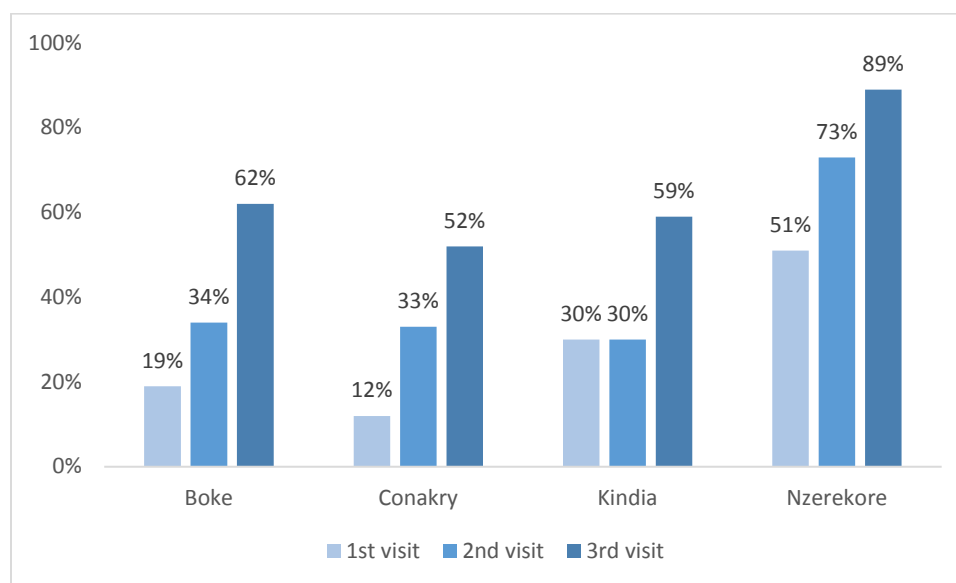
Rapid health system assessment

The Rapid Health System Assessment sought to: (1) rapidly diagnose problems at the regional and prefectural levels that may affect RMNCH services to allow for the prioritization of key areas to be strengthened (2) identify strengths and opportunities in the health system and (3) propose recommendations to be implemented by the various stakeholders involved. This joint assessment was conducted by the MCSP project and the Office of Strategy and Development (BSD) of the MOH. The results of the rapid assessment of the health system confirmed information presented by previous assessments and experiences including weak coordination of stakeholders, poor quality of supervision activities and insufficient advocacy for resource mobilization. The results of this assessment informed the development and implementation of AIGSS activities in Guinea, in particular the focus on including a diverse range of stakeholders in planning processes, stakeholder engagement, and leveraging local resources. The achievements detailed in the sections below demonstrate the progress made on these findings through the AIGSS implementation.

Capacity building of prefectural teams

MCSP worked closely with the BSD to conduct pre-planning workshops and training sessions on stakeholder engagement and resource mobilization. In addition to these trainings, joint quarterly visits were conducted. Technical support is a key element of the AIGSS and aims to strengthen the managerial capacity of the prefectural health system through an ongoing process to assess problems and generate solutions. During the three quarterly visits that were made during the project, the teams noticed a strong improvement in the implementation of planned activities to solve the priority problems. Overall, the rate of achievement of activities and that of the resolution of priority problems increased from 36% at the first visit to 76% at the third visit; the scores by region are shown in the figure.

Figure 1: Evolution of the implementation rate of planned AIGSS activities per region



Some challenges were encountered during the quarterly visits. In particular, most of the teams (15 of 20 districts) noted that activities planned in their actions plans had not been carried out due to the lack of funding. Stakeholder engagement and resource mobilization training was deemed as high priority to alleviate and address this major weakness. Given the importance of this issue and the deep interest of the BSD in the AIGSS, the prefectures of Gaoual and Koundara that were not covered by the project were integrated into the process at the start of this training. Following the training, the prefectural teams started to write funding requests addressed to a local partner and the strongest participants were appointed as AIGSS focal points for each region (3 per region). With the joint support of the project, the BSD and the focal points identified in the regions, the prefectural teams reviewed, submitted, and followed up on their funding requests with a global success rate for resource mobilization of 51% (see table 2 below). The majority of funded requests consisted of in-kind donations to district teams to implement activities such as conducting capacity building activities for community health teams, covering supportive supervision costs, conducting community awareness activities, and furnishing materials or supplies.



Photo : Aicha Drame, a DCS Kaloum Pharmacist and AIGSS focal point, participates in the quarterly visit in the Dixinn commune.

Table 1: Funding requests submitted by the district management teams

Region	# Submitted requests	# Requests funded	% Requests funded
Boke	23	9	39%
Conakry	16	5	31%
Kindia	13	5	38%
Nzerekore	32	24	75%
Total	84	44	51%

To facilitate the ongoing monitoring of ECD activities, MCSP has also developed performance standards for health systems management such as SBM-R standards for healthcare facilities. The first version of these performance standards was developed in collaboration with the Ministry of Health.

Institutionalization of the approach

The BSD showed a strong interest in AIGSS during its collaboration with the project during the implementation in the four regions of the project; and BSD requested the project's support to extend AIGSS to other regions of the country. This request coincided with their interest in reviewing the national planning process to prevent the recurrence of difficulties experienced in recent years. The project provided technical support to the BSD for the revision of the planning process and the development of two new guides for developing operational action plans (one guide for administrative entities and another for healthcare facilities and the appropriate action plan template). These guides incorporate key elements of the AIGSS including the analysis of priority problems, the identification of corrective actions, and the mobilization of resources. Following the end of MCSP support, these revised planning documents were used for 2019 annual planning processes launched in October 2018. Technical assistance for the rollout of the annual planning tools was requested by BSD of MCSP staff now working on the USAID-funded bilateral, HSD.

For the N'zérékoré region, the MCSP Guinea/HSS project organized a workshop to present the AIGSS implementation results and practices to enable the various stakeholders to support the institutionalization of the approach. This session served as a framework for orienting ECDs on the next steps after the end of the project. Partners were very enthusiastic to support the continuation of several MCSP interventions (and

preceding, projects such as MCHIP). The table below shows the commitments of different partners to different priority interventions of the DPS' and Region.

Table 2: Distribution of areas of intervention per Partner

Partner	Area of intervention
UNFPA	EmNOC, material management, coordination of technical and financial partner interventions
TDH	Community health, AIGSS
PLAN GUINEE	IMNCI
IMC	Skills development, AIGSS
OIM	Community Health
PASA	Strengthening of health district through AIGSS, EmNOC, FP, DHIS2 monitoring and archiving

Quality Assurance with the SBM-R approach

The *Standards-Based Management and Recognition* (SBM-R®) process is designed to engage healthcare providers and facility managers in ongoing quality improvement and regular self-assessment of performance. Performance is assessed based on an agreed set of standards for a range of clinical and management domains and includes both inputs, outputs and outcomes of service delivery. The process is supported by periodic external evaluations performed by a team of regional and prefectural SBM-R champions/trainers and project staff to provide an external perspective, using the same standards of performance. Once a facility is performing at the established level for recognition (average of 80% across all domains in use), they can request an external review by the national SBM-R Committee to validate performance. Recognition includes a ceremony with local authorities and stakeholders, installation of a plaque and donation of materials to encourage the facility team to maintain their good work. Many donations are generated from the community and other partners working in the region, and not just the USAID-funded projects that facilitated the introduction of the process.

In Guinea, SBM-R was introduced in 2009 under the USAID-ACCESS-FP and MCHIP projects and with funding from UNFPA. In 2012, after a review of the quality improvement processes in Guinea at the time, the Ministry of Health had expressed its wish to implement the SBM-R methodology nationally. At the end of the MCHIP project in 2014, 48 healthcare facilities, mostly hospitals, Communal Medical Centers and Urban Health Centers, were using the SBM-R process. MCSP's activities were designed to continue supporting 35 health facilities in the project area (three of the four regions, SBM-R was not previously introduced in Boké) that had been using the process and to reinforce its use in the post-Ebola service restoration period.

The MCSP Guinea/HSS project supported the SBM-R National Committee's validation visits and the recognition ceremonies for healthcare facilities that obtained this distinction, following up on the efforts of the MCSP RHS project to reinvigorate the use of SBM-R within the facilities. MCSP Guinea/HSS also introduced the criteria for a second level of recognition that increases the minimum performance standard for recognition and includes additional criteria for management practices and improvements in key service delivery indicators for the facility. The second level was offered to facilities that had maintained performance at or above previously earned first level recognition.

The SBM-R Committee was supported to conduct external assessment of the performance of nine healthcare facilities that requested validation (six for the 1st star and three for the 2nd). Eight facilities were successfully validated: six for the 1st star and two for the 2nd star (see table below). The official recognition and award ceremonies were organized by the SBM-R Committee with the support of USAID projects (MCSP and HC3).

Recognition ceremonies were organized for six high-performing healthcare facilities, while two ceremonies were delayed while donations for the recognition packages were obtained.

Table 3: Results for facilities that requested performance validation

Region	Facilities evaluated	1 st Star	2 nd Star	Validation	Recognition
N'zérékoré	Regional Hospital NZK		X	Meets standards	X
	Prefectural Hospital Yomou	X		Meets standards	Pending
	CSU GONIA	X		Meets standards	X
	CSU Commercial	X		Meets standards	Pending
	CSU Madina		X	Meets standards	X
	CSU Diakolidou		X	Not met	NA
Kissidougou	CSU SOGBE	X		Meets standards	X
Kindia	CSU Manquepas	X		Meets standards	X
Conakry	CMC Ratoma	X		Meets standards	X
Boké	Not applicable				
	9 requested validation	6	3	8 Meet standards	6 Recognized



Left: the SBM-R recognition plaque. Right: The staff of CSU Manquepas

Following the unveiling of the Gold Star, the Prefect of Kindia invited the other health facilities to work to earn their Gold Star as well.

It is important to note that of the 35 facilities using SBM-R before the Ebola epidemic, the MCSP Guinea/RHS project found that performance had dropped off dramatically in many facilities between the end of MCHIP and near the end of the epidemic. Factors contributing to the decline in performance included loss of SBM-R trained staff (deaths and transfers) and ongoing challenges with availability of materials and medications for service delivery and for IPC specifically. Performance was beginning to improve when MCSP RHS ended but only a few facilities were at the level to request recognition. Of 30 facilities assessed at the end of the project, 50% were performing at the minimum desired standard for the three key components (between 75 and 85%). While this is positive progress from the 34% of hospitals and 14% of health centers meeting the minimum as reported by MCSP RHS for July-Sept 2016, there is still more to be done to institutionalize the process at all levels to create the expectation that consistent, quality performance is expected in MOH facilities. A more detailed analysis of persistent challenges or key areas of change was not carried out across the ensemble of facilities, although this is discussed at the facility level during debriefs following SBM-R assessments.

The national SBM-R Committee experienced similar declines in functioning due to the loss of some its members. MCSP HSS was able to advocate successfully for the reestablishment of the committee with new members, which in the post-Ebola era is named the National Committee for Quality Assurance and Patient Security.

To further support the reinvigoration of this quality assurance process, MCSP Guinea/HSS worked with the MOH to identify and train 21 additional SBM-R trainers/supervisor from the four regions. These providers working in DRS/DPS and in facilities can serve a resource to the regions for support supervision, performance monitoring and coaching. With the start of the Health Service Delivery Project (HSD) in 2016, eleven SBM-R trainers were engaged in the scale-up of SBM-R to 20 new facilities.

Collaboration for the revision of a quality assurance monitoring tool

The MCSP Guinea/HSS project engaged with MOH and financial and technical partners in a review of QA processes and tools, initially proposed by the German development assistance program (GIZ). MCSP HSS provided technical support for the adaptation of an integrated monitoring tool for QA to be used twice a year to review health service quality, particularly RMNCH. This tool aims to harmonize the quality improvement tools used by different projects and is to be used on a biannual basis by healthcare facilities and health districts to periodically review performance. SBM-R standards were integrated into the tool and SBM-R was retained as on-going process at facility level.

Support to Strengthen the Health Information System

Access to reliable and timely data is essential to identify trends and needs for additional support. The HMIS strategic plan for 2016-2020 includes the deployment of a new electronic platform based on the DHIS2 software for data management and the improvement of data usage to guide the planning and prioritization of operations at the operational level. USAID-funded MEASURE Evaluation along with the BSD led the introduction of the DHIS2 and Data Use for Decision Making tools, and MCSP HSS was closely engaged in both the national level discussions and set-up, supporting the rollout to the regions and districts, as well as extending the introduction in Boke region.⁴

National level support to strengthen of National Health Information System (NHIS)

MCSP's M&E staff actively participated in all national level discussions of the indicators to be included in the DHIS2, the configuration of the platform, and training of trainers for the rollout, first in two pilot regions and then to other regions. MCSP also supported the revision of routine data collection tools that feed into the DHIS2 and the development of the training module to support the dissemination of new indicators and tools. MCSP contributed to the development of the data validation manual at all levels in order to better assess the quality of the data reported by healthcare facilities. The configuration of new, revised tools was started with the support of the project (and continued by the same team under the HSD bilateral). At the end of the MCSP, partners were organizing their contributions for the printing of the tools.



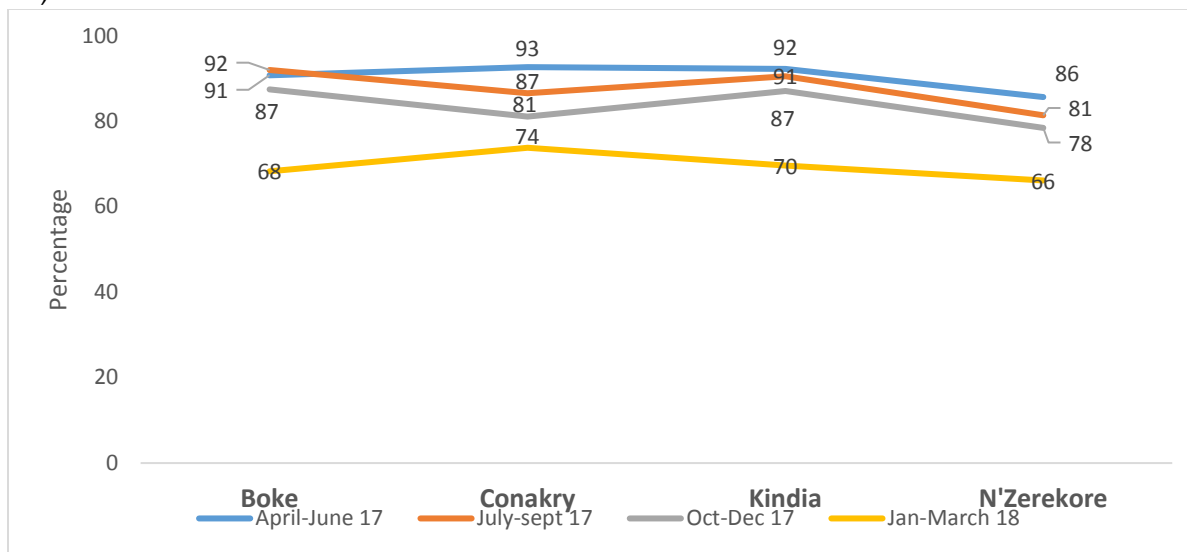
Regional and prefectural capacity building for data management and analysis

MCSP HSS provided technical assistance for the training of DHIS2 users in the 20 districts and 23 hospitals in the intervention area. MCSP's presence in four regions was particularly helpful to providing supportive supervision and monitoring, along with rapid feedback to improve performance with a focus on RMNCH

⁴ <https://www.measureevaluation.org/resources/publications/tr-18-244>.

indicators. Regional M&E advisors facilitated regional level data reviews and inclusion in regional health bulletins. MCSP staff also provided supportive supervision to prefectural and hospital level data managers. The table below shows DHIS2 reporting rates for the four MCSP focus regions.

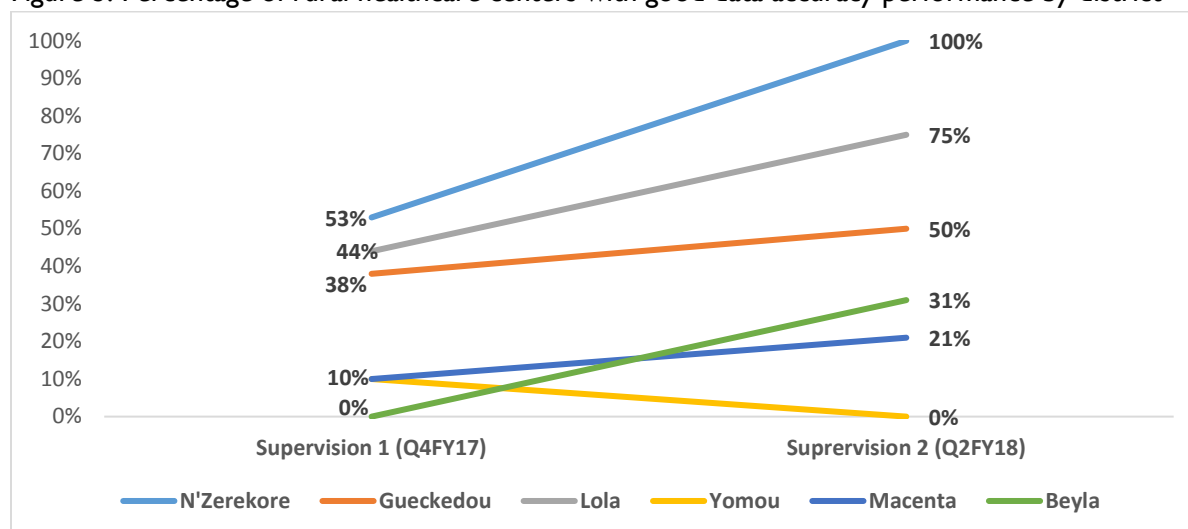
Figure 2: Evolution of the data-reporting rate in DHIS2 for the four project regions (April 2017 - March 2018)



Note: Since the last quarter of 2017, data entry has slowed down with the start of the configuration of new HMIS templates

At the request of the N'zérékoré DRS, MCSP supported the biannual data quality supervision visits to 62 facilities in the six prefectures. Specific recommendations were made in each facility during discussions with supervisors and healthcare providers, and shared with DPS and DRS managers for follow-up. Recommendations to address issues identified included posting data in healthcare facilities and DPS to promote accountability; provide orientation to new staff on the correct use of primary data collection tools and advise all staff on how to complete the logs and reports; strengthen inventory tracking to encourage timely orders to prevent stock-outs. Five of the six prefectures showed improvements in data accuracy between the two supervision visits (see graph below). In Youmou prefecture where data accuracy decreased from already low rates, changes in staffing and lack of monitoring of the action items agreed on during the first visit appear to explain the lack of progress.

Figure 3: Percentage of rural healthcare centers with good data accuracy performance by district



Recommendations and Perspectives

The assessment of incinerators highlighted the ongoing development challenge of donating goods without necessarily supporting functioning. A number of incinerators had been donated by partners without support for installation of ongoing operating costs. It is not appropriate to assume that already limited facility budgets can take on fuel and maintenance costs, let alone installation, with no inputs into the operating budget for the facility or district. In one facility, a donor supports the fuel costs for an older incinerator, so even though a new model that uses less fuel has been installed, it is not being used because facility managers are concerned of losing the financial support. MCSP was able to fill some of the gaps that were identified through the waste management funding under this project. Further, MCSP Guinea/HSS worked with MOH and IPC partners to develop technical resources for maintenance, but there is still a need to develop guidance on planning and budgeting for recurring costs of waste management operation and maintenance, as well advocate with national level authorities to include these costs in national budgeting and requests to donors.

Behavior change for improved IPC practices as well as implication of managers and CHS to play a role in monitoring IPC and holding staff accountable remains challenging, as it does the world over. MCSP tried to work at many different levels from policy, to skills updates and coaching of providers and managers to change this behavior, but the results are still difficult to see. The series of short projects to address Ebola response and post-Ebola recovery led by MCSP that worked in varying geographic areas were not always able to link together support for IPC performance in order to address the issues of ongoing monitoring and accountability. It was fortunate that MCSP was an active award across both the acute response and post-epidemic, and was able to call on the same group of technical experts, but the short-term nature of epidemic response and recovery funding did not always prioritize synergies from one project to the next.

The availability of MOH counterparts to participate in meetings, supervision visits, etc. was an ongoing challenge, especially when the Ebola epidemic brought many partners and technical assistance that are not usually found in Guinea. Postponements and cancellations were common due to changing schedules, forgotten obligations, last minute requests, and general understaffing at the national level. Partners and donors also have an important role to play in the coordination of activities, and in informing MOH of requests for their participation in meetings in a timely manner so that MOH staff can plan their time. The few MOH staff receive multiple last minute requests to be many places at once. MCSP worked to remain flexible as well as to make timely requests for commitment of time by MOH counterparts to complete activities, but the interference can quickly delay activities when MOH is not prepared to set out guidelines for partners.

Similar to the above, frequent transfers of staff between facilities and regional and prefectural health management offices meant that the investment in capacity building for target sites often was not sustained shortly after training. New staff may come from a different region where similar capacity building was not offered. MCSP worked to provide on-site coaching when new staff were encountered during supervision visits, as well as working to address IPC training in pre-service education, but this situation can still have negative consequences for healthcare service availability, as well as at the facility management level to support staff to integrate new services or improved practices in their daily activities.

At the level of district health managers, there is still a lot to do to improve engagement with and coordination of technical and financial partners to ensure better coordination and that support is in response to needs identified in that district. The Comprehensive Approach was a solid start for Guinea and the opportunity to integrate the methodology and tools in the guidance for annual planning has set this up to continue. Since the end of MCSP, the in-country staff who led this work have been requested on several occasions to provide technical assistance to orient national managers on the tools and to facilitate the training in new regions.

The opportunity for MCSP to collaborate with MEASURE Evaluation on the DHIS2 rollout is an example of an important link between USG funded initiatives and projects. MEASURE's mandate was largely at the national level and MCSP was able to facilitate the rollout to regions and districts. As a global award focused on RMNCH, and experience with what is occurring with information recording and use at the service delivery

level, MCSP had a lot to contribute to the discussions of indicators and challenges with data quality and reporting that originate at the facility level.

Annex A: Progress against project monitoring indicators

	Indicator Information	Target		Results				Global achievement and Comment
		Sept 2016 (Phase 1)	Dec 2017 (Phase 2)	April -June 2017	July - Sept 2017	Oct – Dec 2017	Jan –June 2018	
Cross Cutting Indicators								
CC 1	<p>Indicator: Number of people trained</p> <p>Indicator Definition: Number of people trained, including those reached via onsite training</p> <p>Disaggregates: Topics: LMG, Supervision, others ; Cadre: manager, statistician, pharmacist, doctors, pharmacist, Nurse; Function : (Medical Officer of Health), Statistician, Planning/Training/Research, Director, Inspector/Pharmacist, Community Health, Admin/Finance; Sex :Male, Female</p> <p>Data Source/ Collection Method: Training rosters</p> <p>Frequency of data collection: Quarterly</p> <p>Person/Unit Responsible: HSS Advisor</p>	15 (TBC after RHSA)	45	Activities planned for next quarter	65	38	NA	103 people trained. Exceeded target due to the addition of resource mobilization training
CC 2	<p>Indicator: Percent of SBM-R facilities achieving the minimum standards of performance as defined by MOH</p> <p>Indicator Definition: Percent of SBM-R facilities achieving the minimum standards of performance as defined by MOH. Numerator: total number of SBM-R facilities achieving the minimum standards of performance; Denominator: number of SBM-R facilities evaluated</p> <p>Disaggregates: type of facilities (Hospital, health centers); topic (IPC-75% of performance, MNH-80% of performance)</p> <p>Data Source/ Collection Method: Supervision record</p> <p>Frequency of data collection: baseline, end line</p> <p>Person/Unit Responsible: SBM-R Advisor</p>	10%	60%	33% (6/18)	100% (1/1)	0 None assessed in this quarter	50% (15/30)	Of 30 facilities, 50% achieved the minimum standards of performance. Not all facilities are assessed in a given quarter.
National Level Interventions								
<i>Target 1: Key policies and strategies are updated and disseminated (e.g. IPC, HMIS, Immunization, MNH);</i>								
<i>Target 2: Capacity of MOH coordination mechanisms to manage and guide health sector resources and functioning is increased</i>								
1	Indicator: Number of policies or procedures analyzed, consulted on, drafted or revised, approved, and implemented with USG support from project	2 (RH Norms and Procedure	NA	NA	2	NA	4	6 (RH Norms and Procedures, IPC Program

	Indicator Information	Target		Results				Global achievement and Comment
		Sept 2016 (Phase 1)	Dec 2017 (Phase 2)	April -June 2017	July - Sept 2017	Oct – Dec 2017	Jan –June 2018	
	<p>Indicator Definition: Number of policies, regulations or guidelines related to strengthened capacity to manage and guide health sector resources and functioning analyzed, consulted on, drafted or revised, approved, and implemented with USG support from project</p> <p>Disaggregates: program (e.g. IPC, HMIS, Immunization, MNH, etc.); Policy stages: (Process/step: Analysis; Process/step: Stakeholder consultation/public debate; Process/step: Drafting or revision; Process/step: Approval (legislative or regulatory) ;Process/step: Full and effective implementation ;Process/step: Total policies passing through one or more processes/steps of policy change</p> <p>Data Source/ Collection Method: Program records (workshop report, finalized document)</p> <p>Frequency of data collection: Annual</p> <p>Person/Unit Responsible: HSS Advisor</p>	s, and IPC Program and Strategy)						and Strategy, trainers’ guide and module on semi-annual monitoring, Advocacy letter for IPC achievements sustainability, two guidelines for activity planning)
2	<p>Indicator: Number of health sector coordinating mechanisms that are operating as planned</p> <p>Indicator Definition: Number of committees, working groups, etc. that meet at least 80% of their scheduled intervals, with meeting notes circulated to all members.</p> <p>Disaggregates: program/topic (i.e. HMIS, IPC, commodities, HRH, RH/FP) Interval may be weekly, monthly, and quarterly as defined for mechanism. [qualitative review can be added to look at tasks accomplished according to action items from meetings and reporting at subsequent meeting)</p> <p>Data Source/ Collection Method: Program Records, meeting notes</p> <p>Frequency of data collection: Semi-annual</p> <p>Person/Unit Responsible: HSS Advisor</p>	NA (not included in Phase 1)	5 (IPC, HMIS, Child, Community, FP/RH)		3 (IPC, HMIS, FP/RH)		1 (Community Health)	4 coordinating mechanisms convening regularly (IPC, HMIS, FP/RH, Community Health)
Prefectural Level Interventions								
<i>Target 3: Increased capacity of 20 prefectures to monitor and manage high impact interventions to reduce maternal, newborn and child mortality and morbidity</i>								

	Indicator Information	Target		Results				Global achievement and Comment
		Sept 2016 (Phase 1)	Dec 2017 (Phase 2)	April -June 2017	July - Sept 2017	Oct – Dec 2017	Jan –June 2018	
3	<p>Indicator: Number of health facilities visited during quarterly supervision visits conducted by District health management team (supported by project resources)</p> <p>Indicator Definition: Number of health facilities visited during quarterly data supervision visits conducted by District health management teams. During the supervision visit, District team visit all health facilities in its area. The content of the supervision is driven by the make-up of the team and supervision objective. Visits last, on average, 1 day for Health Center and 2 for hospital.</p> <p>Disaggregates: level/type of facility (region, district, Hospital, health centers); region, focus of supervision visit (data quality/DHIS2 rollout, management skills, clinical supervision)</p> <p>Data Source/ Collection Method: Supervision record</p> <p>Frequency of data collection: Quarterly</p> <p>Person/Unit Responsible: HSS Advisor</p>	12	144	51	62	NA	98	211
4	<p>Indicator: Number of periodic DHIS 2 data review meetings at prefecture and regional levels that include health management teams and providers</p> <p>Indicator Definition: Number of periodic data review meetings that include health management teams and providers. The project supports these teams and providers in preparing for and analyzing data at these meetings.</p> <p>Disaggregates: time period (monthly, quarterly), region</p> <p>Data Source/ Collection Method: Program Records, Activity Reports</p> <p>Frequency of data collection: Quarterly</p> <p>Person/Unit Responsible: M&E Director</p>	4	14	6	1	0	8	15 periodic DHIS2 data review meetings held at prefecture and regional levels that include health management teams and providers
5	<p>Indicator: Percentage of sites using DHIS2 with a completion rate of HMIS monthly reports, reaching at least 85%</p> <p>Indicator Definition: Numerator: Number of sites using DHIS2 with a completion rate of monthly HIMS reports,</p>	NA	50% (20)	100% of regions (Conakry=93%; Boke=91%;	75% of regions (Conakry=87%; Boke=92%;	50% of regions (Conakry=81%; Boke=87%;	0% of regions (Conakry=74%; Boke=68%;	The configuration of new HMIS templates since the last

	Indicator Information	Target		Results				Global achievement and Comment
		Sept 2016 (Phase 1)	Dec 2017 (Phase 2)	April -June 2017	July - Sept 2017	Oct – Dec 2017	Jan –June 2018	
	reaching at least 85%; Denominator: Number of health districts using DHIS2 Disaggregates: region; type of sites (District, Hospital) Data Source/ Collection Method: Supervision Records Frequency of data collection: Quarterly Person/Unit Responsible: M&E Director			Kindia= 92; N'Zerekore =86%)	Kindia=91; N'Zerekore =81%)	Kindia=87; N'Zerekore =78%)	Kindia=70; N'Zerekore =66%)	quarter of 2017 has led to a slowdown in DHIS2 data entry
6	Indicator: Number of health districts implementing the <u>Comprehensive Approach to Health Systems Management</u> Indicator Definition: Number of health districts implementing the Comprehensive Approach to Health Systems Management. Disaggregates: region Data Source/ Collection Method: Program records (eg. activities reports) Frequency of data collection: Quarterly Person/Unit Responsible: HSS Advisor	TBC after RHSA	20	20	20	22	22	22 health districts (110%) Two districts were added to satisfy MOH request to complete coverage of Boke region
7	Indicator: Percentage-of health districts that have resolved at least 50% of problems identified with the <u>Comprehensive Approach to Health Systems Management</u> Indicator Definition: Numerator: Number of health district that have resolved at least 50% of priority problems identified with the Comprehensive Approach to Health Systems Management Denominator: total number of health districts implementing the Comprehensive Approach to Health Systems Management. Disaggregates: region Data Source/ Collection Method: Supervision reports Frequency of data collection: Quarterly Person/Unit Responsible: HSS Advisor	TBC after RHSA	16 (80%)	15% (2/13)	57% (4/7)	41% (7/17)	77%(17/22)	77% includes the number of health district with at least 50% of planned AIGSS implemented out of the total number of districts visited in the same quarter.
8	Indicator: Proportion of Hygiene and Safety Committees at hospital supported by the IPC district focal point Indicator Definition: Numerator: Number of Hygiene and Safety Committees at hospital supported by the IPC district	NA	60%	65% (13/20)	25% (5/20)	82% (18/22)	65% (17/26)	65% of CHS receiving support from prefecture IPC focal point.

	Indicator Information	Target		Results				Global achievement and Comment
		Sept 2016 (Phase 1)	Dec 2017 (Phase 2)	April -June 2017	July - Sept 2017	Oct – Dec 2017	Jan –June 2018	
	focal point ; Denominator: Number hospital Hygiene and Safety Committees in place Disaggregates: region Data Source/ Collection Method: Supervision Records Frequency of data collection: Quarterly Person/Unit Responsible: IPC Advisor							
9	Indicator: Number of health facilities that have functioning incinerators or waste pit Indicator Definition: Number of health facilities that have fully functioning incinerators to be able to properly dispose of the increased quantities of disposable and potentially contaminated materials Disaggregates: Data Source/ Collection Method: Supervision and activity records Frequency of data collection: Quarterly Person/Unit Responsible: IPC Advisor	NA	55 (25%)	10 hospitals (50% of Hospital for incinerators)	6 hospitals (30% of hospitals for incinerators)	25 functioning 20 hospitals and 5 health centers of those assessed in Q	84 functioning 12 hospitals; and 72 health centers assessed in Q	84 health facilities total (153% of target) 51 incinerators and 33 waste pits functioning

Annex B: Success Stories

I- The integration of the SBMR process in healthcare facilities leads to significant changes

In the Forecariah healthcare center in the administrative region of Kindia, many healthcare providers benefited from the changes brought on by the integration of the SBM-R approach. According to Ms. Ténimba Traoré, an EmOC nursing assistant at the CSU Forécariah, "before the integration of this approach in our CS, the rare deliveries (1 to 2 per month), were only performed during the day". The intervention of the MCSP project through its SMBR component has strengthened and improved deliveries in the CSU.



The facility was provided medical equipment; the administrator of the CSU has made available delivery materials, medicine kits and consumables; women are now able to benefit from the after-hour services thanks to the development of a nightshift program and the creation of a postpartum observation room. "We are very happy with the increased utilization of our services. Personally, the use of performance standards helped me to improve my technical knowledge and skills in EmOC". The use of the center has increased as the number of PNC users went from 465 (August-December 2016) to 533 (January to May 2017) while deliveries went from 14 (August-December 2016) to 42 (January to May 2017).

For Fatoumata Guilavogui, an FP nursing assistant, "The integration of SBMR at the CSU of Forécariah facilitated the development and equipping of a counseling room for the care of FP patients. This contributes to the decrease in wait time for FP patients and the improvement of privacy and confidentiality. We went from 28 new users from August to December 2016 to 71 for the period of January to May 2017, a 60% increase". Patients and healthcare providers thanked the center for the improvement in the quality of services. Through the use of FP standards, Fatoumata succeeded in convincing a client to keep her implant for a period of five years. The cleanliness of this Forecariah health center has impressed many and is being applauded beyond the facility.



Dr. Yombouno Maurice, a member of the health and safety committee, was pleased to see that a member of the Health and Safety Committee of another hospital (Boké Regional Hospital) was impressed by the comments of some visitors about the cleanliness of his hospital.

It is with great pride that he explains how this member contacted him to inquire about the strategies that their health committee adopted for the cleanliness of the premises and the courtyard. According to Dr Yombouno, the maintenance of cleanliness requires "awareness and involvement of all staff (doctors, nurses, nursing assistants, cleaning staff) in the monitoring and maintaining of sanitation and hygiene activities; the scheduling of one day a week dedicated to thorough cleaning; the installation of several garbage cans in the courtyard and the consultation rooms; regular sensitization sessions for patients and relatives on waste management and the use of toilets; the involvement of all hospital staff in the monitoring and ongoing sensitization of users of our services on the maintenance of cleanliness». A daily monitoring visit is conducted to monitor the application of personal protection and waste management procedures and to provide immediate corrective actions and positive feedback as needed.

In the Cacia urban health center (UHC) in Kindia, training on the performance standards of the SMBR approach enabled providers to advocate for their own cause. Mr Baldé of the community health and hygiene committee (COSAH) of the CSU Cacia Kindia recounts that *"for a long time the service providers, members of the COSAH of the CACIA CSU and the health authorities of the DPS of Kindia, have noted the lack of space within the CACIA UHC. After the training in Module 2 which included resource mobilization strategies for the resolution of problems, we organized an advocacy and sensibilization meeting for the locally elected representatives and religious leaders of the districts covered by the CACIA UHC. This meeting resulted in the proposal of the construction of a new health center. We attribute this success to the SBM-R training that we received"*

From April 2009 to December 2017, the SBM-R approach "quality management of services based on performance standards and recognition" was integrated in 100 health facilities in 37 prefectures / communes, 42 hospitals / CMCs and 58 health centers. The improvement of health services through the SBM-R approach enabled the monitoring of the performance of 42 SBM R sites in the regions covered, the validation of 8 facilities, the recognition of 6 sites and the revitalization of the National Validation and Recognition Committee.

2- Improved waste management in healthcare facilities covered by the MCSP HSS project through its IPC component

The regional hospital of Boko located in Maritime Guinea is the largest healthcare facility in the region with a high volume of patients. Prior to the support of the MCSP project, the hospital had a waste management problem. There was no incinerator, waste sorting was poorly done and the accumulated waste was stored. To alleviate this issue, the project provided the hospital with a UNIVERS Redline model incinerator and trained the head of maintenance, 46-year-old Abdoulaye Keita, on use and preventative maintenance of the equipment as well as waste management. He acknowledges being well-trained "thanks to this program, I now know how to do the best waste treatment and how to maintain a UNIVERS Redline model incinerator", He also proudly talks about his ability to train other staff members "I was able to train a deputy here at the Boko Regional Hospital and also had the opportunity to travel to train other maintenance personnel and to repair non-functional incinerators in hospitals of Gaoual, Mandiana, Mali Yembere, Dalaba, Mamou and Faranah».

A waste disposal program was put in place with the support of the hygiene and security committee from the various services. Every two weeks the waste stock is incinerated and the number recorded. Each focal point is responsible for identifying the problems in his or her department and reporting and giving an update on the situation during the staff meeting.



3- In Guinea, local health teams (ECD) learn to identify and address pressing challenges with the support of the MCSP project /A beautiful story in Beyla....

During the Ebola outbreak, healthcare facilities in the prefecture of Beyla, located in the administrative region of Nzérékoré in Forrest Guinea, and in the rest of the region was avoided by the population. Few preventive and health promotion activities were conducted at the time. During a feedback workshop held Nzérékoré in 2016 for the rapid assessment of the health system, Beyla district health management teams (DHMT) identified "community reluctance to immunization activities" as a priority health issue.

A thorough analysis of the causes of this problem revealed a lack of supervision of community health workers (CHWs) by the administrators of the healthcare centers (CCS). The DHMT identified corrective actions to build the capacity of the CHWs to facilitate and improve the implementation of their activities. They were provided training as well as tools and equipment; their numbers also increased. The DHMT was able to successfully plan activities that were incorporated into its 2017 Operational Action Plan. The management team also negotiated with stakeholders to develop a joint supervision program, form supervision teams and implement the supervision program.

The increase in the number of CHWs, the donation of equipment and supplies, their training and supervision by the CCSs and the DHMTs, have all contributed to the community's increased engagement and commitment in prevention and health promotion activities in general, including vaccination. CHWs now carry out activities in several areas including the fight against malaria, reproductive health and family planning, vaccinations and others. For example, the immunization coverage rates have improved compared to the first half of 2016.

	2016	2017
BCG	78%	105%
Penta III	56%	100%
VAR	64%	92%

According to Dr. Lanciné Doumbouya, Beyla's DHMT Planning / Training and Research Officer, "the AIGSS has been a great help to team members during the planning process (action plan development) and resource mobilization". "... issues related to the completeness and timeliness of the data were resolved through MCSP's support to the HMIS".

Mrs Sény Mamè LOUA is a Community-based Service Manager at the DPS Prefectural Directorate of Health in Nzérékoré. She is also a national HMIS supervision tools' trainer. She highlighted the change that the MCSP project has brought to her region through HMIS support. *"Before, the supervisions of the DHMTs generally related to the management of medicines, the information collected through several tools did not reveal the real problem of the healthcare facilities. The lack of training made it impossible to analyze and interpret the reports and data provided. The training of trainers on HMIS supervision tools organized by the Ministry of Health in collaboration with MCSP, CRS and Measure Evaluation allowed me to understand the importance of the HMIS monitoring tool and using data for decision-making"*.



Training and capacity building through the MCSP HSS solved 95% of the problems on the completeness and timeliness of the HMIS data. Currently all documents are in place in the healthcare facilities to help achieve a good performance. Yet Mrs Loua remains skeptical about the sustainability of achievements once the project is completed "today my concern is how we will manage to continue the supervision of data quality in the health facilities and how to ensure the accuracy of the HMIS data once the MCSP / HSS ends."

The DHMT members of the DPS in N'zérékoré also benefited from the training on supervision tools since they were directly involved. Mrs. Loua stated that these DHMTs that were trained by her are now able to train and guide others on the use of the supervision tools.

Thanks to this HMIS tool, changes were observed in the management of health facilities, which allowed COSAH members to become more involved in the health centers' problems. All the DPS management teams are committed to using and monitoring the implementation of the HMIS monitoring grid during supervisions and regular monitoring.

Annex C: List of presentations at international conferences and publications

“Integration of the SBMR approach to improve the quality of maternal and child health services and family planning.” Poster presentation at Institute for Healthcare Improvement, Africa Forum on Quality and Safety in Healthcare 2018, Durban, South Africa

Annex D: List of materials and tools developed or adapted by the MCSP HSS project

Comprehensive Approach to Health Systems Management
Rapid assessment of the health system in Guinea Report (April – October 2016)
Responding to Health System Needs: Findings and Implications from Rapid Health Systems Assessments of Reproductive, Maternal, Newborn, and Child Health Services (Jan 2018, Brief)
5 things we've learned from a bottom-up approach to health system strengthening (blog post)
Rising from the Ashes: Strengthening Guinea's Local Health Systems after Ebola (blog post)
In Guinea, Local Health Teams Learn to Identify and Address Pressing Challenges (blog post)
The Comprehensive Approach to Health Systems Management (May 2017, Brief)
Guide for Developing Operational Action Plans for Administrative Entities (May 2018)
Guide for Developing Operational Action Plans for Healthcare Facilities (May 2018)
Funding request template for the organization of a meeting to train the Health and Hygiene Committee (CoSaH) members
Utilization guide for CA (AIGSS) materials
Standards of performance for the DRS/DPS (AIGSS)
Introduction to HSS/AIGSS
Orientation to the Comprehensive Approach- PPT presentations
Information sheet for the AIGSS supportive visit
Infection Prevention and Control
National infection prevention and control (IPC) policy in Guinea (August 2016)
National infection prevention and control (IPC) program in Guinea (August 2016)
IPC Norms and procedures
IPC Monitoring and Evaluation Framework
Advocacy letter to MOH for the sustainability of IPC achievements
Job-aids: Waste Management and IPC posters; Guide for autoclaves
Health Information Management Systems
Technical Brief on support to DHIS2 and evolution of service delivery data
Technical brief- HMIS supervision tools
Indicators catalog
Standards-based Management and Recognition (SBM-R)
Factsheets of facilities (one pager) for recognition and hand-over ceremonies
Integration of the SBMR approach to improve the quality of maternal and child health services and family planning (poster presented at IHI Conference, 2018)
Post-epidemic Response
Effective Interventions to Strengthen Health Systems after an Epidemic: MCSP's Response to Ebola in Guinea, Liberia, and Ghana
General project information
Monthly and quarterly reports
Regional results posters presented at project closeout event
Impact Profiles

Annex E: List of national trainers and supervisors per area of intervention of the MCSP HSS project

National and regional trainers trained in SBM-R supportive supervision

Name	TITLE	INSTITUTION
TRAORE Kadiatou	Physician	Conakry / CMC Coléah
DANFAKA Woudé	Head Nurse	Conakry/CMC Flaboyant
KABA Aminata	Director	Conakry/CMC Ratoma
DIALLO Mariama Binta	Midwife	Conakry / CMC Minière
BARRY Houssainatou	Physician	Conakry /CMC Matam
CAMAR Mamadou	Physician	Conakry /CMC Coleah
CAMARA Mariama Cire	CPFR/DSVCO	Conakry /DSVCO
SQUARE Nènè Oumou	Midwife	Kindia
CHERIF Fanta	Midwife	Kindia
BARRY Abdoulaye	CPFR / DRS	Kindia
THIAM Mamadou	Physician HR	Kindia
LOUA Brigitte	PFR / DRS	Kindia
CAMARA J. Christine	CCS Cacia	Kindia
KEITA Saran	SBC/ DPS	Kindia/ Forécariah
CONDE Mohamed Saran	C.M. Reg. Stp Palu.	Kindia/ Forecariah
SOUMAH N'fansoumane	DGA/ Hop.Reg.	Boké
DIALLO Mamadou Alpha	Physician / DPS	Boké
BANGOURA Abdourahmane	CCS Dibia	Boké
BARRY Fatoumata Binta	Midwife	Boké/ Kamsar
TENKIANO Daniel	Physician / DPS	Boffa
SOROPOGUI Therese	MCM /DPS	Kissoudougou

Focal points for the Comprehensive Approach to Health Systems Management

Region	Name	Title/Institution
Boké	Dr Sock Gouressy	DPS/Gaoual
	Dr Boubacar Bangoura	DH/Fria
	Mr Ibrahima Camara	PFR/ Boké
Kindia	Dr Mory Togba	DPS Kindia
	Dr Beavogui Maurice	DH/Telemele
	Dr Fanta Dabo	PFR/DPS Dubreka
Conakry	Dr Fatoumata Conte	DCS Ratoma
	Dr Aicha Drame	Labo-phar./Kaloum
	Mr Keita Mamadou Ben	DMR/Dixinn
Nzerekore	Dr Sanoussy Sidibe	DH/Yomou
	Dr Lancine Doumbouyah	CPFR/Beyla
	Mme Therese Soropogui	MCM/Kissidougou

IPC focal points in healthcare facilities

Sites	Name	Title
HN Donka	Mandiou Diakite	Hygiene Committee
	Marie Khalissa	General Supervisor
HN Ignace Deen	Moussa Koulibaly	Deputy Director
	Mamadou Samba Camara	Head Nurse
HN Sino guinéen	El Sakaye Tolno	Director of Patient Care
CMC Matam	Hadja Fatoumata Konate	General Supervisor
CMC Ratoma	Mr Biolaye Camara	Head Nurse
CMC Coleah	Mme Marguerite Conde	General Supervisor
CMC Minière	Hadja Ramatoulaye Diallo	General Supervisor
CMC Flamboyant	Woude Danfaka	General Supervisor
CMS Jean Paul II	Bandian Dafa	Head physician
Forécariah	Kadiatou Soumah	Midwife /Prefectural hosp
	Saran Keita	DPS
Beyla	Ansoumane Fofana,	Physician/ Prefectural Hosp
	Mamy Héléne Delamou	ATS/CMC Sinko
	Jack Traore	Nurse, C-SBC/DPS
Kissidougou	Thérèse Onivogui	DPS
	Facinet Camara	General supervisor /HP
Kindia	Mamadou Thiam	Physician HRK
	Brigitte Loua	FRP/DPS
Boké	Toumani Diallo	DRS
	Sekou Naba Camara	Laboratory/ HR
	Christian Cheik Camara	Hopital ANAIM
Fria	Kalidou Soumah	MCM/DPS
	Mme Dore	General supervisor/ Prefectural hosp