

MCHIP Guinea End-of-Project Report

October 2010–June 2014



Submitted on:
September 15, 2014

Submitted to:
United States Agency for International Development
under Cooperative Agreement # GHS-A-00-08-00002-000

Submitted by:
Yolande Hyjazi, Rachel Waxman and Bethany Arnold

The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

MCHIP brings together a partnership of organizations with demonstrated success in reducing maternal, newborn and child mortality rates and malnutrition. Each partner will take the lead in developing programs around specific technical areas:

Jhpiego, as the Prime, will lead maternal health, family planning/reproductive health, and prevention of mother-to-child transmission of HIV (PMTCT);

JSI—child health, immunization, and pediatric AIDS;

Save the Children—newborn health, community interventions for MNCH, and community mobilization;

PATH—nutrition and health technology;

JHU/IIP—research and evaluation;

Broad Branch—health financing;

PSI—social marketing; and

ICF International—continues support for the Child Survival and Health Grants Program (CSHGP) and the Malaria Communities Program (MCP).

This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00. The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

Country Summary: Guinea



Selected Health and Demographic Data for Guinea	
GDP per capita (USD)	440
Total population (millions)	11.1
Maternal mortality ratio (deaths/100,000 live births)	724
Skilled birth attendant coverage	45
Antenatal care, 4+ visits	57
Neonatal mortality rate (deaths/1,000 live births)	33
Infant mortality rate (deaths/1,000 live births)	67
Under-five mortality (deaths/1,000 live births)	123
Treatment for acute respiratory infection	38
Oral rehydration therapy for treatment of diarrhea	34
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	50
Modern contraceptive prevalence rate	7
Total fertility rate	5.1
Total health expenditure per capita (USD)	32

Sources: World Bank; Ministère Plan 2012; DHSIV.

Major Activities by Program

- Expand the family planning method mix with long-acting reversible and permanent methods; integrate family planning with postabortion and postpartum care
- Integrate the Standards-Based Management and Recognition (SBM-R®) methodology in hospitals and health centers
- Strengthen comprehensive emergency obstetric and newborn care and prevention of mother-to-child transmission of HIV services in hospitals and urban health centers
- Strengthen community-based health communications and services for family planning, birth planning and complication recognition, management of childhood illness, malaria prevention and treatment, and prevention of postpartum hemorrhage in home deliveries
- Update health strategy documents, protocols, and national health management information system indicators and tools
- Support pre-service education for the medical faculty and the national midwifery school

Program Dates	October 2010–June 2014					
Total Mission Funding to Date by Area	Family Planning: \$3,682,000; Maternal and Child Health: \$3,406,000; HIV: \$999,000; Malaria: \$521,879; Incentive Funds for Gender-Based Violence: \$400,000					
Total Core Funding to Date by Area	Family Planning: \$66,108; Maternal and Child Health: \$156,824					
Geographic Coverage	No. (%) of provinces	4/8 (50%)	No. of districts	20/38 (53%)	No. of facilities	234/461 (51%)
Country and HQ Contacts	Prof. Yolande Hyjazi: yolande.hyjazi@jhpiego.org ; Gassim Cisse: Gassim.cisse@jhpiego.org ; Rachel Waxman: Rachel.waxman@jhpiego.org ; Bethany Arnold: Bethany.arnold@jhpiego.org ; Tsigué Pleah: Tsigue.pleah@jhpiego.org ; Blami Dao: Blami.dao@jhpiego.org ; Serge Raharison: sraharison@mchip.net ; Winifride Mwebesa: wmwebesa@savechildren.org					

Table of Contents

Country Summary: Guinea.....	3
Table of Contents.....	4
List of Tables and Figures	6
Acronyms and Abbreviations.....	7
Acknowledgments.....	8
Executive Summary: Guinea.....	9
Introduction	15
Major Accomplishments.....	18
Family Planning.....	18
MCHIP Interventions.....	18
Improved Access, Utilization and Quality of FP services.....	21
Challenges, Responses and Lessons.....	23
Maternal and Newborn Health.....	25
MCHIP Interventions.....	25
Improved Access, Utilization and Quality of MNH services	29
Challenges, Responses and Lessons.....	31
Child Health	32
MCHIP Interventions.....	32
Improved Access, Utilization and Quality of Child Health Services.....	35
Challenges, Responses and Lessons.....	36
Community Health	37
MCHIP Interventions.....	37
Improved Access, Utilization and Quality of Community-based Health Services	40
Challenges, Responses and Lessons.....	41
Pre-Service Education	42
MCHIP Interventions.....	42
Improved Functioning and Quality of Pre-service Education.....	44
Challenges, Responses and Lessons.....	46
Malaria (October 2011 to December 2012).....	47
MCHIP Interventions.....	47
Quality Improvement: The Standards-Based Management and Recognition methodology (SBM-R)	49
Outcomes of the focus on quality and standards	51
Challenges, Responses and Lessons.....	52
Monitoring and evaluation (m&e) strengthening.....	55
Data quality improvement.....	56

Challenges, Responses and Lessons.....	56
Infection Prevention.....	58
mHealth and mMentoring.....	60
Prevention, screening and Services for Gender based violence.....	64
Program Learning Themes	65
Continuation of PPIUD	65
Decentralizing training by developing regional trainers for FP and EmONC	65
SBM-R	66
mHealth.....	66
mMentoring.....	66
Urban Community Health	67
PPH prevention:	68
PAC and LARC service expansion and uptake	68
Integration of malaria and IMNCI:.....	69
Recommendations and Way Forward	70
Annex 1: Performance Monitoring Plan	72
Annex 2: Success Stories.....	82
Annex 3: List of Presentations at International Conferences and Publications.....	104
Annex 4: List of Materials and Tools Developed or Adapted by the Program.....	106
Annex 5: Program Learning Matrix.....	114
Annex 6: List of MCHIP Facilities and Interventions per Facility	116
Annex 7: List of MCHIP trained trainers.....	117

List of Tables and Figures

Figure 1: Map of MCHIP Intervention areas (indicated in blue).....	16
Table 2: Service delivery indicators for FP services by fiscal year: 2011-2014.....	21
Figure 3: Adoption of long-acting family planning methods by quarter	22
Figure 4: Continuation rates of PPIUD after one year.....	22
Figure 5: Program Learning - PAC and LARC Integration	22
Table 6: Key MNH indicators for MCHIP interventions by fiscal year: 2011-2014	29
Table 7: PMCT indicators for MCHIP interventions - 2014.....	30
Figure 8: Prevention of postpartum hemorrhage in the community	30
Table 9: Service delivery indicators for child health services by quarter: 2012-2014.....	35
Figure 10: Bringing community health interventions to urban areas	39
Table 11: Group education sessions by topics and number of attendees by fiscal year: 2012-2014	40
Table 12: Community-based distribution of modern family planning methods by fiscal year: 2012-2014	40
Figure 13: Evolution of performance indicators for pre-service education at ENSK.....	44
Figure 14: Comments from the faculty and preceptors of ENSK	45
Figure 15: Engagement with private midwifery schools.....	45
Figure 16: Map of PMI intervention areas	47
Figure 17: Lowest, median and highest scores at baseline and last evaluation of performance standards by domain for all facilities implementing SBM-R.....	51
Figure 18: Resources leveraged to address challenges to quality and performance	53
Figure 19: RQAS scores on key performance areas by region.....	56
Table 20: Evolution of the use of the mobile phone network by quarter: 2012-2014	60
Figure 21: Can mMentoring replace post-training follow-up visits following EmONC training?.....	61
Figure 22: Using Tablets to Collect Study Data on LARC in Post-Abortion Care Services	61
Figure 23: Testing a Mobile Safe Childbirth Checklist	63

Acronyms and Abbreviations

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Care
AMTSL	Active Management of the Third Stage of Labor
APIC	Association pour la promotion des initiatives communautaires
APIF	Association pour la promotion des initiatives féminines
BCC	Behavior Change Communication
CAM	Club des amis du monde
CH	Child Health
CHW	Community Health Worker
CMC	Communal Medical Center
DPS	Direction Préfectoral de la Santé (Prefecural Health Directorate)
DRS	Direction Regionale de la Santé (Regional Health Direcotrate)
EmONC	Emergency Obstetric and Neonatal Care
ENSK	Ecole Nationale de la Santé a Kindia
EPI	Expanded Program for Immunization
ESD	Extending Service Delivery project
FANC	Focused Antenatal Care
FMPOS	Faculty of Medicine
FP	Family Planning
GBV	Gender-based Violence
HMIS	Health Management Information Systems
iCCM	Integrated Community Case Management
IEC	Information, Education, Communication
IMNCI	Integrated Management of Newborn and Childhood Illness
IP	Infection Prevention
IUD	Intrauterine Device
LAM	Lactational Amenorrhea Method
LLIN	Long-lasting Insecticide Treated Nets
MCHIP	Maternal and Child Health Integrated Program
MEET-FP	Ministry of Employment, Technical Education and Professional Training
MIP	Malaria in Pregnancy
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
NGO	Nongovernmental Organization
OSPADEC	Organisation Pour La Sensibilisation, La Paix et le Développement des Communautés
PAC	Postabortion Care
PE/E	Pre-eclampsia/Eclampsia
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPFP	Postpartum Family Planning
PPH	Postpartum Hemorrhage
PPIUD	Postpartum Intrauterine Device
PSE	Pre-service Education
RDT	Rapid Diagnostic Test
RH/FP	Reproductive Health/Family Planning
SBM-R	Standards-based Management and Recognition
TL	Tubal Ligation
WAHO	West African Health Organization
WHO	World Health Organization
WHO AFRO	World Health Organization Regional Office for Africa

Acknowledgments

Key partners:

The MCHIP partners, Jhpiego, Save the Children and JSI, Inc., implementing the Guinea project would like to thank our many collaborators and partners.

- The Ministry of Public Health and specifically the Secretary General, the National Directorate of Family Health and Nutrition, the National Directorate of Prevention and Community Health, the National Malaria Control Program, the National IMNCI Program
- The Regional Health Offices of Conakry, Faranah, Kankan, and N'zerekore and the prefectural and communal health offices in these regions
- The healthcare workers in MCHIP supported facilities and the community health agents engaged in bringing health information and services to their communities
- The Ministry of Employment, Technical Education and Professional Training
- The Directors and personnel of the National School of Public Health in Kindia (ENSK)
- The United Nations Organizations: WHO, UNFPA and UNICEF
- USAID Implementing partners
- The local NGOs that collaborated with MCHIP: CAM, APIF, APIC and OSPADDEC
- The local radio stations that partnered with the project

The MCHIP team

In-country Technical Team: Prof Yolande Hyjazi, Dr Gassim Cissé, Dr Bokar Dem, Dr Havanatou Camara, Dr Suzanne Austin, Dr Mamamdou Malal Diallo, Dr Diény Fadma Kaba, Bamba Mamady Camara, Jacqueline Aribot, Dr. Abdoulaye Diallo, Dr Ibrahima Pita Bah, Soufiana Kaba, Bakary Béréké, Dr. Marlyatou Diallo, Feu Facély Kourouma, Damou Rahim Kéita, Save the Children's Mandiana Team: Fatoumata Diakite, Adama Diop and the many community organizers.

Finance, Admin and Operations Team: Mamadou Ahmadou Diallo, Sougoulé Ténin, Thierno Saidou Diallo, El Hadj Mamadou Saliou Bah, Abdoulaye Camara, Almamay Keita Abass Kourouma, Talla Diawara.

HQ Technical Support Team: Dr. Tsigue Pleah, Prof. Blami Dao, Patricia Gomez, Dr Winifred Mwebesa, Dr Serge Raharison, Lindsay Wilson-Williams, Moussa Ly, Anne Pfitzer, Sarah Searle

HQ Program Team: Rachel Waxman, Jennifer Shindeldecker, Nefra Faltas, Bethany Arnold, Soo Kim, Caroline Tran, Joan Peto, Sylvia Alford, Kerry Ross, Shannon Walker, Galina Stolarsky; and Linda Benamor for translation support

Executive Summary: Guinea

In Guinea, the maternal mortality ratio is one of the highest in the world, reported to be 724 deaths per 100,000 live births.¹ This high rate is due in part to very low use of modern contraceptive methods, with only 7.0% of women aged 15–49 using a modern method, and continued high fertility of 5.1 total births per woman in 2012.^{2,3} Unmet need for family planning (FP) is estimated at 24%, lower than many countries in the West Africa region, yet the demand for postabortion care remains high. The leading cause of maternal deaths is postpartum hemorrhage (PPH), mostly due to a lack of quality maternity services that are adequately prepared to respond to emergencies, referred to as emergency obstetric and newborn care (EmONC). In countries such as Guinea where malaria is endemic, malaria is a significant cause of morbidity and mortality for pregnant women and children under the age of five. In Guinea the infant mortality rate was 67 deaths per 1,000 live births in 2012 and the child mortality rate among children under the age of five was 123 deaths per 1,000 live births.

In 2010, the Maternal and Child Health Integrated Program (MCHIP) began working in Guinea to strengthen the integration of FP with maternal, newborn, and child health and to strengthen the continuum of care from the community to the health center to the hospital. MCHIP has engaged with the Ministry of Health and stakeholders at the national level to maintain up-to-date health policies and national guidelines, and to support strengthening the national health management information system (HMIS). The geographic focus of MCHIP's work has reached all intervention areas of the United States Agency for International Development, including the five communes of the capital Conakry and the 15 prefectures of the three eastern regions of Faranah, N'zerekore, and Kankan. MCHIP's interventions cover a population of 6.4 million, 234 facilities, and 1,700 villages.

Starting with a focus on family planning and quality improvement in the first year of activities, MCHIP/Guinea greatly expanded its scope of work and reach in the second year to include, among others: comprehensive EmONC, management of the sick child, pre-service education at the national midwifery school, malaria prevention and treatment, prevention of mother-to-child transmission of HIV (PMTCT), and gender-based violence.

Major accomplishments by technical area and among cross-cutting interventions include:

Family planning interventions have focused on expanding the method mix to include long-acting reversible and permanent methods and ensuring that women are better able to access and select a method that meets their needs. Particular attention was given to linking FP to postpartum and postabortion care (PAC) as entry points to promote healthy timing and spacing of births and the avoidance of unwanted pregnancies. By the end of MCHIP, 110 facilities offered implants (Jadelle), 125 offered interval IUDs, 110 facilities provided counseling to pregnant women on postpartum FP options, 34 facilities offered postpartum IUDs in the maternity ward, and 20 MCHIP-supported facilities offered laparoscopic tubal ligation. The provision of these services is the result of the training of:

- 502 providers on different long-acting FP methods,
- 332 providers in counseling for postpartum care and PAC, and

¹ Institut National de la Statistique (INS) et ICF International. 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples de Guinée (EDS-MICS 2012)*. Calverton, MD, USA: INS and ICF International.

² Ibid. Total fertility rate represents the number of children who would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age-specific fertility rates.

³ UNFPA. 2014. *State of the World Population 2013: Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy*. New York: UNFPA. <http://www.unfpa.org/webdav/site/global/shared/swp2013/EN-SWOP2013-final.pdf>.

- 1,130 community health workers on an integrated package of FP/reproductive health/maternal, newborn, and child health messages to accompany community-based distribution of short-acting methods (pill and condoms).

The training was accompanied by site strengthening activities such as provision of instrument kits and communication and data collection materials; quality improvement using the Standards-Based Management and Recognition (SBM-R) approach; and supportive supervision. MCHIP also developed a pool of 35 trainers and 64 community health worker (CHW) supervisors capable of providing ongoing training and supervision of FP services in facilities and in communities. As a result of MCHIP's support for FP service expansion and quality improvement, HMIS data collected by the project have shown steady increases in:

- The number of women receiving counseling as part of PAC or postpartum services
- The number of women adopting a modern method
- PAC and postpartum services
- New and continuing FP users
- Couple-years of protection

Long-acting and reversible contraception as a proportion of all methods distributed, increased steadily from 10.5 percent in the first semester of 2013, to 11 percent in the third quarter, 15 percent in the fourth quarter, and 16.6 percent and 17.2 percent respectively in first two quarters of 2014.

Service Delivery Indicators for FP Services by Fiscal Year: 2011–2014

INDICATORS	2011	2012	2013	2014 (SIX MONTHS)
Number of new acceptors of modern contraceptive methods	7,107	176,281	197,222	96,418
Number of continuing users of FP methods	–	153,677	131,620	84,370
Couple-years of protection	10,759	66,858	116,032	66,871

Maternal and newborn health interventions have focused on quality improvement and comprehensive EmONC in particular, and, in 2013, expanded to include PMTCT. Eighty-three providers from 20 facilities were trained and updated on clinical skills for comprehensive EmONC and a total of 48 facilities are implementing performance standards for EmONC as part of SBM-R. Training was again accompanied by technical support for the development and updating of training materials, job aids and performance standards, support for site strengthening through the provision of key materials and instruments, including locally fabricated delivery tables and privacy screens, as well as supportive supervision. To support sustainability, 17 trainers in teams of three to four were qualified to provide EmONC clinical training and supervision, an additional 34 trainers were qualified for focused antenatal care, and 22 trainers were qualified to support improved infection prevention practices. As a result of these activities, consistent use of key clinical actions during labor and delivery has improved, including active management of third stage labor, use of the partograph to monitor labor, management of pre-eclampsia and eclampsia using magnesium sulfate, and essential newborn care. An analysis of 16 initial SBM-R facilities showed a decline in postpartum hemorrhage (2% to 1.5%) and post-operative/post-procedure infections (1.1% to 0.5% and 2% to 0%). MCHIP/Guinea also conducted a pilot study of community-based distribution of misoprostol for PPH prevention, which is contributing to multi-country learning on operationalizing this intervention.

Specific to PMTCT, MCHIP supported the PMTCT policy review for the adoption of the World Health Organization's option B+ in Guinea prior to the training of 20 providers from 10

facilities. MCHIP/Guinea worked closely with UNICEF to quantify HIV testing and antiretroviral needs for the new services. In the first six months of PMTCT services, all women attending antenatal care received HIV counseling and testing (n=1,925) and a further 728 women received counseling and testing during labor or postpartum. All women who tested HIV-positive (n=30) received antiretroviral prophylaxis for PMTCT and were referred for ongoing care.

Child health interventions were initiated in 2012 to strengthen the availability and quality of care for sick children. Particular emphasis was given to promotion of the revised and shortened training program of integrated management of newborn and child illness (IMNCI), including developing country-level experience with integrated community case management (iCCM). Working in a pilot area of 20 facilities and their surrounding communities, 38 providers and 101 CHWs were trained and supported to implement the updated package of facility and community interventions. Facilities were provided with supplies, job aids, and revised registers and record-keeping tools. CHWs were provided a kit of supplies, initial stocks of medications, and communication and record-keeping tools for community-based services. In the 15 months following the trainings, more than 20,000 sick children were treated using updated protocols (91% in health facilities). Performance standards for IMNCI were also developed and introduced in three of the pilot facilities, which expanded the use of SBM-R as a quality improvement tool across multiple technical domains.



CHW uses the updated protocol to assess a child's health.

Community health interventions were implemented to improve access to quality health services and health information in rural and urban communities to contribute to a reduction in maternal and child mortality in Guinea. CHWs in Guinea provide a package of services, approved by the Ministry of Health and focused on health promotion messages, including maternal, neonatal, and child health and family planning. They also offer non-prescription FP services and support the management of simple cases of the most common diseases in children under five years. MCHIP reinforced the skills of 1,092 existing CHWs through refresher training, supportive supervision, and provision of bicycles and other materials to support their work in the community. MCHIP also worked closely with the community health supervisors to strengthen their capacity for supervision and monitoring. While most of the work in Guinea with CHWs was focused on reaching rural communities with health information and services, MCHIP also implemented innovative approaches to reach urban communities with health interventions through community organizations and through hair salons, training 241 community organizers and 58 new CHWs. MCHIP-supported CHWs conducted 103,805 group education sessions on FP, maternal and newborn health, and IMNCI over the four years of the project. In the final 18 months of activities, 74,346 group discussions reached 292,164 people. Community-distributed FP contributed approximately one-third of all new and continuing users in MCHIP-supported zones.



MCHIP worked closely with the faculty at ENSK to improve education and training of health care providers in Guinea.

MCHIP supported **pre-service education (PSE)** interventions with the Faculty of Medicine in Conakry and the midwifery program at the National Public Health School in Kindia (ENSK). Activities included support for the development of skills labs where students can get hands-on experience using anatomic models and simulators, and training sessions for faculty and preceptors on effective teaching skills, student performance assessment, and clinical training and mentoring skills for maternal and newborn health. MCHIP worked closely with ENSK to revise the midwifery training curriculum in accordance with recommendations from West African Health Organization and the International Confederation of Midwives to ensure a competency-based approach to education. Quality improvement using SBM-R included adapting performance standards for PSE, training faculty in the problem-solving methodology, completing a baseline assessment, and supporting ongoing follow-up. A review of action plans shows a positive evolution in performance along the five domains of theory, practice, evaluation, infrastructure, and management, with global performance improving from 11% to 67% of standards met between the baseline in December 2012 and January 2014.

Guinea became a focus country for the President's Malaria Initiative (PMI) in November 2011. MCHIP was asked to incorporate interventions to strengthen the prevention and treatment of malaria as part of its 2012 workplan. MCHIP provided technical and financial support for the revision of national policies and protocols for the prevention and treatment of malaria to include updated protocols on case confirmation using rapid diagnostic tests, intermittent preventive treatment of malaria for pregnant women, and communication messages. In PMI's four focus regions, 34 supervisors and trainers were updated as a means to train 136 providers and 102 CHWs using the updated training materials, job aids, and monitoring tools.

SBM-R is a quality improvement methodology developed by Jhpiego to address the need for ongoing attention to the quality of care. By developing an agreed-upon set of performance standards, providers, managers, and community stakeholders are better able to assess the status of health care services at any given time, develop action plans to address gaps, and recognize improvements between assessments. Over the life of the project, SBM-R was introduced in 48 MCHIP-supported facilities. The initial focus included standards for FP services, EmONC, and infection prevention, while additional standards were also adapted and integrated into selected facilities for the surgical and anesthesia skills required for comprehensive EmONC, PMTCT, IMNCI, and PSE. A total of 224 stakeholders, including providers, managers, and community representatives, were trained on SBM-R. To promote sustainability, six trainers were qualified to support SBM-R activities and a further 35 prefectural and regional supervisors were trained to support the process. The Ministry of Health has been highly supportive of this process, forming the National Recognition Committee, including it in the national maternal mortality reduction strategy, and actively looking to donors and partners to scale it up. By the end of the project, 16 facilities achieved recognition for consistent high



A symbol of recognition was placed at the entrance of each facility that met consistent high performance of SBM-R standards.

performance, while others were continuing to see progress and improvements. To address gaps in performance, facility teams successfully leveraged support from local partners as well as their own initiative to make improvements.

While **monitoring and evaluation** is a routine part of project management, MCHIP's efforts to improve data recording and reporting in MCHIP-supported facilities led to a request to support the updating of indicators and tools for the national HMIS. MCHIP's implementation of data quality assurance sampling methods also led to a request to train HMIS staff at all levels on the methodology.

Infection prevention was identified as one of the weakest elements of service delivery and therefore MCHIP developed targeted activities to reinforce trainers' and supervisors' capacity to model good infection prevention skills in conjunction with the National Department for Health and Public Hygiene.

MCHIP supported two initiatives to use mobile phone technology—**mHealth**—to strengthen health care service delivery. A network of 264 mobile phones was distributed to providers and managers to facilitate communications for referrals, stock management, coordination, and epidemiological surveillance, as well as colleague-to-colleague consultation. Over three years of operation, more than 120,000 calls were made. Initial costs for the network were \$6,000, with annual costs for airtime of \$7,000. The second initiative was a pilot using mobile phones to provide mentoring—**mMentoring**—to providers following training in place of an in-person supervision visit.

With all its activities and accomplishments, MCHIP/Guinea has contributed extensively to program learning in several domains of the global MCHIP program, including: integration of services for EmONC and postpartum FP; scale-up of integrated PAC and FP services; linking SBM-R performance improvement with health outcomes; operationalization of community-based distribution of misoprostol for PPH prevention; innovative community interventions to reach urban residents; implementation of the revised IMNCI/iCCM training model and updated protocols; and mHealth technology to support providers and increase access to health care.

RECOMMENDATIONS

Over the course of three and half years a number of important improvements were made in the provision and quality of healthcare services in USAID supported regions. In order to continue to build on these gains, and assist the Ministry of Health of Guinea to continue to improve its capacity to lead and sustain quality services for the people of Guinea, it will be important for donors and partners to sustain their support. The Guinean health system is still very dependent on external assistance and gains can be quickly lost when support fluctuates and/or is accompanied by conflicting strategies and advice.

1. The MOH should be encouraged and supported to continue to institutionalize **SBM-R** as a quality improvement process.
2. The MOH should also be supported to strengthen and institutionalize its coordination and policy setting role in healthcare and public health in general.
3. MOH and partners should be encouraged to make use of the national trainers that were trained by MCHIP in various technical areas and then in training skills. (See Annex 7 for the list of trainers by topic.) These national resources and the training materials adapted in collaboration with MOH under MCHIP can serve to systematize in-service, continuing education efforts.
4. **Family Planning:** The integration of LARC into family planning services should continue, as well as continued integration of FP and Maternal Health services through postpartum

family planning counseling and access to immediate postpartum methods (PPIUD, and implant if guidance changes). An expanded method mix and linking FP to ANC and maternity services increases the opportunities for women to find a method that suits their needs at a time when they interact with the healthcare system and may desire to space or limit future pregnancies.

5. While FP methods posed a particular commodity challenge, the overall supply chain remains weak and ultimately FP commodities need to part of an integrated supply management system to effectively ensure that facilities and community health workers have the drugs and materials to offer the services that other resources are invested in for their education and training.
6. **Maternal and newborn health:** MOH and partners need to continue to identify opportunities to strengthen and perpetuate the capacity of the facilities providing Comprehensive EmONC and PMTCT services and the providers working there to respond effectively to urgent care needs of pregnant women and sick children.
7. Continued support to the midwifery school at ENSK is another important way to ensure that student midwives are adequately prepared from the beginning of their careers to provide quality maternal and newborn care.
8. **Misoprostol for prevention of postpartum hemorrhage:** CHW and ANC distribution of misoprostol for use at home births represents an important opportunity to put in place a practice that can save many women's lives. It will be important to support MOH to extend the use of this medication at community level, by integrating its use into policy and norms and supporting the scale up its implementation.
9. **Child Health:** Lessons should continue to be gathered from the pilot of the updated IMNCI protocols and training in 20 sites.
10. **Community Health:** The extensive investment in training CHWs to date merits focused efforts to continue to support their work, ensure their work is properly recorded and reported and to provide periodic refreshers and updates.
11. **mHealth:** The mobile phone network is a promising approach to improve the connections between and communications among providers for multiple elements of health service delivery at a reasonable cost.

Introduction

In Guinea the maternal mortality ratio (MMR) is one of the highest in the world, reported to be 724 deaths per 100,000 live births⁴. This high rate is due in part to very low use of modern contraceptive methods with only 7.0 percent using a modern method among women aged 15-49 and continued high fertility of 5.1 total births per woman in 2012^{5,6}. Unmet need for family planning (FP) is estimated at 24 percent, lower than many countries in the West Africa region, yet the demand for postabortion care remains high. Fortunately, the acceptance of a modern FP method in PAC services has increased steadily in MCHIP-supported facilities from 63 percent in 2011 to 89 percent in 2013. The leading cause of maternal deaths is postpartum hemorrhage (PPH), mostly due to a lack of quality maternity services that are adequately prepared to respond to emergencies, referred to as Emergency Obstetric and Newborn Care (EmONC)⁷. Malaria is also a significant cause of morbidity and mortality for pregnant women and children under the age of 5 in countries like Guinea where it is endemic. Overall, the infant mortality rate was 67 deaths per 1,000 live births in 2012 and the child mortality rate among children aged 0-5 was 123 deaths per 1,000 live births. In Guinea the HIV prevalence is estimated at 1.7% measured as the proportion of women and men aged 15-49 who are HIV-positive⁸ and interventions in this area are still limited in scope and not integrated into routine maternal health services.

The goal of USAID's Maternal and Child Health Integrated Program (MCHIP) has been to assist in scaling up evidence-based, high-impact maternal, newborn and child health (MNCH) interventions and thereby contribute to significant reductions in maternal and child mortality and progress toward the achievement of Millennium Development Goals 4 and 5.

After transitioning from the previous Reproductive Maternal, Newborn and Child Health global award, ACCESS-FP, in 2010, MCHIP Guinea began working to strengthen the integration of family planning with maternal, newborn and child health and to strengthen the continuum of care from the community to the health center to the hospital. MCHIP has engaged with the Ministry of Health (MOH) and stakeholders at the national level to maintain up-to-date health policies and national guidelines, and to support strengthening the National Health Management Information System (HMIS). The geographic focus of MCHIP's work has reached all USAID interventions area, including the five communes of the capital Conakry and the 15 prefectures of the three eastern regions of Faranah, N'zerekore and Kankan. MCHIP's interventions cover a population of 6.4 million, 234 facilities and 1,700 villages. (See the Map below.) A list of facilities and project interventions is included in Annex 6.

⁴ Institut National de la Statistique (INS) et ICF International. 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples de Guinée (EDS-MICS 2012)*. Calverton, MD, USA: INS et ICF International.

⁵ Ibid. Total fertility rate represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age-specific fertility rates.

⁶ UNFPA. 2014. *State of the World Population 2013: Motherhood in childhood: Facing the challenge of adolescent pregnancy*. New York, New York: UNFPA. <http://www.unfpa.org/webdav/site/global/shared/swp2013/EN-SWOP2013-final.pdf>.

⁷ WHO, UNFPA, UNICEF, AMDD. 2009. *Monitoring emergency obstetric care: a handbook*. Geneva: WHO. Basic EmONC includes provision of antibiotics, anticonvulsants, oxytocics, manual removal of the placenta, assisted vaginal delivery, removal of retained products, and emergency newborn care (including newborn resuscitation). Comprehensive EmONC includes all Basic EmONC functions plus surgical capacity for caesarean section delivery, laparotomy, etc., and blood transfusion.

⁸ Institut National de la Statistique (INS) et ICF International. 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples de Guinée (EDS-MICS 2012)*. Calverton, MD, USA: INS et ICF International.

Figure 1: Map of MCHIP Intervention areas (indicated in blue)



During the first project year in 2011, MCHIP Guinea focused primarily on: 1) improving the quality of EmONC, FP and Infection Prevention (IP) using the Standards Based Management and Recognition (SBM-R) methodology; 2) Improving family planning services and provision of long-acting methods in particular; 3) Strengthening the maternal health and family planning component of pre-service education at the national medical school; and 4) Strengthening community-based activities to promote utilization of and referral to health services, especially FP, in collaboration with other ongoing USAID projects.

During the course of 2011, MCHIP Guinea was asked to assume responsibility for monitoring and supervision support for facilities that were funded to strengthen FP services by another USAID project, the Extending Service Delivery (ESD project). The following year, MCHIP Guinea was asked to greatly expand its scope of work to include, among others: Comprehensive EmONC, management of the sick child, pre-service education at the national midwifery school, malaria prevention and treatment, prevention of mother-to-child transmission of HIV (PMTCT), and gender-based violence (GBV).

As of 2012, the project objectives were:

1. Increase access to high quality family planning (FP) services
2. Increase access to and improve quality of emergency obstetric and newborn care (EmONC) services
3. Improve access to quality Integrated Management of Newborn and Child Illness (IMNCI) services and Community Case Management CCM) for children under 5
4. Strengthen communications for improved community outreach, health information and increased access to a package of community-based health services

5. Strengthen MCH and FP components of medical and midwifery pre-service education and improve the competency-based training capacity of the faculty and preceptors of the Faculty of Medicine in Conakry and the National Public Health School in Kindia.
6. Contribute to improving malaria outcomes and strengthen the quality of services at the facility and community levels (October 2011 to December 2012)

Cross-cutting interventions: A number of MCHIP’s interventions work across the technical areas listed above, in order to build the capacity of health systems, which will promote the sustainability of USAID’s investments. These include:

1. Promotion of the quality improvement approach—standards-based management and recognition (SBM-R)
2. Focus on infection prevention practices across all training and supervision activities
3. Use of mobile technology for health, for example, mHealth and mMentoring
4. Assistance in updating the health management information system (HMIS) indicators and data collection tools and improving the skills of data managers to use the tools, as requested by the Minister of Public Health and Hygiene

In the final year of the project, MCHIP was requested to implement a new initiative to address Gender-based Violence (GBV). The USAID Guinea mission successfully applied for incentive funding for a three year GBV project as an opportunity to link the activities already taking place in reproductive and maternal health services to the prevention and management of GBV. During the last six months of the MCHIP project, in partnership with the American Bar Association’s Rule of Law Initiative, conducted a situation analysis to more clearly understand the local circumstances and identify interventions to increase access to clinical and legal services for GBV as well as prevention initiatives.

This project report is organized by the Objectives and Cross-cutting interventions listed above. Within each technical area, MCHIP’s activities and achievements are organized into categories that closely reflect the WHO Health Systems Framework and six building blocks⁹. MCHIP employed a comprehensive and progressive approach to strengthen FP and MNCH services that ultimately contributed to strengthening many elements in the overall health system and the potential sustainability of USAID’s investment in Guinea.

Health system building blocks	MCHIP intervention categories
<ul style="list-style-type: none"> • Leadership/Governance • Information • Medical products and technologies • Health Workforce • Service delivery • Financing 	<ul style="list-style-type: none"> • Policy interventions • Materials development and dissemination • Site strengthening • Training • Training of trainers • Supportive supervision

⁹ WHO. 2007. *Everybody’s business: Strengthening health systems to improve health outcomes : WHO’s framework for action*. Geneva.

Major Accomplishments

FAMILY PLANNING

MCHIP interventions for family planning have focused on expanding the method mix to include long-acting reversible and permanent methods and ensure that women are better able to access and select a method that meets their needs. Particular attention has focused on linking FP to postpartum and postabortion care, as entry points to promote healthy timing and spacing of births and the avoidance of unwanted pregnancies.

MCHIP Interventions

This activities and achievements of MCHIP interventions in FP are summarized below:

Policy interventions

- ✓ Contributed to the development of the National Action Plan for the Repositioning of FP
- ✓ Supported the revision of reproductive health/family planning (RH/FP) product pricing
- ✓ Updated information, education, and communication (IEC) messages for RH/FP; specifically counseling cards for use at community level and a flipbook for use in facilities, which are used nationwide.
- ✓ Following the completion of Save the Children's pilot study conducted in Mandiana Prefecture, MCHIP conducted a meeting to disseminate the results and advocate for the adoption and scale up of community-based distribution (CBD) of the injectable contraceptive, Depo-Provera. The MOH has since included the CBD injectable strategy in the National FP Repositioning Strategy and is looking for potential donors for scale up of the intervention.

Materials development and dissemination

- ✓ Learning resources packages (training materials) for the implant, intrauterine device (IUD), postpartum insertion of the IUD (PPIUD), and tubal ligation were adapted and validated for use in Guinea.
- ✓ A new job aid was developed for PPIUD, and the flip chart on FP methods was updated to include the integration of long-acting reversible and permanent methods into the method mix.
- ✓ As part of training and supervision activities, MCHIP routinely disseminated a number of job aids for FP and PAC to providers in focus facilities. They included a quick reference on FP eligibility criteria, PPFPP contraceptive options, lactational amenorrhea method (LAM), and for PAC services, a guide to the steps of MVA and FP counseling in PAC services.
- ✓ The FP counseling cards used by community health agents (CHWs) were also updated to improve household-level counseling and method provision and referral.
- ✓ Performance standards for FP services were developed and validated by the MOH for use as part of the quality improvement methodology, SBM-R.
- ✓ The consultation record form of family planning was revised and disseminated to improve the collection of PPFPP data.

- ✓ Reference cards and algorithms for the integration of services were developed and disseminated.
- ✓ Radio messages were recorded and broadcast as a means to recruit women interested in LARC methods to receive free services during training sessions. The messages described the method (mechanism of action, efficacy, advantages for women and infants, who is a potential client, and possible side effects), promoted the availability of the methods at nearby facilities and described when the free services would be available. Starting 2-4 days prior to a training session, the radio messages were broadcast 3-6 times a day in French and local languages appropriate to the region (Malinké, Soussou, Kpèlè, Kissi, Toma, Poular, Konianké). Mobilizing women to attend FP services during training sessions helped ensure enough clients for the supervised practice and skills development of providers.

Site strengthening

- ✓ In conjunction with clinical training activities, instrument kits for the respective long-acting methods were procured and provided to the MCHIP supported facilities. To reinforce infection prevention (IP) practices, decontamination containers, buckets, rubber gloves, etc., were also provided to each facility. Linking this with the training activities served to promote the implementation of the new services at the target facilities.
- ✓ MCHIP staff routinely served as a liaison between facilities, the national pharmacy responsible for distributing FP commodities and the key donors of FP commodities (UNFPA and USAID) in order to address stock issues and avoid stock-outs through timely notification.
- ✓ Data management tools, such as client record cards, registers and monthly report forms were also routinely provided to target facilities.
- ✓ As part of the integration of postpartum family planning counseling into antenatal services, MCHIP introduced the use of a rubber stamp used to mark a woman's ANC card to identify if she had chosen a postpartum method. This stamp (pictured right) communicated the woman's choice to maternity staff, so that the method could be provided (e.g., PPIUD) and/or discussed after delivery (e.g., LAM).
- ✓ MCHIP provided financial support for minor renovations of two facilities as well as support for reorganization of services at two additional facilities in Conakry to improve the functioning of FP and PAC services. Improvements included installing room dividers and screens to increase privacy of consultations and procedures, provision of office furniture, record storage, exam tables, rolling lamps, sterilizers, as well as fans or air conditioners to improve working conditions.

CONTRACEPTION DU POST - PARTUM	
<input type="checkbox"/> MAMA	<input type="checkbox"/> DIU PP
<input type="checkbox"/> INJECTABLES	<input type="checkbox"/> LIGATURE DES TROMPES PP
<input type="checkbox"/> CONDOM	<input type="checkbox"/> IMPLANTS
<input type="checkbox"/> PILULES PROGESTATIVES	
<input type="checkbox"/> PILULES OESTRO-PROGESTATIVES	



- ✓ Referral cards were developed and distributed to maximize the likelihood that mothers, bringing their children to healthcare facilities for vaccination and nutritional counseling, would also receive referrals to FP.

Training

- ✓ 502 providers were trained to insert long-acting methods, including implants (n=213), interval IUDs (n=124) and postpartum IUDs (n=93), and 72 were trained to perform tubal ligations.
- ✓ 332 providers were trained in counseling for postpartum and postabortion family planning (PPFP/PAC-FP).
- ✓ 1092 CHWs who were already providing community based distribution of short acting FP methods (pills and condoms) participated in an update on the integrated package of messages for FP, PAC, MNH, and IMNCI in order to improve the information and education in the community. 58 new CHWs were trained to counsel and provide short acting methods (pill, condom) and health information at the community level. (See Community Health below for more details.)

Training of Trainers

Development of local training capacity was a key investment within MCHIP activities. The trainer development pathway used in MCHIP Guinea, developed by Jhpiego, starts with knowledge and skills standardization in one or more of the courses, such as training in specific methods, counseling skills, etc. After several months of clinical practice, candidate trainers are selected from among proficient, motivated providers and prepared as trainers in clinical training skills. Course completion is followed by mentored co-training, in order to complete trainer qualifications.

The availability of effective trainers is essential in assisting providers to maintain current skills based on evidence-based best practices in health care. The preparation of these trainers allowed MCHIP to scale up training and supervision activities to reach many more facilities in the second and third years, while reducing per-session costs through use of national rather than international trainers. This pool of national and regional trainers in FP and other subjects serves as a potential resource for the MOH and their partners for a variety of training needs. MCHIP worked closely with the MOH to develop plans to make use of these national training resources.

- ✓ 35 trainers were qualified to lead trainings in long-acting methods and provide post training supportive supervision.
- ✓ 64 CHW supervisors (*Chargé SBC*) and 38 NGO community organizers were trained to support FP counseling and activities provided by the CHWs

Supportive supervision

It is not sufficient to bring providers to a training course for a few days to update their skills and then send them back to their worksites without support. Supportive supervision visits are needed to reinforce the implementation of their new skills and to assist providers in resolving challenges in integrating and managing services. In MCHIP, post training site follow-up was an integral part of training activities. Approximately six to eight weeks following training, one or two of the trainers would conduct visits to the facilities to observe trained providers putting their new skills into practice. MCHIP also provided technical and financial support for joint supervision visits with regional and prefectural supervisors. These visits provided an

opportunity to engage regional and prefectural supervisors to better support new and improved services through their routine supervision. MCHIP also provided 13 motorcycles for use by the Community Health Supervisors at the prefectural health offices (DPS) to facilitate their supervision of health centers and CHWs.

- ✓ 1,050 providers were supervised, including 309 for PFP, 149 for PPIUDs 332 for IUDs, 54 for TL and 206 for implants.
- ✓ All of the 1,096 CHWs were supervised by NGO community organizers and/or health facility supervisors.

Improved Access, Utilization and Quality of FP services

By the end of MCHIP, 110 facilities offer implants (Jadelle), 125 offer interval IUDs, 110 facilities provide counseling to pregnant women on postpartum FP options, 34 facilities offer postpartum IUDs in the maternity ward, and 20 MCHIP supported facilities offer laparoscopic tubal ligation (TL).

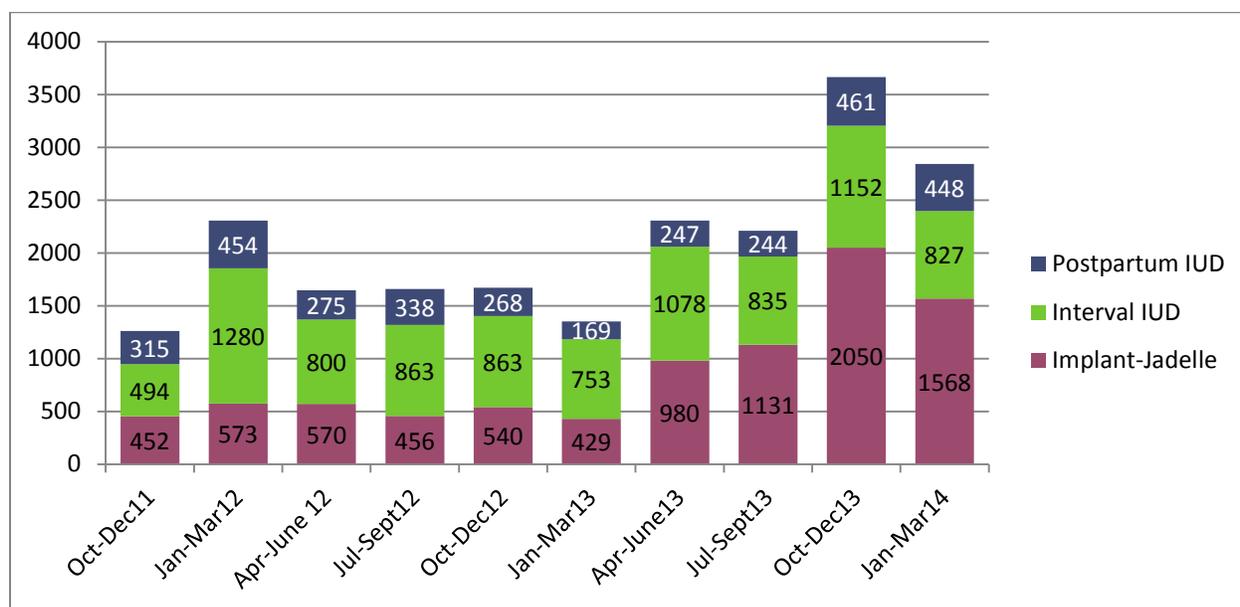
The following indicators were monitored by MCHIP in close collaboration with prefectural and regional data managers. The above investments to strengthen health system capacity to provide quality FP services in Guinea have produced positive outcomes. Long-acting and reversible contraception (LARC) as a proportion of all methods distributed, increased steadily from 10.5 percent in the first semester of 2013, to 11 percent in the third quarter, 15 percent in the fourth quarter, and 16.6 percent and 17.2 percent respectively in first two quarters of 2014.

Table 2: Service delivery indicators for FP services by fiscal year: 2011-2014

Indicators	2011	2012	2013	2014 (six months)
Number and percentage of facilities achieving 80% of FP performance standards	na	na	36/48 (75%)	19/48 (40%)
Number of USG-assisted service delivery points providing FP counseling or services	27	232	234	234
Number of women receiving individual counseling for FP/RH, immediately postpartum or as part of PAC	21,355	25,549	27,760	14,639
Percentage of women who receive individual counseling for FP/RH as part of PAC	100%	99%	99%	100%
Percentage of women who receive individual counseling for FP/RH as part of immediate postpartum care	100%	71%	58% ¹⁰	70%
Percentage of women counseled in PAC services, who accept a modern FP method	73%	81%	89%	90%
Percentage of women counseled in immediate postpartum services, who accept a modern FP method	30%	78%	95%	81%
Number of new acceptors of modern contraceptive methods	7,107	176,281	197,222	96,418
Number of continuing users of FP methods	na	153,677	131,620	84,370
Couple-years of protection	10,759	66,858	116,032	66,871

¹⁰ The decline in postpartum FP counseling was due to underreporting of activities. This was corrected through increased attention to recording during supervision visits

Figure 3: Adoption of long-acting family planning methods by quarter



Note: the decline in new users in Jan-Mar 2013 is related to stock-outs during this period.

Figure 4: Continuation rates of PPIUD after one year

Discontinuation of an FP method most often occurs during the first year of use. Therefore, the continuation rate at one year is a useful indicator to estimate the probability that a person will continue to use a contraceptive method, particularly for long-acting reversible methods. With support of an MPH student intern, physicians and midwives who were providing PPIUD services conducted follow-up phone interviews with a sample of 204 women, who had accepted an IUD in the postpartum period at least one year earlier. The one-year continuation rate was 93.6% (n=191). Differences in continuation rates by location (Conakry vs. cities in the interior) were not statistically significant ($\chi^2=0.005$, $p=0.944$). Although it is difficult to generalize based on only 13 IUD removals, partial or total expulsion was cited as the reason for discontinuation by nearly half (n=5). Other reasons included side effects, switching methods, and situational factors. Ten women discontinued IUD use within the first four months postinsertion. The findings suggest that there was widespread acceptance of IUD services postpartum in this sample. Physician follow-up should also be improved, by extending the follow-up period through the first four months postinsertion and contacting clients by phone when in-person follow-up is not possible.

Figure 5: Program Learning - PAC and LARC Integration

In February and March 2014, the Guinea MCHIP team conducted an assessment to examine the extent of integration of post-abortion care (PAC) services and family planning, especially client uptake of LARCs in the PAC setting. Using a team of 10 data collectors, the MCHIP team collected data from all 38 health facilities in Guinea that offer PAC services. The assessment looked at the availability of infrastructure, trained personnel, equipment, supplies and contraceptive methods in facilities supported by the MCHIP project, as well as facilities supported by UNFPA. The research questions included: 1) what proportion of health facilities offer a full range of contraceptive methods, including LARCs, within PAC?; 2) what are the staffing levels and ability of PAC health workers to offer a quality service?; 3) how does the health system enable or constrain this integration of PAC and family planning?; and 4) Do differential levels of program support to facilities resulted in variability in PAC service performance?

The assessment consisted of a mixed methods approach, including interviews with key informants as well as providers, facility assessments and inventory, provider knowledge and skills assessments (role-play and case studies), and the use of HMIS/service statistics. Overall, 75 PAC providers were interviewed, as well as 38 maternity-in-charges. Data was collected using Google Nexus 10.0 tablets and CommCare, a mobile data collection platform that uses cloud technology. Final results from the data are still being analyzed but show certain regional trends in uptake of family planning as part of PAC services, provider knowledge and skills in PAC and family planning counseling, and more. Overall, good integration of PAC and family planning services was found, with 70% of PAC clients accepting any method and 30% accepting LARC.

The team is preparing to submit a manuscript based on the study findings to share with a larger audience.

Knowledge sharing: MCHIP organized a national FP results dissemination in October 2011 to present the experience of the first group of facilities that integrated LARC methods under ACCESS FP and the first year of MCHIP. This served to launch the scale up of LARC in Guinea through MCHIP, as well as with funding to Jhpiego from UNFPA

MCHIP Guinea staff, in collaboration submitted numerous abstracts to international and regional conferences and were invited to make oral presentations and present posters about the experience and results of introducing LARC including the 2011 and 2013 FP Conferences, Women Deliver in 2013, FIGO Africa in 2013, the conference of the African OB/GYN Society (SAGO), the West Africa regional PAC conference in 2013. A full list of presentations on MCHIP Guinea can be found in Annex 3.

MCHIP Guinea benefitted from and provided south-to-south technical assistance (TA) across MCHIP and Jhpiego projects in West Africa. Specific to FP, MCHIP Guinea staff provided TA to Mali (MCHIP) and Burkina Faso (other funding) for training on PPIUD. With the availability of several well-functioning PPIUCD sites in Conakry, MCHIP staff and national trainers facilitated the regional PPIUD initiative funded by UNFPA to introduce PPIUD in five countries which was held in Guinea in 2013, and are providing follow-up in 2014.

Challenges, Responses and Lessons

The availability of LARC commodities was an ongoing challenge as the services were being rolled out to facilities. In most instances this was not a problem of stocks within the country, but their distribution to regions and prefectures. To address this, MCHIP worked with regional health offices to establish stock management committees to monitor regional stocks and communicate with the prefectures about their stocks and needs as a means to avoid stock-outs. MCHIP also routinely transported commodities to the regions. In the long run, these methods need to be better integrated into the overall health commodity logistics system that brings drugs and product out to the regions.

Coordination and planning of activities was an ongoing challenge. Postponement or cancellation of planned activities was a constant risk due to conflicting plans of different health partners and their demands of the regional and prefectural health offices. MCHIP negotiated with DRS and DPS to maintain planned activities. Further support is needed to strengthen the coordination capacity at all levels of the MOH.

Constant movement of healthcare providers is another common challenge to service delivery. This may include transfer to another post or other responsibilities at the facility such as supervision, meetings, etc. In an effort to make services continuously available, and avoid

disruptions, MCHIP trained two providers in each facility on each of the LARC methods introduced. Following some transfers, MCHIP was able to include new staff in later training sessions.

Finally, the integration of FP and maternal health services through a focus on postpartum family planning presents an important opportunity to reach women with information about FP at a time when they may be very willing and interested to adopt a method for birth spacing as well as her and her infant's health. Introducing PPFPP with counseling during ANC services has the potential to reach the majority of women given the high rates of at least first ANC. Facility births, while not as many, is another important time when women interact with the healthcare system and can benefit from FP information and services.

MATERNAL AND NEWBORN HEALTH

Continuing interventions initiated under the ACCESS-FP global award included support for implementation and monitoring of performance standards for EmONC as part of the SBM-R process during the first year of MCHIP activities. By the end of 2011, 27 facilities in USAID intervention areas were implementing SBM-R. (See complete description of SBM-R inputs and outcomes below.)

In 2012, as part of activity expansion, the MOH requested MCHIP to focus on Comprehensive EmONC to complement recent investments in Basic EmONC training and service strengthening by other donors. Assessment of the first ten MCHIP supported facilities quickly identified the inadequacy of basic delivery and EmONC skills¹¹. Therefore, MCHIP worked to change its interventions to address the complete package of skills needed among doctors and midwives to provide quality delivery care and correct management of obstetric complications. During training and site strengthening, MCHIP also addressed anesthesia capacity needed for surgical services. MCHIP master trainers also identified an important opportunity for integration of family planning by including postpartum counseling and methods, such as IUDs and tubal ligations, in the Comprehensive EmONC training. Finally, the training was used as a platform to test an innovative approach to post training follow-up using mobile phone technology. (See Figure 20 for information on mMentoring.)

MCHIP further expanded MNH interventions in 2013 when USAID requested additional activities to address the lack of quality services for the Prevention of Mother to Child Transmission of HIV (PMTCT). These additional activities came at an opportune time to engage with the MOH in considering the new WHO policy guidance on PMTCT service delivery models and updating national strategy.

MCHIP Interventions

The activities and achievements of MCHIP interventions for MNH are summarized as follows:

Policy interventions

- ✓ MCHIP supported the PMTCT policy review for the adoption of option B+ in Guinea. In addition to treatment to prevent transmission during pregnancy and delivery, HIV-infected women receive life-long antiretroviral therapy.
- ✓ Norms and procedures for PMTCT were then updated in accordance with the adoption of the B+ option. As part of updating and adapting training curricula to accurately reflect current health policies in Guinea and global recommendations for best practices, these documents were validated by the MOH, and they are accepted for use by MOH employees and in MOH facilities.

Materials development and dissemination

- ✓ MCHIP's technical team led the adaptation and update of an EmONC learning resource package originally developed by Jhpiego (for both Basic and Comprehensive skills), which included a reference manual, trainer's guide, participant's guide, and a guide for assessment of provider knowledge and skills, i.e., post training follow-up.

¹¹ WHO, UNFPA, UNICEF, AMDD. 2009 *Monitoring emergency obstetric care: A handbook*. Basic EmONC includes provision of antibiotics, anticonvulsants, oxytocics, manual removal of the placenta, assisted vaginal delivery, removal of retained products, and emergency newborn care (including newborn resuscitation). Comprehensive EmONC includes all Basic EmONC functions, plus surgical capacity for caesarean section delivery, laparotomy and blood transfusions.

- ✓ All of the providers trained in EmONC were also provided with key reference manuals: WHO's *Managing Complications in Pregnancy and Childbirth*, Jhpiego's *Emergency Obstetric Care Pocket Guide* and WHO AFRO's *Recommendations for EmONC in Africa: Provider's guide*.
- ✓ A training guide on anesthesia for EmONC was also developed with technical assistance from Burkina Faso.
- ✓ Several job aids were developed or updated and printed for dissemination to MCHIP-supported facilities. Topics included antenatal care, normal delivery care and management of complications:
 - Focused antenatal care (FANC)
 - Respectful maternity care
 - Birth preparedness and complication recognition
 - Active management of the third stage of labor (AMTSL) to prevent postpartum hemorrhage (PPH)
 - PPH management at the clinical and community levels
 - Management of pre-eclampsia and eclampsia (PE/E)
 - Use of magnesium sulfate for treatment of PE/E, according to available concentrations of the drug
 - Newborn resuscitation
- ✓ The learning resource package for PMTCT, including the reference manual, trainer's guide, and participant's guide were adapted and updated. These documents were validated by the MOH.
- ✓ The learning resources package for the prevention of PPH at clinical and community levels, including the trainer's guide and participant's guide, were also adapted. This was accomplished as part of the pilot study of the distribution of misoprostol for home births (see box). Guinea was one of several MCHIP countries to conduct this study.
- ✓ Performance standards for the following clinical areas:
 - EmONC
 - Obstetric surgery (Comprehensive EmONC)
 - Anesthesia and adult resuscitation
 - PMTCT

Site strengthening

Needs assessments were conducted at each of the target MCHIP supported facilities for EmONC (n=20) and PMTCT (n=10), in order to assess the inputs required to strengthen the sites. Equipment and materials were provided to the facilities to support improved service provision. The needs assessment suggested ways in which services could be better organized to promote the quality of integrated care of women and newborns.

At the Communal Medical Centers (CMC) Minière, Coléah and Matam in Conakry, existing spaces were reorganized to serve as the PAC room. Locally sourced materials and furniture were purchased at reasonable cost. Exam/delivery tables were constructed by local craftsman at 360USD/unit. Locally made privacy screens were also provided to the delivery rooms in four facilities. An advantage of the locally made materials is that maintenance and repair is also available at reasonable cost. When these materials started to show wear and tear, CMC Matam repaired damaged screens from their own funds (140USD) and at Donka the administration replaced the delivery table mattresses for five tables for a cost of 420USD.



A dedicated room for PAC services, and the waiting room for PAC services at CMC Minière

Materials provided to the sites included:

- Locally constructed delivery tables and privacy screens
- Instrument kits for delivery, cesarean section, vacuum delivery (ventouse), postpartum IUD insertion, postpartum tubal ligation, blood pressure cuffs and stethoscopes
- Autoclaves (n=10)
- Anesthesia and resuscitation equipment, including adult and neonatal ambu-bags, laryngoscopes and spinal needles
- Personal protection items: apron, goggles, rubber boots, head covers and face masks
- Infection prevention materials: buckets, trash cans, cleaning gloves and surgical drapes
- Initial stock of consumables, such as cotton, gauze, betadine solution, gloves and drugs (oxytocin, magnesium sulfate, antibiotics, anesthetic), syringes, medical tape, urinary catheters and bags)
- For PMTCT sites, MCHIP worked with UNICEF and the national PMTCT program to quantify and supply antiretroviral therapies and testing reagents to the focus sites.



A locally constructed delivery table and privacy screens at CMC Matam.



New mattresses at Donka University Hospital



Repaired screens at Kankan regional hospital

Clinical training

Training on EmONC engages a team of providers from a facility made up of doctors, midwives, pediatricians and anesthetists. This is important to ensure timely and effective management of obstetric emergencies. EmONC training addresses the leading causes of maternal death such as postpartum hemorrhage and eclampsia/pre-eclampsia, as well as resuscitation of asphyxiated newborns. The training also reinforces routine practices such as labor monitoring using the partograph which can help alert providers to danger signs. Introduction of the Misgav-Ladach technique for cesarean delivery facilitates quicker intervention than traditional methods and consumes less materials and supplies.

- ✓ 20 providers from five facilities were trained in Comprehensive EmONC (CEmONC).
- ✓ 63 providers from 15 facilities were trained in a two-part course that covered Basic EmONC (BEmONC) and CEmONC/PPIUD/TL.
- ✓ 20 providers from 10 facilities were trained on PMTCT protocols.

Training of Trainers

The availability of national trainers for MNH interventions increases the availability of supportive supervision resources as well as capacity to scale up the training of providers on key life-saving services.

- ✓ 17 regional trainers, in teams of three to four, were qualified to provide EmONC clinical training.
- ✓ 34 trainers were trained in FANC.
- ✓ 22 trainers were qualified to support improved infection prevention practices.

Supportive supervision

- ✓ 82 of 83 providers trained in EmONC received post training follow-up visits six weeks after training and again at three months, using the knowledge and skills assessment guide. Post training follow-up along with the action plans developed at the end of the training session are important tools for supporting implementation of new skills and quality of care.
- ✓ Providers from ten sites participated in a pilot study on mMentoring using text messages and voice calls to provide post training follow-up in place of the first field visit at six weeks (see Figure 20 below).
- ✓ 19 of 20 providers trained in PMTCT received post training follow-up visits.

Improved Access, Utilization and Quality of MNH services

Key indicators from the project PMP are presented below to illustrate the improvements in health service provision. It is not possible to definitively determine the cause of these changes, but it seems reasonable to assume that improvements in providers knowledge and skills, site strengthening, as well as MCHIP support for improvement in data collection, as described in Table 6, have contributed positively to these improvements. Key interventions such as routine use of active management of the third stage of labor to reduce the risk of postpartum hemorrhage, and administration of magnesium sulfate to manage pre-eclampsia and eclampsia serve to address the leading causes of maternal mortality.

Table 6: Key MNH indicators for MCHIP interventions by fiscal year: 2011-2014

Indicators	2011	2012	2013	2014 (six months)
Number of women delivering with a skilled birth attendant	na	23,104	27,466/90,356 (30%)	19,300/45,178 (43%)
Number and percentage of women receiving active management of the third stage of labor (AMTSL)	12,063 (81%)	22,415 (88%)	23,245 (96%)	15,746 (87%) ¹²
Number and percentage of women delivering at MCHIP-supported facilities with a completed partograph in their medical record	4,652 (24%)	10,030 (31%)	11,981 (39%)	11,327 (53%)
Number of women with obstetric complications treated at MCHIP-supported facilities	na	366	7,215	2,508 ¹³
Percentage of cases of severe pre-eclampsia and eclampsia treated with magnesium sulfate	98%	98%	100%	98%
Number of newborns receiving essential newborn care	7,090	19,971	24,729	16,678

Among the first 16 sites fully implementing SBM-R, AMTSL rates increased from 61 percent to 89 percent from 2010/11 to 2012 and cases of postpartum hemorrhage declined from 2 percent of births to 1.5 percent, with marked declines at specific facilities. At two hospitals, postoperative infections decreased from 1.1 percent to 0.5 percent, and post-procedure infections decreased from 2 percent to 0 percent.

Once the PMTCT strategy was updated and training completed, positive results were quickly seen in the counseling and testing of pregnant women as well as the support provided to HIV+ women. All women who attended ANC care at the 10 target facilities received counseling and testing with additional women delivering at the facilities receiving counseling and testing.

¹² Stock out of oxytocin occurred during this period

¹³ An outbreak of Ebola during the period reduced population mobility in MCHIP supported regions.

Table 7: PMCT indicators for MCHIP interventions - 2014

Indicators	October 2013- March 2014
Number of service delivery points (SDP) providing the minimum package of PMTCT services according to national standards	10
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	1925
Number of women in labor and given birth who received HIV counseling and testing for PMTCT and received their test results	728
Number of HIV infected pregnant women who received psychosocial support including appropriate reference for ongoing care and treatment in a PTMTCT SDP	21
Number of HIV infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PTMTCT SDP	30
Number of health workers trained in the provision of PMTCT services according to national standards	20

Figure 8: Prevention of postpartum hemorrhage in the community

The Ministry of Health and Social Welfare of Guinea, with technical support from MCHIP, is implementing a combined health facility and community-focused program for the prevention of postpartum hemorrhage (PPH). The program strengthens active management of the third stage of labor (AMTSL) and management of PPH at health facilities as well as counseling and advanced distribution of misoprostol by health care providers, CHWs, and traditional birth attendants (TBAs) for self-administration at home births. The intervention is being implemented in five sub-prefectures of N'Zérékoré prefecture (Gouecke, Soulouta, Womey, Koropara and Yalenzou) in Guinea.

The program design was implemented under the MCHIP Integrated Service Delivery Program. UNFPA supplied misoprostol in-country for the implementation of the learning phase, and the Ministry of Health and Social Welfare distributed it for the five sub-prefectures. Within the MCHIP program the technical guidance and assistance comes from Jhpiego and Save the Children.

A total of 31 health facilities were included in the implementation in these five sub-prefectures and 219 providers, CHWs and TBAs distributed misoprostol to 555 pregnant women. 43% of women received their misoprostol during an ANC visit while 57% received it from a CHW. Among the 555 women, 59% gave birth in a facility (n=329) and 41% gave birth at home (n=226). During interviews with 500 women, 330 reported having taken misoprostol. All women who had delivered at home took the misoprostol as recommended. No serious complications were reported while 24.6% did report minor side effects such as shivering.

MCHIP Guinea benefited from and provided south to south technical assistance for the MNH activities. For the CEmONC training, an anesthesia trainer from Burkina Faso provided support. The Guinea MNH Advisor supported EmONC training in Cote d'Ivoire. MCHIP Guinea also hosted two core funded MNH Champions Workshops due to the availability of multiple practical sites as a result of MCHIP activities.

MCHIP Guinea had the opportunity to share experience and results at several international conferences and meetings. The integration of training for PPIUD and EmONC, and the mMentoring put in place for the monitoring of providers trained in BEmONC were presented at Women Deliver in Kuala Lumpur (2013), FIGO Africa in Addis Ababa (2013) and the annual meeting of Jhpiego in Chiang Mai (2014).

Challenges, Responses and Lessons

As mentioned above for FP, movement of trained providers is an ongoing challenge to continuous service availability. In the EmONC trainings, the teams of providers developed action plans at the end of the training and were encouraged to organize orientations with colleagues to review key knowledge and skills as a means to reduce the impact of provider absences or transfers. This also served to address some resistance to implementing new practices from providers who had not participated in the training.

While MCHIP was able to provide an initial supply of materials needed for anesthesia, routine availability was a problem in all sites. Maintenance of anesthesia and other surgical equipment was also an issue. MCHIP advocated with the facility managers and health authorities to take into account the supply and maintenance needs for anesthesia, an issue for all surgical services, not just obstetrics. As described above, this advocacy did lead to some repairs and resupply funded from local resources. Ongoing advocacy for ensuring anesthesia services and surgical capacity in general, is needed.

CHILD HEALTH

Building on MCHIP's global expertise in Child Health, led by John Snow Inc, interventions were initiated in 2012 to strengthen the availability and quality of care for sick children. Particular emphasis was given to promotion of the revised and shortened training program of Integrated Management of Newborn and Child Illness (IMNCI), including developing country level experience with integrated Community Case Management (iCCM) and the strengthening of the national IMNCI program through the establishment of an IMNCI pilot committee.

MCHIP Interventions

Policy interventions

- ✓ MCHIP supported the MOH to revise policies and strategies for child health, with particular focus on updating the IMNCI protocol for health facility staff, and expanding the existing case management of diarrhea by community health workers (CHWs) to add pneumonia and malaria. A workshop to orient MOH staff on the state-of-the-art recommendations for clinical and community IMNCI was held in November 2011. In July 2012, the community health policy was revised to include integrated Community Case Management (iCCM) by CHWs.
- ✓ MCHIP helped reinvigorate the national IMNCI steering committee led by the MOH and played a key role in supporting its coordination role. The committee includes all key MOH departments involved in child health such as the IMNCI coordination bureau (technical lead), the National Malaria Control Program, the nutrition coordination bureau and the national central pharmacy. It includes also the society of pediatricians and the key partners in child health such as WHO, UNICEF, the World Bank, USAID and implementing NGOs. The committee serves as a forum to discuss policy issues, resolve programmatic challenges, coordinate programs, promote exchange experiences among child health partners and jointly monitor key activities including the revision of the IMNCI training program the implementation and monitoring of iCCM program.
- ✓ The project advocated with MOH to add the Amoxicillin 250mg dispersible tablets to the essential medicines list, and advocated with the national central pharmacy to include this formulation in their regular forecast and procurement. Amoxicillin dispersible tablets are more appropriate for infants and children (compared to traditional scored tablets) and are easier to transport and store (compared to syrups) for distribution in remote health facilities and community sites. CHWs were the priority beneficiaries for the initial phase.

Materials development and dissemination

- ✓ Training materials for clinical IMNCI were updated and adapted, including an update of clinical IMNCI training modules, while reducing the length of training from 11 days to six days. Reference charts were updated based on recommendations in the updated policies (e.g., diagnostic confirmation of malaria, new guidelines on pediatric HIV and new classification of malnutrition).
- ✓ Training materials for CHWs – based on treatment of diarrhea with ORS -- were also adapted and updated to add zinc therapy for diarrhea, case management of pneumonia with antibiotics, malaria confirmation by rapid diagnostic test (RDT) and treatment of confirmed cases with ACT.

- ✓ iCCM-specific materials developed include the training curriculum, referral and counter-referral forms, job-aids and algorithms for community-based care, CHW workbook, and case management protocols.
- ✓ Data management and supervision tools were modified to include a simplified CHW consultation register, a monthly reporting form, a CHW supervision checklist and a monthly supervision reporting forms.
- ✓ IMNCI performance standards for health facilities were elaborated in order to support improvement in the quality of care for children under 5 years and expand the scope of SBM-R activities in MCHIP supported facilities.

Site strengthening

- ✓ A situational analysis of the 20 sites selected by MCHIP in the prefectures of Beyla, Mandiana and Dabola was completed, in order to guide the implementation of clinical and community-based IMNCI.
- ✓ 20 health centers were equipped with materials for case management including respiratory timers, thermometers and scale, oral rehydration kits and education materials such as posters about danger signs and care -seeking.
- ✓ Materials to support iCCM of children were provided to 103 CHWs, including a timer, a small cupboard to store drugs and supplies. In collaboration with UNICEF and PSI, an initial supply of commodities including dispersible Amoxicillin 250mg, low-osmolarity ORS and zinc (known as Orasel zinc)and water treatment solution (sodium hypochlorite 1,2% known as *Sur'Eau*); Record keeping and management tools were also provided.
- ✓ Performance standards for IMNCI were integrated into ongoing quality improvement activities. The urban health centers of Mandiana, Dabola and Diakolidou, were selected because the staff at these facilities were already implementing SBM-R with other technical areas such as infection prevention and family planning.



Materials for the ORT kits and group of the IMNCI trained providers

Training

- ✓ 38 health providers were trained on the revised clinical IMNCI protocols in July 2012 (18 health center directors and 20 EPI agents)



A trainer explaining the IMNCI treatment algorithms to providers

- ✓ In the MCHIP-supported sites in the prefectures of Dabola, Mandiana and Beyla, 101 CHWs were trained in integrated Community Case Management (iCCM) protocols over the course of four training workshops between March and July 2013.
- ✓ By June 2014, the training curriculum and accompanying materials developed with MCHIP's technical support was used to train over 1,000 CHWs nationwide, financially supported by the French Cooperation (Muskoka funds), the World Bank, the West African Health Organisation (WAHO), UNICEF, and Plan Guinée



CHW assessing a sick child



CHW using algorithm to assess a child

Training of Trainers

- ✓ 21 supervisors were trained to be able to support the IMNCI/iCCM activities, including regional and district clinical managers (*chargé de maladie*), the head of community-based health care, pediatrics and the head of the laboratory and pharmacy.

Supportive supervision

- ✓ Post training follow-up of supervisors and providers was provided four to six weeks after the IMNCI training to the 38 health facility staff.
- ✓ Post training follow-up of 89 trained CHWs was provided four to six weeks after training. 12 CHWs were lost to follow-up mostly due to seeking other work, particularly in communities like Mandiana where there are jobs available with the mines.

Improved Access, Utilization and Quality of Child Health Services

- 20,137 cases of diarrhea, pneumonia and fever in children under five were treated by providers in the health centers of Beyla, Mandiana and Dabola over the 15 months following the training.
- 1,964 sick children were managed by CHWs during 12 months following their training in communities in Dabola, Mandiana, Beyla, and Conakry.

Table 9: Service delivery indicators for child health services by quarter: 2012-2014

	Oct-Dec 2012 (facility only)	Jan-Mar 2013 (facility only)	Apr-Jun 2013	Jul-Sept 2013	Oct-Dec 2013	Jan- Mar 2014
Number of children <5 years with symptoms of pneumonia managed	1,445	2265	3,090 Fac: 2765 CBD: 325	2696 Fac: 2478 CBD: 218	3,300 Fac: 3191 CBD: 109	2754 Fac: 2533 CBD: 221
Number of children <5 years with symptoms of diarrhea receiving care management	98	377	971 Fac: 451 CBD: 520	580 Fac: 375 CBD: 205	426 Fac: 351 CBD: 75	858 Fac: 671 CBD: 187
Number of children treated within 24 hours after having fever	118	241	435 Fac: 368 CBD: 67	372 Fac: 345 CBD: 27	100 Fac: 92 CBD: 8	11 Fac: 9 CBD: 2

Two key challenges during this pilot phase were frequent stock-outs, particularly of the tests and medications for treatment of malaria, as well as the Orasel Zinc rehydration solution. Lack of RDTs for malaria led to most cases of fever being referred to the facility. The mobility and frequent reposting of the providers responsible for IMNCI also led to loss of trained providers in the pilot facilities.

Knowledge Sharing:

In October 2011, MCHIP sponsored the travel of an MOH team, led by the Director of Family Health, for a study tour to Rwanda. The delegation met with the Community-Health Desk of the Rwandan Ministry of Health and visited some community sites to learn about the introduction and scale-up of iCCM in Rwanda. Immediately after this trip, the Guinean MOH confirmed its commitment towards a more integrated community-based case management, which led to the establishment of the IMNCI national steering committee, development of the iCCM training materials, and the launch of the program in Guinea.

In March 2014, MCHIP helped organize the iCCM Evidence symposium in Accra, Ghana, attended by more than 400 people from 35 countries of sub-Saharan Africa and 59 international partner organizations. A delegation composed of the IMNCI national coordinator, UNICEF, WHO and MCHIP represented Guinea and had the opportunity to present a poster on the status of the national iCCM program, to learn about state of the art approaches of iCCM implementation, the current landscape and status of evidence and identify actions around eight thematic areas. As a result, the Guinean team developed an operational action plan and presented it to MOH decision-makers and to the IMNCI steering committee for comments, inputs and approval.

Quality improvement

In June 2013, the performance standards for IMNCI developed with technical assistance from MCHIP were finalized and approved. In October the same year, they were introduced in three urban health centers of the prefectures of Dabola, Macenta and Beyla. These health facilities were already using the SBM-R methodology for FP, EmONC and IP and all have care providers trained in the updated IMNCI protocols. The idea was to test the use of SBM-R as a quality improvement approach in the context of clinical IMNCI.

Given the limited number of health facilities involved in SBM-R for IMNCI and the limited implementation time, it was not possible to conduct an appropriate evaluation of the impact on the quality of care. However, there are a number of important lessons we learned through the early implementation phase:

- The SBM-R and IMNCI tools need further fine-tuning and streamlining: while health workers were highly interested in the IMNCI standards, recognized their value and demonstrated strong commitment to use them in their daily activities, the complexity of the tools was perceived as a challenge by the users and they sometimes felt confused.
- While all three health facilities involved have the required set of equipment for case management (consultation table, stethoscope, scale, height gauge, classification table for nutritional status, and kits for Oral Rehydration Therapy corner), the care providers often struggle to identify and prioritize the most important tasks. The large number of standards was perceived to be one of the problems.
- There are encouraging signs of institutionalization and hope for sustainability of the SBMR: for example, the team at health facility of Dabola integrated the action items identified through the SBM-R process into their December 2013 official micro-plan. A minor modification of the indicators to be monitored by the district and the provincial team would strengthen ownership and further promote the accountability at the higher level of the health system.

Challenges, Responses and Lessons

Drugs and supplies for the CHWs to provide the package of services was an ongoing challenge. While MCHIP was able to provide an initial stock with support from UNICEF and PSI, there is the issue of facilities including CHW needs when they estimate resupply needs. Guidance on stock management that includes CHW needs and ongoing advocacy for attention to this issue is needed to avoid stock-outs.

As with other technical domains, movement of providers, both facility-based and CHWs, is a constant challenge to service provision. As the results of the pilot are reviewed, it will be important to make decisions about policy updates and scale-up in an effort to reach saturation of trained providers so that services can be sustained.

Engagement of the leadership of the IMNCI programme within the MOH was an important element of the success of these activities. The IMNCI programme has appropriated the results of the pilot to move forward with revising policies and norms.

COMMUNITY HEALTH

The MCHIP project in Guinea incorporated a community approach to improve access to quality health services and health information in rural and urban communities. Community Health Workers (CHWs) in Guinea provide a package of community-based services approved by the Ministry of Health and focused on health promotion messages about maternal, neonatal, and child health and family planning; offer non-prescription FP services, and support the management of simple cases of the most common diseases in children under 5 years (diarrhea, upper respiratory infection, malaria, malnutrition, etc).

MCHIP reinforced the skills of 1,092 existing CHWs initially trained under the Extending Service Delivery (ESD) project, including building their ability to effectively report data from community-based services. Under the MCHIP project, CHWs were supported to implement the community-based package. Monitoring and supervision was provided by MCHIP in collaboration with the Ministry of Health and local NGOs, as well as Save the Children specifically in Mandiana prefecture.

In many ways urban populations have similar challenges in accessing health services; the cost of transport, knowing where a clinic is located, and knowing when they need to seek care. With the five urban communes of Conakry as one of the main MCHIP intervention zones, it seemed opportune to adapt the CHW profile for urban areas. While most of the work in Guinea with CHWs is focused on reaching rural communities with health information and services, MCHIP also implemented innovative approaches to reach urban communities with health information and interventions, as described below.

MCHIP Interventions

Policy interventions

- ✓ MCHIP supported the update and validation of the national community health policy, which recognize the role and importance of the contribution of CHWs in improving the health system in Guinea. Key updates in the strategy included expanding the service provision component of the integrated CHW package. In addition to health promotion activities, CHWs are now authorized to provide basic care for the three leading causes of child mortality, respiratory infection, malaria and diarrhea.
- ✓ As part of the overall support for the improvement of HMIS indicators and tools, MCHIP worked with the MOH to integrate the collection of community data on FP use into HMIS indicators and tools. (More information on M&E interventions can be found below.)
- ✓ Using results from Save the Children's pilot study conducted in Mandiana Prefecture, MCHIP facilitated a results dissemination meeting to advocate for the adoption and scale-up of community-based distribution (CBD) of the injectable contraceptive, Depo-Provera. The MOH has since included this strategy in the National FP Repositioning strategy. UNFPA is planning to support the extension of CBD injectables in N'zérékoré region, and Save the Children has received USAID funding to establish a learning site in Mandiana and to provide technical assistance to organizations interested in integrating CBD of injectable contraception.

Materials development and dissemination

- ✓ Training modules were developed to focus on improved behavior change communication (BCC) by CHWs, on iCCM and malaria and to strengthen supportive supervision provided by CHWs in charge from health centers and the local NGOs supporting them.
- ✓ Supervision checklists were developed to support follow-up visits, which were conducted to review the delivery of key messages and services.
- ✓ 2,000 counseling cards with messages and images about FP, PFP, PAC, MNCH and IMNCI were printed and distributed to CHWs and CHW trainers. Cards were printed in French and in Malinké.
- ✓ CHWs were provided with a register book and monthly report forms in order to record group education sessions and individual counseling activities and facilitate their transmission to the Community Health Supervisor at Prefectural Health Offices.
- ✓ In the urban community intervention, reference cards were provided by the CHWs to women who were new FP users or continuing users who wanted to change to a method other than the pill or condoms, which required a visit to the health facility. CHWs in urban areas were also provided with counseling cards and activity registers.
- ✓ At the beginning of the project, MCHIP conducted a census of media outlets in the intervention zones. Two radio stations were selected in each region along with four in the city of Conakry based on the size of their audience. Messages on a range of health topics- FP, MNH, Child Health, and PAC were developed and broadcast in French and seven local languages. In the last year of MCHIP alone, 62 messages were broadcast.
- ✓ Five roundtable discussions, in five local languages, on health topics and the role of CHWs in their communities were recorded for radio and rebroadcast 40 times. Participants included the Community Health In-Charge from Prefectural Health Offices, local NGO animators, journalists and radio station staff.
- ✓ In collaboration with a popular local musical artist, two songs with music videos were produced about FP methods and about maternal health respectively. The song and video were widely played by national and private radio stations as well as national and private television stations.

Service strengthening

- ✓ Each CHW received a bag and a kit including counseling cards, checklists, an activity register and medications and supplies for FP services. iCCM or malaria materials and supplies were provided if interventions were in place in their areas.
- ✓ MCHIP provided bicycles to 1,680 villages in the three rural regions. The bicycles are shared by the male and female CHWs in each community. The Health Center Health and Hygiene Committees and community leaders were engaged in the distribution of the bicycles in order to ensure that they are maintained and used for outreach activities.
- ✓ Within Prefectural Health Teams there is one person in charge of supervising community health services (Chargé SBC). MCHIP donated 13 motorcycles, one for each of the rural prefectures, to facilitate supervision of CHWs. Prefectural Health Offices agreed to provide fuel and maintain the motorcycles.
- ✓ Through a competitive process and rapid assessment, four local NGOs were selected to collaborate with MCHIP: APIF (Kankan), APIC (Faranah), OSPADEC (N'zérékoré) and CAM (Conakry). These NGOs were trained and supported to facilitate the implementation of community activities, achieving a 60 percent geographic coverage in MCHIP intervention zones.

Figure 10: Bringing community health interventions to urban areas

Work with CHWs has traditionally focused on rural areas, while in urban areas there are many different sources for information although not necessarily targeted to health information and services. In an innovative strategy to extend the national community-based services to urban areas, MCHIP in collaboration with the MOH and a local NGO, *Club des Amis* (CAM), initiated community education activities in the urban communes of Conakry and eventually the direct distribution of contraceptives by urban community health workers.

The initial task of the selected leaders was to raise awareness within the community on reproductive health and family planning issues and to refer clients to health facilities. Results from the successful partnership between the local associations and the health facilities encouraged MCHIP to position these leaders to become community health agents, by building their technical capacity to support community-based distribution of oral contraceptives as a first step.

A total of 216 association members were trained by MCHIP on reproductive health and family planning messaging. Among these association members, an additional 48 (including eight from the islands of Kassa) were further trained to become CHWs and to distribute contraceptives (condoms, pills, and Cycle Beads).

Additionally, 33 individuals (five SBC supervisors based in the five Communal Health Directorates, 22 EPI officers and six members of CAM) were trained to supervise and monitor the community health activities in Conakry.

MCHIP went a step further in 2013 to try to reach women through hair salons since these businesses often serve as a community hub. Twenty female apprentices and five salon managers were trained as peer educators to ensure the diffusion of messages of FP, PFP, PAC, MNCH, and IMNCI, and referral to nearby public facilities. Ten of the peer educators were later trained on how to counsel and distribute FP methods (pills, condoms, Cycle Beads), thus making them the urban equivalent of a CHW. This new role for hair salon staff was generally well accepted, although Jhpiego would like to conduct a more formal assessment, if funding can be identified. The experience with hair salons also suggests that other small businesses, such as tailor shops, could be engaged to provide similar community health education and services.

Training

- ✓ 1,092 CHWs received refresher training under the joint supervision of MCHIP and SBC supervisors on topics including FP, PFP, healthy pregnancy spacing, lactational amenorrhea method (LAM), breastfeeding, PAC, danger signs during pregnancy and for newborns, IMNCI and BCC. CHWs were also trained on how to properly record health information in their coverage areas within corresponding registers. According to post training follow-up results, 93 percent of CHWs who were visited were performing at a satisfactory level.
- ✓ In the urban communes of Conakry, 241 community organizers were trained to provide health information in their communities, and 58 new CHWs were trained to provide non-prescription forms of contraception in the city of Conakry (members of community associations and groups (*sérès*), and hair salon staff).
- ✓ Linked to specific interventions on iCCM for sick children and on malaria, 101 CHWs were trained on iCCM and 103 were trained on the updated malaria prevention and treatment protocols (see Malaria below).

Training of Trainers

- ✓ 32 community organizers, 12 NGO supervisors and 15 CHW supervisors (district level) from the prefectural health departments were oriented on the health messages and the utilization of the counseling card in order to be able to train the CHWs

Supportive supervision

- ✓ 1,096 of 1,150 (95%) CHWs received at least one post training follow-up visits which were conducted by mixed groups of NGO organizers and district level CHW supervisors with support from MCHIP and Save the Children. .
- ✓ In the regions of Kankan and N'zérékoré, MCHIP organized 12 rounds of joint supervision with the Prefectural Health Directorate and Regional Health Directorate, reaching 48 percent of health centers in the intervention area. Objectives of the joint supervision visits were to verify and assess the quality and rates of the reporting data collected, discuss problems of shortages and restocking of contraceptives and provide feedback and follow up on recommendations from previous supervision visits.
- ✓ Use of bicycles was supervised at least once in each village. More than 80 percent of the bicycles were observed to be in use by the two CHWs in each village, as intended.

Improved Access, Utilization and Quality of Community-based Health Services

MCHIP supported CHWs conducted 103,805 group education sessions on FP, MNH and IMNCI over the four years of the project. In the final 18 months of activities alone, 74,346 group discussions reached 292,164 people. Community distributed FP contributed approximately one-third of all new and continuing users in MCHIP supported zones (see detailed data below).

Table 11: Group education sessions by topics and number of attendees by fiscal year: 2012-2014

Indicators	2012	2012	2013	2014 (6 months)
Number of group educational sessions conducted, by topic	FP: 23,591 MNH: 5,154	FP: 23,591 MNH: 5,154	FP: 22,705 MNH: 8,981 IMNCI: 8,981	FP: 22,987 MNH: 6,810 IMNCI:3,882
Number of attendees	na	na	166,934	132,774

Table 12: Community-based distribution of modern family planning methods by fiscal year: 2012-2014

Indicators	2012	2013	2014 (6 months)
Number of new users and percentage of all new users	49,055 (28%)	67,997 (34%)	29,764 (31%)
Number of continuing users and percentage of all continuing users	52,610 (34%)	77,711 (43%)	31,271 (37%)

In the five hair salons in Conakry, 133 health education talks were given to 1,711 people. 171 new FP users received services through the hair salons, along with 105 continuing users. 180 packets of pills, 31 cycle beads and 451 condoms were distributed by these urban CHWs between December 15, 2013 and March 31, 2014.

Radio spots and roundtables reached an estimated 2.4 million people. The involvement of radio stations helped strengthen and improve the link between the community, CHWs and public health facilities.

Challenges, Responses and Lessons

As with other technical areas, the movement of trained CHWs and their supervisors was an ongoing challenge to service continuity. For CHWs, other financial opportunities were a key source of loss. One response used by the project was to train two CHWs per village. Development of prefectural level trainers was another way that the project developed capacity to update new CHWs and their supervisors as needed. Projects and programs need to ensure they can track the presence of trained workers and plan for a certain amount of loss of trained workers by organizing periodic recruitment and training sessions for new CHWs. A number of materials were provided to the CHWs to help incentivize their work, but the lack of a salary is a limiting factor in generating interest in becoming and remaining a CHW. Working through local NGOs and with CHW associations to support and network CHWs also shows promise as a way to sustain the contribution to health services provided by CHWs.

The challenges with availability of the medications and supplies that are seen in facilities extend to CHWs capacity to provide services as well. The project took a number of steps to address this in the startup of CHW activities but ultimately this becomes an issue for the overall pharmacy logistics system and local capacity to estimate needs appropriately for both facility and community services.

CHW distribution of FP methods provides an important contribution to FP utilization, both in rural and in urban areas. Use of non-traditional actors and varied community resources, such as women's groups and hair salons, are important ways to expand the promotion of and access to FP and other health information.

To strengthen and streamline data recording by providers, it is recommended that MOH and partners develop a single new register for health centers that includes information currently recorded in the IMNCI register. This will lessen the burden of multiple registers and hopefully improve the quality of information recording to better capture what services are being provided in these facilities.

PRE-SERVICE EDUCATION

Interventions with the Faculty of Medicine (FMPOS) to strengthen training skills of faculty and preceptors and to develop a skills lab were initiated under ACCESS-FP and continued under MCHIP. In 2012, MCHIP also began to work with the National School of Public Health in Kindia, which trains midwives and several cadres of nurses and auxiliary health workers.

MCHIP Interventions

Policy interventions

- ✓ To ensure support at the highest levels for strengthening midwifery pre-service education, the MCHIP Director worked closely with the National Director and Deputy Director of the Ministry of Employment, Technical Education and Professional Training (MEET-FP) and the Director of the Kindia Midwifery School to introduce project activities. Focal points from the Ministry and the school were designated to lead the collaboration.
- ✓ The Director of MEET-FP is in the process of integrating the SBM-R performance standards for PSE as the basis for accreditation of private midwifery schools. The SBM-R process is continuing with support of stakeholders until the accreditation process is in place.
- ✓ MCHIP worked with ENSK administrators and MEET-FP to ensure that the number of students fits with the classroom space and practical training sites available.
- ✓ MCHIP assisted MEET-FP to obtain a commitment from the Government of Guinea to recruit 500 qualified teachers for the technical and professional education programs.

Materials development and dissemination

- ✓ Elaboration of performance standards for pre-service education at the Faculty of Medicine and at ENSK
- ✓ Dissemination of skills checklists based on training materials in RH/FP to the skills labs and training sites for the reinforcement of students' skills development
- ✓ Development of management tools for the skills laboratories (ENSK and the Faculty of Medicine)
- ✓ The midwifery training curriculum was revised based on guidance from the West African Health Organization (WAHO) and the International Confederation of Midwives (ICM). In total, 15 modules for the first year, eight modules for the second year, and 10 modules for the third year were revised to focus on a competency-based approach in which topic guides and theoretical training sessions were organized according to the needs of practical work. Each session plan includes a title, specific objectives, teacher's content, an activity/task, required time, materials and resources necessary and the evaluation methodology. This curriculum includes news topics such as, like prevention and management of gender-based violence (GBV), cervical cancer prevention, prevention and early detection of breast cancer.

Site strengthening

- ✓ Interventions at the Faculty of Medicine, initiated under ACCESS-FP and continued under MCHIP, provided assistance to implement the SBM-R process and to strengthen and expand the skills laboratory at the Medical School.

- ✓ To better understand the needs of the Kindia Midwifery School, MCHIP conducted a needs assessment to review current staffing, curricula and teaching resources.
- ✓ Materials and equipment were procured to support the set-up of the Skills Lab at FMPOS and ENSK, including anatomical models, instrument kits, infection prevention materials and reference books.
- ✓ MCHIP also provided documents and resources on FP and MNH to strengthen the ENSK library used by students and preceptors. USAID contributed additional funding for the purchase of computers, projectors and office furniture to support teaching.
- ✓ At the Faculty of Medicine, the Skills Lab activities were monitored through site visits and meetings with pediatric and Ob/Gyn faculty and the head of the medical department. Twenty-six of 34 faculty and preceptors trained used the simulation center to train students in gynecology, obstetrics and neonatal skills.
- ✓ MCHIP's support for the skills lab at ENSK served to leverage additional funds from of MEET-FP and WHO to complete renovations and installation. (photos)
- ✓ Over the course of 2013, MCHIP helped to introduce SBM-R for Pre-service Education at the National Midwifery School in Kindia (ENSK). Performance standards were defined and all modules were conducted with a group of 24 stakeholders. An SBM-R monitoring committee was convened which includes central level representatives, ENS and private midwifery schools.
- ✓ Conducted a baseline performance evaluation of ENSK and three private midwifery schools
- ✓ Provided follow-up to evaluate progress against action plans for instructors and trainers at ENSK

Training

Faculty of Medicine, Conakry

- ✓ 34 faculty and preceptors were trained on using a skills lab to teach key skills using anatomic models and simulators.
- ✓ A workshop on Student Performance Assessment was organized for 16 participants to strengthen skills and resources for assessing students.

National Midwifery School, Kindia (ENSK)

- ✓ 19 faculty and preceptors of ENSK were trained on Effective Teaching Skills (ITS)
- ✓ 18 faculty and preceptors working at 8 different practical sites were updated on clinical supervision and mentoring of students (CTS)
- ✓ 25 staff trained on the management of the skills simulation laboratory; setting up training stations, monitoring trainees practice, etc.
- ✓ 21 staff trained on the use of anatomical models to demonstrate skills, specifically the use of the Mama-Natalie, Neo-Natalie and Zoe models for birthing simulation
- ✓ 20 faculty and preceptors received technical updates on MCHIP core areas such as FANC, PMTCT, MIP, EmONC, FP and GVB to support the effective implementation of ICM core competencies and the principles of task-shifting.

Supportive supervision

- ✓ MCHIP provided regular follow-up to both FMPOS and ENSK to review progress on action plans developed during training sessions and SBM-R

Improved Functioning and Quality of Pre-service Education

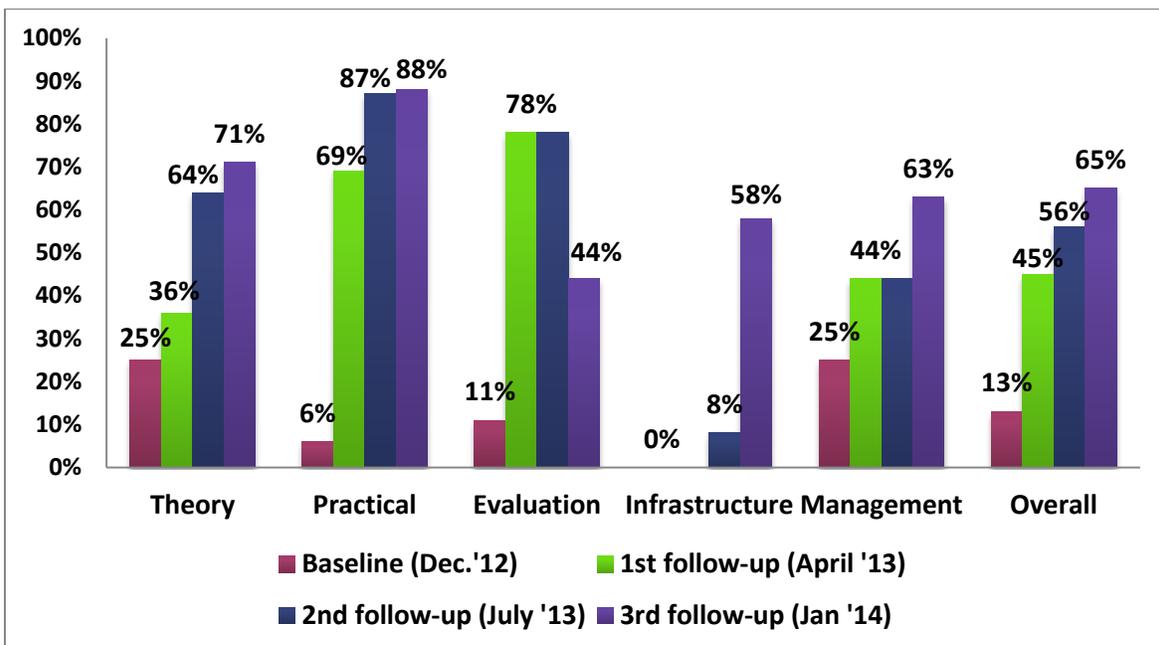
At the first skills lab introduced at the Faculty of Medicine, 76% (26/34) of faculty and preceptors were using the skills lab in their teaching. Instructors were also found to be making good progress on action plans to improve their student assessment.

At ENSK, the evolution of performance standards from December 2012 to January 2014 can be seen in Figure 13 below. Overall performance improved from 11% to 65% from baseline over the three follow-up visits. Theory and practical instruction showed the greatest improvements, and improvements were seen in all five performance areas.



ENSK faculty and preceptors in front the Mission and Vision statements painted at the entrance to the school

Figure 13: Evolution of performance indicators for pre-service education at ENSK



Infrastructure needs and availability of training materials remains the most challenging performance area, although MCHIP support as well as support committed by WHO and the Ministry of Employment, Technical Education and Professional Training (MEET-FP) helped to resolve many issues.



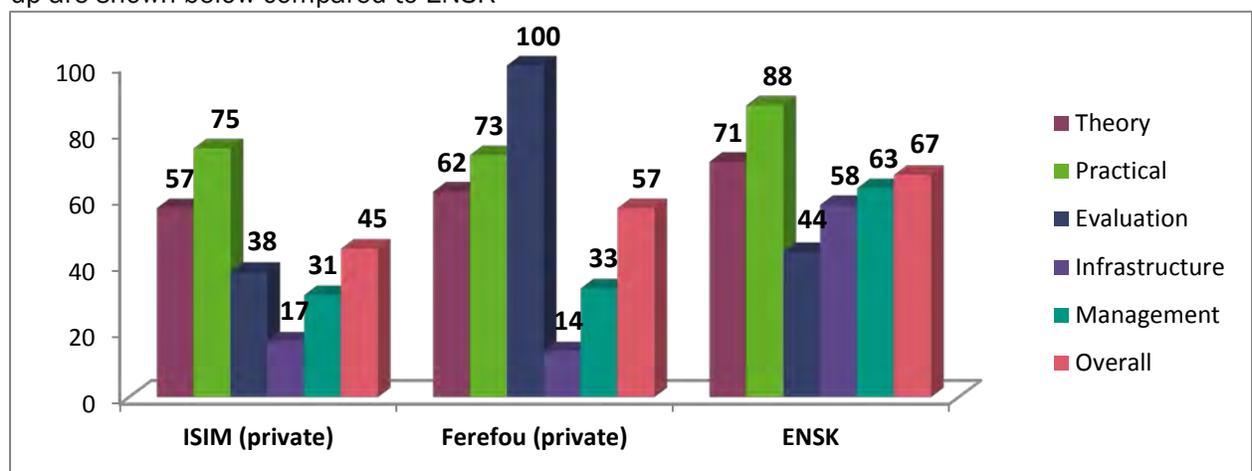
New doors and secure window grates were provided for the skills lab. (before and after)

Figure 14: Comments from the faculty and preceptors of ENSK

- ❖ **Nene Oumou Souare, Lecturer/Preceptor:** “I send big kisses to the entire team for the quality of their trainings. Since the update on reproductive health, my collaboration and my participation in mentoring of midwifery students has improved”
- ❖ **Fatoumata Drame, Preceptor** “Learning skills in the simulation lab greatly reduced my difficulties in conducting coaching with the midwifery students.
- ❖ **Maimouna Balde, Preceptor** “Following the reproductive health training, several gaps in my knowledge and practice (episiotomy repair, conducting a delivery, FP eligibility criteria, PPIUD) were resolved.”
- ❖ **Fatoumata Barry, Lecturer/Preceptor** “Following the RH update, I am much more comfortable teaching the midwifery students. The performance standards have greatly improved the quality of teaching, and assessment of the students.”
- ❖ **Jacqueline Chritiane Camara, Preceptor** “Since the training on RH, we practice in the simulation lab for our own learning ; we also learned how to prepare and implement performance quality improvement plans.”

Figure 15: Engagement with private midwifery schools.

During the implementation of the SBM-R process, participants from five private schools were invited to participate in the training modules. Subsequently, three of the schools have actively implemented this approach with their own resources. Results from two of the private schools at the latest follow-up are shown below compared to ENSK



Challenges, Responses and Lessons

ENSK was very eager to implement an accreditation plan but this can be a lengthy process. Adoption of SBMR for pre-service education not only provided faculty and staff with tools to help improve the quality of education but also gave them a model for future accreditation. The introduction of the SBM-R performance standards as a strategy for improving the quality of education has helped to increase the support from all stakeholders. Ongoing support for this process will be important for assisting ENSK faculty and staff to continue to improve the quality of pre-service education.

The availability of utilities - water, electricity, and internet - is a constant challenge for ENSK. MCHIP supported ENSK to advocate with the Governor and administrative authorities, as well as the utility companies, and cell phone providers, themselves to try and improve the situation.

ENSK does not have resources to offer scholarships to students. MCHIP supported MEET-FP to initiate negotiations with different ministries to help identify such resources.

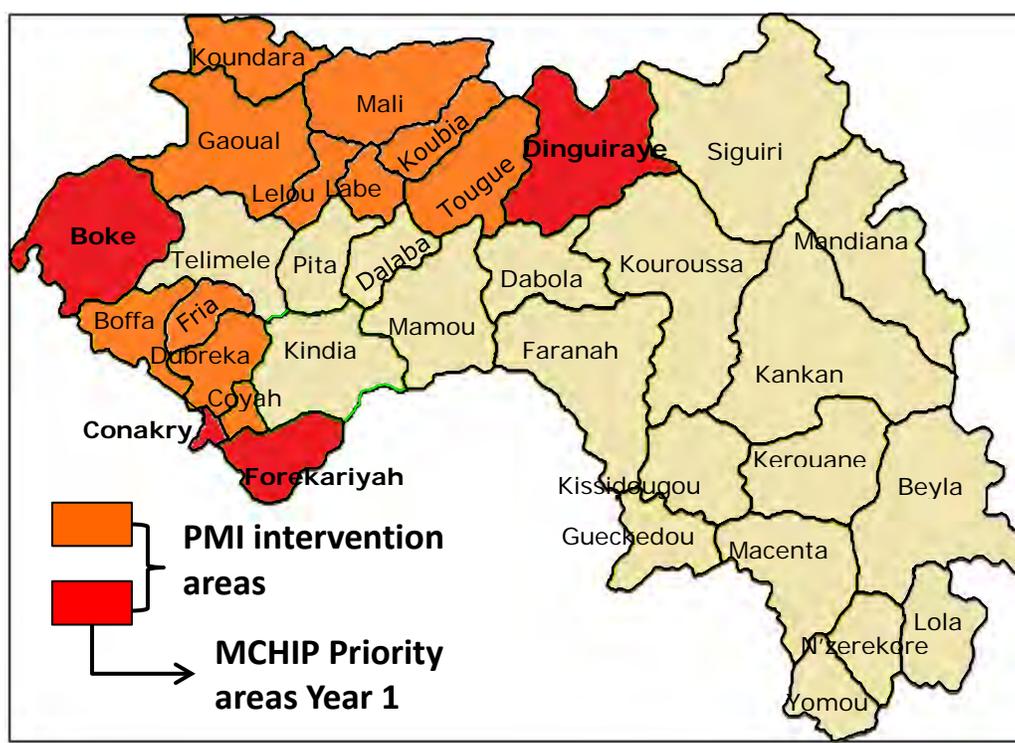
The engagement of the private midwifery schools from the beginning of the SBM-R process not only allowed these schools an opportunity to engage in performance improvement but also helped to establish a similar level of expectations, information and performance at all of the schools.

Simulation or Skills Labs are an important teaching tool that all pre-service education institutions and their students can benefit from.

MALARIA (OCTOBER 2011 TO DECEMBER 2012)

Guinea became a focus country for the President's Malaria Initiative (PMI) in November 2011. MCHIP was asked to incorporate interventions to strengthen the prevention and treatment of malaria as part of its 2012 workplan. Since PMI was developed to compliment Global Fund interventions, the prefectures to be reached with this funding are largely not the same as the USAID intervention areas. For the first year of malaria programming, MCHIP in coordination with *Faisons Ensemble*, focused interventions on four of the 14 PMI intervention areas, the prefectures of Forecariah and Boke, Dinguiraye and the five communes of Conakry.

Figure 16: Map of PMI intervention areas



MCHIP Interventions

Policy interventions

- ✓ MCHIP provided technical and financial support for the revision of national policy and protocols for the prevention and treatment of malaria. Through the leadership of the MCHIP Director and Program Manager, MCHIP provided specific technical input on malaria in pregnancy, management of supplies, supervision tools and communications.
- ✓ MCHIP chaired the Monitoring and Evaluation subcommittee of the National Coordinating Committee for the first edition of the mosquito net distribution campaign in Global Fund zones.
- ✓ MCHIP supported the National Malaria Control Program in the organization of several coordination meetings with USAID/PMI stakeholders to promote synergy and avoid duplication of activities. Local program launch events were held in each of the focus prefectures for the first year of interventions.

Materials development and dissemination

- ✓ Training materials were updated to support the rollout of the new practice guidelines including malaria clinical case management and case confirmation using RDTs, and malaria in pregnancy (MIP), community case management protocols and IEC/BCC for malaria.
- ✓ Management and monitoring tools were prepared, including planning documents and training materials for supervisors for the LLIN distribution campaign to be conducted in 2013.
- ✓ Several job aids were developed and reproduced to support malaria services: algorithms for the management of malaria and MIP (both intermittent preventive treatment (IPTp) and management of malaria in pregnancy.)
- ✓ Community case management protocols were updated along with IEC/BCC materials for malaria.

Site strengthening

- ✓ MCHIP and *Faisons Ensemble* completed a rapid assessment of the priority intervention zones to inform the planning of program activities. The extended stock-out of key drugs and rapid diagnostic tests as well as Sulfadoxine/pyrimethamine (SP) for IPTp for pregnant women were identified as key barriers to be addressed.
- ✓ Malaria job aids were distributed to all facilities in the target prefectures.
- ✓ CHWs were provisioned with a kit of materials to support community-based services: educational materials (malaria flip chart), treatment algorithms, an initial stock of medications and RDTs, record-keeping tools, a tee-shirt and bag to carry the materials.

Training

- ✓ 136 providers were trained in malaria prevention and case management, and 64 providers responsible for antenatal care were trained in MIP.
- ✓ 102 CHWs, eight community animators, two supervisors and one Peace Corps Volunteer were also trained on the messages and actions for malaria prevention and treatment.

Training of Trainers

- ✓ A six-day workshop was held for 34 regional, prefectural and communal supervisors and trainers. The session included clinical updates on malaria including MIP, as well as training skills.

Supportive supervision

- ✓ Post training follow-up visits reached 92 percent of providers and 93 percent of the 101 CHWs trained in updated malaria protocols.

Following this first year of intervention under MCHIP, activities have continued under the bilateral award StopPalu using the protocols and training materials developed by MCHIP. The implementation period for the malaria activities was too short to produce changes in service indicators in the period that MCHIP was active. The collaborative efforts of MCHIP and *Faisons Ensemble* did establish a solid basis for the malaria bilateral project (StopPalu) that was awarded in 2013 with the updating of policies and protocols, preparation of trainers and training materials, all of which are still in use.

QUALITY IMPROVEMENT: THE STANDARDS-BASED MANAGEMENT AND RECOGNITION METHODOLOGY (SBM-R)

SBM-R is a methodology developed by Jhpiego to address the need for ongoing attention to the quality of care. By developing an agreed upon set of performance standards, providers, managers and community stakeholders are better able to assess the status of health care services at any given time, develop action plans to address gaps and recognize improvements between assessments. In Guinea, the MOH had identified the need for quality improvement, which was not adequately addressed through inconsistent external supervision. SBM-R was first introduced in six facilities under the ACCESS-FP project, and MCHIP has worked to progressively expand the use of this methodology in MCHIP supported facilities.

Policy interventions

- ✓ MCHIP worked closely with the MOH as SBM-R was being implemented in order to generate buy-in. As a result, SBM-R was included as an essential strategy in the Road Map for the Reduction of Maternal Mortality.
- ✓ A national validation and recognition committee was formed by the MOH to lead the recognition process.
- ✓ SBM-R has been adopted for use in other regions and prefectures by development partners including UNFPA and the Façons Ensemble project. With technical assistance from Jhpiego, 12 facilities outside of USAID intervention areas are also implementing SBM-R.
- ✓ In a review of different quality improvement methods used in Guinea, the MOH identified SBM-R as the most promising approach and has referred several donors to MCHIP to learn about the methodology.

Materials development and dissemination

- ✓ Performance standards were elaborated in collaboration with local stakeholders for three key clinical areas: family planning (FP), emergency obstetric and neonatal care (EmONC) and infection prevention (IP).
- ✓ As new components were added to MCHIP interventions in Guinea, performance standards were also developed in pre-service education, obstetrical surgery for comprehensive EmONC, anesthesia, IMNCI, PMTCT and PSE.
- ✓ A summary form was developed to facilitate the review of standards during performance reviews, as well as action plans to address identified gaps.

Site strengthening

- ✓ Over the life of the project, SBM-R was introduced in 48 MCHIP supported facilities. MCHIP was also able to leverage resources from UNFPA to introduce SBM-R in a further 12 facilities.
- ✓ As facilities began to identify service gaps using the SBM-R performance standards, many were able to advocate successfully with stakeholders to mobilize resources to address those gaps (see Figure 17 below).
- ✓ The SBM-R process also encouraged providers and managers with support from MCHIP staff to consider how they might be able reorganize services to better meet performance standards, e.g., privacy for FP counseling, ensuring access to FP commodities where PAC and postpartum services are provided, and reorganization of tasks for EmONC and FP among staff available within a facility.

- ✓ The introduction of the SBM-R process served to build capacity among providers for improved recording and analysis of service indicators.
- ✓ When a facility achieves recognition, a certificate and a sign are presented to the facility, along with a package of medical materials and supplies. In several cases, the costs of these materials were funded by UNICEF, local rather than with project funds. The package of materials was defined by the National SBM-R committee and costs approximately \$2,000 for a hospital and \$1,500 for a health center. The kits includes infection prevention materials, medication and consumables, reference materials and job aids, folding screens for privacy, delivery or exam tables.



A representative of the Minister of Health accompanied by the USAID Mission Director and MCHIP Project Director participating in the performance recognition ceremony at CMC Coleah in Conkary, March 2013

Training

- ✓ 224 stakeholders, including providers, managers and community representatives were trained on SBM-R. These groups of stakeholders were progressively trained on the three modules of SBM-R as the process was integrated into new facilities.
- ✓ To promote sustainability and decentralization, six trainers based in the three rural regions were trained and qualified to support SBM-R activities and a further 35 prefectural and regional supervisors were trained to support the process.

Supportive supervision

- ✓ During the initiation phase of the SBM-R modules, MCHIP staff conducted joint visits with regional and prefectural managers to review interim progress and prepare for the next step. Once the entire process is implemented, providers conduct their own self evaluations from time to time to review progress and address new or persistent challenges. When they feel that performance has reach a consistent threshold for recognition, facility teams request a validation visit by the National SBM-R committee.

Outcomes of the focus on quality and standards

By the end of the project, 43 MCHIP supported facilities have completed all three SBM-R modules, 24 received the external validation visit and 14 have achieved recognition by the end of the project. In general, it takes nine months to complete the three modules and interim assessment visits to fully implement SBM-R in a facility. It then takes another 6-8 months following the completion of the three modules for facilities to achieve the minimum threshold for recognition based on their own self-assessment and thus request a visit by the National SBMR committee to validate their results and then conduct a recognition ceremony.



Improved performance was seen in the areas of EmONC, FP, and IP overall in all SBM-R sites. An analysis of the median performance by domain for all SBM-R facilities show improvements between baseline vs. last evaluation of 38 percent to 80 percent for EmONC, 47 to 86 percent for FP, and 23 to 80 percent for IP.

Figure 17: Lowest, median and highest scores at baseline and last evaluation of performance standards by domain for all facilities implementing SBM-R

An in-depth analysis of the results from 16 sites conducted in early 2013, helped to illustrate how improvement in performance contributes to improved health service indicators:

- Between the baseline evaluation and final evaluation, the median performance improved from 31 percent to 88 percent for FP, 24 percent to 80 percent for EmONC and 27 percent to 82 percent for IP.
- Comparing 2011 and 2012, use of AMTSL improved from 66 percent to 89 percent and postpartum hemorrhage declined from 2 percent to 1.5 percent, with individual hospitals seeing reductions from 6 percent to 3 percent.
- Use of the partograph to monitor labor improved from 23 percent to 41 percent.
- Postoperative infection also declined, from 1.1 percent to 0.5 percent in N'zérékoré and 2 percent to 0 percent in Gueckedou.

Challenges, Responses and Lessons

Many people involved in the SBM-R process expressed that SBM-R helped build teamwork in their facility and improved the relationship between the community and the health facility. Facility managers commonly expressed that SBM-R helped them to better contribute to the resolution of problems, since the evaluations helped to prioritize needs and facilitated the staff's presentation of needs to the manager.

Involvement of NGOs, communities and partners in the field helped with the resolution of complex gaps (infrastructure, drinking water, incinerators and ambulance) at health facilities. Donations worth more than \$175,000 were leveraged to support facility improvements. (See Figure 18 below)

The initial process of introducing SBM-R can be time and resource intensive. As MCHIP scaled up the introduction of this quality improvement several lessons were identified that could help the MOH and partners continue to take this process to scale. Training regional trainers was one key way to expand capacity to support the SBM-R process. As more facilities are implementing the process it will be useful to have more resources to support the process from the regional and even prefectural level and not only central level. For recognition ceremonies, the planning of the events and collection of items for the recognition kits were also decentralized as more facilities were successfully validated. It will also be important to work toward regular and documented internal evaluations and peer reviews as a way to ensure that the process continues and progress can be reviewed by supervisors.

Some of the bigger infrastructure, human resources and management systems challenges, such as non-functioning laboratory, frequent transfer of staff, etc., can cause ongoing performance issues for a facility that are difficult to overcome. Nevertheless by having a set of standards that looks at multiple components of the health care delivery system, providers and managers are encouraged to see how their performance fits into a bigger system, which ultimately can serve as an advocacy tool for the bigger changes for performance improvement that are needed.

Figure 18: Resources leveraged to address challenges to quality and performance

Facility	Interventions	Cost (GNF, USD)	Donor	Observations
N'Zérékoré Regional Hospital	Laying floors throughout the facility in an area of 2900 m ²	884.100.000 \$126,300	EU-funded local development project for Forest Guinea	Solicited by the hospital with support of a representative of the Mayor's office to the SBM-R monitoring committee. After Module 2
	Renovation of the maternity building	159.588.490 \$22,798	UNFPA (Through the regional office in N'zérékoré)	Local resource mobilization efforts of the SBM-R committee of the hospital. After Module 2
Diakolidou Urban Health Center, Beyla	Construction of an incinerator	20.000.000 \$2,857	Faisons Ensemble (USAID multisectoral bilateral)	Local resource mobilization efforts of the SBM-R committee of the hospital. After Module 2
	Making external metal trash cans.	1.500.000 \$214		
	Construction of a water point within the facility compound		Rio Tinto mining company	
Madina Urban Health Center, Guéckédou	Generator for lighting delivery rooms	1.850.000 \$264	German NGO: HAMMER FORUM	Local resource mobilization efforts of the SBM-R committee of Urban health centers After Module 2
	Construction of a block of latrines and shower rooms	85.000.000 \$12,142		
	Construction of an incinerator and refuse pit	50.000.000 \$7,143	NGO: MSF Suisse	
	Donation of materials and consumables for infection prevention	3.609.360 \$515		
Kalinko Regional Health Center, Dinguiraye	Buying a 504 car, to serve as an ambulance (to transfer medical and obstetric emergencies to the hospital).	14.500.000 \$2,071	Community contribution through nationals outside the country	Solicitation by health and SBMS committees while implementing the SBM-R process
Faranah Regional Hospital	Donation of 150 bed sheets		Saran Keita, local resident	This donation was offered at the recognition ceremony as testimony of community satisfaction
Kankan Regional Hospital	A kit of IP materials		Mayor's Office	This donation was offered at the recognition ceremony as testimony of community satisfaction



Resources leveraged to resolve challenges identified using the SBM-R process: an ambulance to facilitate referrals, incinerators to manage waste, a new block of toilets, and IP materials to protect providers and clients

MONITORING AND EVALUATION (M&E) STRENGTHENING

Policy interventions

- ✓ At the request of the MOH, MCHIP supported the revision of indicators, registers and monitoring tools of the National HMIS for several programmatic areas, including FP, MNH, IMNCI, malaria and community-based health care.
- ✓ MCHIP initiated the random data quality assessment (RDQA) process for the National Health Management Information System at their request.

Materials development and dissemination

- ✓ In 2012, MCHIP developed improved data collection forms for FP and MCH and distributed them to all facilities and CHWs in order to improve service data collection. These forms were transmitted on a monthly basis to the prefectural level data manager, with a carbon copy going to the regional health office and MCHIP, through MCHIP regional coordinators.
- ✓ Adapted birth registers in health facilities to better capture key MNH services such as AMTSL, initiation of breastfeeding in the first hour after birth..
- ✓ Developed data management supervision tools, and adapted the Lot Quality Assurance Sampling (LQAS) to verify data accuracy by service and facility type.
- ✓ Specific to MCHIP interventions, the team developed and adapted data collection tools for: PPIUD services; the mobile phone network; PMTCT services; BCC activities and use of bicycles by CHWs; and the distribution of misoprostol and counseling on safe delivery for use by CHWs.
- ✓ Continually provided data collection tools (monthly reporting templates) and management tools (individual records, registers, referral cards, etc.) to MCHIP supported facilities.

Training

- ✓ In 2012, MCHIP conducted orientations on new data collection tools on FP and MCH services with 309 providers and community health supervisors (for new community and child health activities).
- ✓ In 2013, the MCHIP Monitoring and Evaluation team trained to 82 managers and service providers. This training focused on the use of primary and secondary management tools for PPFPP/PPIUD and IMNCI.
- ✓ Trained 46 statisticians/monitoring and evaluation officers in the process of Random Data Quality Assurance (RDQA). at the central level of MOH, regional and prefectural directorates of health.
- ✓ Trained 19 statistics officers on data base exploration and data use for decision making.

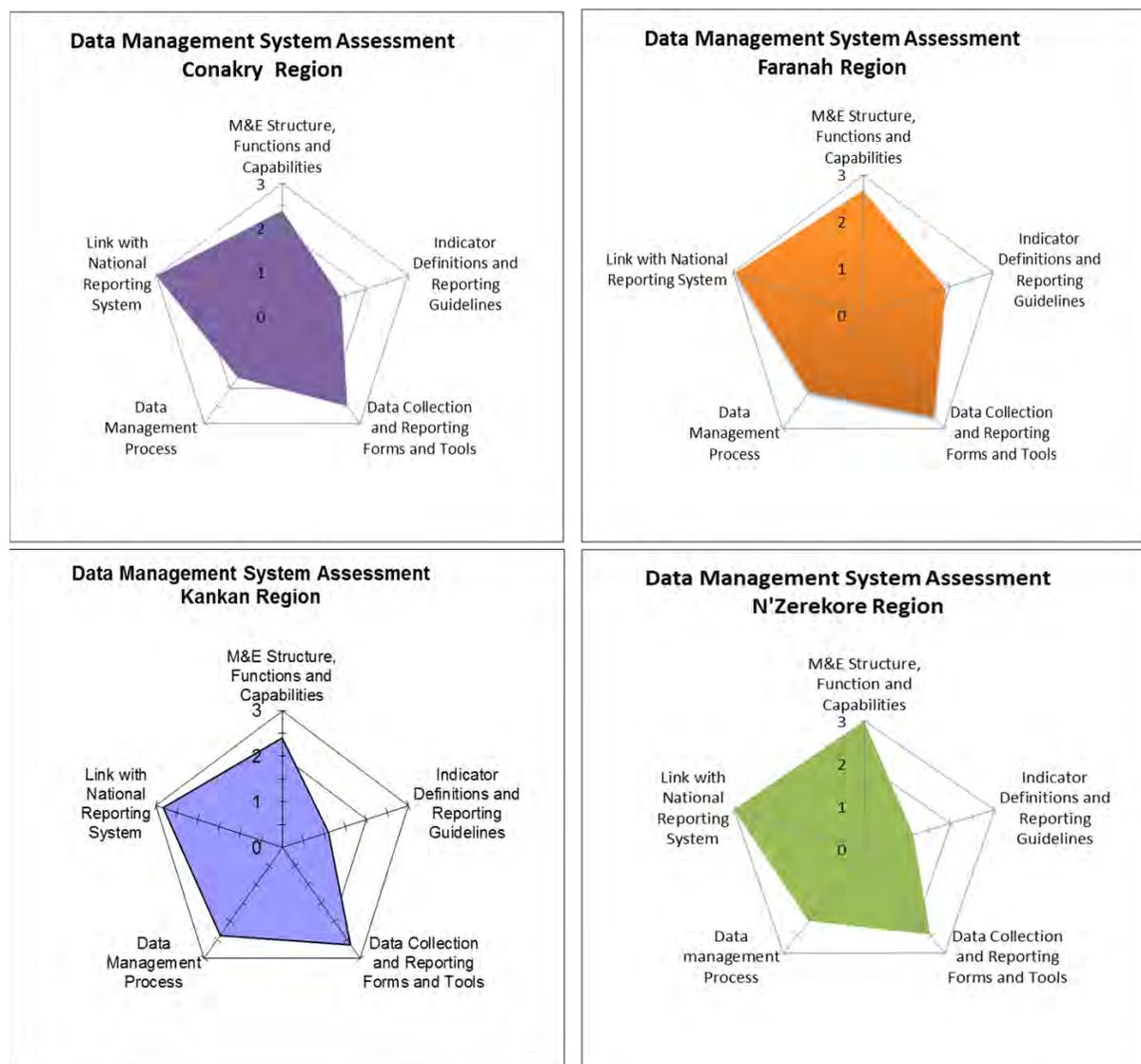
Supportive supervision

- ✓ Conducted quarterly assessments of data quality and the quality of data management in maternal health, FP and PAC services in 198 facilities. RDQA was used during the visits to assess the completeness of data and provide feedback to providers and managers to improve data collection practices. LQAS was used to verify data quality. RDQA was implemented in 17 health facilities in the four regions of the project zone.

Data quality improvement

Results from health facilities data management assessment show that data quality is strongest in PAC services followed by MNH and FP. 66% of structures providing PAC (n=50), 24% providing MNH (n=334), and 22% providing FP (n=234) achieved a performance equal to or greater than 80%. In general, results show that there is a strong link with National Reporting System in the four regions. The region of N'zérékoré has the most well established M&E structure, functions and capabilities, followed by the regions of Faranah, Kankan and Conakry. However, there is a lack of reporting guidelines and definitions of indicators at all levels.

Figure 19: RQAS scores on key performance areas by region.



Challenges, Responses and Lessons

Given the weaknesses of the HMIS system - lack of completeness and timeliness, difficulties transmitting data - MCHIP successfully developed and implemented a data collection form that both allowed the project to capture data in a timely manner and also helped prefectural level data managers in receiving data from the facilities for compilation and reporting to the regions. On a quarterly basis, the MCHIP Regional Coordinators would work with regional data

managers to check that all prefectures had submitted two copies of their forms, one for the DRS and one for MCHIP. The phone network was used to contact DPS offices that still needed to transmit their data. MCHIP also donated motorcycles to the DPS offices to facilitate their movement around the prefecture to support facilities and reinforce data recording and reporting from the facility level. MCHIP also provided stocks of the data collection tools to ensure their availability.

While working in this way with prefectural and regional data managers, MCHIP was able to identify areas of weakness in the data reporting and compilation process and take steps to address these. These observations were used to further improve data collection tools, as well as help to define training needs. Training workshops were organized specifically for data managers, but also during provider trainings in various domains data recording was emphasized. The project had a mantra: “If you do not record it, the service did not happen.” Basically in order to get credit for all the work providers do, it needs to be possible to find it recorded somewhere.

The RQAS process was another tool used to strengthen data quality. Ultimately, MCHIPs in depth work on data collection and analysis led to the M&E team being invited to support and contribute project experience to national level revision of HIMS indicators, tools and guidance.

A particular weakness in the existing system is that prefectural and regional authorities do not use their own data to monitor trends and make decisions about staffing, drug stocks, etc. The project’s database was provided to the regional health offices to facilitate their monitoring of indicators for RMNCH including those that were not included in the HMIS at the time. This also served to promote the use of the data for decision making. Regional health offices only serve as a pass through for data from the prefectural to the national level, yet as a key administrative level in the national health care system, and national government in general, more needs to be done to facilitate regional level management and use of health information.

INFECTION PREVENTION

While infection prevention (IP) practices are part of all MCHIP training activities and the SBM-R quality improvement methodology, project staff observed that IP remains one of the weakest elements of service delivery. Thus MCHIP developed targeted activities to reinforce the capacity of trainers and supervisors to assess and to model good IP skills, so that they will be able to support improv



Regular use of the IP standards have helped ensure the cleanliness of the operating theatre at the Kankan Regional Hospital

Materials development and dissemination

- ✓ Jhpiego's learning resource package for infection prevention was adapted for use in Guinea.
- ✓ Demonstration and practice of proper infection prevention procedures is emphasized in all MCHIP training curricula and training sessions.

Site strengthening

- ✓ Basic supplies like trash cans with a pedal, buckets for decontamination of instruments, and gloves and aprons to protect providers were provided to each facility.
- ✓ The commitment of time for a thorough clean-up made a difference in many facilities and motivated providers to pay more attention to IP practices.
- ✓ Larger waste management issues were identified at some facilities such as lack of adequate incineration or sterilization capacity. MCHIP donated 10 autoclaves to facilities. Advocacy is ongoing to resolve the remaining issues, for example Medecins sans Frontiers supports CMC Coleah and constructed an incinerator once the waste management issues were brought to their attention.
- ✓ Performance standards for IP were introduced in all facilities implementing SBM-R. Improvements in IP practices are found in the description of SBM-R above.
- ✓ Basic items for IP, such as buckets for instrument decontamination, gloves, bleach, etc. were provided to each facility where providers were trained and provided with instruments, including LARC/PM, EmONC, PMTCT, IMNCI. Specific to the EmONC trainings, MCHIP also provided additional protective gear such as face masks, aprons, surgical drapes.

Training of Trainers

- ✓ MCHIP, in collaboration with MSHP, conducted a training of trainers, supervisors and staff from the National Direction for Hygiene. A total of 22 trainers and supervisors from 12 facilities were updated infection prevention practices in order to support improved practices in their worksites.
- ✓ MCHIP trained national trainers were called on by the MOH, with funding from WHO, to provide IP training to providers in several prefectures following the outbreak of Ebola in early 2014.

Supportive supervision

- ✓ Observation and feedback on IP practices were a routine component of all supervision visits led by MCHIP jointly with regional and prefectural health managers.



An old autoclave that did not work well and was costly to operate was replaced by a new one provided by MCHIP

mHEALTH AND mMENTORING

MCHIP introduced the use of 264 mobile phones (call only) within the network of MCHIP-supported facilities, as well as the regional and prefectural health offices, to facilitate communications for a variety of functions. MCHIP also prepared and introduced a data collection form for monthly reporting on the use of the 264 phones in the network. The phone network was based on a recommendation of WHO as a way to replace the defunct radio-call system. Table 20 shows the evolution in the volume of calls using the network, as well as the purpose of those calls. The declines in calls in the last two quarters may be the result of civil unrest and an outbreak of Ebola in the N’zerekore Region, which has the highest rates of phone use for communication among providers and managers.

Table 20: Evolution of the use of the mobile phone network by quarter: 2012-2014

Purpose of Call (%)	Jan-Mar 2012	Apr-June 2012	Jul-Sept 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-June 2013	Jul-Sept 2013	Oct-Dec 2013	Jan-Mar 2014
Number of calls	5,752	10,060	18,319	24,034	29,938	6,769	13,829	5,944	6,465
Referrals (all reasons)	34%	36%	33%	31%	30%	22%	25%	23%	19%
Stock management	27%	24%	31%	30%	30%	24%	38%	26%	38%
Coordination	17%	20%	18%	19%	18%	27%	17%	22%	17%
Consultation with colleague	12%	11%	10%	8%	9%	12%	8%	17%	14%
Epi surveillance	7%	7%	6%	10%	10%	11%	7%	7%	10%

A closer look at the reasons for referral identified that approximately 60% of referrals were for sick children, while 30% were for danger signs during pregnancy and delivery and sick newborns, slightly less than 10% of referrals were for FP, such as referring a health center to a hospital for a long-acting method. Calls regarding referrals were generally made once a provider had obtained agreement from a family to accept a referral. The call was used to inform the receiving facility of the coming referral. If the phone network continues, it is recommended that a counter referral mechanism be added to inform providers of the outcomes of their referral and provide feedback on steps to take when preparing a referral.

The National Directorate of Family Health requested MCHIPs assistance to organize and conduct a workshop on the use of mobile phone for health with funding from UNFPA. The workshop was a first step toward developing a national mHealth strategy.

A review of the costs associated with implementing the phone network provided valuable information for continued support of the network. The initial cost of purchasing the phones and SIM cards was just under \$6000, or an average of \$1500 per region. The recurring costs of cell phone minutes came to \$20,730 for June 2011 through May 2014, or \$7000 per year. This implies approximately \$1750 for recurring costs per region.

During the regional results meetings at the end of MCHIP, the results of the use of the mobile phone network were presented in order to advocate for continued functioning of the network. MCHIP also advocated with the phone company Orange to generate support for the network. Each of the Regional Health Offices with support of their DPS’ and Orange agreed to cover the costs of continuing the phone network in each region.

Figure 21: Can mMentoring replace post-training follow-up visits following EmONC training?

Traditionally, training is followed up by a post-training follow-up visit six to eight weeks after training then a supervision visit takes place at three months. The first visit aims to assist the trainees to implement the knowledge and skills gained during the training and the 3 months visits assesses the knowledge, skills and attitudes of the providers using standard observation checklists. Cost, distance to facilities and scheduling are challenges to completing these two facility visits, therefore MCHIP in partnership with MOH decided to test a mentoring strategy using cell phones.

Key objectives were to assess feasibility, effectiveness for knowledge and skills retention and cost of the intervention. A case control design was used to compare a group of providers who received the traditional follow-up (n=14) with those that received mMentoring (n=30). The mobile mentoring consisted of a schedule of 20 text messages, including quiz questions and using a computer software program to send them, and conducting three cases studies over the phone. Participants were also encouraged to call the mentors - senior OB/GYNs who were among the EmONC trainers - at any time.

In terms of efficacy, all mentees received the text messages, responded to an average of 73 percent of them, and responded correctly 80 percent of the time. Case studies were more problematic in terms of understanding the information and questions over the phones and only 2 participants achieved a score over 85 percent, the standard for competency.

When the three month follow-up visits were conducted knowledge and skills retention was generally better for the group that received traditional post training, on-site support than the group that participated in the mobile mentoring, indicating that this is not yet an equivalent method of supporting providers.

The cost of the mobile mentoring initiative was \$500 for SMS and voice service plus the time of staff to develop the mentoring questions and reminders, set up the software program and mentors to conduct calls. With a relatively low cost for 12 weeks of support it would seem worthwhile to work to refine the phone based support to see if further improvements can be made in helping providers retain knowledge and skills and controlling costs of supervision and mentoring.

There were several opportunities to share the MCHIP experience in implementing the mobile phone network nationally and regionally, including the Global Maternal Health Conference 2013, and a regional mHealth conference in Tanzania in which a delegation of MOH and MCHIP staff attended together.

Figure 22: Using Tablets to Collect Study Data on LARC in Post-Abortion Care Services

In conjunction with the MCHIP Family Planning team, ICT4D and the MCHIP Guinea staff supported the collection of study data on Post-Abortion Care Integration in Guinea.

Platform/Technology

To collect data, we used the CommCare/Open Data Kit platform for Android tablets (<http://commcarehq.org>). Staff worked to translate the paper-based version of the complex study instruments into a form that would automate “skip logic”, automate data validation (for instance, only allowing a certain range of numbers), and to timestamp the data. Tablets also allowed the recording of longer interview questions from respondents by the data collectors.

At the conclusion of each section of the survey, the health worker can save and send the data. The data is sent via wi-fi or via the mobile network to a central database, accessible in the cloud. If no wi-fi or mobile coverage is currently available, the data is saved locally to the tablet or phone, and then can be submitted when coverage is available. This also allows “active data collection” while the data enumerators are in the field: as forms come in, quick reviews of the raw data can be performed, alerting data collectors to possible issues and monitoring their locations in the field.

Data collection in Guinea

Data collectors were trained for one week, and data collection took place over three weeks at 38 sites, with 125 participants. Data has been successfully uploaded and is being cleaned and analyzed. Study data collectors responded to the experience generally positively:

“...I have done many studies with paper survey tools, but here I was seen as interviewer and IT technician; I was at ease and it was easy!”

“... Using tablets is better, because it’s more efficient, comfortable and more secure! ”

“...Using tablets is good; but you still need to have a few paper copies of the questionnaires in case there is an issue with the tablet”.

Figure 23: Testing a Mobile Safe Childbirth Checklist

In conjunction with the World Health Organization (WHO) Safe Childbirth Checklist Collaboration, Jhpiego's Maternal and Newborn Health (MNH) and Information and Communication Technology for Development (ICT4D) groups are developing a mobile technology-based version of the WHO safe childbirth checklist (mSCC).

Prototype mSCC application details

The mobile safe childbirth checklist currently utilizes the CommCare platform, a secure, free and open-source software application with mobile and cloud infrastructure (<http://commcarehq.org>). The application guides the health worker through the checklist with targeted prompts and reminders. If the health worker tries to skip a question, the application reminds them to provide an answer before continuing.

At the conclusion of each section of the checklist, the health worker can save and send the data. The data is sent via wi-fi or via the mobile network to a central database, accessible in the cloud. If no wi-fi or mobile coverage is currently available, the data is saved locally to the tablet or phone, and then can be submitted when coverage is available or downloaded later via a wired connection.

Guinea field testing & refinement

As part of the WHO Safe Childbirth Checklist Collaboration, which works to research the effectiveness and validity of the SCC, Jhpiego field tested the electronic version of the checklist in Conakry, Guinea, in the hands of health workers who are actually managing laboring clients and delivering newborns.

This testing involved focus groups with midwives to obtain feedback about the design of the tool, the perceived amount of training necessary to use the tool, whether or not the tool was perceived as useful, and whether the midwives thought their cohort of fellow midwives would also use the tool. We also observed the midwives managing a labor and delivery in simulation, using pelvic models with the mobile SCC alongside them.

We interviewed and observed 1-3 midwives per day for five days. Midwives were presented with the electronic version of the application to explore. Next, the midwives were read a scenario and simulated a labor and delivery with a pelvic model, using the mobile safe childbirth checklist as best as they could throughout the process. The midwives received no guidance on how to incorporate the checklist into their workflow.

The midwives gathered once more for a follow-up focused discussion to reflect on their experiences using the mSCC. Despite some difficulties, nearly all the midwives said that they liked using the tablet-based checklist, and even preferred it to the paper-based checklist. The focus group leader probed about the amount of training the midwives felt was necessary for the successful implementation of the mSCC. While no one felt that the use of the tablet required "no training at all", nearly all the midwives thought that the tablet could be safely and effectively used by midwives during labor and delivery with "little training". (Most specified several hours, or half a day.)

Rather than focus on specific aspects of the checklist that they didn't like, the midwives immediately jumped to talking about how the checklist could be most useful in their day-to-day work. The checklist, for instance, is meant to be a job aid, and does not in any way replace the patient chart, the partogram, the register, or other documentation that midwives must fill out. Yet the midwives sensed opportunity: they recognized that the mobile safe childbirth checklist had the power to wirelessly transmit data about the patient. They requested that more patient data be added to the checklist, including some data that would be repeated on the chart. They also wished to be able to continue to view all the information about the patients, even after the patient had been discharged from the facility. The features they requested, in essence, added up to an electronic partogram in tandem with a rudimentary electronic health record. This functionality is much more than what the mSCC is intended for, yet it excited the midwives the most.

PREVENTION, SCREENING AND SERVICES FOR GENDER BASED VIOLENCE

The USAID Guinea Mission successfully applied for incentive funding for a project to address Gender-based Violence (GBV) Reduction. In collaboration with the USAID funded legal assistance project led by the American Bar Association, MCHIP initiated activities during the final project year to better understand the scope of the problem and what resources exist in order to prepare for a comprehensive intervention that addresses the health, social support and legal aspects of victims of GBV, as well as communications to increase community awareness and prevention efforts.

- ✓ Literature Review to Inform Situation Analysis for Gender Based Violence: an inventory and review of documents and texts on GBV was conducted in collaboration with Jhpiego Baltimore and the results were used to develop data collection tools for the analysis of the situation of GBV(see report).
- ✓ Making contact with stakeholders (Ministry of Social Welfare, Ministry of Health, the American Bar Association, NGOs and associations working in the field of protection and women's rights). The survey for situational analysis will be conducted under the leadership of the Ministry of Social Action, which is heavily involved in the fight against GBV and in collaboration with the Ministry of Health.
- ✓ Development of the survey protocol for the situation analysis of GBV in Guinea regarding the various components of prevention and management of GBV (see copy of the protocol)
- ✓ Design data collection tools including: Guide for Focus Group, Guide for Resource Inventory, Guide for individual interviews with health care providers and health services, Guide for individual interviews with security officers, Guide for Focus Group with lawyers, Guide for individual interviews with local elected officials and community associations
- ✓ Selection and training of 15 interviewers and 5 supervisors based on their experience in the field of investigations and GBV in particular. Investigators and supervisors include lawyers, doctors and sociologists.
- ✓ Data collection was fielded in June and analysis and report writing were underway as the MCHIP project closed

Program Learning Themes

A summary of the cross-cutting Program Learning themes/question and dissemination outputs are presented in Annex 5

Continuation of PPIUD

What is the rate of continuation for women who receive PPIUD? What were the reasons for discontinuation?

Discontinuation of an FP method most often occurs during the first year of use. Therefore, the continuation rate at one year is a useful indicator to estimate the probability that a person will continue to use a contraceptive method, particularly for long-acting reversible methods. With support of an MPH student intern, physicians and midwives who were providing PPIUD services conducted follow-up phone interviews with a sample of 204 women, who had accepted an IUD in the postpartum period at least one year earlier. The one-year continuation rate was 93.6% (n= 191). Differences in continuation rates by location (Conakry vs. cities in the interior) were not statistically significant ($\chi^2=0.005$, $p=0.944$). Although it is difficult to generalize based on only 13 IUD removals, partial or total expulsion was cited as the reason for discontinuation by nearly half (n=5). Other reasons included side effects, switching methods, and situational factors. Ten women discontinued IUD use within the first four months post-insertion. The findings suggest that there was widespread acceptance of IUD services postpartum in this sample. Physician follow-up should also be improved, by extending the follow-up period through the first four months post-insertion and contacting clients by phone when in-person follow-up is not possible.

Decentralizing training by developing regional trainers for FP and EmONC

Can regional teams be effectively formed and supported to offer training at the regional level? How can this contribute to scale-up? Is this cost effective?

Development of local training capacity was a key investment within MCHIP activities. The trainer development pathway used in MCHIP Guinea, developed by Jhpiego, starts with knowledge and skills standardization in one or more of the courses, such as training in specific methods, counseling skills, etc. After several months of clinical practice, candidate trainers are selected from among proficient, motivated providers and prepared as trainers in clinical training skills. Course completion is followed by mentored co-training, in order to complete trainer qualifications.

The availability of effective trainers is essential in assisting providers to maintain current skills based on evidence-based best practices in health care. The preparation of these trainers allowed MCHIP to scale up training and supervision activities to reach many more facilities in the second and third years, while reducing per-session costs through use of national rather than international trainers. This pool of national and regional trainers serve as a potential resource for the MOH and their partners for a variety of training needs. MCHIP worked closely with the MOH to develop plans to make use of these national training resources. (See Annex 8 for list of trainers by topic)

- 35 trainers were qualified to lead trainings in long-acting FP methods and provide post training supportive supervision.
- 17 trainers, in regional teams of three to four, were qualified to provide EmONC clinical training.
- 34 trainers were trained in FANC.
- 22 trainers were qualified to support improved infection prevention practices.

- 32 community organizers, 12 NGO supervisors and 15 CHW supervisors (district level) from the prefectural health departments were oriented on the health messages and the utilization of the counseling card in order to be able to train the CHWs
- 34 regional, prefectural and communal supervisors and trainers were trained to provide malaria prevention and treatment updates to providers and CHWs.
- 6 trainers based in the three rural regions were trained and qualified to lead SBM-R activities and a further 35 prefectural and regional supervisors were trained to support the process.

SBM-R

Do SBM-R score improvements correlate with improvement of key MNH practices and health outcomes?

By the end of the project, 43 MCHIP supported facilities have completed all three SBM-R modules, 24 received the external validation visit and 14 have achieved recognition by the end of the project. In general, it takes nine months to complete the three modules and interim assessment visits to fully implement SBM-R in a facility. It then takes another 6-8 months following the completion of the three modules for facilities to achieve the minimum threshold for recognition based on their own self-assessment and thus request a visit by the National SBMR committee to validate their results and then conduct a recognition ceremony.

An in-depth analysis of the results from 16 sites conducted in early 2013, helped to illustrate how improvement in performance contributes to improved health service indicators:

- Between the baseline evaluation and final evaluation, the median performance improved from 31 percent to 88 percent for FP, 24 percent to 80 percent for EmONC and 27 percent to 82 percent for IP.
- Comparing 2011 and 2012, use of AMTSL improved from 66 percent to 89 percent and postpartum hemorrhage declined from 2 percent to 1.5 percent, with individual hospitals seeing reductions from 6 percent to 3 percent.
- Use of the partograph to monitor labor improved from 23 percent to 41 percent.
- Postoperative infection also declined, from 1.1 percent to 0.5 percent in N'zérékoré and 2 percent to 0 percent in Gueckedou.

An MCHIP program brief and a journal manuscript are being finalized looking at the experiences across several countries are in process.

mHealth

How were mobile phones (voice channel) used among a group of health workers? Did their use facilitate referral, HIS, stock management, supervision and clinical support?

See mHealth and mMentoring above

mMentoring

Does the use of mobile phone technology to provide mentoring following training in EMONC help with the retention of knowledge and skills?

Traditionally, training is followed up by a post-training follow-up visit six to eight weeks after training then a supervision visit takes place at three months. The first visit aims to assist the trainees to implement the knowledge and skills gained during the training and the 3 months

visits assesses the knowledge, skills and attitudes of the providers using standard observation checklists. Cost, distance to facilities and scheduling are challenges to completing these two facility visits, therefore MCHIP in partnership with MOH decided to test a mentoring strategy using cell phones.

Key objectives were to assess feasibility, effectiveness for knowledge and skills retention and cost of the intervention. A case control design was used to compare a group of providers who received the traditional follow-up (n=14) with those that received mMentoring (n=30). The mobile mentoring consisted of a schedule of 20 text messages, including quiz questions and using a computer software program to send them, and conducting three cases studies over the phone. Participants were also encouraged to call the mentors - senior OB/GYNs who were among the EmONC trainers - at any time.

In terms of efficacy, all mentees received the text messages, responded to an average of 73 percent of them, and responded correctly 80 percent of the time. Case studies were more problematic in terms of understanding the information and questions over the phones and only 2 participants achieved a score over 85 percent, the standard for competency.

When the three month follow-up visits were conducted knowledge and skills retention was generally better for the group that received traditional post training, on-site support than the group that participated in the mobile mentoring, indicating that this is not yet an equivalent method of supporting providers.

The cost of the mobile mentoring initiative was \$500 for SMS and voice service plus the time of staff to develop the mentoring questions and reminders, set up the software program and mentors to conduct calls. With a relatively low cost for 12 weeks of support it would seem worthwhile to work to refine the phone based support to see if further improvements can be made in helping providers retain knowledge and skills and controlling costs of supervision and mentoring.

Urban Community Health

Did use of non-health community agents increase access to health information in an urban environment?

Work with CHWs has traditionally focused on rural areas, while in urban areas there are many different sources for information although not necessarily targeted to health information and services. In an innovative strategy to extend the national community-based services to urban areas, MCHIP in collaboration with the MOH and a local NGO, *Club des Amis* (CAM), initiated community education activities in the urban communes of Conakry and eventually the direct distribution of contraceptives by urban community health workers.

The initial task of the selected leaders was to raise awareness within the community on reproductive health and family planning issues and to refer clients to health facilities. Results from the successful partnership between the local associations and the health facilities encouraged MCHIP to position these leaders to become community health agents, by building their technical capacity to support community-based distribution of oral contraceptives as a first step.

A total of 216 association members were trained by MCHIP on reproductive health and family planning messaging. Among these association members, an additional 48 (including eight from the islands of Kassa) were further trained to become CHWs and to distribute contraceptives (condoms, pills, and Cycle Beads).

Additionally, 33 individuals (five SBC supervisors based in the five Communal Health Directorates, 22 EPI officers and six members of CAM) were trained to supervise and monitor the community health activities in Conakry.

MCHIP went a step further in 2013 to try to reach women through hair salons since these businesses often serve as a community hub. Twenty female apprentices and five salon managers were trained as peer educators to ensure the diffusion of messages of FP, PFP, PAC, MNCH, and IMNCI, and referral to nearby public facilities. Ten of the peer educators were later trained on how to counsel and distribute FP methods (pills, condoms, Cycle Beads), thus making them the urban equivalent of a CHW. This new role for hair salon staff was generally well accepted, although Jhpiego would like to conduct a more formal assessment, if funding can be identified. The experience with hair salons also suggests that other small businesses, such as tailor shops, could be engaged to provide similar community health education and services.

PPH prevention:

Does a scalable model of community based distribution of misoprostol increase access to a uterotonic?

The Ministry of Health and Social Welfare of Guinea, with technical support from MCHIP, is implementing a combined health facility and community-focused program for the prevention of postpartum hemorrhage (PPH). The program strengthens active management of the third stage of labor (AMTSL) and management of PPH at health facilities as well as counseling and advanced distribution of misoprostol by health care providers, CHWs, and traditional birth attendants (TBAs) for self-administration at home births. The intervention is being implemented in five sub-prefectures of N'Zérékoré prefecture (Gouecke, Soulouta, Womey, Koropara and Yalenzou) in Guinea.

The program design was implemented under the MCHIP Integrated Service Delivery Program. UNFPA supplied misoprostol in-country for the implementation of the learning phase, and the Ministry of Health and Social Welfare distributed it for the five sub-prefectures. Within the MCHIP program the technical guidance and assistance comes from Jhpiego and Save the Children.

A total of 31 health facilities were included in the implementation in these five sub-prefectures and 219 providers, CHWs and TBAs distributed misoprostol to 555 pregnant women. 43% of women received their misoprostol during an ANC visit while 57% received it from a CHW. Among the 555 women, 59% gave birth in a facility (n=329) and 41% gave birth at home (n=226). During interviews with 500 women, 330 reported having taken misoprostol. All women who had delivered at home took the misoprostol as recommended. No serious complications were reported while 24.6% did report minor side effects such as shivering.

PAC and LARC service expansion and uptake

In February and March 2014, the Guinea MCHIP team conducted an assessment to examine the extent of integration of post-abortion care (PAC) services and family planning, especially client uptake of LARCs in the PAC setting. Using a team of 10 data collectors, the MCHIP team collected data from all 38 health facilities in Guinea that offer PAC services. The assessment looked at the availability of infrastructure, trained personnel, equipment, supplies and contraceptive methods in facilities supported by the MCHIP project, as well as facilities supported by UNFPA. The research questions included: 1) what proportion of health facilities offer a full range of contraceptive methods, including LARCs, within PAC?; 2) what are the staffing levels and ability of PAC health workers to offer a quality service?; 3) how does the health system enable or constrain this integration of PAC and family planning?; and 4) Do

differential levels of program support to facilities resulted in variability in PAC service performance?

The assessment consisted of a mixed methods approach, including interviews with key informants as well as providers, facility assessments and inventory, provider knowledge and skills assessments (role-play and case studies), and the use of HMIS/service statistics. Overall, 75 PAC providers were interviewed, as well 38 maternity-in-charges. Data was collected using Google Nexus 10.0 tablets and CommCare, a mobile data collection platform that uses cloud technology. Final results from the data are still being analyzed but show certain regional trends in uptake of family planning as part of PAC services, provider knowledge and skills in PAC and family planning counseling, and more. Overall, good integration of PAC and family planning services was found, with 70% of PAC clients accepting any method and 30% accepting LARC.

The team is preparing to submit a manuscript based on the study findings to share with a larger audience.

Integration of malaria and IMNCI:

How do selected PMI countries incorporate WHO Guidance on case management of malaria in children into country-level IMNCI Training and Supervision Guidelines?

The MCHIP Child Health team completed an inventory of IMCI training and supervision tools in PMI countries including Guinea.

Recommendations and Way Forward

Over the course of three and half years a number of important improvements were made in the provision and quality of healthcare services in USAID supported regions. In order to continue to build on these gains, and assist the Ministry of Health of Guinea to continue to improve its capacity to lead and sustain quality services for the people of Guinea, it will be important for donors and partners to sustain their support. The Guinean health system is still very dependent on external assistance and gains can be quickly lost when support fluctuates and/or is accompanied by conflicting strategies and advice.

1. The MOH should be encouraged and supported to continue to institutionalize **SBM-R** as a quality improvement process. This has the potential to strengthen the quality of supervision as well provider engagement in monitoring their own work. The MOH has already shown a great deal of commitment to the SBM-R process as a promising method to improve the quality of care, thus they should be supported to continue to use and to learn from that process.
2. The MOH should also be supported to strengthen and institutionalize its coordination and policy setting role in healthcare and public health in general. This is particularly important in a complex and varied donor environment. Weak coordination and competing priorities was a continuous challenge for MCHIP activities. With the level of resources being invested by USAID, this is an area where support could go a long way to help address these challenges and maximize the effectiveness of USAID and other donor investments.
3. MOH and partners should be encouraged to make use of the national trainers - in Conakry and in the three eastern regions - that were trained in various technical areas and then in training skills. (See Annex 7 for the list of trainers by topic.) These national resources and the training materials adapted in collaboration with MOH under MCHIP can serve to systematize in-service, continuing education efforts. The pool of national trainers also offers opportunities to reduce costs compared to bringing in external technical assistance. Further, MCHIP trained trainers are prepared to lead evidence-based practical trainings. As seen with the EmONC training, numerous other training initiatives in Basic EmONC had not sufficiently changed practices and this had to be redressed as part of the MCHIPs mandate to focus on Comprehensive EmONC.
4. **Family Planning:** The integration of LARC into family planning services should continue, as well as continued integration of FP and Maternal Health services through postpartum family planning counseling and access to immediate postpartum methods (PPIUD, and implant if guidance changes). An expanded method mix and linking FP to ANC and maternity services increases the opportunities for women to find a method that suits their needs at a time when they interact with the healthcare system and may desire to space or limit future pregnancies.
5. While FP methods posed a particular commodity challenge, the overall supply chain remains weak and ultimately FP commodities need to be part of an integrated supply management system to effectively ensure that facilities and community health workers have the drugs and materials to offer the services that other resources are invested in for their education and training. Efforts to expand the availability of methods need to be adequately coordinated with procurement and supply chain functioning to ensure that providers can actually offer the services they are trained on. This is essential for both facility and community based services.

6. **Maternal and newborn health:** 20 hospitals supported to improve Comprehensive EmONC and 10 providing PMTCT services in ANC is an excellent start to ensure the availability of life-saving services for women and newborns, but not the end. MOH and partners need to continue to identify opportunities to strengthen and perpetuate the capacity of these facilities and the providers working there to respond effectively to urgent care needs of pregnant women and sick children. This rightfully must include the infrastructure and supply needs to sustain the availability of services.
7. Continued support to the midwifery school at ENSK is another important way to ensure that student midwives are adequately prepared from the beginning of their careers to provide quality maternal and newborn care.
8. **Misoprostol for prevention of postpartum hemorrhage:** Postpartum hemorrhage is the leading cause of maternal death and often happens so quickly that care cannot be reached in time. CHW and ANC distribution of misoprostol for use at home births represents an important opportunity to put in place a practice that can save many women's lives. It will be important to support MOH to extend the use of this medication at community level, by integrating its use into policy and norms and supporting the scale up its implementation. Misoprostol also has important applications in lower level health facilities managing births that may not be able to store oxytocic drugs properly.
9. **Child Health:** Lessons should continue to be gathered from the pilot of the updated IMNCI protocols and training in 20 sites. The providers and CHWs should continue to receive supervisory and monitoring support prior to conducting an evaluation of the intervention in order to inform future program directions for IMNCI in facilities and communities.
10. **Community Health:** The extensive investment in training CHWs to date merits focused efforts to continue to support their work, ensure their work is properly recorded and reported and to provide periodic refreshers and updates. Engaging with local community based organizations and networks to support CHWs is one promising approach. Another approach may be to provide performance-based small grants to facilities or prefectures to be able to convene regular coordination meetings, as well as conduct supervision. Specific to urban areas, non-traditional means of reaching people with health information and services could also include tailor shops, market kiosks, etc.
11. **mHealth:** the mobile phone network is a promising approach to improve the connections between and communications among providers for multiple elements of health service delivery. The cost is reasonable and should be continued as well as expanded into other regions. There is good potential to engage the mobile phone service providers in support for these regional networks.

Annex 1: Performance Monitoring Plan

INDICATOR		DEFINITION/ CLARIFICATION	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	ACHIEVEMENTS PAST YEARS/ PY6 TARGETS
Cross Cutting Indicators						
CC1	Number of people trained*	<p>Number of people trained including those reached via on-site training</p> <p>Disaggregates: Topic (FP, MH, CH, etc., specific skills: EmONC, AMTSL), cadre (health care worker, CHW), job function, partner organization, institution</p>	Training database	Quarterly	Technical lead for each topic area	<p>PY3: FP: 136 providers, SBM-R: 66 providers</p> <p>PY4: FP: 305 providers, MNH 36 providers, 548 CHWs, IMNCI: 23 supervisors, 18 providers; IP: 22 trainers and supervisors; PSE: 16 faculty and preceptors; Malaria: 34 trainers and supervisors, 180 providers, 102 CHWs.</p> <p>PY5: FP:11 trainers, 383 providers and, 58 CHWs;</p> <p>MNH: 111 providers (including PMTCT), 1092 CHWs; IMNCI: 20 providers, 101 CHWs; Malaria: 20 Providers; M&E: 98 providers; PSE: 83 faculty and preceptor)</p> <p>PY6: MNH: 16 Providers (CEmONC), 33 Providers and 187 CHWs (PPH), FP: 16, M&E: 30 providers</p>
CC2	Number of trained providers who received supportive supervision	Number of trained providers receiving supportive supervision at their work site.	Supervision records	Quarterly	Regional coordinator	<p>PY3:FP 136; PY4: FP: 158 providers, MNH 37 providers</p> <p>PY5: FP: 403 providers; MNH: 71 providers, 727 CHWs; Malaria: 166 Providers and 94 CHWs; IMNCI: 20 providers, 94 CHWs</p> <p>PY6: FP: 186 providers ; MNH: 102 providers, 942 CHWs; PMTCT: 170 providers</p>

CC3	Number and percentage of health facilities achieving/ compliant with at least 80% of performance standards (by topic)	Number of facilities achieving / compliant with at least 80% of performance standards through SBM-R process. Disaggregates: Topic (FP, EmONC, IMNCI, IP), location (facility, pre-service institution)	SBM-R records, SBM-R external assessment	Annual Baseline and Endline	SBM-R Advisor	PY3: EmONC: 5 (18%); FP: 6 (22%); IP: 6 (22%) PY4: EmONC: 12 (32%); FP: 15 (39%); IP: 8 (21%) PY5: EmONC: 22 (46%); FP: 36 (75%); IP: 21 (44%) PY6: EmONC: 14 (29%); FP: 21 (44%); IP: 13 (27%)
CC4	Number of facilities using SBM-R process for quality improvement	Number of facilities using SBM-R process for quality improvement by location Disaggregates: facility, pre-service institution	SBMR reports	Quarterly	SBMR Advisor	PY3: 27 PY4: 38 PY5: 50 (48 for EmONC, FP and IP; 2 for PSE) PY6: 50 (48 for EmONC, FP and IP; 2 for PSE)
CC5	Number of group educational sessions conducted	Number of group educational sessions conducted Disaggregates: Topic, location(facility, community)	Program Records (Group Education Tracking Sheet)	Quarterly	Technical lead for each topic area	PY3: 714 PY4: FP: 23591; MNH: 5154 PY5: FP: 22705; MNH: 8981; IMNCI: 8981 PY6: FP : 22987; MNH: 4179; IMNCI: 6350
CC6 (2013)	Number of people reached by group educational session	Number of people reached by group educational session at facility Disaggregates: Topic, sex	Program Records (Group Education Tracking Sheet)	Quarterly	Technical lead for each topic area	PY3: na PY4: na PY5: 167592 PY6: 124572
CC7	Number of studies conducted	Number of studies, by topic	Program records	Annual	M&E Advisor	PY3: na PY4: PY5: 1 (mMentoring) PY6: (MNH-PPH/Misoprostol)

CC8	Number of improvements to laws, policies, regulations or guidelines*	Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support, by program. Names of documents can be specified (E.g. Guidelines for long-acting methods, Guidelines for using Misoprostol etc.)	MCHIP	Annual		<p>PY3:2 (curriculum PF/ LT; Curriculum PF/DIUPP)</p> <p>PY4: 5 (Curriculum SONUC; Protocole PCIMNE, curriculum PCIMNE Clinique, curriculum PCIMNE – C, Protocole de prise en charge du paludisme; curriculum de formation des prestataires sur la PEC du paludisme)</p> <p>PY5: 2 (Normes et procédures en PTME, Kit de formation PTME : Guide du formateur, Cahier du participant)</p> <p>PY6: 1(Curriculum des Sages-femmes/PSE)</p>
CC9	MCHIP learning and results documented and disseminated to better inform and advance policy dialogue	Number of reports, articles, etc. completed to document MCHIP learning	MCHIP	Annual		<p>PY3: 1 mini-U : Dissemination MLDA Conakry</p> <p>PY4: 1 Poster SBMR and 3 oral presentations – FP conference 2011 Dakar</p> <p>PY5: 3 Posters et 10 presentations (FP Conference, Women deliver, GHC, FIGO, SAGO, PAC meeting, Jhpiego annual meeting)</p> <p>PY6: 4 presentations (CFSC – Burkina, PFP Technical working group forum, Jhpiego annual meeting)</p>
OBJECTIVE 1:Increase access to high quality <u>family planning (FP)</u> services						
Result 1.1 Improved FP service delivery, including provision of long-acting methods in postpartum and postabortion care, at the program facilities through local capacity building, provision of method-specific supplies and quality improvement activities.						
Output Indicators for these results are all found in Cross Cutting section, Outcome indicators are below						
1.2.1	Number of USG-assisted service delivery points providing FP counseling	Number of USG-assisted service delivery points providing FP counseling or services		Annually	FP Advisor, Regional Coords	<p>PY3:27</p> <p>PY4:232</p> <p>PY5: 234</p> <p>PY6: 234</p>

	or services					
1.2.2	Number of women receiving individual counseling sessions in immediate postpartum or PAC for FP/RH as a result of USG assistance*	Number of women who received a counseling in PAC or delivery ward, including for long-acting methods Disaggregates: Service locations (PAC, delivery)	PAC and post-partum logbooks	Quarterly	FP Advisor, Regional Coords	PY3: 21355 (PAC: 1477, FPPP:19878) PY4: 25549 (PAC: 2145, FPPP: 23404) PY5: 27760 (PAC: 1601, FPPP: 27159) PY6: 14639 (PAC: 1140, FPPP: 13499) (6 months)
1.2.3	Percentage of women who receive individual counselling for FP/RH as part of PAC care	<u>Numerator:</u> Number of women who received FP counseling at PAC ward <u>Denominator:</u> number of women recorded as attending service	PAC logbooks	Quarterly	FP Advisor, Regional Coords	PY3: 100% PY4: 99% PY5: 99% PY6: 100%
1.2.4	Percentage of women who receive individual counselling for FP/RH as part of immediate postpartum care	<u>Numerator:</u> Number of women who received FP counseling at delivery ward <u>Denominator:</u> number of women recorded as attending service	post-partum logbooks	Quarterly	FP Advisor, Regional Coords	PY3: 100% PY4: 71% PY5: 52% PY6: 70%
1.2.5	Percentage of women counseled in PAC service who accept a modern FP method	<u>Numerator:</u> Number of women who accepted FP method after PAC <u>Denominator:</u> number of women recorded as attending service	PAC and post-partum logbooks	Quarterly	FP Advisor,	PY3:73% PY4:81% PY5: 89% PY6: 90%
1.2.6	Percentage of women counseled in immediate Postpartum service who accept a modern FP method	<u>Numerator:</u> Number of women who accepted FP method in immediate postpartum <u>Denominator:</u> number of women recorded as attending service	PAC and post-partum logbooks	Quarterly	FP Advisor,	PY3: 30% PY4: 39% PY5: 34% PY6: 42%
1.2.7 (2011 2.2)	Number of new acceptors of modern contraceptive methods as a result of USG assistance*	Disaggregates: Service type/location (FP, PAC, delivery, facility/community), method	PAC and post-partum logbooks Facility logbooks CHW records	Quarterly	FP Advisor, Regional Coords	PY3: HF 11969 PY4: (HF 127226, CBD 49055) PY5: (HF 129225, CBD 67997) PY6: (HF 66652, CBD 29766)
1.2.8 (2011 2.3)	Number of continuing users of FP methods	Continuing users are those who are maintain regular use of the method Disaggregates: service location (facility, community)	CHW's records, Facility logbooks	Quarterly	FP Advisor	PY3: HF 4553 PY4: (HF 101067, CBD 52610) PY5: (HF 102551, CBD 77711) PY6: (HF 53159, CBD 31211)

1.2.9	Couple Years Protection (CYP)*	Number of users of each method (FP method mix) multiplied by a protection factor for each method from published sources.	Facility logbooks and medical records	Quarterly	M&E Advisor	PY3: 10759 PY4: 66858 PY5: 116032 PY6: 66871(6 months)
Result 1.2 Implementation of innovative approaches to expand coverage and reach of the key FP services through integration with immunization events						
Result 1.4: MCHIP learning and results documented and disseminated to better inform and advance policy dialogue on FP						
<i>See Cross Cutting Indicator 7</i>						
OBJECTIVE 2 : Increase access to and improve quality of emergency obstetric and newborn care (EmONC) services						
Result 2.1: Improved EmONC services at 20 facilities in Conakry, Upper and Forest Guinea through local capacity building						
Result 2.2: Improved quality and integrated VCT and PMTCT services through updating learning resources package and capacity building.						
<i>See Cross Cutting Indicators</i>						
Service Statistics related to Result 2.1and 2.2						
2.2.1	Number and percent of women delivering with assistance of a skilled birth attendant*	<u>Numerator:</u> Number of women delivering with assistance of a skilled birth attendant* (in health facilities with SBA). SBA is a trained nurse, or midwife or medical doctor <u>Denominator:</u> Estimate of number of births in the catchment area.	Facility Logbooks	Quarterly	MNH advisor	PY3: na PY4: 23014 PY5: 37722 PY6: 19300 (6 months)
2.2.2 (2011 1.4)	Number and Percent of women receiving active management of the third stage of labor (AMTSL)*	<u>Numerator:</u> Number of women giving birth who received AMSTL at facilities <u>Denominator:</u> Number of women with vaginal births at facilities	Facility Logbooks	Quarterly	MNH advisor	PY3: 12063 (81%) PY4: 22415 (88%) PY5: 31204 (95%) PY6: 15746 (87%)(6 months)
2.2.3 (2011 1.6)	Number and percentage of women delivering at MCHIP-supported facilities with a completed partograph in their medical record	<u>Numerator:</u> Number of women delivering at MCHIP-supported facilities that are assisted during labor using a partograph by a nurse or a doctor. <u>Denominator:</u> All women delivering at MCHIP-supported facilities	Logbooks or medical records	Quarterly	MNH advisor	PY3: 4752 (24%) PY4: 10030 (31%) PY5: 17325 (40%) PY6: 11327 (53%) (6 months)
2.2.4	Number of women with obstetric complications treated at MCHIP-supported	Number of women with obstetric complications treated at the health facilities by type (examples: post-partum hemorrhage, pre-eclampsia/eclampsia,)	Medical records (hospital)	Quarterly	MNH advisor	PY3: 6398 PY4: 7401 PY5: 9683 PY6: 5363 (6 months)

	health facilities, by type					
2.2.5 (2011 1.7)	Percentage of cases of severe pre-eclampsia and eclampsia treated with magnesium sulfate	<u>Numerator:</u> number of pregnant women diagnosed with severe pre-eclampsia/eclampsia whose treatment included a full course of magnesium sulfate <u>Denominator:</u> number of pregnant women diagnosed with severe pre-eclampsia/eclampsia	Medical records	Quarterly	MNH advisor	PY3: 98% (268 cas traités) PY4: 98% (549 cas traités) PY5: 99% (799 cas traités) PY6: 100% (457 cas traités) (6 months)
2.2.6	Number of Maternal Deaths	Number of deaths of pregnant or postpartum women (intra hospital) by cause	Registers	Quarterly	MNH advisor	PY3: na PY4: 117 PY5: 184*(improved recording) PY6: 63 (6 months)
2.2.7	Number of Stillbirths	Number of stillbirths by type (fresh, macerated) at facility	Registers	Quarterly	MNH advisor	PY3: 1538 PY4: 2356 (1079 fresh, 690 macerated) PY5: 2787*(improved recording) (1823 fresh, 964macerated) PY6: 1152 (710 fresh , 442 macerated)
2.2.8 (2011 1.8)	Number of newborns receiving essential newborn care*	ENC includes (clean cord care, drying and wrapping, immediate breastfeeding within one hour of birth)	Registers	Quarterly	MNH advisor	PY3: 6997 PY4: 19971 PY5: 33593 PY6: 16678 (6 months)
2.2.9	Number of asphyxiated newborns successfully resuscitated	Number of newborns not crying or not breathing at birth successfully resuscitated	Registers	Quarterly	MNH advisor	PY3: na PY4: 1378 PY5: 2386 PY6: 1724 (6 months)
2.2.10	Number of service delivery points (SDP) providing the minimum package of PMTCT services according to national standards	A service delivery points refers to the lowest level of service. For example, a hospital, clinic, health center or mobile unit. The minimum package of services for preventing mother-to-child transmission (MTCT) of HIV includes at least all four of the following services: 1. Counseling and testing for pregnant	Registers	Quarterly	MNH advisor	PY3: na PY4: na PY5: na PY6: 10

		women 2. ARV prophylaxis to prevent MTCT 3. Counseling and support for safe infant feeding practices 4. Family planning counseling or referral				
2.2.11	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	The total number of pregnant women who received both HIV counseling and testing including the provision of test results at PMTCT service delivery points.	Registers	Quarterly	MNH advisor	PY3:na PY4:na PY5: na PY6: 1925
2.2.12	Number of women in labor and given birth who received HIV counseling and testing for PMTCT and received their test results	The total number of pregnant women who received both HIV counseling and testing including the provision of test results at PMTCT service delivery points.	Registers	Quarterly	MNH advisor	PY3:na PY4:na PY5: na PY6: 728
2.2.13	Number of HIV-infected pregnant women who received psychosocial support including appropriate reference for ongoing care and treatment in a PMTCT SDP	The total number of pregnant women who received interventions that address the non-physical suffering of individuals and family members, such as mental health counseling; support groups; support for disclosure of HIV status; and bereavement care.	Registers	Quarterly	MNH advisor	PY3:na PY4:na PY5: na PY6: 21 (15 femmes ont été testées positives et toutes bénéficiées d'un soutien psychosocial au cours des visites CPN)
2.2.14	Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT SDP	The number of women who received any PMTCT ARVs to prevent MTCT at PMTCT service delivery points. ARV prophylaxis includes: (1) single dose nevirapine (SD NVP), (2) prophylactic regimens using a combination of two ARVs, (3) prophylactic regimens using a combination of three ARVs, <u>or</u> (4) ART (HAART) for HIV-positive pregnant women eligible for treatment. --- ----- <u>Count all of these types of regimen options</u> in the total number of women who received any PMTCT ARVs.	Registers	Quarterly	MNH advisor	PY3:na PY4:na PY5: na PY6: 30 (15 femmes testées positives durant la période ont reçu leur ARV).

		Desegregate by type of facility				
2.2.15	Number of health workers trained in the provision of PMTCT services according to national standards	Number of facility based delivery care providers performing PMTCT services with at least 80% of standardized procedures; Training refers to new training or retraining of individuals and assumes that training is conducted according to national standards when these exist	supervision reports	Quarterly	MNH advisor	PY3:na PY4:na PY5: na PY6: 20
Result 2.3 Implementation of innovative approaches to expand coverage and reach of key life-saving MNH services through a demonstration of postpartum hemorrhage prevention methods at both facility and community levels.						
2.3.1	Percentage of women who took the misoprostol at the correct time, after home-birth,	<u>Numerator:</u> Number of women correctly using misoprostol after home birth (after 2 nd stage of labor/delivery if infant) <u>Denominator:</u> Number of women receiving counseling and medication for use at home birth who deliver at home	Registers, ANC records, CHW records	Quarterly	MNH advisor	PY3:na PY4:na PY5: na PY6: 100%
2.3.2	Number of women receiving a uterotonic after birth	Number of women receiving a uterotonic (misoprostol, oxytocin) after birth	Registers, CHW records	Quarterly	MNH advisor	PY3:12063 PY4:22415 PY5: 31204 PY6: 16257 (6 months)
2.3.3	Percentage of providers routinely practicing AMTSL for facility deliveries	<u>Numerator:</u> Number of facility based delivery care providers performing AMTSL with at least 80% of standardized procedures <u>Denominator:</u> number of facility based delivery care providers evaluated	supervision reports	Quarterly	MNH advisor	PY3:na PY4:92% PY5: 93% PY6: 85%
Result 2.4: MCHIP learning and results documented and disseminated to better inform and advance policy dialogue on MNH						
<i>See Cross Cutting Indicator 7</i>						
OBJECTIVE 3: To improve access to quality <u>IMNCI</u> services for children under 5						
Result 3.1: National IMNCI Steering Committee demonstrates leadership to manage unified child survival programs						
Result 3.2 and 3.3 : Performance and Quality Improvement for Child Survival developed and introduced; Dynamic Child Survival integrated approaches maintained in 20 health facilities and 100 community sites						
<i>See Cross Cutting Indicators (CC1, CC2, CC3, CC4)</i>						
Service Statistics related to Result 3.2 and 3.3						

3.5.1	Number of children <5 years with symptoms of pneumonia given appropriate medications per the norms*	Number of cases of child pneumonia treated with antibiotics by trained people health workers in USAID supported programs, by location Desegregation: facility, community	situation analysis	Baseline, End line	CH advisor	PY3:na PY4:na PY5: na PY6: na
3.5.2	Number of children <5 years with symptoms of pneumonia managed	Number of children <5 years with symptoms of pneumonia managed, by location Desegregation: facility, community	Logbooks or medical records	Quarterly	CH advisor	PY3:na PY4: na PY5: (HF 8953, CBD 543) PY6: (HF 5724, CBD 330) (6 months)
3.5.3	Number of children <5 years with symptoms of diarrhea receiving appropriate drugs per norms*	ORT, Zinc. Number of cases of child diarrhea treated through USG-supported programs with: a) oral rehydration therapy (ORT), b) zinc supplements	situation analysis	Baseline, End line	CH advisor	PY3:na PY4:na PY5: na PY6:na
3.5.4	Number of children <5 years with symptoms of diarrhea receiving care management	Number of children <5 years with symptoms of diarrhea receiving care management, by location Desegregation: facility, community	Logbooks or medical records	Quarterly	CH advisor	PY3:na PY4:na PY5: (HF 1301, CBD 471) PY6: (HF 1022, CBD 262) (6 months)
3.5.5	Number and Percentage of children treated within 24 hours after having fever*	Percentage of children treated within 24 hours after having fever* at facility <u>Numerator:</u> number of children treated within 24 hours after having fever <u>Denominator:</u> number of children treated within 24 hours for fever	Logbooks or medical records	Quarterly	CH advisor	PY3:na PY4:nd PY5: (HF 1303, CBD 94) PY6: (HF 101, CBD 10) (6 months)
Result 3.6: Lessons learned from MCHIP's interventions documented and disseminated to stakeholders						
See Cross Cutting Indicator 7						
OBJECTIVE 4:Strengthen communications for improved community outreach, health information and increased access to a package of community based health services						
Result 4.1. Increased demand for health services from the community based on targeted messaging by the agents communautaires (AC)						
See Cross Cutting Indicators: CCI1, CCI2, CCI3, CCI5, CCI6						
Result 4.2: Implementation and documentation of innovative approaches to expand coverage and reach of key messages for FP, and MNCH						
Result 4.3: Cross-learning between organizations promoting community health programs shared and documented						
See Cross Cutting Indicator 7						

OBJECTIVE 5: Strengthen MCH and FP components of <u>medical and midwifery preservice education</u>, including improving the competency-based training capacity of the faculty and preceptors						
Result 5.1. Medical and midwifery preservice and continued education strengthened to support national capacity building of health care professionals to provide high-quality health care.						
<i>See Cross Cutting section CCI1</i>						
5.1.1 (2011 3.2)	Number of faculty and preceptors that achieve 80% of clinical training performance standards	Number of faculty and preceptors that achieve 80% of clinical training performance standards	Routine SBM-R assessments	Annually	MCHIP	PY3:na PY4: na PY5: training done during last quarter PY6: 19/38
5.1.2 (2011 3.1)	Number of users of the clinical skills lab	Sign-in sheet with name, date, department, cadre, by institution (medical school, midwifery school); by category (faculty, student)	Sign-in sheet	Quarterly	MCHIP	PY3:26 PY4:435 PY5:493 PY6: 228 (6 months)
OBJECTIVE 6: To contribute to improved malaria outcomes and strengthening the quality of services at both facility and community levels.						
Result 6.1: Supervision conducted for 200 previously trained providers from Hospital, Health Center and Health Post levels in 3 prefectures and Conakry and 100 community health agents in 3 prefectures trained on updated malaria service delivery guidelines.						
<i>See Cross Cutting Indicators</i>						
Malaria Service Statistics related to Result 6.1						
<i>Note: due to unavailability of drugs and supplies required for service provision, which was outside the scope of MCHIPs work, it was not possible to report to report on service provision indicators in 2012 or for the final quarter of MCHIPs support for malaria programming.</i>						
Result 6.2: Documentation of MCHIP's contribution to malaria programming in Guinea completed.						
<i>Included in Cross Cutting Indicator 7</i>						

Annex 2: Success Stories

L'utilisation du Misoprostol pour l'hémorragie du post-partum

20 Mai 2014, District de Bangouéta, Préfecture de N'Zérékoré :

Mme Thérèse KOLIE a 20 ans. Elle est ménagère, et épouse de Léonce SAGNO, un cultivateur. Pour Thérèse, l'accouchement de ses enfants est quelque chose très difficile.

Au 1er accouchement, Thérèse a eu une hémorragie du Post Partum (HPP) grave (vertige, perte de connaissance). Au 2ème accouchement, elle a eu encore une HPP grave (vertige, perte de connaissance, et référence à l'Hôpital Régional de Nzérékoré).

Selon Thérèse, après ses 2 accouchements, la montée laiteuse était faible et la qualité de son lait n'était pas bonne, les bébés faisaient de la diarrhée à répétition. Elle avait des lochies abondantes et prolongées (plus de 14 jours).

Au cours de sa dernière grossesse l'année passée, elle a informé sa belle-mère, son mari et le chef de poste de santé, dès la 1ère Consultation Pré Natale de ses hémorragies du postpartum graves quelle était victime.

Elle a fait 4 visites de CPN au cours de sa grossesse. Après la dernière CPN, après un consentement éclairé relatif au programme Misoprostol, mené par MCHIP (Maternal and Child Health Integrated Project), elle a reçu de l'AC 3 comprimés de Misoprostol qu'elle devrait garder jusqu'à l'accouchement et avaler dès que le bébé arrive.

L'accouchement a eu lieu le 2 janvier 2014 à 15 h 55. Après l'accouchement, l'AC a vérifié s'il n'y avait pas un 2ème bébé et elle a demandé à Thérèse d'avalier les 3 comprimés de Misoprostol, emmené par MCHIP. Après la prise du médicament, le placenta est tombé tout seul et sans saignement abondant.

Mme Thérèse affirme que les lochies étaient comme les menstrues et avaient durées 8 jours, elle ne changeait qu'une seule fois de garniture par jour. Elle a eu une bonne montée laiteuse, « je faisais même un engorgement mammaire et vous avez vu mon bébé évolue très bien. »

« Je remercie le programme Misoprostol et demande d'en envoyer pour toutes les femmes, ce médicament nous a aidé mon bébé et moi d'être en bonne santé. Je vais expliquer à toutes mes amies que c'est le meilleur des médicaments, » dit-elle. « Il est très fort. »



Receiving husbands' support for family planning, prepared by Save the Children

May 2014, prefecture of Dabola, region of Faranah

Mr. Seydou Cisse aged 43 years, is a CHW from the village of Diabakania, located at 22 Km from the head of the prefecture. Mr. Cisse has worked for more than 10 years as a community health worker (CHW) in his village. According to him, before the MCHIP project, it was difficult for women to feel comfortable using family planning and some husbands were not comfortable with the idea of their wives using a modern method of contraception. "Because of the different sensitization activities conducted showing the benefit of birth-spacing, today, I am sought after by husbands requesting family planning for their wives. Some come with their wives and others call me to tell me that they will send their wives to me in the evening to receive family planning."

Français : Mai 2014--Mr Seydou Cisse, âgé de 43 ans, est CHW du village de Diabakania, situé à 22 Km du chef-lieu de la préfecture. Il travaille depuis plus de 10 ans comme agent communautaire de santé (CHW) dans son village. Selon lui, avant le projet MCHIP, les femmes venaient difficilement se faire planifier, et certains maris n'étaient pas d'accord sur l'utilisation d'une méthode moderne de PF par leurs femmes. « A cause des différentes sensibilisations réalisées montrant le bénéfice de l'espacement des naissances, aujourd'hui, je suis convoité par les maris pour planifier leur femme. Certains se déplacent avec leur femmes et d'autres m'appellent pour me dire que je vais t'envoyer ma femme ce soir pour la PF, » dit-lui.

Motivation d'être CHW, prepared by Save the Children

Mr Thierno Aliou Diallo, âgé de 42 ans, l'Agent Communautaire de Santé (CHW) du village de Dhaibatou, dans la région de Faranah, n'était qu'un simple citoyen au départ. Il a beaucoup aimé les activités que mène le CHW de son village, un jour il est parti trouver le CHW titulaire à son domicile lui demandant de devenir son assistant. Ce dernier avant d'accepter cette doléance a expliqué aux sages et aux autorités du village. Ces groupes ont murit l'information et ont accepté la proposition. Ils ont donné un rendez-vous pour une rencontre, à la suite du quel, ils l'ont félicité et encouragé et l'ont confiés au CHW pour un transfert de compétences. Selon Thierno Aliou Diallo, « Nous travaillons ensemble depuis plus de cinq ans. Maintenant, aujourd'hui je suis devenu le CHW titulaire de mon village en remplacement du premier qui est maintenant moins actif à cause de sa vieillesse. C'est moi qui participe maintenant à toutes les formations et les réunions mensuelles pour le compte rendu des activités de mon village aux CS. »

« Pour l'offre des services de PF, j'ai rencontré certaines difficultés d'ordre promotionnel au début car parler de la PF était un tabou chez nous, mais aujourd'hui, j'ai réussi à convaincre la plupart des maris et des femmes sur l'utilisation des méthodes de PF, » dit-lui.

« Malgré les difficultés liées aux ruptures de contraceptifs, je suis la référence pour l'offre des services de PF et même d'autres activités communautaires dans le cadre de la santé. »

Community external resource mobilization through the SBM-R

SBM-R training helped improve not only the technical skills needed to support clients, but also the advocacy skills necessary to help facilities fulfill their needs. For example, through the advocacy training, a hospital was able to receive an ambulance from the people of Belgium, solar panels from the people of China, and beds and mattresses from the people of Canada.

Declaration by the Télimélé Hospital General Supervisor.



Community Recognition of Regional Hospital of Kankan performance.

It is an opportunity for us to testify that since some time, we are seeing efforts to improve the cleanliness of the premises, the availability of the staff of the hospital, of the availability of medicines for the care of mothers and children.

Also clients come out of the hospital, satisfied with services received. These efforts contribute without any doubt to improve the health of populations of Kankan, including that of mothers and children who are preferred targets of the Government of the President, Professor Alpha CONDE.

I thank the American through USAID people who funded this work which today is this recognition ceremony; MCHIP/Jhpiego, for its technical assistance and consistency in monitoring activities; the staff of the hospital and all the authorities for their willingness to cover the needs of the health of the populations of Kankan.

Statement by the Mayor of Kankan



Commentaires d'une AC sur le PCIMNE

2014, préfecture de Dabola, région de Faranah :



Dabola est une des 20 préfectures appuyé par le Projet MCHIP dans le domaine de la Santé maternelle, néonatale infantile et planification familiale, aussi bien dans les formations sanitaires que dans les communautés à travers les agents communautaire de santé.

Madame Catherine Koulibaly, a 51 ans, et elle est l'AC-PCIMNE dans un quartier de Dabola. Elle a partagé ces remarques par rapport au travaille fait dans la préfecture de Dabola, région de Faranah, par le projet MCHIP :

« Je tiens à témoigner ici lors de la restitution

régionale de Faranah pour exprimer ma satisfaction vis-à-vis de ce projet. En effet, ce projet m'a permis d'être utile à ma communauté à travers la formation que j'ai reçue. »

« Depuis ma formation en PCIMNE communautaire, j'ai eu l'opportunité de conseiller les femmes, sur leur santé et celle de leurs enfants surtout dans les communautés qui sont loin des CS. Maintenant, je suis en mesure de détecter les problèmes de santé des enfants et de les prendre en charge selon les cas, car en plus de la formation, j'ai reçu le matériel nécessaire. J'ai des produits pour le diagnostic et le traitement du paludisme simple et de la diarrhée non compliquée de moins de deux jours. J'ai aussi des produits contraceptifs (pilules) que je distribue aux femmes selon leur choix et leur éligibilité, » explique-elle.

« Pour les cas de paludisme grave, de diarrhée de plus de deux jours ou avec complication et lorsque les femmes désirent une méthode de contraception autre que les pilules, je les réfère au CS. Pour cela, je les encourage, les rassure et leur explique l'importance de la référence afin de les convaincre à accepter de se déplacer vers les structures sanitaires. »

« Merci le projet MCHIP, Merci de m'avoir donné cette opportunité d'être un « petit docteur » pour les familles qui sont reculées et qui souvent n'ont même pas les informations nécessaires sur la santé maternelle, infantile et la PF. »



Le PF et le CPN : le travail important d'une Agent de santé communautaire

Octobre 2013, village de Dandou, préfecture de Kissidougou

Ruth Findouno, a 42 ans et elle est l'AC depuis 10 ans, dans le village de Dandou, dans la sous – préfecture de Firawa, dans la préfecture de Kissidougou. « Avant que je ne commence mes activités d'AC, il y avait beaucoup de femmes dans mon village qui n'allaient pas au centre de santé, qui ne connaissaient pas les méthodes de PF et qui n'osaient pas parler de leurs besoins en contraception. »

Selon elle, « maintenant, les femmes ont confiance en moi, je leur donne des conseils et les sensibilise sur l'importance de la CPN, de la PF et de la vaccination des enfants. Je leur fournis des contraceptifs qui sont à ma portée (pilules) et je les réfère lorsqu'elles veulent une autre méthode de contraception. »

Le travail n'arrête pas au PF et au conseil. « Mon rôle ne se limite pas à cela, mais je contribue aussi à la recherche active des femmes enceintes pour la CPN et à la sensibilisation des femmes pour qu'elles fassent leur première CPN le plus tôt possible et accouchent dans une structure sanitaire, » explique-elle.

« Les femmes, y compris moi – même sont très heureuses maintenant avec la PF, car elles ne sont plus angoissées à l'idée de faire un enfant chaque fois qu'elles ont un contact sexuel avec leur époux. »



En effet, les statistiques de cette sous – préfecture montrent que le nombre d'utilisatrices de PF est passé de 138 en 2012 à 412 en 2013 et en 2013, 53 femmes ont été référées pour les MLDA (30 pour implants et 23 pour DIU). Ces chiffres montrent un progrès très important. *Ruth Findouno, durant une supervision de l'ONG APIC sur le terrain.*

Quelques mots d'une utilisatrice de DIU

2013, préfecture de Kissidougou :

Madame H a 28 ans, mariée, et elle est la mère de 4 enfants, dont le dernier a 5 ans. De plus, elle est une cliente utilisatrice de DIU.

Selon elle, « je me suis mariée très tôt (17- 18 ans) et j'ai fait des grossesses assez rapprochées ; en effet, mon mari n'attendait pas les deux ans et il y avait 14 mois entre mes enfants. J'étais très gênée, vis-à-vis de mes copines, car soit j'étais enceinte, soit j'étais avec des enfants. Je considérais que j'avais beaucoup d'enfants pour mon jeune âge. Je vivais dans l'angoisse de concevoir alors que je ne le souhaitais pas. Je n'avais pas le courage d'en parler autour de moi. »



« Un jour, les AC sont venus chez moi et m'ont parlé de la

PF. J'ai eu le courage de leur expliquer ma situation et elles m'ont sensibilisées et accompagnée au CS. »

« Au CS, j'ai été très bien accueillie par la sage-femme qui m'a montré toutes les méthodes de PF. Je n'étais pas rassurée et hésitais à choisir une méthode. La sage-femme m'a rassurée et j'ai choisi le DIU, car c'est une méthode discrète, qui me mettrait à l'abri des grossesses pendant longtemps. Pour me rassurer d'avantage la sage-femme est restée en contact téléphonique avec moi. »

« Quelques temps après la pose du DIU, la sage-femme m'a appelée pour avoir des nouvelles et j'étais à Conakry, car j'avais commencé à faire du commerce. Maintenant, je suis bien portante, j'ai grossi, je m'occupe de mes enfants, je me sens à l'aise avec mes copines et j'ai même commencé à faire du commerce sur Conakry et vraiment je suis heureuse, » dit-elle.

« Je remercie le projet qui a formé les AC et les sages- femmes pour soulager les peines des femmes. »

Kissidougou est une des 20 préfectures appuyé par le Projet MCHIP dans le domaine de la Santé maternelle, néonatale infantile et planification familiale, aussi bien dans les formations sanitaires que dans les communautés à travers les agents communautaire de santé.

L'affectation des motos pour les districts sanitaires de Faranah

2013, Région de Faranah :

En Juin 2013, le Projet MCHIP-USAID a affecté des motos aux quatre Districts sanitaires de la Région de Faranah qui a révolutionné les activités des Services à Base Communautaire(SBC) dans plusieurs domaines.

- Accessibilité : les Chargés SBC viennent désormais dans les communautés ou ils n'avaient pas l'habitude de venir avant MCHIP, y compris Dabola, les communautés de Banko Koro et Kansonko, secteurs du District de Finala, et la sous-préfecture de N'dèma.
- Suivi des activités : l'obtention de ce moyen précieux de déplacement a permis aux chargés SBC d'être auprès des AC pour les aider à résoudre les problèmes de santé de leurs communautés et de suivre les activités des SBC.
- Promptitude et Complétude : l'obtention de ces moyens a permis d'améliorer à tous les niveaux le rapportage des activités communautaires.
- Renforcement des capacités : Capacités des AC /communautés renforcées grâce à l'obtention de ce moyen de déplacement.
- Appui : les activités communautaires sont appuyées à travers l'obtention de ce moyen de déplacement, notamment, les campagnes de vaccination des enfants et des femmes.

La remise des motos a été une véritable histoire de réussite du projet MCHIP pour les Services à Base Communautaire en faveur de l'amélioration de l'état de santé des femmes et des enfants



Renforcement des compétences dans la région de Faranah

2013, Région de Faranah:

Madame Fatoumata Camara, dite Koumba, est ATS de l'Hôpital Régional de Faranah. Elle est chargée de l'unité de PF et faisant fonction de sage-femme. Quand elle venait au service, elle n'avait suffisamment pas d'expériences pour exercer ses fonctions.

Elle apprécie à juste valeur les apports de MCHIP dans le cadre du renforcement de ses compétences avec le processus de SBM-R. Selon elle; c'est grâce à MCHIP qu'elle exerce ses multiples fonctions et peut se prendre en charge.

Pour elle la différence entre MCHIP et les autres projets réside à trois niveaux: expériences pour l'acquisition des connaissances, acquisition de matériels, et surtout le suivi post-formation des prestataires. Elle affirme qu'elle « n'a pas entendu parler de suivi post-formation dans un autre projet ». Elle s'engage d'être aux services de MCHIP partout où le besoin sera.



La prise-en-charge intégrée des maladies de l'enfant au niveau communautaire

Village de Bèrèla-koura, région de Faranah :

Mme Madina Barry est l'Animatrice Communautaire du village de Bèrèla-koura, préfecture de Dabola. Elle a été choisie par sa communauté pour assister à la formation des AC sur la PCIMNE Communautaire. Au retour de la formation, ils ont fait la restitution au Centre de Santé pendant les réunions mensuelles. Arrivée à Bèrèla-koura, elle a organisé la même restitution au cours de laquelle elle a expliqué les 4 pathologies : le paludisme, la pneumonie, la diarrhée et la malnutrition. A la fin de la restitution, le chef de District et ses conseillers ont fait le plaidoyer auprès des mères d'envoyer leurs enfants malades chez l'AC avant de prendre n'importe quelle décision pour ces pathologies mentionnées ci-dessus. Ce qui fut fait.

Il faut reconnaître que Madame Madina Barry a une sous-préfecturale dans le cadre de la Prise en Charge Intégrée des Maladies au niveau communautaire.

Pendant le dernier Suivi Post-Formation des AC, Mme Madina Barry a obtenu une note d'haute performance à travers son engagement et ses expériences.



Madame Madina Barry arrêtée pendant la réunion mensuelle des AC au CS de Bissikrima.

Lettre d'un prestataire

District sanitaire de Dinguiraye :

Monsieur Youssouf SYLLA est le Chargé des Services à Base Communautaire du District Sanitaire de Dinguiraye, reconnaît avoir reçu assez de formations à travers le Projet MCHIP-USAID-Guinée sur: l'amélioration de la qualité des soins ; le suivi/supervision intégrés des structures sanitaires des activités communautaires ; l'évaluation des structures sur les standards de performance (SBM-R) ; l'évaluation de la technologie de contraception ; la Communication pour le Changement de Comportement ; et la lutte contre le paludisme.

Comme il explique, « l'évaluation des structures sur les standards de performance (SBM-R) qui d'ailleurs a permis à une de mes structures encadrées à avoir sa reconnaissance de performance de qualité des soins dans les 3 domaines : la Planification Familiale, le Soins Obstétricaux Néonatal d'Urgence (SONU), et la Prévention des Infections--c'est le CSR Kalinko de Dinguiraye. »

Écrit-lui, « Je reconnais avoir reçu ces expériences mentionnées ci-dessus seulement avec le Projet MCHIP-USAID dont je continue à faire bénéficier les prestataires des structures sanitaires et les animateurs communautaires de ces leçons apprises. »

Il donnait quelques données intéressantes, par exemple : 80% des animateurs communautaires ont bénéficié de la formation sur la technologie contraceptive ; 70% ont reçu la formation sur la communication pour le changement de comportement ; 90% des AC ont bénéficié de la formation sur les messages de PF, SMNI et PCIMNE ; et 30% ont bénéficié de la formation sur le paludisme.

« Il faudra ajouter l'affectation d'une moto pour la DPS de Dinguiraye dont je suis le gestionnaire, qui nous permet de joindre les bouts dans le district mais aussi en dehors de notre district. Ce précieux moyen de déplacement nous appuie techniquement, administrativement, financièrement, et socialement et il a permis d'élever mon niveau de vie. Le jour qu'on m'a affecté cette moto, j'ai dit au coordinateur régional MCHIP de Faranah que je compte faire 100% dans le système de rapportage tant que je puis prendre une pierre et lancer et m'inscrire dans cette direction. C'est pour dire à la direction de ce grand projet merci et merci. »

Après 30 ans, il y a toujours l'apprentissage

Lola, région de N'Zérékoré :

Dr Yaya Camara est le Directeur de l'hôpital (DH) préfectoral de Lola depuis 2008. Il dirige les services de la maternité et de la chirurgie. Au terme des travaux de la 2ème session 2013 du CTRS (Comité Technique Régional de la Santé) à N'Zérékoré, Dr Camara a confié ses sentiments sur les formations qu'il a bénéficié en SONUB et SONUC organisées par MCHIP à Conakry, respectivement en Juin et Décembre 2013.



Il a plus de 30 ans à la fonction publique et selon lui, « J'ai reçu assez de formations au cours de ma carrière de médecin. J'ai été coopérant en Guinée-Bissau et dispose de beaucoup d'expériences de terrain. En 2013, quand MCHIP-Guinée m'a convié à la formation en SONU

avec mes deux sages-femmes de la maternité, je ne voulais pas honnêtement y prendre part, car je m'estimai pétri d'expériences récoltées au fil des ans. Mais en comparant les autres formations et celles organisées par MCHIP, j'ai la conviction d'avoir bénéficié du complément qui était le manque à gagner. »

Dit-lui, « A mon retour dans mon hôpital, j'étais fier de moi et j'avais surtout compris qu'il me restait encore à apprendre énormément de choses essentielles pour la pratique quotidienne. »

« J'ai développé une confiance en moi car, la formation était de suivi d'évaluation, de supervision, de monitoring par téléphone de vive voix ou par SMS. A cause de ce processus de formation et d'encadrement, je ne me pose plus de questions avant d'entrer au bloc comme c'était le cas auparavant et je constate que ma technique opératoire est fortement améliorée. »

« Formé, équipé en matériels, doté en médicaments et consommables, suivi et supervisé, c'est une première dans ma longue carrière de médecin, » partage-lui.

« A Lola, j'organise avec les sages-femmes formées en SONU, et des mises à niveau du personnel du District. C'est un net changement qui est en train de s'opérer dans la prise-en-charge de nos malades ou chacun trouve son compte. »

« Grand merci à MCHIP-Guinée. »

Histoire de succès en résumé :

Village de Tangodou, Préfecture de Beyla :

Madame Aïssata Sidibé a 27 ans. Elle est mariée et avec sa cinquième grossesse, avec 4 enfants vivants.

Trainant une grossesse de 32 semaines, elle s'est sentie mal à l'aise, réveillée par un saignement spontané au troisième trimestre de sa 5ème gestation. Seule avec sa belle-mère, abandonnée par son mari en quête d'un bien être, a tenté une solution, celle de sauver sa vie. Pour cela, elle emprunta un vélo, premier moyen de transport à sa portée. Vu l'état de la piste et l'inconfort de sa monture, elle n'en pouvait plus aller au Delas. Le cycliste désemparé, la confia à la providence en la laissant seule en bordure de route. Jeudi étant le jour de marché hebdomadaire de Samana, S/P voisine, un camion d'un autre âge, bondé de passagers, avec bagages bord-a-bord, a pris Dame Assata comme nième passagère. Tout au long du parcours, les douleurs et le saignement empiraient et tous les passagers furent indisposés par ses cris de lamentation. Arrivée au CS de Samana, où l'équipe de supervision PCIMNE communautaire avait été reçue il y a quelques 3 heures environ, fut interpellée par le Chef de Centre Santé et sa matrone et tout s'arrêta du côté supervision pour faire face à l'extrême urgence obstétricale. A la réception et prise-en-charge au niveau du centre de santé, elle a eu une consultation d'urgence et une évaluation des paramètres vitaux, y compris le TA, fréquence respiratoire, température, etc.

Le diagnostic de présomption était un saignement du troisième trimestre (Placenta Prævia suspect). La conduite tenue y compris la prise d'une voie veineuse à l'aide d'un cathéter et administration des solutés de remplissage (Sérum Salée 500 cc 5%0) ; préparation des accompagnants pour l'évacuation d'urgence dont : (1 Homme et deux Femmes) ; aménagement de l'ambulance de fortune (véhicule du projet CR-MCHIP-G/NZ) ; et l'installation confortable et sécurisée de la femme permettant à l'équipe d'opérer (continuer perfusion et évaluer les paramètres).



Préparation à l'évacuation de l'urgence (SONU) Village Samana

Quelques points clé comprennent :

- Information de l'équipe de la maternité de Beyla par flotte téléphonique de l'arrivée d'une urgence obstétricale;
- Au CS de Moussadou, village situé à 10 km de Beyla, réapprovisionnement en soluté;
- Réception à l'Hôpital Préfectoral de Beyla par l'équipe d'urgence après 3 heures de route

Le diagnostic à l'admission était Placenta Prævia Marginal avec un état général satisfaisant. L'équipe a décidé d'opérer par césarienne de faire accoucher un bébé mort-né suite hémorragie intra-utérine (PPM). Après toutes ces tribulations, le pronostic maternel est bon.



A la réception de l'urgence à l'Hôpital de Beyla.



Madame Assata Sidibé, la veille de son intervention à l'Hôpital préfectoral de Beyla, avec un coordinateur de MCHIP.

Santé maternelle : Sages-femmes de l'hôpital régional de Kankan et l'hôpital préfectoral de Kissidougou

Avril à juin 2013, préfecture de Kissidougou, région de Kankan :

Au cours du suivi post formation réalisé dans les hôpitaux de Kankan et Kissidougou, deux prestataires se sont confiés à l'équipe de suivi.

Une sage-femme de Kankan mariée mère de trois enfants travaille dans la salle d'accouchement depuis 2002. Elle a reçu une formation en 2012 en SONUC et PF à travers le projet MCHIP.

Elle déclare « je ressens de la satisfaction après cette formation car je suis capable de réaliser un accouchement normal, placer une ventouse, réparer l'épisiotomie, la déchirure du col et la PEC de l'éclampsie ». Un exemple récent, au cours de ma dernière garde j'ai reçu une femme avec une crise d'éclampsie du postpartum au 16^e jour de son accouchement. J'ai fait des injections de Sulfate de magnésium (MgSO₄) selon le protocole SONU. D'ici le matin la dame était consciente, j'ai continué durant les jours suivants, la surveillance de paramètres vitaux, et l'administration des médicaments contre l'hypertension artérielle ; elle est sortie guéri au 9^e jour de son hospitalisation. Ce jour-là, j'étais fière de moi-même et j'ai dit que ma formation a réussi, ça m'a fait aimer d'avantage mon métier de sage-femme, car mes clientes se sentent soulagées. Merci MCHIP pour ces acquis ».

Mademoiselle Bintou Diomande, est une sage-femme âgée de 33 ans, en service à la maternité de l'hôpital préfectorale de Kissidougou depuis 2012. Elle a été formée par le projet MCHIP sur



les Soins Obstétricaux et Néonataux d'urgences Complet. Cette sage-femme témoigne selon ce qui suit : « La science évolue tous les jours, ce que j'ai appris à l'école de sages-femmes en obstétrique et dans plein d'autres disciplines me servait bien sûr ; mais avoir la compétence et la connaissance, l'amélioration de la qualité dans mes prestations, et la confiance

en soi-même sont le résultat d'une formation que j'ai reçu de MCHIP sur les Soins Obstétricaux et Néonataux d'Urgences Complets. »

« Avant cette formation, j'étais un complément d'effectif dans mon service et j'exerçais mon métier de sage-femme de façon incorrecte et désordonnée; en plus je n'avais aucune notion sur la prévention des infections, la structure dans laquelle je travaillais recyclait les gants, sans compter les risques liés à cette pratique néfaste. Il m'arrivait même de fuir les éclampsiques, car je ne savais pas ce qu'il fallait faire, alors que maintenant , je peux prendre en charge ces cas d'éclampsie sans agitation et de manière satisfaisante. »

«Après la formation, j'ai fait la restitution et j'ai été nommée responsable de la salle d'accouchement. Mon expérience et ma technique de réanimation du nouveau-né dans le bloc opératoire et dans la salle d'accouchement m'ont fait valoir le nom de la Déesse des nouveaux nés. »

Le projet MCHIP, assiste le ministère de la santé dans le renforcement des capacités des prestataires de santé dans les domaines de la santé de la reproduction et la planification familiale afin de réduire le taux de mortalité maternelle et néonatale.

SBMR : Introduction à l'approche d'amélioration de la qualité des services dans le Centre de Santé Amélioré (CSA) de Banankoro

Banankoro, région de Kankan, préfecture de Kérouané :

Je m'appelle Kaba Fako Condé. Je représente la Communauté de Banankoro dans le Comité de Santé et Hygiène chargé de la gestion du CSA et aussi dans la mise en œuvre du processus SBM-R. À cet effet j'ai participé à toutes les étapes de la mise en œuvre du SBM-R depuis mars 2012 : formation des parties prenantes aux 3 modules ; évaluation de la performance de base et suivi de l'évolution de la performance du CSA ; analyse des lacunes et identification de stratégies pour les corriger.



La mise en œuvre du SBM-R dans notre Centre a apporté beaucoup de changements. **Avant il y avait des problèmes importants:**

- **En SONU :** Insuffisance des séances de causeries éducatives ; le counseling aux clientes était très pauvre ; la prise en charge de la femme lors de l'accouchement et celle du nouveau-né n'étaient pas toujours réalisées correctement.
- **En PF :** il y avait souvent une rupture de stock de contraceptifs et d'outils de gestion.
- **En PI :** Insuffisance de matériels de protection personnelle et de matériels d'entretien des locaux. La décontamination n'était pas systématique, la gestion des déchets n'était pas effectuée selon les instructions du ministère.

Actuellement, ça va beaucoup mieux. En effet : Le processus d'analyse et de résolution des problèmes se fait de façon participative a renforcé l'esprit d'équipe dans la gestion du processus de changement. C'est ainsi que plusieurs problèmes ont été résolus au cours des 2 mois qui ont suivi le module 1 et l'évaluation de la performance de base. Après le module 2, nous avons identifié les lacunes persistantes prioritaires à résoudre pour améliorer notre performance. Ce sont notamment, l'aménagement de la fosse à déchets ; l'insuffisance du matériel d'entretien ; l'éclairage du CSA ; la mise en place de point d'eau ; et rendre fonctionnel l'autoclave.

En application du cours reçu, le comité du suivi SBM-R au niveau du CSA a mis en place une commission de plaidoyer pour rencontrer des **opérateurs miniers privés**. Des contributions ont été obtenu, en espèces variant chacun entre 200 000 Fg et 800 000 de la part de 4 opérateurs économiques, mais aussi en nature (peinture, panneaux solaires, par un 4^e opérateur). La peinture a été utilisé pour la rénovation des salles d'hospitalisation, le système d'éclairage solaire est installé et est fonctionnel, notamment dans la salle d'accouchement.

Ainsi, le 2^e suivi de la performance du CSA, a montré une bonne amélioration de notre performance par rapport à l'évaluation de base :

SONU : Base (42%) ; 1^{er} suivi (52%) ; 2^{ème} suivi (79%) ; Défis en 3 mois atteindre (90%)

PF : Base (54%) ; 1^{er} suivi (85%) ; 2^{ème} suivi (81 %) ; Défis en 3 mois atteindre (95 %)

PI : Base (62%) ; 1^{er} suivi (57%) ; 2^{ème} suivi (86 %) ; Défis en 3 mois atteindre (95%)

Au cours de 6 premiers mois qui ont suivi l'intégration de l'approche comparativement à la période précédente, les indicateurs de services se sont améliorés : en santé maternelle, l'application de la GATPA est passée de 98% à 100% et il y a une utilisation systématique du sulfate de magnésium pour le traitement de l'éclampsie. En planification familiale, le nombre de nouveaux utilisateurs et d'utilisateurs réguliers ont plus que doublé durant la période.

« Tout le personnel et la communauté de Banankoro sont très content et remercie le MSHP et l'USAID à travers MCHIP pour la mise en œuvre de cette approche au CSA de Banankoro. ».

La supervision et la motivation un duo gagnant pour une prestation accrue de services de qualité accrue

Préfecture de Dabola, région de Faranah :

Nous sommes au mois de mars, dans la préfecture de Dabola (région de Faranah), au CS Arfamoussaya situé à 36 km du district sanitaire et couvrant une population de 21 836 habitants. La conseillère suivi-évaluation s'entretient avec le chef de centre, dans le cadre d'une supervision sur la qualité et la gestion des données des activités de PF et de Santé maternelles soutenues par le projet. C'est en vérifiant le nombre de fiche de consultation PF avec le registre qu'elle a constaté que Condé plaçait des DIU chez les femmes provenant de 2 autres centres autour du centre dans lequel il travaille.



En demandant le motif d'une telle convergence des femmes vers son centre, Condé raconta que, le suivi que la conseillère technique fait avec lui par téléphone a constitué un tournant marquant dans la prestation de services qu'il offrait jusque-là. En plus de cela, la supervision reçue par lui a également permis de mieux maîtriser la technique d'insertion du DIU et prendre confiance dans ses actes. A partir de là dira-il, « j'ai cherché à convaincre les clientes, notamment en me focalisant sur le counseling des clientes multipares. »

Fodé S. Condé, 45 ans, est responsable du centre de santé d'Arfamoussaya depuis avril 2012, avant cela il a été Agent PEV pendant 4 ans au CS Dogomet. Il exerce depuis 12 ans dans les soins de santé primaires dans la préfecture de Dabola et a toujours évolué en Haute guinée depuis la fin de sa formation à l'école de soins de santé de Kankan (1993-1997). Il est marié et père de 4 enfants dont le plus jeune est âgé de 2 ans.

Il dira, « les formations que j'ai suivies avec MCHIP et le suivi m'ont apporté beaucoup de choses et a permis de changer ma pratique dans la prévention des infections, et maîtriser la technique pour charger le DIU dans son emballage. »

« Je reçois une vingtaine de clientes pour la PF par mois, et le bouche à oreille a permis d'augmenter le nombre de bénéficiaire du DIU grâce aux clientes satisfaites ». Il reconnaît que Dr S. Austin, conseillère technique PF du projet MCHIP et Dr Camara M., médecin à la maternité de Dabola formé aussi par MCHIP, à travers la supervision ont permis d'améliorer sa technique et l'encouragement à faire plus.

MCHIP-Guinée œuvre en République de Guinée depuis 2011 dans les domaines de la santé maternelle, infantile et néonatale dans 4 régions administratives sur 8 que compte le pays et couvre près de 229 structures sanitaires. Le projet a déjà renforcé les capacités du CS de Arfamoussaya et celui de Dogomet à travers la formation dans de nouveaux domaines en Guinée, comme le counseling PF du postpartum, mais aussi celui de la pose et retrait du DIU, de la PCIMNE Clinique et Communautaire.

Guinean Woman's Life Saved by Quick Actions of Health Care Providers



Thanks to MCHIP training, Dr. Barry, with midwives at the Regional Hospital of Faranah, helped save the life of a new mother. Here he views the maternity department's partograph chart.

By Alisha Horowitz,

Published in Jhpiego's monthly e-newsletter in April 2013

<http://www.jhpiego.org/en/content/guinean-woman%E2%80%99s-life-saved-quick-actions-health-care-providers>

This article was also cross posted on the MCHIP website: <http://www.mchip.net/node/1703>

Conakry, Guinea—When Dr. Mamadou Oury Barry first saw Hawa Condé, the 23-year-old patient was crying out, “I’m going to die.” The young mother had reason to fear. She had given birth 24 hours earlier at her home in the village of Tiro, and though the labor and delivery of her baby boy had gone smoothly, the placenta had not been delivered.

“She told me that she felt dizzy and that her body was tingling. She kept moaning and crying out,” said Dr. Barry, 45, Head of the Maternity Department at the Regional Hospital of Faranah, describing Hawa’s state when he first examined her. “Her condition was serious, her life was in danger.”

Hawa understood well the importance of expelling the placenta—after all, it was her third delivery. Accompanied by a relative, Hawa had walked to the local health center in Tiro, where she was told to go immediately to Faranah for treatment. It took some time to arrange for a car for the 20-minute drive.



Hawa Conde, in the maternity ward, after Dr. Barry helped prevent her from bleeding to death.

hanging umbilical cord. After closely following the prescribed EmONC steps, including appropriate infection prevention measures, the doctor and two midwives worked together to manually remove the placenta and then properly disposed of it.

“We felt relieved because we were able to stabilize her. If she had stayed at home, she could have died within hours...” said Dr. Barry, a father of four children whose wife is a nurse at a local health center.

The hospital in Faranah is among 38 health facilities in Guinea that have benefited from other efforts led by Jhpiego and partners to strengthen health care delivery in four regions of Guinea using a Jhpiego-pioneered quality improvement approach. Jhpiego introduced Standards-Based Management and Recognition (SBM-R®) in 2009 at six health facilities. This practical, systems-strengthening approach provides health workers and facilities with tools and methods to improve performance and quality of services. The focus was on building the capacity of health care providers in family planning and infection prevention, as well as fortifying their skills in EmONC.

Before SBM-R was introduced at the regional hospital in 2010, the facility faced challenges related to poor infection prevention practices; incorrect disposal of medical waste; lack of a water source on site (staff fetched water from the river); lack of training for new providers on management of obstetric emergencies; and

Once Hawa arrived at the hospital, the staff took swift action. Midwives brought Hawa into the delivery room and gave her an injection of oxytocin to help the uterus contract to deliver the placenta, but they were unable to deliver it. They then called in Dr. Barry to help.

Thanks to training that Dr. Barry and other staff had received in emergency obstetric and newborn care (EmONC) through a Jhpiego-supported effort to improve services at the hospital, he was able to take immediate action on this day in July 2012. This training took place at the request of the Ministry of Health and through the U.S. Agency for International Development’s (USAID’s) flagship Maternal and Child Health Integrated Program (MCHIP).

In Hawa’s case, Dr. Barry quickly assessed her condition. He found that she had very low blood pressure, an accelerated pulse, rapid breathing, a very pale complexion and a



Dr. Mamadou Oury Barry with his patient, Hawa Conde, and her new baby.

occasional stock-outs of contraceptive methods. Through SBM-R, the hospital staff have addressed many challenges and achieved successful results in key performance target areas. The most notable increase was in family planning, which went from 61 percent of performance standards achieved at the initial assessment to 91 percent achieved in April 2012. The results for EmONC were also impressive—increasing from 52 percent to 80 percent for the same time period.

The hospital now has an on-site water pump, improved infection prevention practices, increased numbers of clients using delivery and family planning services, and expanded staff training opportunities. During a visit to the hospital, the Minister of Health, Dr. Naman Keita, congratulated the staff on the facility's cleanliness.

For Dr. Barry, SBM-R has led to direct improvements in patient care. "SBM-R has greatly helped the facility, especially in the management of complications and the hygiene of the structure and equipment," he said. "Now we have drugs for emergencies. Before, that was lacking and there were frequent stock-outs."

Dr. Barry puts his skills into action daily—whether ushering in students for training, helping a young man with filling a prescription or stabilizing a patient's condition. He said the regular supervision that is part of SBM-R has been particularly motivating. "We have seen an increase in the number of obstetric emergencies we receive, which have increased by nearly 50 percent in three years. We have been able to reduce the number of deaths from abortion, pre-eclampsia and postpartum infections."

Hawa may not be aware of the work to strengthen health care services for women and their families, but she is grateful for the care she received. Sitting up in bed later that day, the exhausted mother calmly held her newborn son and tried to nurse him while he squirmed.

"When we came to the hospital. . . I was worried because the placenta hadn't come. They gave me an injection. . . ," she said. "When the placenta came out, I felt relieved."

Celebrating Jhpiego's 40th Anniversary around the World



Jhpiego President and CEO Leslie Mancuso and Dr. Alain Damiba, Senior Vice President for Technical Leadership and Global Programs, joined members of the Guinea team in events that showcased their respective programs and expertise.

The Guinea team, led by Dr. Yolande Hyjazi, held a market place of interventions at which technical staff demonstrated Jhpiego's achievements in strengthening postpartum family planning services and access to long-acting family planning methods. Introduction of the organization's quality assurance approach, Standards-Based Management and Recognition (SBM-R®), contributed to the success of these program efforts.

Honored guests and partners attending the celebratory event shared the progress made in Guinea since 2010, when Jhpiego began working in the country through MCHIP. Nancy Estes, USAID Mission Director for Guinea, recognized the impact of a successful partnership between Jhpiego/MCHIP and the Ministry of Health and Public Hygiene. Through this collaboration, more women and families are receiving basic emergency obstetric care and family planning services in the 200 health institutions supported by MCHIP.

Dr. Edouard Nyankoye Lama, Guinea's Minister of Health, congratulated Jhpiego for its dedication to providing health care to the Guinean people, and for reaching its 40th year of innovating to save lives. "I [want to] take this opportunity to express, on behalf of the President and the Prime Minister, our thanks, our gratitude and satisfaction to Jhpiego for all the efforts made," Dr. Lama said in his remarks.

The Prime Minister's wife, Madame Jeanette Grovogui Fofana, said that she and her husband are committed to improving the health of Guineans. "I am ready, with my husband, to support

all the partners involved in the development of our country, and particularly Jhpiego, who contributes effectively to the reduction of maternal and infant mortality and to accelerate progress in achieving MDGs [Millennium Development Goals] 4 and 5,” she said.

Madame Fofana also represented the First Lady, Madame Djénné Kaba Condé, who invited Jhpiego’s President and CEO and Senior Vice President to her home.

Dr. Goma Onivogu, a health care leader in Guinea, was among the Jhpiego alumni who attended the event. She expressed her appreciation for the skills she acquired during Jhpiego-supported workshops: “[My skills] gave me the opportunity to improve care at the maternity ward in Deen Hospital, to improve my teaching at the School of Medicine, and also improve my performance as National Director of Public Health.”

To celebrate the organization’s four decades of maternal health work, guests delivered a rousing rendition of “Happy Birthday”—in French and English—as Dr. Mancuso cut a big cake.

Excerpted from: <http://www.jhpiego.org/en/content/celebrating-jhpiegos-40th-anniversary-around-world;>

SBM-R helps facilities make important changes

January 2012, N’Zérékoré Regional Hospital:

Photo: Yaya Koulibaly, Custodian at N’Zérékoré Regional Hospital



“I have been working in this hospital since February 27th, 1980. Since then, I’ve seen personnel come and go, I’ve observed the role of employees during their time here, and I’ve observed the NGOs that have supported us. Above all, I’ve witnessed the evolution of sanitation at this facility.

When I started, the inside of the hospital was full of plants, wild birds, sheep, and other small ruminants who had invaded the courtyard looking for something to eat. My responsibilities were to sterilize the surgical equipment and clean the operating suite.

The hospital rooms used to be maintained by patients’ parents. Snakes hid in the bathroom and birds made their nests there. Frankly, it was dangerous to go to the bathroom, especially at night, because there was no wall separating the hospital from neighboring homes and abandoned buildings. It was in 1988 that a wall was built around the hospital with funding from Doctors Without Borders.

After the integration of SBM-R, I saw that my role became more official. I was trained, given a uniform, and I received equipment for my job. Cleaning and waste collection are done according to written rules now. I saw the mayor and other health facilities intervene in the sanitation and rehabilitation of our hospital.



It is true that MCHIP accompanied us but without the leadership of the hospital's Assistant Director General, we could not have accomplished what we have. This man is a manager of the people. He taught us what to do and he worked alongside us. Look at the courtyard and how clean it is. The bathroom is even better. You could eat a meal in there!"

Radio messaging about implant training benefits both providers and clients

August 2012, N'Zérékoré region:

Madame Delamou is 34 years old. She has given birth to six children. Her youngest child is six months old. Her husband works as a mason. The couple lives in the Gbama II neighborhood of N'Zérékoré. Delamou received a free Jadelle implant during a training for service providers organized by MCHIP/Guinea in the N'Zérékoré prefecture. After receiving the implant, her husband said, "we learned about family planning by listening to a rural radio station in N'Zérékoré. We found out about this training and the offer of this new method. We said to each other that this was an opportunity we shouldn't miss. That's why I decided to accompany my wife when she received this family planning method – the implant. Our only motivation is that we no longer want to have another child because the cost of raising a child is enormous. I am only a simple mason. We just get by."

Using radio messaging to promote family planning and birth spacing

August 2012, N'Zérékoré region:

Madame Théa is a young woman of 19 years old. She is a housekeeper and she lives in the Tilepoulou neighborhood of N'Zérékoré. Her husband, who is 32, was trained as an engineer. He is currently unemployed. The young couple has a 13-month-old daughter.

After hearing messages about family planning on the radio, the couple decided to use a family planning method. The radio program was supported by MCHIP/Jhpiego. The key messages focused on family planning and birth spacing, with a particular emphasis on the use of IUDs as a long-acting family planning method.

Madame Théa's husband had this to say: "I opted for birth spacing due to the fact that I am responsible for paying household expenses, my wife is illiterate, and I am unemployed. Family planning is beneficial for the children because each one will know who is the oldest and my wife will be able to accompany me to cultivate rice in the fields."

The radio programs encourage men to discuss family planning with their wives. This point is very important because contraceptive prevalence is higher when men are involved in the decision-making process.

Success with post-partum IUD acceptance

August 2012, Macenta:

Madame Camara is a 35-year-old housekeeper and wife of a farmer. Her family lives in the Mohamed V neighborhood of Macenta. She has five living children. One of her children is deceased. Camara recently gave birth to triplets – all girls – at the Hermakono health center. After the birth, she was counseled on long-acting family planning methods and she received a post-partum IUD.

Camara expressed herself by saying, “When the labor pains started last night, I called my doctor to come examine me. She directed me to the Hermakono health center where she works. I already have children in my care, I was not expecting triplets, and my husband is in Liberia. When the doctors asked me if I wanted to have other children, I told them no. For me, triplets are another responsibility and I want to rest for at least five years. After being counseled on various family planning methods, I chose to use the PPIUD – a method I wasn’t familiar with before.”

The urban health center in Hermakono is supported by the MCHIP/Jhpiego project where the SBM-R approach was integrated a year ago. Today, the facility’s providers are trained in EmONC and long-acting, reversible family planning methods (IUD, PPIUD, implants, etc.).

Community participation in provision of EmONC at the Rural Health Center (CSR) of Kalinko-Dinguiraye

Kalinko is a sub-prefecture of 40,723 inhabitants. It is the site of a rural health facility located 75 kilometers from the administrative center of the Dinguiraye prefecture, where the referral hospital is located.

The SBM-R process was initiated at the Kalinko-Diguiraye Rural Health Center in September 2010. The facility has completed the training modules and is a candidate for recognition of its performance in family planning, EmONC, and infection prevention.

The SBM-R process, which identified current gaps and ways to address them, allowed the Kalinko community to:

- repair a well that had been broken for more than three years, thereby improving access to water for the health center and the neighboring population
- invite expatriates living in Angola to donate an ambulance to the health center, citing the example of the Fodécariah district (which donated a motorcycle-ambulance to its health post) for inspiration

Comprehensive EmONC training changes the vision of maternal health at the Matam Communal Health Center in Conakry

This past June, the community medical center in Matam was buzzing with activity. Patients were ushered into a large tent in the middle of the waiting room before being directed to exam rooms. In another part of the center, workers tried to finish additions on the center's buildings in a race against the clock before the start of winter.

The Matam health center is situated in the commune of the same name, one of the five communes of Conakry, the capital of Guinea. Three providers – a doctor, a midwife, and a government nurse – were working at their respective posts.

Dr. Thierno Sadou Diallo is the manager of the post-abortion care room and the adjoining delivery room. He has been practicing since 2001 and has always served at the Matam center. Aminata Manyoula, a midwife, has been working for seven years in the delivery room and the prenatal consultation room, which includes the PMTCT unit. Alpha Amadou Diallo is a nurse-anesthesiologist with more than twenty-five years of experience. He has spent the past sixteen years at the Matam center. He works in the operating room and in the hospitalization room.

MCHIP/Guinea aims to reinforce the capacities of health personnel. These three providers were brought together by the MCHIP/Guinea project, which has targeted the Matam center in addition to four other health facilities. The providers recognize how much they have benefited from the MCHIP/Guinea training.

For Dr. Thierno Sadou, the MCHIP/Guinea project has allowed him to develop new skills and knowledge in comprehensive EmONC after having been trained in long-acting family planning methods. Dr. Thierno Sadou has also strengthened his skills in post-abortion care with assistance from Jhpiego. He says, "I thank MCHIP and Jhpiego for having trained me and even modeled for the care and treatment of women in general in so many aspects." For Alpha Amadou, the promotion of spinal anesthesia for Caesarian sections comforted him because although he was familiar with this method before, it was not used in practice. For Aminata, the benefit is huge because she can now monitor a normal delivery, apply a vacuum, repair an episiotomy, and care for newborns according to established norms. Each of the providers personally recognizes that the program changed his/her practice.

Dr. Thierno Sadou says, for example, "Before, one didn't respect the closure plans of the cell wall and it was not uncommon for us to repair the perineum multiple times." He adds that he is relieved, saying, "Transfusion is possible now, just like treatment for hemorrhage in the third trimester."

Alpha Amadou willingly recognizes that his work method has changed considerably since the training in comprehensive EmONC. "If at the beginning I underestimated what the training offered me, by the second week of the course, I understood there was a mountain to climb...Now my colleagues come to me to learn." In the same way that his behavior has changed toward doctors and patients, Amadou has noticed that the work environment has improved significantly. The team used to be poorly motivated but that has changed. In this way, the training brought the teams in the operating room (for example, the attendant, the traditional birth attendant, the anesthesiologist, and physician) and the hospitalization room closer together.

The benefits of the MCHIP/Guinea project are also apparent at the patient level. The patient in the photo just had her fifth C-section. She chose to undergo a tubal ligation after her baby was delivered. The operation is very different from what she experienced before because she was

awake during the procedure this time. She tells herself she is satisfied with the care that she received for her and her baby. She had never been to the Matam center before.

Dr. Thierno Sadou Diallo says, “With spinal anesthesia, the woman is aware of her environment, she can hear us, we can talk to her and reassure her throughout the operation, she can see her baby and know the sex as soon as the baby is delivered.”

“Matam has become a hospital. Doctors and midwives surround us!” a patient tells Aminata in the delivery room. Aminata says, in effect, that women are increasingly satisfied with the care they receive when they come to Matam to give birth.

The MCHIP/Guinea project has already reinforced the capacities of the Matam center by providing equipment and material for post-abortion care, childbirth, and infection prevention. The project has also supported the Ministry of Health by training providers of the Matam center in new domains in Guinea such as counseling for post-partum family planning, insertion and removal of implants, insertion of interval and post-partum IUDs, and tubal ligation.

As a result, 138 women received a post-partum IUD since the introduction of this method in the Matam center in March 2011. Fourteen women have undergone tubal ligation since August 2011. MCHIP also contributed to the center’s performance improvement in the domains of family planning, EmONC, and infection prevention through the implementation of the SBM-R process.

Using SBM-R performance standards to reduce maternal deaths in N’Zérékoré
October 2011, Yomou, N’Zérékoré region:

Dr. Sanoussi Sidibe serves as the director of the prefectural hospital in Yomou and head of the maternity service in the N’Zérékoré health region. He was appointed to the position in 2009 but had never applied the AMTSL technique before working with MCHIP/Jhpiego, despite a high rate of postpartum hemorrhage at Yomou Hospital. Thanks to the introduction of performance standards for EmONC and infection prevention, an initiative led in partnership with MCHIP/Jhpiego, the doctor celebrated some impressive results this past April. A number of general improvements were made but he was particularly struck by the success of the AMTSL technique. Dr. Sidibe shared his assessment and observations in an interview with Abdoulaye Diallo, Junior Monitoring and Evaluation Advisor.



Dr. Sanoussi Sidibe, Director of Yomou Hospital and head of the maternity service

What do you think of the application of AMTSL on the maternity ward at Yomou Hospital?

I would first like to applaud the use of AMTSL in our health facilities. Since AMTSL was implemented in our hospital and health centers, we have observed the following:

1. A reduction in the incidence of postpartum hemorrhage, followed by a reduction in the demand for blood products (Lactated Ringer’s solution, plasma, etc.)

2. A significant drop in total maternal deaths at Yomou Hospital and a decrease in deaths due to postpartum hemorrhage in particular, even for critical cases referred by rural health centers

According to MCHIP data, there were no deaths at Yomou Hospital in the second semester of 2011. Eight deaths were reported during the second quarter of 2010. The application of standards has allowed providers to manage complicated cases appropriately.

Dr. Sidibe made several recommendations, including:

1. What we would like to recommend, above all, is to expand this activity to other care facilities (i.e. health centers where women give birth) because if the first level of care is not handled correctly, women will not come to the hospital. This is the catastrophe that we will face.
2. We need to continue to support the SBM-R process and to reinforce the training of health workers. It is important to recognize that regular performance evaluations at the management level also had an impact on the care of pregnant women.

In conclusion, we wish to thank the MCHIP/Jhpiego partners for their efforts. This project has truly improved the quality of services at the hospital, both on the maternity ward and on other wards. In effect, the SBM-R process even influenced the pediatric service because infection prevention was a real problem at Yomou Hospital. With the introduction of SBM-R, noticeable improvements were made.

In the months to come, MCHIP/Jhpiego will continue to support the SBM-R process at Yomou Hospital. Furthermore, the project will be launched in new facilities with the goal of making quality EmONC and family planning services more widely available.

Annex 3: List of Presentations at International Conferences and Publications

Topic	Title	Conference/ Journal	Authors, Dates
Family Planning	Oral presentation: The role of "champions" in Improving the rate of the Family Planning Acceptance in Post-Abortion Care, ICFP Senegal, December 2011	International Conference on Family Planning, 2011, Senegal	Yolande Hyjazi, December 2011
	Poster presentation: Integrated health services: Improving the Quality of performance in Guinea for EmONC and FP, ICFP Senegal, December 2011	International Conference on Family Planning, 2011, Senegal	Bokar Dem, December 2011
	Presentation: Leveraging EmONC intervention for effective LAPM strengthening in Guinea, FIGO Africa 2013	FIGO Africa, 2013, Ethiopia	Yolande Hyjazi, Blami Dao, Tsigue Pleah, Oct 2013
	Presentation: MLDA: Elargir le choix contraceptif dans le cadre des SAA en Guinee (PAC LARC in Guinea), FIGO Africa 2013	FIGO Africa, 2013, Ethiopia	Yolande Hyjazi, Tsigue Pleah, Oct 2013
	Presentation: Partogramme: Qualite de l'utilisation et point de vue des prestataires en Guinee, FIGO Africa 2013	FIGO Africa, 2013, Ethiopia	Blami Dao, Oct 2013
	Presentation: Expanding access to long acting and permanent family planning methods (LAPM) through CEmONC, ICFP 2013	ICFP 2013, Ethiopia	Yolande Hyjazi, Nov 2013
	Presentation: Use of long acting reversible contraceptive (LARC) methods in postabortal period, ICFP 2013	ICFP 2013, Ethiopia	Yolande Hyjazi, Nov 2013
	Presentation: Lessons from Guinea's Integration of Family Planning (PPIUD) and Maternal Newborn Health--What works? ICFP 2013	ICFP 2013, Ethiopia	Tsigue Pleah, et al, Nov 2013

Topic	Title	Conference/ Journal	Authors, Dates
Maternal Health	Presentation: Processus d'integration des soins apres avortement en Guinea		Suzanne Austin, 2013
SBM-R	Poster: Improving the Quality of Integrated FP and MNH Services Using Standards Based Management and Recognition (SBM-R), Guinea, FIGO Africa 2013	FIGO Africa, 2013, Ethiopia	Tsigue Pleah, et al, Oct 2013
	Présentation sur la téléphonie Mobile dans le domaine de la santé au GMHC 2013	Global Maternal Health Confernce, 2013	2013
	Présentations sur la téléphonie mobile dans la santé et les expériences de mMentoring et d'utilisation de la flotte de MCHIP, à l'atelier de reflexion sur l'utilisation de Téléphonie mobile dans la santé organisé par le MSHP	National meeting, Guinea	2012
mHealth	Presentation: Mobile phone use for integrated health services- -Guinea experience, GMHC 2013	Global Maternal Health Confernce, 2013	Jacqueline Aribot, Jan 2013
	Utilisation de la telephonie mobile pour ameliorer les services de SR/PF-exerience de la Guinee, GMHC 2013	Global Maternal Health Confernce, 2013	Jacqueline Aribot, Jan 2013

Note: Several manuscripts on Program Learning topics are in process or in press, see Annex 5 for details

Annex 4: List of Materials and Tools Developed or Adapted by the Program

Family Planning	Hard copy	Electronic copy
Training material/curriculum		
1. Dispositif Intra Utérin du Post Partum :		
• Le Manuel de référence DIUPP, mars 2011	X	X
• Le Guide du formateur DIUPP, mars 2011	X	X
• Le Cahier du participant DIUPP, mars 2011	X	X
2. Ligature des trompes :		
• Le Manuel de référence LT/ AL par Minilaparotomie, Mars 2011	X	X
• Le Guide du formateur LT/AL par Minilaparotomie, Mars 2011,	X	X
• Le Guide des participants LT/A par Minilaparotomie, Mars 2011L,	X	X
• Series de Presentations PPT		x
3. Dispositif Intra Utérin d'Intervalle:		
• DIU/Directives pour les programmes de PF (Manuel de référence), Juillet 2006, Jhpiego	X	X
• DIU/Directives pour les programmes de PF /Guide du participant, Juillet 2006, Jhpiego	X	X
• DIU/Directives pour les programmes de PF /Guide du formateur, Juillet 2006, Jhpiego	X	X
4. Implant - Jadelle		
• Implants Jadelle ppt.		X
• Jadelle Prevention des infections ppt.		X
• Jadelle Counseling ppt.		X
5. Planification du Postpartum		
• Plan de session et matériels didactiques		X
Job aids		
6. Planification familiale		
• Messages pour les clients sur le DIUPP	X	X
• Option pour la contraception en post partum	X	X
• Fiche de consultation rapide pour les critères de recevabilité médicale de l'OMS	X	X
• La MAMA une méthode de planification familiale pour la femme allaitante	X	X
• Comment être raisonnablement sûr que la cliente n'est pas enceinte	X	X
7. Intégration de la Planification Post partum		
• Cachet/Tampon	X	
8. Intégration PF/PE/Nutrition		
• Algorithme 'Intégration PEV/Nutrition et la PF du post partum	X	X

• Carte de référence PF/ Nutrition	X	X
• Carte de référence PF/PEV	X	X
Supervision and data collection documents		
9. Liste de vérification pour le counseling DIUPP	Guide du formateur DIUPP, Cahier du participant DIUPP	
10. Liste de vérification pour l'insertion post placentaire	Guide du formateur DIUPP, Cahier du participant DIUPP	
11. Liste de vérification pour l'insertion post partum	Guide du formateur DIUPP, Cahier du participant DIUPP	
12. Liste de vérification pour l'insertion per césarienne	Guide du formateur DIUPP, Cahier du participant DIUPP	
13. La fiche d'apprentissage pour les compétences en counseling pour la LT/AL par minilaparotomie	Guide du formateur LT/AL, Guide du participant LT/AL	
14. Fiche d'apprentissage pour les compétences Clinique en matière de minilaparotomie d'intervalle	Guide du formateur LT/AL, Guide du participant LT/AL	
15. Fiche d'apprentissage pour les compétences Clinique en matière de minilaparotomie post partum	Guide du formateur LT/AL, Guide du participant LT/AL	
16. Liste de vérification- Insertion et retrait du DIUI	Guide du participant DIUI, Guide du formateur DIUI	
17. Liste de vérification – insertion de l'implant Jadelle		X
18. Liste de vérification - retrait de l'implant Jadelle		X
19. Grille de supervision des prestataires en gestion des données SR/PF		X
Documents de collecte de données		
20. Clinique		
• Fiche de consultation PF (amendée)	X	X
• Rapport mensuel CS	X	X
• Rapport mensuel CMC/HP	X	X
• Rapport mensuel DIUPP	X	X
• Registre DIUPP	X	X
• Base de données SR/PF		X
21. Communautaire		
• Rapport mensuel ACS	X	X
• Rapport mensuel superviseur ACS	X	X
• Rapport mensuel ACS diffusion des messages PF/SMI/SAA -	X	X
• Rapport mensuel superviseur ACS diffusion des messages PF/SMI/SAA	X	X
• Base de données SBC (Service à base communautaire)		X
Communication documents		
22. Clinique		
• Boîte à images PF du prestataire clinique 'Les conseils et le choix d'une méthode de contraception'	X	
23. Communautaire		
• Carte conseil PF pour les Agents communautaires (jeux de 10 cartes reliées et plastifiées)	X	

Reports		
24. Rapport d'Evaluation: Déterminer le taux de continuité à un an parmi les femmes qui ont reçu le DIU post-partum dans les structures de sante formées par MCHIP-Guinée		X
25. Rapport de suivi post formation dans les sites du DIUPP		X
26. Rapport de formation des prestataires en counseling PF post partum		X
27. Rapport de l'atelier national de restitution des resultats du projet de l'injectable au niveau communautaire a Mandiana		X
28. Rapport de l'atelier de restitution regionale des resultats du projet de l'injectable au niveau communautaire a Mandiana		X
Maternal and Newborn Health	Hard copy	Electronic copy
Training materials/curriculum		
1. Guide du formateur obstétricien ou sage-femme en SONU	X	X
2. Formation continue en soins obstétricaux et néonataux (Essentiels, Base, Complets) – Guide de l'apprenant, Avril 2012	X	X
3. Formation continue en soins obstétricaux et néonataux (Essentiels, Base, Complets) - Manuel de référence pour la résolution de problèmes, Mars 2012	X	X
4. Guide de l'apprenant en anesthésie pour les SONU		X
5. Standards de performance en Chirurgie Obstétricale		X
6. Standards de performance pour l'anesthésie en SONUC, Novembre 2012	X	X
Job aids		
7. Job aid 'CPN Focalisées '	X	X
8. Dépliant 'Le Respect dans les soins de maternité : Les droits universels des femmes pendant la période périnatale'	X	X
9. Affiche 'Aider la mère à survivre: saignement après la naissance /Plan d'actions – Se préparer pour la naissance' '	X	*
10. Affiche 'Plan d'Action : Aider les bébés à Respirer- Préparer un accouchement'	X	*
11. Aider la mère à survivre: saignement après la naissance/ Guide du Prestataire – Apprentissage et pratique en équipe	X	*
12. Affiche 'Préparation à l'accouchement et préparatifs en cas de complications/Matrice de responsabilités partagées'	X	*
13. Jobs aids 'Règles de dilution du sulfate de magnésium'	X	X
14. Jobs aids 'Dose d'entretien du sulfate de magnésium'	X	X
15. Jobs aids 'Utilisation du sulfate de magnésium'	X	X
Supervision documents		
16. Directives pour l'évaluation des prestataires compétents après leur formation en soins de santé maternelle et néonatale, Jhpiego 2006	X	

17. Cahier de suivi des prestataires formés en anesthésie pour les SONU	X	X
Communication and data collection documents		
18. Cartes conseil pour la SR/PF incluant l'hémorragie du post-partum - niveau communautaire avec le Misoprostole (Jeux de 10 cartes reliées plastifiées)	X	
19. Vidéo sur la préparation à la naissance (Artiste André Flamy)		X
20. Rapport mensuel d'activités CMC/HP - Volet Soins Après Avortement	X	X (M&E)
21. Rapport mensuel d'activités CS - Volet SR/PF	X	X (M&E)
22. Rapport mensuel d'activités CMC/HP - Volet SR/PF	X	X (M&E)
Reports		
23. Rapport de l'atelier de quantification des produits de santé		X
24. Rapport de l'atelier de validation des standards de performance en anesthésie réanimation		X
25. Rapport de mission: Atelier de finalisation et validation des documents de politique et programme de la sante de la reproduction		X
26. Rapport de la mission de lancement du programme de prévention de l'hémorragie du post partum dans 5 sous-préfectures de Nzérékoré.		X
Infection prevention documents	Hard copy	Electronic copy
27. Prévention des infections : Directives à l'intention des structures sanitaires aux ressources limitées, 2003, Jhpiego	X	X
28. Prévention des infections : Kit de ressources d'apprentissage/ Guide du participant, Juillet 2004, Jhpiego	X	
Prevention of Mother-to-Child Transmission (PMTCT)	Hard copy	Electronic copy
Training material/curriculum		
29. Guide du formateur en eTME du VIH, aout 2013	X	X
30. Guide du Participant en eTME du VIH, aout 2013	X	X
31. Manuel de référence de la PTME du VIH, aout 2013	X	X
32. Standards de performance en PTME	X	X
33. Normes et procédures en eTME du VIH, mars 2013	X	X
Supervision and data collection documents		
34. Liste de vérification en eTME		Guide du participant
35. Grille d'évaluation de la gestion des données - Santé maternelle, 2012	X	X (M&E)
36. Grille d'évaluation de la gestion des données - Soins Après Avortement, 2012	X	X (M&E)
37. Rapport mensuel CS	X	X (M&E)
38. Rapport mensuel CMC/HP	X	X (M&E)
39. Registre de CPN CS	X	X (M&E)
40. Registre d'accouchement CS/HP	X	X (M&E)

Report		
41. Rapport de mission Nairobi, ETME		X
Child Health	Hard copy	Electronic copy
Training material/curriculum		
Clinique		
1. Standards PCIMNE clinique		X
Communautaire		
2. Curriculum de formation des agents communautaires (ACS), Février 2012		X
3. Algorithmes de prise en charge du paludisme simple; de la Pneumonie, de la diarrhée et du dépistage de la malnutrition au niveau communautaire (4 pages), Février 2012		X
4. Protocole de prise en charge des cas par les ACS		X
5. Cahier de l'agent communautaire		X
6. Registre de consultation de l'agent communautaire PCIMNE		X
Supervision and data collection documents		
7. Livret des tableaux PCIMNE clinique		X
8. Fiche de supervision PCIMNE niveau communautaire		X
9. Registre de consultation de l'agent communautaire	X	
10. Rapport mensuel de l'ACS		X
11. Rapport mensuel du superviseur ACS	X	
12. Rapport mensuel CS		X
13. Base de données PCIMNE_C, 2013		
Strategic documents		
<ul style="list-style-type: none"> Guide de mise en œuvre de la PCIMNE communautaire 		X
Reports		
<ul style="list-style-type: none"> Rapport synthèse de la formation des chef de centre de sante de Diakolidou et son suppleant sur l'utilisation des standards de performance PCIMNE 		X
Pre-Service Education	Hard copy	Electronic copy
Training material		
1. Standards de performances pour l'enseignement de base à l'Ecole Nationale de la Santé de Kindia (section 1 à 5) , 2012	X	X
a. Fiches de synthèse (par domaine), 2012	X	X
b. Formulaire récapitulatif, 2012	X	X
2. Standards de performances pour l'enseignement de base à la faculté de médecine de Conakry (section 1 à 5, Guide d'utilisation), 2010	X	X
3. Programme de formation de la filière sage-femme (curriculum), 2014	X	X
Supervision and data collection documents		
4. Registre FMPOS, 2010		X

5. Registre de présence FMPOS, 2010		X
6. Registre ENSK, 2013		X
7. Registre de présence ENSK, 2013		X
8. Fiche d'inventaire ENSK, 2014		X
Reports		
9. Rapport d'Analyse de la situation de l'école de la sante de Kindia (ENSK): Filière sages-femmes		X
10. Ecole national de la santé de Kindia : Evaluation de la filière sage-femme ppt		X
Malaria		
1. Analyse rapide du Programme de Lutte contre le Paludisme		X
2. Prévention et contrôle du Paludisme Pendant la grossesse : Manuel de référence pour les prestataires de soins de santé, Deuxième édition, Révisé janvier 2014		X
3. Prévention et contrôle du Paludisme Pendant la grossesse : Guide de Facilitateur, Deuxième édition, Révisé janvier 2014		X
4. Prévention et contrôle du Paludisme Pendant la grossesse : Manuel du Participant, Deuxième édition, Révisé janvier 2014		
5. Manuel de formation des agents de santé pour la prise en charge du paludisme : Manuel du participant, Révisé en janvier 2014		X
6. Manuel de formation des agents de santé pour la prise en charge du paludisme : Guide du Formateur, Révisé en janvier 2014		X
7. Algorithme de prise en charge des cas de paludisme chez les enfants de moins de 5 ans		X
Standards-Based Management and Recognition	Hard copy	Electronic copy
1) Curriculum de formation sur les 3 modules SBM-R	X	X
Performance Standards		
2) Planification familiale		
• Standards CMC/Hôpital	X	X
• Standards Centre de santé	X	X
• Fiches de synthèse CMC/Hôpital	X	X
• Fiches de synthèse Centre de santé	X	X
3) Soins Obstétricaux Néonataux d'Urgence		
• Standards CMC/Hôpital	X	X
• Standards Centre de santé	X	X
• Fiches de synthèse CMC/Hôpital	X	X
• Fiches de synthèse Centre de santé	X	X
4) Prévention de l'infection		
• Standards CMC/HP	X	X
• Standards Centre de santé	X	X
• Fiches de synthèse CMC/Hôpital	X	X
• Fiches de synthèse Centre de santé	X	X

Monitoring & Evaluation	Hard copy	Electronic copy
Training		
1) Module d'orientation sur le SIG pour les ONG	X	X
2) Module d'orientation sur le SIG pour les superviseurs AC et C-SBC	X	X
3) Présentation du processus RDQA	X	X
4) Fiche de suivi des sessions de formation	X	X
5) Base de données des sessions de formation (Access)		
Supervision		
6) LQAS- Sante maternelle, Hôpital		X
7) LQAS - Planification familiale, Hôpital		X
8) LQAS- Sante maternelle, Centre de sante		X
9) LQAS - Planification familiale, Centre de santé		X
10) Registre de distribution et de sensibilisation sur le Misoprostol, AC		X
11) Grille de remplissage des indicateurs pour le RDQA		X
12) Fiche de suivi post formation des AC (salon)		X
13) Fiche de suivi post formation SBC (communauté)		X
Reports		
14) Rapport de Mission: Atelier de révision des outils de collecte du système national d'information sanitaire		X
15) Rapport de Mission: Réunion de partage d'expériences sur la mise en œuvre du SBM-R tenue a Maputo		X
16) Rapport de Mission: Réunion de partage des résultats de la phase pilote de l'intégration PEV/PF tenue à Monrovia		X
17) Rapport de mission: Global Maternal Health Conference		X
Project Progress Reports	Hard copy	Electronic copy
English-language reports		
1) MCHIP Guinea FY1102 Q2 Report		X
2) MCHIP Guinea FY1103 Q3 Report		X
3) MCHIP Guinea FY1104 Annual Report no PMP		X
4) MCHIP Guinea FY1201 Q1 report		X
5) MCHIP Guinea FY1202 Semi Annual Report		X
6) MCHIP Guinea FY1203 Q3 Report		X
7) MCHIP Guinea FY1204 Annual Country Summary		X
8) MCHIP Guinea FY1301 Q1 Report Summary		X
9) MCHIP Guinea FY1302 Semi-annual Country Summary		X
10) MCHIP Guinea FY1303 Q3 report Summary		X
11) MCHIP Guinea FY1304 Annual Report		X
French-language reports		
12) 1101 MCHIP Guinee Rapport trimestriel Q1		X
13) 1102 MCHIP Guinea FY11 Q2 report		X
14) 1202 MCHIP Guinee Rapport trimestriel Q2		X

15) 1203 MCHIP Guinee rapport trimestriel Q3		X
16) 1204 MCHIP Guinea Rapport Trimestriel Q4		X
17) 1301 MCHIP Guinee Rapport Trimestriel Oct-Dec 2012		X
18) 1302 MCHIP Guinee Rapport Trimestriel		X
19) 1303 MCHIP Guinee Rapport Trimestriel		X
20) 1401 MCHIP Guinee Rapport Trimestriel		X
21) 1402 MCHIP Guinee Rapport Trimestriel		X

* available on reprolineplus.org

Annex 5: Program Learning Matrix

Guinea		
Program Learning (PL) Question	Product	Reference
What is the rate of continuation for women who receive PPIUD, and what were the reasons for discontinuation?	Program Brief	MCHIP. (2014). Déterminer le taux de continuité à un an parmi les femmes qui ont reçu le DIU post-partum dans les structures de santé formées par MCHIP-Guinée. End of Project Report: Guinea. (in press)
	Program Brief	ENGLISH VERSION: MCHIP. (2014). Continued contraceptive use: An evaluation to determine the continuation rate at one year among post-partum IUD users in Guinea. (in press: DEC) FRENCH VERSION: MCHIP. (2014). Améliorer la continuation contraceptive : Une évaluation pour déterminer le taux de continuité à un an parmi les utilisatrices de DIU post-partum en Guinée. (in press: DEC)
Did use of non-health community agents increase access to health information in an urban environment?	PowerPoint Presentation	MCHIP. (2014). End of Project Report: Guinea. (in press)
How do selected PMI countries incorporate WHO Guidance on case management of malaria in children into country-level IMNCI Training and Supervision Guidelines?	Program Brief	MCHIP. (2014). Inventory of IMCI Training and Supervision Tools in PMI Countries. (in press: DEC)
Do SBM-R score improvements correlate with improvement of key MNH practices and health outcomes?	Program Brief	MCHIP. (2014). Improving the quality of integrated FP and MNH services using Standards-based Management and Recognition (SBM-R). (in press: DEC)
	PowerPoint Presentation	MCHIP. (2013). Improving the quality of integrated FP and MNH services using Standards-based Management and Recognition (SBM-R). FIGO Africa.
Does integration of support to EmONC and PFP services increase the utilization of PFP?	PowerPoint Presentation	MCHIP. (2013). Leveraging EmONC intervention for effective LAMP strengthening in Guinea. FIGO Africa, Ethiopia.
	PowerPoint Presentation	MCHIP. (2013). Expanding access to long acting and permanent family planning methods (LAMP) through CEmONC. ICFP, Ethiopia.
PAC and LARC service expansion and uptake	Peer Reviewed Journal Article	N/A (Expected Completion Date: Sept 30th).
Does the use of mobile phone technology to provide mentoring following training in EMONC help with the retention of knowledge and skills?	Program Brief	N/A (Expected Completion Date: Sept 30th).

Guinea

Program Learning (PL) Question	Product	Reference
Does a scalable model of community based distribution of misoprostol increase access to a uterotonic? (ALSO UNDER MH MATRIX)	Peer Reviewed Journal Article	N/A (Expected Completion Date: Sept 30th).
	Program Brief	N/A (Expected Completion Date: Sept 30th).
Decentralizing training by developing regional trainers for FP and EmONC: Can regional teams be effectively formed and supported to offer training at the regional level? <ul style="list-style-type: none"> • How can this contribute to scale-up? • Is this cost effective? 	Program Brief	N/A (Expected Completion Date: Sept 30th).

Annex 6: List of MCHIP Facilities and Interventions per Facility

MCHIP-GUINEE

Repartition des activités menées dans les structures sanitaires par région FY11-FY12-FY13

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPF	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire		
Conakry	Kaloum	HN Ignace Deen	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Oui	Oui	Oui	Non	Oui	Non	Non	10	MCHIP		
		CS Koulewondy	Oui	Non	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	6	MCHIP	
		CS Kassa	Oui	Non	Non	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	5	MCHIP	
		CS Boulbinet	Oui	Non	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	6	MCHIP	
		CS Port	Oui	Non	Non	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	5	MCHIP	
		PS Fotoba/CS Kassa	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP	
	Dixinn	CMC Minière	Oui	Oui	Oui	Oui	Oui	Oui	Non	Oui	Non	Oui	Oui	Non	Non	Oui	Non	Non	9	MCHIP	
		HN Donka	Oui	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Oui	Oui	Oui	Non	Oui	Non	Non	10	MCHIP	
		CS Hafia	Oui	Non	Oui	Non	Non	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	5	MCHIP	
		CS Dixinn	Oui	Non	Oui	Non	Oui	Non	Oui	N	Oui	Oui	Oui	Non	Non	Non	Non	Non	6	MCHIP	
		CS Maciré	Oui	Non	Oui	Non	Oui	Non	Non	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	5	MCHIP	
		INSE (HN Donka)	NA	NA	NA	NA	Oui	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1	MCHIP	
	Matam	Infirmierie Univ. CKY	oui	NA	Oui	NA	NA	NA	NA	NA	NA	NA	Oui	NA	NA	NA	NA	NA	3	MCHIP/autre	
		CS Madina	Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
		CMC Coleah	Oui	Oui	Oui	Oui	Oui	Oui	Non	Non	Non	Oui	Oui	Non	Non	Oui	Non	Non	8	MCHIP	
	Ratoma	CMC Matam	Oui	Oui	Oui	Oui	Oui	Oui	Non	Oui	Oui	Oui	Oui	Oui	Non	Oui	Non	Non	11	MCHIP	
		CS Koloma	Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
		CS Kobaya	Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
		CS Simbaya gare	Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
		CMC Ratoma	Oui	Oui	Oui	Oui	Oui	Oui	Non	Oui	Oui	Oui	Oui	Oui	Non	Oui	Non	Non	11	MCHIP	
		CS Lambanyi	Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
		CMC Flamboyant	Oui	Oui	Oui	Oui	Oui	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Oui	Non	Non	9	MCHIP
		CS Jean Paul II	Oui	Oui	NA	NA	NA	NA	NA	NA	Oui	Oui	Oui	Oui	Oui	NA	NA	NA	7	MCHIP	
		CS Wanindara	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Oui	Oui	Oui	Non	Non	Non	Non	4	MCHIP	
		CS Kaporo	Oui	Non	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	6	MCHIP	
		CS Sonfonia	Oui	Non	Oui	Non	Non	Non	Non	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	5	MCHIP	
	Matoto	CS Kalima (privée)	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP	
		CS Matoto	Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
		CS Gbéssia Port I	Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
		CS Dabompa	Oui	Oui	Oui	Non	Oui	Oui	Non	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
		CS Tombolia	Oui	Oui	Oui	Non	Oui	Oui	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	8	MCHIP	
		CS Yimbaya	Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP	
CS Tanèhè		Oui	Oui	Oui	Non	Oui	Non	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	7	MCHIP		

MCHIP-GUINEE

Repartition des activités menées dans les structures sanitaires par région FY11-FY12-FY13

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPF	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire	
		Clinique St-Gabriel (confessional)	NA	NA	NA	NA	Oui	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1	MCHIP	
Total des sites de la région - Conakry			30	29	29	29	30	29	29	7	29	30	7	5	29	29	29			
Nbre de sites intégrés par offre de service			30	19	27	7	28	2	23	5	29	31	4	0	7	0	0			
% de sites intégrés par offre de service			100%	66%	93%	24%	93%	7%	79%	71%	100%	103%	57%	0%	24%	0%	0%			
Kankan	Kankan	CSU Daloba Sékou Camara	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP	
		CSU Kabada	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	5	MCHIP
		CSU Kankankoura	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	4	MCHIP
		CSU Missira	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	4	MCHIP
		CSU Salamani	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	5	MCHIP UNFPA
		CSU Senkefara	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	4	MCHIP
		HR Kankan	Non	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	oui	Oui	Oui	oui	Oui	Non	Non	9	MCHIP
		Balandou	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	4	MCHIP
		Baté Nafadji	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	4	MCHIP UNFPA
		Boula	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	3	MCHIP
		Gbérédou-Baranama	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	1	MCHIP
		Karfamoryah	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	1	MCHIP
		Koumban	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	1	MCHIP
		Mamouroudou	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	1	MCHIP
		Missamana	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	1	MCHIP
		Morybaya	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	1	MCHIP
		Sabadou-Baranama	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	1	MCHIP
		Tinitioulin	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	4	MCHIP
	Tokounou	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	3	MCHIP	
	Kérouané	CSU Kérouane	Non	Non	Non	Oui	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	Non	3	MCHIP
		HP Kérouane	Non	Oui	Oui	Oui	Non	Non	Non	Oui	Non	oui	Non	Oui	Non	Non	Non	Non	6	MCHIP
		CSA Banankoro	Non	Oui	Oui	Oui	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Oui	Non	Non	5	MCHIP
Damaro		Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	Non	4	MCHIP	
Komodou		Oui	Non	Oui	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	Non	5	MCHIP	
Konsankoro		Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	Non	4	MCHIP	
Linko		Oui	Non	Oui	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	3	MCHIP	

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPF	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire	
		Sibiribaro	Oui	Non	Oui	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	5	MCHIP	
		Soromayah	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
	Kouroussa	CSU Kouroussa	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	4	MCHIP
		HP Kouroussa	Non	Oui	Oui	Oui	Oui	Non	Non	Non	Oui	Non	oui	Non	Oui	Non	Non	Non	7	MCHIP
		Babila	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Balato	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Banfèlè	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Baro	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Cisséla	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP
		Douako	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Doura	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Kiniéro	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	3	MCHIP
		Komala	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Koumana	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP
		Sanguianah	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP
	Mandiana	CSU Mandiana	Oui	Non	Oui	Oui	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Oui	Non	6	MCHIP
		HP Mandiana	Non	Oui	Oui	Oui	Non	Non	Non	Non	Oui	Non	oui	Oui	Oui	Non	Non	Non	7	MCHIP
		Balandougouba	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	5	MCHIP
		Dialakoro(Mandiana)	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	4	MCHIP
		Faralako	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
		Kantoumanina	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Kiniéran	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	3	MCHIP
		Kondianakoro	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	3	MCHIP
		Koundian	Oui	Non	Oui	Non	Oui	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP
		Morodou	Oui	Non	Oui	Non	Oui	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP
		Niantanina	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
	Saladou	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP	
	Sansando	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP	
	Siguiiri	CSU Bolibana	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	3	MCHIP
		CSU Siguiiri koro	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP
		CSU Siguiiri koura	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP
		HP Siguiiri	Non	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	oui	Oui	Oui	oui	Non	Non	9	MCHIP

MCHIP-GUINEE

Repartition des activités menées dans les structures sanitaires par région FY11-FY12-FY13

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPF	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire	
		Bankon	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Doko	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP	
		Franwaliya	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Kiniébakoura	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Kintinian	Oui	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP	
		Maléah	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Naboun	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Niagassola	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Niandankoro	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP	
		Norassoba	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP	
		Nounkounkan	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP	
		Siguirini	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
Total des sites dans la région - Kankan			70	70	70	70	70	70	70	5	70	70	5	5	70	3	70			
Nbre de sites intégrés par offre de service			32	6	37	13	27	5	0	5	17	70	3	5	2	3	0			
% de sites intégrés par offre de service			46%	9%	53%	19%	39%	7%	0%	100%	24%	100%	60%	100%	3%	100%	0%			
Faranah	Dabola	CSU Dabola	Oui	Non	Oui	Oui	Oui	Oui	Non	Non	Non	Oui	Non	Non	Non	Non	Non	6	MCHIP	
		HP Dabola	Oui	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	Oui	Oui	Oui	Oui	Non	10	MCHIP	
		Alfamoussaya	Oui	Non	Oui	Non	Oui	Oui	Non	Non	Non	Non	Oui	Non	Non	Non	Non	5	MCHIP	
		Banko	Oui	Non	Oui	Non	Non	Oui	Non	Non	Non	Non	Oui	Non	Non	Non	Non	4	MCHIP	
		Bissikirima	Oui	Non	Oui	Non	Oui	Oui	Non	Non	Non	Non	Oui	Non	Non	Non	Non	5	MCHIP	
		Dogomet	Oui	Non	Oui	Non	Oui	Oui	Non	Non	Non	Non	Oui	Non	Non	Non	Non	5	MCHIP	
		Kankama	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	1	MCHIP	
		Kindoye	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	1	MCHIP	
		Konindou	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Oui	Non	Non	Non	Non	2	MCHIP	
		Konso	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	1	MCHIP	
		Dinguiraye	CSU Dinguiraye	Oui	Non	Oui	Oui	Oui	Oui	Non	oui	Non	Non	Oui	Non	Non	Non	Oui	Non	6
	HP Dinguiraye		Oui	Oui	Oui	Oui	Oui	Oui	Non	oui	Oui	Non	Oui	Oui	Oui	Non	Non	Non	10	MCHIP
	Dialakoro(Dinguiraye)		Oui	Non	Oui	Non	Oui	Non	oui	Non	Non	Non	Oui	Non	Non	Non	Non	Non	5	MCHIP
	Diatifère		Oui	Non	Oui	Non	Oui	Non	oui	Non	Non	Non	Oui	Non	Non	Non	Non	Non	5	MCHIP
	Gagnakaly		Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP
			Kalinko	Oui	Non	Oui	Oui	Oui	Non	oui	Non	Non	Oui	Non	Non	Non	Oui	Non	6	MCHIP
		Lansanaya	Non	Non	Non	Non	Non	Non	oui	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP	

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPF	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire	
		Mbonet	Non	Non	Non	Non	Non	Non	oui	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP	
		Sélouma	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP
	Faranah	CSU Abattoir	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	5	MCHIP
		CSU Marché	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	4	MCHIP
		HR Faranah	Oui	Oui	Oui	Oui	Oui	Non	Non	Non	Oui	Non	Oui	Oui	Non	oui	Non	Non	9	MCHIP
		Banian	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	4	MCHIP
		Beindou(Faranah)	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP
		Hèrèmakono/Faranah	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP
		Kobikoro	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP
		Marella	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	4	MCHIP
		Nialia	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP
		Passayah	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	1	MCHIP
		Sandénia	Non	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	3	MCHIP
		Songoyah	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	1	MCHIP
	Tiro	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	3	MCHIP	
	Kissidougou	CSU Dar-el salam	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	6	MCHIP
		CSU Hèrèmakono/Kissi	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	6	MCHIP
		CSU Madina	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	6	MCHIP
		CSU Limanya	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	6	MCHIP
		HP Kissidougou	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	Oui	oui	Oui	Non	Oui	Non	Non	9	MCHIP
		Albadarya	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	2	MCHIP
		Banama	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	2	MCHIP
		Bardou	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	3	MCHIP
		Beindou(Kissi)	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	3	MCHIP
		Fermessadou	Non	Non	Oui	Non	Oui	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	4	MCHIP
		Firawa	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	2	MCHIP
		Gbangbadou	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	3	MCHIP
		Kondiadou	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	2	MCHIP
		Manfran	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	4	MCHIP
		Sangardo	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	5	MCHIP
		Yèndè	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	Non	5	MCHIP

MCHIP-GUINEE

Repartition des activités menées dans les structures sanitaires par région FY11-FY12-FY13

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPP	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire	
		Yombiro	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	1	MCHIP	
		CSU Sogbé	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	3	MCHIP	
		PS Manfran	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	2	MCHIP	
		Clinique AGBEF	Oui	NA	Oui	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2	UNFPA	
Total des sites dans la région - Faranah			51	50	50	50	50	50	50	4	50	51	4	4	50	4	49			
Nbre de sites intégrés par offre de service			28	4	33	13	26	6	9	4	15	50	4	3	2	4	0			
% de sites intégrés par offre de service			55%	8%	66%	26%	52%	12%	18%	100%	30%	98%	100%	75%	4%	100%	0%			
Nzérékoré	Beyla	CSU Diakolidou	Oui	Non	Oui	Oui	Oui	Oui	Non	Non	Non	oui	Non	Non	Non	Oui	Non	6	MCHIP	
		HP Beyla	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	Non	oui	Oui	Oui	Non	Non	Non	9	MCHIP
		CSU Sobakono	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP
		Boola	Oui	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP
		Fouala	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Gbackédou	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP
		Gbessoba	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Koumandou	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Moussadou	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Nionsomoridou	Non	Non	Non	Non	Oui	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	3	MCHIP
		Samana	Non	Non	Oui	Non	Oui	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP
		Sinko	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP
		CMC Sinko	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP
		Diassadou	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Diaraguerela	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Sokourala	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
	Karala	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Gueckedou	CSU Guéckédou lélé	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
			CSU Madina(Gueckedou)	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	6	MCHIP
			CSU Mangala	Oui	Non	Oui	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	5	MCHIP
		CSU Sokoro	Oui	Non	Non	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	3	MCHIP	
		HP Guéckédou	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	oui	oui	Oui	Non	Non	Non	9	MCHIP	
		Bolodou	Oui	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	3	MCHIP	
		Fangamadou	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP	

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPF	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire
		Fermessadou(Gueckedou)	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
		Guendembou	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
		Kassadou	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
		Koundou	Non	Non	Non	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP
		Nongoa	Non	Non	Non	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	3	MCHIP
		Ouendé kenema	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
		Tékoulo	Non	Non	Non	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	3	MCHIP
	Lola	CSU Lola	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP
	Lola	Maternité Lola	Oui	Non	Oui	Oui	Oui	Non	Non	Oui	Non	oui	Non	Oui	Non	Non	Non	7	MCHIP
	Lola	Bossou	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
	Lola	Foumbadou	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
	Lola	Gama bèrèma	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	3	MCHIP
	Lola	Guéassou	Non	Non	Non	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP
	Lola	Kokota	Non	Non	Non	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP
	Lola	Lainé	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
	Lola	Nzoo	Oui	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP
	Lola	Toukarata	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP
	Macenta	CSU Bowa	Oui	Non	Oui	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	5	MCHIP
	Macenta	CSU Hèrèmakono(Macenta)	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	6	MCHIP
	Macenta	CSU Patrice	Oui	Non	Oui	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	5	MCHIP
	Macenta	Maternité Macenta	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	oui	Oui	Oui	Non	Non	Non	9	MCHIP
	Macenta	Balizia	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
	Macenta	Bofossou	Oui	Non	Oui	Non	Oui	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	5	MCHIP
	Macenta	Fassankoni	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
	Macenta	Kouankan	Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	4	MCHIP
	Macenta	Koyama	Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	4	MCHIP
	Macenta	Oreime	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
	Macenta	Panziazou	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP
	Macenta	Sérédou	Oui	Non	Oui	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	4	MCHIP
	Macenta	Zébéla	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPP	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire		
		Sengbedou	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP		
		Bilikala	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP	
		Vasseredou	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP	
		Wantanka	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP	
		Daro	Non	Non	Non	Non	Non	Non	Non	Non	Non	Oui	oui	Non	Non	Non	Non	Non	2	MCHIP	
	Nzérékoré	CSU Commercial	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP	
		CSU Dorota	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP	
		CSU Gonja	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP	
		CSU Horoya	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP	
		CSU Mohomou	Oui	Non	Oui	Oui	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	5	MCHIP	
		Maternité Nzérékoré	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	Non	oui	Oui	Oui	oui	oui	Non	10	MCHIP	
		CSU Sokoura	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP	
		Clinique AGBEF	Oui	NA	Oui	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2	MCHIP UNFPA
		Bounouma	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP UNFPA	
		Palé	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Gouécké	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Oui	2	MCHIP	
		Kobela	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Koropara	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Oui	1	MCHIP	
		Koulé	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP	
		Samoé	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	2	MCHIP	
	Soulouta	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Oui	1	MCHIP		
	Womey	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Oui	1	MCHIP		
	Yalenzou	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Oui	4	MCHIP UNFPA		
	Yomou	CSU Yomou	Oui	Non	Non	Oui	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	oui	Non	3	MCHIP	
		Maternité Yomou	Oui	Oui	Oui	Oui	Oui	Non	Non	Oui	Non	Non	oui	Non	Oui	Non	Non	Non	8	MCHIP	
		Banié	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Bétha	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Bignamou	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	1	MCHIP	
		Bowé	Oui	Non	Non	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	3	MCHIP	
		Diécké	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP	

MCHIP-GUINEE

Repartition des activités menées dans les structures sanitaires par région FY11-FY12-FY13

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPF	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire	
		Pella	Oui	Non	Oui	Non	Oui	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	4	MCHIP	
Total des sites dans la région - Nzérékoré			84	84	84	84	84	84	84	6	84	84	6	6	84	3	5			
NBre de sites intégrés par offre de service			37	5	31	19	36	6	0	6	26	84	4	6	1	3	5			
% de sites intégrés par offre de service			44%	6%	37%	23%	43%	7%	0%	100%	31%	100%	67%	100%	1%	100%	100%			
Kindia	Télimélé	CSU Télimélé	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	non	Non	Non	Non	Non	Non	3	UNFPA	
		HP Télimélé	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	non	Non	Non	Non	Non	Non	3	UNFPA
	Kindia	HR Kindia	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	non	Non	Non	Non	Non	Non	2	UNFPA
		CS Manquepas	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
		Clinique AGBEF	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
	Dubreka	HP Dubreka	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	3	UNFPA
		CSU Dubreka	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	3	UNFPA
		CSR Khorira	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
		CSR Tondon	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
		CSR Tanene	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
	Forécariah	CS Farmoreah	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Kaback	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CSU Forecariah	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Sikhourou	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Bokaria / Kaliah	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Benty	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Kakossa	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Moussayah	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Bassiah/ Allassoyah	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
CS Maferinya	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI		
HP Forecariah	Non	Non	Non	Non	Non	Non	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI		
Nbre de sites intégrés par offre de service-Kindia			10	0	10	4	0	0	11	0	0	0	0	0	0	0	0			
Boké	Boké	CSU Correrah	Non	Non	Non	Non	Non	Non	Oui	Non	Non	non	Non	Non	Non	Non	Non	1	MCHIP-PMI	
		CS Dabiss	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Bintimodia	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Tanènè	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		PS Katougouma/ CS Tanènè	Non	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI

MCHIP-GUINEE

Repartition des activités menées dans les structures sanitaires par région FY11-FY12-FY13

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPF	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire
		PS Kankanko/CS Bintimodia	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		HR Boké	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		Clinique Kalepiné/Kamsar	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		Clinique Sorez	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		PS Koukouba/CS Kanfarandé	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Kanfarandé	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CSU Koulifanya	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Malapouya	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Kayenguissa/Kamsar	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CSU Dibia	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CSA Sangaredi	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Kassopo/Kamsar	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Kolaboui	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Sansalé	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
		CS Confessionnal Anastasis	Non	Non	Non	Non	Non	Non	oui	Non	Non	Non	Non	Non	Non	Non	Non	1	MCHIP-PMI
Nbre de sites intégrés par offre de service-Boké			0	0	0	0	0	0	20	0	0	0	0	0	0	0	0		
Labé	Labé	Clinique AGBEF	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
		HP Labe	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	3	UNFPA
		CSU Leysaré	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	3	UNFPA
	Mali	HP Mali	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
		CSU Mali	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
		CSR Yiberin	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
	Tougué	CSU Tougué	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	1	UNFPA
		HP Tougué	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	1	UNFPA
	Lélouma	CSU Lélouma	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
		HP Lélouma	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
	Koubia	CSU Koubia	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
		CSR Pilimini	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA

MCHIP-GUINEE

Repartition des activités menées dans les structures sanitaires par région FY11-FY12-FY13

Région	Commune/ Préfecture	Structure sanitaire	DIU interv	DIUPP	Implant	SBMR	PFPP	PCIMNE	PALU	LT/AL	MIS	PF	SONUC	SONUB	PI	eTME	Miso	Nombre d'offre de service par site (n=13)	Partenaire
		HP Koubia	Oui	Non	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	2	UNFPA
Nbre de sites intégrés par offre de service - Labé			13	0	13	2	0	0	0	0	0	0	0	0	0	0	0		
Mamou	Pita	CSU Pita	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	1	UNFPA
		HP Pita	Oui	Non	Oui	Oui	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	Non	1	UNFPA
Nbre de sites intégrés par offre de service -Mamou			2	0	2	2	0	0	0	0	0	0	0	0	0	0	0		
Total des sites intégrés par offre de service			152	34	153	60	117	19	63	20	87	235	15	14	12	10	5		
Zone MCHIP	Nombre total de sites		235	235	235	235	235	235	57	22	235	235	23	232	232	232	5		
	Nombre de sites intégrés par offre		125	34	127	48	117	19	32	20	87	235	15	14	12	10	5		
	% de sites intégrés par offre de		53%	14%	54%	20%	50%	8%	56%	91%	37%	100%	65%	6%	5%	4%	100%		
Hors Zone MCHIP	Nombre total de sites intégrés		27	0	26	12	0	0	31	0	0	0	0	0	0	10	5		

Annex 7: List of MCHIP trained trainers

Formateurs Planification Familiale

Prénoms et Nom	Titre	Sites	Domaine de PF
Niveau National			
Aminata KABA	Gynécologue – Obstétricien	CMC de Ratoma	Technologie contraceptive, DIU, DIUPP, PFPP
Sire CAMARA	Médecin	CMC de Ratoma	Technologie contraceptive, Implant, DIU
Thierno Sadou DIALLO	Médecin	CMC de Matam	Technologie contraceptive, DIUPP, DIU
Nene Aissatou DIALLO	Médecin	CMC de Matam	Technologie contraceptive, Implants
Mamadou CAMARA	Médecin	CMC de Coleah	Technologie contraceptive, DIUPP, DIU
Hadja DIOP	Sage – femme	CMC de Coleah	Technologie contraceptive, DIUPP, DIU, Implants
Mariame DOUMBOUYA	Sage – femme	CMC de Matam	Implant, PFPP
Mariame Binta DIALLO	Sage – femme	CMC de la Miniere	Technologie contraceptive, DIUPP, DIU, Implants, PFPP
Fatoumata Guilinty DIALLO	Medecin	MSHP	Technologie contraceptive, DIU, Implants
Oumou CISSOKO	Médecin	HN Donka	Technologie contraceptive, DIU
Oumou Hawa BAH	Gynécologue – Obstétricien	HN Donka	PFPP, DIUPP
Aboubacar SOUMAH	Gynécologue - Obstétricien	HN I.Deen	PFPP, DIUPP
Région of N'zérékoré			
Maimouna SOW	ATS	Maternité Macenta	DIU, Implants, DIUPP, PFPP
Helene Goule	Sage femme	CS de Gonia	Implants, DIU
Mamadou Saidou Camara	ATS	CCS Seredou	DIU
Fatouma Kolie	Sage femme	HR N'zérékoré	DIU
Koura Domani Conde	Médecin	HR N'zérékoré	Technologie contraceptive, DIU, PFPP
Région de Faranah			
Kebe Guilavogui	Sage femme	Maternité de Kissidougou	Implants
Aïssata Tolno	Sage femme	CSU Dinguiraye	Implants
Mamadouba Camara	Medecin	Maternite Dabola	Technologie contraceptive, Implants
Bintou Diomande	Sage femme	Maternite de Kissidougou	DIU, DIUPP
Région de Kankan			
Aissatou Keita	Sage femme	HP de Siguiri	Implants, DIU, DIUPP, PFPP
Louise Lamah	Medecin	CSA de Banankoro	Implants
Saran Keita	Sage femme	CS Siguiri koro	DIU
Sonah Kandé	Sage femme	Maternite Kouroussa	DIU, DIUPP
Saran Kourthim Kaba	Sage Femme	HR de Kankan	Technologie contraceptive, DIU, DIUPP

Formateurs SONU

Prénoms et Nom	Titre	Sites
National		
Kaba Aminata	Gynécologue Obstétricien	CMC Ratoma
Camara Sire	Médecin	CMC Ratoma
Barry Alpha Oumar	Anesthésiste réanimateur	HN Donka
Diallo Thierno Sadou	Médecin	CMC Matam
Cisse Bintou	Sage-femme	HN Donka
Diallo Ibrahima Sory	Pédiatre	INSE
Bah Aissatou	Sage -femme	HN Donka
Bah Oumou Hawa	Gynécologue Obstétricien	HN Donka
Barry Mamadou Oury	Médecin	Maternité sans risque
Region de Kankan		
Camara Fatoumata	Sage-femme	HR Kankan
Souaré Mamady	Médecin	HR Kankan
Kadouno Paul Faya	Gynécologue obstétricien	HP Siguiri
Condé Mariama	Infirmière anesthésiste	HR Kankan
Region de Faranah		
Diomandé Bintou	Sage-femme	HP Kissidougou
Bangoura Karim	Médecin	HP Kissidougou
Region de N'zérékoré		
Kourouma Moussa	Infirmier anesthésiste	HR N'Zérékoré
Sow Maimouna	Sage-femme	HP Macenta
Yaradouno Paul Saa	Médecin	HR N'Zérékoré
Region de Conakry		
Konate Mariama	Infirmière anesthésiste	HN Ignace Deen
Conte Ibrahima	Gynécologue obstétricien	HN Ignace Deen
Keita Hawa	Sage-femme	HN Ignace Deen
Bah Elhadj Mamoudou	Gynécologue obstétricien	HN Donka
Sacko Aminata N'Mayoula	Sage-femme	CMC Matam
Diallo Alpha Oumar	Infirmier anesthésiste	CMC Matam

Formateurs pour la Prévention des Infections

Hôpital National Donka :	CMC Coleah
Dr Oumou Hawa Bah	Dr Camara Mamadouba
Mme Bintou Cisse	Mme Diop Adama Hawa
Hôpital National I.Deen	Région de Kankan
Dr Goma Onivogui	Mme Kourtim Saran Kaba – HR de Kankan
Dr Conte Ibrahima	Mme Aissatou Keita – HP de Siguiri
CMC Ratoma	Région de Faranah
Dr Cire Camara	Dr Mamadou Oury Barry – HR de Faranah
Dr Mamadouba Camara	Dr Camara Mamadouba – HP de Dabola
CMC Minière	Région de N'Zerekore
Mme Mariama Binta Diallo	Dr Koura Domani Conde
Dr Saran Camara	DGA Hop Régional de N'Zerekore
CMC Matam	
Dr Thierno Sadou Diallo	
Melle Mariama Doumbouya	
CMC Flamboyant	
Dr Laouratou Drame	

Formateurs SBM-R

Région N'Zérékoré
Dr Mamadou Aliou BARRY
Dr Lucie Lila CONDE
Région Faranah
Dr Halimatou SQUARE
Dr Ibrahima NABE
Région Conakry
Dr Adama Hawa BALDE
Dr Fatoumata Guilinty DIALLO

Formateurs/superviseurs paludisme

Nom	Qualification	Fonction	Lieu De Travail	Prefecture/ Commune
Ibrahima CAMARA	Medecin/Generaliste	Chargé de la Formation	DPS Boke	Boké
Mamadou Alpha DIALLO	Medecin/Generaliste	Chargé SBC	DPS Boke	Boké
Aboubacar CONTE	Medecin/Generaliste	MCM	DRS Boke	Boké
Mamady TRAORE	Medecin/Generaliste	Point Focal	DCS Dixinn	Conakry
Bangaly BANGOURA	Medecin/Generaliste	Point Focal	DCS Kaloum	Conakry
Oumou BARRY 2	Biologiste	Point Focal	DCS Matoto	Conakry
Moussa SAMOURA	Biologiste	Conseiller Suivi Evaluation	PNLP	Conakry
Albert Soko SAGNO	Medecin/Generaliste	MCM	DCS Matoto	Conakry
Alpha Oumar BARRY	Medecin/Generaliste	MCM	DSVCO	Conakry
Lamine KEITA	Medecin/Generaliste	MCM	DCS Matam	Conakry
Adama Hawa BALDE	Medecin/Generaliste	Chargé de la Formation	DCS Ratoma	Conakry
Oumou BARRY 1	Medecin/Generaliste	MCM	DCS Kaloum	Conakry
N'gamet CISSE	Medecin/Generaliste	Point Focal	DCS Matam	Conakry
Fama KOUROUMA	Agent Technique De Santé (ATS)	Chargé Statistique	DPS Dinguiraye	Dinguiraye
Kemoko Mickiry CAMARA	Medecin/Generaliste	MCM	DRS Faranah	Faranah
Souleymane SYLLA	Medecin/Generaliste	MCM	DPS Forécariah	Forécariah
Sekou SYLLA	Medecin/Generaliste	MCM	DRS Kindia	Kindia
Souleymane DIALLO	Medecin/Generaliste	Chef de Section	DPS Labe	Labe