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HEALTH AND POPULATION ASSESSMENT

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This report presents the findings and analysis of a contracted assessment team. It does not represent the opinions, recommendations, or commitments of USAID/Guinea or the United States Government.

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Acronyms

ADB	African Development Bank
AFPAMNIG	Association des Femmes pour le Promotion de l'Allaitement Maternel et la Nutrition d'Enfant en Guinea
AGBEF	Association Guinenneen pour le Bien-Etre Familial
AGP	Guinean Press Agency
AIDS	Acquired Immune-deficiency Syndrome
ARI	acute respiratory infections
ATS	Assistant Technique Sanitaire
BEPR	Office of Studies, Planning and Research, Ministry of Public Health and Social Affairs
BFH	baby friendly hospital
BI	Bamako Initiative
BND	national budget
CBD	community-based distribution
CBG	Bauxite Company of Guinea
CBORS	Cereal Based Oral Rehydration Solution
CCCD	Combatting Childhood Communicable Diseases Project
CCS	head of health center
CNP	National Population Commission
CNSR	National Center for Training and Research in Rural Health
CPE	Comités Prefectoraux pour l'Enfance
CPTAFE	Committee on Traditional Practices Effecting Women's and Children's Health
CREN	Nutrition Education and Rehabilitation Center
DAAF	Directorate of Administrative and Financial Affairs/Ministry of Public Health and Social Affairs
DAN	Food and Nutrition Division/Ministry of Public Health and Social Affairs
DHS	Demographic and Health Survey
DPS	Prefectural Director of Health
DPTP	diphtheria, pertusis, tetnus plus polio vaccine
ECONMEC	Conakry Household Consumption Study
EEC	European Economic Community
EM	essential medicines
EMP	Population Education Program/Education a Mateiale Population
EPI	Expanded Program on Immunization
EPS	Health Education Section
FIGUIA	Aluminum Company of Fria
FINEX	external financed investments
FP	family planning
FPLM	Family Planning Logistics Management Project
FY	fiscal year
GF	Guinean franc
GNP	gross national product
GOG	Government of Guinea
GTZ	Gesellschaft fur Technische Zusammernarbeit
HMIS	health management information system
IBFAN	International Baby Food Action Network
IEC	information, education and communication
INSE	Institute for Child Health and Nutrition

IRH	regional inspector of health
IUD	intra-uterine device
JHPIEGO	Johns Hopkins Program in International Education in Gynecology and Obstetrics
KAP	knowledge, attitudes and practices
KFW	Kreditanstait fur Wierderaubau
LAM	lactational amenorrhea method
LTO	Leprosy, tuberculosis and onchocerciasis program
MCH	maternal and child health
MPF	Ministry of Plan and Finance
MSPAS	Ministry of Public Health and Social Affairs
NAC	National AIDS Committee
NGO	non-governmental organization
NPHCP	National Primary Health Care Program
OCP	Onchocerciasis Control Project
OR	operations research
ORS	oral rehydration salts
ORT	oral rehydration therapy
ORSEC	Organization de Secours en cas de Catastrophe
OVODEC	Organisation Voluntaire pour la Developpment Economique et Culturel
PCV	Peace Corp volunteer
PEV	Expanded Program of Immunization
PHC	primary health care
PNP	National Population Policy
PSI	Population Services International
PVO	private voluntary organizations
RNES	Recherche Nationale Essentielle pour le Sante
RTG	Guinean Television and Radio
SNAC	Surveillance Nutritionelle a Assise Communautaire Project
SEAS	Bureau of Social Affairs
SIAC	Community-based Information System
SMI	sante maternelle et infantile
SNIS	National Health Information System
SOGUIPAH	Guinean Palm Oil and Hevea Company
STD	sexually transmitted disease
SWOT	strengths, weaknesses, opportunities and threats
TBA	traditicnal birth attendant
TDR	Program for Research and Training in Tropical Disease/World Health Organization
TFR	total fertility rate
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children, Education Fund
USAID	United States Agency for International Development
VSC	voluntary surgical contraception
WHO	World Health Organization

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II. EXECUTIVE SUMMARY

INTRODUCTION

At the request of USAID/Guinea, a team of consultants conducted an assessment of the health and family planning sector in the Republic of Guinea. Field work was carried out during the period March 10 -April 22, 1994.

The purpose of the assignment was "...to provide background information needed by USAID/Guinea to address basic strategy options in developing a follow-on project." The present USAID project in this sector, scheduled for completion in 1995, is a nationwide effort to combat HIV/AIDS and to expand the availability of family planning through the social marketing of contraceptives, and through the integration of family planning services into the package of primary health care services offered in Ministry of Public Health and Social Affairs (MSPAS) health centers. This program is being implemented by Population Services International (PSI). Previously, USAID had supported a project aimed at improving the health of children through participation in the Africa Child Survival Initiative -- Combatting Childhood Communicable Diseases Project.

This assessment team was encouraged to look broadly at issues affecting the quantity and quality of health care services being delivered throughout Guinea:

- The key health problems facing the country;
- The characteristics of institutions, public and private, which deliver or support health services;
- The social and economic factors affecting health care;
- The domestic and donor resources available to improve health outcomes.

Analysis of these issues suggests a variety of ways that USAID might continue to contribute to improvements in health service delivery, and therefore to better lives for Guineans.

KEY FINDINGS

1. The Government of Guinea (GOG) has made substantial and impressive progress over the past decade in implementing its primary health care (PHC) program. Accomplishments include: the integration of a package of primary care services in more than 80% of health centers; adoption of a Population Policy; implementation of a cost recovery system that covers operating expenses in many health centers; and development of plans for the decentralization of key management functions to the regional and prefectural levels.

2. The GOG, in particular the MSPAS, expresses a high degree of commitment to, and ownership of, its primary health care program. Detailed plans for program implementation are rationally conceived and follow appropriate international guidelines. There continues to be heavy reliance on donor funding for program implementation, but there is a specific set of program plans of Guinean origin which guide donor contributions.

3. A variety of indicators of health status paint an alarming picture. Infant mortality and child mortality are 150 and 250 per 1000 live births, respectively. Measles and acute respiratory infections (ARI) together account for about one-third of deaths. The next top four causes are malnutrition (13%), malaria (11%), diarrhea (9%) and tetanus (9%).

4. While the Guinean government clearly supports efforts to reduce fertility, Guinean society remains essentially pro-natalist, with high fertility and low use of family planning. The total fertility rate is 6.0, and use of modern contraception is estimated at around 2%. Knowledge of modern contraception is low -- 55% of men and 28% of women have heard of at least one method -- and fertility preferences are high, with women desiring six children and men desiring nine. Only 14% of women wish to space children and 8% wish to stop childbearing. While breastfeeding is virtually universal in Guinea, very few women practice exclusive breastfeeding.

5. Although there is considerable variation around the country, overall utilization of health facilities appears to be quite low. Many health centers and hospitals have extremely low caseloads.

6. Actual utilization and coverage of health services is very difficult to estimate because of a variety of data collection, processing, and analysis problems.

7. Quality of care needs improvement in many areas; including use of treatment algorithms, client counselling, cleanliness and infection control, and facilities maintenance.

8. Basic support functions at the central MSPAS level are weak -- among them critically important services such as drug supply and distribution, management information and research, and finance and administration. Personnel and budgetary control are highly centralized, leaving regional and prefectural managers with little authority or flexibility to implement programs.

9. The existing system of personnel training, deployment, and utilization is weak: 1) there are imbalances in the geographic distribution of personnel; 2) job descriptions are lacking or inadequate at all levels; and 3) training and supervision are inadequate.

10. The GOG's stated commitment to increase the percentage of the national budget devoted to health is a positive step, but there is conflicting information on the level of this increase. Even if higher estimates of expenditure are realized, the percentage will remain below internationally recommended levels.

11. Additional threats to the adequate financing of health care include possible reductions in the level of UNICEF support to the primary health care system and the possibility of a devaluation of the Guinean franc.

12. There is considerable potential in the private and parastatal sector to complement public sector health programs, particularly in the area of family planning.

KEY CONCLUSIONS

1. Despite its problems, the basic structure Of tha public health care system in Guinea, and its achievements to date, form a foundation upon which future program efforts can be built. However, if program momentum is to be maintained, the system will require heavy support from the donor community for the foreseeable future.

2. The implementation of the primary health care cost recovery system, in accordance with the principles of the Bamako Initiative, greatly improves prospects for sustainability. The ability of many health centers to generate sufficient funds to cover operating expenses and to accumulate reserve funds is most impressive. The extent to which the fees may represent a financial barrier to care, however, needs further study.

3. Private and parastatal sector health providers can be mobilized to complement public sector services. Programs should be undertaken to take advantage of this resource. However, reaching a significant percentage of the population would require the involvement of many different private sector organizations/individuals that are not administratively linked.

4. The public health care system may be approaching a financial crisis. Substantial increases in GOG allocations are needed, in addition to donor support, to meet the basic needs of the program. It is doubtful that the GOG will be able to commit additional funds in the immediate future to contribute without reducing allocations to other important programs (e.g., education, agriculture).

5. One means of ameliorating the financial crisis, irrespective of its eventual proportions, is to quickly streamline MSPAS operations by decentralizing personnel and budgetary authority to the regional and prefectural levels. Decentralization would also help reduce the central level management burden, allowing concentration on such key issues as drug supply, management information, and personnel deployment. Donor agencies should actively encourage and support decentralization.

6. The newly organized Central Pharmacy will dictate, to a large extent, how well the PHC program will function. It is critical that this drug supply and distribution system operate effectively and efficiently. Donors need to coordinate their efforts and resources to assure that Central Pharmacy receives the technical assistance it requires.

7. Deficiencies in collecting and analyzing data, and in the dissemination and utilization of findings, weaken the system as a whole. Technical assistance and institution-building interventions are needed to allow the MSPAS to use data for program decision-making, as well as to answer basic questions regarding program performance.

8. While some elements of the PHC program are more effective than others (the immunization program, for example, has achieved the greatest coverage rates), all interventions are in need of intensive support from the GOG and the donor community. Priority-setting is difficult in a situation where needs are so broad and profound -- each of 6 different childhood diseases, for example, accounts for 9-25% of child deaths. Frequent, frank, and action-oriented communication among the MSPAS and donors is critical to the process of building a coherent program which makes good use of everyones' resources.

9. Low utilization rates for the health system as a whole are probably attributable to a combination of factors including: inadequate information and education, poor accessibility, poor service quality, cost barriers, and traditional beliefs and practices. Continued general program development, as well as special interventions, are needed to reduce these barriers to utilization.

10. Increases in family planning acceptance are likely to be modest over the next few years, with more rapid increases possible in urban areas. Factors facilitating increased use include increased knowledge through stronger community education efforts, continuing gains in service availability, increased provider motivation, and decreases in infant mortality.

11. Variations in program performance provide opportunities to improve program performance. Common-sense management and operations research can be used to apply lessons learned from more successful program efforts (e.g. immunization) and more successful prefectures (e.g. Kissidougou) to less successful interventions and c

GENERAL RECOMMENDATIONS

The assessment team recommends that USAID/Guinea proceed to develop as extensive a program of assistance to health and family planning service delivery as its budgetary constraints and program management capacity will allow. We encourage USAID to be creative in using its resources by seeking opportunities to complement the efforts of other donors, and to utilize other resources that may be available within AID, such as centrally-funded projects.

A separate report submitted to USAID as a companion document to this assessment contains a number of specific programmatic options that USAID might consider if it designs a follow-on project in this sector. Some are quite extensive in scale, while others are relatively modest. The process of choosing among them, or among any number of other worthwhile interventions, will be an interesting program design process.

Some of the recommended areas of intervention are:

1. Broad assistance to health and family planning service delivery efforts: child survival promotion; maternal mortality prevention; family planning service expansion; creation of "model decentralized prefectures".

2. Technical assistance to the central level of the MSPAS: strengthening management information and research capability; assistance to the Central Pharmacy; development of decentralized training teams.

3. Private sector initiatives: management capacity-building for AGBEF; assistance to private pharmacists; private sector grants program; training for private sector providers.

4. Special programs: health education using Peace Corps volunteers; DHS analysis and repeat survey; nutrition-related interventions; expansion of long-term family planning methods.

III. INTRODUCTION

A. COUNTRY PROFILE

1. Introduction

The purpose of this health and family planning sector assessment, as stated in the Scope of Work, is "...to provide background information needed by USAID/Guinea to address basic strategy options in developing a follow-on project." USAID has, for more than a decade, provided assistance in various forms to the health system in Guinea; including a program of assistance in child survival and, more recently, an important project in HIV/AIDS and family planning which combined elements of the public and private sectors. The assessment team's mandate included instructions to look broadly at Guinea's health needs, to analyze the health problems facing the country and the institutions that are trying to address them, and to identify some programmatic areas where USAID intervention could be most effective. Assisting the Guinean people in this way is exceptionally important work, and USAID's interest in continuing its program is gratifying. This assessment team is particularly pleased to set the project development process in motion.

We have identified more needs, and more problems requiring solutions, than can be reasonably addressed by any one donor agency. We hope that this assessment will therefore be useful in a broader sense to the Guinean Ministry of Public Health and Social Affairs, to other Guinean institutions working in the health sector, and to other members of the international donor community. There is more than enough work to keep everyone occupied.

2. Health System Overview

In 1988, the Republic of Guinea began to implement a primary health care program. Now only five years old, this still emergent program has made remarkable progress in increasing the accessibility, utilization and effective coverage of basic health services. Family planning is a relatively more recent addition to the Guinean health care scene, and gains are thus less impressive. Nonetheless, significant progress has been made in a short period of time in improving the availability of family planning services. While this report identifies many weaknesses and raises many questions about long term sustainability, we must not forget that there is much evidence that bodes well for the success of this innovative and bold experiment:

- The Guinean government is committed to the program and is pursuing the goal of achieving the primary health care integration of health centers in all of the country's 346 sub-prefectures by the end of 1995.

- In 1993, a comparative evaluation of Bamako Initiative implementation by five African countries came to the unequivocal conclusion that "Guinea has the most developed and most clearly successful program".

The goals of the national strategy are these:

- To provide mothers and children with preventive and curative pre and post-natal services, with an emphasis on immunizations.
- To insure self-financing of health centers at the sub-prefectoral level.
- To create a health information system.
- To create an epidemiological surveillance system decentralized to the levels of sub-prefectures and sentinel villages.

The maternal and child services delivered in "rationalized health centers" include the following:

- Pre-natal care
- Supervised childbirth
- Post-natal care for mother and child
- Expanded Program on Immunization
- Oral rehydration therapy for diarrhea
- IEC
- Additional services currently or soon to be integrated include family planning, sexually transmitted diseases, HIV/AIDS, the safe motherhood initiative and ARI

In addition to the public sector health delivery system, Guinea also features a variety of private and parastatal sector health providers that complement government efforts. These include an active private family planning organization (AGBEF), health facilities within large commercial organizations, and a significant number of private pharmacists and other private practitioners.

Viewed from the international context, Guinea's maternal and child health priorities and programs are consistent with the mandated action that emerged from the World Summit for Children in September 1990. Table I compares the goals of Guinea's National Action Plan with the those of the plan being promoted by the major international health organizations including UNICEF, USAID, WHO, World Bank, PVOs, universities and others.

TABLE I

HEALTH GOALS FOR THE MID-DECADE (1995)
NATIONAL ACTION PLANS

GOALS	INTERNATIONAL	GUINEA
IMMUNIZATION COVERAGE		
DIPHTHERIA	90%	75%
POLIOMYELITIS	90%	75%
ERADICATION IN SELECTED COUNTRIES	+	-
WHOOPING COUGH	90%	75%
MEASLES	90%	80%
90% CASE REDUCTION	+	-
95% MORTALITY REDUCTION	+	-
TETANUS		
CHILDREN	90%	80%
WOMEN OF CHILDBEARING AGE	100%	80%
NEONATAL TETANUS ELIMINATION	+	-
TUBERCULOSIS (BCG)	90%	80%
ORT FOR DIARRHEAL DISEASES	80%	80%
HALVING OF DEATHS DUE TO DIARRHEA	+	-
MALNUTRITION		
PREVALENCE OF IODINE DEFICIENCY	0%	35%
PREVALENCE OF VITAMIN A DEFICIENCY	0%	?
PROMOTION OF BREASTFEEDING		
EXCLUSIVE FOR 4-6 MONTHS	+	+
START IMMEDIATELY AFTER BIRTH	+	+
BABY FRIENDLY HOSPITAL INITIATIVE	+	+
ACUTE RESPIRATORY INFECTIONS		
ONE-THIRD REDUCTION OF DEATHS DUE TO ARI	+	-
FAMILY PLANNING (IEC AND SERVICES)		
AVAILABLE TO ALL COUPLES	+	-
INTEGRATED INTO HEALTH SERVICES		+

The main difference between Guinean and international objectives are that these in Guinea are more modest, given the current inadequacy of coverage and acute unmet needs for physical, human and financial resources. For example:

- It is premature to talk of eradication of diseases such as poliomyelitis and neonatal tetanus.
- The prevalence of Vitamin A deficiency is not known, thus a survey is being planned.
- Data are not yet available in the health information system to provide the basis for estimates of disease specific mortality rates

The following pages provide specific analysis of health and family planning indicators, and of policies that affect the delivery of health and family planning services.

3. Health and Family Planning Indicators

Explanatory Note

This report contains many numbers. Let the reader be aware that they are not as precise as they may seem and should be interpreted with caution for a variety of reasons:

1. Until the next national census, no accurate numbers exist for estimates of population size and growth rates. Sources available now come from at least four different so rces:

   - The last official census, 1983
   - The United Nations proposed three growth rate hypotheses, 1989
   - The figures of an administrative census that have never been officially released, 1990
   - The pre-election census, 1993

   This means the numbers used in estimating target groups are often not valid, reliable, or comparable, especially when no attempt has been made to adjust 1983 numbers to the present. The lack of good demographic data is a major hindrance to the quantification of project planning, implementation, monitoring, and evaluation that is now a standard requirement in the computer age. An example of the problem is seen in the monitoring exercises of the PHC\EPI\EM program. The coverage estimates from the monitoring of the PHC program, are invariably too high, because the denominators, almost always based on the 1983 census, are too small, sometimes by as much as 100%. Thus the government's estimate of 55% immunization coverage is probably inflated, albeit by an unknown factor.

2. The numbers presented from the 1992 Demographic and Health Survey (DHS) are based on preliminary tabulation and have not been weighted to correct for missing data or bias resulting from the sample design.

3. Health service data, even when fairly complete, often do not accurately reflect the distribution of disease in the community. Malnutrition, for example, is grossly under reported.

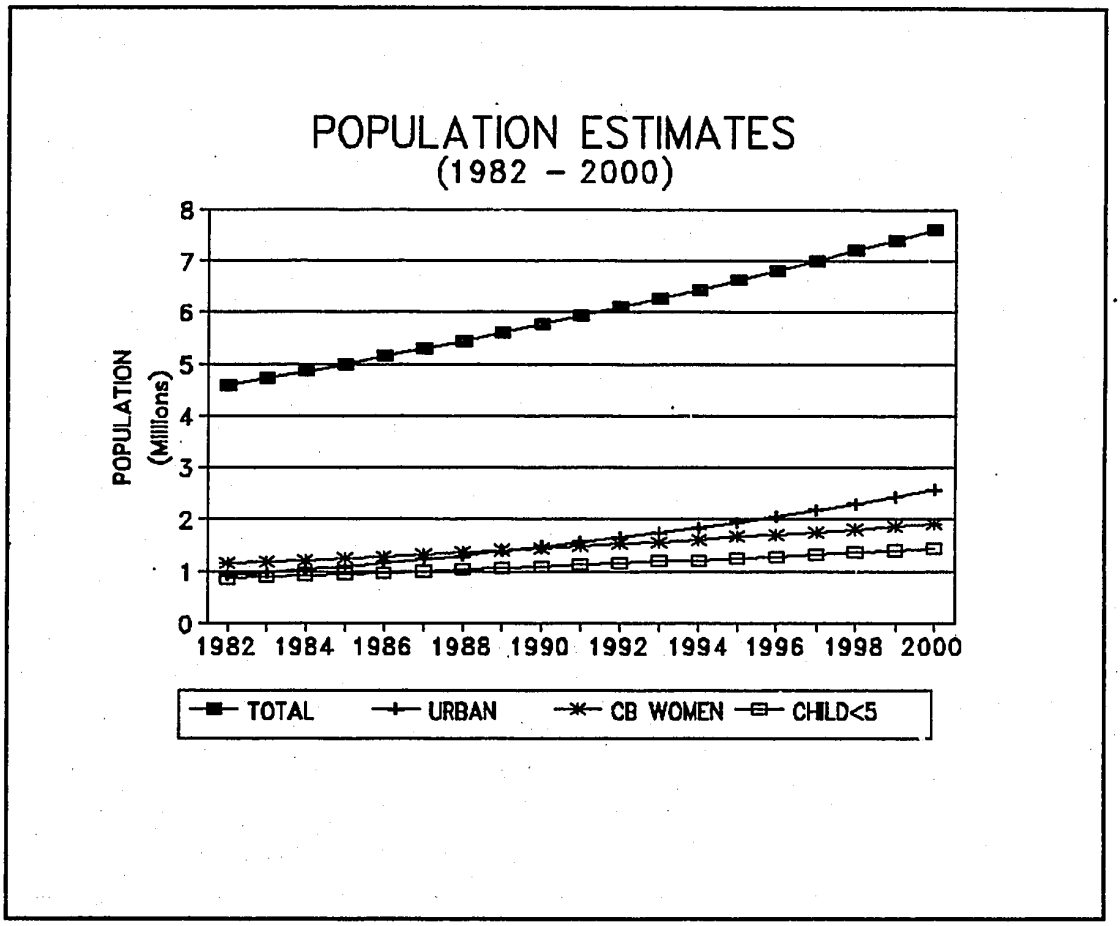
4. People tend to have many diseases at once, thus reported single causes of mortality and morbidity are biased and incomplete.

5. Estimates from probability surveys are subject to statistical error. For example, the 95% confidence interval for the commonly used World Health Organization (WHO) 30 cluster design, is the estimated value plus or minus 10%.

Population

We estimate Guinea's population in 1994 to be about 6.4 million, with 1.8 million (29%) living in cities over 10,000. At average annual growth rates of 2.8% and 5.7%, the number of years required for doubling of the total and urban populations are 25 and 12 years respectively. Figure I shows the trends to the year 2000. (Note that these data do not include the substantial influx of refugees from Liberia and Sierra Leone).

FIGURE I



Of particular interest, given the emphasis of this assessment on family health issues are the 1994 estimates for certain target populations: about 268,000 infants; 1.2 million children under five; and 1.6 million women of childbearing age (15-49).

Selected Demographic Indicators

The trend lines of seven demographic indicators from 1982 to 1992 have remained essentially horizontal. (Appendix III: Tables II and III). The interpretation is that Guinea continues to be a pro-natalist society with high fertility (total fertility rate (TFR) = 6), and high infant and child mortality at 150 and 250/1000 live births respectively. The resultant life expectancy at birth is 44 years.

It is important to note that Guinea's public health program has not yet had enough time to have a measurable impact on child survival. This fact impacts on the possibility of a successful family planning program. International comparative studies have consistently showed a high correlation between lower under five mortality rates and increased contraceptive prevalence rates. Kenya, for example, which after many years of intensive family planning programs, has achieved significant reduction of its national TFR to 5.9, has an under five mortality rate of 82, one-third that of Guinea.

Because of problems of under-reporting and misattribution of cause of death, estimates of maternal mortality are often unreliable. The Population Reference Bureau (1994) estimates maternal mortality in Guinea to be 900 per 100,000 live births. This is substantially higher than the estimate of 650 for the West Africa region as a whole.

Child Health Status Indicators

The major causes of child mortality and morbidity as reported by the Ministry of Public Health and Social Affairs (MSPAS) are shown graphically in Appendix III; Figure III.

Measles and acute respiratory infections (ARI) together account for about one-third of deaths. The next top four causes are malnutrition (13%), malaria (11%), diarrhea (9%) and tetanus (9%). Malaria is the main reason for outpatient visits (28%), followed by ARI and measles (25%) and diarrhea (15%). The fact that only 1% of visits are for malnutrition suggests that few effective services are offered for this condition.

4. Preliminary DHS Results

Since the DHS (conducted in 1992 and now being analyzed) is a source of relatively recent and high quality data, we looked with interest at the preliminary tabulations. The analyses, summarized for the four natural regions plus Conakry, are presented in Appendix III. Some preliminary results are summarized below.

Female Fertility

About 50% of women are in polygynous marriages and were adolescent mothers. Average TFR is 6.0, with a high of 6.7 in Upper Guinea and a low of 5.5 in Conakry. The average birth interval is 35 months. (See Appendix III; Table V)

Reproductive Health Knowledge

Men are more knowledgeable than women regarding modern contraception and STD/AIDS. One out of two men has heard of at least one modern method of contraception, compared to only one-third of women. Knowledge of STD/AIDS is higher, being claimed by 80% of men and 47% of women. Knowledge of contraception is highest in Conakry. (See Appendix III; Table VI)

Reproductive Health Attitudes

Women want fewer children than men; 6 versus 9, yet only 14% claim they want to space future pregnancies and only 8% want to stop childbearing. Interestingly almost twice as many men as women approve of family planning (FP) messages on radio/TV; 72% versus 48%. (See Appendix III; Table VII)

Knowledge of AIDS

About two-thirds of respondents know of AIDS as a sexually transmitted disease. Men are better informed by a ratio of 2 to 1 (15% versus 7%) that condoms can provide protection. (See Appendix III; Table VIII)

Knowledge of Condoms

Twice as many men as women claim to know a condom source; 24% versus 11%. The most frequent source stated by women was hospitals, while men mentioned pharmacies most often. (See Appendix III; Table IX).

Health Care for Pregnancies in the Last Five Years

An average of 40% of women have had at least two doses of tetanus toxoid in the last five years, ranging from a high of 75% in Conakry to a low of 24% in Upper Guinea. Only 25% of women deliver in a health facility. Again Conakry is highest at 75%, but this time Middle Guinea is lowest at only 12%. (See Appendix III; Table X)

Child Mortality and Morbidity

In the West African region only Niger, Guinea Bissau, and Sierra Leone are estimated to have an under five mortality rate higher than Guinea's 248/1000 live births.

It is important to note that averages can hide a wide range of variability. The rate varies from a low of 164 in Conakry to a high of 321 in Forest Guinea. Likewise for the infant mortality rate, Forest Guinea at 195 is almost double that in Conakry (100). These striking differences are likely a result of regional variations in nutritional status, epidemics, and quality of reporting. (See Appendix III; Table XI)

Children are sick much of the time. About one out of six had diarrhea and/or ARI in the two weeks prior to the interview and one out of three had a fewer.

Health Care Delivered to Children

As measured by the immunization coverage rate of children 12-23 months, about one out of three children are getting effective care. Conakry is highest at 48% and Upper Guinea is lowest at 18%. These estimates are much lower than numbers derived from national monitoring data for two reasons. As previously mentioned, the target group is usually calculated from the 1983 census. It is also restricted to five kilometers around an integrated health center and two kilometers around a health post.

44% of mothers claim that their children receive increased fluids for diarrhea, with one out of five claiming that ORS, anti-malarials and antibiotics are given for diarrhea, fever and ARI respectively. (See Appendix III; Table XII)

Breastfeeding for Children

One out of four mothers claim that breastfeeding was started within one hour after birth while over 50% started within 24 hours. On average children in Guinea are breast fed up to about two years. In Middle Guinea, it was reported that more than 50% of the mothers continue to breast feed up to 28 months. However, in Conakry and among mothers with secondary education, breastfeeding duration decreased. Mothers with higher education breast feed for 13 months. Exclusive breastfeeding, with its attendent contraceptive and health effects, is relatively rare in Guinea. Only about 0.4% of infants are exclusively breastfed during the first five months after birth. (See Appendix III; Table XIII)

Summary of this Brief Overview of the DHS Data

The survey is a rich source of data that will be of great use in providing a better understanding of the dynamics of maternal and child health and family planning in Guinea. There is much variability, with geography and gender being important determinants. In general, but not always, knowledge is higher among men and for those living in Conakry.

Infant mortality is highest in Middle, Upper and Forest Guinea, where effective delivery of health care is also lowest. It is not surprising that these are also the zones of highest total fertility rates and least desire to space further pregnancies.

5. Health and Population Policy

Guinea's "Fundamental Law" supports health as a basic right and implicates the State as an important actor in guaranteeing this right. A basic health policy was formulated based upon the strategy of primary health care and was formally adopted by the Second Republic during its first National Conference on Health in July, 1984.

Health Sector Strategy

Beginning in 1987, the Government of Guinea (GOG) began to implement the principles of the Bamako Initiative; a steady evolution towards fuller commitment has occurred. (See Appendix IV). In February 1993, the "Health Sector Policy for the Republic of Guinea" was published, moving Guinea's National Primary Health Care Program (NPHCP) further towards Bamako Initiative standards. The following guidelines are established by this policy:

- Assure the availability of quality health services, at affordable prices, at all levels of the health structure pyramid;
- Create health services that are geographically accessible and culturally acceptable;
- Assure the viability and sustainability of the health system.

Specific structural, institutional, and organizational measures are specified in the policy. These include decentralization, institutional reform, and increased operational efficiency and effectiveness.

While the policy expresses the GOG's view that it does not have sufficient resources to achieve health objectives within a reasonable period of time, the priorities cited represent an ambitious scope of work. The Health Sector Policy goals are relatively broad, with neither time-frames nor measurable

outputs attached to many of them. Given the scarcity of resources, the MSPAS will need to determine specific priorities among PHC interventions and disease control options.

National Population Policy (PNP)

On May 5, 1992, a Presidential decree announced the adoption of the Declaration of the National Population Policy for Guinea by the Council of Ministers. Non-quantifiable objectives and sector strategies are provided. Goals related to health, to be achieved by 2010, include: increasing the contraceptive prevalence rate (CPR) to 25%; reducing the mortality rate to 13%; and reduction of the rate of population growth to 2%. Analysis linking these goals to programmatic options is not included.

Draft Code of Individuals and Families

The proposed Family Code, currently under consideration by the GOG, was drafted by the Bureau for Social Affairs (SEAS) with assistance from local and international non-governmental organizations (NGOs). Of particular interest is Article 337, the first two sentences of which are:

> "Each citizen has the right to determine the size of his\her family in order to assure adequate food, needed education, and appropriate care for its members. Each Guinean woman may decide, with regard to her personal and family situation, to practice child spacing and family planning."

The critical issue is whether this language eliminating the common practice of requiring spousal consent will be retained. National debate in the health sector confirms the view that mandated consent would perpetuate a major obstacle to women who may seek to space their children or limit their family size.

National Breastfeeding Policy

The GOG ratified the International Code for Marketing of Breast Milk Substitute, but there is not a Guinean version of the code. There are no government regulations concerning the importation, advertisement, and sale of breast milk substitutes and other infant food.

Personnel and Human Resource Use Policies

Two important issues for the Guinean government that impact on all sectors, including health, are:

- personnel deployment problems including concentration of civil servants in urban areas, especially Conakry;
- the costs associated with training many skilled personnel that the economy cannot absorb.

Detailed analysis of current personnel and resource use policies of the MSPAS was beyond the scope of this assessment, but key issues are raised in Section IV. below.

Maternity Leave

Guinean labor laws stipulate that working women receive twelve weeks of maternity leave, including salary; four weeks before confinement and eight weeks after delivery. In addition, mothers are allowed to come to work one half-hour late and leave one-half early after returning to work. In practice few women receive these benefits. Most often they work until several days before confinement and resume working shortly after delivery for fear of losing their jobs.

IV. SYSTEMS ANALYSIS

A. ANALYSIS OF INSTITUTIONS

1. Ministry of Public Health and Social Affairs (MSPAS)

A. Central Level

Structure, Personnel and Function

At the central level, the MSPAS is composed of the Cabinet, General Secretariat, National Directorates, Divisions and Sections. However, the health system is going through a reorganization process which must be approved by the Ministry of Administrative Reforms before it can be fully operational. Thus, the current configuration may not be the final one. For the time being, while the National Directorates and upper segments of the Ministry's administrative structures have been approved, proposals related to Divisions and Sections are still under review at the Ministry of Administrative Reforms.

The PHC program is managed at the central level by a coordinating unit in charge of supervising, training, monitoring activities and providing resources to Regional Inspectors and prefectural Directorates of Health. This unit has given strong support to the program, with financing from UNICEF and the GOG. However, as UNICEF support may change significantly in 1995[1], the MSPAS is in the process of distributing the coordinations unit's activities to various other central agencies, such as the National Directorate of Hospital Care for supervision, the direction of Financial and Administrative Affairs for training, and BEPR for data collection, planning, and research. The rationale for this distribution of responsiblities is, in principle, to make the PHC program less dependent on a single management structure (i.e., the coordination unit) which has been largely donor-supported. Although the coordination unit will not be disbanded, it is not clear yet what its future function will be. While this issue was discussed during the annual review meeting in Kindia in March, 1994, final resolution has not been reached. It seems apparent that distribution of the coordinating units responsibilities to other units which are already resource-poor and over-burdened will not adequately address the possible loss of UNICEF resources.

A more promising development is the MSPAS plan to decentralize to the regional and prefectural level. Under this plan, some of the coordination unit activities such as training, supervision, resource allocation, program data collections and analysis would become regional and prefectural

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1 UNICEF's current cycle of project support to the program expires in 1995. It is unclear at present how this support will be structured in the future, but it is clearly possible that there will be a reduced level of financial support.

responsibilities. As the program expands geographically it becomes imperative to decentralize functions and activities to ensure effective management of resources and maintain/increase the quality of care.

Strengths

- Ministry officials show a strong commitment to and ownership of the primary health care program. Many political and administrative steps recommended by international donors or internal evaluations have been taken to improve service delivery and program management. They are open and frank about discussing issues related to program implementation and ready to take appropriate corrective measures if needed. Particularly encouraging at this stage of the program is the decision to decentralize some vital functions to regions and prefectures.

- Internal communication at the central level is frequent if not always optimally effective -- all directors, chiefs of divisions, and heads of sectors/programs meet weekly with the Minister of Public Health and Social Affairs, his cabinet members, and the Secretary General to discuss issues and address problems. Likewise, regular meetings are held at directorate, division and section levels. MSPAS also initiates each year an overall program review session involving each Regional Inspector, central directorates and program heads, donors agencies and NGO representatives. The meeting for 1994 was held March 28 - April 7. The meeting was an open and frank discussion on health policy, program achievements, problems, and future plans.

Weaknesses

- Any change in organizational structure of the Ministry is dependent on the Ministry of Administrative Reforms, so the MSPAS does not have the autonomy to organize itself according to the importance of its programs. Two aspects of the ongoing MSPAS reorganization are particularly problematic: the Ministry of Administrative Reforms has rejected MSPAS' proposals to elevate Maternal and Child Health/Family Planning (MCH/FP) from a Section to a Division; and the BEPR from a Division to a Directorate.

- Financial management and personnel systems are weak, calling into question the absorptive capacity for major new program initiatives which would require extensive financial and administrative support from the central level.

- BEPR, which has a significant scope of work encompassing the entire Ministry, has only Divisional status. This

situation explains, in part, the weak infrastructure at BEPR; does not allow for effective communication between services; and weakens the ability of the MSPAS as a whole to use data and research results for decision making.

The BEPR is responsible for: 1) planning; 2) collecting and analyzing statistical data, including a quarterly feedback bulletin and annual statistical report; and 3) coordinating operations research activities. However, BEPR does not have sufficient qualified staff to undertake these tasks. BEPR is poorly housed and lacks adequate computer equipment. The quarterly feedback bulletins have not been issued since 1989, and the last annual report, for 1991, was issued in 1993. Although some planning exercises and research projects have taken place, improvements in strategic planning and research capabilities are needed that will require substantial external assistance--a combination of additional training and on-site technical assistance.

- The attachment of BEPR to the cabinet as it is now can make it vulnerable to political changes both in terms of resource utilization and service productivity.

- The PHC program has focussed largely on immunization -- other services like maternity care and family planning have received less attention. For example, the safe motherhood imitative, while only just beginning, has few financial resources.

- Personnel management is a major area of weakness. There are no formal job descriptions, appointments to positions are not necessarily made according to professional competence, and there is no rational system for deployment of personnel in accordance with programmatic needs or individual skills. At the central level, the great majority of positions are filled by physicians and, to a much lesser extent, by pharmacists and biologists. There are no paramedical personnel holding central positions; while experienced nurses and midwives have shown good skills in management, supervision and training in other African countries.

Opportunities

- Strong political commitment to a nationwide, decentralized primary health care program can be translated into program success through carefully designed, cooperatively developed projects, infrastructure development, and technical assistance.

- In order to have sufficient organizational status and power to effectively lobby for programmatic resources, MCH/FP should be elevated at least to a Divisional level. The inconsistent nature of the organizational structure is exemplified by the Divisional status of Nutrition, which could easily be merged with MCH/FP.

- Providing employment opportunities for a broader range of personnel (especially non-physicians) at the central level could provide motivation for paramedical personnel at the lower levels of the system.

- Some of the weaker systems at the central level (e.g. DAAF, BEPR) could be substantially improved by relatively modest (in dollar terms) investments in training and infrastructure.

- The process of decentralization to the Regional and Prefectural levels of such critical functions as personnel management, budget control, drug distribution, and training is critical to the continued development of the PHC program. Donor assistance should be designed so as to encourage and facilitate this process.

Threats

- MSPAS stresses decentralization but it is not clear yet how some of the associated problems will be addressed and therefore how long it will take to implement. These problems include: the slow approval process at the Ministry of Administrative Reforms; possible resistance to change within the MSPAS; the establishment of new administrative mechanisms to support decentralized decision-making and budget control; and the inevitable variation in capacity of regional and prefectural administrators to take on new responsibilities. (Problems associated with decentralization are more fully discussed in the Conclusion section).

- MSPAS's action can be hampered by inappropriate decisions and long delays in decision making on the part of Ministry of Administrative Reforms, since it is unclear whether this Ministry makes decisions based on programmatic need or merit.

- Personnel deployment is a crucial factor in successful decentralization and service provision. It is not certain that MSPAS will be able to deploy personnel from cities to rural areas so that equity is reached in geographical human resource distribution.

B. Regional Level

Structure, Personnel and Function

There are two main health functions at the regional level; 1) management function carried out by the Regional Inspector of Health (IRH) and his staff, and 2) secondary health care provision at the regional hospital.

The IRH is headed by a Regional Inspector in charge of supervising health services in the region, monitoring PHC program performance, coordinating NGO activities, and securing other sector interventions (such as Ministry of Interior decentralized services). IRHs are assisted by Regional Inspector of Pharmacies, cold chain officers, and maintenance officers.

Regional hospitals provide secondary curative care. They vary in size and quality of infrastructure--some are well equipped, others are not. They are staffed and equipped to meet basic emergency needs, mostly in surgery and obstetrics.

Strengths

- Regional Inspectors provide a basic administrative structure upon which to build a more decentralized primary health care system. Implementation of the central level decision to decentralize financial and personnel management, training, data collection and analysis, maintenance, drug distribution, and planning will greatly increase the effectiveness of IRHs.

- Regional hospitals are functional to varying degrees and meet basic emergency needs (e.g., hernias c-sections, etc.).

- Part of the decentralization process is to allow hospitals greater budget control. Part of this budget will continue to come from costs recovered by sale of essential drugs and services, but there will also be access to funds that are now controlled at the central level. In addition, there are plans to enhance community involvement in hospital affairs through the establishment of two committees: 1) A committee of advisors with representatives from city government, local ministerial representatives, and hospital staff representatives; 2) A committee of users to assist in setting fees and dealing with issues related to consumers.

- Essential drug warehouses are built and will open soon in three regional capitals -- Labé, Kankan and N'Zérékoré. Kindia will be supplied from the central warehouse in Conakry.

Weaknesses

- The Regional Inspectors of Health do not have sufficient authority and means to manage health services, and therefore are not be as efficient or effective as they should be.

- While Regional Inspectors develop yearly workplans, they have limited resources to implement their plans as they do not have direct personnel or budgetary control. For example, they receive gas coupons from the MSPAS which are purchased at the central level by UNICEF or from GOG budget allocations, rather than having direct control over a budget for transport needs. Similarly, while there is a maintenance officer in each region, there are not sufficient resources to adequately maintain physical facilities and equipment. In geographic areas receiving substantial donor assistance, the IRH functioning is often enhanced (e.g., World Bank assistance in Middle Guinea).

- Communications between prefectural health services and IRHs and between IRHs and the central level, are very poor since telephones often do not work. Messages are often hand carried by messengers.

- IRHs do not routinely receive service statistics data from the regional and prefectural hospitals or from the prefectural directorates, except monitoring data which is received twice a year. Therefore IRHs use incomplete data for management purposes.

- Regional Hospitals effectiveness is limited because of essential drug stock-outs and a lack of skilled personnel to operate sophisticated equipment purchased by external donors. Support services are therefore often not available (e.g., x-rays, anesthesia).

- Hospital utilization is low, with the greater number of patients typically found at obstetrics and surgery wards. (This judgement of "low utilization" is based in part on impressions gained during site visits, when few patients were found either hospitalized or waiting for consultations. These impressions are supported by available data: the regional hospital at Labé (68 beds), for example had an average of 4.5 hospitalizations and 22 consultations per day in 1993). While referral rates vary considerably, there are generally few referrals made from the prefectural hospitals or nearby health centers. The few cases that are referred are again surgery and obstetrics cases. The reasons for low utilization of hospitals are not definitively known, but the likely factors are: lack of knowledge (at the community level) of the health care system, lack of trust in the quality of care, poor accessibility, and high cost of care for a good number of inhabitants of the region.

Opportunities

- Decentralization provides a major opportunity to improve the effectiveness of management at this level.

- The imminent opening of regional warehouses provides the opportunity to assure improved drug supply and distribution through technical assistance to pharmacy staff at the regional level.

- Training and technical assistance targeted specifically at the needs of individual regional hospitals could alleviate problems associated with their inability to use and maintain certain types of equipment.

Threats

- The greatest threat to improved management and service delivery at the regional level is the status quo -- a continued lack of authority and direct access to resources.

C. Prefectural Level

STRUCTURE, PERSONNEL AND FUNCTION

It is at this level that the PHC program is actually implemented. The prefecture (the equivalent of "district" in WHO terminology), has three structural components: 1) the prefectural directorate of health, responsible for management of primary care activities; 2) the prefectural hospital which is the referral center; and 3) the health center and health post where health services are provided to the community. (Note that while most health centers have been integrated into the PHC system, most health posts have not.)

The Prefectural Directorate of Health is the cornerstone of the PHC program. The director and his staff are in charge of giving refresher training to health providers in various activities related to preventive and curative care. They monitor program progress in health centers and help carry out simple planning processes (identifying problems that preclude normal utilization of services, setting objectives for immunization, pre-natal care and curative care coverage and activities to be accomplished to meet objectives in a six month period). Monitoring of program progress is performed each semester. Supervision of health centers is scheduled to be performed each month by the prefectural director, sometimes with a team drawn from the prefectural staff.

When the MSPAS decentralization plans are realized, the prefectural directorate of health will contain the following sections:

- planning
- PHC
- pharmacy and laboratory
- training
- epidemiology
- statistics
- social affairs
- secretariat

Current staffing patterns vary widely from region to region and prefecture to prefecture -- in some, only the primary care section is staffed. Others have a basic complement of four professional staff working under the Director.

Prefectural hospitals provide secondary care at the prefectural level. Utilization of services is generally low, although there are significant regional variations. The quality of facilities also varies greatly, with many having benefited from external assistance in renovation while others are waiting for such assistance.

The focus of service delivery in the PHC program for the period 1988-1995 is the health center. The program aims at improving access to a minimum package of good quality

preventive and curative care including: immunizations for children and women aged 15-49; prenatal care; and primary curative care. The principal objective has, in practice, been to improve immunization coverage, and this has been where most success has been realized. A key element of health center functioning is the integration of essential drugs in health centers with a cost recovery mechanism.

A management committee composed of representatives from the community and the head of the health center manages funds recovered from the sale of drugs and services. Another important function of the committee is social mobilization so that community members, particularly pregnant women and children, utilize health services. Outreach teams provide service beyond a radius of five kilometers around the health center.

Before a center is integrated into the PHC program, extensive training takes place for the center's staff members in immunization procedures, prenatal care, refresher training in curative care with diagnostic and treatment algorithms, and drug management. The management committee members are trained in financial management and utilization of funds recovered.

As of March 1994, 290 health centers (84% of the total of 386) in the country had been integrated into the program. The objective is to integrate remaining centers by the 1995. Integration was made possible by external funding, primarily by UNICEF.

The process of integrating health posts into PHC program is the same as health centers. Their utilization and management have the same characteristics as health centers. However, there is no systematic plan to integrate health posts -- their integration is left to the initiative of local authorities.

Strengths

- The GOG should be commended for the careful and successful implementation of this PHC program, also referred to as the Bamako Initiative. A total of 290 centers out of 386 nationwide are integrated and operational. As a result of the program, coverage for a variety of services had risen markedly from exceptionally low levels in 1986. The MSPAS estimated that 75% of the population lives within a five kilometer radius of an operational health center and many that are beyond five kilometers benefit from outreach team services. By contrast in 1986 access to health care was minimal because of shortages of drugs and dilapidated facilities.

- Prefectural Directorate of Health and health center personnel generally show strong commitment in implementing PHC program activities (supervision, training, monitoring, social mobilization, provision of curative and preventive care). They are helped in this by community-level management committees and representatives of Ministry of Interior. The success of

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Weaknesses

- In spite of considerable organizational success, utilization of health services remains low. Some of the reasons are:

  a. Quality of care issues: competence of some providers is questionable; training inadequate; algorithms are not followed, unfriendly behavior of health personnel is often a deterrent to service utilization.

  b. Drug stock-outs often occur and prevent poorer people from receiving adequate care, since they cannot purchase higher priced drugs from other sources.

  c. Facilities are sometimes dilapidated and equipment is sometimes lacking or needs to be replaced.

  d. Transportation is a major problem nationwide, rendering some facilities virtually inaccessible to many potential clients.

  e. The referral system is weak.

  f. While the strength of the effect is not known, it is certain that the fee for service/medication system discourages (or perhaps prohibits) utilization by some number of poor people.

- Data is not properly collected and used in decision making.

- Supervisors are insufficient in number and often do not seem to have the resources to be effective. Supervision visits often have to be cancelled or postponed because of insufficient numbers of vehicles, lack of fuel, and lack of supervisors.

- Generally, the directors of health at the prefecture level are poorly housed and equipped. They do not have financial resources to manage services. There is often little planning at the directorate level, although this varies considerably.

- Some important services such as family planning and maternity care receive relatively less attention from service providers, program managers and communities.

Opportunities

- If decentralization occurs, personnel availability should increase both at managerial and service delivery levels, and utilization of personnel should be more effective.

- Additional services -- such as family planning, Leprosy, tuberculosis and onchocerciasis program (LTO), ARI, and laboratory facilities -- can be rapidly integrated if resources are available and commitment at managerial level secured.

Threats

- The expansion of program could lead to an increase in workload at the managerial level and therefore to a decrease in motivation. As a consequence, supervision and training might not be performed well and quality of care could decrease.

- Maintenance of infrastructures and equipment is the responsibility of the community but reserve funds often do not cover such expenses, either because of budget constraints or questionable budgeting decisions.

- New policy in drug supply (full cost recovery at the Central Pharmacy) could lead to increased costs at the service delivery sites, which could in turn decrease utilization of services.

2. Other government institutions

There are a number of other GOG institutions which play a role in the delivery of health care in Guinea. In-depth organizational analyses for each of these institutions was not possible, but certain preliminary comments are presented below.

Social Affairs

While Social Affairs is part and parcel of the Ministry of Health (the "AS" in "MSPAS"), for all intents and purposes they are separate institutions, with autonomous organizational structures. Social Affairs appears to suffer from substantial internal instability which could reduce the effectiveness of any contribution they might make to health programs. However, they do have access to established community networks -- many of them women-oriented -- which could be useful in grass roots health education campaigns.

Ministry of Education

Resources at the Ministry of Education could be brought to bear on some of the pressing health education needs of Guinean health professionals and the general public. The Ministry has existing expertise and resources to support health education and training, in the form of the Institute Pedogogique National, the Literacy Program, and networks of students, teachers and parents throughout the country.

The opportunity for synergy exists, since USAID is already investing heavily in the education sector.

Ministry of Interior

The Ministry of the Interior has broad responsibility for the coordination of community-level activities throughout the country, a role that is likely to increase in importance as the GOG pursues its decentralization strategy. Interior is already collaborating in the promotion of health activities through its Prefecture-based Directors of Micro-Realization, who facilitate the formation of health center management committees and help identify resources for the construction of health posts. There is substantial variation in the level of activity among Prefectures -- an opportunity exists to enlist the support for health promotion of this important community resource.

Ministry of Plan and Finance

This Ministry, of course, is extremely important to all government functions in that it controls the budgetary and financial control processes. As the MSPAS lobbies for additional resources from the overall GOG budget, it is critical that good working relations with Plan and Finance be maintained. Plan and Finance is also the repository of the most accurate information with respect to budgeted and actual expenditures on health care. MSPAS and its donors will need to involve appropriate officials from this Ministry as the difficult process of decentralization unfolds.

Ministry of Administrative Reform

The salient function of this Ministry, as it relates to health care, is to approve any organizational changes proposed by the MSPAS. This appears to be a very slow process, which may not always take the functional needs of the MSPAS into account. There is thus the possibility of this Ministry serving as a significant administrative barrier to positive change.

Breastfeeding and Nutrition-Related Organizations

The Institute for Child Nutrition (Conakry), the National Training and Research Center (Maferinya), the National School of Public Health (Kindia), the School of Medicine (Conakry), are all potential sources of research collaboration in nutrition and breastfeeding.

3. Private Sector

Structure

For purposes of this discussion, the private/parastatal health delivery sector in Guinea consists of the following types of institutions:

- Private health establishments such as clinics, medical offices, pharmacies, and private laboratories;
- Health institutions which are part of industrial, commercial, private or parastatal service enterprises;
- Social institutions with autonomous management such as National Social Security System or the Red Cross;
- NGOs working in the area of health;
- The "informal sector" within which one would classify traditional practitioners, village midwives, and other small retail stands which sell medications.

Involvement of these types of institutions in the delivery of health services has been specifically encouraged by the GOG, both in formal documentation (e.g., the Proposal for the National MCH/FP Program) and in more informal declarations by government officials.

The private/parastatal sector differs fundamentally from the public sector in several ways:

1. It serves a population which often does not seek health and family planning services from institutions in the public sector, e.g., employees of large commercial firms.
2. Many of these institutions are concerned with the generation of profit in exchange for their services -- a fact which necessarily limits the types of services they might offer and their target clientele.
3. These institutions are often more flexible than those of the state, and they sometimes adapt more readily to specific local needs.
4. These institutions often intervene in particular areas of health which are their exclusive specialties and which enable them to satisfy particular needs, as in the case of traditional practitioners, village midwives, or religious institutions.

The key institutions providing or otherwise supporting the delivery of health services in the private sector are as follows:

1. The hospitals of the Bauxite Company of Guinea (CBG), the Aluminum Company of Fria (FRIGUIA); the Société Aurifere de Guinée (SAG); AREDOR, the diamond mining company located in Gbenco in Upper Guinea; medical centers of the Guinean Palm Oil and Hevea Company (SOGUIPAH), and the National Tobacco Company.

2. Thirty health centers belonging either to commercial agents or NGOs, all of which are capable of providing quality health and family planning services. Included in this number are the clinics of Association Guinenneen pour le Bien-Etre Familial (AGBEF), the Guinean International Planned Parenthood Federation (IPPF) affiliate, which plays a major role in the delivery of family planning services.

3. Fifteen private clinics and approximately twenty private medical offices which are equipped with reliable laboratory facilities.

4. The country has 183 private pharmaceutical dispensaries and four wholesale pharmaceutical distributors.

5. Guinea also has a large number of traditional healers and village midwives (several thousand) capable of distributing services at the community level.

6. The emerging Central Pharmacy system is organized as a parastatal, but is adequately discussed elsewhere in this report.

7. The National Social Security System is responsible for making substantial payments directly to health care providers on behalf of workers (approximately GF 2.5 billion per year), and manages critical social service programs such as maternity leave.

<u>Strengths</u>

- The political and legal atmosphere is favorable to involvement of the private sector in health delivery.

- Health care providers associated with many of the larger commercial interests in Guinea generally offer a higher standard of clinical service than is offered elsewhere in the country.

- According to the General Director of Works, approximately 1,170,000 Guineans receive health services through private sector providers. This number consists largely of employees of large companies and their families. In addition, an estimated 250,000 people living near private

or parastatal health centers use these services either because access to the public clinics is difficult or because the quality of services offered by the private clinic is better.

- As many as two million people are thought to utilize traditional healers or village midwives for some part of their health care needs.

- The private family planning association, AGBEF, has gained substantial experience in delivering FP services; and could provide an important adjunct to public sector programs in this area. AGBEF has often served as the family planning services innovator in Guinea, piloting such concepts as promotional agents and community-based distribution.

Weaknesses

- The private/parastatal sector consists of a large number of organizations and individuals providing health services, with little or no coordination among them. At present, no mechanism exists through which to develop a coherent program or channel assistance.

- The private sector has shown little interest in family planning activities, outside of the important program carried out by AGBEF and the USAID-supported social marketing of condoms project implemented by PSI.

- There is a general lack of knowledge among managers of private companies of the benefits of family planning for the productivity of their companies or the health and output of their employees.

- Private sector facilities tend to emphasize curative care.

- The private sector has generally not been involved in the formulation of national policies or action plans in health and family planning. This is particularly important for the National Social Security Program, which plays a substantial role in the funding of health care and pursues what is effectively a pro-natalist policy.

- Even though AGBEF has played a major and critical role in the introduction of family planning services in Guinea, it suffers from a number of important weaknesses as compared with other IPPF-affiliate organizations that are playing major roles in FP introduction in other countries. Some of the problems that need to be addressed before AGBEF expands its present activities are:

  - Overall program management is deficient. Decision-making is overly centralized and often reactive

rather than proactive. There is a need for personnel with more specialized experience in the technical and managerial aspects of family planning programs, and the number of employees nationwide may be excessive in relation to the scope and potential impact of ongoing projects. The April 1993 evaluation of the Social Marketing Project concluded that AGBEF's staff of 21 regular employees plus 15 FAMPOP agents might be insufficient. As of April 1994, AGBEF has approximately 70 employees--a number that may represent an over-correction. The number of personnel in various categories (support staff, clinicians, motivators, and IEC agents) should be examined in light of work-load and productivity.

- The appointments system using written cards is inappropriate for what is largely an illiterate clientele.

- The range of services offered on site is inadequate in spite of the presence in some sites of trained personnel and necessary equipment (e.g., IUD patients are referred to hospitals and are often lost to follow up).

- Basic clinical equipment is often lacking or does not meet international standards.

- Minimum hygiene and infection prevention standards are not met in the clinics.

- The information system (from client cards to centralized records) is inadequate, resulting in unreliable data, poor follow-up of clients, and difficulties in maintaining contraceptive stocks.

Opportunities

- As compared with public sector sites, many relatively well-equipped private sector clinics have the potential to offer a full range of family planning services, from the pill to voluntary surgical contraception (VSC), as well as STD/AIDS testing.

- Educational efforts among managers of private companies and the National Social Security System concerning the economic and health benefits of family planning could lead to significant policy and service delivery changes.

- AGBEF offers an important structure upon which to build a stronger family planning program in Guinea, if appropriate management and technical improvements can be made.

- The potential of the traditional sector to deliver basic health services deserves further exploration. Research into current practices and areas of possible intervention is an important first step.

- The potential of private pharmacists to be more actively involved in the social marketing of selected health products (e.g., oral contraceptives, ORS, impregnated mosquito nets) needs further exploration.

Threats

- The number of autonomous organizations and individuals involved in private sector health delivery makes it relatively more difficult to design manageable programs that will reach large numbers of people.

- The for-profit status of many private sector providers necessarily limits the range of primary care interventions that they might undertake.

- Unless AGBEF is able to strengthen its internal management and planning capabilities, it may have difficulty meeting the sometimes competing demands of different donors.

B. ANALYSIS OF EXISTING PROGRAMS

1. Family Planning

Importance

The United Nations and the international donor community have stressed the importance of family planning in curbing the speed of population growth in developing countries, as a means of assuring the right of women to determine the number and spacing of their children, and as a means of improving the health of women and children. GOG officials indicated their agreement with these principles in 1992 by adopting a Population Policy which specifically supports a strong national family planning program. The need is great, as evidenced by the very low contraceptive prevalence rate (CPR) of 1-2%. The GOG objective for the year 2010 is 25%, to be achieved through a network of public and private sector providers.

The new Population Policy is a particularly welcome development, since the repudiation of the pro-natalist policy of the First Republic in 1984 did not bring quick changes in the family planning field. For many years, no policies or programs had been initiated to establish family planning development as a service. The PHC program launched in 1988 did not include family planning in the minimum package of services provided at health centers and health posts. It was only in the 1991-1993 MSPAS plan that objectives were set forward providing guidelines in family planning policy and services.

Strategies and activities to meet these objectives include:

1. rapid integration of FP into all health centers of PHC program;

2. training personnel at all levels in contraceptive technology;

3. provision of contraceptives to health centers; and

4. launching an IEC program.

In 1992, development of FP services in health centers was officially started. Before that, the United Nations Fund for Population Activities (UNFPA) had only a pilot family planning center at Corinthie in Conakry; while AGBEF had been running an IEC campaign, and had opened a clinic in Conakry. As of early 1994, however, there are 118 MSPAS health centers where family planning is integrated, mostly under the sponsorship of UNFPA and Population Services International (PSI)/AGBEF.

These centers are distributed as follows:

Upper Guinea	32 sites
Forest Guinea	32 sites
Middle Guinea	17 sites
Lower Guinea	26 sites
Conakry	11 sites
Total	118 sites

Monitoring of FP activities during MSPAS routine monitoring sessions was started in December 1993 in some regions and February 1994 in others.

TABLE II

	Method	Number of Clients	% of clients using method (within region)
Forest*	Pill	970	52
	Injectable	547	29.32
	IUD	48	2.6
	Condoms	215	11.52
	Spermicides	85	4.55
Upper*	Pill	777	53.25
	Injectable	474	32.48
	IUD	1	.07
	Condoms	106	7.26
	Spermicides	101	6.92
Middle (statistics for one center in Labe)*	Pill	22	44.9
	Injectable	14	28.6
	IUD	3	6.12
	Condoms	6	12.24
	Spermicides	4	8.16

* Data for the entire Middle Guinea region are not available. Data for the Forest and Upper Guinea regions are derived from PSI reports.

Strengths

- There is growing GOG commitment to family planning, as evidenced by the Population Policy, the draft Family Code, and the inclusion of FP in MSPAS workplans.

- A number of technical documents have been issued, such as guidelines for contraceptive prescription and guidelines for integration of FP into PHC program health centers.

- The range of contraceptive methods provided is appropriate for a program at this stage of development. It is particularly encouraging to see that VSC has been introduced at an early stage (four operational VSC sites), although the total number of VSC procedures performed nationwide in 1993 was only 177.

- An active private family planning organization, AGBEF, could serve as a platform for additional activities (see more detailed discussion under "Private Sector Programs".)

Weaknesses

- The quality of services, based on the team's observations, varies from region to region and prefecture to prefecture. In Upper and Forest Guinea, for example, follow-up is more regular than elsewhere. In general, supervision is not regularly performed and is even totally lacking in some prefectures due to unavailability of trained supervisors. Poor clinic environments often deter clients from seeking family planning services (e.g. lack of dedicated space where confidentiality can be maintained).

- In some regions women must have their husband's consent before receiving FP services.

- On the whole, use of family planning services remains very low. As discussed earlier, the DHS survey indicates that substantial unmet demand exists. While some of this demand may have been satisfied by services introduced after 1991, there is little doubt that there are many couples who would avail themselves of more readily available, accessible FP services.

- The number of personnel trained in FP is quite low and they are often displaced because of frequent staff turnover. For example, in Forest and Upper Guinea there are 13 centers where FP services have been interrupted because of staff transfer.

- Knowledge of modern contraceptive methods, while variable around the country, is surprisingly low on the whole (55% for men, 28% for women). IEC related to family planning is weak at all levels, including mass media, service point materials, community education, and individual counseling.

- Contraceptive stock-outs occur frequently. Reasons include the relatively recent addition of contraceptives in the drug procurement system, inefficiencies in in-country distribution and difficulties in procuring certain types of contraceptives through the AID system.

Opportunities

- More effective IEC efforts, particularly at the community and service delivery point levels, should result in impressive increases in knowledge of, and favorable attitudes toward FP.

- Increased availability of quality services could result in substantial increases in use, given the evidence of unmet demand. It is likely, however, that progress will be much slower in rural areas.

Threats

- Religious and traditional pro-natalist beliefs may hinder FP acceptance in many parts of the country.

- Improvements in FP information and service delivery are not always coordinated (i.e., some areas have information but inadequate services and vice versa.)

2. HIV/STD/AIDS Prevention

Importance

AIDS and sexually transmitted diseases (STDs) are important public health problems. Since the first recognized Guinean AIDS patient in 1987, 780 cases have been reported by the middle of 1993. About 2% of the cases have been children and 40% of the adults have been women. 91% are HIV1, 4.5% are HIV2 and 4.5% have both viruses. Sero-prevalence surveys on blood donors, STD out-patients, and rural populations have been done. Prevalence levels are generally under 2%, the highest found thus far being 2.9% of 1,511 blood donors.

A few sentinel sites for STDs are functioning. A survey in 1992 on 1200 people found 27% positive for gonorrhea and 3% for syphilis.

Strengths

- With the help of WHO, a national commission and program for STD/AIDS has been functioning since 1987. In spite of very limited resources, a national policy has been developed and the program is ready to be integrated into the PHC program. Successful partnerships of note exist with the University of Montreal, PSI for IEC and social marketing of condoms, and the EEC and Belgian Red Cross for support to the national transfusion center.

Weakness

- Financial resources have been extremely inadequate. For example, last year only $8,000 was available for laboratory supplies. Clearly, some significant number of AIDS deaths are unreported because of lack of diagnostic tests. Other priority needs are felt in the areas of training, decentralized surveillance, and operations research.

Opportunities

- Detailed strategies and guidelines exist, waiting to be implemented.

Threats

- HIV/AIDS prevalence appears to be low relative to surrounding countries--surveillance is needed to monitor high risk groups and geographical areas. Of particular concern is Forest Guinea with its massive influx of refugees.

- STDs present the challenge of resistance to antibiotics and the costs of diagnosis and treatment. Means to cover these costs must be found to improve women's reproductive health and the effectiveness of family planning services.

3. Nutrition and Breastfeeding

Importance

As noted earlier in this report, and as explained in detail in Appendix VIII, malnutrition is a major health concern in Guinea (the second leading cause of infant mortality), and there are few effective services to combat the problem. Following the ENCOMEC (1990), ENAMOG (1991) and PADSE (1991) findings on the critical nutritional status of women and children in Guinea and based on the FAO/WHO recommendation after the International Conference on Nutrition (1992), a national nutrition policy and action plan was drafted by the Food and Nutrition Division (DAN) of the MSPAS. However, the document has not been signed nor is the action plan

implemented. A national technical committee on nutrition has also been created but is not yet operational.

There is no specific plan of action or strategies for ongoing nutrition interventions. However, there is a draft document detailing a National Food and Nutrition Surveillance System (MSPAS/DAN, 1993); as well as a new project called Surveillance Nutritionelle a l'Assise Communautaire (SNAC), which will implement the national surveillance system with assistance from UNICEF.

Nutrition occupies a secondary position among the services delivered in health centers and other health establishments. Although nutrition is mentioned as a component of the primary health care package to be delivered in all health centers; in practice, the level of performance of nutrition activities is quite low. The problems include insufficient numbers of trained personnel, lack of nutrition IEC materials,and absence of space for nutrition counselling and interventions.

In some urban health centers such as Conakry, however, nutrition activities are quite intense. In one such center, a separate room is being renovated, and staff demonstrate weaning foods preparation. At the Institute for Child Health and Nutrition, there is a Nutrition Rehabilitation and Education Center which carries out a number of activities in childhood nutrition -- including growth monitoring, education of mothers, demonstration of weaning food preparation and counselling on breastfeeding.

Strengths

- The government seems committed to positive action to improve the nutritional status of the population, especially that of women and children. A Nutrition Policy and Action Plan have been formulated and a follow-up technical committee has been set up.

- The new Nutrition Surveillance system is based on principles of community participation, thereby increasing prospects for sustainability.

Weaknesses

- There is a lack of representative baseline information on which to base nutrition activities. No national nutrition survey has been conducted.

- There are insufficient funds to carry out large scale nutrition studies and programs.

- There are insufficient human resources specifically trained in the area of food and nutrition, both at the central and field levels.

Opportunities

- Adoption of the National Nutrition Policy and Action Plan will provide a legal framework for the implementation of a specific nutrition program.

- Several donors are increasingly interested in the financial support of nutrition activities, increasing the likelihood that some of the 18 nutrition programs defined by DAN will be funded.

Threats

- Nutrition problems have been so long underestimated that it may still take some time before significant nutrition programs are undertaken.

National Breastfeeding Activities

While there are no written guidelines for breastfeeding activities, the promotion of breastfeeding is mentioned as one of eight strategies in the draft of the National Nutrition Policy and Action Plan. The MSPAS/DAN has prepared a draft declaration on the government policy on breastfeeding to broadcast during a public appearance of Ministry officials on TV, but this broadcast has yet to occur. A knowledge, attitudes, and practices (KAP) survey on breastfeeding practices has been planned by the MSPAS in the four national regions. The survey has already covered Forest Guinea and has been started in Middle Guinea.

UNICEF is the principle donor acting for the promotion of breastfeeding in Guinea. The WHO/UNICEF document "Ten Steps to Successful Breastfeeding" have been widely disseminated to health and paramedical personnel, and an information campaign on breastfeeding has been launched through the media. Information and communication seminars on breastfeeding have also been organized allowing some 200 health professionals to become acquainted with breastfeeding promotion.

UNICEF, in cooperation with MSPAS, has also designated the Ignace Deen Hospital in Conakry to become a Baby Friendly Hospital (BFH). Experimental activities started one year ago. After evaluation, the BFH initiative may be extended to other hospitals in the country.

The Association des Femmes pour la Promotion de l'Allaitement Maternel et la Nutrition d'Enfant en Guinée (AFPAMNIG) is a locally organized NGO whose primary objective is to promote breastfeeding in Guinea. Their initial activity was the organization of a seminar at the Matoto Council in Conakry in January 1994. The aim was to sensitize health workers on the need for the promotion and support of breastfeeding.

AFPAMNIG is now following up the recommendations of the seminar which include:

- The formulation of national breastfeeding policy and a national code for marketing breast milk substitutes.
- The improvement of breastfeeding conditions for the Guinean women in government and private sector offices.
- Creation of breastfeeding support groups composed of health workers in prenatal care, expanded drug programs, ORT and nutrition activities.
- Formation of breastfeeding support groups composed of mothers within the same community.

Strengths

- The presence of a national NGO, AFPAMNIG, whose general objective to promote breastfeeding.
- The ongoing development of a decentralized primary health care system with community participation provides fertile ground for breastfeeding promotion.

Weaknesses

- The absence of comprehensive breastfeeding policy or guidelines to integrate breastfeeding in MCH/FP services.
- Breastfeeding promotion is limited or non-existent at some health facilities -- immediate breastfeeding is not universally encouraged and substitute liquids are frequently provided.
- Insufficient financial resources to support the development of national policy, IEC, community-level support groups, and related activities.
- Limited research activities on breastfeeding.

Opportunities

- The draft national nutrition policy document includes breastfeeding as one strategic option to fight against malnutrition in young children.
- UNICEF and other international donors are interested in sponsoring breastfeeding promotion activities.
- There are many women's NGOs which can incorporate breastfeeding in their community activities.
- Incorporating information about the fertility suppressing effects of breastfeeding (the Lactational Amenorrhea Method) into both breastfeeding and family planning promotional efforts could have positive synergistic effects.

Threats

- There are many traditional breastfeeding practices which could interfere with breastfeeding promotion. They are:
  - late initiation of breastfeeding
  - providing potentially harmful liquids before breast milk
  - prevention of exclusive breastfeeding during the first 4-6 months by early introduction of nutritionally poor weaning foods.

4. Immunization

Importance

The EPI remains the top priority in the child survival strategy of the 1990's quite simply because it is the most cost-effective approach we have to combat six childhood diseases.

When Guinea launched its PHC program in 1987 at the beginning of the Second Republic, the immunization coverage of infants was only about 5%. This put it into the category of "Lower Coverage Countries" faced with extreme economic hardship and a very under-developed and non-functional health system. Given this history, it is remarkable that coverage of children aged 12-23 months has progressed to an estimated 30% in 1992 (DHS) and 55% in October, 1993 (MSPAS National Survey). Coverage in sub-prefectures without integrated health centers varied between 13 - 15%. The precise immunization coverage rate in 1994 is unknown, and differing estimates generate some controversy. For reasons explained earlier (see the introduction to "Health and Family Planning Indicators), each existing source of data known to this assessment team is flawed. The DHS data collected in 1992 is probably the most reliable, but it is now three years old. The MSPAS survey in 1993 is largely based on underestimates of local population: the coverage estimate of 55% is thus almost certainly overstated. The only reasonable conclusion to draw is that the actual immunization coverage rate lies somewhere between 30% and 55%. While this lack of precision is troublesome, it should not obscure the fact that impressive gains have been made in a relatively period of time.

Strengths

- The EPI is the strongest component of the PHC program. Given its commitment to the 1995 goals of polio, tetanus and measles reduction, the government is exploring its options for increasing coverage. A major goal is that all sub-prefectures in the country will have at least one integrated health center by the end of 1995. Advanced strategies are also being used to reach beyond health centers to health posts and communities.

Weaknesses

- The problem of dropouts between DPTP1 and DPTP3 has not yet been solved. It is hoped that increasing integration of MCH/FP programs will markedly reduce "missed opportunities". On the other hand, this strategy means that much vaccine is wasted in low volume centers where a bottle of 10-20 doses may have to be opened for only one child.

- Because of the weakness of supervision, such activities as aseptic technique and routine maintenance of refrigerators are not as good as they should be.

- The numbers used for surveillance and monitoring are often not valid. The MSPAS recognizes that its surveillance systems are weak. As explained above, the twice yearly monitoring exercise is not yet an accurate instrument for coverage estimation because in the majority of cases the target populations are still being calculated on the basis of the 1983 census.

Opportunities

- Operations research will be needed to test new strategies to reduce vaccine wastage. Options now being considered include:

  - Buying vaccine in smaller dose containers

  - Limiting vaccinations to relative high volume days, such as market days

  - Organizing special "vaccination days" in the communities

Threats

- The key question is how to assure adequate financing and sustainability in the medium and long run. Of particular concern are the costs of purchase and maintenance of expensive equipment such as vehicles and refrigerators.

5. Diarrheal Diseases

Importance

Diarrheal diseases are of major importance for child health and survival. Service statistics show that they account for 9% of child mortality and 15% of outpatient visits. The DHS survey found an average 2-week prevalence of 16%, ranging from a high of 21% in Conakry to a low of 9% in Lower Guinea. Increased fluids, including breastfeeding, were being given in about 40% of cases and ORS packets were claimed to have been

used in one of five episodes. A survey conducted by the MSPAS in 1993 found that 70% of mothers claimed to know about ORS, the lowest level of 50% being found in Conakry.

Epidemics of diarrheal diseases occur periodically in Guinea. An outbreak of salmonellosis was reported in 1993 and cholera has tended to appear in eight year cycles. Refugee camps in Forest Guinea and densely populated urban zones represent high risk areas.

Strengths

- The Combatting Childhood Communicable Diseases (CCCD) project was instrumental in helping Guinea launch its national program. Activities have been maintained since the end of the project in 1991 and PRITECH has also provided assistance in the development of a training strategy and studying the feasibility of local production of ORS packets. Now there is national commitment to the 1995 goal of 80% of diarrheal episodes being treated by oral rehydration therapy. WHO is providing support to the development of a 1994-1998 strategy.

Weakness

- In spite of knowledge and training in the use of ORT, many health providers do not use it as much as they should. There is still a strong reflex to reach for the I.V. solution and many health centers do not have the minimum equipment necessary for a functional "rehydrating corner". In some centers, potable water is not easily available. When mothers are sent home with a packet and instructions there is a high probability that in many cases, the preparation and volume of the fluid administered may not be correct.

Opportunities

- This is the time to build on the successes of the past and move forward. Possibilities for effective assistance include:
  - Support to operations research
  - Social marketing of ORS packets
  - Refresher training to emphasize the positive synergism of measles vaccination, breastfeeding, Vitamin A supplements, and nutritional evaluation and rehabilitation

Threats

- ORT can be supplemented by antibiotics in the management of some diarrheal diseases such as shigella, salmonella and cholera. Effective guidelines are needed, in the form of revisions to the treatment algorithms, which will guide providers in appropriate diagnosis and treatment of such cases.

6. Malaria

Importance

Malaria is a major public health and development problem in Guinea, representing the chief complaint in about one-third of all medical visits. Some of the important effects are these:

Health

- **Mother**
  Anemia
  Fetal loss
  Low birth weight babies

- **Children under five**
  28% of the reported morbidity
  11% of the reported mortality

Development
  Direct costs of prevention and treatment
  Indirect costs of lost work and productivity

Strengths

♦ Guinea is an active member of the WHO elaboration of a regional malaria control strategy and work plan for 1993-1999. USAID Washington (Africa Bureau and Office of Health) has committed $2.2 million to WHO's regional office for Africa for priority activities during 1994-1996.

Key elements of the national policy adopted in 1993 include:

- Integration in the PHC program
- Identification of first and second line drugs
- Promotion of personal protection by means of impregnated nets, curtains and window screens
- Improvement of support strategies
- National coordination and evaluation
- Training
- Epidemiological information systems
- One surveillance post per region
- Community based information
- Strengthening of operations research capabilities
- KAP studies
- In-vivo testing for chloroquine resistance
- Entomological studies

Weakness

♦ One of the major constraints in the effectiveness of chemoprophylaxis of pregnant women is that they come for prenatal visits only when there are perceived problems. This is often late in the pregnancy.

Opportunities

- This is the time for the program to harmonize diagnostic and treatment algorithms with the new ARI program being developed.
- Lessons learned from the social marketing of condoms may be useful for impregnated mosquito nets.

Threats

- Major threats to the epidemiology of malaria come from rapid urbanization and development of resistance of plasmodium falciparum to chloroquine and other anti-malarials.

7. Acute Respiratory Infection (ARI)

Importance

Acute diseases of the lower respiratory tract (Pneumonia, bronchitis, etc.) are of major importance for child health and survival. Service statistics show that non-specific ARI and measles combined account for about one-third of child mortality and one-fourth of the reasons for medical visits. The main reason that measles is so deadly in developing countries is due to widespread malnutrition.

The DHS survey found an average 2-week prevalence of 14%, ranging from a high of 21% in Middle Guinea to a low of 11-13% in the rest of the country. The average measles immunization coverage is 43%, ranging from a high of 63% in Conakry to a low of 24% in Upper Guinea. Outbreaks of measles occur on occasion, especially in urban areas. A significant number of cases are often found to have been immunized. This may be due to a combination of a breakdown of the cold chain and children getting measles at ages younger than 9 months.

Strengths

- With the help of WHO, Guinea is beginning to develop a new program to be added to the battle for child survival. The addition of ARI-specific interventions to the existing PHC services will attack a major cause of child morbidity and mortality.

Weaknesses

- The program in its present state is in the section of infectious diseases and not integrated in the PHC system.

Opportunities

- The CCCD project showed that being a partner in a new program at the start provides great opportunities for sustainable impact.

Threats

- The biggest threat to this program today is that a source of needed technical assistance and resources has not yet been identified.

8. Infectious Diseases

Importance

Major diseases in Guinea are currently grouped by the National Service for Health Information (SNIS), part of the BEPR, into the four categories shown in the following table:

TABLE III
SNIS CLASSIFICATION OF MAJOR DISEASES

EPIDEMIC POTENTIAL		OTHER	
EPI	NON EPI	COMMUNICABLE	NON COMMUNICABLE
Diphtheria Measles Neo-natal tetanus Poliomyelitis Whooping Cough	Cholera Meningitis Plague Typhoid Yellow fever	ARI Dracunculiasis General tetanus HIV/AIDS Leprosy Malaria Onchocerciasis Other diarr. diseases Rabies STD Schistosomiasis Trypanosomiasis Tuberculosis	Cardio-vascular Dermatological Diabetes Female: Urogenital Hypertension Male: Urogenital Malnutrition Neurologic Other metabolic Psychiatric Pulmonary Trauma

With the exception of malnutrition, the diseases of major public health importance are infectious or parasitic and fall in the first three columns.

EPI (see detailed discussion above)

Note that although BCG provides protection against tuberculosis, this disease is classified as a non-epidemic disease. Given the alarming resurgence of tuberculosis in some parts of the world, including the United States, increased surveillance is needed to see if it should be reclassified.

Potential Epidemics (Non-EPI)

The program for these diseases lies in the Communicable Diseases Section of the Division of Prevention. Under it there is a sub-section of Immunizations/Epidemics/ Catastrophes. One of the main functions of the immunization branch is yellow fever shots for pilgrims going to Mecca.

Epidemics are not uncommon occurrences. Being in the meningococcal meningitis belt that stretches across Africa, Guinea has a meningitis problem almost every year from January to the beginning of the rains. This year is no exception and by the end of March, over 500 cases had been reported in the prefecture of Siguiri in Upper Guinea. The estimated attack rate during the month of March for Siguiri was 25 cases/10,000 population. (See Appendix III).

Since cholera has appeared historically in eight year cycles and last occurred 1986, there is special concern for current surveillance. The last yellow fever epidemic occurred in 1990 and there is danger of a recurrence, since it is now being reported in Ghana.

Non-Epidemic Communicable Diseases

The LTO program coordinates the strategy to control leprosy, tuberculosis and onchocerciasis. A survey in 1988 found a leprosy prevalence of about 2%. Over 4000 new cases were diagnosed in 1993, 15% of which were children under five. Also in 1993 over 6000 new cases of tuberculosis were diagnosed by positive sputum. About one million people are exposed to onchocerciasis, causing blindness in an estimated 20,000. The highest risk zone is Upper Guinea.

Trypanosomiasis, the cause of sleeping sickness, is thought to be on the increase. A survey supported by WHO and the French is being carried out to asses the situation. Schistosomiasis is a problem, particularly in Forest Guinea. The outbreak of intestinal schistosomiasis in northern Senegal in recent years is a reminder that this disease also has epidemic potential.

Strengths

- The strategy of integration of the LTO program and health center laboratories into the PHC system is being implemented. The program for leprosy, being older and more functional than the one for tuberculosis started in 1990, is providing the framework for expansion. Support is being given by the NGO Philafricaine. Onchocerciasis Control Program radios, in 26 prefectures of the country, provide means of communication.

Specific impact of the addition of these interventions into the PHC system includes:

- A seminar for regional and prefectoral teams in epidemiological surveillance and rapid alert was held in April 1993 with the help of WHO

- Increased collection and microscopic examination of smears and sputum for leprosy and tuberculosis diagnosis

- More cost-effective case management

- Tuberculosis (two months supervised plus six months in community)

- Community based delivery of Ivermectine for onchocerciasis

Weakness

- The weak health information and epidemiological surveillance systems are currently a major handicap to planning, implementation and evaluation of the PHC program.

Opportunities

- Assistance is being sought to help refine and implement plans that have been made. The French are currently providing support to the BEPR and the Germans have also expressed an interest in so doing.

Threats

- The increasing worldwide return of tuberculosis reminds us of the necessity of constant vigilance against the changing patterns of potentially epidemic diseases. The questions of cost are also important. Adequate treatment of tuberculosis is expensive and the reduced international funding of the OCP requires new strategies for sustainability.

- Historical evidence and events in neighboring countries suggest the danger of impending cholera and yellow fever epidemics.

C. ANALYSIS OF SUPPORTING FUNCTIONS

1. Drug Supply and Distribution

Structure

Formerly, PharmaGuinée, a para-statal organization, provided public health sites with drugs purchased with government funds in accordance with quantity and service guidelines issued by the MSPAS. This system of drug distribution failed, because of poor management practices. Some of PharmaGuinée's specific problems include frequent stock-outs, declining government allocations for drugs, a defective logistics system, and poor financial management in general. (PharmaGuinée still carries a significant debt to European pharmaceutical companies). A project sponsored by the African Development Bank (ADB) is rehabilitating PharmaGuinee into a new supply and distribution system, the Central Pharmacy.

Central Pharmacy: The Central Pharmacy, like its predecessor, will be a para-statal organization, although all details of its organization and management are not yet determined. (While major changes in staffing patterns are not expected, it is likely that Central Pharmacy employees will no longer be public sector bureaucrats.) There will be a "Users Advisory Committee" which will include members from the NGO community. Several members of the Users Committee will also sit on a Management Committee, which will be responsible, among other things, for nominating the Director General who will be appointed by the President of the Republic.

ADB has been providing technical assistance in the organization of the Central Pharmacy and will be providing stock for the first few years. The technical assistance is scheduled to be phased-out soon, although it is possible that further assistance may be agreed to. Stock will be distributed to three regional warehouses (Lower Guinea will be served directly from Conakry) on a cost recovery basis. Health centers will then purchase stock from the regional warehouse. The Central Pharmacy will purchase drugs in bulk in accordance with the pooled needs of all its users, with preference given to generics where they are available. Stocks will include contraceptives.

The financing of operations of the Central Pharmacy is not completely clear. Central Pharmacy sources indicate that it expects to "mark-up" the price of stock to a margin sufficient to recover the cost of central management. This would, of course, represent a significant price increase which would have to be met either through subsidies or consumer price increases. The MSPAS has indicated that it anticipated that health centers and hospitals would be provided with subsidies to cover any increase in drug costs, but it is unclear how such subsidies might be funded.

The Central Pharmacy has been awaiting its first tranche of stock, which is expected imminently. Since this new organization has not actually been operational, it is difficult to assess its effectiveness or potential.

UNICEF: Parallel to PharmaGuinee, the PHC program has its own drug distribution system sponsored by UNICEF. The program purchases drugs through UNIPAC and distributes them to integrated health centers. Each center purchases its share according to its needs. Payment is made to the Bureau of Essential Drugs of the program, based in Conakry. To date, UNICEF has provided all essential drugs free of charge, and the Bureau has used funds collected to capitalize a revolving fund, which will be used for drug purchases when this UNICEF assistance ends. The program has regional warehouses in each region except Lower Guinea (which is supplied directly from Conakry. This parallel distribution system is scheduled to last for five years and will end in 1995, when it will be completely integrated into the Central Pharmacy system.

Other Sources: Some NGOs and donors that assist health centers and hospitals have their own mechanisms for supplying drugs to their assisted centers. These also will be integrated into the Central Pharmacy system.

Strengths

- The system of internal distribution of the PHC program, and systems put in place by other donors and NGOs, have been reasonably effective, although there is substantial local and regional variation in frequency of stock-outs.

- The Central Pharmacy will soon take over drug distribution for the public sector and will be supplying to all public facilities. In theory, this new system represents a rational approach to addressing the country's drug supply and distribution needs.

Weaknesses

- In practice, the new Central Pharmacy system could present a major problem to the further expansion of the PHC program because the Central Pharmacy is a large and fairly complicated organization that is emerging from an organization that had many problems. All areas of management of the system are of concern, given the experience with PharmaGuinée. Particular attention should be given to financing issues, financial management, and the top-to-bottom logistics system.

- There are reports of some stock-outs of essential medicines and contraceptives at health centers and hospitals. At health centers and hospitals that are not yet integrated there is virtually no stock -- since they are not yet covered by the essential drug program. At health centers which are integrated, stock-outs are relatively less frequent although they do occur with some regularity, and with significant local and regional variation.

- Contraceptive stock-outs have also occurred. Contraceptives for the national MCH/FP program are provided mostly by UNFPA and distributed through the essential drug program to those 28 centers in Middle Guinea and Lower Guinea for which the integration of FP has been supported by UNFPA. For those health centers in the Upper and Forest Regions for which FAMPOP has supported the integration, FAMPOP has been managing distribution through a modification of the system: FAMPOP bypasses the central warehouse in Conakry and distributes contraceptives directly to the regional warehouses which then supply the service sites. It is worth noting that contraceptive stock-outs are not entirely attributable to Guinea inefficiencies: There have been substantial problems in procuring Depo-provera and oral contraceptives through the AID procurement system.

Opportunities

- The installation of a new drug distribution system provides the opportunity to "do it right the first time". This will require substantial monitoring at all levels of the system, and is likely to require substantial technical assistance to both anticipate and solve problems.

Threats

- Drug distribution is key to the functioning of the overall health system. Any shortcomings in the operations of the new Central Pharmacy will reverberate throughout the system.

- Those health centers and hospitals presently enjoying relatively effective drug supply by virtue of outside assistance may be resistant to the change-over to the new Central Pharmacy system.

2. Information, Education, and Communication (IEC)

Key Findings

Given the extremely low level of literacy and relatively low utilization rates of existing health services, especially among women and adolescent girls, changing attitudes and behavior to improve health in Guinea are formidable challenges. Current strategies based on IEC activities performed by formal health agents are important, but will not lead to rapid changes in behavior. This is due not only to limited numbers of personnel and means of communication and transportation, but also to the limited ability of even the best health promoters to change behaviors that are encouraged or supported within the social context.

Preliminary DHS data suggest that access to and utilization of mass media (television and radio) are below the 60% coverage rate suggested by earlier estimates; lowest coverage is in the Forest Region. There are large differences in coverage rates and access between regions and sexes; see Appendix III. While mass media campaigns can rapidly increase knowledge, and often begin to change attitudes, rapid behavior changes will probably not occur without a focus on community-based health education and counseling alongside quality service delivery.

DHS data indicates very limited (<25%) communication between spouses about family planning. Both men and women seem to believe their partners approve of FP less often than they actually do, except in Lower Guinea where women seem to overestimate their partner's approval significantly. This data has major implications for audience segmentation and specificity of messages, and points to the need for research and message development in a decentralized manner.

The most noteworthy IEC activities in the health sector have been characterized by heavy donor support and partnerships among a variety of governmental and non-governmental agencies working towards similar objectives. They are also characterized by an emphasis on one or two messages, as opposed to a large package of health messages, and by efforts at community mobilization.

Strengths

- Many potential governmental partners exist with special access to some target groups, as well as some existing level of human and material resources (e.g., the Social Affairs Directorate of MSPAS; the Ministry of Education: school children and their parents, teachers, literacy program attenders and their families; and the National Directorate for the Promotion of Women: women involved in income generation, network of elected representatives).

- Great interest in health IEC exists among media representatives at all levels.

- Numerous international and local NGOs are interested in increased involvement in health education, and in community organization and education.

- UNFPA and PSI/FAMPOP are already working with MCH/FP department of MSPAS to develop an IEC program for family planning.

Weaknesses

- Lack of coordination among the various actual and potential collaborators.

- Despite a considerable amount of KAP research done, results are not widely available -- there is thus a general lack of knowledge about how best to bring about behavioral change.

- There is not yet a strong, vocal constituency for family planning in Guinea -- making it more difficult to produce and disseminate direct messages on "sensitive" topics.

- The interpersonal communication/counseling component of family planning does not receive the support needed for success (e.g., service providers are not generally rewarded for taking the time necessary with individual clients to effectively counsel for family planning).

- Under the FAMPOP project, a lack of clear delineation of duties between MSPAS personnel and AGBEF IEC staff could create problems later on if service providers view family planning IEC as outside of their scope of work.

Opportunities

- Enhanced community-based education can be achieved by accessing social networks. This requires the collection of basic anthropological/ethnographic data.

- Revision of training modules and approaches in contraceptive technology could improve family planning counselling and community promotion.

- Sensitization of health center chiefs in encouraging their staff to promote FP to clients seeking other services could alleviate current training deficiencies in this area. Health Center staff do not always seem to view FP promotion as part of their job descriptions, although promotion of EPI is almost universally seen as a central role.

- Support for decentralization would include support for an enhanced role of DPS in supporting IEC and counseling (for FP as well as other interventions).

- The early experiences of AGBEF promotion agents using locally produced print materials will be a useful guide to future efforts.

- While radio and other mass media are useful for information, interpersonal communication networks must be built to achieve behavioral change.

Threats

- Internal competition for resources within MSPAS makes the task of identifying resources for IEC all the more difficult.

- There is over-centralization of decision-making as well as human resource development for IEC.

- Emphasis on IEC could create demand in some areas before quality services are available. This is a very serious problem which could result in deepened mistrust of the health delivery system among potential clients frustrated by the lack of services.

3. Information Systems and Research

Key Findings

The ability of key institutions in health to collect, analyze, and utilize data for management decision-making is very limited. At the central level of the MSPAS, the division charged with this responsibility is severely limited by inadequate resources and trained personnel (see the discussion of the BEPR elsewhere in this report). Data collection at the regional and prefectural levels is similarly lacking, although some Prefectures assisted by external organizations are able to produce exemplary management and planning reports -- the GTZ-assisted Prefectures of Gueckedou and Kissidougou are examples.

Operations research capacity is similarly constrained, and there is no systematic mechanism for housing the results of studies that are conducted. Thus, the health system in Guinea suffers from an inability to pro-actively conduct the information-gathering and research activities that would help guide programmatic decisions, and is also unable to take full advantage of the results of studies that are conducted on an ad hoc basis.

A more complete discussion of sources of data and constraints to its use can be found in the document Health Information Assessment in Guinea, September 1993, by Boyd and LaPointe.

Strengths

General:

- Some vertical programs are able to collect, process, analyze and use data for program management (e.g., PEV).

- The semi-annual monitoring process has excellent potential for program monitoring and improvement.

- The 1992 DHS, when fully analyzed, should provide good baseline data for design of future activities, and is certainly the most recent and reliable source of data on health.

- Some interesting and useful research is being done in an unsystematic way; but there are problems of quality and availability of results.

BEPR:

- Has been able to produce some planning documents; though usefulness for implementation is variable.

- Some annual statistical reports are also generated, albeit with considerable delays.

- Have developed some formats for data collection, and conducted some training in data collection.

- Existing staff have a good understanding of what the BEPR should be able to do, had it sufficient staff and resources.

Weaknesses

General:

- A lack of recent, accurate denominator data (i.e., good estimates of population at the Prefecture level) hampers all information system and research activity.

- There is no mechanism to disseminate and use results of research that is being conducted.

BEPR:

- Not able to produce information in a timely fashion (e.g., statistical report for 1991 published in September '93).

- Inability to gather, process and utilize data generated at the field level.

- Virtual absence of feedback to the field.

- Insufficient resources: Human, technical, material.

Opportunities

General:

- A full analysis of the 1992 DHS data would provide useful information.
- The identification of a means of gaining access to already existing research results would be a major service to other researchers and program planners.

BEPR:

- Relatively modest investments in infrastructure and training, perhaps in collaboration with other donors, could take advantage of existing staff strengths and motivation.

Threats

- Investments at this level of the health system, while important, are far removed from the service delivery point, and therefore may not be of high donor or GOG priority.

4. Health Financing

Key Findings

The 1993 budget for Guinea was approximately GF 838 billion (USD 864 million), with the budget for 1994 expected to grow to GF 883 billion (USD 910 million). Since 1989, the Guinean franc has gradually lost value against the U.S. dollar, the exchange rate increasing from 592 to 970. While no specific plans for additional devaluation of the currency, the possibility of such an adjustment exists.

National financial resources are clearly constrained and this must be taken into consideration in the design of development activities. Increased spending in one social service sector would likely come at the expense of spending in another sector. Activities identified should therefore leverage existing GOG, international, and local financing; rather than generate large requirements for additional government financing. Activities which build on existing initiatives or mobilize other resources will have higher likelihood of success than will completely new programs, unless they are very cost effective.

The following analysis is based on financial data obtained from GOG sources, the most accurate data presently available on health care financing in Guinea. It should be noted, however, that the data are difficult to interpret for a variety of reasons -- including, for example, inconsistencies in the GOG treatment of debt payments in overall budgets. A historical summary of GOG allocations for the health sector, i.e., the budget of the MSPAS, is shown in the following table (US dollar conversions are also shown):

EVOLUTION OF MSPAS BUDGET (GF 000,000)

	Salaries	Other Recurring	Invest.	Total	Change
89	2,700.0	2,052.8	8,855.01	3,607.8	
90	3,277.6	1,443.9	10,631.7	15,303.2	+12.5%
91	5,800.0	1,655.9	18,781.9	26,237.8	+71.5%
92	11,098.5	1,565.5	21,215.0	33,879.0	+29.1%
93	11,577.5	1,566.5	20,706.8	33,850.8	-0-

Sources: Salaries and operating expenses from MPF, Budget Direction.
Investment for 91/92/93 from MPF, Investment Direction.
Investment for 89/90 from UNICEF Social Sector Analysis.

EVOLUTION OF MSPAS BUDGET (US$ 000)

	GF/$	Salaries	Other Recurring	Invest.	Total	Change
89	592	4,561	3,468	14,958	22,986	
90	660	4,966	2,188	16,109	23,187	+1%
91	754	7,692	2,196	24,910	34,798	+50%
92	902	12,304	1,736	23,520	37,560	+8%
93	950	12,187	1,649	21,797	35,652	-5%

The sum of the first two columns in the table above is the MSPAS recurring cost budget, while the third column represents investments including donor financing. Donor contributions represents as much as 75-80% of the investment budget; and it appears that all donor contributions are listed in the investment budget, even those amounts expended for recurring costs. Thus, MSPAS depends upon external financing of approximately GF 15 billion (USD 15.4 million) in order to support its investment budget, while GOG financial resources are used primarily to cover salary and operating costs.

The recurring cost budget is of special interest, since it represents the GOG contribution to the day-to-day operating costs of the PHC program. Recurrent cost financing has been relatively flat in recent years, with the same amount budgeted for both 1992 and 1993. There is some controversy regarding the amount budgeted for 1994. Sources at the MSPAS have indicated, with considerable satisfaction, that the non-salary portion of this budget would rise by more than 100% -- to GF 3.5 billion. However, a few days before the end of this assessment (i.e. in late April 1994), sources at the Ministry of Plan and Finance indicated that the budget would be only GF 415 million (USD 427,000). If this lower figure is correct, there are seriously negative implications for the health care system.

Another cause for concern is the fact that approximately 67% of the non-salary recurring cost budget is used to purchase imported goods. Any currency devaluation would thus greatly reduce the purchasing power of this budget.

The preceding figures indicate the allocated budgets. Cash flow constraints or reductions in anticipated revenues in a given year sometimes preclude the disbursement of the allocated budget. An analysis of actual expenditures of non-salary recurring costs over the past three years indicates that, on average, the MSPAS expended over 86% of budgeted funds for operations. (It is assumed that the personnel costs are fairly completely disbursed.)

We conclude that, considering inflation, Guinea's capacity to finance the sector has gradually been eroded at the same time that service coverage is expanding, utilization levels are low, and some aspects of the quality of care have been questioned. If, as MSPAS officials believe, there will be substantial increases in allocations for health, then the situation will improve somewhat. But while the GOG has documented its priority for the health sector, it has yet to demonstrate financial commitment by increasing resources allocated to the health sector to a level comparable to other countries or those recommended by the WHO. Increasing the share of general revenues allocated to health/population has generally been a difficult task in developing countries.

If Government revenues remain flat, as predicted by most experts, any growth in the MSPAS budget will come at the expense of other Ministries. Since increasing the health budget is said to be a Government priority, it is hoped that health funding will not come at the expense of other social programs. Rather, budgets such as public companies or defense spending would be more appropriate targets.

FINANCING OF SERVICE DELIVERY

Sources

Various cost elements of health service delivery are financed by various sources:

- Salaries for core staff are supported by the MSPAS and paid by the MPF according to the Ministry of Reform payroll. The MSPAS has indicated its commitment to continue to support personnel costs. The staffing policy for an integrated health center is the following: one doctor, one midwife, two aides or nurses, one matron (generally paid with local resources), four ATS or other auxiliaries. However, in practice staffing patterns vary.

- Additional staff often are financed by the health center's local budget or by the prefectural government's budget.

- Capital improvements to infrastructure (and new infrastructure itself) are usually financed by NGO's, World Bank loans, donors and community initiatives. Often the community provides approximately one-third of the cost through in-kind labor. (Some health centers have been financed by U.S funds, including Peace Corps.)

- Marginal costs are virtually all financed by the clients themselves through the cost recovery component; the only operating costs not covered are health workers salaries. This is a major achievement of the program and one that is not replicated in many developing countries.

This represents a relatively diverse range of financial sources which is a positive indication of future sustainability.

Fees Charged

The pricing structure in health centers is based on a set of prices for standard diagnoses, with the fee paid covering both consultation and drugs. An average mark-up of 250% on drug costs was calculated to cover drugs and other operating expenses, with a maximum fee of GF 2400 in health centers.

On average, health centers' reserves are sufficient to cover their "incompressible"[2] cost for nine budget periods (six

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2 "Incompressible" costs include essential drugs, management tools (e.g., patient registers, reporting forms,and administrative materials), fuel for refrigerator and outreach activities.

months each or 4.5 years total) - without any further local revenue. On average, reserves are sufficient to cover "incompressibles" plus "other" costs for five budget periods (six months each or 2.5 years total). Health centers are authorized to program expending one-third of their reserves each period. As of December 1993, the total of reserve funds nationwide exceeds GF 1.7 billion.

An important aspect of the cost recovery program is that all revenue generated remains at the local level to be spent according to the budget established locally by the management committee. None of the funds are remitted to the central government treasury (as is often the case in other countries). There is some discussion of establishing a solidarity fund by requiring each health center to remit a small portion of their revenue to a central point which would then re-distribute the funds to assist health centers in poorer areas that were not breaking-even. However, this is yet to be implemented.

With each health center's management committee controlling funds generated, there is a legitimate concern with the potential for misuse of funds or outright embezzlement, particularly since some reserve funds exceed GF 25 million (USD 27,000). It is therefore interesting to note that Regional Inspectors are required to report systematically, at the semi-annual monitoring reviews, on any embezzlement of funds detected during supervision and the plans and progress in recovering funds. The Regional Inspector's report for Middle Guinea for 1993 indicates that GF 2.8 million was embezzled, representing 0.28% of receipts. Of this amount, GF 350,000 had been recovered, and steps were being taken to recover the rest. There is little doubt that abuse exists in a cost recovery system as decentralized as this one. However, the openness with which it is discussed, and the procedures in place to quantify and minimize its effects, are quite impressive.

Ability to Pay

Most service providers questioned said that fees charged for services posed a problem for some patients, but that the requirement to pay for services does not deter people from seeking and obtaining services. Reportedly, on rare occasions fees are waived, often the extended family assists with payment.

Nonetheless, while revenue collections are substantial, utilization rates were felt to be low in some of the regions (e.g., Upper and Middle). This suggests the question: is the current fee structure a more significant barrier to utilization than is believed? (Certainly other factors affect

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Other" costs include such elements as office furniture,motorcycle maintenance, travel, personnel incentives, cleaning and maintenance supplies, and contingencies.

utilization, including infrastructure, sanitation, the individual provider, etc.) If this might be the case, is the current fee structure contributing to the financial strength and financial sustainability of the system at the expense of better health outcomes which perhaps could be obtained if fees were lower and appropriate utilization higher?

The variability of utilization patterns indicates that the propensity to consume health services varies greatly by region, suggesting the need for an analysis of the price elasticity of demand. Such an analysis may be able to be conducted with data available for Conakry, but apparently not for other regions at this time.

In the final analysis, it appears that the cost recovery program is sufficiently well-established and successful in generating financing with which to assure supply of essential drugs, basic supplies, and motivation to personnel that it would be a mistake to make wholesale modifications to the scheme. The Guinea program has proved that an effective cost recovery system can be established and can contribute to improved quality of services. Nonetheless, it may be feasible to make marginal adjustments that could improve health status by increasing utilization without significantly undermining revenue generated to support operations through cost recovery. In fact, if fees are reduced but still maintained at a level which exceeds marginal cost of providing services, surplus revenue should increase rather than decrease from increased utilization.

Strengths

- The health care system is characterized by a variety of funding sources including government, donors, and users. Prospects for sustainability are thereby enhanced.

- The cost recovery system is successful in generating sufficient funds to cover the marginal costs of health center operations. This is an impressive achievement which many other countries, some at higher levels of development, have been unable to match.

Weaknesses

- GOG contributions to health care are well below internationally recommended levels.

- The MSPAS investment budget is heavily dependent on donor financing.

- Actual expenditures for health care have been consistently below budgeted levels.

Opportunities

- The GOG and its donors should fund those programs which leverage existing GOG, donor, and local resources; rather than creating new demands on scarce GOG resources.

- An investigation of the price elasticity of demand for health services in Guinea would lead to a variety of interesting findings; such as the contribution of cost of services to depressed utilization of services, and the possibility that price decreases could actually increase revenue through increased demand.

Threats

- Government financial resources may be sufficiently constrained that additional allocations for health are unlikely, or may be made only at the expense of other social programs.

- Any devaluation of the Guinean franc could have serious consequences for the recurring cost budget, which supports the procurement of imported goods.

- Conflicting estimates concerning the 1994 MSPAS recurrent cost budget raise questions regarding the ability of the MSPAS to cover operating expenses, meet conditions precedent for donor financing, and attract new donor funding.

5. Human Resource Development

Key Findings

The MSPAS has approximately 7,052 salaried employees as of January 1994; more than 5,900 were trained as service providers. Since 1992, approximately 77 employees have retired and 73 new employees hired. The majority of retirees were contractual support staff while the majority of new employees are service providers (76% physicians, midwives and health technology assistants). There is also an unknown number of contractual employees paid by health centers and hospitals out of revenues generated through the cost-recovery scheme, as well as at least 600 trained, non-salaried TBAs throughout the country.

Almost every major donor report since 1988 has emphasized the need for a rationalized system of personnel deployment, especially given the high percentage of physicians (45%) and midwives (55%) in Conakry and the comparative under-staffing of health centers outside of Conakry and the four regional capitals.

An important question is whether the existing numbers of personnel could fill the demands made by the current system

even if a re-deployment plan were fully implemented. A preliminary analysis (see Appendix IX) shows that the MSPAS cannot currently fulfill its own staffing requirements; and, given restrictions of the Structural Adjustment Program, numbers of personnel will not increase substantially in the next few years.

There are five institutions involved in the pre-service training of health care professionals: the School of Medicine (Conakry); a professional training center for midwives, registered nurses and public health aides (Kindia); and three secondary schools for health training auxiliary health workers.

The content of pre-service training requires some revision if it is to serve the goals of the National Health Sector Policy. Pedagogical materials have not been reviewed or revised in at least six years, and do not reflect priorities of the GOG--curriculum and practical training are oriented to hospital-based curative as opposed to primary and preventive care. Many older providers claim that those graduating now have less practical experience than when the schools were based in Conakry, and therefore younger agents require much more formal and informal in-service training.

Approximately 60% of current MSPAS service delivery personnel have been trained for the PHC program, with a heavy emphasis on EPI and management of essential drugs. By comparison, only about 6% of current MSPAS staff have received training in contraceptive technology or family planning management or IEC. Much of the in-service training to date has been "cascade training" (i.e., selected service providers are trained in particular aspects of service provision, and are then expected to pass these skills on to their colleagues at the service delivery point). Although the costs are low, the results are uneven at best and often unsatisfactory. Training is oriented only toward <u>service delivery</u>; those who are expected to pass on their skills are not trained as <u>trainers</u>. In addition, supervisors often have received different training than those they supervise, and sometimes have not received any training in new elements of the PHC program. Development of a group of health trainers has begun, but efforts have been mostly limited to the central level.

A. Personnel Management/Deployment

<u>Strengths</u>

- The MSPAS Health Sector Policy places a major emphasis on human resource development including implementation of a Re-deployment Plan based on population-based needs assessments, norms and job descriptions, development of human resource use policies and development and implementation of career planning.

- Plans for in-depth studies and options analyses for personnel incentives have been developed.

Weaknesses

- Job descriptions are generally lacking throughout the personnel system. There is thus no formal means of identifying and prioritizing tasks for employees.

- There are insufficient staff employed by the MSPAS to fulfill its existing staff requirements, even if personnel were rationally re-deployed from relatively over-served areas (e.g. Conakry) to relatively underserved areas.

- Major re-deployment is likely to prove difficult unless some system of incentives for service in underserved areas is introduced.

- Current reliance, in many prefectures, on supervision by a single person is not functional, especially in prefectures with many health centers.

- MSPAS managers at the prefectural and regional levels have, at present, no discretionary powers in personnel matters; including hiring/termination or staffing patterns.

Opportunities

- Assistance to the central government for the design of studies and analysis in the areas of personnel deployment, compensation, and training would begin to address key problems in these areas. Although World Bank documents indicate support for implementation of re-deployment and personnel policy development, additional technical assistance may be required to continue administrative reform and functional implementation of the reforms.

- Implementation of decentralized authority in the area of personnel could considerably enhance operating efficiency, program effectiveness, and worker motivation.

Threats

- Many personnel-related problems are sufficiently intransigent, both for practical and political reasons, that there is real danger of wasting effort on the development of more policies that will not be implemented. The first step should therefore be identification of achievable reforms.

B. Pre-Service Training

Strengths

- Training institutions for auxiliary workers are regionally-based, thus increasing the likelihood that trainees will remain in the regions to work--assuming that personnel management is effectively decentralized.

- An impressive effort to provide physicians-in-training with appropriate exposure to PHC and preventive health led to the program at the Rural Health Training Center in Maferinyah, where most medical students spend part of their final year.

Weaknesses

- The public sector has employed less than 5% of those graduated from all five pre-service training institutions since 1991. The remaining 95% seek employment in private sector health programs, although it is believed that the majority work outside of health care or are unemployed.

- Training curricula have not been revised in at least six years, and thus do not reflect current knowledge or program priorities.

Opportunities

- Strengthening existing indigenous pre-service training institutions, curricula and related systems could reduce reliance on donor assistance in this area.

Threats

- Reductions in Ministry of Education staffing and funding levels in concerned departments, the inability to coordinate efforts with MSPAS, and the geographical difficulties involved in working in five different cities, all pose substantial threats to improvements in this area.

C. In-Service Training

Strengths

- The MSPAS has committed to decentralization of in-service training, based upon the establishment and support of multi-disciplinary regional and prefectural training teams. An updated National Health Training Plan is currently being developed -- the original Plan (IDA, 1989) was not operationalized.

Weaknesses

- Until training resources are sufficient, the PHC program cannot meet its objectives in a cost-effective way and continued reliance on "cascade training" will not produce the desired results.

- A major review/revision is needed of the nationally-used training modules for contraceptive technology, family planning management and IEC.

- Management and supervision training needs to be strengthened. Review of current training modules and techniques and development of explicit checklists might improve consistency of supervision and impact.

Opportunities

- Operations research could demonstrate the differential effectiveness of supervision teams in various prefectures as a means of improving supervisory performance.

- Curriculum changes need to be made to reflect current MSPAS policy and programmatic emphasis. This would be facilitated by institutionalizing a collaboration process for curriculum review between the Ministry of Education and the MSPAS.

- A major opportunity for a donor exists to support the MSPAS as it decentralizes training capabilities, simultaneously emphasizing the development of training skills while reinforcing technical skills and use of algorithms. Since many of the potential members of a prefectural training team also perform supervisory functions, support designed at improving training can also improve both the content and style of supervision.

Threats

- Any continued delay in the process of decentralization poses a major danger for the success of efforts to improve in-service training.

D. SUMMARY OF SELECTED DONOR ACTIVITIES

1. UNICEF

UNICEF has been the principal donor providing assistance to the primary health care integration effort nationwide. Funding has been provided for the costs associated with integrating health centers into the system, essential medicines, and the costs associated with supervision of the program. It is anticipated that UNICEF assistance will be reduced beginning in 1995 -- the extent to which the cost recovery system can support drug procurement and distribution needs careful investigation and planning.

2. UNFPA

UNFPA is in the midst of a major program of assistance designed to integrate family planning into health centers in Middle and Lower Guinea.

- A four year (92-96), $6 million project with the following objectives:

  1) establishment of a population policy
  2) improvement of quality and accessibility of FP services (targets: services in 362 health centers, and 15% prevalence)
  3) improvements in the status of women, including education and reproductive health

- Geographic focus: Middle and Lower Guinea, Conakry. The health center at Coronthie (Conakry) is their training and referral center.

- Individual projects planned under the grant are:

  1) Integration of FP into 100 health centers, including training of staff; provision of equipment, supplies, contraceptives, and monitoring tools; IEC activities in the community; and integration of STD/AIDS prevention. ($1,200,000)

  2) Formulation of the Population Policy, and associated activities (training for leadership, donors' conference, etc.) ($1,400,000)

  3) Demographic data collection and analysis ($850,000)

  4) Development of training materials and curricula for population education; provide training to school directors, central and regional education coordinators; introduce population education in primary schools; production and distribution of mass media materials. ($785,000)

5) Development of FP IEC materials and programs for education of local and regional community leaders and the general public. ($400,000)

6) Women and development project: support for the Direction of Women's Affairs; sensitization of leadership; integration of FP training in the Center of Women's Promotion; development of the Family Code; support of income generating activities of NGOs. ($500,000)

3. World Bank

The World Bank has historically financed, through credit programs, the construction and renovation of health facilities, including both hospitals and health centers. It has recently completed plans for a new credit program totalling $24.6 million over 6 years designed to: 1) expand coverage and improve quality of health, nutrition and family planning service delivery systems; and 2) improve sector organization, management and resource mobilization. The request for approval was submitted on 7 February '94.

- Geographic focus: Middle Guinea (three prefectures) and Lower Guinea (four prefectures).

- Key elements:

  1) rehabilitation, construction and maintenance of 20 health centers, two improved health centers, and four hospitals ($11.5 million);
  2) procurement of drugs, vaccines, and materials ($3.3 million);
  3) training, technical assistance, equipment, and operating costs to support programs ($2.2 million); and
  4) other infrastructure development and management improvements (construction and/or renovation of management/supervisory facilities; management training; and support for development of cost recovery -- $9.7 million). This last element will include assistance to 18 prefectures and is specifically intended to encourage and support decentralization efforts.

- Project includes the co-financing of a "coordination workshop" for key GOG and donor community players.

Many of the health facilities renovated by the Bank in Lower and Middle Guinea remained underutilized. While the reasons for this are many and complex, it is felt that a key element missing from the program is intensive, on-site technical assistance, both clinical and managerial.

4. GTZ

For ten years, GTZ has provided assistance in health programs, as part of a larger development assistance effort, in Gueckedou and Kissidougou prefectures in the Forest Region. This assistance, while limited geographically, has been intensive in nature, including both infrastructure development and long-term, on-site technical assistance. GTZ plans to replicate this assistance effort in Faranah beginning later this year.

5. KFW

KFW has just completed (in March 1994) a proposal which will co-finance, with UNFPA, the integration of family planning in 110 health centers in Lower and Middle Guinea. This project is scheduled for 1994-1998, at a total cost of $2.8 million of which $2.2 million will be financed by KFW grants and $600,000 by UNFPA. An additional $300,000 is to be contributed by the GOG.

Major funding categories are construction, equipment, and vehicles (35%), contraceptives (18%), training and technical assistance (16%), IEC development (14%), and operating costs (16)%.

V. CONCLUSIONS

The preceding analysis describes a public health care system that has accomplished a great deal in a brief period of time, that has the potential to continue to grow, and that can be complemented by health services delivered through the private sector; but which faces a number of very serious problems which, if not positively confronted, could undermine the significant achievements of the past decade.

Certainly the most important and obvious conclusion to be drawn from this analysis is that the Guinean people suffer from a variety of serious health problems -- some health indicators are among the worst in the world. In a wide range of program areas -- child survival, maternal health, nutrition, family planning, STD/HIV/AIDS -- there are numerous opportunities to improve existing programs and to launch new initiatives. The key questions revolve around how such assistance should be designed and targeted.

The most important conclusions that the assessment team has reached can be grouped in four broad areas:

1. The strengths of the system;

2. The problems associated with future financing;

3. The importance of the decentralization process;

4. The problems associated with under-utilization of the system.

<u>The Strengths of the System</u>

- The leaders of the public health care system in Guinea recognize that they own and operate the system. While the critical importance of donor funding and technical assistance is well understood, there is in no sense an abdication of responsibility for the design, implementation, or ultimate success or failure of the system. The Guinean leadership continue to pro-actively design a series of programs that are uniquely their own. This sense of ownership and responsibility should facilitate the tough decision-making necessary for success.

- The framework of the system -- central management; regional management and hospitals; and prefectural management, hospitals, health centers, and health posts -- provides a rational structure upon which to build an effective health delivery system. To be sure, there are management and clinical problems at every level. But since the longest journey begins with a single step, it is encouraging that the basic structure is sound.

- The cost recovery system, which predates the Bamako Initiative, actually performs its purpose; and consequently, greatly improves prospects for sustainability of the program. At the health center level, medicines and services appear to be priced within the reach of a significant proportion of the population, and these centers are by and large covering their operating expenses from these fees.

- Private sector health care providers have the collective potential to reach large numbers of clients, and can fill coverage and programmatic gaps in the public health system. Mobilizing the private sector for widespread impact, however, could prove to be administratively challenging; since few organizations serve large numbers of people.

Future Financing

- The amount of money being made available for health care from the national budget is difficult to ascertain: amounts actually expended are generally well below budgeted figures; and often conflicting budget and expenditure information is obtained from various sources. For example, two knowledgeable sources -- one from the MSPAS and the other from the Ministry of Plan and Finance -- provided very different budget figures ($3.5 million vs. $415,000) for the 1994 MSPAS recurrent cost budget, exclusive of salaries.

- Even if higher estimates are correct, expenditures for health as a percentage of the national budget are still well below international recommendations, and below expenditure levels for many other countries in the region.

- UNICEF, which has been the principal donor supporting the primary health care system, will reach the end of its current funding cycle in 1995. While the nature and level of continuing support has not been determined, there is a strong likelihood of a reduced level of funding. It is unclear how the MSPAS would cover any loss of UNICEF support.

- For 1993 and 1994, the proportion of the MSPAS recurrent cost budget which was or will be expended on imported goods and services is approximately 67%. If there were to be a significant currency devaluation, as has recently occurred in neighboring CFA countries, the purchasing power of the budget would be seriously compromised.

- While examination of the entire national budget of Guinea was well beyond the scope of this assessment, there are indications that allocation of resources on the national level may be a zero-sum game. If additional GOG allocations are forthcoming for health care, this might well be at the expense of other important social programs, such as education or agriculture.

- The imminent launch of the new Central Pharmacy system raises questions with important implications for health financing. If Central Pharmacy operating costs require increases in costs of essential medicines, these costs would have to be covered by higher consumer costs or GOG subsidies. Higher consumer costs could reduce demand for services, while government subsidies would have to be found in an already woefully inadequate budget.

- Clearly, the level of expenditures on health care is of critical importance -- the health care system could well be approaching a financial crisis. Given all of the uncertainties involved, future developments should be followed closely.

Importance of Decentralization

- Given the scarcity of resources available for health care from the Guinean government, it is critical that resources be utilized in the most efficient and effective ways. While decentralization does not guarantee success, there are a number of compelling arguments which suggest that a transfer of decision-making and budget authority in key areas away from the central MSPAS to the regional and prefectural levels could result in substantial gains in program effectiveness.

- Among the most important problems for health care delivery are human resource shortages and inequitable personnel deployment. Because budget constraints so severely limit prospects for new hiring, and because deployment problems are very difficult to solve in the short run, it is very important that existing staff be directly responsive to their immediate supervisors.

- Guinea is characterized by a high degree of geographic and ethnic diversity. Flexibility in staffing patterns and in program design is needed to address particular problems of the various regions and groups of people. Effective decentralization would give regional and prefectural managers this flexibility.

- The central level of the MSPAS has substantial management and technical problems, solutions to which are critical to the success of the program. These include the launch of the Central Pharmacy, improvements in financial management, and strengthening the data analysis and research capabilities of the BEPR. Decentralization of personnel and operating expense functions would allow central management to concentrate on a relatively smaller number of issues, and thereby give greater attention to these critical problems.

- Central MSPAS leadership has spoken strongly in support of decentralization, and this is most encouraging. There has, however, been substantial pressure to decentralize both from the regional and prefectural levels of the MSPAS as well as from the donor community. MSPAS leadership needs to quickly demonstrate its commitment through actual transfer of authority to the field level.

- Some regions and prefectures appear to be better equipped than others to take on greater managerial and financial responsibilities. The MSPAS and the donor community need to be aware of these differences, so that appropriate technical assistance can be provided and so that the lessons learned in better-performing areas are used in improving the system as a whole.

- The field-level implementation of decentralization will not be a simple process. There are numerous administrative and financial procedures to be worked out and field tested -- e.g., flow of funds, payroll procedures, hiring/termination procedures, delineation of regional vs. prefectural responsibilities, etc. The MSPAS and donors supporting the process might be wise to decentralize with <u>deliberate</u> speed, perhaps establishing several model decentralized prefectures as a way of testing new policies and procedures.

<u>Under-utilization of the Health Care System</u>

- Much has been written, by this assessment team and others before it, of the success Guinea has experienced in its integration of primary health care and implementation of the principles of the Bamako Initiative. At the same time, it is widely recognized that, in general, this primary health care system remains <u>under-utilized</u>. In considering this apparent paradox, it is important to understand that the success of the system is largely measured against the virtual lack of primary care services and complete lack of cost recovery only ten years ago. Thus, the MSPAS has successfully launched a program and has made much progress -- but large numbers of Guineans still either cannot or choose not to avail themselves of the services offered.

- It is important to note that utilization appears to be variable across levels of the system (e.g. health centers appear to be more highly utilized than are hospitals), and across geographic areas (e.g., health centers and hospitals visited in Forest Guinea had substantially higher caseloads than in Middle and Upper Guinea). Uncertain data quality and limited data analysis (discussed elsewhere in this report) make these anecdotal observations impossible to quantify and verify.

- The reasons for this under-utilization are surely numerous, and have not been systematically studied. Based purely upon observation (and some speculation), this assessment team believes the most important factors to be the following:

  - Lack of **knowledge** among the population of the importance of primary health care, and of what the PHC system has to offer.

  - Lack of **accessibility** of services: transportation is extremely difficult in Guinea because of lack of transport and poor roads. Many Guineans may not use public health facilities simply because it is so difficult to get there.

  - Lack of **trust and confidence** in the system. It is likely that many Guineans have not had high quality interactions with the formal health care system. Even in integrated centers, the quality of care very often leaves much to be desired.

  - Lack of **money** to obtain care. This is the other side of the coin of the Bamako Initiative. While the elasticity of demand for health care services in this population is not known, there are surely a significant number of Guineans for whom the modest fees for services and drugs pose a major barrier to care. Health centers and hospitals routinely report that they provide care for the indigent at no cost, but many of the indigent may never come.

  - Guinea also remains a highly **traditional** society (or, perhaps, a collection of highly traditional societies). Many people may seek care from traditional practitioners, or from no one at all. It is said, for example, that many births are unattended because women are expected to deliver their babies alone, receiving assistance only after the cord has been cut.

- Determining the relative contribution of each of the above factors to the general problem of low utilization is an important and difficult research task. The apparent variability in utilization across regions and prefectures noted earlier may provide an opportunity to gain some insight through operations research: An examination of a sample of high- and low-volume centers could identify key differentiating factors.

- Clearly, there is much that can be done at the service delivery level to improve utilization. Community education efforts, continued integration of health centers, improvements in the quality of service delivery, and critical examination of the role of cost of services (with possible introduction of special services for the poorest Guineans) should all lead to increases in the number of people who seek care.

- There are also opportunities to reach certain populations and to deliver special services, such as family planning, through private sector providers.

STRATEGIC OPTIONS

A presentation of programmatic options for future health and population program development

HEALTH AND POPULATION ASSESSMENT

REPUBLIC OF GUINEA

MARCH - APRIL 1994

CONDUCTED BY:

SEATS/JSI

in collaboration with:
BASICS
WINS

This report presents the findings and analysis of a contracted assessment team. It does not represent the opinions, recommendations, or commitments of USAID/Guinea or the United States Government.

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STRATEGIC OPTIONS FOR FUTURE PROGRAM DEVELOPMENT

In March - April 1994, a team of consultants conducted a health and population sector assessment in the Republic of Guinea, at the request of USAID/Guinea. The purpose of that assignment was analytical in nature -- to provide USAID with a clearer view of the nature and extent of health and family planning problems in the country, and with an analysis of the various institutions that contribute to the delivery of services. The team was specifically not requested to identify or begin any development of a potential USAID health or population project. Indeed, at the time of the assessment, USAID had not yet decided if it will continue to provide major support in the health sector after the completion of its present project.

Nonetheless, in the course of its work, the assessment team naturally identified particular areas of need; and, being composed of individuals with strong programmatic orientations, the team had various ideas for program interventions that might address those needs.

Based upon its analysis, (which can be found in the separate report entitled "Health and Population Sector Assessment April - May 1994") the assessment team identified a number of programmatic options that USAID (or other donors) might wish to consider in any development of future projects in health and/or family planning. These are summarized in the following pages.

This is by no means an exhaustive list -- there are many other worthwhile activities that could be undertaken. For example, USAID could opt to continue its successful support to HIV/AIDS prevention and family planning promotion, presently being undertaken in collaboration with Population Services International and AGBEF. We have attempted to identify some of those important programmatic areas that would represent new areas for USAID support.

Some of the options are very broad and ambitious in scope, while others are relatively modest in terms of required inputs and breadth of impact. Some would require major investments of time and energy merely to develop as fully conceptualized project proposals. All would obviously require much more thought and refinement. The aim in this document is simply to present a series of ideas that the assessment team hopes will be useful to those who will continue the important work of improving health care in Guinea.

EXPANSION OF FAMILY PLANNING SERVICE DELIVERY

OPTION: Assist in the integration and ongoing support of family planning activities into PHC program health centers.

STRATEGIC IMPORTANCE:

Family planning is the missing component in the minimum package of services provided by the health centers.

ANTICIPATED IMPACT:

Family planning services would be available in a greater number of service delivery sites. The number of contraceptive users would increase and the quality of services provided would be improved.

POSSIBLE AREAS OF INTERVENTION

- Training of health center personnel in supervision, contraceptive technology, program management
- Provision of clinical equipment and contraceptives
- Assistance in logistics management
- Renovation of health centers
- IEC materials development
- Information and education outreach
- Improvement of interpersonal communication skills for health workers
- Development/improvement of management tools
- Procurement of vehicles and fuel

ANTICIPATED SUSTAINABILITY:

Health center budgets will be used to buy contraceptives and to pay for the marginal costs of center operations. Costs of any renovation, training, and technical assistance would be non-recurring following the project period.

GEOGRAPHIC FOCUS:

Conakry and other selected prefectures (family planning acceptance is likely to be highest in urban areas for the near term).

TECHNICAL ASSISTANCE NEEDS:

A contractor would be in charge of procurement, training, technical assistance and general program management.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

1. Availability of a contractor.

2. Adequate functioning of contraceptive logistics system through the Central Pharmacy.

3. Decentralization of personnel and budget authority to those prefectures selected would enhance the effectiveness of this program.

4. Special care should be taken in determining geographic focus, given the often limited success of large-scale family planning projects in other low prevalence countries.

"MODEL DECENTRALIZED PREFECTURE" DEMONSTRATION PROJECT

OPTION: Provide wide-ranging, intensive, long-term financial and technical resources to create one or more "model decentralized prefectures".

STRATEGIC IMPORTANCE:

1. The long-term effectiveness of the GOG's primary health care program depends, in large part, on the successful decentralization of personnel and budgetary control to the regional and prefectural levels. This process requires the active support of donor agencies.

2. Experience has shown that the most successful prefectures in the primary care system are receiving intensive support from a donor agency.

ANTICIPATED IMPACT:

Service delivery systems, and therefore health outcomes, would improve in the target areas to a greater degree than in non-target areas. The success of the decentralized model would be demonstrated, thereby increasing the government's willingness to decentralize nationwide.

POSSIBLE AREAS OF INTERVENTION

- Training of prefectural and health center personnel in supervision, clinical skills, program management
- Provision of clinical equipment
- Assistance in logistics management
- Renovation of facilities
- On-going clinical and management TA

ANTICIPATED SUSTAINABILITY:

This would require a ten-year program of assistance from the donor, and would be quite expensive. This type of intensive provision of resources would not be sustainable without outside assistance, but the existing system should be sufficiently improved by the end of project so that the improvements would sustain themselves.

TIMING ISSUES:

A project of this magnitude would require considerable time for negotiation and planning.

GEOGRAPHIC FOCUS:

Prefectures selected according to some set of criteria increasing likelihood of success -- e.g., existing renovated facilities, opportunities for synergistic inputs (USAID education target areas, or areas where other donors provide complementary inputs), proximity to existing "success stories" like GTZ-assisted prefectures, etc.

TECHNICAL ASSISTANCE NEEDS:

Long-term, on-the-ground technical assistance by a multi-disciplinary team is essential.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

1. Willingness of the GOG to make resources and authority available to selected prefecture(s).

2. Properly functioning Central Pharmacy..

IMPROVEMENT IN CHILD SURVIVAL PROGRAMS

OPTION: Provide assistance to the national Plan of Action program for child survival, which is a subset of the more comprehensive PHC program.

STRATEGIC IMPORTANCE:

Child mortality, 250/1000 live births, is very high, being surpassed in sub-saharan Africa only by Guinea Bissau, Sierra Leone, Mozambique, Angola and Niger. Guinea's strategy is coordinated with the international priority goals of reduction of neo-natal tetanus, poliomyelitis, measles and micro-nutrient deficiencies. Reduction of high child mortality has been shown to be an important determinant of the success of family planning programs in "emergent" countries.

ANTICIPATED IMPACT:

Proven cost-effective interventions exist for the diseases responsible for about 2/3 of under five mortality. Included are vaccine preventable diseases (particularly measles), ARI, malaria, dehydrating diarrhea and malnutrition.

ANTICIPATED SUSTAINABILITY:

Three programs supported by the CCCD project have already achieved some degree of sustainability; EPI, malaria and diarrheal diseases. Programs for ARI and micro-nutrients (Iodine and Vitamin A) are just now being launched.

TIMING ISSUES:

A "round table" is planned for mid-1994, the purpose of which will be to identify and coordinate foreign assistance needed to support the national PHC program. This meeting should prove very important, given possible changes in the nature and level of UNICEF support to this program.

GEOGRAPHIC FOCUS:

While it is true that the "prefecture" is a priority focus for assistance, sustainability requires that needs be addressed at all levels, from the community to Conakry. New programs require relatively more assistance at the national level.

TECHNICAL ASSISTANCE NEEDS

Support activities for these programs including operations research, training, supervision, IEC, information systems, management and epidemiological surveillance.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

1. High commitment of the GOG to the program

2. High interest and commitment of the international community (NGO's, UNICEF, USAID, WHO, World Bank, other bilateral assistance)

3. Strategies developed that address important issues such as internationally accepted norms, measurable objectives and milestones, effective decentralization, increased community participation, partnerships with the private sector, long term sustainability

4. AID supports projects that can provide assistance; BASICS, OMNI, WIN, etc.

IMPROVING MATERNAL REPRODUCTIVE HEALTH

OPTION: Provide assistance to two national programs that are complementary to family planning and necessary for reproductive health: STD/AIDS and safe motherhood.

STRATEGIC IMPORTANCE:

At an estimated level of 900/100,000 live births, maternal mortality is extremely high. STDs are widespread and have an impact on both maternal and child health and the success of family planning. The prevalence of AIDS is currently low, but the disease alone and in combination with tuberculosis represents an important public health threat.

ANTICIPATED IMPACT:

There is no simple cost-effective intervention. No vaccine or effective treatment for AIDS is anticipated in the near future. Diagnosis and treatment of STD's requires minimal laboratory services and antibiotics. The development of resistance to antibiotics is also a problem. Our best strategies include IEC aimed at behavioral change and the widespread availability of condoms which not only help prevent diseases but also unwanted pregnancies.

ANTICIPATED SUSTAINABILITY:

Since the safe motherhood and STD/AIDS programs are just beginning it is difficult to assess either long-term costs or prospects for sustainability. Clearly, however, primary care in these areas is less expensive than curative interventions and other costs associated with these health problems.

TIMING ISSUES:

Strategies and work plans exist for the staged integration of these programs into the PHC system, starting now.

GEOGRAPHIC FOCUS

While it is true that the "prefecture" is a priority focus for assistance, sustainability requires that needs be addressed at all levels from the community to Conakry.

TECHNICAL ASSISTANCE NEEDS

Support activities for these programs including operations research, training, supervision, IEC, information systems, management and epidemiological surveillance.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

1. Guinea is receiving support from WHO's Global Program on AIDS.

2. UNDP may provide support to the safe motherhood initiative

3. AID supports projects that can provide assistance; AIDSCAP, PSI, etc.

STRENGTHEN THE CENTRAL PHARMACY

OPTION: Assist the Central Pharmacy in the design and/or development of adequate logistics, financial, and other administrative systems.

STRATEGIC IMPORTANCE:

The Central Pharmacy is a newly created entity and its strengths at this point are unknown, but any weaknesses will negatively impact the PHC program.

ANTICIPATED IMPACT:

By strengthening the Central Pharmacy's capabilities, the likelihood of drug and contraceptive stock-outs can be minimized, and the overall costs of the system can be kept lower.

ANTICIPATED SUSTAINABILITY:

The Central Pharmacy will have its own budget, and in principle, self-sustaining. Investments in technical assistance up front are likely to reduce costs of inefficiencies later.

TIMING ISSUES:

Assistance would be needed as soon as possible after responsibilities have been transferred to the Central Pharmacy.

GEOGRAPHIC FOCUS:

National -- Central and regional facilities.

TECHNICAL ASSISTANCE NEEDS:

AID funds a contract, the Family Planning Logistics Management (FPLM) Project, which specializes in contraceptive logistics management. This project should be contacted for possible coordination of technical assistance needs.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

1. If possible, Guinea should be added to the list of FPLM priority countries.

2. Other donors assisting Central Pharmacy (e.g. ADB) should be contacted to coordinate assistance.

STRENGTHENING THE BEPR

OPTION: Enhance the independent research capability of BEPR.

STRATEGIC IMPORTANCE:

At this stage of the PHC program, there is a need for an improved management information system and operations research capability to help define and solve problems, and implement new programs. There is a lack of skilled personnel to coordinate these research activities.

ANTICIPATED IMPACT:

By strengthening the BEPR, its ability to undertake much needed research initiatives will be increased. With research findings the MSPAS will be better equipped to manage their programs.

POSSIBLE AREAS OF INTERVENTION

- Training of personnel
- Provision of equipment
- Establishment of a health research center which would be responsible for collecting and housing copies of reference materials related to health in Guinea.
- Dissemination of research results

ANTICIPATED SUSTAINABILITY:

Operations research can be done at all levels of the health system at a relatively low cost. Government or community health centers can allocate funds for some type of research.

GEOGRAPHIC FOCUS:

Central Level

TECHNICAL ASSISTANCE NEEDS:

An AID contractor would need to be responsible for assessing training needs and arranging for appropriate training programs.

RELATIVE IMPORTANCE/PRIORITY:

Medium

ENABLING CONDITIONS:

1. Availability of AID contractor.

2. Discussion with other donors interested in assisting BEPR (e.g., French and German aid organizations).

DEVELOPMENT OF REGIONAL/PREFECTURAL TRAINING CAPABILITIES

OPTION: As the MSPAS decentralizes, it will need support in the development of regional and prefectural training teams which will be important factors in the improvement of quality of care.

STRATEGIC IMPORTANCE:

The centralized approach to training, which has emphasized clinical training but not the training of trainers, has not served Guinea well. The MSPAS commitment to decentralization provides the opportunity to develop effective training teams throughout the country.

ANTICIPATED IMPACT:

Regional and prefectural training teams, with both clinical and pedagogical skills, would provide a resource for the improvement of clinical practice and supervision.

ANTICIPATED SUSTAINABILITY:

The decentralized, team approach to training would assure that clinical and training capabilities would not be lost through staff retirement or transfer. Since teams would be trained as trainers, the system would be relatively self-sustaining in terms of personnel.

GEOGRAPHIC FOCUS:

National

TECHNICAL ASSISTANCE NEEDS:

Assistance in curriculum review and redesign, and in the initial round of training would be needed. Some resources (e.g. Ministry of Education for pedagogical skills) are available locally.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

Continued commitment to decentralization from the MSPAS.

PRIVATE SECTOR FAMILY PLANNING PROMOTION

OPTION: Create a grants program to fund family planning activities in the non-governmental sector (e.g., private and para-statal health facilities, commercial organizations with health facilities, NGOs, and the traditional sector). A grants review committee might be composed of representatives from the GOG, the private sector community, the donor, and a contractor responsible for managing the program.

STRATEGIC IMPORTANCE:

The private sector presently plays a very limited role in the delivery of FP services. Creation of a grants program would take advantage of the entrepreneurial nature of the sector, while alleviating some of the difficulties inherent in mobilizing the large number of relatively small institutions involved.

ANTICIPATED IMPACT:

This program would assist in extending FP services to that significant portion of the population which obtains health services from private sector providers; would address specific issues unique to the private sector; and would provide a mechanism for involving a wide variety of organizations in FP service and support.

ANTICIPATED SUSTAINABILITY:

Sustainability of specific projects would vary depending on their nature; however, some successful private sector activities are sustainable virtually by definition (e.g., addition of FP services to commercial health services following demonstration of health and economic benefits to managers).

GEOGRAPHIC FOCUS:

National

TECHNICAL ASSISTANCE NEEDS:

A contractor, perhaps a local NGO, would have responsibility for assisting potential grantees in proposal preparation, providing technical assistance to ongoing projects, and managing the grants program.

RELATIVE IMPORTANCE/PRIORITY:

Medium high

ENABLING CONDITIONS:

1. A reliable source of contraceptives (i.e., a functional Central Pharmacy).

2. Availability of an organization to manage the program--either an outside contractor or additional resources within USAID itself.

TRAINING OF PRIVATE SECTOR PROVIDERS

OPTION: Provide short term training to private sector health care providers in some or all of the following areas: family planning technology, management of FP programs, IEC/counseling, prevention and treatment of STD/HIV/AIDS, laboratory techniques, and logistics management and statistics.

STRATEGIC IMPORTANCE:

The private sector presently plays a very limited role in the delivery of FP services, but has potential to reach a significant client population.

ANTICIPATED IMPACT:

This program would assist in extending FP services to that significant portion of the population which obtains health services from private sector providers; and -- because some private sector sites represent the most sophisticated medical facilities in the country -- could eventually produce excellent training facilities for both public and private sectors.

ANTICIPATED SUSTAINABILITY:

Private sector health providers tend to be stable in their jobs to an extent not seen in the public sector. Thus, individuals trained in this program would be likely to sustain the resulting service delivery, and perhaps to pass their skills on to colleagues over an extended period of time.

GEOGRAPHIC FOCUS:

National

TECHNICAL ASSISTANCE NEEDS:

Technical assistance in training might be necessary until effective local training teams with time for this type of activity became available.

RELATIVE IMPORTANCE/PRIORITY:

Medium

ENABLING CONDITIONS:

1. Existence of national training capability

INSTITUTIONAL STRENGTHENING OF AGBEF

OPTION: Provide technical assistance to AGBEF in improving: management systems and practices; supervision practices; IEC materials and health education techniques; and the quality of clinical services.

STRATEGIC IMPORTANCE:

Although AGBEF has a leadership position in the promotion and provision of family planning services, it suffers from a variety of technical and managerial weaknesses. If AGBEF is to take on an expanded service delivery role, these problems must first be addressed.

ANTICIPATED IMPACT:

Improved management and clinical practices, enabling AGBEF to better manage its current portfolio and to absorb additional activities.

ANTICIPATED SUSTAINABILITY:

This type of assistance, aimed at improving management capacity, is short-term in nature. It should enable the organization to make better use of available resources and to generate additional income from a variety of sources.

TIMING ISSUES:

Improvements in management capacity should precede any significant additions to AGBEF's current project portfolio.

GEOGRAPHIC FOCUS:

National

TECHNICAL ASSISTANCE NEEDS:

International TA would be required for a detailed needs assessment, design of an assistance package, and for provision of specific technical inputs.

RELATIVE IMPORTANCE/PRIORITY:

Medium high

ENABLING CONDITIONS:

Openness of AGBEF management to critical review of

EXPANSION OF PHARMACIES' ROLE IN PHC

OPTION: Provide training and technical assistance to pharmacists in: contraceptive technology, STD/AIDS prevention, IEC and social marketing techniques for appropriate products.

STRATEGIC IMPORTANCE:

Pharmacists are often clients' first line of contact with the health care system. In some areas, they are more accessible than health centers. Pharmacies represent an important source of information and service for FP and STD/HIV/AIDS prevention.

ANTICIPATED IMPACT:

There are 183 pharmacies distributed throughout Guinea. Building on the excellent penetration achieved by the PSI social marketing project, this network could be utilized to deliver a wider range of socially marketed products (e.g., pills and impregnated mosquito nets), as well as health education messages.

ANTICIPATED SUSTAINABILITY:

High likelihood of sustainability in accordance with supply and demand.

GEOGRAPHIC FOCUS:

National

TECHNICAL ASSISTANCE NEEDS:

The continued assistance of a contractor experienced in social marketing would be necessary for this activity.

RELATIVE IMPORTANCE/PRIORITY:

Medium

ENABLING CONDITIONS:

1. Functional contraceptive supply system.

2. GOG approval for social marketing of additional products.

3. For the social marketing of oral contraceptives, significantly increased demand for pills will probably be necessary for economic viability.

EXPANSION OF LONG-TERM FAMILY PLANNING METHODS

OPTION: Assist in strengthening voluntary surgical contraception (VSC) capabilities.

STRATEGIC IMPORTANCE:

The early introduction of permanent and long-term contraception in young programs has been shown to increase overall program performance. VSC has already been introduced in Conakry and two other regional hospitals. However, its performance is hampered by a shortage of competent personnel, equipment and supplies.

ANTICIPATED IMPACT:

Immediate service to those clients requesting a long-term or permanent method, and overall increases in family planning program performance.

POSSIBLE AREAS OF INTERVENTION

- Training of personnel in VSC/minilap and counselling techniques
- Provision of equipment
- Introduction of Norplant

ANTICIPATED SUSTAINABILITY:

This activity could possibly be supported by regional hospital budgets in the future. Subsidies for equipment maintenance and perhaps to reduce costs to clients in the short-term would probably be necessary.

GEOGRAPHIC FOCUS:

Regional hospitals and major private institutions

TECHNICAL ASSISTANCE NEEDS:

An AID contractor (e.g. AVSC, JHPIEGO) would be responsible for technical assistance in training and performing services. It will also be their responsibility to procure the necessary equipment.

RELATIVE IMPORTANCE/PRIORITY:

Medium high

ENABLING CONDITIONS:

1. Availability of the AID contractor

STUDY OF PRICE ELASTICITY OF DEMAND FOR FAMILY PLANNING SERVICES

OPTION: Conduct a study or studies to determine: the extent to which demand for family planning services may be depressed by the price levels currently charged; to develop a model for the degree to which utilization might increase as a function of reductions in price; and to analyze the potential effects of such price decreases on health center budgets.

STRATEGIC IMPORTANCE:

While the PHC cost recovery program has been successful in generating revenue to cover operating costs at many health centers, there is legitimate concern that some segments of the population may be unable to afford services. This may be particularly true for services which may be viewed as "discretionary", such as family planning.

ANTICIPATED IMPACT:

An improved understanding of the relationship between family planning use and cost of services could lead to a more rational pricing policy, improved accessibility, and higher rates of acceptance.

ANTICIPATED SUSTAINABILITY:

Questions of sustainability are not applicable to the research itself, although the results could contribute significantly to program sustainability.

GEOGRAPHIC FOCUS:

Sample(s) should be representative of the nation as a whole.

TECHNICAL ASSISTANCE NEEDS:

Outside technical expertise would be required in all phases of the research.

RELATIVE IMPORTANCE/PRIORITY:

High

ASSISTANCE TO PEACE CORPS HEALTH EDUCATION EFFORTS

OPTION: Assist the network of Peace Corps volunteers working in health centers around the country by designing a standard package of appropriate health education materials, and training both the PCVs and associated health center staff in their use.

STRATEGIC IMPORTANCE:

Peace Corps Guinea will soon have approximately 30 volunteers assigned to health centers, providing assistance in health education. This will allow both USAID and Peace Corps to take better advantage of this technical assistance network plugged directly into the community. The inherent leveraging of uniquely American resources is particularly attractive.

ANTICIPATED IMPACT:

The effectiveness of health education messages will be enhanced, thereby increasing knowledge of and use of associated health services.

ANTICIPATED SUSTAINABILITY:

Not sustainable on a local basis, but the activity is relatively low cost; and the training of health center staff will assure skills transfer to some degree.

GEOGRAPHIC FOCUS:

National, according to PCV assignments.

TECHNICAL ASSISTANCE NEEDS:

Some technical assistance may be required for development or adaptation of materials. TA for training in the effective use of materials would be necessary, and may be available locally.

RELATIVE IMPORTANCE/PRIORITY:

Medium

ENABLING CONDITIONS:

Some current volunteers have developed their own health education materials.

DHS ANALYSIS AND REPEAT SURVEY

OPTION: Sponsor additional analysis of the 1992 DHS, and fund a cooperative effort to conduct another DHS, using both the AID contractor charged with this responsibility and appropriate local resources.

STRATEGIC IMPORTANCE:

The lack of reliable data is a continual constraint to the design of PHC program efforts, and to the measurement of program impact.

ANTICIPATED IMPACT:

Full analysis of existing DHS data, in collaboration with Guinean researchers (see discussion of BEPR elsewhere in this report) would provide valuable data and analysis experience. Another DHS survey, after an appropriate interval, would provide important comparative data in conjunction with the 1991 survey now being analyzed. It would also provide a valuable training opportunity for Guinean researchers, and would provide baseline data for program planning.

ANTICIPATED SUSTAINABILITY:

Not applicable (one-time activity).

TIMING ISSUES:

A five-year interval between surveys is typical.

GEOGRAPHIC FOCUS:

National

TECHNICAL ASSISTANCE NEEDS:

The AID contractor charged with responsibility for DHS surveys should be involved in all phases of the survey design, implementation, and analysis.

RELATIVE IMPORTANCE/PRIORITY:

Medium

ENABLING CONDITIONS:

1. Availability of appropriate local organization(s). Presumably BEPR, but other partners could also be involved.

IODINE DEFICIENCY INTERVENTIONS

OPTION: Carry out an emergency intervention against iodine deficiency diseases (e.g. goiter and cretinism) with the distribution of iodized salt and the provision of iodized oil or tablets through the essential medicines program.

STRATEGIC IMPORTANCE:

Iodine deficiency is a major cause of growth failure and mental retardation in children, as well as physical malformation and still births in adult women.

ANTICIPATED IMPACT:

Reduction of the prevalence of iodine deficiency diseases.

ANTICIPATED SUSTAINABILITY:

This is a temporary short-term measure. Longer-term measures, especially the local production of iodized salt should be considered.

GEOGRAPHIC FOCUS:

Middle and/or Upper Guinea

TECHNICAL ASSISTANCE NEEDS:

Contractor involved in micronutrient deficiency such as the OMNI project.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

Availability of appopriate technical assistance.

NATIONAL NUTRITION POLICY

OPTION: Provide necessary financial and technical assistance to the MSPAS/DAN in order to finalize the draft National Nutrition Policy and Action Plan and make it operational.

STRATEGIC IMPORTANCE:

Malnutrition is a major cause of childhood morbidity and mortality, and exacerbates the effects of other childhood diseases. This activity would provide an official framework for the improvement of nutritional status.

ANTICIPATED IMPACT:

Once the action plan becomes operational the nutrition projects which have been defined could be submitted to donors for funding. This would be a first step in reducing the country's high prevalence of nutritional diseases.

ANTICIPATED SUSTAINABILITY:

An operational nutrition policy and action plan represents a low cost first step for the country to deal with its nutrition problems. The potential sustainability of follow-on projects would vary.

GEOGRAPHIC FOCUS:

Central

TECHNICAL ASSISTANCE NEEDS:

Services of a person specialized in nutrition policy matters would be useful.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

No significant barriers to this activity exist.

NUTRITIONAL STATUS SURVEY

OPTION: Assist the MSPAS/DAN, in collaboration with other international donors (e.g. FAO, WHO, World Bank, UNICEF) to organize and carry out a national nutrition survey.

STRATEGIC IMPORTANCE:

The precise nature and regional variation of nutritional deficiency in Guinea are not well understood. A study of the existing nutrition situation would provide more reliable data on which targeted nutrition interventions could be based.

ANTICIPATED IMPACT:

Reliable data on the nature, magnitude, and severity of nutritional problems, and their distribution according to residence (rural/urban), natural regions, sex, age, and economic conditions would allow for definition and planning of nutrition interventions.

ANTICIPATED SUSTAINABILITY:

This one-time intervention would lead to the development of a variety of programs which would vary in terms of cost and potential sustainability.

TIMING ISSUES:

Planning meetings should start as soon as the National Nutrition Policy and Action Plan are operational.

GEOGRAPHIC FOCUS:

National

TECHNICAL ASSISTANCE NEEDS:

A contractor experienced in planning and conducting large scale surveys.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

1. An approved and operational nutrition policy.

2. A variety of donors are interested in nutrition, raising the possibility of cost sharing arrangements.

BREASTFEEDING POLICY WORKSHOP

OPTION: Sponsor a workshop with representatives of AFPAMNIG, MSPAS, and other local or regional experts to formulate a National Breastfeeding Policy and a National Code for the Marketing of Breast Milk Substitutes.

STRATEGIC IMPORTANCE:

A national policy on breastfeeding and a code for the marketing of breast milk substitutes would provide an official and legal basis upon which to build breastfeeding promotion.

ANTICIPATED IMPACT:

With an official written policy and operational guidelines for the integration of breastfeeding into existing MCH services, the promotion of breastfeeding would have a higher profile and a better chance to attract additional financing. Government regulations on the sale of breast milk substitutes would help control importation and commercialization of infant formula and other baby foods.

ANTICIPATED SUSTAINABILITY

A sound breastfeeding policy is the necessary first step for sustainable breastfeeding activities.

TIMING ISSUES:

Breastfeeding policy and legislation are pre-requisites for other activities in this area. It is thus important to act as soon as possible.

GEOGRAPHICAL FOCUS:

Central

TECHNICAL ASSISTANCE NEEDS:

A contractor (e.g., from WELLSTART) experienced in the development of breastfeeding policy might be needed to work with Guinean counterparts.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

1. The government previously ratified the International

INTEGRATION OF BREASTFEEDING PROGRAMS INTO EXISTING HEALTH AND FAMILY PLANNING PROGRAMS

OPTION: Provide financial support and technical assistance to design and implement a project aimed at the integration of breastfeeding promotion into MCH and family planning programs.

STRATEGIC IMPORTANCE:

The breastfeeding situation in Guinea is critical. Although 93% of mothers breastfeed, there are widespread negative practices which work against optimal breastfeeding, thus compromising both infant and women's health.

ANTICIPATED IMPACT:

Improved breastfeeding practices would lead to increased child survival as well as increased intervals between pregnancies.

ANTICIPATED SUSTAINABILITY

A well planned project could be sustainable. AFPAMNIG's objectives of fund raising, creating a network of breastfeeding support groups, training, research and evaluation all contribute to sustainability.

TIMING ISSUES:

The program should be undertaken as soon as a breastfeeding policy is ratified.

GEOGRAPHICAL FOCUS:

Program should begin in Conakry and expand to other regions based upon the availability of funding and growing expertise of the implementing agency.

TECHNICAL ASSISTANCE NEEDS:

Contractors such as Wellstart and MotherCare could provide technical assistance in program development and implementation. Also organizations such as the International Baby Food Action Network in Ouagadougou could provide assistance.

RELATIVE IMPORTANCE/PRIORITY:

High

ENABLING CONDITIONS:

The nationwide survey on breastfeeding practices to be

APPENDICES

HEALTH AND POPULATION ASSESSMENT

REPUBLIC OF GUINEA

MARCH - APRIL 1994

CONDUCTED BY:

SEATS/JSI

in collaboration with:
BASICS
WINS

This report presents the findings and analysis of a contracted assessment team. It does not represent the opinions, recommendations, or commitments of USAID/Guinea or the United States Government.

APPENDICES

Following are a series of documents produced as part of the Health and Population Assessment conducted in the Republic of Guinea during March - April 1994. Virtually all of the substantive material is summarized in the Assessment Report. Much of the information in these appendices is therefore duplicative. The additional detail, however, may prove useful to those looking in depth at particular issues.

APPENDICES

I. Assessment Scope of Work

II. Methodology

III. Demographic and Health Indicators

IV. Bamako Initiative Status Report

V. Private Sector Assessment

VI. Maternal and Child Health Assessment

VII. Nutrition and Breastfeeding Assessment

VIII. Information, Education, and Communication Assessment

IX. Health Financing Assessment

X. Human Resources Development Assessment

XI. Persons Contacted

XII. Bibliography

APPENDIX I

PIO/T No. 675-0510-3-31059

PIO/T No. 675-0510-3-31059
Attachment I

GUINEA HEALTH AND FAMILY PLANNING SECTOR ASSESSMENT SCOPE OF WORK

PURPOSE:

The purpose of the Health and Family Planning Sector Assessment is to provide background information needed by USAID/Guinea to address basic strategy options in developing a follow-on project. The new project, planned for authorization in late 1994 or early 1995 calendar year of fiscal year, would be the successor to the current Social Marketing of Contraceptives Project (675-0227), executed through a Cooperative Agreement (also called "Family Planning Options") with Population Services International (PSI). The follow-on project is tentatively envisioned to strengthen the integration of family planning and HIV/AIDS control activities into the existing primary health care system operated by the Ministry of Health.

The underlying strategy question to be addressed by this assessment is the extent to which project implementation should be carried out through public sector, private sector, or Non-Governmental Organization (NGO) sector entities. Perhaps the most important part of this is an analysis of the institutional characteristics of the Ministry of Health.

BACKGROUND

From 1958 to 1984, Guinea followed a socialist-centralist planning model that resulted in one of the lowest incomes per capita and some of the poorest health and education conditions in West Africa. When the Second Republic was declared in 1984, it inherited a health system that had almost totally collapsed, resulting in health indicators that are among the worst in Sub-Saharan Africa.

The current population in Guinea is estimated at 6.4 million and has an annual growth rate of 2.8 percent. Forty-six percent of the population is under 15 years of age. Health service coverage and utilization rates are low, resulting in high rates of infant and maternal mortality, 149 and 9 per 1000 respectively. Closely spaced births and illegal abortions contribute to the high maternal and infant mortality rates and rapid population growth. In a 1989 publication, the World Bank estimated that there were 57,390 people for every physician and 6,380 people for every nurse. Life expectancy is only 45.1 years. More than 18 percent of new born babies weigh less than 2.5 kgs. The disease profile dominated by communicable and parasitic diseases including malaria, and respiratory and diarrheal diseases, results in an estimated 25 percent of children dying before five years of age. Contraceptive prevalence rates are less than 2 percent, making them among the lowest in Africa. Access to safe water is only 42 percent in rural areas, less in urban areas.

Constraints to increasing service coverage and participation rates include: (a) lack of drugs and operating means and poor staff performance resulting in poor service quality; (b) weak sector organization and institutional capacity; (c) inadequate budgetary allocations to the sector (2 percent of the total Government recurrent budget in 1991), as well as poor resource management due in part to previous investment decisions.

At the World Population Conference in Mexico City in 1985, Guinean President, Lansana Conté, renounced his predecessor's pro-natalist policies and declared the right of all Guineans

Complementary project-funded actions include: (a) a sub-grant to the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) to train university medical faculty in reproductive health; and (b) assistance to the 1991 Demographic Health Survey. The key to sustainability will be the successful integration of FAMPOP's family planning services into the NPHCP.

In a recent mid-term evaluation of the FAMPOP, it was pointed out that the improvements in the health system that can be attributed to the NPHCP were most evident in the Forest Region, and less so in the Upper Regions. In the Forest Region the system is working substantially better with technical and financial assistance from Belgium, Switzerland and Germany. Their assistance has contributed to the building and organizing of a regional drug depot, the construction of several new health posts and improving the logistics of supply and distribution in the region. On the other hand, conditions in the Upper Guinea confirm limited expectations. There are consistent reports of essential drugs being unavailable because of administrative and management problems at the central supply distribution point in Conakry. Community participation in management and support of the health centers vary from considerable to hardly at all. The use of these funds and the capacity of the centers to buy and maintain a sufficient supply of contraceptives are issues that will need careful review.

PSI has made subagreements with both the National AIDS Committee and the local family planning non-governmental organization, AGBEF, for major portions of the FAMPOP program. AGBEF's activities include Information, Education and Communication (IEC) campaigns and training of health center personnel in support of family planning, and other reproductive health services. AGBEF recently became affiliated with International Planned Parent Federation (IPPF).

After just eight years, AGBEF has an annual budget over $500,000 US, sixty-two employees, and 2,800 volunteers working in three model clinics in different regions of the country delivering family planning services and contraceptives. The 1993, FAMPOP mid-term evaluation major findings recognized the valuable contribution AGBEF h[illegible]de in supporting the development of family planning services, though the need for [illegible]tional development was indicated. Further analysis is needed to determine the effectiveness of this and other service provider agencies and establish a strategy to develop effective management structures in the private and public sectors.

In terms of financing for health care, the GOG's budget allocation has been consistently low. Between 1977-1985, Guinea allocated an average 3.9 percent of the national budget to the health sector, much less than the 8-12 percent prescribed by the World Health Organization. Because of limited finances and the restraints imposed on the Guinean economy by the economic structural adjustment program, it is likely that the GOG will be heavily dependent, for years to come, on donor resources to reform and improve its primary health care system. On the positive side, however, some innovative cost recovery mechanisms, which support health care financing, regionalization and self-reliance, are being addressed in the NPHCP.

USAID/Guinea has found that even though donor collaboration in the health and population sector has been good, the diversity of funding makes it difficult to develop a truly national family planning program. Therefore, the assessment will also need to explore issues related to donor coordination.

I. TITLE

Guinea Health and Family Planning Sector Assessment

II. OBJECTIVE

The objective of this buy-in or work order will be to provide a five-person, multi-disciplinary team to conduct an assessment of the Guinean health and family planning private and public sectors. The assessment will assist USAID/Guinea and the GOG in the development of a strategy for USAID assistance in the sector to effectively address the primary health needs of the Guinean population, particularly women, children and low income families.

III. STATEMENT OF WORK

A. General Tasks

The assessment will provide an in-depth analysis of the National Primary Health Care Program (NPHCP), including a close examination of its service delivery and cost recovery systems, management, and the sustainability of the Program. The assessment will determine to what extent the NPHCP addresses the quality of and access to health care; appraise the capacity of the NPHCP to absorb additional health and family planning programs; identify the constraints to the availability of personnel and equipment and the supply and distribution of drugs; examine the ability of the GOG to finance the most critical medical and health services; evaluate the capacity of the health and sanitation agencies to respond to the health needs of the population and recommend strategies for strengthening those agencies where necessary, and examine issues associated with donor coordination in the health and family planning sector.

Finally, the assessment will provide USAID/Guinea with pragmatic investment options in the health and family planning sector, including information that can be used to develop a short, medium and long term strategy for the sector. USAID anticipates that relevant areas will include reproductive risk, family planning and STD/AIDS prevention.

B. Specific Tasks and Responsibilities

The Health and Family Planning Sector Assessment team will:

1. Provide an overview and analysis of current information on the health, fertility and nutritional status of the target population, including:

(a) the status of health delivery services in the public, private and NGO sector;

(b) constraints and facilitating factors to improved health services and health status (as measured by indicators such as life expectancy, infant and maternal mortality, malnutrition);

(c) challenges that may hinder future improvements; and

Complementary project-funded actions include: (a) a sub-grant to the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) to train university medical faculty in reproductive health; and (b) assistance to the 1991 Demographic Health Survey. The key to sustainability will be the successful integration of FAMPOP's family planning services into the NPHCP.

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USAID/Guinea has found that even though donor collaboration in the health and population sector has been good, the diversity of funding makes it difficult to develop a truly national family planning program. Therefore, the assessment will also need to explore issues related to donor coordination.

5. Make recommendations for potential growth, modification, and redesign for USAID/Guinea population related activities.

6. Identify and analyze health and family planning programs sponsored by other donors in terms of coverage, vested interests, effectiveness, and resource level. Special emphasis should be placed in the identification of areas of complementarity, and in the level, appropriateness, adequacy, and relevance of donor response. Potential duplication of efforts or conflict of interests should be clearly noted and evaluated.

7. Design a framework for assessing options for USAID/Guinea assistance within its portfolio in the health and family planning sector, and application to the range of options for USAID/Guinea investment.

8. Review the health and family planning information and data base system in place, and their use in management decisions. The team will specifically look into the recently concluded Demographic Health Survey, appraise its value as a decisional tool, identify potential analysis which could be derived from it, and advise on Mission's future links to it. In this context, the assessment team will make specific recommendations on USAID/Guinea's role in the future generation of health and family planning data, their analysis and their use by decision makers. The team will make recommendations on the most cost effective way to produce the data required by USAID/Guinea (i.e. impact and progress indicators).

9. Evaluate the current and proposed health and family planning strategies in terms of their burden on Mission management. Assessment team will offer solutions in terms of personnel requirements and contractual approaches. In addition, team will identify the centrally and regionally funded projects or services which the Mission could access to facilitate activities design, implementation and evaluation.

10. Look at the following in terms of Information, Education and Communication activities:

- existence of capacity to do IEC related formative research, message conception and pretesting and production in MOH and NGOs;

- breadth and scope of IEC activities through both public and private (NGO) sectors, including interpersonal communication, printed materials (posters, brochures, etc), and mass media communications, including the quality, effectiveness and impact of those activities;

- a review of IEC related research done in Guinea (KAPs, qualitative research etc., evaluation surveys, etc.)

- recommendations for improvement

IV. TEAM COMPOSITION, QUALIFICATIONS AND RESPONSIBILITIES

The team shall consist of five persons, as indicated below. The team as a whole must have strong French language competence. All team members should have fluency at the Speaking-3/Reading-3 level on the Foreign Service Institute (FSI) competency scale.

The team as a whole must also have substantial African experience, including some Francophone Sub-saharan experience. Specific professional and disciplinary competence is proposed as follows:

A. Health Planner/Team Leader

The Health Planner/Team Leader will be responsible for management and coordination of the assessment team. S/he will provide general guidance to the team members and take a lead role in: (a) the planning of assessment tasks; (b) directing all assessment presentations, discussions and debriefings to the Mission; and (c) drafting and editing the assessment report, overseeing its timely finalization and submission to USAID.

S/he will be responsible for: identifying health/family planning sector investment options for USAID/Guinea; assessing the capacity for management and implementation of health services delivery by the Ministry of Health and Regional Health Departments; assessing needs in terms of health infrastructure, equipment, manpower planning capacity and allocation of staff; and identifying the constraints to integrating the principles of the Bamako Initiative into the public health system.

Masters degree in health, management and administration or related field, PhD preferred. Five to ten years experience in planning and implementing health programs in developing countries that have limited technical, human and financial resources; experience working in the area of institutional management development and organizational effectiveness in developing countries that have limited management capabilities; experience working with diverse organizations and groups. Experience in Sub-Sahara Africa highly desirable, as is experience in leading similar assessment or evaluation teams. Strong writing/editing skills.

B. Epidemiology/Child Survival Specialist

The Epidemiology/Child Survival Specialist will be responsible for analyzing the effectiveness of delivery and training for pre-service and in-service MCH and child survival services, e.g., EPI, diarrheal diseases control and tuberculosis. S/he will examine the: status and impact of malaria on the Guinean population; effectiveness of management, control and prevention; health and management information systems of the public, private and NGO sectors.

Masters degree in public health or related field. Minimum of five to ten years experience in designing, implementing managing, and evaluating population and family planning and maternal/child health (MCH) programs in developing countries. Experience in Sub-Sahara Africa highly desirable.

C. Health/Family Planning Private Sector Specialist

The Health/Family Planning Private Sector Specialist will be responsible for: analyzing private sector health and family planning activities; and exploring the prospects for private sector, NGO, and other non-public sector support to health care delivery in Guinea.

Masters degree in public health, demography or relevant social science. At least 5 years experience in population and family planning in the private sector and NGO environment; and at least 3 years experience in developing countries. Experience in Sub-Sahara Africa highly desirable.

D. Health/Finance Specialist

The Health/Finance Specialist will be responsible for examining the health sector cost-effectiveness in terms of sources, levels and structure of financing.

Graduate degree in economics, finance or related field and a minimum of five years in designing, implementing and evaluating the economic and financial aspects of health and family planning related programs, preferably in Africa.

E. Organizational Management Specialist

Responsible for: analysis of effectiveness of structure, organization and operations of selected health and family planning organizations at the central, regional and local levels, including assessment of the capacity and management systems, human resources, and commodity management of these organizations, as well as assistance in analysis of infrastructure and equipment needs.

Graduate degree in Public Health or in an organizational or administrative science with a focus on health/family planning sectors; at least 5 years experience in population/family planning and management in the private sector and NGO environment and at least 3 years experience in lesser developed countries preferably in Africa.

V. METHODOLOGY

The assessment team members will carry out their responsibilities in Conakry and on field trips to the Guinean interior. In Conakry, the team will meet initially with the Mission Director, General Development Officer, Health/Pop/Nutrition Assistant, the Program and Project Development Officers for briefing and planning sessions. The team will then meet with Ministry of Health (MOH) officials and other relevant GOG offices.

The team will take field trips to rural and urban sites to observe and assess public, private and NGO sector health institutions, programs and services. The field visits will be planned in collaboration with USAID and the MOH and will include agents from relevant GOG offices. The up-country travel will include meetings with regional GOG health and family planning authorities, as well as with private sector and NGO health and family planning officials.

The team members will gather information for the assessment by reviewing background reports, health education material, statistical abstracts, annual reports and other health and family planning sector documents, which will be made available by USAID, the GOG, donor agency staff and other consultants. The team will also review and analyze data and statistics related to the population, health status, service delivery and coverage.

In addition reviewing and analyzing documents and reports, the assessment team will conduct interviews with relevant health and family planning officials in USAID, the GOG, (in particular, the local, regional and national staff of the Ministry of Health), and personnel in the international donor, NGO and private sector communities.

VI. REPORTS AND DELIVERABLES

To satisfy reporting requirements:

(1) The assessment team will orally brief USAID Director and/or designated staff on its accomplishments and work progress o/a the mid-point of the assessment (approximately 4 weeks after team's arrival in Guinea).

(2) The assessment team will orally brief USAID Director and/or designated staff on its findings, conclusions and recommendations three working days before departing Guinea.

(3) The assessment team will submit a draft assessment report for USAID review and comment at least five working days prior to the departure of the bulk of the team from Guinea.

(4) After the review of the draft report by the Mission, the team will incorporate the recommended changes into a final assessment report. The team leader will be expected to remain in Conakry 3-5 days after the departure of other team members in order to leave behind a nearly final draft of the assessment.

(5) Within three weeks after receipt of the Mission's comments of the draft, the team will deliver to USAID/Guinea by express mail:

(a) twenty-five copies of the final assessment report in English;

(b) twenty-five copies of the final assessment report translated into French; and

(c) a diskette(s) containing both the English and French versions of the final assessment report, formatted in Wordperfect 5.1.

The team will also deliver ten copies of the final assessment report in English to Guinea Desk Officer, Dina Esposito for distribution in AID/W and one final assessment report in English to POL/CDIE/DI, ACQUISITIONS, Room 209, SA-18, AID/W.

The assessment report must include the following elements:

(1) Clear labeling of major observations/findings, analysis of those findings, and recommendations where appropriate.

(2) Clear identification of the principle project strategy options along with the recommendations of the assessment team.

(3) An Executive Summary, not to exceed 3 single-spaced typed pages, briefly stating the purpose of the assessment and concisely summarizing the most important observations and recommendations of the team, including the major objectives and elements proposed for the new project.

(4) A Table of Contents.

(5) The main body of the report should be kept as brief as possible, preferably under fifty pages, with any supporting analysis or documentation placed in an appendices.

The team members will stay at a local hotel while in Conakry. USAID will assist with in-country logistical arrangements, including hotel and departure flight reservations, meeting and assisting at airport for arrival and departure. Team members will have access to the USAID cashier for check-cashing and to the Embassy health unit for medical emergencies. Provision for emergency evacuation (SOS) insurance is the responsibility of the team members.

USAID will be only able to provide limited and occasional transportation assistance from its motor pool. The team should therefore be prepared to rent vehicles for most local and domestic travel by road.

APPENDIX II

Assessment Methodology

This assessment of the health and population sector of the Republic of Guinea was undertaken at the request of the USAID Mission to Guinea. The primary funding mechanism was a buy-in from USAID/Conakry to the AID Office of Population contract with John Snow, Inc. entitled "Family Planning Service Expansion and Technical Support" (SEATS). Additional support was provided by two other AID projects, BASICS and WINS.

Team members were:

Alpha Dieng	Patrick Kelly
Andrew Fullem	Julienne Ngo Som
Thomas Hardy	David O'Brien
Meba Kagone	Elaine Rossi

The assessment began with a two-day team planning meeting in Dakar, Senegal, on March 8-9, 1994. The team travelled to Guinea on March 10. Initial briefings were held with USAID, resulting in minor modifications to the scope of work. Field work and report writing continued from March 11 - April 22, 1994.

The team reviewed a substantial amount of documentation from a variety of sources. USAID/Guinea provided historical and background information from its files. The Ministry of Public Health and Social Affairs (MSPAS) opened its files, as did several other government agencies, including the Ministry of Plan and Finance. Donor agencies and non-governmental organizations in Guinea were also very generous in sharing information. A list of documents that were used during the assessment appears in Appendix XIII.

Interviews were carried out with a wide range of people who deliver, fund, support, and use the Guinean health care system. These included many Government of Guinea officials; managers, clinicians, and support staff of the health care delivery system; donor agency, NGO, and technical assistance personnel; private sector officials and health care personnel; and a variety of users of the Guinean health care system.

Field visits were undertaken to all four of the natural geographic regions of Guinea, where the team attempted to view a cross-section of the health delivery system. Every effort was made in each region to look at all management and service delivery levels in the public sector, as well as to examine donor and NGO assistance as it is provided in the field. One team member visited multiple regions to look specifically at private sector health activities.

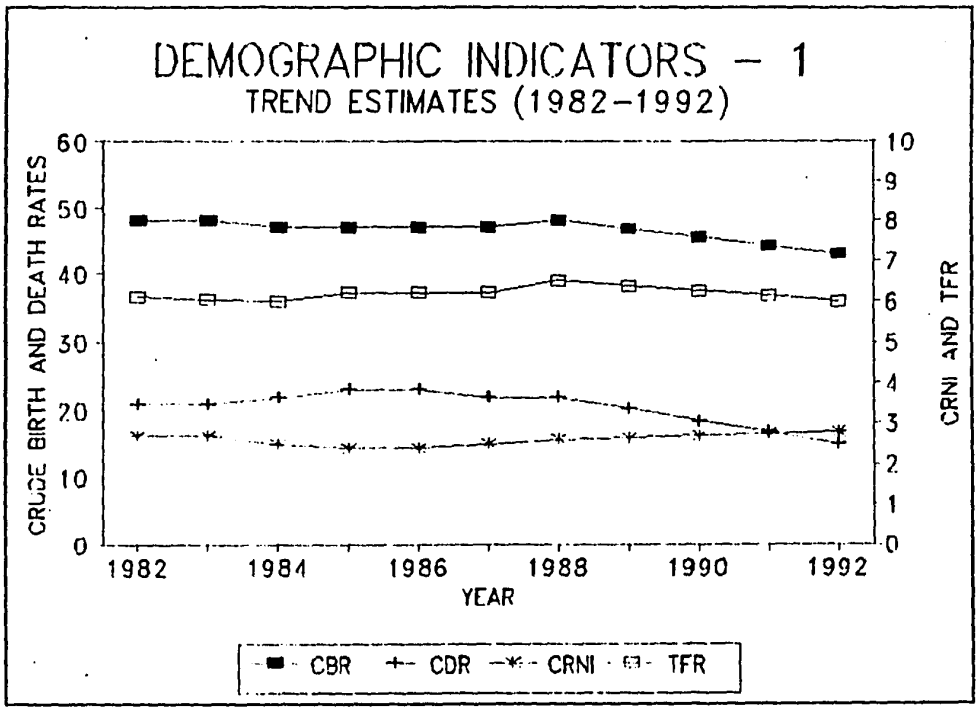
APPENDIX III
DEMOGRAPHIC AND HEALTH INDICATORS

TABLE I
POPULATION ESTIMATES
(1982 - 2000)

YEAR	TOTAL POP	URBAN POP	URB/TOT	WOMEN (15-49)	CHILD (0-4
1982	4591901	915821	20	1147975	868328
1983	4724178	971178	21	1181044	893342
1984	4860265	1029881	21	1215066	919076
1985	5000273	1092133	22	1250068	945552
1986	5144313	1158147	23	1286078	972790
1987	5292504	1228152	23	1323126	1000812
1988	5444963	1302388	24	1361241	1029642
1989	5601813	1381111	25	1400453	1059303
1990	5763182	1464593	25	1440796	1089818
1991	5929200	1553121	26	1482300	1121212
1992	6100000	1647000	27	1525000	1153510
1993	6270800	1740879	28	1567700	1185808
1994	6446382	1840109	29	1611596	1219011
1995	6626881	1944995	29	1656720	1253143
1996	6812434	2055860	30	1703108	1288231
1997	7003182	2173044	31	1750795	1324302
1998	7199271	2296908	32	1799818	1361382
1999	7400851	2427831	33	1850213	1399501
2000	7608074	2566218	34	1902019	1438687

HYPOTHESES:
TOTAL ANNUAL GROWTH RATE = 2.8%
URBAN ANNUAL GROWTH RATE = 5.7%
CB WOMEN = WOMEN OF CHILDBEARING AGE = POPULATION X 25%
CHILDREN (0-4) = POPULATION X 18.9%

FIGURE I



CBR = CRUDE BIRTH RATE
CDR = CRUDE DEATH RATE
CRNI = CRUDE RATE OF NATURAL INCREASE
TFR = TOTAL FERTILITY RATE

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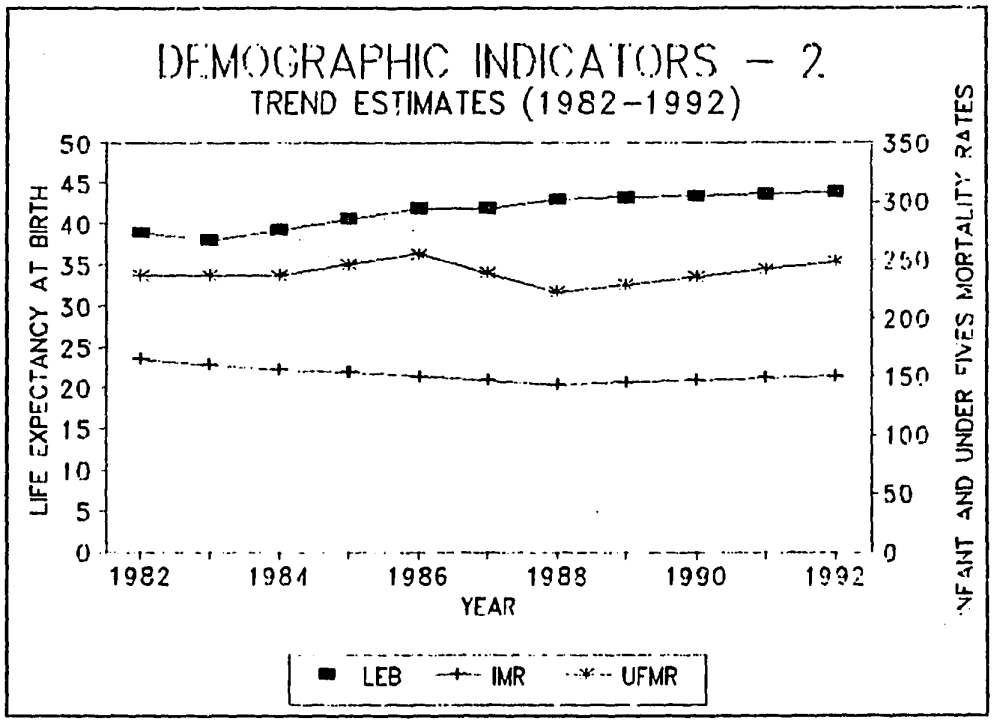
FIGURE II



LEB = LIFE EXPECTANCY AT BIRTH
IMR = INFANT MORTALITY RATE
UFMR = UNDER FIVES MORTALITY RATE

TABLE II
DEMOGRAPHIC INDICATORS

YEAR	SMOOTHED PUBLISHED DATA						
	CBR	CDR	CRNI	IMR	LEB	TFR	UFMR
1982	48.0	21	2.7	165	39.0	6.1	236
1983	48.0	21	2.7	160	38.0	6.1	236
1984	47.0	22	2.5	156	39.3	6.0	236
1985	47.0	23	2.4	153	40.7	6.2	246
1986	47.0	23	2.4	150	42.0	6.2	255
1987	47.0	22	2.5	147	42.0	6.2	239
1988	48.0	22	2.6	143	43.0	6.5	222
1989	46.8	20	2.7	145	43.3	6.4	229
1990	45.5	19	2.7	147	43.5	6.3	235
1991	44.3	17	2.8	148	43.8	6.1	242
1992	43.0	15	2.8	150	44.0	6.0	248

FIGURE III

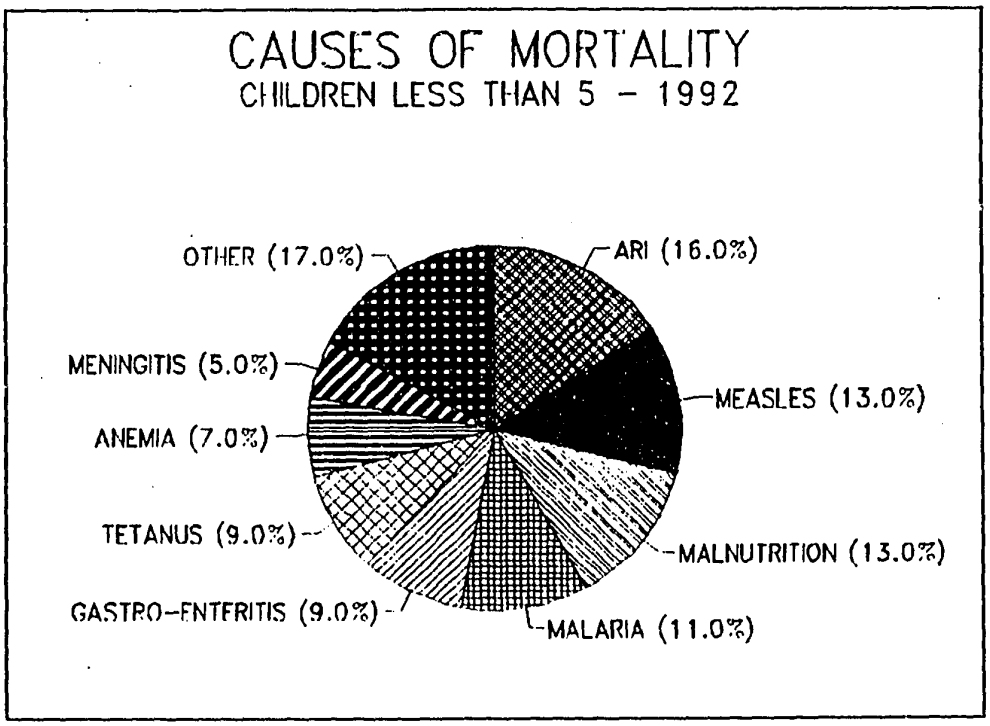


TABLE III
CHILDREN UNDER 5 - 1992
CAUSES OF MORTALITY

CAUSE	%
ACUTE RESPIRATORY INFECTIONS	29
NON-SPECIFIC	16
MEASLES	13
MALNUTRITION	13
KWASHIORKOR	2
MARASMUS	7
VITAMIN DEFICIENCY	4
MALARIA	11
DIARRHEAL DISEASES	9
TETANUS	9
ANEMIA	7
MENINGITIS	5
OTHER	17
TOTAL	100

FIGURE IV

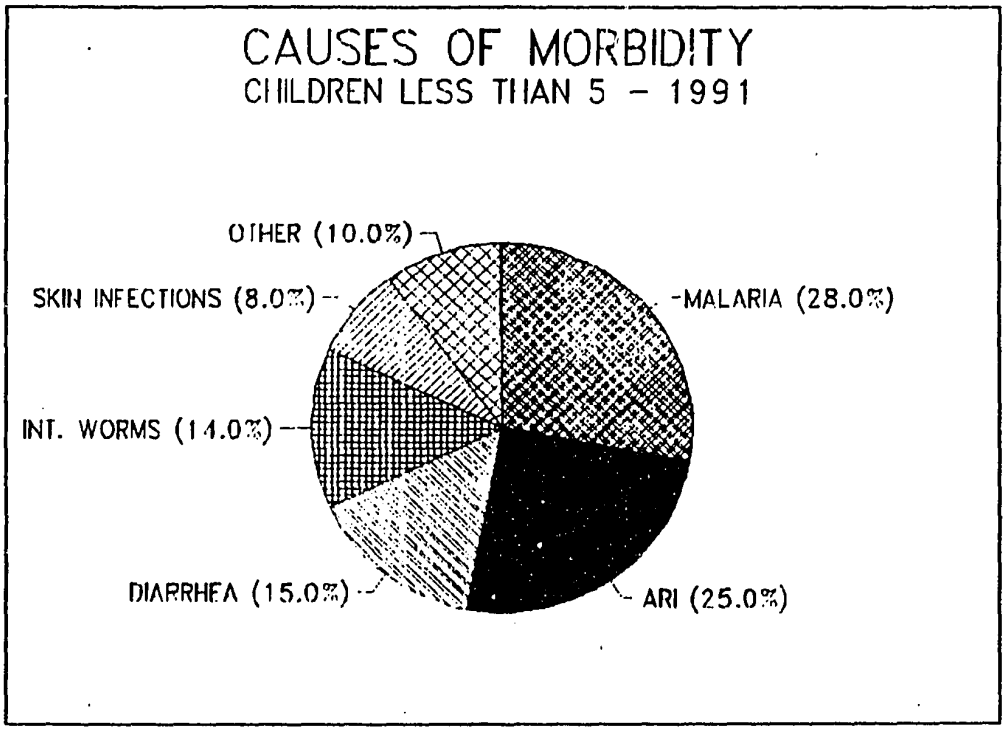


TABLE IV
CHILDREN UNDER 5 - 1991
CAUSES OF MORBIDITY

CAUSE	%
MALARIA	28
ACUTE RESPIRATORY INFECTIONS	
NON-SPECIFIC	24
MEASLES	1
DIARRHEAL DISEASES	15
SKIN INFECTIONS	8
INTESTINAL WORMS	14
ANEMIA	2
EYE DISEASES	2
MALNUTRITION	1
OTHER	5
TOTAL	100

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PRELIMINARY DHS ANALYSES

TABLE V
FEMALE FERTILITY BY ZONE
WOMEN (15-49)

ZONE	FI	PG	AF	TFR	BI
CONAKRY	17	38	38.3	5.5	34.4
LOWER GUINEA	16	56	49.6	5.8	35.5
MIDDLE GUINE	15	54	50.7	6.0	36.4
UPPER GUINEA	16	46	56.3	6.7	33.8
FOREST GUINE	15	40	54.9	6.0	33.6
AVERAGE %	16	48	50.4	6.0	35.1

FI = AGE AT FIRST INTERCOURSE
PG = POLYGYNY
AF = ADOLESCENT MOTHER OR PREGNANT (15-19)
TFR = TOTAL FERTILITY RATE
BI = BIRTH INTERVAL IN MONTHS

TABLE VI
REPRODUCTIVE HEALTH KNOWLEDGE BY ZONE
MEN AND WOMEN

ZONE	MCC			CCS	KSTD			PSTD			TSTD		
	F	M	M/F	F	F	M	M/F	F	M	M/F	F	M	M/F
CONAKRY	61	84	1.4	38	82	93	1.1	76	94	1.2	34	77	2.2
LOWER GUINEA	17	53	3.2	10	53	81	1.5	77	91	1.2	32	89	2.8
MIDDLE GUINEA	51	66	1.3	10	56	85	1.5	74	98	1.3	9	39	4.4
UPPER GUINEA	7	39	5.4	4	25	65	2.6	87	85	1.0	24	73	3.1
FOREST GUINEA	11	39	3.6	4	26	80	3.1	55	96	1.8	40	97	2.4
AVERAGE %	28	55	2.0	11	47	81	1.7	74	94	1.3	29	74	2.6

MCC = KNOWLEDGE OF MODERN CONTRACEPTION
CCS = KNOWLEDGE OF A MODERN CONTRACEPTION SOURCE
KSTD = KNOWLEDGE OF A SEXUALLY TRANSMITTED DISEASE(INCLUDING AIDS)
PSTD = KNOWLEDGE THAT THERE IS PROTECTION AGAINST STD'S
TSTD = KNOWLEDGE THAT THERE IS TREATMENT FOR STD'S

TABLE VII
REPRODUCTIVE HEALTH ATTITUDES BY ZONE
MEN AND WOMEN

ZONE	BPA			WTS	WTL			INC			AFPM		
	F	M	M/F	F	F	M	M/F	F	M	M/F	F	M	M/F
CONAKRY	39	34	0.9	20	15	10	0.7	5	5	1.0	72	77	1.1
LOWER GUINEA	28	12	0.4	16	7	6	0.8	7	10	1.5	58	84	1.4
MIDDLE GUINEA	13	24	1.8	13	5	4	0.8	7	9	1.3	44	57	1.3
UPPER GUINEA	27	17	0.6	15	9	3	0.4	6	11	1.8	40	59	1.5
FOREST GUINEA	28	20	0.7	12	8	11	1.4	6	8	1.4	35	83	2.4
AVERAGE %	28	55	2.0	14	8	7	0.9	6	9	1.3	48	72	1.5

BPA = BOTH PARTNERS APPROVE OF FAMILY PLANNING
WTS = WANT TO SPACE FUTURE PREGNANCIES
WTL = WANT TO LIMIT FURTHER BIRTHS
INC = IDEAL NUMBER OF CHILDREN
AFPM = APPROVE OF FP MESSAGES ON RADIO/TV

TABLE VIII
KNOWLEDGE OF AIDS BY ZONE
MEN AND WOMEN

ZONE	KA			SR			KT			KP			KMP		
	F	M	M/F	F	M	M/F	F	M	M/F	F	M	M/F	F	M	M/F
CONAKRY	92	83	0.9	51	60	1.2	68	69	1.0	80	78	1.0	17	33	2.0
LOWER GUINEA	81	42	0.5	54	66	1.2	68	88	1.3	55	87	1.6	7	15	2.1
MIDDLE GUINE	80	78	1.0	68	73	1.1	64	87	1.4	81	91	1.1	3	10	4.0
UPPER GUINEA	46	51	1.1	46	56	1.2	57	65	1.2	66	73	1.1	4	8	2.3
FOREST GUINE	53	48	0.9	16	30	1.8	60	69	1.1	49	79	1.6	3	7	2.8
AVERAGE %	70	61	0.9		57		64	77	1.2	68	82	1.2	7	15	2.2

KA = KNOWLEDGE OF AIDS AS A STD
SR = RADIO AS THE FIRST INFORMATION SOURCE
KT = KNOWLEDGE OF MEANS OF TRANSMISSION
KP = KNOWLEDGE THAT ONE CAN BE PROTECTED AGAINST AIDS
KMP = KNOWS CONDOMS PROTECT AGAINST AIDS

TABLE IX
KNOWLEDGE OF CONDOMS AND AIDS
MEN AND WOMEN

ZONE	KAC			KCS			PS			MS			HS		
	F	M	M/F	F	M	M/F	F	M	M/F	F	M	M/F	F	M	M/F
CONAKRY	45	71	1.6	33	52	1.6	65	72	1.1	37	47	1.3	51	20	0.4
LOWER GUINEA	21	37	1.8	12	21	1.7	31	60	1.9	29	52	1.8	58	16	0.3
MIDDLE GUINE	11	28	2.5	5	14	2.6	28	62	2.2	33	39	1.2	35	10	0.3
UPPER GUINEA	6	25	4.0	4	14	3.3	45	60	1.3	19	40	2.1	66	21	0.3
FOREST GUINE	9	28	3.1	6	20	3.5	35	50	1.4	43	22	0.5	37	14	0.4
AVERAGE %	17	37	2.3	11	24	2.2	47	64	1.4	34	41	1.2	50	17	0.3

KAC = KNOWS ABOUT CONDOMS
KCS = KNOWS A CONDOM SOURCE
PS = PHARMACIES AS A SOURCE OF CONDOMS
MS = PUBLIC MARKETS AS A SOURCE OF CONDOMS
HS = HOSPITALS AS A SOURCE OF CONDOMS

TABLE X
HEALTH CARE FOR PREGNANCIES IN LAST 5 YEARS

ZONE	PN	TT2	DHF	DTP
CONAKRY	93.8	74.5	73.3	83.2
LOWER GUINEA	64.7	51.4	24.0	26.7
MIDDLE GUINEA	38.4	28.1	12.4	15.4
UPPER GUINEA	40.2	23.6	16.2	20.9
FOREST GUINEA	64.1	36.2	21.6	26.0
AVERAGE %	59.9	39.9	25.0	29.4

PN = PRENATAL CARE
TT2 = AT LEAST 2 DOSES OF TETANUS TOXOID
DHF = DELIVERY IN A HEALTH FACILITY
DTP = DELIVERY BY A TRAINED PERSON
(DOCTOR OR NURSE/MIDWIFE)

TABLE XI
CHILD MORTALITY AND MORBIDITY

ZONE	NM	IMR	CM	UFM	D2	R2	F2
CONAKRY	56	100	71	164	21	13	34
LOWER GUINEA	52	107	120	214	9	12	25
MIDDLE GUINEA	73	152	93	231	19	21	49
UPPER GUINEA	94	177	121	276	13	11	27
FOREST GUINEA	85	195	156	321	19	11	36
AVERAGE %	73	150	115	248	16	14	35

NM = NEONATAL MORTALITY (< 1 MONTH)
IMR = INFANT MORTALITY RATE (0-11 MONTHS)
CM = CHILD MORTALITY (1-4 YEARS)
UFM = UNDER FIVES MORTALITY (0-4 YEARS)
D2 = DIARRHEA IN THE LAST 2 WEEKS
R2 = RESPIRATORY INFECTION IN THE LAST 2 WEEKS
F2 = FEVER IN THE LAST 2 WEEKS

TABLE XII
HEALTH CARE DELIVERED TO CHILDREN

ZONE	12-23 MONTHS			CHILDREN UNDER FIVE			
	BCG	MEASLES	CC	IFD	OPD	AMF	ARI
CONAKRY	85	63	48	40	36	21	31
LOWER GUINEA	63	51	32	50	17	20	12
MIDDLE GUINEA	51	36	25	38	11	12	23
UPPER GUINEA	43	24	18	47	6	13	21
FOREST GUINEA	66	43	26	51	35	31	35
AVERAGE %	60	43	29	44	21	19	23

BCG = TUBERCULOSIS VACCINE
MEASLES = MEASLES VACCINE
CC = COMPLETE COVERAGE
IFD = INCREASED FLUIDS DURING DIARRHEA
OPD = ORS PACKET USED DURING DIARRHEA
AMF = ANTI-MALARIAL FOR FEVER
ARI = ANTIBIOTICS FOR RESPIRATORY INFECTION

TABLE XIII
BREAST-FEEDING FOR CHILDREN

ZONE	B1H	B1D
CONAKRY	30	53
LOWER GUINEA	44	61
MIDDLE GUINEA	25	50
UPPER GUINEA	26	35
FOREST GUINEA	61	84
AVERAGE %	38	58

B1H = STARTED WITHIN 1 HOUR AFTER BIRTH
B1D = STARTED WITHIN 1 DAY AFTER BIRTH

TABLE XIV
RADIO LISTENING BEHAVIOR

ZONE	RY			RN			RR		
	F	M	M/F	F	M	M/F	F	M	M/F
CONAKRY	38	68	1.8	96	94	1.0	3	2	0.9
LOWER GUINEA	11	33	3.0	94	88	0.9	9	8	0.9
MIDDLE GUINEA	12	30	2.6	39	62	1.6	63	40	0.6
UPPER GUINEA	5	29	5.4	68	89	1.3	40	9	0.2
FOREST GUINEA	3	16	6.5	87	83	1.0	2	4	2.0
AVERAGE %	12	35	2.9	79	85	1.1	22	12	0.5

RY = LISTENED TO THE RADIO YESTERDAY
RN = LISTENERS WHO LISTEN TO NATIONAL RADIO
RR = LISTNERS WHO LISTEN TO RURAL RADIO

TABLE XV
IEC ON THE RADIO

ZONE	AIDS			FPM			AFP		
	F	M	M/F	F	M	M/F	F	M	M/F
CONAKRY	55	68	1.2	25	30	1.2	72	77	1.1
LOWER GUINEA	79	33	0.4	8	17	2.2	58	84	1.4
MIDDLE GUINEA	90	30	0.3	1	4	2.5	44	57	1.3
UPPER GUINEA	81	29	0.4	3	2	1.0	40	59	1.5
FOREST GUINEA	63	16	0.3	4	2	0.6	35	83	2.4
AVERAGE %	76	35	0.5	6	13	2.2	48	72	1.5

AIDS = HEARD ABOUT AIDS FOR THE FIRST TIME ON RADIO
FPM = HEARD ABOUT FP METHODS FOR FIRST TIME ON RADIO
AFP = APPROVED OF FP MESSAGE HEARD ON THE RADIO

APPENDIX IV.

BAMAKO INITIATIVE STATUS

Requirement	Implemented/Strengths	Remarks/Weaknesses
Selection of district level in the health system	District level selected: prefectural directorate of health	Prefectural directorate lacks human and material resources (insufficient to properly carry out activities, skilled supervisors, support staff), lack of funds, insufficient number of vehicles and supervisory teams, EM logistics
Support of government and local administration to PHC (including mobilization of external assistance)	External assistance mobilized (UNICEF, World Bank, NGOs, etc.) Local administration assists in social mobilization and ---- with support staff to health centers	Where external assistance is not secured there is no activity related to BI. BI is difficult to implement Limited assistance of local administration to health financing. For long time government assistance in funds lacked. In 1993-94 health budget increased and funds should be available to regional and prefectural directorate of health. As yet nothing is available.

APPENDIX IV.

BAMAKO INITIATIVE STATUS

Requirement	Implemented/Strengths	Remarks/Weaknesses
Initial training in basic skills to launch BIs activities (supervision, monitoring, EM management, algorithms, financial management) for service providers Training of community representatives in financial management Orientation of community representatives on BIS Sensitization of communities before launching activities cost recovery	Initial training of personnel performed in curative care, PHC, EPI, management, algorithm Communities sensitized Management committees selected and trained and oriented Cost recovered from purchase of EM and services	Although training performed, technical competence of health aides and ATS, nurses and midwives at health centers can be questioned. Algorithms are not used. Poor quality of services FP not included in minimum package of services provided at most health centers Low utilization of services especially FP and assisted deliveries.

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APPENDIX IV.

BAMAKO INITIATIVE STATUS

Requirement	Implemented/Strengths	Remarks/Weaknesses
Central and Intermediary support to the district level	Supervision and monitoring visits made at health centers by PHC/EPI/EM coordination unit and by Regional Inspector of Health	As program expands supervision becomes difficult often planned supervision is not carried out (around 30-40%). Supervisors do not bring about needed changes to improve quality of care and management. Supervisors sometimes lack supervisory skills. There are not enough supervisory teams to carry out supervision as scheduled. Lack of motivation of supervisors. Lack of resources to carry out supervision (vehicles, fuel, competent supervisors in all activities)

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APPENDIX IV.

BAMAKO INITIATIVE STATUS

Requirement	Implemented/Strengths	Remarks/Weakness
Community Involvement in financial management and in carrying out activities related to health services.	Health committees engaged in managing funds recovered from purchase of drugs and services. Engaged in social mobilization and IEC activities. Attend monitoring sessions and health centers	Limited engagement in definition of community health problems and planning. Limited engagement defining health problems and bottlenecks in implementing PHC activities at health centers.
Constitution of revolving funds to be used to purchase EM and maintenance.	Funds obtained from cost recovery used to cover basic operating costs of health centers. Reserve funds used in part to cover maintenance costs in some zones.	Limited access to reserve funds. Kept in bank and can loose value as time elapses. Problems of maintenance and amortization are not resolved (investments).

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APPENDIX IV.

BAMAKO INITIATIVE STATUS

Requirement	Implemented/Strengths	Remarks/Weakness
Existence of referral hospitals	Referral hospitals exist in each region and prefecture.	Referral hospitals often lack: · basic equipment to perform technical work · lack of skilled personnel to run available equipment (radio, anesthesia) · insufficient number of skilled clinicians. · low utilization of services and referral system · stock out of drugs

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APPENDIX V

Private Sector Assessment

In countries such as Guinea which have opted for free market economies, both the private and para-public sectors are expected to play either a major role in the economic sector or act as logical partners in health and family planning matters. This sector includes:

- private health establishments such as clinics, medical practices, pharmacies and private labs;
- the health dispensaries of industrial and commercial enterprises, or private and para-public services;
- autonomous social institutions such as the National Social Security System (CNSS) or the Red Cross;
- Health Oriented Non Governmental Organizations (NGOs); and
- the informal sector which includes traditional healers, village midwives and small-scale medical suppliers.

The role of the leading partner in health and family planning matters within the private and more precisely, non-state controlled sectors can be defined thus:

1. In the first instance, this sector handles health and family planning demands which are not covered under the public health system. This usually includes patients and people who seek service from private clinics, medical practices, labs and other health dispensaries of private and para-public enterprises.

2. Additionally, this sector is involved in commercial activities which are different from those of the public domain as is the case of the clinics, medical practices and other labs cited above as well as for dispensaries, wholesale distributors and pharmaceutical industries.

3. Furthermore, their structures are frequently more flexible than state run establishments or sometimes more adapted to providing immediate and timely assistance. This is the case with NGOs which in addition to providing financial assistance, provide more efficient services in areas or zones where state support has proved to be insufficient or inadequate.

4. Finally, private sector health programs/practitioners can provide health or family planning services which are usually their areas of specialization and which allow them to satisfy particular needs for religious or traditional purposes. This is the case with traditional healers, village midwives or denominational establishments which promote or develop natural family planning methods.

The importance of these types of private, para-statal, traditional or religious actors within the Guinean health and family planning systems cannot be overlooked. In general, they play three fundamental roles: they collaborate closely with the public sector as part of the process of integrating family planning within the public health structures; additionally, they provide service in areas which fall within their competency as can be witnessed with vast numbers of private/para-public medical or pharmaceutical facilities; finally, they expand the therapeutic and contraceptive services through village midwives and promoters of natural family planning methods.

However, despite the undeniable presence of the private sector within the health and family planning system in Guinea, despite its importance and diversity, both the government and the populations are yet to exploit its full potential. Before reaching this objective, it will be necessary to overcome deficiencies and other limitations of this sector by adopting and implementing appropriate strategies for greater impact and expansion.

The strategies to be adopted will be determined from the following analysis of the strengths and weaknesses of the actions of the latter.

Strengths and Weaknesses of the Private Sector

A pluralistic and liberal political system was installed in Guinea at the advent of the Second Republic in 1984. This brought about several changes within the economic and social sector as evidenced by the emergence of several private sector ranging very often from small businesses (trading, wholesale trade, crafts industry), big/medium size businesses (fishing, construction, manual labor etc.) or large production units to former public services which were declared companies with mixed economies (industrial mining, agro-industries, pharmacy). Health and planning were not marginalized by this policy as a result of the primary role of the private sector. The dynamic, diverse and technical skills demonstrated by this sector should guarantee its future participation as a leading partner in its collaborative efforts with the government.

The major strengths of these sectors are in:

- a very favorable political/legal framework within which they operate;
- the existence of possibilities upon which the most legitimate expectations can be pinned.
- a realistic and encouraging partnership between state and private sector.
- a favorable political/legal climate for family planning in the private and para-public sectors.

The following indicators present an alarming demographic situation in the country: infant mortality rate - 150%; average maternal mortality rate of 500 for every 100,000 births; birthrate - 48%; coverage of health centers across the entire country in 1988 - 28.9%; annual population growth rate 2.6%; average age of marrying women - 16.9 yrs; rate of fertility average 6.1. This situation should encourage the government to:

a) Develop, or better yet, encourage family planning as a means of ensuring family welfare (Fundamental Law which was adopted in 1990) or as a population political strategy which would "reduce the gross birth rate of 25% by the year 2000" (Declaration of Population Politics under decree n° 92/144/prg/sgg/of 4/6/92). Such resolutions which do not necessarily address the private and para-public sectors do, however, represent (as is the case with the others, a possible recourse which could provide support for their family planning programs) a guarantee against all suspicion or ambiguity concerning the legality and appropriateness of such an activity.

b) to re-think its health policy and to call not only upon the private and para-public sectors but also on traditional practices and NGOs "to remove the constraints...which have been preventing the country from reaching its stated objectives" (declaration of sectorial politics on health, February 1993)

c) to re-define its options within maternal and child health (MCH) and in this light, promote a partnership with the private and para-public sectors "and encourage them to contribute generously to the improvement of maternal and child health, as well as the health of women in general" (Proposal by the National MCH/FP Program).

d) develop a partnership between the public and private sectors. Support for such an undertaking is provided in the National MCH/FP Proposal: "Coordination between interventions (private and para-public sectors) will be assured by the MCH/FP or the Family Health section; concerted research will be carried out between all participants to promote uniformity in training criteria, service standards and management tools.

Participation in such a project would not be limited. It would be open to all private/para-public organizations, the traditional as well as the religious, the lucrative and the non-lucrative, as long as they contribute positively to the development of health and population activities. It seems clear that the government's only wish is to concert with its partners, not to impose its will - a policy which has the advantage of encouraging confidence and trust in the joint venture. Finally, it is worth noting that the government is fully aware of both the quantitative and qualitative contributions of this sector, in short, the hidden potentials of this sector.

The strengths the private sector's contribution to the improvement of health and family planning activities in Guinea can be summarized under four basic criteria. These are: the quality of services, the target population, diverse intervention techniques, and the existence of a social security system which will help perpetuate health and family planning programs.

a) In terms of service quality, the private sector, especially health dispensaries of large enterprises, clinics, medical practices and other private labs have the following advantages:

- they offer better technical expertise than the public sector: this is especially the case with the following - the Compagnie des Bauxites de Guinée (CBG), the Société des Alumines de Fria ou d'Aredor, the Société d'Exploitation du Diamant in Gbenco, in upper Guinea. This is also true with medical centers such as those at the Société Guinéene des Palmiers à Huile et d'Hevea (SOGUIPAH) or the Entreprise National des Tabacs which basically has a more complete medical staff, modern equipment, a wider range of, and readily available medical assistance. As far as family planning is concerned, the medical centers are capable of offering a wider range of services, from oral contraceptives to surgical contraception, including services for STDs/AIDS (they often have well equipped labs for sero-bacteriology) and can even handle sterility;

- they can offer quality service: the availability of the medical staff, of equipment and drugs: proper hygiene; adequate sterilization of medical equipment;

- they maintain regular service reports (monthly) and a satisfactory filing system of patient records.

It is worth noting that these comments only refer to the profit making establishments within the private and para-public sector in its efforts to provide quality services. They do not often include the NGO and traditional sectors.

The private sector in Guinea also plays a major role in medical coverage. In essence, this sector provides service to a considerable percentage of the population, notably to:

- Employees and families of companies mentioned earlier and those employees and family members of companies which do not provide health services to patients/employees who seek services in clinics, medical practices and private labs. According to the Labor Department, the total number of people seeking medical services in these centers is 1,170,000 (workers and families).

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- People living within the proximity of the private and para-public health centers who seek medical services either because they do not have easy access to the closest public center or because of better service in these private centers. The number of people seeking such services is quite high in particular in Kamsar, Fria, Conakry, Gbenco and Diecke. According to medical authorities, the number of people in these communities is no less than 250,000;

- People who visit NGO or NGO managed centers such as the AGBEF model clinics, private catholic dispensaries which serve up to 50,000 people;

- People, who because of their culture or financial status can only visit traditional practitioners. The predominant users are the rural populations and the numbers can be as high as 1,500,000 or even 2,000,000.

It can, therefore, be concluded that the number of people served by the private sector is quite substantial and can reach as high as 2,500,000. Furthermore, this category seems to be comprised of that segment of the population which is in dire need of family planning. This segment also has the highest birthrate (among the working class group, the birthrate can be as high as 60% and the rural milieu in Middle Guinea where the fertility rate is much higher than the national average).

One of the major contributions of the private sector to the development of health and family planning programs is the diversity of the services provided. As was earlier demonstrated, this can be attributed to:

- the private sector's more complete and functional health care infrastructures which are often lacking in the public sector. There are approximately 30 centers in Guinea which belong either to companies or NGOs which are quite capable of developing highly competent health and family planning programs; in addition, there are some twenty private medical practices which sometimes have dependable laboratory equipment.

- as far as strategy is concerned, this sector's flexibility and capabilities allow it to succeed where the public sector cannot (for example, in such areas as social marketing and community-based distribution). In this respect, it is worth noting that the country has 183 private pharmacies, 4 wholesale distributors and a central pharmacy which services the para-public structures. Guinea also has several village midwives (several thousands) who could contribute to the success of important community based distribution programs.

- the private sector can develop its own programs, or offer technical assistance to the public sector, or simply provide financial or in-kind assistance. At least ten national/international NGOs are currently providing such services in Guinea.

With respect to the National Social Security System, the following exist in Guinea:

- a national social security system exists with some 2160 subscribers (companies) as well as 57,557 insured members (workers). The system covers reimbursements, patient care in cases of extended hospitalization (beyond 8 days) and contraception. It also covers welfare for the children of the insured (age limit, 16 yrs; max. number of children 10). Employees also receive half of their salary during the 14 week maternity leave.

- an health care mutual fund which is not operational will eventually cover civil servants (50,000), workers of the modern sector (40,000), workers in the informal sector (20,000) as well as their family members. The mutual fund package will include curative and preventive health care, essential drugs and lab tests.

There is, therefore, little doubt that the private sector is well positioned to assist the government in implementing its health and population programs. It is quite clear that this sector has been active and has gained considerable experience in health and family planning matters which should be drawn upon to establish and implement a more complete and ambitious program.

The government/private sector partnership program was initiated at the end of the 1980s and is, therefore, quite young. It began with the appearance of NGOs which either implemented their own programs liaised with government efforts. The most noticeable are:

- AGBEF which collaborates with such international NGOs as Population Services International (PSI), Family Planning International Assistance (FPIA) or which uses financial assistance from international organizations (World Bank, UNFPA, IPPF) to develop its own administrative and technical structures, and provides assistance in integrating family planning in health centers around the country. It is also contributing to the development of information, education, communication and family planning activities across the whole country. This is being done with innovative techniques (work with the informal sector, a proposal to work with pharmacists, distribution at the community level etc.)

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It should be noted that AGBEF plays a leading role in family planning matters. In this regard, AGBEF has succeeded in integrating this activity in 80 health centers in different regions of Guinea. Additionally, it has 3 model clinics (1 in Conakry, 1 in Kindia and 1 in Nzerekore)

- With its 6 million dollar grant for the FAMPOP project, PSI is in the process of developing an important social marketing program for condoms across the entire Guinean territory. Working in close collaboration with the National STD/AIDS Control Committee and AGBEF, FAMPOP has succeeded in promoting the increased use of condoms.

- CERAC-SANTE is a local NGO which operates in the Kindia district. It assists in the renovation of health centers and posts within this locality, carries out health education activities (family planning, nutrition, vaccination etc..) trains village midwives and manages women's groups.

- Several European NGOs intervene in specific areas. Some are involved in hospital and health center renovation, restocking drugs and medical equipment, training medical staff and improving their management systems. Others, such as Médecins du Monde provide aid to the Kindia district hospital; the Association Françaises des Volontaires du Progrès assists the Forecaria health center; Médecins sans Frontières and Medicus Mondi operate in Upper Guinea, while the Belgian Médecins sans Frontières operates in tropical Guinea.

- The Catholic church, on the other hand, is in the process of developing natural family planning program with the creation of a national association which would promote this activity. It has also created a natural family planning service in 7 dispensaries in Conakry;

- The Association for Voluntary Surgical Contraception (AVSC) helped with the development of mini-lap capabilities in 5 public health centers (3 in Conakry, 1 in Nzerekore and 1 in Labe)

The private sector is very active in the Guinean health and family planning process. It has more or less secured its place as a partner to public authorities, especially in regards to the major role played by the AGBEF in family planning and other family and population domains. The same can be said for PSI with its STD/AIDS control program via its social marketing of condoms and also for the activities of other NGOs.

However, despite the actions of the numerous NGOs in the national health and family planning program, despite their dynamism and

important service to the country's developmental process, the public sector has yet to exploit the full potential of this sector.

Upon closer inspection of the preceding analysis of the private sector, it can be discerned that the profit making private and para-public companies are not involved optimally in health and population programs. Additionally, the State/Private sector partnership seems somewhat fragmented due to the failure on the part of the private sector to grow while providing support to the government.

The major weaknesses of the private sector in health and family planning are:

- absence of a program for the private sector;
- lack of noticeable interest in family planning by the private/para-public sectors, and
- the need to improve the quality of NGO services

Notwithstanding the leading role played by the private sector, it must be stated that there is no national health and family planning program. In essence:

a) there is neither structure, coordination, supervision, nor management of such a program in the country. Furthermore, even though a system of coordination is deemed necessary by the Ministry of Health and Social Affairs, it only exists as a proposal. As far as a management structure is concerned, this cannot exist until some action is taken to coordinate and plan private sector health activities of companies, clinics, medical practices and private labs, without forgetting NGO health structures, the pharmaceutical professions and traditional practices.

b) with respect to sponsorship, there is no single project to support the private sector program, despite considerable efforts by external aid sources. Local NGOs such as the AGBEF or their international counterparts such as PSI, FPIA, AVSC or Médecins Sans Frontières, have been successful in receiving aid but this was used to develop public health structures, and not to develop health and family planning activities in the private sector. It is true that two companies in downtown Conakry received modest assistance for their family planning programs. Unfortunately there are no other examples.

c) with regard to the objectives of the government and particularly the family planning target group, there is no proper census of working class families. No program exists aimed at working women. There are 250,000 women of child bearing age are within this sector of the population. There is also no family

planning program for the rural populations which almost always seek traditional practitioners, especially as pertains to maternity and contraception.

There is a decided lack of interest in family planning activities by the profit making private/para-public sector. Mention should be made of the marginal allocations to family planning by the private sector, notably, those made by profit making enterprises.

Family planing in this instance consists of advice which is frequently given to large families, in other words, when it is already too late to plan. This attitude is, however, not irreversible. It is often due to:

a) misunderstanding by company directors of the positive aspects of family planning for company productivity and worker output.

b) lack of health IEC campaigns within companies. Emphasis is usually placed on curative care. Furthermore, records seldom show family planning statistics, even when this is indicated as part of their programs.

c) non-participation of the private/para-public sectors in the development of national health and population policies. In this case, lack of participation by the National Social Security System in the elaboration and implementation of such policies is deeply regretted. Ironically, this organization has implemented one of the most classic pro-birth policies, one in which workers with families receive allocations for each offspring; the package includes coverage for a maximum of 10 children for each worker - with an age limit of 17 for educated children and 16 for those who are not literate; and the payment of half of employee salary during the 14 week maternal leave. As long as the CNSS continues such policies, it will be difficult to convince those in the lower income bracket to practice spacing between births. Launching an intensive family planning information campaign could impact on behavior.

A third observation is that the quality care and services among various private sector service providers is not uniform, and in some instances is not better than that offered by the public sector.

a) There is a vast disparity in the quality of services provided by NGOs. This is due in part to the funding on a regional basis of activities. AGBEF, for example seems to obtain better family planning results in Upper and Tropical Guinea than in Middle and lower Guinea because of the difference in the quality of the centers and better equipment in Upper Guinea. Differences can also be observed in the NGO approach,

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as can be witnessed in the cases of FPIA and AGBEF where the patient record filing system and follow up procedures are more efficient in the former. FPIA, in particular, seems to master its filing system and is, therefore, is able to determine drop out rates and determine numbers of acceptors more easily than some of its counterparts.

The problem of coordination and harmonization of activities needs to be resolved rapidly.

b) The quality of services in several integrated centers is average, even within 2 of the 3 AGBEF model clinics.

- service after consultation is limited to delivery of oral contraceptives, of injectables and condoms. There is practically no IUD insertion service, whereas the majority of the clinics have facilities for gynecological examinations. Very often, the patients are referred to hospitals which unfortunately, do not have family planning records;

- equipment sterilization is very often very poor;

- In general, the reception at the AGBEF model clinics is not friendly enough to motivate patients; and

- there is an alarming shortage of technical and administrative supplies within the family planning centers; this includes shortage of cupboards or filing cabinets for patient files, shelves, moving lamps, trash cans trays, calculators, separate files for family planning, STDs and sterility - all of which are minimum requirements in a family planning center.

c) The information system is no more reliable in the AGBEF centers than in the health centers where family planning is supposed to be integrated:

- patient files are not arranged in such a manner which would allow for easy follow-up.

- lack of proper administrative support makes it difficult to maintain a reliable inventory of the stock of contraceptives; and

- centralization of statistical data at the AGBEF headquarters prevents the regional coordinators from obtaining needed information to continue the family planning integration process in the health centers.

The fourth observation is that very few local NGOs participate in the national health development program: to date only 6 of the 50 recognized by the Service de Coordination des Interventions des ONG (SCIO) participate in the program. Additionally, with the exception of the AGBEF, the action is localized and coordination with the government seems to be insufficient.

These are the principal weaknesses which characterize the contribution of the private sector to health development in Guinea. A brief summary would include the following salient points: lack of collaboration between government and the profit making private/para-public sector; insufficient coordination between NGOs working with the government; and the need to improve the approaches of the former.

The consequences of these problems that national coverage, particularly in family planning is very partial since the most important part of the population which is in dire need of planning is excluded. This group consists mainly of workers in the modern sector and their families; furthermore, several health outposts which receive NGO support offer average quality services and do not have the necessary management techniques for these programs, for statistics and logistics; finally the lack of cooperation between the government and the private sector represents a tremendous loss in terms of revenues since increased involvement with the private sector would increase the number of structures for development programs, hence additional resources for this purpose.

Conclusions

Despite a real effort by the public authorities to include the private sector in the national health and population policy, impact has been minimal in the absence of a specific program for this sector. Nevertheless, neither the potential nor opportunities for increased activities and growth are lacking in this sector.

With regard to potential, the private and para-public profit-making arm of this sector have management abilities, human resources and infrastructure, all of which are real assets which should be exploited. Furthermore, they serve a very important sector of the population which, it should be understood, is not served by the public sector.

It has also been demonstrated that NGO support to public activities has some shortcomings in areas of coordination, service delivery, management and follow-up.

In discussing the issue of continuity, a point has been made to the existence of concrete opportunities and inherent capacity for growth within the National Social Security system. The possibilities involve future implementation of a mutual fund which would guarantee prevention and cure for subscribers from state agents to workers from the modern and informal sectors. The difficulty facing the mutual fund lies in its inability to obtain credit to implement activities.

Suggestions and Recommendations

1) Identify an external sponsor for the national family planning program to be used for the private sector. The grant should be used on private/para-public health structures, on all enterprises with health structures, and on NGOs wishing to develop family planning activities. It should also be used on all private/para-public associations which are interested in promoting family planning. Finally, the same grant should be used to carry out research on the influence of the traditional sector, contraceptive methods, as well as a feasibility study on community based distribution. The modalities for the distribution of the grant should be drawn up including:

   - Creation of a coordinating committee which would include representatives from the Ministry of Health and Social Affairs, the Ministry of Planning and Finance, the sponsor, and the executing agent of the national family planning program in the private sector, and

   Examination by the above committee of requests from different private sector groups which are interested in developing family planning activities.

2) Provide assistance in the following areas:

   - Conduct a KAP study on the attitudes of the working class regarding contraception and appropriate informational and educational advertisements to be developed. Also carry out a study and research on contraception in the traditional sector and the feasibility of developing community-based distribution programs;

   - Organize short-term training sessions on family planning clinics, on management of family planning programs, on IEC/counselling, on prevention and treatment of STD/AIDS, on caring for the sterile, on laboratory techniques, and on logistic management and statistics;

   - Provide administrative supplies, (filing cabinets, cupboards, files, suspensions, consultation cards, appointment cards, inventory registers, registers, stands etc.) technical material (examination tables, moving lamps, IUD equipment, stethoscopes, tensiometers, thermometers, IEC equipment, small laboratory equipment etc.); and

   - provide contraceptives and assistance in surgical contraception in private health centers.

3) Contract with an agency with experience in private sector family planning programs. It will have the following responsibilities.

- management of program funds;
- preparation of meetings for the requests committee;
- provision of assistance in formulating requests;
- purchase and supply of assistance material;
- organization and financing of training sessions;
- stocking of contraceptives for groups which benefit from the assistance;
- initiation, preparation and financing research related activities, studies and development of IEC messages;
- supervision of sponsored family planning activity;
- retrieval of statistical information from the groups receiving aid from the program; and
- elaboration of periodic activity reports (quarterly) for the sponsor and the Ministry of Health and Social Affairs.

4) Provide the following assistance to pharmacists under the executing technical agent:

- train service providers in contraception technology, prevention of STDs/AIDS, IEC, and social marketing;
- provide within the framework of the program, condoms, oral contraceptives, injectables and IUDs to be sold at reasonable prices; and
- provide them with the means to organize information and awareness campaigns on family planning and prevention of STDs/AIDS.

5) Provide the following assistance to the AGBEF under the executing agent:

- revision of the training modules for clinical family planning and IEC;
- improvement of supervisory standards;
- improvement of patient registration technique, filing of their dossiers and follow up on family planning subscribers;
- improvement of IEC activities by evaluating existing practices and developing better models; and

- improvement of the quality of family planning services using equipment comparable to those used in the model clinic, using better trained clinic staff (friendly receptionist to encourage patients, family planning clinic and counselling for midwives, management of family planning programs for the coordinators).

6) Provide assistance to other NGOs in the following areas:

- education and awareness on family planning, prevention of STDs/AIDS, immunization, prevention of diarrheal diseases and nutritional protection;

- development of the social marketing of condoms, launching and developing social marketing ORS packages and mosquito nets; and

- studies and experiments in community level contraceptive distribution, ORS packages and mosquito nets.

7) Assist traditional practitioners to become involved in the MCH/FP national program by:

- providing assistance in research on traditional contraception;

- encouraging village midwives to participate in the distribution of contraceptives, ORS packages and mosquito nets in community-based distribution programs.

8) Provide technical and material support to the Division de la Medicine du Travail (which is in the process of becoming an autonomous organization) to allow other enterprises to buy into its program and to develop awareness campaigns for socio-professional groups.

9) Provide support (in the form of credit for activity initiation) to the CNSS Health Care Mutual Fund and eventually provide assistance to the 15 health centers to be built.

APPENDIX VI
MATERNAL AND CHILD HEALTH

ACRONYMS

CBORS	Cereal Based Oral Rehydrating Solution
CCCD	Combatting Childhood Communicable Diseases Project
ORSEC	Organisation de Secour en cas de Catastrophe
SNIS	National Health Information System
PHC	Primary Health Care (PEV/SSP/ME)
DPTP	(DPT + Polio)
RNES	Recherche Nationale Essentielle pour la Santé
SIAC	Community Based Information System
DHS	Demographic and Health Survey
TDR	WHO's Program for Research and Training in Tropical Disease
OCP	Onchocerciasis Control Program
LTO	Leprosy, tuberculosis and onchocerciasis program

EXPANDED PROGRAM ON IMMUNIZATION

IMPORTANCE

The EPI remains the top priority in the child survival strategy of the 1990's quite simply because it is the most cost-effective approach we have to combat six childhood diseases. When Guinea launched its PHC\EPI\EM program in 1987 at the beginning of the Second Republic, the immunization coverage of infants was only about 5%. This put it into the category of "Lower Coverage Countries" faced with extreme economic hardship and a very under-developed and non-functional health system. Given this history, it is remarkable that coverage of children aged 12-23 months has been slowly and surely progressing to an estimated 30% in 1992 (DHS) and 55% in October, 1993 (MSPAS National Survey).

INTERNATIONAL GUIDELINES

Three of the global goals of the mid-decade depend to a large extent on coverage reaching 90% and above; the eradication of poliomyelitis and neo-natal tetanus, 90% reduction in measles cases and 95% reduction in measles mortality.

The Universal Child Immunization strategy of the 1980s didn't pay enough attention to sustainability with the result that in some countries coverage rates have markedly dropped from peaks of about 80%. One of the problems of EPI sustainability is that vaccine costs represent only about 10-12% of total program costs. Some of the components of strategies for the 1990s are as follows:

- WHO/Geneva has recently put new emphasis on EPI by upgrading it to a Global Program, as has already been done for AIDS and malaria.
- Special initiatives are being implemented
- EPI is a key component of the Bamako Initiative
- UNICEF has promoted the Child Vaccine Initiative
- USAID has funded the Measles Initiative and the Vaccine Independence Initiative

STRENGTHS

The EPI is the strongest component of the PHC program. Given its commitment to the 1995 goals of polio, tetanus and measles reduction, the government is exploring its options for increasing coverage. A major goal is that all subprefectures in the country will have at least one integrated health center by the end of 1995. Advanced strategies are also being used to reach beyond health centers to health posts and communities.

WEAKNESSES

The problem of dropouts between DPTP1 and DPTP3 has not yet been solved. It is hoped that increasing integration of MCH/FP programs will markedly reduce "missed opportunities". On the other hand, this strategy means that much vaccine is wasted in low volume centers where a bottle of 10-20 doses may have to be opened for only one child.

Because of the weakness of supervision, such activities as aseptic technique and routine maintenance of refrigerators are not as good as they should be.

The numbers used for surveillance and monitoring are often not valid. The MSPAS recognizes that its surveillance systems are weak. Finally, the twice yearly monitoring exercise is not yet an accurate instrument for coverage estimation because in the majority of cases the target populations are still being calculated on the basis of the 1983 census.

OPPORTUNITIES

Operations research will be needed to test new strategies to reduce vaccine wastage. Options now being considered including:

- Buying vaccine in smaller dose containers
- Limiting vaccinations to relative high volume days, such as market days
- Organizing special "vaccination days" in the communities

THREATS

The key question is how to assure adequate financing and sustainability in the medium and long run. Of particular concern are the costs of purchase and maintenance of expensive equipment such as vehicles and refrigerators.

RECOMMENDATIONS FOR ASSISTANCE

PUBLIC SECTOR

- Central
  - Support to the national program
  - Introduce a variation of the Vaccine Independence Initiative

The criteria that have been considered in other countries include:

- Level of government commitment
- GNP per capita
- At least 50% coverage
- Absorptive capacity of local UNICEF office
- Strength of the local currency
- Continuation of activities started in the CCCD project
- Operations research capabilities and resources
- Epidemiological surveillance and evaluation

- Region
  - Surveillance
  - Prefecture
  - Surveillance

- Sub-prefecture
  - Assistance in valid estimates of target populations
  - Testing and evaluation of new strategies
  - Community based activities
  - KAP studies to find ways to reduce immunization drop-outs
  - TBAs
  - Registration of births

PRIVATE SECTOR

- Search for partners to join Rotary and the Lion's Club in the support of immunization programs

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MALARIA

IMPORTANCE

Malaria is a major public health and development problem in Guinea, representing the chief complaint in about one-third of all medical visits. Some of the important effects are these:

Health
- Mother
  - Anemia
  - Fetal loss
  - Low birth weight babies
- Children under five
  - 28% of the reported morbidity
  - 11% of the reported mortality

Development
- Direct costs of prevention and treatment
- Indirect costs of lost work and productivity

INTERNATIONAL GUIDELINES

A malaria vaccine developed in 1988 is currently being tested by WHO's Program for Research and Training in Tropical Disease (TDR) in Tanzania. Preliminary results have shown the production of an immune response without adverse effects in children, leading to the hope that the vaccine could be in general use within four years. Until such time as this wish comes true, suggested strategies include the following:

- Focused prevention and case management
- Pregnant women
- Presumptive treatment and chemoprophylaxis (Especially for the first pregnancy)
- Children
- Recognition that malaria and pneumonia are often clinically indistinguishable and may occur simultaneously
- Personal protection
- Impregnated mosquito nets have been shown to be effective

STRENGTHS

Guinea is an active member of the WHO elaboration of a regional malaria control strategy and work plan for 1993-1999. USAID/ Washington (Africa Bureau and Office of Health) has committed 2.2 million dollars to WHO's regional office for Africa for priority activities during 1994-1996.

Key elements of the national policy adopted in 1993 include:

- Integration in the national PHC system
- Identification of first and second line drugs
- Promotion of personal protection by means of impregnated nets, curtains, and window screens
- Improvement of support strategies
- National coordination and evaluation
- Training
- Epidemiological information systems
- One surveillance post per region
- Community based information (SIAC)
- Strengthening of operations research capabilities (RNES)
- KAP studies
- In-vivo testing for chloroquine resistance
- Entomological studies

WEAKNESSES

One of the major constraints in the effectiveness of chemoprophylaxis of pregnant women is that they come for prenatal visits only when there are perceived problems. This is often late in the pregnancy.

OPPORTUNITIES

This is the time for the program to harmonize diagnostic and treatment algorithms with the new ARI program being developed. Lessons learned from the social marketing of condoms may be useful for impregnated mosquito nets.

THREATS

Major threats to the epidemiology of malaria come from rapid urbanization and development of resistance of Plasmodium falciparum to chloroquine and other anti-malarials.

RECOMMENDATIONS FOR ASSISTANCE

PUBLIC SECTOR

- Central
  - Support to the national program
  - Integration into the PHC program and decentralization
  - Continuation of activities started in the CCCD project
  - Operations research capabilities and resources
  - Epidemiological surveillance and evaluation

- Region
  - Surveillance post
  - Prefecture
  - Training and supervision

- Sub-prefecture
  - Use of new algorithms for diagnosis and treatment
  - Community based activities
  - Village committee (village based information system)
  - Male village health workers (Sanitation)
  - TBAs (Use of impregnated materials)

PRIVATE SECTOR

- Social marketing of impregnated materials

CONTROL OF DIARRHEAL DISEASES

IMPORTANCE

Diarrheal diseases are of major importance for child health and survival. Service statistics show that they account for 9% of child mortality and 15% of outpatient visits.

The DHS survey found an average 2-week prevalence of 16%, ranging from a high of 21% in Conakry to a low of 9% in Lower Guinea. Increased fluids, including breastfeeding, were being given in about 40% of cases and ORS packets were claimed to have been used in one of five episodes. A survey conducted by the MSPAS in 1993 found that 70% of mothers claimed to know about ORS, the lowest level of 50% being found in Conakry.

Epidemics of diarrheal diseases occur periodically in Guinea. An outbreak of salmonellosis was reported in 1993 and cholera has tended to appear in 8 year cycles. Refugee camps in Forest Guinea and densely populated urban zones represent high risk areas.

INTERNATIONAL GUIDELINES

In March 1994, USAID was honored by the international health community for its support to the discovery 25 years ago of the effectiveness of oral salts and glucose for the treatment of acute dehydrating diarrheas. This cost-effective, simple treatment is considered by many to be one of the most important public health advances of the 20th century. The effect is so rapid and dramatic, that if you have seen it used successfully once, you will become a believer. Yet in spite of these rave reviews the battle to generalize the use of ORT is far from being won. Some of the key obstacles include:

- The reluctance of medical practitioners to give up intravenous fluids and ineffective (and sometimes dangerous) anti-diarrheal medicines
- The wish of busy mothers that the treatment should stop the diarrhea

Current guidelines include the following:

- Food and increased fluids, including breastfeeding, in the home is important
- Home prepared sugar and salt solutions are now discouraged since mixing errors can result in dangerous hypertonic solutions
- Cereal based oral rehydrating solutions (CBORS) may be a useful supplement to standard ORS packets

- Appropriate use of antibiotics

- Potable water and sanitation programs should be linked to a diarrheal control strategy that includes ORT

STRENGTHS

The CCCD project was instrumental in helping Guinea launch its national program. Activities have been maintained since the end of the project in 1991 and PRITECH has also provided assistance in the development of a training strategy and studying the feasibility of local production of ORS packets. Now there is national commitment to the 1995 goal of 80% of diarrheal episodes being treated by oral rehydration therapy. WHO is providing support to the development of a 1994-1998 strategy.

WEAKNESSES

In spite of knowledge and training in the use of ORT, many health providers do not use it as much as they should. There is still a strong reflex to reach for the I.V. solution and many health centers do not have the minimum equipment necessary for a functional "rehydrating corner". In some centers, potable water is not easily available. When mothers are sent home with a packet and instructions there is a high probability that in many cases, the preparation and volume of the fluid administered may not be correct.

OPPORTUNITIES

This is the time to build on the successes of the past and move forward. Possibilities for effective assistance include:

- Support to OR
- Social marketing of ORS packets
- Refresher training to emphasize the positive synergism of measles vaccination, breastfeeding, Vitamin A supplements and nutritional evaluation and rehabilitation

THREATS

ORT can be supplemented by antibiotics in the management of some diarrheal diseases such as shigella, salmonella and cholera. Guidelines are needed for diagnosis and treatment.

Anti-diarrheal medicines are difficult to control.

POSSIBLE RECOMMENDATIONS FOR ASSISTANCE

PUBLIC SECTOR

- Central
  - Support to the national program
  - Operations research
  - Health facilities survey
  - KAP survey of mothers
  - Treatment algorithms (Importance of nutrition, breastfeeding)
  - Epidemiological surveillance of diarrheal outbreaks
- Region
  - Surveillance
- Prefecture
  - Training and supervision
- Sub-prefecture
  - Rehydrating corners in health centers
  - Community based activities
  - IEC linkages with water projects (SNAPE)
  - Promotion of breastfeeding and feeding
  - Appropriate technology
  - Rice and/or cassava based fluids

PRIVATE SECTOR

- Social marketing of ORS packets

ACUTE RESPIRATORY INFECTIONS

IMPORTANCE

Acute diseases of the lower respiratory tract (pneumonia, bronchitis, etc.) are of major importance for child health and survival. Service statistics show that non-specific ARI and measles combined account for about one-third of child mortality and one-fourth of the reasons for medical visits. The main reason that measles is so deadly in developing countries is due to widespread malnutrition.

The DHS survey found an average 2-week prevalence of 14%, ranging from a high of 21% in Middle Guinea to a low of 11-13% in the rest of the country. The average measles immunization coverage is 43%, ranging from a high of 63% in Conakry to a low of 24% in Upper Guinea. Outbreaks of measles occur on occasion, especially in urban areas. A significant number of cases are often found to have been immunized. This may be due to a combination of a breakdown of the cold chain and children getting measles at ages younger than 9 months.

INTERNATIONAL GUIDELINES

The ARI program of WHO has existed since 1982. The global mid-decade child survival goals call for:

- One-third reduction of mortality due to ARI
- 90% reduction of measles cases
- 95% reduction of measles case mortality

Main components of the current strategy include:

- EPI immunization coverage of at least 90% of children under one.
- This will protect against diphtheria, whooping cough, and measles.
- Promotion of breastfeeding immediately after birth, continued during illness
- Colostrum provides antibodies and prolonged, full breastfeeding provides good nutrition
- Proper case diagnosis and management
- Recognition of the overlap of malaria, pneumonia and diarrhea
- Avoidance of useless and sometimes harmful cold and cough medicines
- Training mothers to recognize when to seek care
- Importance of rapid breathing and chest-indrawing, with or without fever

STRENGTHS

With the help of WHO, Guinea is beginning to develop a new tool to be added to the battle for child survival.

WEAKNESSES

The program in its present state is in the section of infectious diseases and not integrated in the PHC system.

OPPORTUNITIES

The CCCD project showed that being a partner in a new program at the start provides great opportunities for sustainable impact.

THREATS

The biggest threat to this program today is that a source of needed technical assistance and resources has not yet been identified.

POSSIBLE RECOMMENDATIONS FOR ASSISTANCE

PUBLIC SECTOR

- Central
  - Support to the national program
  - Operations research
  - Health facilities survey
  - KAP survey of mothers
  - Integration into the PHC program and decentralization
  - List of essential medicines
  - Avoidence of cough medicines and inappropriate antibiotics
  - Treatment algorithms (Overlap of ARI, malaria and diarrhea)
  - Special effort to increase measles immunization coverage
  - Epidemiological surveillance of measles outbreaks
- Region
  - Medical education in medical and paramedical schools
  - Surveillance
  - Baby friendly hospitals
- Prefecture
  - Training and supervision
  - Baby friendly hospitals

- Sub-prefecture

  - Introduction of services
  - Baby friendly maternities
  - community based activities
  - TBAs
  - Promotion of early breastfeeding after birth
  - Appropriate technology
  - Simple aids to counting respiratory rates

STD/HIV/AIDS

IMPORTANCE

AIDS and STDs are important public health problems. Since the first recognized Guinean AIDS patient in 1987, 780 cases have been reported by the middle of 1993. About 2% of the cases have been children and 40% of the adults have been women. 91% are HIV1, 4.5% are HIV2 and 4.5% have both viruses. Seroprevalence surveys on blood donors, STD out-patients and rural populations have been done. Prevalence levels are generally under 2%, the highest found thus far being 2.9% of 1511 blood donors.

A few sentinel sites for STDs are functioning. A survey in 1992 on 1,200 people found 27% positive for gonorrhea and 3% for syphilis.

Some of the possible effects of these diseases and their linkages with reproductive health, child health and family planning are as follows:

- AIDS signs overlap with those of other diseases, complicating diagnosis
- Weight loss, fever and diarrhea are common major signs of AIDS
- Cough and tuberculosis are minor signs of AIDS

Impact of maternal health on child health:

- AIDS
- Impact of maternal death on the probability of child survival
- Perinatal transmission of HIV to the child
- Can occur through breastfeeding
- STDs
- Conjunctivitis of the newborn (Gonorrhea and Chlamydia)
- Congenital syphilis

Impact of maternal health on family planning:

- STDs hinder the successful use of IUDs

Impact of family planning on maternal health:

- Condoms help reduce the spread of STDs

INTERNATIONAL GUIDELINES

The maternal and child health and family planning strategy for the 1990's calls for integrated programs that focus on the improvement of reproductive health and address the problems of STDs and HIV/AIDS. Until there is a cure for AIDS, the emphasis is on education aimed at promoting the behavioral change necessary to reduce transmission. New attention is being paid to the high risk group of adolescents.

STRENGTHS

With the help of WHO, a national commission and program for STD/AIDS has been functioning since 1987. In spite of very limited resources, a national policy has been developed and the program is ready to be integrated into the PHC system. Successful partnerships of note are the University of Montreal, PSI for IEC and social marketing of condoms and the EEC and Belgian Red Cross for support to the national transfusion center.

WEAKNESSES

Financial resources have been extremely inadequate. For example, last year only $8,000 was available for laboratory supplies. Other priority needs are felt in the areas of training, decentralized surveillance and operations research.

OPPORTUNITIES

Detailed strategies and guidelines exist, waiting to be implemented.

THREATS

HIV/AIDS prevalence is currently low and surveillance is needed to monitor high risk groups and geographical areas. Of particular concern is the forest region with its massive influx of refugees.

Sexually transmitted diseases present the challenge of resistance to antibiotics and the costs of diagnosis and treatment. Means to cover these costs must be found to improve women's reproductive health and the effectiveness of family planning services.

POSSIBLE RECOMMENDATIONS FOR ASSISTANCE

PUBLIC SECTOR

- Central
  - Support to the national program
  - Integration into the PHC program and decentralization
  - Operations research capabilities and resources
  - Epidemiological surveillance and evaluation
- Region
  - Surveillance
- Prefecture
  - Training and supervision
- Sub-prefecture
  - Linkages with prenatal and family planning services
  - EPI (Immunizations for HIV positive children)
  - Community based activities
  - IEC
  - Distribution of condoms

PRIVATE SECTOR

- Linkages with NGO's, commercial sector

INFECTIOUS DISEASES

IMPORTANCE

Major diseases in Guinea are currently grouped by the National Service for Health Information (SNIS) into the four categories shown in the following table:

TABLE
SNIS CLASSIFICATION OF MAJOR DISEASES

EPIDEMIC POTENTIAL		OTHER	
EPI	NON EPI	COMMUNICABLE	NON COMMUNICABLE
Diphtheria Measles Neo-natal tetanus Poliomyelitis Whooping Cough	Cholera Meningitis Plague Typhoid Yellow fever	ARI Dracunculiasis General tetanus HIV/AIDS Leprosy Malaria Onchocerciasis Other diarr. diseases Rabies STD Schistosomiasis Trypanosomiasis Tuberculosis	Cardio-vascular Dermatological Diabetes Female: Urogenital Hypertension Male: Urogenital Malnutrition Neurologic Other metabolic Psychiatric Pulmonary Trauma

With the exception of malnutrition, the diseases of major public health importance are infectious or parasitic and fall in the first three columns.

EPI (Already discussed). Note that although BCG provides protection against tuberculosis, this disease is classified as a non-epidemic disease. Given the alarming resurgence of tuberculosis in some parts of the world, including the United States, increased surveillance is needed to see if it should be reclassified.

POTENTIAL EPIDEMICS (NON EPI)

The program for these diseases lies in the Communicable Diseases Section of the Division of Prevention. Under it there is a sub-section of Immunizations/Epidemics/Catastrophes. One of the main functions of the immunization branch is yellow fever shots for pilgrims going to Mecca.

Epidemics are not uncommon occurrences. Being in the meningococcal meningitis belt that stretches across Africa, Guinea has a meningitis problem almost ever year from January to the beginning of the rains. This year is no exception and by the end of March, over 500 cases had been reported in the prefecture of Siguiri in Upper Guinea. The estimated attack rate during the month of March for Siguiri was 25 cases/10,000 population.

Since in the past cholera has appeared in eight year cycles and last occurred 1986, there is special concern for current surveillance. The last yellow fever epidemic occurred in 1990 and there is concern, since it is currently being reported in Ghana.

NON-EPIDEMIC COMMUNICABLE DISEASES

The LTO program coordinates the strategy to control leprosy, tuberculosis and onchocerciasis. A survey in 1988, found a leprosy prevalence of about 2%. Over 4000 new cases were diagnosed in 1993, 15% of which were children under five. Also in 1993 over 6000 new cases of tuberculosis were diagnosed by positive sputum. About one million people are exposed to onchocerciasis causing blindness in an estimated 20,000. The highest risk zone is Upper Guinea.

Trypanosomiasis, the cause of sleeping sickness, is thought to be on the increase. A survey supported by WHO and the French is being carried out to asses the situation. Schistosomiasis is a problem, particularly in Forest Guinea. The outbreak of intestinal schistosomiasis in northern Senegal in recent years is a reminder that this disease also has epidemic potential.

INTERNATIONAL GUIDELINES

Strengthening of national and international surveillance systems are a high priority. WHO is currently sounding the alarm over the menacing worldwide return of tuberculosis. Particularly disturbing is the rapid evolution of resistance to therapeutic drugs and the association of tuberculosis with AIDS.

STRENGTHS

The strategy of integration of the LTO program and health center laboratories into the PHC system is being implemented.

The program for leprosy, being older and more functional than the one for tuberculosis started in 1990, is providing the framework for expansion. Support is being given by the NGO Philafricaine. Oncherciasis Control Program radios, in 26 prefectures of the country, provide means of communication.

Specific impact of decentralization includes:

- A seminar for regional and prefectoral teams in epidemiological surveillance and rapid alert was held in April 1993 with the help of WHO
- Increased collection and microscopic examination of smears and sputum for leprosy and tuberculosis diagnosis
- More cost-effective case management
- Tuberculosis (two months supervised plus six months in community)
- Community based delivery of Ivermectine for Onchocerciasis

WEAKNESSES

The weak health information and epidemiological surveillance sytems are currently a major handicap to planning, implementation and evaluation of the NPHCP.

OPPORTUNITIES

Assistance is being sought to help refine and implement plans that have been made. The French are currently providing support to the BEPR and the Germans have also expressed an interest in so doing.

THREATS

The increasing worldwide return of tuberculosis reminds us of the necessity of constant vigilance against the changing patterns of potentially epidemic diseases. The questions of cost are also important. Adequate treatment of tuberculosis is expensive and the reduced international funding of the OCP requires new strategies for sustainability.

POSSIBLE RECOMMENDATIONS FOR ASSISTANCE

PUBLIC SECTOR

- Central
  - Support to the national program
  - Integration into the PHC program and decentralization
  - Operations research capabilities and resources
  - Epidemiological surveillance and evaluation
  - SNIS
  - ORSEC
  - EPI antigens (Some high risk countries have added yellow fever)
- Region
  - Surveillance
- Prefecture
  - Training and supervision
- Sub-prefecture
  - Quality of services
  - Laboratory
  - Community based activities
  - Support to the information system (SIAC)
  - Distribution of Ivermectine (AFRICARE has experience in Nigeria)

PRIVATE SECTOR

- Collaborat

APPENDIX VII

THE STATE OF BREASTFEEDING AND NUTRITION IN GUINEA

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AS PART OF THE

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BREASTFEEDING AND OTHER CHILD FEEDING PRACTICES

Initial Breastfeeding and the Introduction of Pre-lacteal Feeding During the First 24 Hours after Birth

In Guinea almost all mothers breastfeed: the percentage of ever breastfed children is 93.3% (DHS, 1991). Table 1 summarizes the 1992 DHS data with respect to initiation and prevalence of breastfeeding. Breastfeeding patterns vary little according to urban/rural residence or sex of child. 57.8% of Guinean mothers initiate breastfeeding within 24 hours after delivery, while only 37.8% begin within one hour.

Potentially harmfully substances are often given to the baby instead of breast milk during the first 24 hour period following delivery (Vohou et al, 1994). These include: Kinkeliba solution, "talisman" goat, sheep and cow's milk, sweet potato leaf solution, plain and sweet water (see Table 2). According to this study, during the first 24 hours following delivery, 39.5% of mothers in Conakry gave kinkeliba solution to their infants, 23.5% gave sweet water and 3.6% infant formula. Only 18.5% of the infants received breast milk, and 14.8% received no feeding at all.

Duration of Breastfeeding

On average, children in Guinea are breastfed up to about two years (DHS, 1992). This duration varies little according to urban/rural residence, regions or assistance at delivery. However, breastfeeding duration becomes shorter as educational level increases: 24 months for mothers with no formal education, 19 months for those with secondary education, and only 13 months for those with higher education (Table 3).

Table 1: Initial Breastfeeding

VARIABLES	% CHILDREN EVER BREASTFED	START WITHIN 1 HOUR	START WITHIN 1 DAY
Gender			
Male	93.3	38.0	58.2
Female	93.2	37.7	57.3
Residence			
Urban	93.0	32.8	55.5
Rural	93.4	39.8	58.7
Regions			
Conakry	92.1	29.8	52.9
Lower Guinea	96.3	43.8	61.3
Middle Guinea	93.1	24.6	49.8
Upper Guinea	87.6	25.9	25.4
Forest Guinea	95.7	61.0	84.4
Education Level			
None	93.5	38.3	57.7
Primary	93.1	38.7	60.7
Secondary	92.2	33.8	58.3
Higher Ed.	80.4	23.3	51.1
Assistance at Delivery			
Medically Trained	93.6	32.8	55.3
Traditional	94.9	49.2	65.2
None (or other)	95.0	33.6	55.0
Place of Delivery			
Health Facilities	94.4	34.7	57.2
At Home	95.4	39.0	58.4
Total	**93.3**	**37.8**	**57.8**

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Table 2: Liquids Given to Infants Before Breast Milk

LIQUIDS	%
Kinkeliba	23.6
Talisman	37.7
Other Liquids	38.7
Plain Water	11.0
Sweet Water	10.9
Fresh Milk	5.7
Skimmed Milk	3.3
Goat Milk	1.5
Cow's Milk	2.9
Sweet Potato Leaves	2.6
Tamarind	0.5
Ground nut	0.4

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Table 3: Duration of Breastfeeding

	MEAN BREASTFEEDING DURATION (MONTHS)
Residence	
Urban	21.8
Rural	24.1
Regions	
Conakry	20.8
Lower Guinea	23.0
Middle Guinea	24.3
Upper Guinea	23.3
Forest Guinea	24.6
Educational Level	
None	23.8
Primary	22.4
Secondary	19.0
Higher	12.9
Assistance at Delivery	
Medically Trained	22.6
Traditional Midwives	24.1
None	24.3
Gender	
Male	23.3
Female	23.8
National Average	**23.5**

Exclusive Breastfeeding

The prevalence of exclusive breastfeeding in Guinea is very low. According to the latest DHS data, only 0.4% of infants are exclusively breastfed during the first 4 to 6 months. Less than 5% of children one month old receive breast milk only. As shown in Table 4, no infants in Conakry had received exclusive breastfeeding during the first month of life. The rate of exclusive breastfeeding increases slightly as the child gets older (up to five months), but is never higher than 5.2%. Exclusive breastfeeding during the first 0 - 3 months is lowest in Conakry, among mothers with secondary education, and, interestingly, among those assisted at delivery by medically trained personnel.

Table 4: Exclusive Breastfeeding

	% BY AGE : MONTHS SINCE BIRTH		
	0 - 1	2 - 3	4 - 5
Residence			
Urban	2.1	4.2	4.5
Rural	5.6	5.6	5.4
Regions			
Conakry	0.0	3.0	3.0
Lower Guinea	7.1	7.2	5.8
Middle Guinea	7.1	7.1	8.0
Upper Guinea	5.3	5.6	6.2
Forest Guinea	1.2	2.9	2.2
Educational Level			
None	4.4	5.3	4.9
Primary	9.6	5.9	4.2
Secondary	0.0	3.6	13.0
Gender			
Male	5.7	6.0	5.1
Female	4.0	4.5	5.3
Assistance at Delivery			
Medically Trained	1.8	3.9	3.7
Traditional	6.3	4.6	3.4
None	5.6	6.7	7.5
Average	**4.8**	**5.2**	**5.1**

Breastfeeding and other Supplementary Foods

The introduction of other foods starts very early in life and continues up to 36 months (Table 5). 67.7% of month-old infants in Guinea receive breast milk along with plain water, and 31.3% receive breast milk with some food supplements. Such supplements may include infant formula, other milks and liquids, and mushy solids.

The ENAMOG study in Middle Guinea showed that supplementary foods are given to children using either spoon (16.2%), bottle (4.1%) or calabash (2.2%). Porridges are the principal supplements found in Middle Guinea -- the types of porridges and ingredients are found in Table 6. About half of the mothers use maize.

Table 5: Breastfeeding and Supplementation

AGE	BREAST AND PLAIN WATER	BREAST AND SUPPLEMENTS	INFANT FORMULA	OTHER MILK	OTHER LIQUIDS	MUSHY SOLIDS
0 - 1	62.7	31.2	4.1	7.7	19.1	16.7
2 - 3	47.3	43.5	12.5	22.3	22.0	14.7
4 - 5	45.5	45.6	5.4	12.3	28.9	21.9
6 - 7	30.3	62.6	6.2	12.5	34.4	37.3
8 - 9	34.8	52.1	6.8	6.5	32.1	34.1
10 - 11	30.7	64.7	11.7	16.0	31.4	41.2
12 - 13	22.8	68.0	2.9	16.1	36.8	55.5
14 - 15	22.3	62.6	5.6	11.2	48.5	53.1
16 - 17	13.5	70.9	11.5	11.7	51.4	58.2
18 - 19	32.4	51.6	7.7	13.1	33.9	38.8
20 - 21	6.7	77.4	9.8	16.5	61.5	64.0
22 - 23	14.6	61.6	5.1	8.1	49.7	53.9

Table 6 : Types of Porridges prepared for children

BASIC FOODS	%
Cereals	
Fonio	13.1
Maize	51.4
Rice	22.9
Tubers	
Taro	1.6
Sweet Potato	0.6
Other	10.7

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Food Taboos and Children's Diet during Illness

Food taboos and superstitions affecting pre-school children's nutrition in Guinea are suspected to be widespread and to be the main cause of protein energy malnutrition. In Middle Guinea, foods forbidden to sick young children include meat (15%), fish (8.8%), egg (1.2%) and other (74.7%). Foods provided to sick children are mainly starchy with little protein content. During episodes of diarrhea, 22.1% of mothers (Table 7) reduced breastfeeding frequency (see Table 7).

Table 7 : Feeding practices during Diarrhea

BREASTFEEDING FREQUENCY	PERCENT	AMOUNT OF FLUID	PERCENT
Same as usual	64.9	Same as usual	34.5
Reduced	22.1	More	42.1
Increased	8.8	Less	16.3
Stopped	0.8	Missing	7.1
Missing	3.5		
None	33.2		

Knowledge, Attitudes and Practices Negative to Breastfeeding

Many routine practices in health service delivery are not favorable to breastfeeding initiation and continuation. Mothers are not sensitized to attend prenatal care. In Middle Guinea, 72.9% of the routine prenatal care visits did not include breastfeeding information. After delivery, mothers are often separated from newborns and feeding is initiated with liquids other than the colostrum. Women are often not actively encouraged to breastfeed. There is excessive commercial promotion of breast milk substitutes in hospitals, maternities and health centers. Some samples of artificial milks are distributed free of charge to health personnel and to lactating mothers.

In Middle Guinea, the ENAMOG study showed that virtually all children in the sample received another liquid before breast milk. One third of the children received a liquid called "talisman". Kinkeliba, an infusion from local herb was also immediately provided to children after birth. When mothers were asked why they did not give breast milk to the child, the reasons stated were:

- Lack of milk secretion (20%)
- Breast milk was bad for the baby (5.1%)
- Sore breasts (3.8%)
- Stomach Ache (2.2%)
- Other Reasons (8.4%)

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The attitudes and beliefs about colostrum in Guinea are not known. But one can infer from supplementary feeding practices that Guinean mothers do not recognize the importance of colostrum during the first hours of life.

Conclusions

The prevalence of breastfeeding in Guinea is quite high, with around 93% of infants breastfed at some time. The vast majority are breastfed throughout the first year of life, and the mean duration of breastfeeding is about 2 years. However, exclusive breastfeeding is quite rare, and there are many practices which discourage effective breastfeeding. They include:

- Separation of the mother from the child;
- Providing unnecessary liquids before breast milk;
- Late initiation of breastfeeding;
- Inappropriate timing and composition for complementary foods.

Such practices expose young children to diarrheal diseases, decreased resistance to infectious diseases, and early malnutrition.

While Guinean mothers seem to be motivated to breastfeed, a number of behavioral and knowledge-related problems appear to work against optimal breastfeeding practices:

1. The importance of colostrum does not seem to be recognized either by health workers or the mothers themselves.

2. The prevalence of exclusive breastfeeding is low. Early introduction of other liquids such as water; cow, goat and sheep milks; "kinkeliba" and talisman liquids is almost universal. These liquids, often given as first fluids, may behave harmful for several reasons :

    - They could be contaminated, thereby introducing pathogenic bacteria directly to the child's body. This could lead to diarrhea or/and other infectious diseases;

    - If given in large amounts, the liquids could satiate the infant, and thus reduce the baby's desire to breastfeed;

    - Reduced frequency of breastfeeding reduces breast stimulation and flow of breast milk. This can leads to the paradoxical conclusion that the milk secretion is insufficient for the child.

3. Breastfeeding is often not discussed during prenatal care. (Exceptions exist, such as Ignace Deen Hospital, Conakry, which has been designated as a UNICEF Baby Friendly Hospital.)

4. Complementary foods, often introduced at around 4 - 6 months, are given too early and are of questionable quality.

Recommendations

Guinean mothers need support to successfully practice exclusive breastfeeding for the first 4 - 6 months. To achieve this:

- There is a need to define a national policy on breastfeeding;

- Health workers, including traditional birth attendants, need to be trained to include breastfeeding counselling in prenatal and postnatal care;

- A network of breastfeeding support groups should be created within local communities;

- There is a need to integrate breastfeeding promotion into existing IEC activities for family planning and diarrheal disease control activities, thereby taking advantage of breastfeeding's contraceptive and anti-diarrhea effects.

POLICY, LEGISLATIVE AND WORK ENVIRONMENTS AFFECTING BREASTFEEDING IN GUINEA

Efforts to Promote Breastfeeding

National Breastfeeding Activities

While no written guidelines exist for breastfeeding activities in Guinea, the promotion of breastfeeding is mentioned in the draft of the National Nutrition Policy and Action Plan. Breastfeeding is mentioned as one of the eight intervention strategies in the Plan.

The Food and Nutrition Division of the MSPAS has prepared a draft Declaration of Government Policy on Breastfeeding for a future television broadcast, and an MSPAS KAP Survey has begun in Middle Guinea and is planned for Forest Guinea.

In recognition of the socio-economic, health and nutritional benefits of breastfeeding, a variety of institutions and community-based groups are being progressively mobilized for the promotion of breastfeeding.

International Organizations' Effort

UNICEF is the principal donor promoting breastfeeding in Guinea (UNICEF/GUINEA, 1993). The WHO/UNICEF booklet **"Ten Steps to Successful Breastfeeding"** has been widely disseminated to health and paramedical personnel, and a UNICEF-sponsored information campaign on breastfeeding has been launched through the media. Information and communication seminars on breastfeeding have been organized to acquaint some 200 health professionals with breastfeeding principles. The MSPAS, with UNICEF support, has designated the Ignace Deen Hospital in Conakry as a "Baby Friendly Hospital" (BFH), with experimental activities begun in 1993. After evaluation, the BFH initiative may be extended to other hospitals in the country.

The World Bank is sponsoring a nationwide survey on breastfeeding practices in Guinea through the MSPAS. Data collection has already begun in Middle Guinea.

Women's Association for the Promotion of Breastfeeding and Infant Nutrition in Guinea (AFPAMNIG)

Recognizing the need to improve present breastfeeding practices and infant nutrition, a group of interested Guinean women created an NGO in 1993 called "Association Maternel et la Nutrition de d'Enfant" (AFPAMNIG). AFPAMNIG, the Guinean counterpart for the International Baby Food Action Network (IBFAN), is the only officially organized body in the country whose primary objective is breastfeeding promotion. This

ambitious non-profit organization has as its general objective "to promote breastfeeding in order to ensure the survival and the development of all children in Guinea". Some of the specific objectives of AFPAMNIG for 1996 include :

- To enable 90% of mothers to start breastfeeding within half an hour following delivery.

- To ensure that at least 85% of nursing mothers in Guinea practice exclusive breastfeeding during the first six months.

- To ensure that at least 70% of nursing mothers continue breastfeeding with proper complementary foods up to at least 18 months.

AFPAMNIG's intervention strategies are based on IEC, training, policy intervention, operational research, supervision and evaluation activities.

One early activity was the organization of a seminar in Conakry in January 1994, with sponsorship by UNICEF. The aim was to sensitize health workers on the need for the promotion and support of breastfeeding. The next step for AFPAMNIG is to follow up the recommendations of the seminar which include:

At the national level

- The development of national code for marketing of breast milk substitutes;

- The improvement of breastfeeding conditions for Guinean women in the workplace.

At the level of the health center

- Creation of breastfeeding support groups composed of health workers in prenatal care, EPI, ORT and nutrition programs.

At the local level

- Formation of breastfeeding support groups composed of mothers within the same community.

Training and Research Institutions Activities in Breastfeeding

The Institute for Child Health and Nutrition (INSE) is involved in breastfeeding promotion, even though the audience is limited to clients attending the Nutrition Education and Rehabilitation Center (CREN). INSE has also carried out a survey in Conakry which revealed information on practices inhibiting breastfeeding, such as infrequent initiation of breastfeeding immediately after birth; frequent use of substitute fluids; and widespread bottle feeding. These findings are being used as basis for breastfeeding counselling at CREN.

Legislation Affecting Breastfeeding Promotion

Legislation on breast milk substitutes

The Guinean Government has ratified the International Code for Marketing of Breast Milk Substitutes, but has yet to produce its own version of the Code. There are no government regulations concerning the importation, advertisement and sale of breast milk substitutes and other infant food. As a consequence, a wide variety of brands of infant formula, baby cereals, baby fruits and vegetables are available in pharmacies and shops. These products are advertised through mass media, hospitals and health centers. Even though commercial milks are very expensive and beyond the reach of many Guineans, a substantial part of already limited income is spent on breast milk substitutes and weaning cereals. Making a bad situation worse, the quantity given to children is often insufficient, resulting in under-nutrition. Infant formula and other baby foods found in the Guinean market are listed below:

INFANT FORMULA AND BISCUITS	BABY CEREALS	CANNED PUREES
Mursine	Bledilac Croissance	Fruit Exotiques
Calliasec	Bledine Lacté-Fruits	Riz Carrottes
	Cerelac	Pomme Rouge
SMA		
GUIGOZ		

All the products marketed are manufactured abroad (in Europe) and imported to Guinea.

Working Women and Maternity Leave Policy

In Guinea, labor law stipulates that working women obtain a 12 week maternity leave -- four weeks before confinement and eight weeks after delivery. Mothers' salaries are paid in full during this period. The code also stipulates that mothers should be allowed to come to work half an hour late and to leave half an hour before the regular closing time. However, the private sector does not always apply the Code and most mothers are forced to work until a few days before confinement and resume work very early after delivery. They are afraid they might lose their benefits or even their jobs, especially for women who are employed in small private businesses (shops, pharmacies, etc). Even Guinean mothers working in the non-formal sector cannot interrupt their normal work schedules before and after delivery. Often, for economic reasons and due to their many responsibilities at home, they work until just a few days before delivery and resume work soon after.

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Women's Work Load

Like most women in West Africa, Guinean women have heavy work loads, both inside and outside their homes. In rural areas, the majority are farmers engaged in food production. Within the home they are responsible for meal preparation, child care, husband care, dish- and clothes-washing, cleaning, and search for water and fuel. In the urban areas, women perform household tasks similar to their rural counterparts. In addition, they may work in the formal sector as government or private sector employees, or they may be involved in commercial activities of their own such as small trading. Thus, both urban and rural women work long hours at home as well as in farms, offices, and markets. This gives them very little time for exclusive and optimal breastfeeding. In addition, government and private sector offices have no facilities for child care, including breastfeeding.

Support Groups for Women

As mentioned earlier, AFPAMNIG is the only national support organization for women for the promotion of breastfeeding. However, there are many womens' organization in Guinea which may serve as support groups. They are loosely associated under the National Coordination of Womens' NGOs. Beside gender, common bonds among the members include social, occupational, economic, religious or geographical factors. Some of these NGOs are:

- Association des Femmes pour la Promotion de l'Allaitement Maternel et la Nutrition de l'Enfant en Guinée (breastfeeding)
- Association des Sages Femmes de Guinée (midwives)
- Association des Professionelles de la Communication (female journalists)
- Association des Femmes Guinéennes pour la recherche et le developpement (researchers)
- Association des Anciennes Normaliennes de Guinée (school teachers)
- Association des Femmes Entrepreneurs de Guinée (business women)
- Groupement des Femmes d'Affaires de Guinée (business)
- Amicale des Femmes de la CNSS
- Ligue des Secrétaires de Guinée (secretaries)
- SIDALERTE (AIDS)

- Comité International des Femmes Africain pour le development

- Association Guinéenne pour l'Assainissement de Conakry (hygiene and sanitation)

- Association Guinéenne pour le bien être familial (family planning)

- Association Guinéenne pour la reinsertion des Toxicomanes (drug abuse)

- Cellule de Coordination sur les Pratiques Traditionnelles Affectant la Santé des Femmes et des Enfants (opposing traditional practices endangering the health/nutrition of women and children)

Conclusions

The fact that little national attention and donor agency funding have been directed to maternal and child nutrition, as compared with other components of the primary health care package, has certainly contributed to the general neglect of breastfeeding as an important health strategy in Guinea. As seen elsewhere in this report, the MSPAS has an enormous task in dealing with a host of health problems with severely constrained resources; and AFPAMNIG, the only NGO concerned with the promotion of breastfeeding and optimal infant nutrition, has limited funds and human resources. Factors facilitating and constraining breastfeeding promotion are as follows:

Facilitating factors

- Although there is no national code on breast milk substitute, the government had ratified the international Code for the marketing of breast milk substitutes.

- AFPAMNIG has stated as one of its major activates to create a National Committee for the formulation and application of a National Code for marketing breast milk substitutes.

- UNICEF has initiated Baby Friendly Hospital activities and has held sensitization campaign and seminars.

- AFPAMNIG has been able to accomplish some breastfeeding promotion activities since its creation in 1993 despite its very limited means.

- The World Bank is financing a survey on breastfeeding practices.

- The draft National Nutrition Policy and Action Plan include breastfeeding promotion as one the strategic options to prevent malnutrition in children.

- The high percentage of women in organized women's groups represent a network through which breastfeeding support groups can be established (as AFPAMNIG plans to do).

- The Food and Nutrition Division has prepared a public statement for the Ministry of Health on the promotion of breastfeeding in Guinea.

- The liberal maternity leave policy, when enforced, can allow women working outside the home the opportunity to breastfeed during the two months after delivery.

Constraints to Breastfeeding Promotion

- The absence of a comprehensive policy on breastfeeding.

- AFPAMNIG, the only national organization active in breastfeeding promotion, is new and has limited resources.

- Several brands of infant formula and other baby foods are sold in the Guinean market, and are advertised in the mass media, and in hospitals and health centers. Mothers and health workers themselves sometimes serve as advertising agents.

- Guinean women perform many roles and work long hours, limiting the time available for optimal breastfeeding.

- In many health centers, even those where there is some infant nutrition education, breastfeeding counselling is not included in the protocol.

- The family planning program pays little attention to breastfeeding as a birth spacing method, even though its contraceptive effects are widely recognized in addition to its nutrition and health benefits.

Recommendations

- There is a need to formulate a national policy on breastfeeding as a basis for breastfeeding promotion in Guinea.

- A Guinean version of the International Code on Marketing of Breast Milk substitutes needs to be prepared and implemented.

- Until such a code is adopted, the Government should take temporary measures to stop advertising of infant formula in health centers.

- Women's NGOs should be offered training in breastfeeding to enable them to disseminate information about breastfeeding to members of their organizations.

- Guinean men should be sensitized about the needs for their wives to practice exclusive breastfeeding the first 4 - 6 months.

- AFPAMNIG needs to be strengthened with substantial financial support to enable it to implement the training, IEC and policy formulation activities.

HEALTH SERVICES

Formal Health Care Services

Health care for the majority of Guineans is provided through government decentralized facilities. They include teaching hospitals (in Conakry) regional and prefectoral hospitals, health centers and health posts (Table 8).

Table 8: Number and Distribution of Government Health Facilities

Health Facilities	Level	Number	%
University Teaching Hospitals	Conakry	2	0.16
Regional Hospitals	Regions	4	0.33
Prefectoral Hospitals	Prefectures	29	2.40
Health Centers	Community	385	31.81
Health Posts	Local	790	65.30
Total	**National**	**1210**	**100.0**

Prenatal care is provided in all the government health facilities. Listed services to be provided by the health centers in the area of MCH include:

- Pre- and Post-Natal Care;
- Immunization of pregnant women against tetanus;
- Immunization of children against communicable diseases;
- Treatment of Diarrhea;
- Family Planning;
- Nutrition Surveillance

The absence of breastfeeding promotion in this list of services is particularly troubling.

Distribution of Health Personnel at the National Level

Latest statistics (1991) from the MSPAS state the distribution of health personnel as follows :

Doctors: 745	-	1 doctor for 7,427 inhabitants
Pharmacists: 141	-	1 pharmacist for 40,816 inhabitants
Midwives: 350	-	1 midwife for 16,430 inhabitants
Health Agents: 1202	-	1 health agent for 4,787 inhabitants
Health Tech.: 2415-	-	1 health technician for 2,383 inhabitants

Traditional Health Providers

The population living in rural areas do not always have access to modern health facilities for MCH services. According to the 1992 DHS, about 72.5% of deliveries take place outside of formal health services, and up to 70% of births are not attended by medically trained personnel. Of these births, about 30% are attended by traditional birth attendants (TBAs). Some TBAs have received training by the MSPAS to enable them to provide better care to mothers after delivery.

Private Sector Health Care Facilities and MCH Services

There are some private health clinics and NGO hospitals, which provide mainly curative health services. While some MCH services are provided, breastfeeding promotion and other nutrition activities are very limited.

Integration of Breastfeeding Promotion into other Ongoing PHC Programs

There are no operational guidelines in the majority of health facilities related to breastfeeding. The only exceptions are a few facilities with special programs, such as Ignace Deen Teaching Hospital, an experimental Baby Friendly Hospital site.

Conclusions and Recommendations

The absence of any articulated policy means that the promotion of breastfeeding is insufficient throughout the Guinea primary health care program. However, there are potential supportive factors for integration and promotion of breastfeeding as part of the MCH care:

- The decentralized nature of the MSPAS health infrastructure.
- The policy of integration of all MCH services, based on the Bamako Initiative.
- The many opportunities in MCH/FP Services (EPI, ORT, FP) for integration of breastfeeding counselling.
- The acceptance of TBAs by the MSPAS as important partners in MCH care at the community level.

The following factors represent constraints to optimal breastfeeding in health services:

- Again, the absence of a national policy clearly mandating the integration of breastfeeding in MCH/FP program, with written protocols on breastfeeding for all health facilities.

- Many areas of Guinea are not fully covered in terms of health facilities for MCH.

- Insufficient number of health providers. The ratio of patients to health care provider is still very high. For instance, there is one midwife for every 16,430 inhabitants and one nurse for every 4,787 inhabitants. Insufficient health care providers in maternity wards may represent a constraint to effective counselling.

- Lack of personnel trained in nutrition.

Recommendations

- Because of the constraints faced by the MSPAS in initiating new programs, AFPAMNIG should be utilized as an important supplementary resource for breastfeeding promotion. An important activity for early support would be to organize workshops of relevant policy makers and other personnel to formulate a strategy for the integration promotion of optimal breastfeeding within the Guinean health services.

- Trained nutritionists (rather than other health workers who may have some knowledge of nutrition) should be integrated into the health provider network.

RESEARCH AND TRAINING PROGRAMS FOR HEALTH CARE PROVIDERS

Training

Providers of MCH care are mainly medical doctors in obstetrics and pediatrics, midwives, nurses and health technicians. There are six institutions in Guinea where pre-service training takes place:

- School of Medicine in Conakry
- National School for Health in Kindia
- National Secondary Schools for Health in each of the three natural regions outside Conakry (Labé, N'Zerekoré, Kankan)
- The Faculty of Medicine
- The National School for Doctors, Pharmacists, Midwives and Biologists.

In-service training is done mainly at two schools :

- The National Center for Training and Research in rural health (CNSR) in Maferinya;
- The Institute for Child Health and Nutrition (INSE).

At CNSR, medical students in their seventh year learn the essentials of the Primary Health Care Program in a rural setting. INSE provides training in maternal and child nutrition, including breastfeeding, for health workers from various health centers in the country.

Conclusions

Since breastfeeding is not specifically mentioned in most pre- and in-service training for health providers, there are opportunities to improve training by including this subject. Training factors supportive of breastfeeding include :

- Some teachers in the training institutions are medical doctors with strong international backgrounds, who should therefore be sensitive to the need to enhance training in this area. They also frequently hold important administrative positions enabling them to influence policy.
- Many MCH workers express strong interest in updating their knowledge in infant nutrition, including breastfeeding.

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Constraints against breastfeeding in training programs for health workers in Guinea include :

- Absence of policy mandating the integration of breastfeeding as a subject in training curricula.

- Lack of nutrition-specialist teachers among training personnel, and insufficient training materials.

Recommendations

- There is a need to formulate a policy for the creation of maternal and child nutrition departments in the existing training schools for health workers.

- The present curricula need to be revised for the inclusion of up-to-date information on nutrition and breastfeeding.

Research

Health Information System

There is an established health management information system (HMIS) under the National Statistical Information System. The HIS is designed to gather data and information from all levels of the health system, and is intended to help the government use statistical data from the various health facilities for management decision-making. Information provided by HIS could also be utilized to measure the impact of health interventions. Unfortunately, there are serious constraints to the effective collection and analysis of these data (see the detailed discussion of these problems elsewhere in this assessment). Even if these problems were to be adequately addressed, there would still be a lack of adequate information on breastfeeding, since breastfeeding promotion and surveillance are not explicitly included within the health services.

Research Capabilities

The Institute for Child Nutrition in Conakry, the National Training and Research Center of Maferinya, the National School Public Health in Kindia, the school of Medicine in Conakry and the Food and Nutrition Division (DAN) of the MSPAS are potential research resources in breastfeeding. A study on breastfeeding practices in Conakry has been carried out jointly by the DAN and INSE during the ENCOMEC Survey (1991), yielding data on :

- Timing for the initiation of breastfeeding
- Prelacteal liquids
- Exclusive breastfeeding prevalence
- Bottle feeding prevalence
- Abandonment of breastfeeding

Conclusion

Factors supportive of the development of an adequate research capability in breastfeeding include:

- The existence of the National Information System to collect and analyze data from health facilities.

- The availability of potential research institutions, in particular the Institute of Child Health and Nutrition (INSE) and the Food and Nutrition Division.

- The commitment of interested researchers who have already been involved in research activities on breastfeeding practices.

Constraints to research activities on breastfeeding include:

- Lack of funding for research
- Lack of scientific equipment and research facilities
- Insufficient trained researchers
- Lack of computer equipment and software, and trained personnel for data processing and analyses.

Recommendations

- The Food and Nutrition Division should be provided with computer equipment and software, and some of its personnel trained to analyze breastfeeding and other nutrition data.

- The Institute for Child Health and Nutrition should be strengthened in terms of scientific and computer equipment, and the research capabilities of its staff enhanced.

Other institutions should be evaluated in terms of their potential to carry out research activities. For example, the food analysis laboratory at the university could be a site for analysis of the nutritional value and microbial properties of prelacteal foods traditionally given to infants and young children.

INFORMATION, EDUCATION AND COMMUNICATION ACTIVITIES

Formal Media for Health Communication

National Radio, Television and Newspaper

Despite the low literacy and income levels that limit the immediate potential of mass media for delivering health-related messages, radio, television and newspapers remain an important channel for such communication:

- UNICEF has provided support for the training of journalists for broadcasting information in local languages.
- National TV covers about 60% of the country, with some programs in local languages, and has already broadcast programs concerning child health issues.
- Cultural and entertainment-oriented groups have held shows on health issues, and discussion programs have been organized featuring health experts.
- The Guinean News Agency (AGP) has developed plans to publish articles child health issues on a regular basis.
- Horoya, the government newspaper, has written articles on health centers and covered government actions regarding child health issues.

Rural Radio

The Guinean Government has installed regional rural radio stations in the capitals of the four natural regions. Programs, debates, and interviews in health and nutrition have been broadcast to sensitize, educate and mobilize the rural population.

Rural Newspapers

A local NGO called "Organisation Voluntary pour le Developpment Economique et Culturel (OVODEC) publishes a bilingual bulletin (French-Poular) and distributes it free of charge to local communities. The bulletin addresses a variety of subjects, including health.

Informal Channels of Communication

Traditional Social Communication

Some groups involved in traditional social communication could become involved in the delivery of health-related messages:

- The artists of Ballet National Djoliba and comedians of the Theater National de Guinée, have utilized dance, song, and theater to deliver information on health issues. Several public performances in French and in local languages have been sponsored by UNICEF.

- Women's NGOs and local representatives of the Secretariat for Social and Women's Affairs could form the basis for grass-roots breastfeeding support groups.

- Prefectoral level groups called "Comités Prefectoraux pour l'Enfance" (CPE) are froming with the support of the government and UNICEF for the purpose of promoting child welfare. These groups could also be used to support breastfeeding and other child nutritional issues.

Breastfeeding Communication Efforts

There is no clearly-defined, national-level communication program where breastfeeding is the main theme. Although the Division of Health Education has defined a National Policy on Health Education, including nutrition, breastfeeding IEC is not specifically mentioned.

Effort to develop educational materials for Breastfeeding and Infant Nutrition

There is lack of educational materials in breastfeeding for both mothers and health care providers. However, the Food and Nutrition Division has produced a flip chart on breastfeeding infant and maternal nutrition, and the Nutrition Education and Rehabilitation Center (CREN) of the Institute of Child Health and Nutrition has also develop some patient information and weaning food recipes based on local foods.

Conclusion

While overall health education efforts in Guinea do not include breastfeeding as a theme, there are factors facilitating communication on this topic:

- There is precedent for health issues to be broadcast on national radio and TV.

- Guinea Newspaper Agency and Horoya have planned to allocate space for the publication of information on health issues.

- OVODEC has the potential to develop breastfeeding articles and publish them in rural newspapers in local languages.

- There is a wide variety of informal channels of communication through which breastfeeding information could be passed, including songs, dance, theater; women's groups; and Prefectoral Children's Committees.

- Nutrition is one of the priority programs identified in the National Health Education Policy defined by the HED.

- The Division of Food and Nutrition and the Nutrition Education Rehabilitation Center have initiated the development of educational materials.

Among the constraints to breastfeeding communication are that most formal media use French as the official language, and that most visual aids in health centers are designed for literate people. In addition, the mass media fail to reach many people living in rural areas.

Recommendations

- AFPAMNIG should collaborate with DAN, HED, and CREN to develop an overall breastfeeding strategy and action plan.

- AFPAMNIG should receive the financial support necessary for the mass production of the flip chart on breastfeeding produced by DAN.

- Local artists in the Ballet National and the Theater National de Guinée should be supported in the development of traditional social communication.

- AFPAMNIG should use women NGOs, local representatives of the State Secretariat for Social and Women's Affairs, and the Prefectoral Children's Committees to form breastfeeding support and information networks.

- OVODEC should get the financial support necessary to promote breastfeeding using rural newspapers in local languages.

APPENDIX VIII

INFORMATION\EDUCATION\COMMUNICATION

I. INTRODUCTION

Given the extremely low level of literacy and relatively low utilization rates of existing health services, especially among women and adolescent girls, changing attitudes and behavior to improve health in Guinea are formidable challenges. Current strategies based on information, education, and communication (IEC) activities performed by formal health agents are important, but will not lead to rapid changes in behavior. This is due not only to limited numbers of personnel and means of communication and transportation, but also to the limited ability of even the best health promoters to change behaviors that are encouraged or supported within the social context.

Ministry of Public Health and Social Affairs activities in the area of health education and IEC have increased dramatically since 1988. While there is a National Health Education Policy, published in June of 1993, it has not been fully implemented and resources allocated are not adequate to do so. Although there have been marked improvements in planning and management of IEC actions at the central level, coordination and quality of IEC activities are insufficient in many cases at various levels in the system. There have been annual workplans developed at the MSPAS central level each year since 1990. Strategic planning for IEC at the MSPAS is virtually absent but may not be important if decentralization occurs as planned.
Preliminary DHS data suggest that access to and utilization of mass media (television and radio) are below the 60% coverage rate suggested earlier; lowest coverage is in Forest Guinea. There are large differences in coverage rates and access between regions and sexes. While mass media campaigns are well-suited to rapidly increasing knowledge, and often beginning to change attitudes, rapid behavior changes will probably not occur without focusing on community-based health education and counseling alongside quality service delivery.

DHS data indicates very limited (<25%) communication between spouses about family planning. Both men and women seem to believe their partners approve of FP less often than they actually do, except in Lower Guinea where women seem to overestimate their partner's approval significantly. This data has major implications for audience segmentation and specificity of messages, and points to the need for research and message development in a decentralized manner.

The most noteworthy IEC activities in the health sector have been characterized by heavy donor support and partnerships among a variety of governmental and non-governmental agencies working towards similar objectives. They are also characterized by an emphasis on one or two messages, as opposed to a large package of health messages, and by efforts at community mobilization.

Two examples of these types of programs are the EPI portion of the PHC\EPI\EM (MSPAS, UNICEF, many NGOs), and the prevention of AIDS\STDs (MSPAS, USAID, NAC, etc). Both of these have received substantial financial and technical support, and the IEC components have been implemented by a group of public sector partners as well as private or NGO organizations and their networks of volunteers working at all levels of the health delivery system.
Although the main actor in health education and IEC is the MSPAS, a number of actions have been carried out by other governmental institutions as well as by NGOs. These are briefly described below.

II. Governmental Organizations

A. Ministry of Public Health and Social Affairs (MSPAS)

Public Health:

As the proposed new MSPAS organizational chart indicates, the Prevention Division includes most of the programmatic sections concerned with maternal and child health and disease control. The Health Education Section (EPS), however, is located under the National Division for Health Promotion; it has the mandate to coordinate and provide IEC assistance for all activities. Housed in a relatively new building with ample space and decent working conditions, the EPS has a staff of three that have benefited from training in materials development and design. There seems to be comparatively less emphasis on counseling, inter-personal communication and community education as compared to health structure-based IEC and print materials. There is no specialized personnel for reproductive health or family planning IEC assigned to the EPS. The Section owns a small collection of audio-visual equipment, but no means of production. The environment of scarcity of resources often has the Section competing with programmatic sections in order to obtain resources to perform its role; in spite of this, there seems to be a high level of collaboration when it is requested. Some donors have financed IEC actions through projects connected to programmatic initiatives; it has been suggested that this is one of the causes of the poor quality of existing print materials in Guinea.

With current staff levels and organizational structure, it will be difficult for the EPS to coordinate all health education activities. The 1993 Health Education Policy announces the creation of an inter-ministerial National Consultative Council for Health Education, whose role will be to orient and assist in the implementation of the Policy during annual meetings. At the prefecture level, many IEC campaigns are initiated by other governmental agencies and NGOs. Local health officials are not always aware of all of these actions, and the central level has incomplete information on field-based research and activities.

In spite of severe constraints including limited human and material resources, the EPS has contributed to a number of achievements in health education and IEC. Consistent leadership at the central level, and some donor support, has led to improved management and planning capabilities. Since 1991, a number of important initiatives have been implemented with assistance from this division, including the development of a health education training module and its use to train health agents in all four regions. Materials have been developed for both health workers and community members. Equipment provided by both USAID and the World Bank's PDSS project several years ago have been maintained in good working order. Although centralized development of health education messages for Guinea is probably not a sound strategy due to large regional differences, recent efforts to segment the national audience and determine priority subjects for each segment are important steps. Segmentation as presented in the National Health Education Policy should be reviewed and revised in the light of the new DHS data and available field-based research from each region.

On regional and prefectural levels, additional training and follow-up for supervisors and health providers in sites delivering FP services is required to develop inter-personal communication skills. Numerous providers remarked on their lack of confidence in their FP counseling skills and ability to appropriately educate community groups and individuals.

Social Affairs:

The State Secretary for Social Affairs became a part of the Ministry of Public Health in 1992 and retains a separate administrative structure. The National Direction for Promotion of Women has established networks at regional, prefectural and many sub-prefectural levels, and manages thirty-eight Women's Training Centers. Many of the income generating activities currently supported at regional, prefectural and sub-prefectural levels also include health education components on subjects such as nutrition, vaccination, hygiene, female excision, and child spacing as well as education aimed at reducing juvenile deliquancy and increasing the participation of women in the economy. MSPAS officials seem relatively uninformed about programs that Social Affairs undertakes; there is no evidence of collaboration between these two portions of the MSPAS for IEC.

B. Ministry of Education and Professional Training

The Ministry of Education houses two programs actively involved in health education. One is a UNFPA-funded project administered under the National Pedagogical Institute (IPN), and other activities are integrated into the program of the Literacy Section.

The IPN is a research and teacher training center with more than one hundred professional staff, a youth radio program, a photography laboratory, and a print shop. Since 1984, IPN has

housed the Population Education Project (EMP) funded by UNFPA. Achievements of the EMP include substantial audience research (teachers, students, parents) as well as successful pilot programs in more than forty primary schools, five secondary schools and two "ecoles normales". Additional activities have complemented the primary program, including production of dramas for television in four languages, development of comic books about family size, STD\AIDS, and the environment, and educational sessions organized for parents, women, and community leaders.

Objectives of the third phase (1994-96) of the EMP Project include expansion of the program into at least 1,000 primary schools, 20 secondary schools and all eight "ecoles normales" in Guinea. If these goals are achieved, more than one-third of children currently attending school will benefit from the program. One important result could be the complete integration of the field-tested primary school modules into existing primary school curriculum. UNFPA funds are not sufficient to enable complete achievement of the objectives.

The Literacy Program operates throughout Guinea, and receives support from international NGOs working in education and rural development as well as from UNICEF. Trained staff exist in all prefectures and some sub-prefectures, and collaboration with local governmental and NGO partners is stressed in workplans. The Literacy Program has a mandate to provide technical assistance to and coordinate all literacy efforts. Literacy programs (and materials) have been developed in all major local languages. The content used within the literacy programming is determined according to local economic activities and social problems. Information on these subjects is provided by technicians and adapted to local circumstances whenever possible. For example, health messages about preventing malaria, hygiene and food and nutrition are usually provided by MSPAS staff. On-going collaboration exists between representatives of the Literacy Program and those of NGOs, Ministries of Public Health and Social Affairs, Interior (Micro-realization), Agriculture in many prefectures. The Literacy Program collaborates with representatives of Social Affairs to focus on female literacy and utilizes their training centers when possible.

At the beginning of the PHC\EPI\EM program, the Literacy Section played the important roles of assisting in mobilizing communities as well as training the members of the Management Committees of health centers (many of whom are illiterate or illiterate in French). Some Ministry of Education staff would like to renew collaborative efforts in support of the NPHCP.

C. Ministry of Communication

Collaboration between the Ministry of Communication and the MSPAS has been essential to the support of the PHC\EPI\EM program. Guinean Radio and Television (RTG) includes National Television (reaching Conakry and the four regional capitals), National Radio, and four Rural Radio stations created in 1990.

RTG has well-trained, dedicated and enthusiastic staff in spite of material difficulties. Rural Radio does not have complete coverage except in Middle Guinea, but the technical problems have been identified and resources are being sought to improve transmission equipment in N'zerekore, Kankan, and Kindia.

Current programming for television and radio allot regular time for health education. One 45 minute slot per week on television is scheduled, and French language radio programs on health are broadcast three times per week for 15-20 minutes. Daily programs of 25 minute duration in the main local languages are broadcast on National Radio. Health programming on Rural Radio varies from station to station, but health subjects seem to receive a fair amount of attention. For all these mass media, public service announcements are usually broadcast without charge.

Use of these means of communication is clearly important even though no impact studies have been completed. Since the DHS shows relatively low levels of knowledge about family planning, current strategies aimed at rapidly increasing knowledge through radio are essential at this early stage of development of the FP program.

Radio Rural staff have skills in audience research techniques, and could be invited to join efforts to identify additional communication channels, materials and messages for target groups.

D. Ministry of Youth, Art and Sport

The Ministry of Youth has a National Direction of Youth and Popular Education. There is a system of 35 or 36 Youth Centers throughout Guinea, but many of them are dilapidated and unequipped. It would take a large effort to upgrade and use existing material and human resources to provide IEC to youth through this Ministry. However, their participation in activities in a decentralized strategy should be solicited; it is possible that in certain prefectures, their role could be substantial.

E. Ministry of the Interior

While the Ministry of the Interior's representatives are responsible for oversight, coordination and support of local government efforts in many sectors, they seem to be overburdened especially in prefectures with many schools and integrated health centers. For basic political mobilization and IEC aimed at political and community leaders, their role is important in all health education efforts. These representatives may also be the best informed about the multiplicity of local activities by governmental and non-governmental partners.

III. Guinean Non-Governmental Organizations

A. Guinean Association for Family Well-Being (AGBEF)

By far the most important local NGO for family planning IEC, AGBEF has been responsible for implementing a number of innovative programs. Created in 1984, it is still early in it's institutional development but has placed a certain accent on development of IEC expertise. Guinea's IPPF affiliate, it has benefited from a variety of funding sources and the participation of many volunteers.

As a collaborative organization supporting GOG policy, IEC efforts are coordinated with the MSPAS (including the Social Affair's Direction of Promotion of Women). Many AGBEF volunteers are GOG employees working in health and education, including specialists in communications.

USAID\PSI's FAMPOP project has supported AGBEF's expanded efforts in IEC through the use of 15 promotion agents throughout Upper and Forest Guinea. These agents are relatively new, and no conclusions can be drawn about impact or cost-effectiveness. There has been some discussion of the fact that all the promotion agents are men; this was not a policy decision but rather a result of the selection process. This may limit their ability to educate and influence women. Also, there is a questions as to how they will influence men towards actively seeking child spacing. Sustainability is questionable, however, since 100% of the costs associated with these agents are paid through FAMPOP. An effort to completely document results of this effort should be made as it has major implications for the development of further IEC actions.

B. National AIDS Committee (NAC)

The NAC has probably produced the largest variety of IEC materials aimed at supporting a specific health message in Guinea. The Technical Committee for the Fight against AIDS is the executing body of NAC actions, and prefectural committees composed of volunteers from both the public and private sector function throughout the country, especially in major urban areas. NAC receives support from a number of sources, including USAID (FAMPOP), WHO and Canadian assistance.

C. Committee on Traditional Practices Affecting Women's and Children's Health (CPTAFE)

CPTAFE is the Guinean chapter of Geneva-based Inter-African Committee on Traditional Practices. It is a volunteer organization. CPTAFE is implementing a training and information campaign targeting journalists, health professionals, community and religious leaders and traditional health practitioners although current funding levels are insufficient to mount a nationwide campaign. CPTAFE aims to eradicate female genital

mutilation, harmful nutritional taboos, early marriage (before age 18), scarification and tattooing, and repudiation. CPTAFE supports positive traditions including child spacing and breastfeeding.

D. Coordination des ONG Féminines

Although this coordinating body does no health education directly, its member organizations include many concerned with health (AGBEF, SIDALERTE, Guinean Midwives Association, etc). Efforts to coordinate and expand health education, especially in reproductive health, should utilize and support this coordination body.

IV. Private Sector

Time did not permit an in-depth analysis of activities in education and advertising related to health in the private sector. One important remark is that some MSPAS clinics have posters promoting use of breast milk substitutes; this is incompatible with the role of the MSPAS in promoting positive health behaviors. Finally, anecdotal evidence from market vendors selling pharmaceuticals and contraceptives indicates that they do not provide health education; AGBEF is beginning pilot work with market vendors.

FAMPOP's experience with social marketing of condoms stands out as an example of using media and local commercial networks to raise awareness, even if sales have not risen dramatically. AIDS messages were broadcast on TV using 14 spots in 4 languages, and on radio via 34 spots in 5 languages. There has been some sensitivity about spots from the religious community. Impact on urban populations on the coast and Middle Guinea has been shown by increased awareness of AIDS and AIDS prevention techniques as well as recognition of the Prudence brand; the program also sites the creation of an environment in which sex-related topics can be discussed in public. However, the translation of knowledge into action requires more motivational messages. Before behaviors can change, education and information levels need to be increased. Further experiments in social marketing of other health products will benefit greatly from this first experience, especially in understanding the importance of linking classic social marketing techniques with community health education efforts.

V. S.W.O.T.

STRENGTHS:

- Multiple governmental partners with special access to some target groups as well as some level of human and material resources
- Ministry of Education: school children and their parents, teachers, literacy program attenders and their families etc.
- The National Directorate for the Promotion of Women: women involved in income generation as well as network of elected representatives in some cases below the sub-prefecture level in large villages
- Great interest in health IEC among media representatives at all levels
- Numerous, international and local, NGOs interested in increased involvement in health education and sometimes in community organization and education
- UNFPA and PSI\FAMPOP are already working with SMI\FP department of MSPAS to develop an IEC program for FP.

WEAKNESSES:

- lack of coordination (this is also be an advantage to rapid decentralization)
- There seems to be quite a bit of KAP research done, but results take years to be analyzed\published; general lack of knowledge about what research has been done, where, and what the results mean for changes in behavior
- There is not yet a strong, vocal constituency for FP in Guinea
- For breastfeeding, policy framework needs to be established to support any programmatic efforts
- The interpersonal communication\counseling component of FP has not received the support needed for this component to be successful in the context of a FP program. Under the FAMPOP project, lack of clear delineation of duties between MSPAS personnel and AGBEF IEC staff may create problems later on as service providers view FP IEC as outside of their scope of work.

OPPORTUNITIES:

- Support real community-based education by accessing social networks; need basic anthropological\ethnographic data

- Agents trained in contraceptive technology (using the MSPAS modules) don't feel confident in their ability to counsel for FP or promote FP in the community. See "In-service training" for training recommendations in the Human Resource Appendix. Supervisors need to be able to help solve these problems and reinforce progress made by health agents.

- Although the team was told that health education had been integrated into the ordinogrammes, this was not confirmed. At health centers visited where ordinogrammes were available, agents did not believe that the ordinogrammes provided guidance.

- Potential role of health center chiefs and other staff in encouraging their staff to promote FP to clients seeking other services; current training does not promote this type of integration of messages\interpersonal communication. Health Center staff do not always seem to view FP promotion as part of their job descriptions, although promotion of EPI is almost universally seen as a central role.

- Reinforce the role of DPS in supporting IEC and counseling for FP as well as other interventions

- Improve research\design\production of print materials at local levels; watch experiences of AGBEF promotion agents as first test of results.

- Build regional and prefectural research capacities (audience research and OR)

- Multiple existing organizations, including some with community networks, to work with; can help target various groups by better coordination

- Use radio and other mass medias for information, must build interpersonal communication networks for behavior change

- Building on existing structures and resources

- Social marketing of MSPAS health structures for reproductive health care

- Support expansion of EMP program and additional printing of materials that have already been field tested for distribution in areas of FP project action; help them avoid formation en cascade of teachers

THREATS:

Central MSPAS

- Lack of incentives to coordination
- Competition between sections of the MSPAS for resources
- Insufficient human and material resources available to section EPS

Regional and prefectural

- Lack of incentives to good coordination between various Ministries
- Many target groups requiring different messages
- Over-centralization of decision-making as well as human resource development for IEC
- Politicization of actions in some Ministries
- Demand creation before quality services are available to respond to demand
- Reticence to shift responsibility - and resources- for IEC from central level regions and prefectures
- Lack of experience in community soundings and mobilization of MSPAS personnel
- Need to move rapidly from increases in knowledge to changes in practices of both service providers and target populations

RECOMMENDATIONS:

1. Establish a reading room or non-lending library on population and MCH\FP; it would make sense to do it in Conakry.

2. Give equal attention to the use of social networks and community organizations as to the outreach component of MSPAS work. Utilize all governmental and non-governmental infrastructure and mobilization efforts.

3. Work at prefecture level to increase ability to do basic audience research and design messages for local use. For materials, concentrate on those accessible to the majority (i.e. illiterate) population and those who make decisions about the concerned interventions.

4. Finance printing and distribution of materials (for students and teachers) developed under EMP program; finance expansion of primary school program into schools in zones where USAID is financing FP service delivery.

5. Do not suggest major funding of health education or IEC coordination at the MSPAS central level- resources need to be destined for prefectural levels (including Conakry prefectures)

APPENDIX IX

HEALTH SECTOR FINANCING ASSESSMENT

Information for this assessment has been obtained from a variety of sources including MSPAS, Ministry of Plan and Finance (MPF), USAID, UNICEF, and a variety of program and donor analyses. However, there were often significant variations in data in different reports. Because of these inconsistencies in information, every attempt was made to obtain data from the most reliable source which, for most of the data herein, was felt to be the MPF. Because problems of data quality and consistency limit our ability to draw definite conclusions, it is recommended that those designing and monitoring health programs continue to collect data and observe trends in health financing.

This assessment is organized as follows:

I. National Budget
II. Health Budget
- Overall Health Budget
- Investment Budget
- Recurrent Cost Budget
- Recurrent Cost Expenditures

III. Financing of Service Delivery
- Sources
- Fees Charged
- Budgets, Cost and Revenue
- Ability to Pay
- Equity
- Efficiency

IV. Sustainability
V. Conclusion

I. NATIONAL BUDGET

The table below shows the growth and contraction of the overall Government of Guinea (GOG) budget for the past five years in terms of recurrent costs, investments from the national budget (BND), total provided by Government of Guinea sources, and externally financed investments (FINEX). Until '93, the GOG national budget grew steadily, mostly financed by receipts from the bauxite industry. In '93, the budget was reduced by one-third.

EVOLUTION OF THE NATIONAL BUDGET (GF 000,000)

	Recur't (Change)	Inv. BND	Tot. GOG (Change)	Inv. FINEX	Grand Total
89	213,033 (--)	32,730	245,763 (--)	135,200	380,963
90	252,018 (+10%)	33,300	285,318 (+16%)	173,000	458,318
91	368,251 (+46%)	40,008	408,259 (+43%)	202,739	610,997
92	718,752 (+95%)	40,800	759,552 (+86%)	274,815	1,034,367
93	504,614 (-42%)	59,237	563,851 (-34%)	275,000	838,851
94	577,282 (+14%)	55,600	632,882 (+12%)	250,000	882,882

Source: Ministry of Plan and Finance (MPF), Direction of Budget

- The overall 94 budget was announced just days prior to the completion of this mission; the distribution by specific Ministries and categories are still to be determined.
- Although the total national budget declined significantly in '93, the Government share allocated to investment increased significantly.
- In 1993, externally financed investment was level. The percentage of the national budget financed by external investments has remained fairly stable at 27 - 37%.

The exchange rate GF for US Dollars has changed as follows in recent years: 1989: GF 592/$US; 1990: GF 660; 1991: GF 754; 1992: GF 902; 1993: GF 950.

Recurrent budget figures should be regarded with caution since they include widely fluctuating debt payments -- much of which is actually financed by the Paris Club rescheduling agreement.

Clearly, national financial resources are constrained and this must be taken into consideration in the design of any health activities. Activities identified should leverage existing GOG, international, and local financing; rather than generate large requirements for additional Government financing. Activities which build on existing initiatives or mobilize other resources will have higher likelihood of success than will completely new programs, unless they are very cost effective.

II. HEALTH BUDGET

A. Overall Budget

EVOLUTION OF MSPAS BUDGET (000,000)

	Salaries	Fonctn't	Invest.	Total	Change
89	2,700.0	2,052.8	8,855.01	3,607.8	
90	3,277.6	1,443.9	10,631.7	15,303.2	+12.5%
91	5,800.0	1,655.9	18,781.9	26,237.8	+71.5%
92	11,098.5	1,565.5	21,215.0	33,879.0	+29.1%
93	11,577.5	1,566.5	20,706.8	33,850.8	-0-

Sources: Salaries and operating expenses from MPF, Budget Direction.
Investment for 91/92/93 from MPF, Investment Direction.
Investment for 89/90 from UNICEF Social Sector Analysis.

Public sector financing for health care has been relatively flat in recent years. The total above appears to indicate a growth trend, however there are at least two factors to consider. As indicated below, the source of most of the Investment financing is external -- from donors, NGO's, and loans from the World Bank or ADB. Also, the increase of all civil service salaries by 100% in 1991 increases the salary figures in a somewhat artificial manner. Most of the GOG financing is for salaries and operating costs, which has declined since '89.

EVOLUTION OF MSPAS INVESTMENT BUDGET

	Inv.-BND	(% Expended)	Inv.-FINEX	(% Expended)	Tot.Bud.	(% Exp.)
91	2,184.5	(97.6%)	16,597.4	(60.3%)	18,781.9	(64.7%)
92	2,020.0	(68%)	19,195.0	(51%)	21,215.0	(52%)
93	4,743.5		15,963.3		20,706.8	
94	6,171.0		21,159.6		27,330.6	

Source: MPF, Direction of Investment

The figure above indicates the amount budgeted for MSPAS Investment by source and, in parentheses, the percentage of the budgeted amount actually spent. Actual expenditure information is not yet available for '93. From 92 to 93 and 94, the amount budgeted from the national budget (BND) grew by 135% and by 30% whereas investment financed by external sources remained relatively level. Nonetheless, the amount of the budget that was actually expended was fairly low.

As a result, considering inflation Guinea's capacity to finance the sector has gradually been eroded at the same time that service coverage is expanding, utilization levels are low, and some aspects of the quality of care have been questioned.

The GOG has documented its priority for the health sector but has yet to demonstrate its financial commitment by increasing resources allocated to the health sector to a level comparable to other countries or those recommended by the WHO. Increasing the share of general revenues allocated to health/population has generally been a difficult task in developing countries. If this is achieved, it is an important indication of GOG commitment.

If Government revenues remain flat, as predicted by most experts, any growth in the MSPAS budget will come at the expense of other Ministries. Since increasing the health budget is said to be a Government priority, it is hoped that health funding will not come at the expense of other social programs. Rather, budgets such as public companies or defense spending would be more appropriate targets. However, this is yet to be determined.

B. Recurrent Cost Budget

The MSPAS budget for recurrent costs has been growing modestly in recent years -- both in absolute terms and in proportion to the national budget -- though not sufficient to keep pace with inflation. This is indicative of the priority that the Government is beginning to place on the financing of health services, notwithstanding the severe constraints on financial resources.

The following are budgeted amounts including personnel and MSPAS-supported operating costs.

EVOLUTION OF THE RECURRENT COST BUDGET (000)

	National	Health	Percent
'89	213,033,000	4,752,838	2.23
'90	252,018,000	4,671,503	1.85
'91	368,250,469	7,455,880	2.03
'92	718,751,500	12,664,000	1.76
'93	504,613,500	13,144,000	2.61
'94	530,000,000	15,100,000	2.84

Source: Interviews with the Ministry of Plan and Finance, Direction of Budget. They were also sought from other donors' analyses and the MSPAS, but the Ministry of Plan and Finance data was felt to be most reliable.

The budget figures for '94 have not yet been finalized by the Government. The figures for '94 cited above were estimated roughly with the assistance of Ministry of Plan and Finance. Prior to any further analysis based on these figures, they should be verified. Reportedly, the budget is to be published imminently.

It is difficult to determine trends because of the aberration of 1991 in which all civil servant salaries were increased by 100%, thus causing a somewhat artificial spike in the trend.

- However, if '92 is considered as a base year (subsequent to the salary increase of '91), the recurrent cost budgets for '93 and '94 increased by 48% and 61% over '92 levels.

EVOLUTION OF THE RECURRENT HEALTH BUDGET (Sal + Op'ns) (GF 000,000)

	Salaries (Change)	Op'ns (Change)	Total	Op'ns/Total
89	2,700	2,052	4,752	43.2%
90	3,227 (+19.5%)	1,444 (-42.2%)	4,671	30.9%
91	5,800 (+79.7%)	1,656 (+14.7%)	7,456	22.2%
92	11,098 (+91.4%)	1,566 (-5.8%)	12,664	12.4%
93	11,577 (+4.3%)	1,567 (+.01%)	13,144	11.9%

- The recurrent cost budget has been increasing, but the increase is comprised of personnel cost.
- The small increase in the operations budget has not kept pace with inflation.
- Informal sources indicate that in '94 the salary budget is expected to increase by about 3%, and the operations budget is expected to double. This needs to be verified when budget is released.
- The World Bank has reportedly obtained Government agreement on annual non-salary recurrent expenditure levels as follows as condition to their loan:

  FY94: GF 2.3 billion (+46.8%)
  FY95: GF 3.4 billion (+47.8%)
  FY96: GF 4.5 billion (+32.4%)

  To the best of our knowledge these allocations are not reserved for any specific activities.

In addition to the MSPAS funding, the National Social Security Administration (Cassie National de Securite Sociale) expended GF 2,696,598,403 in 1992 for medical services. This amount added to the recurrent costs of the MSPAS raises the percentage of the national resources allocated to health to 3.36%.

C. Health Budget Expenditures

The preceding tables indicate the allocated budgets. Cash flow constraints or reductions in anticipated revenues in a given year sometimes preclude the disbursement of the allocated budget. The table below shows budgeted operating costs as actually expended over the past three years. (It is assumed that the personnel costs are fairly completely disbursed.)

- This indicates that, on average, the Government expended over 86% of budgeted funds for operations.
- The absolute amounts of MSPAS budgeted and expended from '91 to '93 has varied relatively little (about 6%); most operations costs have been supported by the communities through the cost recovery program and donors.

OPERATING BUDGET EXPENDITURES

	Budgeted	Expended	Percent
'91	1,655,880,000	1,371,944,951	82.85%
'92	1,565,500,000	1,335,529,695	85.31%
'93	1,566,500,000	1,426,256,444	91.04%
Total	4,787,880,000	4,133,731,090	86.33%

- Operating budget excludes salary costs and capital investments.
- The budgeted figures were provided by the MPF from preliminary reports; expended figures were obtained from MPF computerized accounting reports.

- The data above appear to indicate that the financial commitment to health has increased only slightly over the past few years.
- These data also appear to indicate that the Government is attempting to increase the funds earmarked to provide health institutions with equipment and supplies, not only personnel.

II. FINANCING OF SERVICE DELIVERY

A. Sources

Various cost elements of health service delivery are financed by various sources:

- Salaries for core staff are supported by the MSPAS and paid by the MPF according to the Ministry of Reform payroll. The MSPAS has indicated its commitment to continue to support personnel costs. The following are standard monthly salaries:

Technical Health Assistant (ATS)	900,000/month
Mid-wife	112,000
Health Aid	112,000
Doctor (new grad)	151,420
Doctor (average in seniority)	163,600

  The staffing policy for an integrated health center is the following: one doctor, one midwife, two aides or nurses, one matron (generally paid with local resources), four ATS or other auxiliaries. However, in practice staffing patterns vary.

- Additional staff often are financed by the health center's local budget or by the prefectoral government's budget.

- Capital improvements to infrastructure (and new infrastructure itself) are usually financed by NGO's, World Bank loans, donors and community initiatives. Often the community provides approximately one-third of the cost through in-kind labor. (Some health centers have been financed by U.S funds, including Peace Corps.)

- Marginal costs are virtually all financed by the clients themselves through the cost recovery component; the only operating costs not covered are health workers salaries. This is a major achievement of the program and one that is not replicated in many developing countries.

This represents a relatively diverse range of financial sources which is a positive indication of future sustainability.

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B. Fees Charged

The pricing structure in health centers is based on a set of prices for standard diagnoses, with the fee paid covering both consultation and drugs. An average mark-up of 250% on drug costs was calculated to cover drugs and other operating expenses, with a maximum fee of GF 2400 in health centers. Fees vary according to the age of the client.

HEALTH CENTER FEES CHARGED

	0 - 4 Yrs Old		> 5 Years Old	
	W'out Lab	- With Lab	W'out Lab	- With Lab
Local treat. ORS Oral Contracpt.	200	200	200	200
Oral treatment w/o antibio.	300	450	600	1,000
Oral treatment w/anitbio.	500	650	1,000	1,400
Injections	850	1,000	2,000	2,400
Vaccination	Gratuit		Gratuit	
Prenatal			600	600
Delivery			1,000	1,000

HOSPITAL FEES CHARGED

	Prefectoral H.	Regional H.	National H.
Outpt. cons.			
Adult	1,000	1,300	1,700
Child	500	700	1,000
Surgery			
W/O interv'n	12,000	15,000	20,000
With interv'n	30,000	40,000	52,000
Maternite			
Normal deliv.	3,000	4,000	6,500
Cesarean	10,000	13,000	17,000
Other assist. deliv.	5,000	6,500	8,500
General Consultation	12,000	15,000	20,000
yPediatrics			
0 - 5 years	2,500	4,000	5,000
5 - 14 years	5,000	6,500	8,500
Private Room	1,000	1,500	2,000

Patients are required to make a deposit in these amounts at the time of hospitalization.

C. Budgets, Cost and Revenue

Health Centers' use two main budget categories for their locally controlled costs:

- "Incompressible" costs include essential drugs, management tools (e.g., patient registers, reporting forms,and administrative materials), fuel for refrigerator and outreach activities.

- "Other" costs include such elements as office furniture, motorcycle maintenance, travel, personnel incentives, cleaning and maintenance supplies, and contingencies.

A sample (not scientifically selected) of six health centers in Middle, High, and Forest - four of which are relatively urban and two of which are relatively rural - provided the following budget information:

HEALTH CENTER COSTS AND RESERVES (Jan - June '94)

	Incompressible	Other	To Reserves	Total Bud	RESERVES
#1	2,249,317	2,355,375	1,376,557	5,981,249	8,900,000
#2	2,777,465	1,945,000	1,598,885	6,321,350	28,482,368
#3	1,829,881	1,912,600	1,134,669	4,877,150	23,517,171
#4	551,112	241,500	38	792,650	5,018,397
#5	1,823,590	738,500	34,210	2,596,300	12,333,279
#6	743,378	560,732	(160)	1,303,950	13,697,697
Avg.	1,662,457 (45.6%)	1,292,285 (35.5%)	690,700 (18.9%)	3,645,442 (100%)	15,324,819

- ▶ On average, health centers' reserves are sufficient to cover their "incompressibles" cost for nine budget periods (six months each or 4.5 years total) - without any further local revenue.

- ▶ On average, reserves are sufficient to cover "incompressibles" plus "other" costs for five budget periods (six months each or 2.5 years total). Health centers are authorized to program expending one-third of their reserves each period.

- ▶ This indicates that urban centers can attain full marginal cost recovery.

- It was stated at a public meeting that the total of reserve funds nationwide as of December '93 exceeds GF 1.7 billion, as follows:

Revenues	GF 3,498,459,345
Expenditures	1,698,532,285
Balance/Reserves	GF 1,799,927,060

- The impact of the Central Pharmacy (refer to overall Assessment section on Logistics for more details on Central Pharmacy) on this system could complicate this achievement: Presumably the Central Pharmacy will be operated on a full cost recovery basis which will require prices at the health center level to be set at a rate sufficient to also pay for central costs. This may prove to render drugs too expensive for patients; it will need to be managed vigorously. (The Secretary General of MSPAS subsequently indicated that the periphery level would receive some subsidy for procurement of drugs to cover central costs. Therefore, central costs of the Central Pharmacy would be indirectly subsidized. But this has not yet been established as a procedure.)

An important aspect of the cost recovery program is that all revenue generated remains at the local level to be spent according to the budget established locally by the management committee. None of the funds are remitted to the central government treasury (as is often the case in other countries). There is some discussion of establishing a solidarity fund by requiring each health center to remit a small portion of their revenue to a central point which would then re-distribute the funds to assist health centers in poorer areas that were not breaking-even. However, this is yet to be implemented.

It is also interesting to note that Regional Inspectors are required to report systematically, at the semi-annual monitoring reviews, on any embezzlement of funds detected during supervision and the plans and progress in recovering funds.

D. Ability to Pay

The Conakry Household Consumption Study (ENCOMEC) conducted with Cornell University in 1990/91 indicates the following points which, although specific to Conakry, raise issues.

1. The greatest proportion of people in Conakry expend between GF 12,000 - 30,000 monthly per capita (about 50% of households).

2. The average per capita expenditure for a member of a household headed by someone self-employed in the ag/fishing/mining sectors is GF 25,246.

3. Not surprisingly, household size shows a strong negative correlation with per capita expenditures, suggesting that FP might be most appropriately targeted towards the poorest segment of society.

4. For the bottom 30 percent, the average household size is 9.66 people.

5. Households in the bottom two quintiles are calorie deficient on average. These households have less flexibility in allocating their households resources and are more vulnerable to price and policy changes.

6. In Conakry, the population that makes greatest use of health centers is the poor: Of those in the bottom 30 percent, 24% of males and 27% of females use the health centers. This proportion decreases as expenditure level increases.

7. In Conakry on average, 2.11% of per capita expenditure is spent on health. This percentage generally increases as income increases. For the lowest 30 percent, 1.85% of income is spent on health, as indicated in the following:

Food	57.12%
Housing, utilities, tax	14.88
Fuel	6.70
Transport	6.31
Personal, discretionary, recreation	5.52
Domestic consumables	3.18
Clothes	2.97
Health	1.85
Education	1.47
Total	100.00%

8. The total per capita monthly expenditure for the bottom 30 percent is GF 13,699.

9. At GF 13,699 monthly expenditure per capita per month, 1.85% would come to about GF 3,000 for all health care for a year.

Although the ENCOMEC study addresses only Conakry, the household financial situation is usually even more constrained in the countryside and is usually more cyclical and dependent on the harvest.

The study indicates the severity of the financial situation confronting that segment of the population that most uses health centers. This could have important implications for program design.

Health centers visited in the field, without exception, had financial reserve accounts ranging from GF 5,000,000 to 28,000,000. Obviously this is a strength in the financing and financial sustainability of the Guinea healthcare system. It

also has important positive implications for quality, since the reserve funds increase the likelihood of maintaining stocks of essential drugs as well as other supplies, equipment, and personnel.

Most service providers questioned said that fees charged for services posed a problem for some patients, but that the requirement to pay for services does not deter people from seeking and obtaining services. Reportedly, on rare occasions fees are waived, often the extended family assists with payment.

Nonetheless, while revenue collections are substantial, utilization rates were felt to be low in some of the regions (e.g., Upper and Middle). This suggests the question: is the current fee structure a more significant barrier to utilization than is believed? (Certainly other factors affect utilization, including infrastructure, sanitation, the individual provider, etc.) If this might be the case, is the current fee structure contributing to the financial strength and financial sustainability of the system at the expense of better health outcomes which perhaps could be obtained if fees were lower and appropriate utilization higher?

The variability of utilization patterns indicates that the propensity to consume health services varies greatly by region, suggesting the need for an analysis of the price elasticity of demand. Such an analysis may be able to be conducted with data available for Conakry, but apparently not for other regions at this time.

(We understand that the World Bank might currently be supporting a larger scale household expenditure study which might respond to this need. Reportedly it indicates that the average household size is 6.54, spent GF 81,463 on goods and services, of which 4,628 was spent on health.)

If the MSPAS and USAID/Guinea determine that project resources would be most appropriately allocated to specific geographic areas, an analysis of the price elasticity of demand and household expenditure patterns should be conducted in those areas in order to continue to refine the cost recovery system and optimize health output. For example, in parts of Middle Guinea (and perhaps Upper Guinea), utilization appears low in spite of strong infrastructure and relatively reliable availability of essential drugs. If USAID resources were to be allocated there, it would be important to know more about the effect of price on demand, as well other factors that affect utilization. A baseline study of health status and service utilization would enable program managers to determine the impact of services over time.

On the other hand, in Forest Guinea it appears that utilization is quite high and price might not be a barrier. Nonetheless, it may be worth conducting a local study to better understand which expenditures are foregone in order to

purchase health services. If the purchase of health services is at the expense of food and nutrition, the benefit of the expenditure might merit reconsideration.

- In the final analysis, it appears that the cost recovery program is sufficiently well-established and successful in generating financing with which to assure supply of essential drugs, basic supplies, and motivation to personnel that it would be a mistake to make wholesale modifications to the scheme. The Guinea program has proved that an effective cost recovery system can be established and can contribute to improved quality of services. Nonetheless, it may be feasible to make marginal adjustments that could improve health status by increasing utilization without significantly undermining revenue generated to support operations through cost recovery. In fact, if fees are reduced but still maintained at a level which exceeds marginal cost of providing services, surplus revenue should increase rather than decrease from increased utilization.

The emphasis on a positive financial balance should not be the preeminent indicator of a facility's success. The objective should not be to generate a surplus at all cost, but to attain a financial balance that will enable the system to maximize health outcomes.

E. Equity

The Guinean health program should be congratulated for having implemented its cost recovery program as well as it has. Nonetheless, for a variety of reasons the system will require continued "fine-tuning" as the health program continues to evolve. One issue that might be addressed is equity of the existing program.

For at least two reasons, fee-for-service systems with standard fees throughout the country pose structural equity issues. (1) Standard fees across the country do not take into consideration local variability in ability to pay. The GF 2000 fee for a treatment with injection might present a different dilemma for a person of median income in Tougue than for a person of median income in Conakry. (2) Some feel that fee-for-service systems unfairly burden those who are ill or most likely to become ill (perhaps the elderly or the poor).

Prepayment of the cost of care is an approach that spreads the financial risk of illness across a larger population and can be used to fund some preventive activities and therefore has some advantages. Under a prepayment system, ready cash is not required at the time when health care is received.

However, it also requires a greater range of administrative duties and a higher level of financial management expertise.

More sophisticated financial analysis is required to establish rates to break-even. Working capital management can also be more complicated. Administrative mechanisms to assure compliance and quality of care monitoring can also be more complex.

Although it is premature for the national program to embark on a prepaid system in view of the well-established fee for service system, the MSPAS and USAID/Guinea should consider experimenting with piloting a prepaid component in a very limited number of prefectures in which the utilization is relatively high. This would provide useful information with which to plan future adjustments to the system -- adjustments which might not be advisable today but may be in the future. Moreover, considering the relative sophistication of the Guinea health consumer, they might perceive prepayment as an attractive option.

F. Efficiency

Simply increasing the resources for health will not necessarily improve the system unless they are deployed efficiently. Adding resources to an inefficient system without improving the production process will result in little improvement. Any imbalances in the resources available cause the entire system to be constrained by the most limited resource. For example, if trained personnel are relatively plentiful, but medications are not available; the system in total will not be able to function much beyond the limits of available medication. The resources that are less constrained then become underutilized.

Increasing efficiency generally involves improving management capacity to attain greater output per unit of input. The policy of the MSPAS is to decentralize more authority and resources to the prefectoral (DPS) level. The new administrative structure proposed will include a financial and administrative unit at each level. However, the processes and procedures to implement this decentralization are not evident, nor are the resources - human, financial, technical - to achieve it. At the regional inspectorate and prefectoral directorate levels, administrative and technical procedures will need to be developed and implemented. This will require a major effort to implement, much less plan. It may be difficult to fund these activities from current MSPAS budget, but it would be good donor investment in developing capability to improve efficiency for the future.

IV. SUSTAINABILITY

Sustainability issues affect several different aspects of programs including financial, organizational, and policy aspects. In addition to support for service delivery, sustaining improvements requires strengthening national and/or local capacity to manage resources effectively

Currently, there are certain conditions favorable to sustainability of health and family planning service delivery activities, just as there are certain factors that could undermine future sustainability. Factors favorable to sustainability include the following:

- Political commitment to primary health care and, to an extent, family planning on the part of the Direction of Public Health is clearly evident in policy documents and the level of priority accorded various programs.

- Community management and participation in financing activities strengthens chances for sustainability by increasing likelihood of obtaining inputs to support marginal costs of providing services.

- Integration of a range of activities at the service site makes it difficult to isolate/terminate selected activities that might be vulnerable to a loss of political support in the future.

- Diversity of funding organizations makes the program less vulnerable to the vicissitudes of any single agency.

Some of the constraints to sustainability of program achievements include the following:

- Financial commitment on the part of the Government of Guinea has not been strong, therefore reducing the potential leverage of donor resources and causing the program to rely too much on international financing.

- Allocation of national resources to SMI/PF program is constrained by virtue of its position within the MSPAS organization as a Section.

- Institutional development activities still need to take hold and be reinforced to compensate for the apparent lack of same during the First Republic.

- Lack of apparent demand for services among some segments of the population could be a source for future reduction in political and financial commitment.

Each of the above mitigating factors can be strengthened by activities discussed elsewhere in this assessment. Likewise, project activities can build upon each of the favorable conditions. However, it is important to establish the role and priority of sustainability of project activities at the design phase in order to facilitate correct implementation.

Projects can be designed in such a way as to emphasize either (1) obtaining outcomes that occur during the term of the project itself, and (2) developing structure and resources to attain objectives after the term of the project is completed. Some projects attempt to do both. However, a problem arises when it is not determined *a priori* which of the above is pre-eminent.

Although the two need not be mutually exclusive, trade-offs are often involved between the two as sustainability competes with other project goals. If the priority is not clearly established at the outset, it can lead to confusion regarding allocation of resources and programmatic decision-making during project implementation.

If the project is to emphasize institutional development activities and, perhaps, to sacrifice expansion of activities in order to achieve other objectives, the project should not be held accountable for short term demonstration of substantial service delivery output and vice versa.

At this still early stage in the development of the Guinea MCH/FP program, it would seem advisable to place priority on continuing to develop access to high quality services and continuing to develop the institutional capacity to support improved service provision. Although this implies (and, in fact, requires) attention to sustainability of project activities, it also should imply assignment of secondary priority to sustainability. If this is the case in the design phase, it should be explicitly specified at the design phase in order to clarify future decision-making and implementation.

V. CONCLUSION

In many situations and health programs in Guinea activities are carried out quite successfully at the field level. However, there remain reports of shortages of basic pharmaceuticals, fuel, vehicles, equipment and proficiently trained personnel. To address these needs, the GOG will need to continue to focus sharply on the economics of the health sector.

A coherent health care financing strategy can enable the GOG and USAID/Guinea to work on two important axes at the same time: (1) increasing access to high quality family planning and related health services; and (2) policy reform to increase resources and improve resource allocation.

Government involvement in the health/population sector is limited by an overall constraint on the public budget, in spite of the high level of commitment on the part of MSPAS officials. Nonetheless, in order to have significant impact on the national health/population program, donor agencies need to work with the national program if they wish to have significant impact over the long term. This would seem to argue against developing major, totally new activities in the public sector. Future projects should leverage existing GOG, local, and international financing; build on or integrate into existing initiatives; and seek to mobilize other resources. The health sector financing strategy that USAID/Guinea should encourage the GOG to pursue should focus on resource mobilization, resource allocation, efficiency, and equity.

Resource mobilization approaches should include facilitating private sector involvement (including market-based, employment-based, and insurance initiatives); encouraging increased GOG financial support to the health sector; and maintaining appropriate emphasis on cost recovery.

In resource allocation, approaches should encourage increased GOG financial support to SMI/PF and to operating costs, and directly support activities at the intermediate and periphery levels in order to continue to push resources closer to the service delivery level.

To maintain and improve efficiency, activities should continue to improve management, encourage decentralization and focus on maintaining availability at service sites of the range of resources necessary to provide services -- most notably contraceptive and drug supply.

To enhance equity of health/population service provision, consideration should be given to further analyzing household expenditures and service utilization in specific areas to be identified and to testing other cost recovery mechanisms to refine the current system.

The risk of diminishing sector resources should be addressed by including a specific review of sector budgetary allocations and expenditures in annual reviews of project performance. USAID may wish to consider agreeing with the GOG to certain financial conditions prior to implementation. In principle, this is a strong way to push policy development. However, it should also be considered with caution since in some countries, preconditions have resulted in very significant delays in implementation of activities.

Nonetheless, in future reviews and analysis it is important to keep in mind that the financing strategy should not be misconstrued to represent the ultimate objective of health sector activities. The financing strategy should be maintained as a means to assist achievement of health sector objectives.

APPENDIX X

HUMAN RESOURCE DEVELOPMENT ASSESSMENT

This section refers primarily to public sector human resource development. The official private sector, including NGOs, currently employs only a small percentage of trained health workers. However, it is widely believed that the "unofficial" private sector includes some MSPAS employees providing services for remuneration (inside and outside of Ministry facilities), especially in urban areas.

HEALTH PERSONNEL

The MSPAS Health Sector Policy places a major emphasis on human resource development including implementation of a Re-deployment Plan based on population-based needs assessments, norms and job descriptions, development of human resource use policies and development and implementation of career planning.

The MSPAS has approximately 7,052 salaried employees as of January 1994; more than 5,900 were trained as service providers. Since 1992, approximately 77 employees have retired and 73 new employees hired. The majority of retirees were permanent contractual employees (52% maintenance and cleaning workers and drivers) while the majority of new employees are service providers (76% physicians, midwives and health technology assistants). There is also an unknown number of contractual employees paid by health centers and hospitals out of revenues generated through the cost-recovery scheme, as well as at least 600 trained, non-salaried TBAs throughout the country.

SELECTED MSPAS PERSONNEL, BY CATEGORY (1\94)

Administrators	7
Finance Specialists	6
Physicians	941
Pharmacists	199
Midwives	371
Nurses	1291
Laboratory Technicians	169
Health Technology Assistants	2471
Book-keepers	41

Almost every major donor report since 1988 has emphasized the need for a rationalized system of personnel deployment, especially given the high percentage of physicians (45%) and midwives (55%) in Conakry and the comparative under-staffing of health centers outside of Conakry and the four regional capitals. Hospitals tend to have more complete staffing according to MSPAS

guidelines than do health centers, with the exception of centers in Conakry which are over-staffed. More than 34% of public sector health employees work in Conakry, covering about 15% of Guinea's population and assuring central-level functions. In 1992, re-deployment of some personnel both within Conakry and towards other regions was completed. Progress since 1992 on re-deployment is difficult to assess given the limited availability of current personnel distribution data. Sources within the MSPAS admit that while some progress has been made towards implementing the existing Re-deployment Plan, there are serious political difficulties confronting completion of the task. For Conakry itself, further re-deployment away from over-staffed facilities will be possible in 1994 as new health centers are integrated into the NPHCP.

A relevant question is whether the existing numbers of personnel could fill the demands made by the current system even if the Re-deployment Plan were fully implemented. A preliminary analysis shows that MSPAS minimum staffing requirements (BEPR:1988) may contribute to some of the current inequities in deployment:

TYPE OF STRUCTURE	PERSONNEL PER STRUCTURE	PERSONNEL IN TOTAL
UNIVERSITY HOSPITALS	358	716 (2)
REGIONAL HOSPITALS	140	280 (4)
PREFECTURAL HOSPITALS	103	2884 (28)
HEALTH CENTERS	8-9	3040 (380)
TOTAL		6920

This chart does not take into account health posts or central-level Ministry staff not based in service delivery sites. Assuming the integration of all 380 health centers into the NPHCP, almost all current personnel would be accounted for if these staffing patterns were followed. Of the 941 physicians employed by the MSPAS, 852 would be involved in actual service delivery (including one physician per health center). Clearly, the MSPAS cannot currently fulfill its own staffing requirements and given restrictions of the Structural Adjustment Program, numbers of personnel will not increase substantially in the next few years.

As noted above, recent hiring opportunities have been used by the MSPAS to add personnel perceived to be in short supply in the public sector; they may or may not be those needed most by the MSPAS. As noted above, administrative and financial specialists are in extremely short supply and current numbers cannot provide

needed coverage at the central level and in the six largest hospitals.

A detailed analysis of existing job functions, job descriptions, personnel categories and needs within the MSPAS program - with an emphasis on the NPHCP- would enable rational re-deployment and hiring practices. Current problems in administration, financial management, supervision, and logistics require special attention.

PRE-SERVICE EDUCATION AND TRAINING

The School of Medicine, located in Conakry, is part of the university system. The number of graduating physicians varies between 100-200, with current classes closer to the high end of the class size. An impressive effort to provide physicians-in-training with appropriate exposure to PHC and preventive health led to the program at the Rural Health Training Center in Maferinyah. Although most medical students spend part of their final year at the Center in Maferinyah, the content and quality of this training may not be adequate. A detailed analysis of this part of the medical training program is not currently available.

The other four pre-service training institutions for health personnel are included administratively within the Ministry of Education. These are a professional school training midwives, registered nurses and public health aides (in Kindia) and three secondary schools of health (N'zerekore, Kankan, and Labé) which produce auxiliary health workers including health technology assistants and laboratory assistants. An average of 560 paramedical personnel complete training each year, of which approximately 80 are midwives and nurses.

The content of pre-service training requires some revision if it is to serve the goals of the NPHCP. Both pedagogical skills and materials have not been reviewed or revised in at least six years, and do not reflect priorities of the GOG: curriculum and practical training are oriented to hospital-based curative as opposed to primary and preventive care. Many older providers claim that those graduating now have less practical experience than when the schools were based in Conakry, and therefore younger agents require much more formal and informal in-service training.

IN-SERVICE TRAINING

As noted above, even new graduates require in-service training to perform the job descriptions specified at most levels of the MSPAS system. Central-level coordination and record-keeping about in-service training are inadequate, although reforms are currently being implemented; therefore, only estimates of recent training can be made. Approximately 60% of current MSPAS service delivery personnel have been trained for the national program, with a heavy emphasis on EPI and management of essential drugs.

By comparison, only about 6% of current MSPAS staff have received training in contraceptive technology or family planning management or IEC.

Much of the in-service training to date has been "cascade training". Although the costs are low, the results are uneven at best and often unsatisfactory. Supervisors often have received different training than those they supervise, and sometimes have not received any training in new elements of the NPHCP. Development of a group of health trainers has begun, but efforts have been mostly limited to the central level. Some central level personnel participated in a special pedagogy workshop organized for them by the IPN; apparently financial constraints have limited follow-up and expansion of these efforts in spite of much interest on the part of the MSPAS.

The MSPAS has committed to decentralization of in-service training, based upon the establishment and support of multi-disciplinary regional and prefectural training teams.
An updated National Health Training Plan is currently being developed; the original Plan (IDA, 1989) was not operationalized.

Decisions about major directions of USAID assistance to the health sector will determine the content of in-service training needs. Three dichotomies should be considered in making the final decisions:

1. Technical versus Managerial Training

While there are certainly great needs for technical training, especially as new or improved interventions are added to the PHC\EPI\EM system, the need for comprehensive management training is also evident. Emphasis for management training should be placed on those personnel functioning as Prefectural Health Directors (DPS) and Heads of Health Centers (CCS); the four Regional Health Inspectors should be consistently involved..

One of the major weaknesses of the current MSPAS system is management, yet - as is the case in most countries - pre-service education provides almost no basis for performing these functions. Training in use of the NPHCP management tools has been provided to some of the staff of health centers, and most of the tools are used (to some extent) in most integrated centers. Bi-annual monitoring of health centers has supported increased use of certain tools, but completeness and quality of basic data collected is uncertain. Use of the collected information on a local level to monitor progress and correct problems was not observed consistently. Training in and use of management tools is less standardized in hospitals, with the exception of some tools related to the management of the essential drug supply.

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2. One Technical Intervention versus Packages of Interventions

Training of health personnel in one intervention (ie family planning) at a time may provide certain advantages, including a more specific focus geared to donor concerns and ability to provide in-depth scientific and practical knowledge in a limited time period. However, designing modules (or combining modules) that emphasize related packages of services can help to emphasize integration and quality of services for the community. For example, one package could be those interventions usually offered by the "Pre- and Post-Natal Care" personnel: pre- and post-natal care with additional emphasis on identification and referral of high-risk pregnancies, family planning, breast-feeding, and STD\AIDS prevention.

3. Primary Care versus Referral Care Training

If the NPHCP is to meet its own objectives, standards for and quality of care at referral sites needs to be improved. Clearly, USAID can determine which level of the system to target its interventions. For example, delivery of services through the health center and post system could be emphasized, or support could be given to the whole pyramid of public sector services for a given intervention or package of interventions (ie community-based distribution, health posts, health centers, prefectural hospitals for complications and\or serious cases, etc).

STRENGTHS, WEAKNESSES, OPPORTUNITIES, THREATS
AND RECOMMENDATIONS

1. PERSONNEL

- The GOG experiences the same deployment problems in almost all important sectors of government intervention, including education, rural development and agriculture. Plans for in-depth studies and options analysis for personnel incentives for all sectors have been developed. Standardized GOG policies could have specific positive or negative impacts on sectors supported by USAID; in the health sector, where some community-level decision-making determines payments of salary supplements, this could constitute a threat to MSPAS policy development and attempts to support community participation.

  RECOMMENDATION: USAID\Guinea should consider offering assistance to the central government for the design of the studies and analysis of data and options, and policy process.

- Although World Bank documents indicate support for implementation of re-deployment and personnel policy development activities in the health sector, additional technical assistance may be required to continue administrative reform and functional implementation of the

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reforms. Threats include wasting efforts to overcome intransigent political problems and development of more policies that will not be implemented.

RECOMMENDATION: Provide additional technical support in administrative and personnel policy development as needed at the central level, and assist in implementation to support decentralization. Some inputs could be tied to performance on re-deployment (i.e. performance-based planning for overseas training, additional equipment for central offices, etc.) Special attention needs to paid to the issue of incentives for service in underserved areas.

- Current reliance on one person per prefecture (DPS) to perform all supervision is not functional, especially in prefectures with many health centers. DPS should lead a small team of supervisors (including non-physician personnel with high-levels of training and experience) to increase supervision frequency and coverage rates and to reduce the burden on DPS so other task may be prioritized as decentralization occurs.

  RECOMMENDATION: Support pilot zones of supervision teams (several prefectures) to see how it works and what the results are (operations research).

2. PRE-SERVICE TRAINING

Although the public sector has employed less than 5% of those graduated from all five institutions since 1991, continued inadequacies of pre-service training should be corrected to avoid continued dependence on donor assistance to meet basic pre-service training needs for the NPHCP. Major threats to the success of interventions in pre-service training include reductions in Ministry of Education staffing and funding levels in concerned departments, the inability to coordinate efforts with MSPAS, and the geographical difficulties involved in working in five different cities.

- Both USAID and the World Bank have planned interventions in this area, but coordination of efforts is essential to ensure sustained impact and rational use of donor funds.

  RECOMMENDATION: Require coordination of donor plans by the Ministry of Education before funding additional interventions.

- In order for any curriculum changes to be effective, they need to reflect current MSPAS policy and programmatic emphasis. Therefore, special consideration needs to be given to institutionalizing the collaboration process for curriculum review between the Ministry of Education and the MSPAS. The major threat is dispersion of effort with little impact.

RECOMMENDATION: Emphasize improvements in curriculum in areas of importance to the NPHCP where training and skills are notably weak in pre-service institutions, such as reproductive health, nutrition, and ARI.

Efforts (like that of JHPIEGO) to upgrade both knowledge and teaching skills in reproductive health are especially important given the epidemiology of morbidity and mortality among the reproductive age population. However, greater programmatic impact would be obtained more rapidly if these efforts focused on regional training team members in the future (see below).

3. In-Service Training

- A major opportunity for a donor exists to support the MSPAS as it decentralizes training capabilities, simultaneously emphasizing the development of the training skills while reinforcing technical skills and use of algorithms. Until training resources are sufficient, the NPHCP cannot meet its objectives in a cost-effective way and continued reliance on "cascade training" will not produce the desired results.

  Since many of the potential members of a prefectural training team also perform supervisory functions, support designed at improving training can also improve both the content and style of supervision.

  RECOMMENDATION: Support the development of decentralized national training capabilities, beginning in one region and its prefectures if resources do not allow a more widespread effort. Focus on improving training skills with the help of the National Institute of Pedagogy. Since trainers will need to be able to provide training and refresher courses to support the whole NPHCP, emphasize the content of standard MSPAS modules and treatment algorithms. (See comments above on one intervention training versus packages of interventions.)

- Members of this team and MSPAS personnel (as well as staff of both UNFPA and USAID-financed projects designed to support addition of family planning to health center services) have noted the need for a major review of the nationally-used training modules for contraceptive technology, family planning management and IEC.

  RECOMMENDATION: Provide both financial and technical support for a review and revision of family planning training modules. Breastfeeding and LAM need to be integrated into the standard training. Since their design in 1992, there have been notable changes in international standards of practice and experiences from local use imply some changes are needed.

  NOTE: The family planning training modules and the related algorithms need to be consistent; if either one is improved, the other also needs to be adjusted.

- Use of algorithms is not consistent throughout Guinea, impacting on the quality of care and the cost of the care delivered in integrated health centers and posts. Results of bi-annual monitoring include comparisons of costs per treatment as well as per case, and indicate variations of up to 33%. A major threat could be moderated if the MSPAS requested this assistance, and therefore was committed to what could be major changes in algorithms.

  RECOMMENDATION: Finance limited research into barriers to proper use of algorithms in several parts of Guinea. If results indicate that the main barriers can be corrected by punctual interventions, such as redesign of the tools or refresher training, these interventions should be financed.

- If the decision is made to support both primary care and referral centers for family planning or a package of reproductive health services, a number of actions need to be financed to support development of sound training practices.

  RECOMMENDATION: Develop new training modules for referral sites, as well as referral criteria to be integrated into basic training modules and algorithms.

- Management and supervision training needs to be strengthened. Review of current training modules and techniques and development of explicit checklists might improve consistency of supervision and impact. (Those being supervised should know what the standards are.)

  RECOMMENDATION: Support a national seminar on supervision for all IR and DPS to review and revise supervision checklists. Collective ownership of these tools is important.

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APPENDIX XII

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APPENDIX XI

Partial List of Persons Contacted

The assessment team contacted scores of people throughout Guinea during this assessment. The assistance of those not specifically mentioned below is gratefully acknowledged.

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Dr. Karifa Douno	Chief, Pharmacy
Dr. Hassimion Bangorra	Chief, Essential Medicine Program
Dr. Boubacar Sall	
Dr. Mohamed Sylla, Jr.	Coordinator, PCH Program
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Dr. Boubacar Toure	Maternity Without Risk Program
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MSPAS (Regional)

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MSPAS (Prefectural)

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Dr. Gilber Milmono	Chief, Kuida Health Center
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Dr. Cisse	Director of Maternity, Nzerekore Regional Hospital

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Alpha Fode Dembele	Radio Rural, Kankan
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Alpha Boubacar Barry	Deputy Director, Institut Pedogogique National
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CNSR

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AFPAMNIG

Dr. Namba Diankanbe Kaba	National Coordinator

INSE

Dr. Kourouma Sekou Tidiane	Director
Mrs. Fofana	Centre de Récupération et d'Education Nutritionnelle
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Dr. Disatty Keita	Director

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Dr. Ibrahim Nadhel Diallo	Head, Chemistry Department
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