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**USAID/GUINEA STRATEGIC OBJECTIVE #2
RESULTS FRAMEWORK DEVELOPMENT REPORT**

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Submitted to:

Strategic Objective #2 Core Team

Submitted by:

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Introduction

In January of 1997, USAID/Guinea engaged Management Systems International (MSI) to assist in the development of the Mission's health sector Results Framework. Between January 15 and February 14, a two person MSI team worked with the Mission to accomplish three main tasks:

1. Conducting a series of focused key stakeholder interviews and analyzing the results of these interviews;
2. Planning and facilitating a two and a half day strategic planning workshop involving a comprehensive range of health care practitioners, managers and policy makers including Ministry of Health employees, private voluntary organizations, non-governmental organizations and international donors; and,
3. Facilitating Mission finalization of the Strategic Objective #2 (health sector) Results Framework.

Accomplishment of these three tasks was performed a sequential process. The interviews, combined with ongoing consultation with the Strategic Objective (S.O.) core team, provided the basis for development of the workshop program. The workshop outcomes, synthesized by the MSI team, provided the basis for refinement and finalization of the Results Framework (RF). This last task was accomplished through a two stage process. First, the MSI presented a synthesis of the workshop outcomes in RF format and facilitated the S.O. core team's development of consensus on a slightly modified version of this synthesis. Second, the MSI team worked with the S.O. core team to develop a final RF which included Mission priorities and key workshop outcomes in a RF format consistent with Agency and Africa Bureau guidance.

This report follows the sequential process of the assignment. Section I covers the process, methodology and results of the key informant interviews. Section II provides a brief description of the workshop. A more detailed description is provided in the Workshop Proceedings Report which has also been prepared by MSI. Section III outlines the RF development process. Section IV provides conclusions and Section V focuses on next steps.

Section I: Key Informant Interviews

In preparation for the Strategic Objective (S.O.) #2 workshop, the MSI team interviewed key stakeholders which intervene directly or indirectly in the Guinean health sector. These organizations included the European Union, the French Cooperation, UNDP, UNFPA, UNICEF, PSI, AGBEF, the World Bank, KFW, and Medecins Sans Frontieres (Belgium). A set of focus group interviews with Ministry of Health personnel were canceled by the ministry due to a death in the Minister's family. The interviews were structured to collect information on: (1) health sector priorities and constraints; (2) the organizations' priority health sector development goals; (3) mechanisms to improve donor coordination; and (4), organizational strengths and weaknesses. This information helped the MSI team to design the strategic planning workshop for maximum effectiveness.

Methodology

The interviews were conducted by one or both member of the MSI team. The organizations interviewed were represented by the local director, health expert or both. Due to the time constraints of those interviewed, interviews seldom exceeded 45 minutes. The interviews were conducted informally, though previously selected topics were addressed. These topics were:

- Priorities for health programs to be implemented in the next five years;
- Main constraints to the implementation of the suggested programs;
- Determining factors in the current low utilization of preventive health services;
- Basic services to be offered at health centers;
- Donor coordination needs, approaches and potential benefits;
- Perceptions of USAID's areas of greatest expertise; and,
- Health programs the organizations interviewed will implement in the next five years.

Findings From the Interviews:

There was a vast array of suggestions for **priority programs** to be implemented in Guinea. Nevertheless, some common themes emerged clearly.

- Six out of the ten organizations interviewed mentioned the need of improving basic education as a sustainable path to health improvement.
- Six out of ten also suggested that decentralized and community-based actions should be in the center of any chosen approach to direct health interventions.

- Child health including extensive immunization activities was suggested by five out of ten interviewed.
- Other suggestions focused on: (1) maternal health; (2) malaria prevention/treatment programs; (3) training of managers and health care providers to improve overall quality of care; and, (4) STD/AIDS prevention/treatment. Family planning, the area in which USAID has historically been most active, was mentioned by only one organization.
- Some organizations pointed to the necessity for development of a wider approach to health status improvement including a variety of activities aimed at sustainable development. Activities suggested included basic and vocational education, in-service training, and stimulation of income-generating activities.

Major problems or constraints to the implementation and successful development of programs mentioned by more than half of the organizations included:

- Lack of basic management skills and training at all levels of the Public Health System including the central ministerial level, hospitals, and health centers.
- Lack of decision-making power at a central and peripheral level. The “need for decentralization” theme resurfaced here.
- Lack of transparency in the decision-making and bureaucratic processes.
- High, and in many cases unaffordable, costs of service and drugs at the public health service delivery points.

Regarding low-service utilization of preventive health services:

- Cost of services, the lack of health awareness and traditional resistance factors was pointed out as main causes by six out of eight interviewed;
- Access in terms of distance to the health unit was not seen as a major cause by eight out of nine organizations.
- Low quality services and lack of trust in the modern health system were regarded as important factors by four out of eight.
- In terms of family-planning, lack of quality of care including lack of discretion and privacy were seen as main constraints to access and demand. Another factor pointed out by two organizations was low empowerment of women in the family planning decision making process and the strong religious bias towards large families.
- One Organization mentioned that they felt that service utilization was not low and that demand is increasing rapidly considering that the National Health Program has been in place for only three to four years.

Only four organizations discussed **basic services to be offered at the Health Center level**. Suggestions included: maternal health; child health including nutrition and development; Immunization; treatment of malaria and other endemic diseases; STD prevention and treatment; family planning; and, first level curative services.

Nine out of the ten organizations contacted expressed the need for a **more adequate donor coordination**.

- Suggested outcomes of coordination included: a savings in human and economic resources; fewer gaps among programs; exchanges of experience and lessons learned; and, development of guidelines for programs and projects.
- Most organizations suggested that the Ministry of Health lead the coordination process. Some organizations suggested that initial difficulties should be expected because of the Ministry's lack of expertise in this area.
- It was suggested by most that the operation of this coordination effort be rotational with, for instance, meeting hosted by a different donor or NGOs every six months. It was further suggested that the meeting's agendas be preset and that, from the large meetings, smaller working groups could be organized according to expertise or working area. It was thought that the working groups might focus on regions and projects within a certain area of expertise (i.e., reproductive health, immunization, etc.). The working groups would discuss and propose areas for closer collaboration including sharing of financial and human resources. It was suggested that the working groups might meet more frequently (every one to three months).
- The presence of the private sector in the donor coordination group was seen as premature by eight out of ten Organizations. Nevertheless, it was suggested that private sector organizations might be called in for focussed discussions whenever appropriate.

USAID's **strongest expertise** was seen by most as in the reproductive health area. Some organizations, nevertheless, did not understand very well the modus operandi of AID: A donor, an executing agency, or both?

Note: Most of the organizations interviewed mentioned that they felt that the USAID strategic planning workshop seemed a good idea and might have a positive impact on the successful development of the health sector and its ongoing and future programs.

The organizations interviewed were asked to describe **their priority health programs for the next five years**. What follows is a summary of their responses.

UNDP

1. "Good Governance". This program involves support of the GOG in its decentralization effort through improving and increasing basic and vocational education at the community level. The program is ongoing and targets men and women in both rural and urban areas.
2. Ongoing support of socio-economic development through income generating activities (such as microenterprise development). This program targets mostly women in rural areas.
3. Eradication of poverty. This ongoing program involves basic education, vocational and in-service training. The program targets both sexes in urban and rural areas in the regions of upper and middle Guinea.

MEDICINS SANS FRONTIERES (Belgium)

1. Improvement of health care delivery systems in four prefectures of the Forest Region. This program, which ends in 1998, aims to rehabilitate the Kankan Hospital, improve its management capabilities through training, improve health professionals training through training of trainers for nurses and in-service training of surgeons (conducted by visiting surgeons from Belgium). Prefecture Hospitals and some health centers in the Forest Region are also to be rehabilitated, equipped and receive training. These efforts are to be partly developed and implemented by GTZ.

UNFPA

1. Integration of family planning at 342 Health Centers. This program involves training, equipment and supplying of contraceptives. To date, about 100 health centers have fully integrated family planning programs. This programs targets mainly women of reproductive age. Implementation is ongoing in Conakry, Middle and Lower Guinea and is to begin in the Upper and Forest Regions.
2. Increased health awareness (I.E.C.). This program involves development of IEC materials and mass media campaigns. The program targets women of reproductive age in urban and rural Guinea.
3. Increased access to family planning. This program involves community based distribution of contraceptives through the Health Ministry distribution net.

AGBEF

1. IEC activities targeting policy-makers, the general adult population, and adolescents.

2. Improving the quality of family planning service delivery. This program involves training of providers in AGBEF clinics. AGBEF has one clinic in Conakry and 4 other clinics in regional centers. AGBEF trains family planning providers at the request of the Ministry of Health, working closely with the Ministry and UNFPA to improve quality of care through training in health centers.
3. Integration of family planning in public health centers. This program involves training, equipment and contraceptive distribution. In collaboration with the Ministry, USAID, B.M., FPIA and UNFPA, AGBEF expects to cover the whole country in the near future.
4. Center for women's development. This program involves vocational training for adolescent mothers. The program is to be developed in collaboration with UNFPA in Middle and Lower Guinea.

PLAN INTERNATIONAL

1. Maternal Health. This ongoing program has 3 components: IEC, TBD training and setting up of delivery centers at the community level. 50 centers are already operating in Upper Guinea and the Forest Region.
2. Malaria prevention. This program includes IEC, hygiene and sanitation measures as well as distribution of impregnated mosquito nets. In addition to prevention, treatment of sick patients, particularly children, is also addressed. The program focuses on the Forest Region.
3. Child health. This program involves: (1) nutrition improvement through education and food supplements; and, (2) immunization rate increase through child to child surveillance. The program works in the Upper and Forest regions.

FRENCH COOPERATION

1. Epidemiologic surveillance. This program involves the development of an epidemiology information system. The program is in place and is run by Dr. Dantere at the Ministry of Health. French assistance is winding down.
2. Rehabilitation of hospitals in Mamou, Kindia and two other towns. The program includes rehabilitation and equipment as well as training of MDs and other health care providers.
3. Support to Management, Administration and Finance at the DNES, DNS and DAAF.
4. Training of pharmacists. The French grant scholarships for private and public pharmacists to study in France.
5. Revision and updating of the curricula of the Medical School as well as of the main School of Nursing in Conakry.

THE WORLD BANK

Nothing planned at present. Future programing may involve rural health.

THE EUROPEAN UNION

1. Improvements in quality of care. This program involves support to the decentralization process through training of managers.
2. Training of health care providers.
3. Rehabilitation of hospitals. This programs will be implemented through European NGOs. Specific activities have yet to be determined.

UNICEF

1. Health and nutrition. This ongoing program will have different interventions at the community, prefectural and central level aimed at: (1) increasing immunization rates; (2) increasing iodine intake; and, (3) increasing breast-feeding. The target population will be children five and under in urban and rural areas.

KFW

1. Reproductive health. This program, already being implemented in collaboration with UNFPA, aims the integration of family planning services in public health centers. It targets women of reproductive age and adolescents. The geographic regions targeted are Middle Guinea, Lower Guinea and Conakry.
2. National health program. This program will involve training of health care providers and renovation of hospitals and health centers. This program is to be implemented according to the Ministry's needs. Apparently KFW's scope of work is not yet decided.
3. Hospital Renovation with GTZ in Farranah and construction of a hospital at Forrerkraria.
4. Social marketing of contraceptives. This program will be implemented in collaboration with PSI.

PSI

1. Reproductive health including family planning (FP) and STD/AIDS prevention. This program involves integration of FP services at public health centers. FP providers are trained

by AGBEF. This program targets adolescents and women in reproductive age as well as men, in Conakry and the regions of Upper and Forest Guinea. The rest of the country will be covered by KFW, GTZ and UNFPA.

2. Social marketing of contraceptives. The whole country will be covered. At present only condoms and spermicides are being distributed at about 3.500 sites. The pill will be introduced in a near future. KFW and UNFPA will share the costs of contraceptives.
3. IEC (FP) at the national level. National and local mass media will be used.
4. Interpersonal counseling. This programs targets unmarried adolescents in Conakry.

Section II: The USAID/Guinea Health Program Strategic Planning Workshop

Consistent with the reengineering's emphasis on participation, transparency and client focus, the Mission asked MSI to facilitate a planning workshop involving the full range of health care implementation stakeholders in Guinea. To this end, USAID/Guinea invited some 80 health care practitioners, managers and policy makers to participate in the workshop. Roughly half the participants were Ministry of Health employees working at the national, regional and sub-regional levels. The remainder of the participants came from non-governmental organizations (NGOs), private voluntary organizations (PVOs) and the donor community. The stated objective of the workshop, developed by the MSI team in collaboration with members of the S.O.2 core team, was to "Refine USAID/Guinea's Provisional SO2 Results Framework". The workshop was held at the hotel Camayenne in Conakry on the third, fourth and fifth of February.

A. Workshop Structure and Methodology

Structurally, the workshop moved sequentially from the general to the specific and from a lecture format into a highly participatory process. The morning of the first day began with formal opening statements by the USAID Director and by the Minister of Social Affairs (standing in for the Minister of Health who had a death in the family), followed by discussions of norms, objectives and logistics. This was followed by a series of presentations including:

1. Key concepts of reengineering;
2. USAID's program worldwide and in Guinea; and,
3. The provisional S.O.2 Results Framework.

Because of logistics difficulties, this sequence was changed, with the discussions of processes, objectives, logistics and the key concepts of reengineering preceding the formal opening presentations.

These presentations set the stage for a series of group presentation and analysis activities which consumed the afternoon of the first day and the entire second day of the workshop.

Development of the workshop methodology began during team planning in Washington. With the assistance of MSI staff Janet Tuthill and Donald Spears, the team elaborated a two-phase group work methodology this involved:

- focused discussion resulting in consensus in small groups of five to seven participants;
- report-outs and further consensus building in groups of 20 to 25; and,
- plenary report-outs, followed by analysis of common themes and differences.

This methodology was based on a realistic assessment of what was needed for a truly participatory process given the number of participants and time constraints: (1) consensus reached in a reasonable time in small groups; (2) groups of less than thirty picking from a limited set of options (in this case, the consensus decisions of the small groups); and, (3) validation and discussion in the very large plenary group.

In refining and finalizing the workshop methodology during the week before the workshop, the team faced three challenges: (1) it was important that S.O.2 core team members and other key stakeholders buy into the two phase group work methodology described above; (2) the logistics of the group work process needed to be very efficient; and (3) the questions and issues which the participants focused on during the group work had to be crafted such that they made sense to the participants, could be responded to in the time available and provided data directly applicable to the provisional RF. These three challenges are discussed in turn.

1. It was important for the **S.O.2 core team members to buy into the two-phase group work methodology**. None of the team members were experienced with such a methodology and they expressed doubts about its practicality and effectiveness. The MSI team responded to these concerns in two ways. First, the MSI team delivered a series of short presentations on participation, explaining that with 80 to 100 participants, the two phase methodology would be the only way to get true participation because of the limitations of large group dynamics. The MSI team also explained how readily and effectively Guineans engage in participatory group work. Finally, particular attention was paid to the logistics of group work, designing an extremely efficient group work process.
2. Given the potential for participants doubting the usefulness of the workshop and the potential unwieldiness of the two-phase group work methodology, the MSI team saw **development of an efficient group work process** as very important. In order to create workgroups with proportional representation of the main groups in attendance: (1) Ministry officials; (2) NGO and PVO representatives; and (3) donors, the small and medium sized groups were predetermined. The facilitators broke the participants into 12 randomly selected groups of seven to eight and seated each group at a separate table. The tables were numbered from one to twelve and also identified by color. Four colors: blue; red; yellow; and green, were used with each color shared by three tables making up a medium sized group. During small and medium group work, the blue and yellow groups worked in the main workshop room while the red and green groups worked in separate break-out rooms. This methodology was followed during group work on the afternoon of the first day and during the entire second day of the workshop.

Before deciding upon the process, the MSI team considered a number of less deterministic alternatives and consulted a range of S.O.2 team members and other stakeholders. The consensus appeared to be that, in terms of group logistics, efficiency was more important than empowerment. The group work process was presented to the participants as:

The group work process was presented to the participants as:

In small groups of 5 to 7 people:

1. Engage in a brainstorming process
2. Chose the best ideas
3. Develop consensus

In medium sized groups of 20-25 people:

1. Present the consensus of each small group
2. Develop common themes and differences
3. Develop consensus

In plenary session:

Present common themes, important differences and consensus decisions of the smaller groups.

Day 1 Group Work

On the afternoon of day one, work focused on the following task:

Access and demand for reproductive health services (FP/MCH/STD-AIDs) are two critical factors for the health of Guinea's population.

- *What should be the three most important priorities for improving access and demand over the next five years?*
- *For each of the priorities chosen, please indicate whether it is linked principally to access, demand or both.*
- *For each of the priorities chosen, what might be the most appropriate programs, activities or projects?*

This work to developing consensus on key issues and priorities was designed to serve as a basis for the group work on the S.O.2 Results Framework which occurred on day two. The medium sized groups reached consensus on the following priorities:

| Priorities Selected | Group Blue: Tables 1,2,3 | Group Red: Tables 4,5,6 | Group Yellow: Tables 7,8,9 | Group Green: Tables 10,11,12 |
|---|-----------------------------|----------------------------|-------------------------------|---------------------------------|
| Availability of Resources (Human and Financial) | | Access | Access and Demand | Demand |
| Information, Education and Communication | Demand | Demand | | |
| Quality of Services | Access and Demand | Access and Demand | Access and Demand | |
| Geographic Coverage | Access | | Access and Demand | Access |
| Acceptability of Services | | | | Demand |
| | | | | |

Report-outs on these medium group consensus decisions were conducted on the morning of day two. After an analysis of common themes and differences, two participants “aggregated” these priorities as:

- Availability of Financial and Human Resources;
- Quality of Services; and
- IEC for Promotion of Services through Improved Knowledge.

The brief but vivid debate which followed focused on the need for prioritizing geographic access and the Government of Guinea’s role in the prioritization process.

Day 2 Group Work

After a brief overview of some key principles of Results Framework development, the second half of the morning and the entire afternoon were devoted to group work focused directly on the S.O.2 Results Framework. The group work task was articulated as follows:

1. *Do the Intermediate Results (relating to access, demand and linkages) in the Provisional S.O.2 Results Framework provide the necessary and sufficient conditions for achievement of the Strategic Objective?*

If they do please go on to question two. If not, please suggest changes or additions.

2. *The results under each of the Intermediate Results contribute to their achievement. Do these groups of results provide the necessary and sufficient conditions for*

achievement of the Intermediate Results to which they are linked? If not, please suggest changes and additions.

Group work followed the two-phase methodology used on day one with the same randomly-selected groups organized in the same fashion. To allow the groups to work in a free and unbiased way, the USAID S.O.2 team members participated in neither the working groups nor the facilitating process. However, some team members were present as observers and some of the small groups called upon them to explain aspects of the provisional Results Framework (RF). These team members had been coached by the MSI facilitators to provide explanations in as neutral a manner as possible.

By the end of the afternoon of day two, the medium sized “color” groups had reached consensus and reported out in plenary session. What follows is a description of their suggestions. For the sake of clarity and utility, the changes suggested by the groups are presented in terms of levels of achievement within the RF. For the sake of brevity, this description presupposes a knowledge of the provisional RF. Readers without such knowledge will find a copy of the provisional RF annexed. In this description, unmodified results statements from the provisional RF are in italics. All suggested changes are underlined.

The Strategic Objective and Intermediate Results Levels

None of the groups suggested fundamental changes at these levels. One group suggested the substitution of M.C.H. (Maternal and Child Health) for R.H. (Reproductive Health) in the Strategic Objective. Another group suggested the addition of the word “decentralized” before “services and products” in Intermediate Results 2.1 (“access”) and 2.2 (“demand”).

Lower Level Results

Suggested changes at these levels were more numerous.

Under IR 2.1 - “*Increased access to quality services and products in FP/MCH and STD/AIDS-prevention*” the following lower level results were suggested:

1. Improved Sanitary Coverage/ Geographical access
 - 1.1 Increased Delivery Sites / Public Health Centers.
 - 1.2 Increased Community Based Services
 - 1.3 Increased availability of FP and Health products through Social Marketing
 - 1.4 Improved Rural Roads
2. Improved Quality of Services as an alternative to *Improved service delivery*

3. Increased Availability of FP, vaccines and health products at the public health centers
 - 3.1 Existence of an efficient health products' distribution system
5. Improved affordability of services
6. *"Increased availability of health products through community based distribution"*

Under IR 2.3 - *"Increased demand for FP/MCH and STD/AIDS-prevention services and products"* the following lower level results were suggested:

1. *"Improved Quality of Services" (no change).*
2. *Improved knowledge and behavior of (alternatively) (a) women, (b) target groups and decision-makers, and clients*
 - 2.1 women and children
 - 2.2 men and adolescents
3. Increased acceptability of services
 - 3.1 Opinion leaders and decision makers
 - 3.2 Civil associations/consensus building

Under IR 2.3 - *"Linkages"*

Two additional second level results were added. The end result reads:

1. *"Innovative linkages and partnerships strengthened /established" (no change)*
2. *NGO and community organizations' capacity and involvement strengthened*
3. Improved collaboration between private, public and traditional sectors
4. Improved government intersectoral collaboration to solve health system problems

Several indicators were also added by the participants. Most of these indicators were in the areas of Maternal and Child health and reflect the participant's consensus on the importance of these areas in the overall end result to be achieved.

Day Three

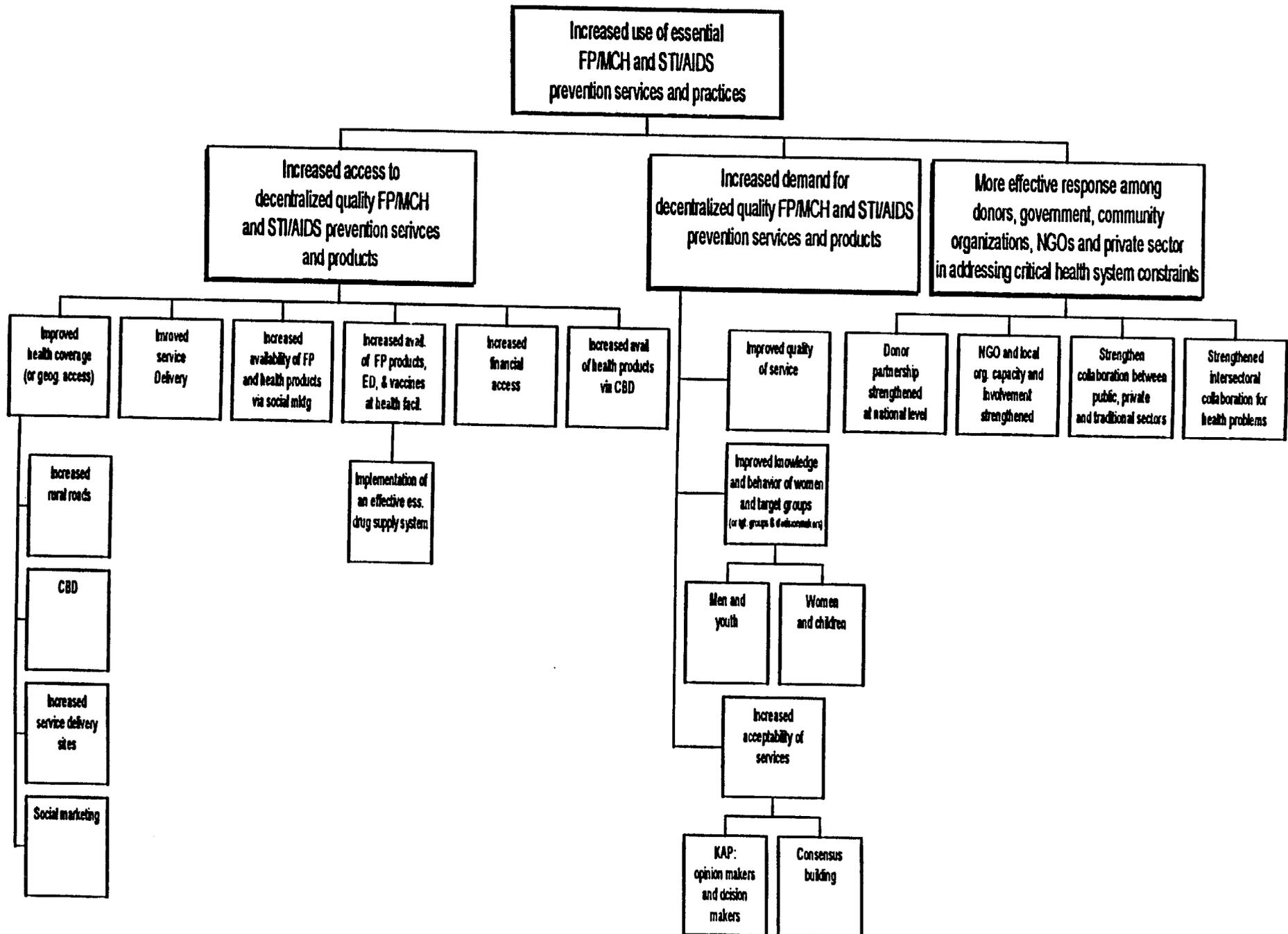
On the evening of day two, the MSI facilitators created a composite Results Framework including the results described above and suggested indicators. Perhaps 25 feet long and eight feet high, this composite served as the basis for discussion on day three of the workshop. It is replicated on the following page. The day began with a review of day two followed by a detailed presentation and discussion of the composite. This was followed by a brief discussion of which implementors were most active in the key areas identified and those areas in which USAID interventions might be most appropriate. This discussion was truncated by participants who felt that such a discussion should take place under the auspices of the Ministry of Health rather than USAID.

Before the break, USAID S.O. team members described next steps as:

Finalization of the RF on the basis of the composite RF; and,

Development of Results Packages involving coordination and joint programing.

The workshop ended with closing speeches by the USAID Director and the Minister of Social Affairs.



B. Evaluation Results

Participants assessments of the workshop were overwhelmingly positive. 90% or more of the participants rated the facilitation, organization and materials good or excellent. When asked what they liked most about the workshop, most participants mentioned the group work, teamwork and/or participatory process. Participants criticisms of the workshop were limited and contained no dominant common themes.

50 participants filled out the workshop evaluation form, responding to the following questions:

Which aspects of the workshop did you like the most?

- The group work sessions, teamwork and/or participatory process (60%). This response accounts 31 of the total of 104 responses (30%) as many participants mentioned more than one aspect of the workshop.
- The large group discussions (28%).
- The organization of the workshop (26%).
- The first day description of the reengineering process (14%).
- The twelve other responses were wide ranging and none of them were shared by more than 8% of respondents.

Which aspects of the workshop did you like the least?

- 20% of responding participants wrote "none".
- 10% cited the fact that the SO2 results framework seemed already complete.
- The remaining 21 responses were widely scattered with none of them shared by more than 8% of respondents.

How would you rate the facilitation process? Participants responded to this question by circling one of five options: Excellent; Good; Mediocre; Somewhat Poor; and, Poor.

- 92% of participants rated the facilitation good or excellent.
- 8% rated it mediocre.

How would you rate the organization of the workshop? Participants responded to this question by circling one of five options: Excellent; Good; Mediocre; Somewhat Poor; and, Poor.

- 94% of responding participants rated the organization good or excellent.

- 6% rated it mediocre.

How would you rate the workshop materials? Materials distributed included the workshop agenda, participant list, draft Results Framework with narrative and a Results Framework/Reengineering presentation. Participants responded to this question by circling one of five options: Excellent; Good; Mediocre; Somewhat Poor; and, Poor.

- 90% of participants rated the materials good or excellent.
- 10% rated them mediocre.

Which aspects of the participatory group work process did you like the most?

- 68% of responding participants mentioned the sharing of ideas, free discussion and teamwork.
- Complementarily of group member's ideas (32%).
- 28% mentioned group's ability and willingness to reach consensus.
- 10% commended group member's willingness to work.
- Most of the remaining 10 responses echoed these themes commenting upon, for example, effective participation by group members and friendships developed.

Which aspects of the participatory group work process did you like the least?

Of the 19 different responses to this question, only three were shared by more than three participants.

- 18% of responding participants cited the length and/or sterility of discussions.
- 10% mentioned that some people impose their ideas on others.
- 8% cited difficulties in reaching consensus.

Section III: Results Framework Finalization Process

The MSI team facilitated the S.O. team in a two step results framework finalization process. The first step involved reaching consensus on a RF synthesis which captured the significant contributions of the workshop in a clear and simple manner. To this end, the MSI team developed a synthesis draft RF out of the composite RF which emerged from the workshop. After less than an hour of discussion, the S.O. team reached consensus on a slightly modified version of the MSI synthesis.

The second step was much more difficult and time consuming. It involved development of a final RF out of the workshop synthesis. Over three days and ten hours of meetings, the S.O. team gradually refined results statements, developed indicators and fine-tuned the causal logic of the RF. What emerged from this process was the RF depicted on the following pages. At the time of the MSI team's departure, this RF was undergoing final modifications.

The second step was guided by the following set of observations provided by the MSI team:

1. *All results statements should be stated as results to be achieved. This means that:*
 - a) *Result statements (RSs) should not contain any causality or description of process. Thus, for example, "through Social Marketing" or "through CBD" should not be parts of a RS.*
 - b) *All results statements should contain an action verb and, in principle, verb placement should be consistent.*
 - c) *RSs should answer the question "In order to do/accomplish what?". If a RS seems to be describing a process, it should be changed to represent what that process will accomplish.*
2. *Coverage at each level of the RF should be comprehensive. This means that if we are going to use RSs which are two levels below the IRs, that level needs to contain all RS which make up the necessary and sufficient conditions for achievement of results at the next level. In terms of what you are required to submit to Washington, just one level below the IR may be fine. Some Missions are required to go only to the IR level. We need to check.*
3. *This comment is based on the principle articulated in "c)" above. The IR and, to a lesser extent, the RSs under "Linkages" do not look like RSs. They look like descriptions of processes. Looking at your indicators, your IR, stated more as a result, might be "Health Care Management System Functioning Effectively" with indicators defining "functioning effectively". We should discuss this as this set of results looks quite weak.*
4. *Many people fell into the trap of thinking that RSs should contain direct references to those programs which the Mission is investing most in. This is not the case. RSs should describe the results of those interventions with indicators defining the results statements.*

5. *With the additions from the workshop, do the results at the sub-IR level represent necessary and sufficient conditions?*
6. *In order to finalize the RF structure, we need to identify key indicators because indicators define pragmatically what we mean by RSS. We have included below a brief description of the criteria for selection of performance indicators.*

Performance Indicators

Performance indicators clarify the intent of a results statement by defining the unit of measurement that is to be used in assessing performance and identifying very specifically what is to be measured. Indicators can and should be developed for results at all levels of a results framework. In fact, if the same or similar indicators appear for results at different levels of a results framework, this indicates that the if - then logic of the results framework is suspect and that it may be appropriate to eliminate one of the two results possessing similar indicators.

This is a simple example of a result -- performance indicator relationship:

| | | |
|---|-------|---|
| <u>Result:</u> Non-traditional exports increased | ----- | <u>Performance Indicator:</u> Value of export sales of lemons, limes, melons and raspberries. |
|---|-------|---|

In this example, non traditional exports are defined as a specific set of products and "increase" is defined as change in value.

As we go through the process of developing performance indicators for each of our results, we should bear in mind the following criteria:

1. ***One strong indicator is worth more than ten weak indicators. It is important to search for the best indicators for key results and to be conservative about the number of indicators selected. Information must be collected for each indicator and information is never free.***
2. ***Each result statement should have independent indicators. Results on a lower level of a results framework should not be used to prove achievement at a higher level.***
3. ***Indicators should be valid in the sense that they should measure what the results statement says and not something else.***
4. ***Indicators should be reliable, such that if measured twice, the same result would be forthcoming. The measurement scale and procedures should remain constant over time.***
5. ***The practicality of indicators is key. Indicators are useless unless data can be collected on the indicator frequently enough to be useful to program managers.***

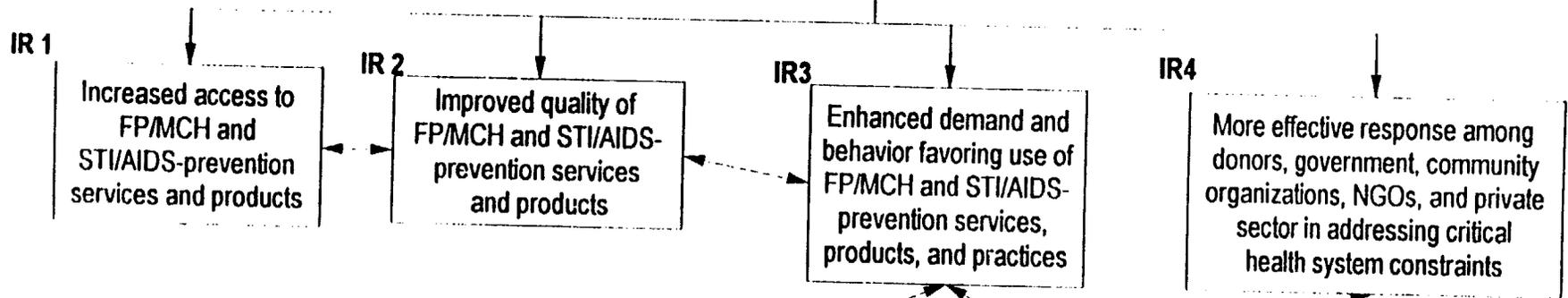
6. *Affordability is equally important. The cost of getting data should not exceed its value.*

The results framework and indicators developed by the S.O.2 team are portrayed on the following pages.

A. Draft Results Framework

SO 2

Increased use of essential FP/MCH and STI/AIDS-prevention services and practices



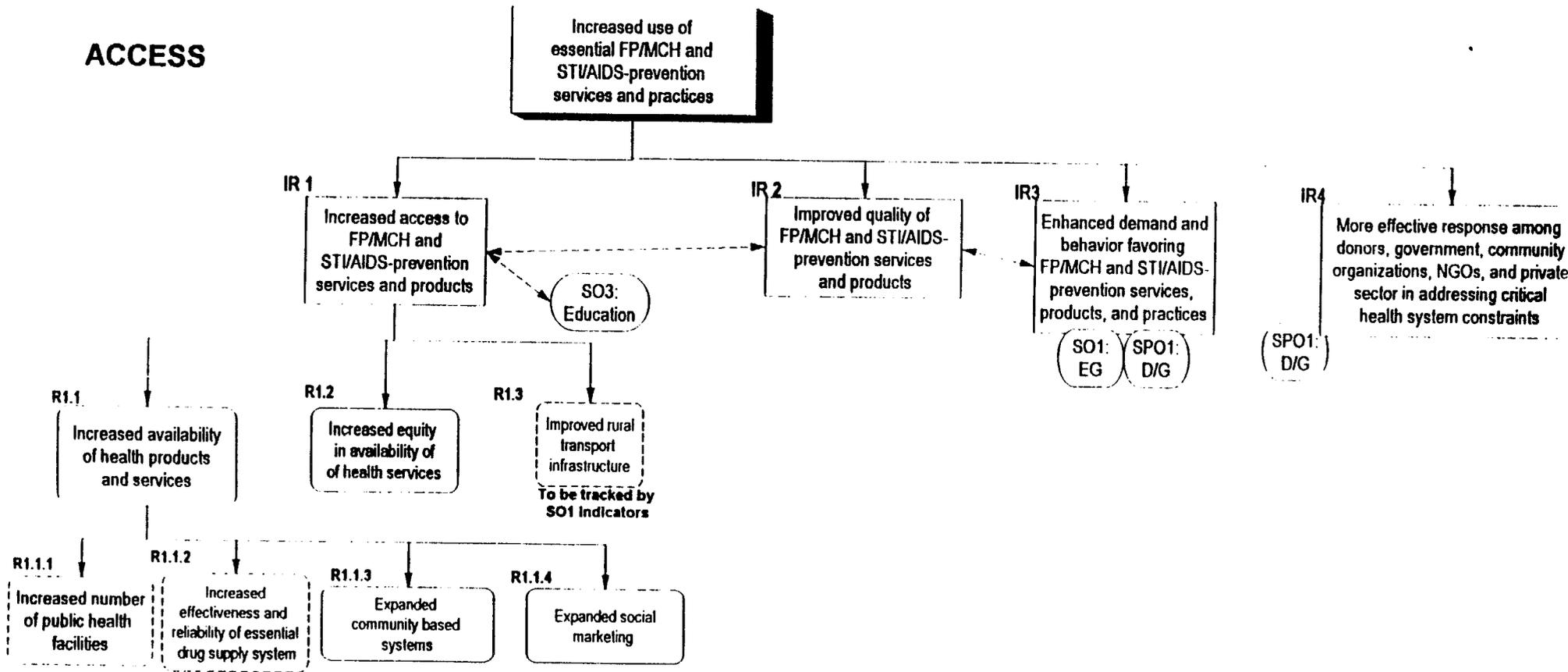
SO3: Education

SO1: Economic Growth

SPO1: D/G

- Key =
- Strategic Objective
 - Intermediate Result
 - Result, USAID Not Directly Responsible
 - Related USAID SO Linkage

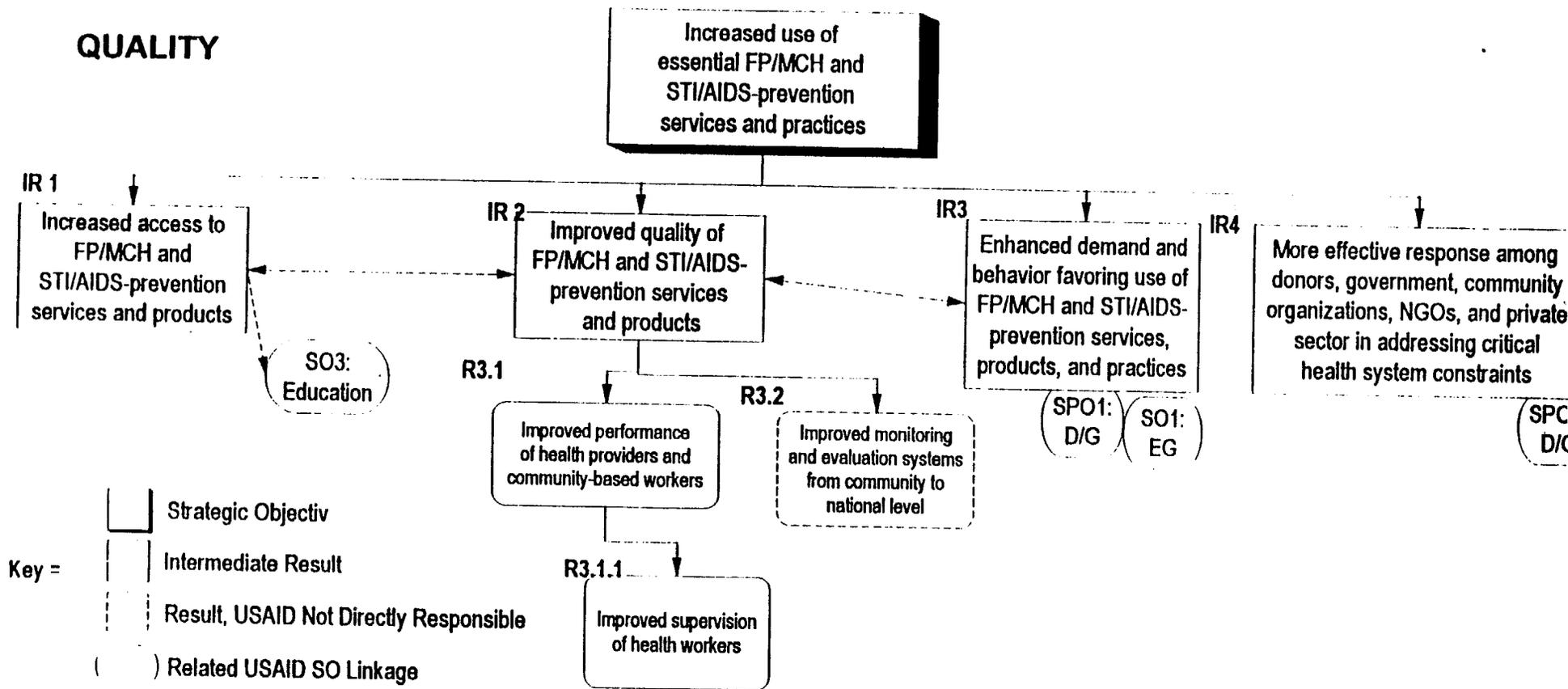
ACCESS



Key Partners:
GoG, WB, EU, GTZ, NGOs

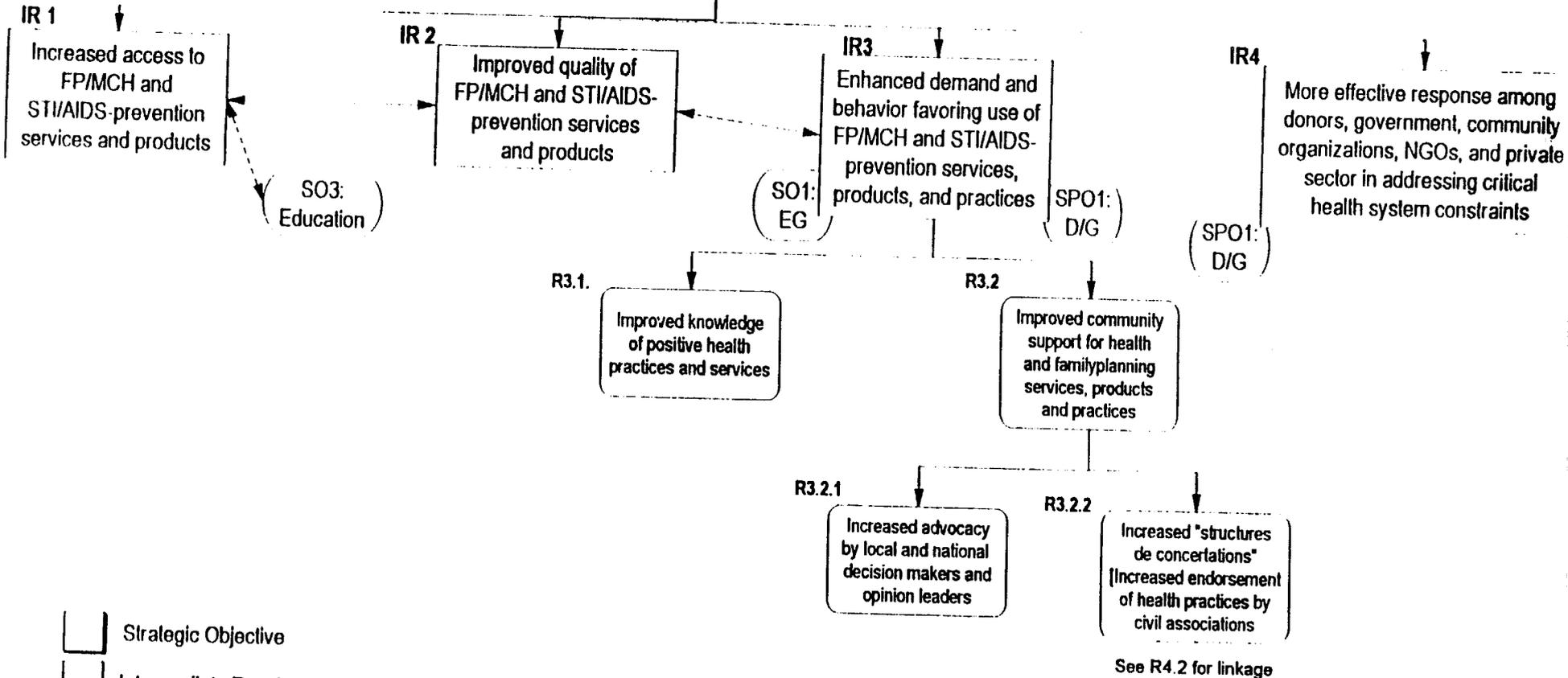
- Key =
- Strategic Objective
 - Intermediate Result
 - Result, USAID Not Directly Fully Responsible
 - Related USAID SO Linkage

QUALITY



DEMAND/BEHAVIOR CHANGE

Increased use of essential FP/MCH and STI/AIDS-prevention services and practices



- Key =
- Strategic Objective
 - Intermediate Result
 - Result, USAID Not Directly Responsible
 - Related USAID SO Linkage

LINKAGES

Increased use of essential FP/MCH and STI/AIDS-prevention services and practices

IR 1

Increased access to FP/MCH and STI/AIDS-prevention services and products

SO3: Education

IR 2

Improved quality of FP/MCH and STI/AIDS-prevention services and products

IR 3

Enhanced demand and behavior favoring use of FP/MCH and STI/AIDS-prevention services, products, and practices

(SPO1: D/G)

SO1: EG

IR 4

More effective response among donors, government, community organizations, NGOs, and private sector in addressing critical health system constraints

(SPO1: D/G)

R4.1

Donor partnership strengthened at national level

R4.2

NGO and local organization capacity and involvement strengthened

R4.3

Intersectoral collaboration within government and between public, private and traditional sectors to solve health problems strengthened at all levels

R4.4

Improved district health management

Key Partners: CoG, WB, EU, GTZ, NGOs, WHO, UNICEF

Key =

- Strategic Objective
- Intermediate Result
- Result, USAID Not Direct Responsible
- Related USAID SO Linkage

B. Indicators

SO:

- Increased immunization rates:
Maternal health: TT among WRA
Child health: measles coverage
- Safer sex indicator:
FROM G/PHN/HIV:
Combination of:
--Decrease in reported non-regular sexual partners
--Increase in reported barrier method use with regular sex partners
--Increase in reported barrier method use with non-regular sex partners
- ORT use
- CPR increased

IR 2.1 "ACCESS"

- % of service delivery points offering package of quality services
- Number of contraceptives and ORS packets sold
- # frequency of essential drug stock outs
e.g. % of facilities reporting no drug supply stockouts over the last 3 months and with adequate drug supply for 3 months
- # of contraceptives distributed by method
- # of other health products distributed by category
- Emergency obstetrical referral systems in place
- # of women with serious obstetric complications receiving emergency obstetric care
- # of community-facility referral systems developed in target areas benefiting OB emergency care
- Supply of specific health products via specific supply conduits (e.g. fixed point, CBD, social marketing, etc)

R 2.1.1 Increased availability of health products and services

- % of population within 5 km of health center
- % of population within 15 km of fixed health facility offering family planning, CS, and STI/HIV prevention services (Mali)
- % of population served by CBD within 15 km of fixed health facility providing CS, FP, and STI/HIV prevention services (Alex/Mali)
- % of population covered by CBS

R 2.1.2 Increased Equity:

- % of health center clients charged appropriate fees (fee structure): match between what people payed and what they should have been charged
- Expenditure on health per capita (national, region, prefecture)
- Expenditure for maternal health and family planning as reported by households (special study)
Disaggregate by men/women
- Means testing policy in place (Y or N)
- % of cost sharing revenue for primary and preventive health care available at districts (by activity) --(Agency common indicators)

R2.1.3 Improved rural transport infrastructure

- SO1 tracking indicators used for SO2 target areas
- % of population with means to reach the facility and referral center if required (measured in travel time?)

IR2.2 "QUALITY"

- % of missed measles vaccination
- % of clients who would recommend services to others
- # of women with specified obstetric complications receiving emergency care
- % of clients seen by health personnel who receive care according to norms and standards for FP, IMCI, STDs, and obstetrics

R2.2.1 Improved Performance

- % of health center personnel following selected protocols
- Proportion of clients provided services according to norms and standards

IR2.3 "DEMAND"

- % of women seeking breast-feeding guidance
- % of women and men seeking family planning services
- % of caretakers seeking ORS
- % of clients seeking STD care

R2.3.1 "Knowledge"

- Proportion of caretakers who can state signs and symptoms (diarrhea, malaria, and/or ARIs) requiring treatment and who can state rules for home case management
- % of people aged 15-49 citing at least 2 acceptable ways of protection from HIV infection
- % of all adults (men/women) who can identify 4 of 7 warning signs of maternal complications of pregnancy and childbirth.
- % of adults of women and men, 15-49 who know at least 2 methods of FP/modern contraception methods.

- % of population knowing key information about services: e.g., fee structure, location, hours)

R2.3.2 "Community Support"

- # of communities with health committees in health center management and outreach
- # of community-based (or communities with) solidarity funds established for selected referrals
- % of CRD resources allocated to health each year in target areas
- idea: an indicator to measure local decision makers discussion of health matters in public (village meetings, etc) or process indicator measuring number of meetings on health at prefectural level or number of local policies/regulations on health
- % of men/women who perceive economic and social returns from health [FP, CS, maternal health, HIV/STI prevention]

IR2.4 "LINKAGES"

R2.4.1

- Number of partnerships agreement (e.g., MOU) established

R2.4.2

- (Net) Revenue generation of NGOs/local organizations

R2.4.3

- # of civil/social (e.g. CRD) organizations trained in management and advocacy for health
- # of health networks at all levels established/strengthened

R2.4.4

- % DPS and CS staff trained in financial, budgeting, and planning management skills
- % recurrent, non-salary costs of CS and DPS contributed by local cost recovery vs. MOH support vs. other funding sources in target areas
- # CS/DPS staff trained in financial management and budget planning in target areas

Section IV: Conclusions

It is important to note at this juncture that the MSI team was engaged to facilitate a multifaceted process involving: (1) key informant interviews; (2) workshop methodology development, facilitation and logistics; and (3) facilitation of the RF finalization process. The MSI team was not engaged to perform an analysis of the Guinean health care system nor to make detailed recommendations for the development of results packages.

Thematic Conclusions:

The focus here is upon common themes which emerged from the interviews and the workshop, both the day one work on priorities and programs and the day two work on the provisional RF. These common themes, identifying key health sector priorities and constraints, have served as the basis for the ongoing process of finalization of the RF:

1. Quality of services;
2. Geographic coverage/access;
3. Equity and affordability of services;
4. Coordination of activities;
5. Social acceptability; and
6. Information, education and communication.

Methodological Conclusions:

1. Comparison of the results of the interviews and the consensus outputs of the workshop validates the themes described above. Thematically there is a high degree of correlation between the two data sets.
2. The interview methodology worked well. Few interviews took more than 45 minutes, the data collected lent its self to useful analysis, and this analysis essentially predicted many of the eventual results of the workshop.
3. The two stage participatory group work methodology was effective. This is show by the quality of the outputs of the process and by participants highly enthusiastic comments about the process in the workshop evaluation.
4. Plenary sessions should have been limited to presentations, report-outs and analyses of common themes and differences. In main part, they were. However when, upon two occasions, more substantial discussion was attempted, results were less than satisfactory.

5. Most members of the S.O. team were too heavily invested in the draft RF presented at the retreat. The workshop should have occurred at a point when the team's ideas were clear but they were still able to discuss them with some flexibility. It is a credit to the workshop design and S.O. team members willingness to observe rather than participate that this inflexibility did not compromise the results of the workshop.

Section V: Next Steps Considerations

The S.O.2 team's next step is to develop Results Packages (RPs). This section describes a set of issues which should be taken into consideration during that process.

Results Packages

The RPs will be detailed blueprints for achieving specific results or a specific set of results in the S.O.2 results framework. The basic question which will guide the formation of these RPs packages will be "What is the most efficient and effective way to organize activities such that the results identified through the strategic planning process are achieved?" One way that the RPs may be formed is by organizing them around the S.O. and associated results. Another way that the RPs may be formed is by organizing them around a set of IRs from several S.O. which are unified by managerial or logistics concerns such as geographic proximity or involvement of the same set of agencies and organizations. In some instances, one result may be judged so important that it alone becomes the focus of a results package.

The process of developing and implementing RPs might involve the following steps:

1. The S.O. team, with assistance from HTS, identifies a set of provisional results packages;
2. RP teams are formed, from Mission staff and representatives of other agencies and organizations that are carrying out activities or intend to carry out activities related to each RP.
3. The RP teams reexamine the management logic for the formation of their RPs and make changes as appropriate. If the changes suggested are significant, this process involves negotiation with S.O. teams and/or other RP teams;
4. The RP teams develop a comprehensive set of activities to accomplish the results for which they have taken responsibility. Some of these activities are already either planned or underway.
5. The RP teams determine responsibility for each activity. Determination of responsibilities is a function of pragmatic criteria such as which organizations have existing programs, comparative advantage in experience or expertise, and availability of resources.
6. Where "responsibility gaps" (key activities without implementors) exist, the RP teams make every effort to fill the gaps, either by developing new programs for which one of the organizations represented on the team takes responsibility or by soliciting assistance from other appropriate organizations.
7. The RP teams develop a detailed implementation and monitoring plans including detailed time frames and responsibility charts.
8. The RP teams monitor the implementation process and progress towards results.

IRs 1 and 2: Access and Demand

IR1 "access" focuses on service delivery. IR2 "demand" focuses on use of services. They are thus two sides of the same coin. As a practical matter, this means that it may be appropriate to develop results packages which focus on both these IRs and associated results.

IR 4: Linkages

In Section III of this report, it is suggested that an earlier version of the "linkages" IR and associated results is weak because the results statements sound like process steps and the indicators are ill defined. These weaknesses have not been fully addressed in the present iteration of the RF.

- Though the lower level results are clear, the IR is still vague. What is a "more effective response"? Perhaps the IR could be restated as "Effective coordination of health care". Such a result would be beyond the Mission's manageable interest and thus could be shaded to show that it will be achieved primarily by other organizations.
- Indicators such as # of partnerships; training in advocacy; and, health networks established can not bear the full weight of an IR. If the IR is shaded, indicators at the IR level become less important. Better indicators for the lower level results should still be found if the Mission is going to take responsibility for their achievement.

It is suggested that the HTS team look at what actually needs to be done under linkages and that the S.O.2 team revisit the IR informed by the HTS analysis.

Performance Monitoring

Section III of this report lists a large number of potential indicators. The RPs should contain detailed performance monitoring plans for monitoring progress towards targets selected on the basis of those indicators finally selected. It will be important to remember that indicators are worthless unless we can collect practical, affordable and timely data on them. Steps in the performance monitoring system development process are listed below.

1. Development of baseline data for each indicator. Clearly, planning for performance measurement is not complete until the sources of information for performance indicators are identified and decisions are made about how and by whom these data will be collected. From a practical perspective, existing data series are a desirable source of information on program performance **if they exist**.
2. Development of targets for each indicator. Targets determine how much is expected to be done, by when, and at what level of quality. Essentially, targets restate indicators in terms of **quality, quantity and time**.

Quantity: Quantity targets answer questions about "how much" of a change is expected.

Quality: Quality targets establish expectations about "how good" the results of programs need to be.

Timeliness: Timeliness targets establish our expectations about "when" objectives will be achieved.

Performance targets are often expressed upon a yearly basis but they can be set at shorter intervals. An important point here is that we should be setting targets from the beginning of RP activities.

3. Development of up to date data sets showing progress from baseline start points for each indicator.
4. Development of detailed plans to:
 - a) collect and analyze data for each indicator in as simple and cost effective a manner as possible;
 - b) feed impact data to RP managers in a timely manner; and,
 - c) make impact data available, in a user friendly form, for RP evaluation and the NMS.
5. Development of a detailed workplan for installation and implementation of the performance monitoring plan.

ANNEX A
Workshop Agenda

**CALENDRIER DE L'ATELIER DE PLANIFICATION
STRATEGIQUE DU PROGRAMME DE SANTE DE L'USAID
CONAKRY 3,4,5 FEVRIER 1996**

| | |
|----------------|---|
| Jour 1: | Lundi 03/02/1997 |
| 8h00 | Arrivée et installation des participants |
| 8h30 | Le Discours de Monsieur le Directeur de l'USAID |
| | Ouverture officielle de l'atelier par Monsieur le Ministre de la Santé |
| | Présentation de l'équipe MSI, le calendrier de l'atelier, définition des normes de travail, discussion d'ordre logistique |
| : | Présentation des objectifs de l'atelier |
| | Présentation générale des concepts clefs du reengineering et du Plan Cadre des Résultats. |
| 10h30 | Pause |
| | Rappel du programme d'assistance de l'USAID dans le domaine de la santé, son expertise et son expérience |
| | Présentation du Plan Cadre des Résultats de l'Objectif Stratégique No .2 de l'USAID/Guinée. |
| | Introduction à la dynamique des groupes de travail de l'après midi |
| 12h30 | Pause |
| 13h00 | Petits groupes de travail sur la tâche #1: <i>Priorités, programmes et projets de la sante reproductive</i> |
| 14h30 | Rapport et synthèse des travaux des petits groupes en groupes de 20 à 25 personnes. |
| 15h30 | Fin de session |

Jour 2: Mardi 04/02/1997

- 8h30 Description des accomplissements du jour 1 et Présentation du programme du jour 2.
- 8h50 Synthèse des rapports sur les priorités, programmes et projets du secteur de la santé en session plénière.
- 9h20 Description de la tâche #2: **Analyse du Plan Cadre des Résultats: Première Etape** en petits groupes.
- Petits groupes de travail sur l'analyse du Plan Cadre des Résultats: Première Etape.
- 10h30 Pause
- 10h50 Rapport et synthèse des travaux de groupe, en groupe de 20-25 personnes
- 11h50 Synthèse et rapport sur les programmes du secteur de la santé, projets et activités en session plénière
- 12h30 Pause
- 13h00 Description de la tâche #3: **Analyse du Plan Cadre des Résultats: Seconde Etape** en petits groupes.
- Petits groupes de travail sur l'analyse du Plan Cadre des Résultats: Seconde Etape.
- 14h00 Rapport et synthèse des travaux des petits groupes, en groupe de 20 à 25 personnes
- 14h45 Synthèse et rapport sur l'analyse du Plan Cadre: Seconde Etape des Résultats en session plénière
- 15h30 Fin de session

Jour 3**Mercredi 05/02/1997**

- 8h30 Description des accomplissements du jour 2 et Présentation du programme du jour 3.
- 8h50 Résumé des Résultats des petits groupes de travail et intégration de ces Résultats dans le Plan Cadre des Résultats de l'objectif stratégique No.2 de l'USAID/Guinée
- 9h45 Discussion du Plan Cadre des Résultats de l'objectif stratégique No.2 de l'USAID/Guinée en session plénière
- 11h15 Evaluation de l'atelier
- 11h30 Observations de l'USAID
- 11h45 Fermeture officielle de l'atelier par le Ministre de la Santé
- 12:30 Fin de l'atelier

ANNEX B

List of Workshop Participants

LISTE DES INVITES

MINISTERE DE LA SANTE

Dr. Kandjoura Dramé, Ministre de la Santé
Dr. Mohamed Sylla, Secrétaire Général de la Santé
Dr. Yéro Boye Camara, Conseiller du Ministre chargé de la Politique Sanitaire

Directeurs Nationaux

Dr. Mohamed Lamine Touré, Directeur National de la Santé
Dr. Sékou Condé, Directeur National des Etablissements de Soins
Dr. Kékoura Kourouma, Directeur National de Labo-Pharmacie

Chefs de Division, Sections et Programmes

Dr. Thierno Souleymane Diallo, Chef du Bureau d'Etude, Planification, et Recherche
Dr. Ali Kamano, Chargé de la Formation et de la Recherche
Mr. Moussa Kourouma, DAAF
Dr. Pogba Gbanacé, Chef de la Division Medecine Traditionnelle
Dr. Mahi Barry, Chef de la Division Prévention
Dr. Raphiou Diallo, Chef de la Division Promotion de la Santé
Dr. Macoura Oularé, Chef de la Division Alimentation, Nutrition
Dr. SAA Didimio Sandouno, Chef de la Division Soins
Mr. Abdoulaye Diallo, Chef de la Division Infrastructure, Equipement et Maintenance
Mr. Lamine Daffé, Chef de la Division Médicaments
Dr. Karifa Douno, Chef de la Div. Etablissements Biopharmaceutique et Affaires Professionnelles
Dr. Soukeynatou Traoré, Chef de la Section SMI/PF
Dr. Malifa Baldé Coord. du Prgm. Nat. de Soins de Santé Primaires
Dr. Aboubacar Savané, Coordinateur du Programme National de lutte contre les MST/SIDA
Dr. Antoinette Helal, Coord. du Prgm. Nat. de lutte contre les maladies diarrhéiques.
Dr. Mamadi Condé, Coordinateur du Programme Santé et Nutrition
Dr. Fatoumata Camara, Coord. du Prgm. Nat. de Lutte contre le Paludisme
Dr. Madina Rachid, Coord. du Prgm. Nat. de Santé de la Réproduction

Inspecteurs Regionaux de la Sante (IRS)

Dr. Namory Keita, Directeur Régional de la Santé/Ville de Conakry
Dr. Robert Sara Tambalou, IRS Boké Dr. Momo Camara, IRS Faranah
Dr. Alpha Oumar Barry, IRS Kindia Dr. Ousmane Sow, IRS Kankan
Dr. Sakoba Keita, IRS Mamou Dr. Mohamed Lamine Dramé, IRS NZérékoré
Dr. Kalifa Bangoura, IRS Labé

Directeurs Préfectoraux de la Santé (DPS)

| | |
|------------------------|---------------------------|
| 1 DCS Ville de Conakry | 1 DPS Région de Labé |
| 1 DPS Région de Boké | 3 DPS Région de Faranah |
| 1 DPS Région de Kindia | 3 DPS Région de Kankan |
| 1 DPS Région de Mamou | 3 DPS Région de NZerekoré |

REPRESENTANTS DES AGENCES INTERNATIONALES ET DES ONGS

UNICEF

Mr. NDolamb Ngokwey, Représentant
Dr. Isselmou Ould Boukhary, Chef du Programme Santé
Dr. Facinet Yattara, Administrateur Santé

Organisation Mondiale de la Sante (OMS)

Dr. MameThierno Aby Sy, Représentant

Banque Mondiale

Mr. Eduardo Locatelli, Représentant

PNUD

Mr. Cyr Mathieu Samaké, Représentant

Mme Sohna Keita, Chef de Programme

FNUAP

Mme Agniola Zinzou, Représentante

Mr. Mahmoudou Kaba, Chef de Programme

PSI

Mme Theresa Gruber-Tapsoba, Directrice

Dr. Jean Patrick Ducongé, Conseiller en Planification Familiale

Mr. Dana Ward, Conseiller en Marketing Social

Dr. Kékoura Camara, Conseiller Politique

Dr. Fatoumata Kanté, Responsable de la Formation

Mr. Thierno Oumar Diallo, Coordonnateur des activités d'IEC

Africare

Mr. John "Bick" Riley, Directeur

Dr. Sean Kennedy, Conseiller du Programme DFSI

GTZ

Mr. Bertholb Böes, Représentant

Dr. Alois Dörlemann, Chef du Projet Santé Rural

KFW

Dr. Klaus Hornetz, Expert en Santé Publique

Dr. Ina Bosch, Conseiller Technique

Plan International

Dr. Kodjo Aluka, Directeur National

AGBEF

Mme Camara Georgette Safo, Présidente

Dr. Bandian Sidimé, Directeur Exécutif

Mr. Lamarana Diallo, Coordinator National de l'AGBEF

ASFEGMASSI

Mme Hadja Marietou Sylla, Présidente

SIDALERTE

Mr. Mohamed Sano, Président

AFPAMNIG

Dr. Hadja Namba Djankanagbé, Présidente

CPTAFE

Dr. Hadja Mariama Djélo, Présidente

Dr. Morissanda Kouyaté, Secrétaire Général

Corps de la Paix

Mme Kathy Tilford, Directrice

Mme Maria Hamadama, Chef Programme Santé

3P Guinée

Dr. Maïmouna Diallo, Présidente

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Cooperation Française

Mr. Pierre Pedico, Conseiller pour le secteur Santé

Centre Canadien d'Etude et de la Cooperation Internationale (CECI)

Benoit-Pierre Laramée, Directeur Régional

Bureau d'Appui a la Cooperation Canadiene (BACC)

Jean-Jules Riopel, Directeur

Medecins Sans Frontiere Belgique

Mr. Alain Decoux, Représentant

INTRAH

Dr. Perle Combary, Chargée Régionale de Programme et Evaluation (Lomé)

CLUSA

Mr. Benjamin Lentz, Représentant

Save the Children

Mme Joyce Marie Lamelle, Guinea Program Representante

Ambassade de Japon

Mr. Toru Kanzawa, 2ème Secrétaire

AUTRES MINISTERES

Ministère des Finances, de l'Economie et du Plan

Ministère de l'Administration du Territoire et de la Décentralisation

Ministère des Affaires Sociales, de la Promotion Feminine, et de l'Enfance

USAID/GUINEE

Mr. John Flynn, Directeur

Mme. Pamela Callen, Directeur Adjoint

Mme. Helene Rippey, Chef de l'Equipe SO2

Mr. Alpha Souleymane Diallo, Chef Adjoint de l'Equipe SO2

Dr. Mariama Bah, Chef des Projets Santé

Mme. Aissatou Bah, Membre de l'Equipe SO2

Mme. Roukiatou Kallo, Membre de l'Equipe SO2

Mme. Marie Claude Traoré, Membre de l'Equipe SO2

Mme. Aminata Camara, Membre de l'Equipe SO2

Mr. Mohamed Koné, Membre de l'Equipe SO2

USAID/WASHINGTON

Mr. Alex Ross, USAID/Washington

Dr. Erin McNeill, USAID/Washington

LES AUTRES MISSION DE L'USAID

Mme Susan Woolf, USAID/Cotonou

ANNEX C

Provisional Results Framework

Agency Goal

Stabilizing World Population and Protecting Human Health

Critical Assumptions

- * The GOG continues to support the National Primary Health Care Program including decentralized management of health care and cost recovery systems;
- * Critical commodities are available for project activities at reasonable prices.
- * Associations and individuals in the private sector health delivery system will contribute to the achievement of the GFPH activity (package) objectives;
- * Key donors such as the World Bank, WHO, KFW, UNFPA, GTZ and EU accept to develop a comprehensive multi-donor initiative to address key policy, management, and resource constraints;
- * USAID's implementing partners maintain strong linkages among the various components of the programs and take lead role in coordinating donor collaboration;
- * USAID/G continues to emphasize the core value of "managing for results" and allows appropriate flexibility to the implementing partners in the design and implementation of programs.

USAID/G's Program Development Goal

Improved economic and social well being of all Guineans in a participatory society

Strategic Objective Two

Increased use of essential FP/MCH and STI/AIDS-prevention services and practices

1. CPR increased by at least 1 percentage point per year in Conakry and other selected urban areas, and by 0.5 percentage point in the targeted rural regions of the project;
2. CYP increased from 39,000 to x (to be determined during design phase).
3. Measles vaccination coverage increased from 55% to 80% in targeted areas;
4. Use of ORS most recent episode of diarrhea increased from 24.5% to 50% in targeted areas.
5. Safer sex target to be determined during design phase.

Intermediate Results

Increased access to quality services and products in FP/MCH and STI/AIDS-prevention

ACCESS

Increased demand for FP/MCH and STI/AIDS-prevention services and products.

DEMAND

Linkages established among donors and other partners established which address critical health system constraints.

LINKAGES

55

ACCESS

Increased access to quality services and products in FP/MCH and STI/AIDS-prevention

1. Increased percentage of public sector service delivery points offering package of quality services.
2. Increased percentage of private sector service delivery points offering package of quality services.
3. Increased number of contraceptives and ORS packets sold through social marketing.
4. Decrease percentage of missed measles vaccine.

Improved service delivery

Increased availability of FP and health products through social marketing.

Increased availability of health products through CBD.

- *Increased number of health center personnel trained who have mastered relevant knowledge
- *Increased proportion of patients cared for by health center personnel who receive treatment following the norms and standard case management for:
 - family planning
 - IMCI
 - HIV/AIDs
- *Increased percentage of women with serious obstetric complications receiving emergency obstetric care
- *Increased percentage of health personnel following drug prescribing protocols including utilization of generic drugs.

- * Number of condoms distributed
- *Number of Oral Contraceptive Pills (OCPs) distributed
- *Number of injectable contraceptive doses distributed
- *Number of ORS packets distributed.

- * Number of condoms distributed
- *Number of spermicides distributed
- *#of ORS packets distributed
- *Number of referrals to health facility for other methods.

DEMAND

Increased demand for FP/MCH and STI/AIDS-prevention services and products.

1. Increase percentage of women seeking breastfeeding guidance
2. Increase percentage of women seeking family planning services
3. Increase in percentage of mothers seeking ORS
4. Increase in percentage of mothers having immunization cards
5. Increase in percentage of clients seeking STD care

Improved quality of services

Increased knowledge of selected home health practices

(See indicators under ACCESS improved service delivery)

NOTE: These may be incorporated in 3 more general statements about increased percentage of caretakers who have knowledge of:

2) Preventive behaviors

3) Home Health care practices

*** Increased% of caretakers who report knowledge of treatment for mild/moderate diarrhea;**

*** Increased % of women knowing what age to start supplementing breastmilk;**

*** Increased % of women of child bearing age reporting knowledge of danger signs of pregnancy;**

*** Increased % of WRA reporting knowledge of at least one method of modern contraception.**

*** Targeted population can identify at least 2 appropriate means of protection from HIV infection.**

1- Targeted conditions

2- Preventive behaviors

3- Home health care practices

*** Increased% of caretakers who report knowledge of treatment for mild/moderate diarrhea;**

*** Increased % of women knowing what age to start supplementing breastmilk;**

*** Increased % of women of child bearing age reporting knowledge of danger signs of pregnancy;**

*** Increased % of WRA reporting knowledge of at least one method of modern contraception.**

*** Targeted population can identify at least**

LINKAGES

Working linkages among USAID and other partners established which address critical health system constraints.

1. Decreased frequency of stock-outs reported by health centers.
2. Improved supervision through decentralized management of resources
3. Improved staffing pattern at the periphery;
4. Increased MOH budget and decentralized financial resources allocation to the periphery;
5. Adequate facilities and equipment to support quality service delivery in the health centers at all level;
6. Increased critical mass of trained personnel available at the district level to implement the decentralized health management policy and strategies.

Strengthened national level donor partnerships

- * Formal MOH-led coordination council established and functioning;
- * Number of partnership contracts developed with selected donors: KFW, WB, GTZ, UNFPA and WHO;
- * Number of Joint planning/programming, monitoring and evaluation activities conducted with other donors.

Strengthened community level partnerships.

- * Formal MOH-led regional and district level coordination councils established and functioning;
- * Increased percentage of prefectures (districts) with community representative management committees;
- * Increased number of partnership programs among donors and implementing organizations;
- * "Safety net" procedures put in place and functioning in targeted communities.

Strengthened NGO partnership

- * Increased percentage of population with access to services via NGO partnerships

But de l'Agence

Stabilisation de la population mondiale et protection de la santé humaine de façon durable

Hypothèses Critiques

- * Le Gouvernement Guinéen continue à soutenir le Programme National de Soins de Santé Primaires y compris les systèmes décentralisés de gestion des soins de santé et de recouvrement de coûts;
- * Les produits essentiels sont disponibles à des prix raisonnables
- * Les prestations des services de santé des Associations et des individus du secteur privé contribuent à la réalisation des objectifs de l'ensemble des activités du Projet Guinéen de Planification Familiale et de Santé;
- * Les Principaux bailleurs de fonds tels que la Banque Mondiale, l'OMS, la KfW, le FNUAP, la GTZ et l'UE, l'UNICEF acceptent de développer une initiative concertée en vue de faire face aux contraintes liées à la politique de base, de gestion et de ressources;
- * Les partenaires d'exécution de l'USAID maintiennent de solides liens entre les différentes composantes des programmes et assument le rôle de chef de file en coordonnant la collaboration des bailleurs de fonds.
- * L'USAID/GUINEE continue à mettre l'accent sur la valeur principale de "gérer pour des résultats" et donne une flexibilité appropriée aux partenaires d'exécution dans la conception et la réalisation des programmes.

But du Programme de Développement de L'USAID/Guinée

Amélioration du bien être social et économique de tous les Guinéens dans une société participative.

Objectif Stratégique No Deux

Utilisation Accrue des Services et Pratiques de PF/SMI et de Prévention des MST/SIDA.

Cibles Illustratives:

- * Le taux de prévalence contraceptive ayant augmenté d'un pourcentage de point au moins par an à Conakry et dans les autres zones urbaines sélectionnées et par 0,5 pour-cent dans les régions ciblées du projet;
- * La couverture vaccinale anti-tétanique (2 injections ou plus pendant la grossesse) chez les femmes enceintes passant de 23,6% en Haute Guinée et de 35,7% en Guinée Forestière à des pourcentages à déterminer pendant la conception de la nouvelle activité.
- * La couverture vaccinale contre la rougeole passant de 55% à 80% dans les zones ciblées.
- * L'utilisation du Traitement de Réhydratation Orale au cours du récent épisode de diarrhée enregistrant une augmentation de 42% à 80% dans les zones ciblées.
- * Une cible pour une sexualité saine à déterminer pendant la phase de conception du projet.

Résultats Intermédiaires

Accès accru aux services de qualité et produits de PF/SMI et de prévention des MST/SIDA

Demande accrue pour les services de qualité et produits de PF/SMI et de prévention des MST/SIDA

Une Réponse plus effective et soutenue des bailleurs de fonds, du gouvernement, des organisations communautaires, des ONG et du secteur privé aux contraintes critiques du système sanitaire.

ACCES

DEMANDE

LIENS

ACCES

Accès accru aux services de qualité et produits de PF/SMI et de prévention des MST/SIDA

Indicateurs illustratifs

1. Pourcentage des points de prestation du secteur public offrant des paquets de service de qualité.
2. Pourcentage des points de prestation du secteur privé offrant des paquets de services de qualité.
3. Nombre de contraceptifs et de sachets de Sels réhydratation orale vendus à travers le marketing social.
4. Pourcentage des opportunités manquées de vaccination contre la rougeole.

Prestation de service améliorée

- *Nombre de personnel de santé formé, ayant maîtrisé des connaissances appropriées.
- *Proportion de patients traités par le personnel des centres de santé suivant les normes et standards de gestion des cas: . de PF, Gestions des cas intégrés et de prévention des MST/SIDA.
- *Pourcentage des femmes avec de sérieuses complications obstétricales recevant des soins d'urgence obstétricale.
- *Pourcentage du personnel de santé respectant les protocoles de prestation des médicaments y compris l'utilisation des médicaments génériques.

Disponibilité accrue des produits de PF et de santé à travers le marketing social

- * Nombre de condoms distribués.
- * Nombre de pilules distribuées.
- * Nombre de doses de contraceptifs injectables distribués.
- *Nombre de sachets de sel de réhydratation orale distribués.

Disponibilité accrue des produits de santé à travers la distribution à base communautaire

- * Nombre de condoms distribués
- * Nombre de spermicides distribués.
- * Nombre de sachets de sels de réhydratation orale distribués.
- * Nombre d'évacuations effectuées aux établissements de soins pour autres méthodes.

DEMANDE

Demande accrue pour les services de qualité et produits de PF/SMI et de prévention des MST/SIDA

Indicateurs illustratifs

1. Pourcentage des femmes sollicitant des conseils pour l'allaitement maternel;
2. Pourcentage des femmes sollicitant des services de planification familiale;
3. Pourcentage des femmes sollicitant des sachets de réhydratation orale
4. Pourcentage des mamans ayant des cartes de vaccination;
5. Pourcentage des clients sollicitant des soins contre les maladies sexuellement transmissibles.

Amélioration de la qualité des services.

Les indicateurs de "Amélioration de l'offre des services" seront utilisés pour suivre le progrès de ce résultat intermédiaire, en presumant que l'amélioration de la qualité des services contribuera à l'accroissement de la demande des services.

Amélioration de la connaissance et du comportement des femmes et enfants ciblés

- * Pourcentage des mamans et des garde enfants connaissant les règles de prise en charge des diarrhées simples et modérées.
- * Pourcentage des femmes connaissant l'âge d'introduction des aliments de supplément au lait maternel.
- * Pourcentage des femmes en age de procréer ayant des connaissances sur les signes de danger d'une grossesse.
- * Pourcentage des femmes ayant des connaissances d'au moins une méthode moderne de contraception.
- * La population cible peut identifier au moins deux moyens appropriés de protection contre l'infection VIH

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LIENS

Une Réponse plus effective et soutenue des bailleurs de fonds, du gouvernement, des organisations communautaires, des ONG et du secteur privé aux contraintes critiques du système sanitaire.

Indicateurs illustratifs:

1. Fréquence des ruptures de stock reportée par les centres de santé.
2. Nombre de personnel formé au niveau du district pouvant mettre en oeuvre la politique et les stratégies de décentralisation du secteur santé.
3. Accroissement du budget du Ministère de la Santé et décentralisation des ressources financières allouées à la périphérie.
4. Adeguation des infrastructures et des équipements pour appuyer l'offre des services de qualité à tous les niveaux.
5. Durée de vie des partenaires clefs.
6. Durée de vie de l'impact.

Partenariat des Bailleurs de fonds renforcé au niveau national

- * Un conseil de coordination du Min. de la Santé établi et en état de fonctionnement.
- * Nombre de contrats de partenariat établis avec des bailleurs sélectionnés (U.E. KFW, BM, GTZ, UNFPA, OMS)
- * Pourcentage de préfectures (districts ayant établi des comités de gestion représentatifs de la communauté).

Renforcement de la capacité des ONG locales et des organisations communautaires

- * Génération de revenu
- * Utilisation de revenu

ANNEX D

Key Concepts of Reengineering

La restructuration

<< le re-engineering >>

- ◆ **La restructuration nous demande de reprendre les présuppositions fondamentales sur lesquelles les bureaucraties sont construites et de refaire ces organisations autour des résultats voulus au lieu de les faire fonctionner par départements ou services. Ce processus nous force à développer des nouvelles façons de penser et de voir le monde.**

**De: Seamless Government, a Practical Guide to Reengineering in the Public Sector
By: Russell M. Linden - 1994**



L'USAID restructuré

- ◆ **Nouveau système d'opérations
(qui inclu les quatres valeurs de base)**
- ◆ **Nouveau système de gestion**
- ◆ **Les politiques et les principes d'opération très
clairs.**



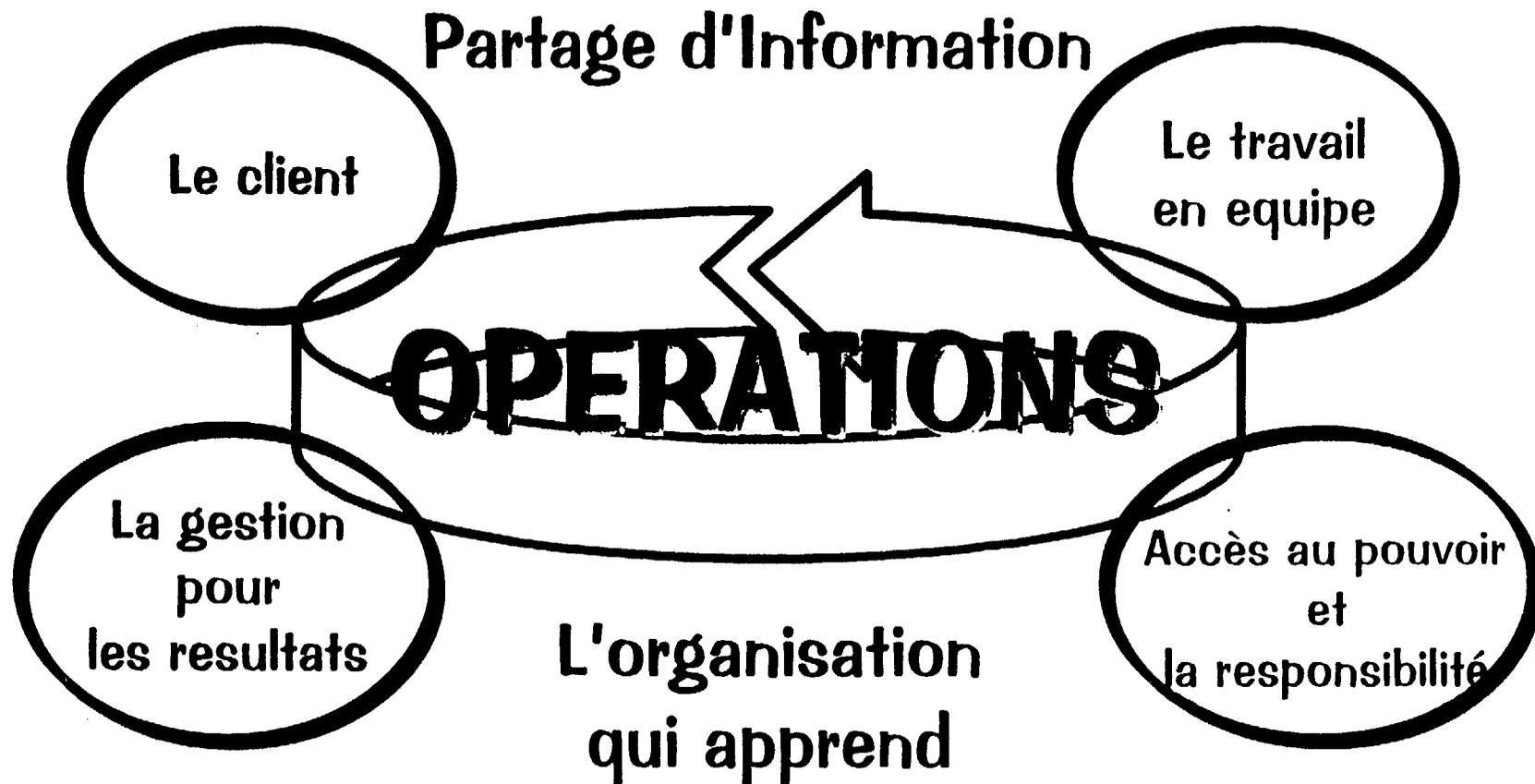
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Un Nouveau Système d'Opérations

- ◆ **Les resultats ambitieux mais attenables**
- ◆ **L'autorité pour les ressources, les outils et l'information**
- ◆ **Des procédures améliorées**
- ◆ **La collaboration entre équipes, partenaires et clients**



Valuers de Base



Gérer pour les resultats

- ◆ **Connaître le client et ses besoins**
- ◆ **Connaître les resultats voulus**
- ◆ **Comprendre le processus pour atteindre les resultats**
- ◆ **Utiliser l'information/les données pour nous montrer le progrès**
- ◆ **Avoir l'autorité pour prendre des mesures correctifs (changer le processus, ou changer le resultat)**



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Comment la planification a-t-elle changer?

- ◆ La participation à tous les niveaux
- ◆ La planification et la programmation conjointe
- ◆ Les liens plus explicites entre l'atteinte des resultats et la budgetisation



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L'approche de l'USAID à la gestion stratégique et les mesures de performance

- ◆ **Met l'accent sur les resultats**
- ◆ **Augmentation du focus et du choix <stratégique> des ressources et de stratégies d'action**
- ◆ **Mesurer et faire des rapports sur les resultats**
- ◆ **Analyser l'information sur la performance pour apprendre, re-planifier et améliorer la performance**
- ◆ **Utiliser l'information pour raconter les resultats du programme de l'USAID**



Le Cadre des Resultats

- ◆ **Identifie les responsabilités organisationnelles et l'horizon pour chaque resultat**
- ◆ **Démontre l'intégration des resultats des objectifs stratégiques selon besoin (Le cadre des resultats n'est pas forcément linéaire dans sa logique ni dans sa présentation)**
- ◆ **Sert comme outil d'éducation et de présentation de rapport**
- ◆ **Défini les indicateurs de performance et les cibles**



Le cadre des resultats - Les fonctions

Propulsé par la gestion
NON PAR
Les rapports

Fondé sur
l'expérience
pratique

- La planification
- La gestion
- La communication
- Construire le consensus et l'adhésion
- Les rapports



Les objectifs stratégiques

Le resultat le plus ambitieux dans un programme particulier qu'un unité d'opération (avec ses partenaire)s peut matériellement influencer et pour lequel il peur se tenir responsable.



L'objectif stratégique

- ◆ **Un resultat important, clair et objectivement mesurable**
- ◆ **Le resultat le plus haut pour lequel l'unité d'opération peut prendre responsabilité**
- ◆ **Lier aux objectifs USAID et son but principal**
- ◆ **Attenable entre 5 et 8 ans**

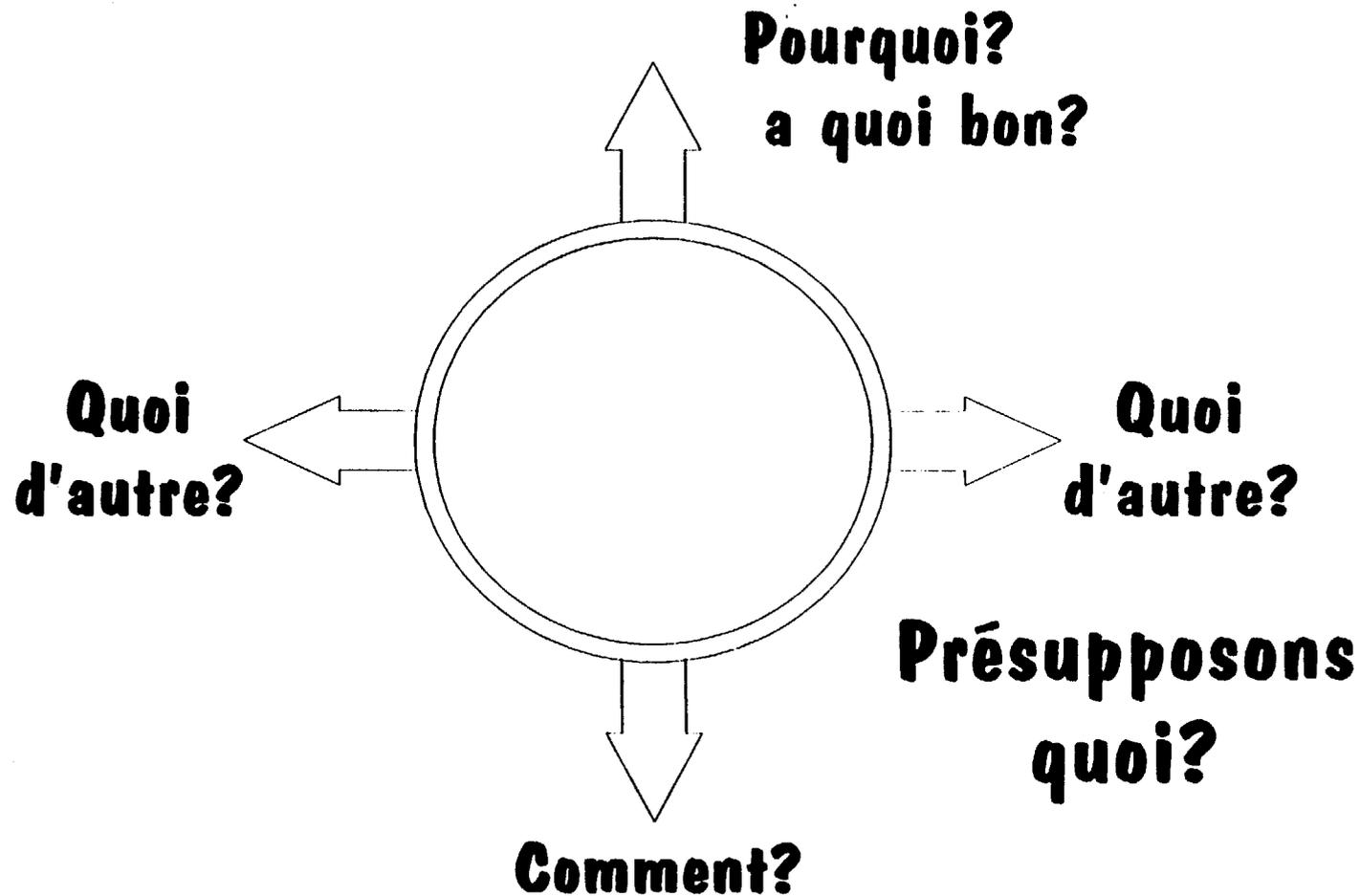


Les bons cadres de résultats montre la logique consistente

- ◆ **Les liens entre les résultats intermédiaires (RI) et les objectifs stratégiques (OS) sont causales de nature.**
- ◆ **La relation logique entre les RIs et les OSs est directe et claire où les RIs sont les resultats qui contribuent aux OS**
- ◆ **Les RIs representent les resultats des partenaires ainsi que ceux de l'USAID**

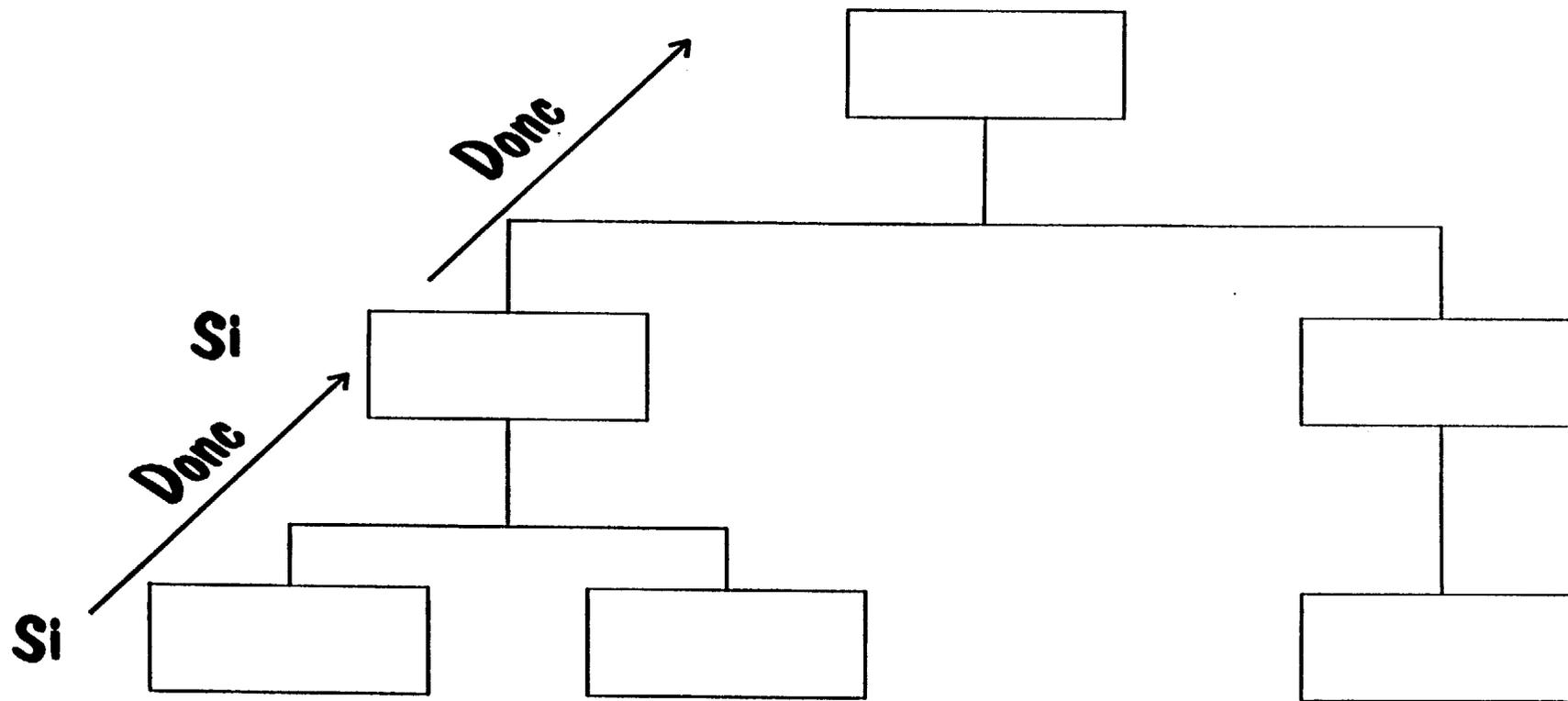


Les associations logiques entre les Oss et les RIs



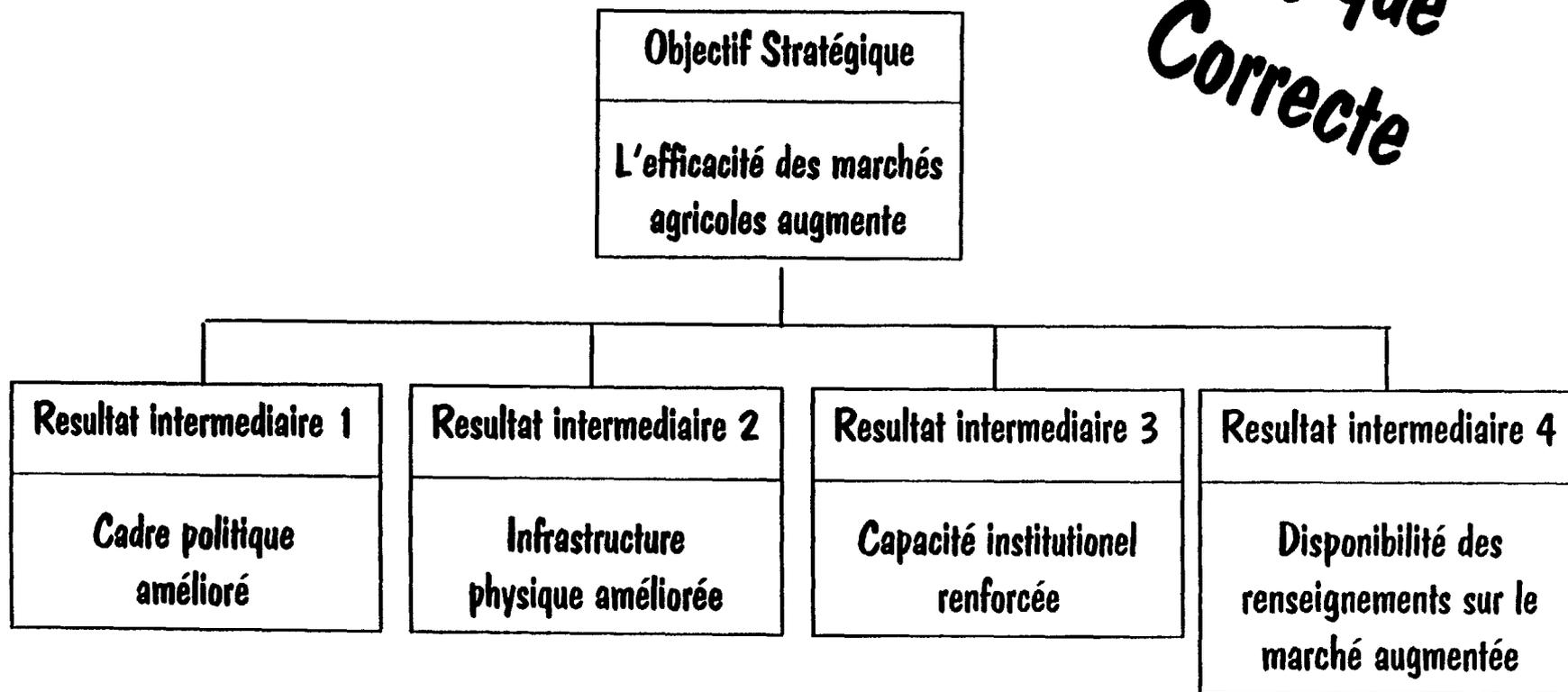
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Les cadres des resultats offrent une representation graphique des liens de causes et effets



Les liens causes - effets

*Logique
Correcte*



De bons cadres de resultats représentent un niveau de responsabilité réaliste

- ◆ **L'OS est le resultat le plus haut pour lequel la Mission USAID peut influencer et pour lequel il peut se tenir responsable**
- ◆ **Le nombre et la gamme des présuppositions critiques qui lient les RIs et les OSs sont raisonable**



Les caractéristiques des résultats

- ◆ **Représente les résultats - pas les activités ou le processus**
- ◆ **Pas un combinaison de plusieurs résultats**
- ◆ **Le résultat est mesurable et objectivement vérifiable**



<Checklist> pour la planification

- ◆ Est-ce que les OS et les RIs sont énoncés comme des résultats?
- ◆ Est-ce qu'ils sont objectivement vérifiables?
- ◆ Est-ce que les liens entre les résultats sont causales et non pas catégoriques?
- ◆ Est-ce que les liens comment/pourquoi et si/donc sont directs et clairs?
- ◆ Est-ce que les OS sont des résultats que l'USAID peut accomplir?
- ◆ Est-ce que les présuppositions sont raisonnables?
- ◆ Est-ce que les RIs montrent les résultats des partenaires ainsi que l'USAID?



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Le suivi et l'évaluation de la performance

Afin de gérer pour les résultats, les unités d'opération doivent régulièrement collecter, analyser et utiliser l'information sur la performance. L'information sur la performance joue un rôle critique dans la prise de décision pour la planification et la gestion.



2

La participation dans les mesures de performance

- ◆ **Les revues de performance doivent inclure les clients et les partenaires quand les unités d'opération le juge approprié**
- ◆ **Les clients et les partenaires doivent participer dans la planification des mesures de performance et pour**
- ◆ **La collecte et l'interprétation de l'information sur la performance**



Les OS et les RIs financés par l'USAID doivent...

- ◆ **Avoir au moins un indicateur pour suivre la performance**

- ◆ **Chaque indicateur doit avoir des données de base et un cible**



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Les cibles de performance et les données de base

◆ Cible de performance

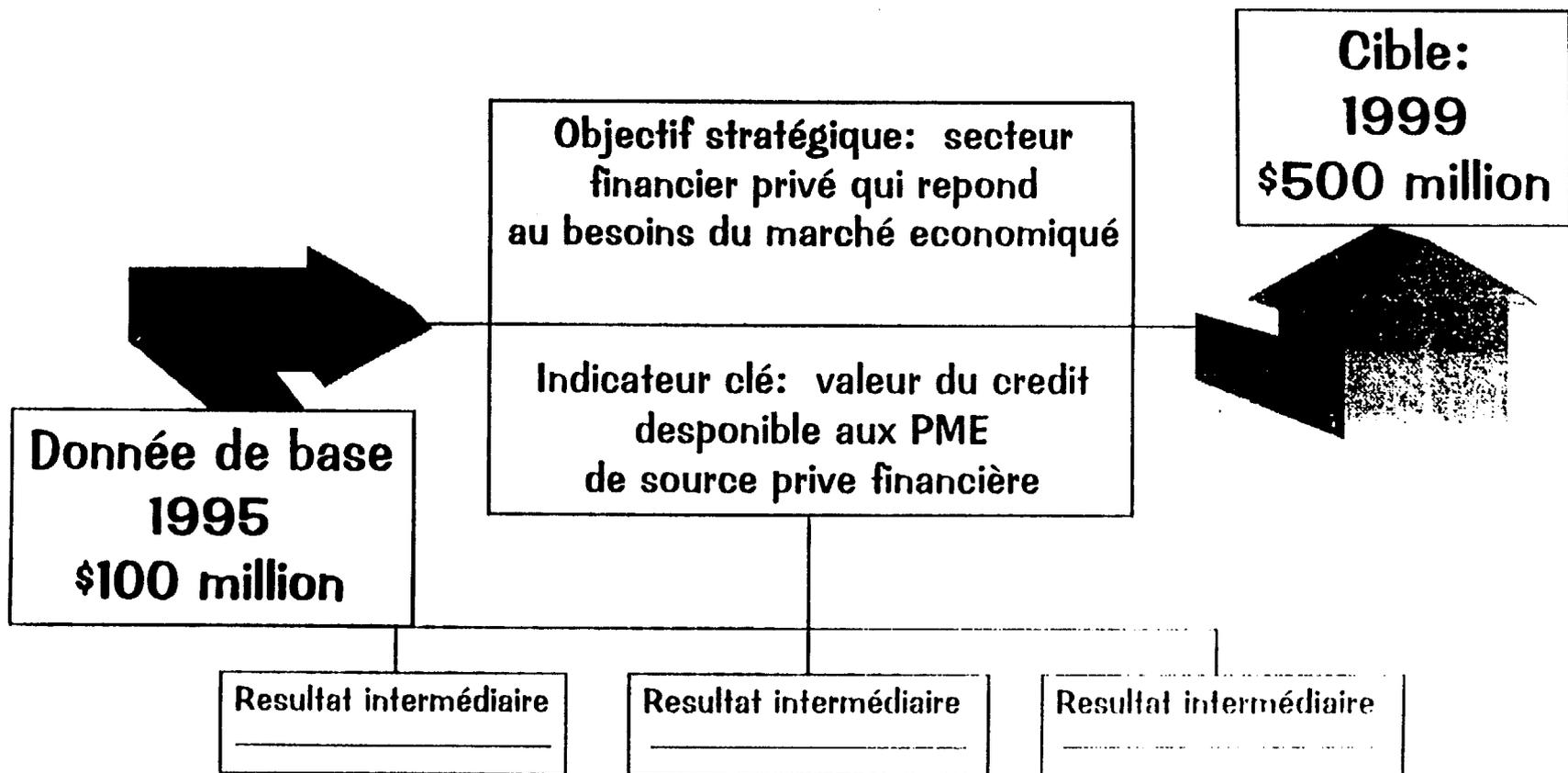
- ❖ Les résultats spécifiques attendues avec des horizons explicites contre lesquels les résultats actuels seront comparés et analysés

◆ Les données de base du performance

- ❖ La valeur attribué à un indicateur au début de la période de performance; les données de base sont utilisées pour comparer le progrès dans l'atteinte d'un résultat



Cible et Données de Base: Une illustration



L'équipe de l'objectif stratégique

- ◆ **USAID: personnel et agents (équipe de base)**
- ◆ **partenaires**
- ◆ **intéressés, et**
- ◆ **clients**

... travaillent ensemble pour atteindre l'OS.



L'équipe de l'objectif stratégique

- ◆ **Organise et se gère de façon autonome**
- ◆ **Détermine comment les resultats clés seront atteints**
- ◆ **Détermine les ressources nécessaires pour atteindre les resultats de l'OS**



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Le <paquet> des resultats

**Le concept de gestion par lequel l'USAID
organise et met en marche le travail pour
atteindre les resultats dans un temps précis et
avec le budget convenu.**



Au minimum le paquet de resultats comprend une association de...

- ◆ **Resultats, et**
- ◆ **Activités associés
qui forment un ensemble raisonnable pour
gérer pour les resultats**



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ANNEX E

**Opening and Closing Statements
by
Mr. John Flynn, USAID Director,
and
Ms. Kaba Saran Daraba,
Minister of Social Affairs**

SR

EXCELLENCE, MADAME LE MINISTRE DES AFFAIRES SOCIALES, DE
LA PROMOTION FEMINE ET DE L'ENFANCE,

EXCELLENCE, MONSIEUR LE MINISTRE DE LA SANTE,

MESDAMES, MESSIEURS,

CHERS PARTENAIRES,

EN AVRIL DERNIER NOUS NOUS SOMMES RENCONTRÉS AVEC
PLUSIEURS D'ENTREVOUS POUR EXPLIQUER LE CONCEPT DE
PARTENARIAT DANS LE CADRE D'UNE NOUVELLE APPROCHE DE
GESTION - *LE REENGINEERING*- QUE L'USAID A ADOPTÉ.

LA RÉUNION D'AUJOURD'HUI EST UNE SUITE LOGIQUE DE NOTRE
DERNIÈRE RENCONTRE, QUI CONSISTE ESSENTIELLEMENT A
METTRE EN PRATIQUE LE CONCEPT DU PARTENARIAT. C'EST
DIRE DONC QUE NOUS ALLONS NOUS REPOSER SUR LES QUATRE
VALEURS FONDAMENTALES DU REENGINEERING:

- LA FOCALISATION SUR LE CLIENT, POUR NOTRE CAS, NOS
CLIENTS SONT LES BENEFICIAIRES DE NOS ACTIVITES, LES
POPULATIONS A LA BASE;
- L'ORIENTATION VERS LES RESULTATS: C'EST EN GRANDE
PARTIE L'OBJET DE NOTRE TRAVAIL CES JOURS-CI.



- LA DELEGATION ET LA RESPONSABILISATION;
- ET ENFIN LE TRAVAIL EN EQUIPE.

DANS LE CADRE DE LA RÉVISION DE SON PLAN STRATÉGIQUE 1997 -2003, L'USAID/GUINÉE VOUDRAIT ÉTENDRE SES ACTIVITÉS DE PLANIFICATION FAMILIALE À CELLES DE LA SANTÉ MATERNELLE ET INFANTILE ET DES MST/SIDA.

POUR CE FAIRE, L'USAID EN S'APPUYANT SUR LES VALEURS FONDAMENTALES CITÉES PLUS HAUT, VOUDRAIT ASSURER UN PROCESSUS DE TRAVAIL ORIENTÉ VERS DES RÉSULTATS TANGIBLES, EN COLLABORANT ÉTROITEMENT AVEC VOUS.

CETTE APPROCHE SE BASE SUR UN PLAN CADRE DE RÉSULTATS QUI DÉTERMINE LES RÉSULTATS À ATTEINDRE, IDENTIFIE LES RESPONSABILITÉS DES ORGANISATIONS AU NIVEAU DE CHAQUE RÉSULTAT ET LE TEMPS MIS POUR RÉALISER CELUI-CI.

EN PLUS, LE CADRE DES RÉSULTATS DÉFINIT LES CIBLES ET LES INDICATEURS DE PERFORMANCE ATTENDUS.

L'OBJECTIF CENTRAL DE CET ATELIER SERAIT DE DISCUTER, AMENDER CE PLAN CADRE DE RÉSULTATS DE FAÇON QU' IL REFLÈTE VOTRE APPORT. CET ATELIER PERMETTRA SANS DOUTE AUX ET AUTRES D'AVOIR UN MÊME NIVEAU DE COMPRÉHENSION

DES OBJECTIFS PRIORITAIRES DE NOS DIFFERENTES

ORGANISATIONS DANS LE SECTEUR DE LA SANTÉ.

JE SOUHAITE UN PLEIN SUCCÈS À CET IMPORTANT ATELIER. POUR

CELA, IL REQUIERT DE CHACUN DE VOUS UNE PARTICIPATION

ACTIVE. L'USAID QUANT À ELLE NE MENAGERA AUCUN EFFORT

POUR ASSURER LE PLEIN SUCCÈS DE NOTRE ENTREPRISE

COMMUNE, CECI POUR LE BENEFICE ULTIME DES POPULATIONS

GUINEENNES.

JE VOUS REMERCIE.

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**Atelier de planification stratégique du programme de santé de
l'USAID
Conakry, 3, 4, 5 février 1997**

**Discours de clôture de Madame le Ministre des Affaires sociales et
de la Promotion féminine *et de la Condition féminine***

Monsieur le Directeur de l'USAID Guinée,

Mesdames et Messieurs les participants,

Depuis trois jours, vous vous êtes efforcés à affiner le plan cadre des résultats provisoires de l'objectif stratégique de l'USAID dans le domaine de la santé pour la période 1997 - 2002.

Cet important exercice a permis à la Mission de l'USAID en Guinée, au département de la Santé, et à tous les autres partenaires impliqués dans l'amélioration de la santé des populations guinéennes, d'identifier ensemble des objectifs clairs et d'adopter des stratégies appropriées pour une meilleure intervention du Gouvernement américain dans ce domaine.

Vos débats ont porté essentiellement sur la recherche de la disponibilité des ressources, d'une meilleure qualité des services et d'un bon système d'information, d'éducation et de communication.

À cet effet, le gouvernement guinéen et les populations de notre pays gardent l'espoir que les ressources humaines, matérielles et financières nécessaires seront activement recherchées en collaboration avec l'USAID et d'autres partenaires en vue de faire de ce programme, un modèle de coopération internationale.

Le Ministère de la Santé Publique donne, au nom de mon Gouvernement, l'assurance que tout sera mis en oeuvre pour la réalisation de ce programme dans un système de collaboration franche, dynamique et transparente.

Mesdames et Messieurs les participants,

Je vous invite à considérer votre participation à cet atelier comme le début de votre propre engagement dans la mise en oeuvre des activités qui vont en découler.

Je voudrais demander à Monsieur le Directeur de l'USAID - Guinée de traduire aux autorités américaines, la profonde gratitude de notre pays ainsi que notre disponibilité totale dans la recherche en commun du bien-être de la société guinéenne.

Nous adressons aux experts de M.S.I. nos vives félicitations pour la compétence et la maîtrise du sujet dont ils ont fait montre tout au long de cet atelier.

Ces félicitations s'adressent également à tous les autres partenaires et à tous les participants qui ont déployé tant d'effort et d'énergie pour faire de cet important atelier une réussite totale.

En vous souhaitant du succès à vos différents postes de travail, je déclare clos l'atelier de planification stratégique du programme de santé de l'USAID.

Je vous remercie.

EXCELLENCE, MADAME LE MINISTRE DES AFFAIRES SOCIALES, DE
LA PROMOTION FÉMININE ET DE L'ENFANCE,

EXCELLENCE, MONSIEUR LE MINISTRE DE LA SANTÉ,

MESDAMES, MESSIEURS,

CHERS PARTENAIRES,

AUX TERMES DE 3 JOURS INTENSES, RICHES EN IDÉES ET DONT
LES RÉSULTATS NOUS COMBLENT, JE ME DOIS DE VOUS FÉLICITER
POUR LES EFFORTS LOUABLES QUE VOUS AVEZ CONSENTIS.

LES RÉSULTATS DE CET ATELIER SONT D'AUTANT PLUS
IMPORTANTES POUR NOUS, QU'ILS OFFRENT A L'USAID LES OUTILS
NÉCESSAIRES POUR ÉLABORER SON PLAN STRATÉGIQUE EN
MATIÈRE DE SANTÉ. L'USAID SE RÉJOUIT ÉGALEMENT DU CLIMAT
DANS LEQUEL L'ATELIER S'EST DÉROULÉ. C'EST UN CLIMAT
PARTICIPATIF DANS UN ESPRIT D'ÉQUIPE.

ASSURÉMENT, VOUS VOUS ÊTES APPUYÉS SUR LES VALEURS
FONDAMENTALES DU RE-ENGINEERING.

JE SALUE VOTRE PARTICIPATION ACTIVE.

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NOTRE COLLABORATION NE S'ARRÊTERA PAS AUX RÉSULTATS DE CET ATELIER. ELLE CONTINUERA DANS TOUTES LES PHASES DU PROCESSUS JUSQU'À LA RÉALISATION DES RÉSULTATS QUE NOUS AVONS ENSEMBLE IDENTIFIÉS. C'EST DONC DIRE QUE NOUS COLLABORERONS DANS LA PROCHAINE PHASE; L'ÉLABORATION DES "PAQUETS DES RÉSULTATS", C'EST LA PLANIFICATION. NOUS COLLABORERONS ÉGALEMENT DANS L'EXÉCUTION, LE SUIVI ET L'ÉVALUATION DE L'ACTIVITÉ QUI DÉCOULERA DES RÉSULTATS DE CET ATELIER.

JE PUIS VOUS GARANTIR QUE L'USAID FOURNIRA LE FINANCEMENT ET L'ASSISTANCE TECHNIQUE POUR CETTE ACTIVITÉ.

PERMETTEZ-MOI DE REMERCIER LES CADRES DU MINISTÈRE DE LA SANTÉ QUI N'ONT MÉNAGÉ AUCUN EFFORT POUR ASSURER LE PLEIN SUCCÈS DE CET ATELIER. JE REMERCIE ÉGALEMENT LES INSTITUTIONS INTERNATIONALES ET LES ONG QUI ONT BIEN VOULU PARTICIPER À CET ATELIER.

MES REMERCIEMENTS S'ADRESSENT AUSSI A NOS COLLABORATEURS DE WASHINGTON ICI PRÉSENTS, POUR LEUR INESTIMABLE ASSISTANCE TECHNIQUE.

JE VOUDRAIS ENFIN FÉLICITER L'ÉQUIPE DE M.S.I. POUR LA
QUALITÉ DE SA PRESTATION.

JE VOUS SOUHAITE UNE BONNE FIN DE RAMADAM ET BON
RETOUR A CEUX QUI VIENNENT DE LOIN.

JE VOUS REMERCIE.

ANNEX F
Documents List

USAID Documents

USAID/Zimbabwe Results Framework SO3 "Reduced Fertility and Increased use of HIV/AIDS Preventative Measures, 1996

USAID/Guinea Results Review for FY 1995, March 1996

S.O. Results Framework USAID/Guinea, December, 1996

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ANNEX G
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