

PRISM: Household Survey Report

PRISM II (Randy Wilson, Steve Redding, Tanou Diallo)

October 2006

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PRISM II

Household Survey Report 2006



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Introduction

Context

The 2006 survey of households covered populations in the administrative regions of Faranah and Kankan – except the prefecture of Kissidougou where the project ceased operation in 2003. In this first section, the demographic and socio-cultural aspects of these populations are reviewed, as well as the interventions in the area of primary health over the last three years.

Demographic and Socio-cultural Context

The ideal framework for a socio-cultural description in Guinea is the natural region, in contrast to the administrative region. From the point of view of natural divisions, the 2006 survey would cover the natural region of Upper Guinea, comprising all 8 prefectures. This totality, corresponding to the intervention zone of the current phase of the PRISM project, covers a total area of around 101,258 kms² and contains an estimated total population in 2006 of 1,384,000 inhabitants, or an average population density of 13 persons per km².

The population of Upper Guinea is composed of two large ethnic groups: the Malinkes and the Peuls. The Malinke ethnic group is comprised of sub-groups, of which the most frequently encountered are the Soninké, the Diallonkés, the Kouranko, the Koniaka and the Wassoulounka. The Toucouleurs are mainly assimilated into the Peul ethnic group.

Agriculture and livestock constitute the two principal activities of the populations in the localities reached by the survey. These occupations were noted, respectively, in 50% and 30% of the localities. In the household survey, small business, gold panning and fishing were cited, respectively, in 12%, 6% and 3% of the localities as principal activities.

Health Context, Actors and Interventions

The target zone for the survey is composed of two health regions, corresponding to the two administrative regions of Faranah and Kankan, and eight health districts corresponding to eight prefectures (not counting Kissidougou). This zone contains 2 regional hospitals, 6 prefectoral hospitals, 16 urban health centers, 80 rural health centers, and around 110 health posts in which PRISM has developed its training and integration activities in technical areas as diverse as ante-natal consultation, syndromic management of STIs integrated management of childhood illness (IMCI), family planning, community management, etc. At the same time PRISM implements IEC activities in underserved populations.

In addition to PRISM, several projects and programs have some specific interventions in the zone for several years. The largest among them are SAVE THE CHILDREN in the

Overview of Results

The household survey has the objective to measure on the one hand the performance of the health projects and programs operating in Upper Guinea, in terms of improving some result indicators, and on the other hand, to measure the effects and impacts of these programs in terms of knowledge and behavior of the population in health sector activities.

The 2006 survey is the third household survey conducted by PRISM, after that of 2002 and 2003. It highlights comparisons of 2006 results to data taken in 2003 from the 5 intervention zones where the project worked with various partners, instead of the 9 prefectures surveyed in 2003. Consequently, the survey has reduced the sample size from 6,500 to 3,772 households, ensuring reliability for key indicators calculated to scale for the 5 intervention zones. Also, several additional indicators are introduced in this survey to take into account the project's new interventions. These new indicators cover aspects of governance and IEC, as well as that of the effectiveness of partnerships. Two large categories of indicators were measured: knowledge indicators and practice indicators (behavior and attitude).

In order to draw qualitative information on the project interventions across all the health centers, the survey identified a sample of health facilities that fall close to the selected clusters. For these centers, the survey developed four types of questionnaires:

- Knowledge, attitude and practices (KAP) with three different informants concerning the organization and function of management committees and mutual health organizations (MHOs). The targets for these interviews were: committee members, health center head and village chief.
- Resource inventories, both human and material (equipment, IEC materials and medicine) necessary to provide the minimum service package in Health Centers.
- Evaluation of the coverage and quality of two radio broadcast program series directed at health providers on interpersonal communication and the management of cervical cancer.
- KAP study of community agents and their supervisors concerning community based services (Note: These results are the subject of a separate report.)

In general, the development of the results that appear in PRISM's operational action plan was very positive between 2003 and 2006:

- The Contraceptive Prevalence Rate almost doubled, from 6.6% to 13%.
- The percentage of men who affirm that they used a condom during their sexual encounters with non-habitual partners has gone from 58% to 73%.
- The percentage of adolescents who know that the condom is a method of preventing HIV/AIDS has doubled for women (from 23% to 50%) and has strongly increased for men (from 45% to 72%)

- The stigma toward people living with HIV/AIDS seems to have reduced, because the proportion of adults declaring they are not opposed to contacts with people with HIV/AIDS has increased from 6% to 23%.
- The percentage of infants who benefited from exclusive breastfeeding in their first six months of life increased from 35% to 49%.
- Mothers' knowledge about foods rich in Vitamin A and Iron has improved (from 43% to 53% for Vitamin A and from 64% to 70% for Iron)
- The percentage of children between 12 and 23 months who have completed vaccination schedules (with vaccination cards) has gone from 54% to 78%. This positive trend is practically the same for the various doses of antigens.

Other indicators have not changed significantly:

- The percentage of women who had at least 3 antenatal consultations, of which one occurred during the ninth month of pregnancy, has remained around 42-43%.
- The percentage of men who affirm that they have used a condom during their last commercial sexual encounters has stayed around 80%.
- The percentage of children with diarrhea who received ORS has increased slightly from 29% to 35%, but stock outs of ORS, which were also evident in 2003, persist to the present day.

Some questions for which there were no 2003 baselines for comparison gave nevertheless some interesting observations:

The stock situation in health centers of some essential medicines remains concerning – more than half the health facilities experienced stock outs in ORS, doxycycline, ophthalmic ointment, and Ringer solution.

The majority of health facilities offer the range of the minimum package of services, but new services including HIV/AIDS consultation (16% of sites), management of cervical cancer (8%) and post-abortion care (52%) are not yet generally available.

The training and refresher coverage of health personal seems to be good for the most part, but one quarter of the health centers do not have personnel who are trained in stock management (which could contribute to the problems of stock-outs cited above).

As for equipment, among the list of 52 articles identified as essential, 8 were unavailable at 50% of the health facilities visited.

One third (36%) of households were familiar with one or another form of management committee in their villages, and, among those who were familiar with them, the great majority (91%) knew at least one person who was a member of the committee. The awareness rising on the committees seems more advanced in the intervention zones of SCF (54%) and ADRA (42%).

The Mutual Health Organization Program seems to attract many subscribers: 64% of those who had heard of the mutual health organization subsequently subscribed. Nevertheless, across Upper Guinea, only 38% of households were aware of the mutual health organization.

- Radio seems to be available in the majority of households, and 68% of households listen to radio regularly. 70% of providers interviewed in the health facilities had

followed at least one broadcast concerning interpersonal communication developed by the PRISM project – but very few followed the entire series. Only 19% had followed one episode of the broadcasts concerning cervical cancer. At the household level broadcasts on health are second place in popularity of all broadcasts (75% of listeners, after news broadcasts at 80%).

Objectives and Methodology

Objectives and Scope of the Survey

Three principal objectives are targeted by the 2006 survey:

- a. Determine the status of the result indicators in 2006 in Upper Guinea.
- b. Measure the effects of the PRISM II interventions and other projects and programs in terms of knowledge and practices of the populations in the public health sector.
- c. Compare the performance of the different forms of partnership in which PRISM finds itself in the two regions.

Among the indicators of intermediate results, defined by the project in collaboration with USAID, several have an annual frequency and are indicators of effect or of impact that cannot be measured except at the community level by surveys conducted at the level of the household. PRISM II has committed to providing results to USAID, in October 2006, concerning these indicators of which the source is the household survey 2006. The second phase of the project, started in September 2002, highlights the nutritional aspects of several activities targeting the improvement of quality of care as a strategic objective. A partnership agreement was signed in 2003 between PRISM and Helen Keller International (HKI) in this area. Since then other agreements were signed with ADRA, SAVE THE CHILDREN and AFRICARE. New indicators, within the framework of this collaboration, must be defined and their baselines determined. Since 2003, two other components have also developed: the training of service providers by way of radio broadcasts and the relaunching of community level activities to support health management committees and mutual health organizations.

Due to USAID's particular interest in better understanding the synergies potential in partnership, the survey seeks to obtain reliable results for each of the 5 zones below at the level of the same prefectures as in the survey of 2003:

Zone	Health Districts	Partners	Region
1	Dinguiraye & Dabela	Africare & PRISM	Faranah
2	Faranah	PRISM	Faranah
3	Kouroussa & Mandiana	Save & PRISM	Kankan
4	Kankan and Kerouane	PRISM	Kankan
5	Siguiri	ADRA & PRISM	Kankan

The Demographic Health Survey of 2005 the results of which have just been published in August 2006, only provides information for the national and regional levels. The availability of intermediate result indicators at the lowest level allows all stakeholders to orient and manage its interventions better.

The Household Survey 2006 is a survey of multiple components. To facilitate the comparison of results with the results of surveys already implemented, we have retained

the methodology and collection instrument more or less intact. Module 1 is a questionnaire structured in 11 components from A to K:

- A. Identification
- B. Demographic Characteristics
- C. Literacy and instruction
- D. Utilization of services and pricing of treatment
- E. Prenatal Consultation
- F. Child Vaccinations
- G. Nutritional Knowledge, Attitudes and Practices
- H. Breastfeeding
- I. Diarrhea Treatment
- J. Family Planning
- K. STI/AIDS Knowledge, Attitudes and Practices

The questionnaire design is not classic. The individuals are registered in columns, and their identification numbers appear on each pages of the questionnaire. This permits the possibility to discern each group of individuals targeted at any level of questionnaire administration. Moreover, the questionnaire is entirely pre-coded, which no doubt saves time.

In order to assess the rather qualitative aspects of the project's new directions, we have added two small modules to the household questionnaire:

Module 2: Community-based services

Module 3: Other community activities: Management committees, mutual health organizations and IEC.

Leveraging the field study required by the survey, we have integrated a mini-survey on a sub-sample of Health Centers (around 25%) that are thought to cover the populations in the clusters chosen for the household survey. This survey at the Health Center provides us qualitative data that permits us to track the development of the CBD program, IEC, financing of services by mutual health organizations and governance (CPSC, etc.). This part of the survey is presented in 7 modules:

Module 4: Management: CPSC/CoGes Membership

Module 5: Management: Head of Health Center

Module 6: Management: Village Chief

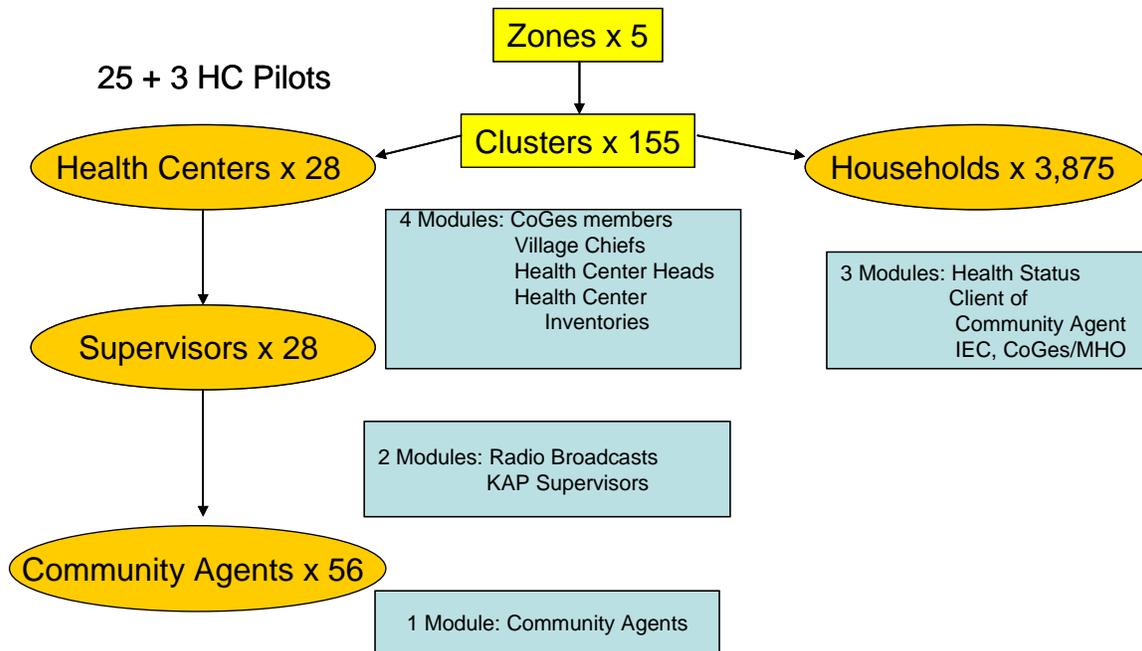
Module 7: Health Center Inventory

Module 8: CIP Radio Broadcasts et Uterine Cancer

Module 9: KAP of Supervisor of Community Agents

Module 10: KAP of Community Agent

PRISM Household Survey 2006 Organization



Sampling

To facilitate the comparison with the 2003 survey, the sampling plan has not been substantively changed. The survey is based upon a random sample of households taken, after implicit stratification, by “Proportional Probabilities of Size” of sampling units. Implicit stratification consists of arranging the sampling units in a hierarchical geographic order, and in accumulating population or household effectives of these units, in order to ensure the probability of choice proportional to their size in terms of the population or the households.

The sampling basis of the 2006 Survey is made up of “counting zones” defined at the time of the general population census in 1996. This is a relatively old sampling basis (10 years), but it is the only available one that is exhaustive. It was used for the major national surveys such as the DHS of 1999, and the ongoing national poverty monitoring survey. We have discussed with those responsible in the National Census Department the possibility of having more recent data from the 2005 DHS, but it appears that the updating of the “counting zones” has been done after the national sampling exercise, and consequently, there were very few counting zones updated in Upper Guinea.

The sampling exercise took place in three steps. At the first step, counting zones were determined; at the second step, segments of the counting zones equaling an average of 100 households each were defined; and, as a third step, households were chosen in which interviews would be done. The cartographic data of the RGPH of 1996 indicate that the

coverage zone of the survey (Upper Guinea) was divided into 963 counting zones. Deciding to segment the large-size counting zones into smaller and more homogenous surveying units in terms of size (segments of 100 households) we have a total of 2,243 segments.

Determination of simple size

The rate of DPT3 vaccination coverage was used for the determination of the sampling size. It was calculated on the basis of children of age 12-23 months and its status was 65.1% in our survey zone, according to the Household Survey of 2002. The 12-23 months age group has a very low vaccination rate in the majority of African populations. It is between 2.5 and 3.0% of the total population. However, the vaccination coverage has a particular strategic importance for the ministry of Public Health and for PRISM. For these reasons we have chosen it as our key indicator for the determination of the sample size required for reliable results at the scale of each of the 5 zones of the survey area.

For this survey, the formula for determining the sampling size is that of the UNICEF Multi-Indicator Cluster Survey (MICS III)¹:

$$n = \frac{[4 (r) (1-r) (f) (1.1)]}{[(0.12r)^2 (p) (n_h)]}$$

Or,

n equals the required size of the sample, expressed as the number of households for the key indicator;

4 is an adjustment factor allowing us to arrive at a confidence interval of 95%;

r is the rate of coverage estimated for the key indicator;

1.1 is an adjustment factor hended in order to increase the sample size by 10% for non-response;

f is the cluster effect;

0.12r is the margin of error tolerated at the 95% confidence level;

p is the percentage of the population represented in the denominator, and

nh is the average household size.

Using the DPT3 vaccination rate as our key indicator for determining the minimum sample size required, we have derived the following values as our parameters:

R	65.1%	DTC3 coverage rate for children aged 12-23 months – PRISM 2003 Household Survey
F	1.5	Cluster effect factor
P	3%	Percentage of the population represented in the denominator (children

¹ Unicef, Chapter 4 : MIC3. Multiple Indicator Survey Manual, p. 4.11.

		of age 12-23 months, as per the National Census of 1996)
n _h	6.1	Average household size (DHS 2005)

UIT these values, the simple size required for the calculation of a reliable DPT3 vaccination coverage rate is:

$$n = \frac{(4*0.651*(1-0.651)*1.5*1.1)}{(0.12*0.651)^2*.03*6.1}$$

= 1,343 households. This simple size is required whatever the geographic scope for which we calculate a reliable DPT3 coverage rate, which is to say with an acceptable margin of error of 5%. If reliable results are desired at the level of the five PRISM intervention zones, it would be necessary to multiply this size by the number of zones, or around a total sample size of 6,713 households for the five survey zones.

This sample is relatively large and cannot be used for obvious reasons of time and resources. We have therefore optimized this size by using the adjustment factor suggested by Vijay Verma (A critical review of MICS sampling methodology, April 1995): $D^{0.65}$ where D is the number of sub-states. In our case the adjustment factor is $5^{0.65} = 2.85$ and the total sample size is therefore $1,343 \times 2.85 = \mathbf{3,822 \text{ households}}$. With this sample size, the reliability of estimations would be acceptable, but weaker for the sub-states than for the totality of the survey zone. Taking into account the fact that we were looking for clusters of 25 households (same size as the Survey of 2003), distributed across 5 zones, we have finally retained **a total sample of 3,875 households**.

Taking the sample

The 3,875 households to survey must be divided proportionally among the 5 zones and the urban and rural milieu of these prefectures. We have decided to proceed by the implicit stratification method and to select 25 households by secondary survey unit. The sizes recommended are 10 to 40 households.

The number of segments to survey is equal to $3,875/25 = 155$. The survey basis, composed of the list of counting zones (with the exclusion of the Kissidougou prefecture), has been chosen according to the PRISM zone, the administrative region, the prefecture, the sub-prefecture, and the residential milieu. The population effectives of the counting zones were divided by the average household size multiplied by 100 to determine the number of segments of 100 households per counting zone. The numbers of segments have been accumulated and the pace of sampling in the counting zones determined by dividing the total number of segments (2.243) by the number of segments to sample (155).

Organization of survey

Technical preparation of the survey

The technical preparation of the survey has been ensured by the PRISM Monitoring and Evaluation unit, in collaboration with StatView International. This team took charge of the development of the survey methodology, including the sample taking, and the development of the initial version of the questionnaire.

The PRISM senior staff, as well as the technical component managers examined and revised the documents produced by the Monitoring and Evaluation Unit. Their comments and suggestions allowed the substantial improvement of the survey questionnaire.

The questionnaires underwent another series of revisions during the three-day surveyor training and the one-day pre-test in Coyah prefecture.

The provisional version of the survey protocol was also submitted to critiques and the approval of the Ministry of Public Health, by way of its National Ethics Committee of Health Research (CNEERS).

Organization of data collection

Data collection in the five zones was implemented in the field by 50 agents, divided into ten teams. Each prefectural team was composed of 4 surveyors, a driver and a team leader. StatView took charge of the recruitment and training of surveyors as well as team leaders, in close collaboration with the PRISM Monitoring and Evaluation Unit. Each prefectural team was equipped with a 4X4 vehicle during the 30 days of data collection.

The PRISM monitoring and evaluation team made field visits to ensure that the survey was being implemented as planned, as well as to ensure the survey's technical, logistical and administrative aspects. These visits to the various teams were opportunities to review with the team leaders the questionnaires already filled out, and to send those to the PRISM office that were judged to no longer be corrected in the field.

Data collection calendar

The team leader and surveyor training took place from the 22nd to the 24th of August 2006. During the surveyor training, the questionnaire was explained in French the first day, and then translated into Malinké, Pular and Kissi in the two following days. The 25th of August was devoted to the pre-test in the Coyah prefecture, followed by a day of analysis of results and revision of the questionnaires. The 28th of August was devoted to the translation of the texts into Malinké and Pular.

Data collection took place from the beginning to the end of the month of September.

Data input and analysis

The input of data was done using data masks developed in MS Access. A team of 20 input agents recruited by MSH to work for three weeks to complete the input. The data were verified at the end of each day by the supervisor and corrections were made before the analysis.

The analysis was done in several steps. An initial series of analyses by theme was produced for EPI Info 2003. These thematic analyses were the subject of a round table in which 30 partners worked together to draw out observations, identify supplementary analysis areas to be covered, and to propose recommendations for further actions to undertake to maximize the results (See “Roundtable Report for Household Survey 2006). After the roundtable, an additional cleaning of the data in the database was done – principally to correct problems with the coding of ages and the identification of mothers of the children aged 12-23 months, a target group for several of the indicators. Then deeper analysis was done on EPI Info to produce the final indicators.

Summary of 2003 Results

Pre-natal consultation and childbirth. The results of the 2003, compared to those of the 1999 Demographic Health Survey (DHS), show that substantial progress had been made in the area of frequency of pre-natal visits and deliveries made by trained personnel. In fact, the percentage of women living in Upper Guinea who made at least one pre-natal consultation during their last pregnancy went from 56% in 1999 to 84% in 2003. The percentage of women who made at least three pre-natal consultations, of which one was in the ninth month of pregnancy, as recommended by the Ministry of Public Health, is equal in 2003 to 42% in Upper Guinea, 45% in the Faranah Region, and 44% in Kankan Region. The proportion of births that were assisted by trained personnel (medical personnel or village-level trained birth attendants) went from 48% in 1999 to 62% in 2003. In 1999, only 17 women in 100 in Upper Guinea had given birth in a health facility, against 29% in 2003 (27% in the Faranah Region, and 30% in the Kankan Region).

Mother and child vaccination. The vaccination coverage rates have clearly improved between 1999 and 2003. The percentage of pregnant women who received vaccination at least one time against tetanus went from 53% in 1999 to 78% in 2003. The percentage of children who have a health card went from 41% in 1999 to 66% in 2003. This improves the quality of information about vaccination. The vaccination coverage of children from 12 to 23 months for BCG went from 62% in 1999 to 87% in 2003, an improvement of 40%. Vaccination coverage against measles has improved by 71%, going from 42% in 1999 to 72% in 2003. The percentage of children from 12 months to 23 months who received the DPT3 went from 40% in 1999 to 65% in 2003, an improvement of almost 63%. The percentage of children who received all the vaccinations recommended by the Expanded Program of Immunization (EPI) went from 30% in 1999 to 51% in 2003, an improvement of 70%.

Nutrition and breastfeeding. The nutrition indicators were new in 2003, and did not figure in the DHS of 1999. PRISM was able to measure the baselines in 2003 for these indicators. The percentage of mothers of children of less than 2 years, living in Upper Guinea who know of at least one food rich in Vitamin A was found to be 43% (31% in the Faranah region and 46% in the region of Kankan). The percentage of mothers who know of at least one food rich in iron was found to be 64% (59% in the Faranah region, and 67% in the Kankan region). Still in Upper Guinea, 65% of children from 6 to 23 months of age had received Vitamin A over the last six months. The results of the survey indicated moreover that 32% of women of Upper Guinea had received Vitamin A in the six weeks following their last delivery (30% of women in Faranah, and 31% of women in Kankan). Regarding breastfeeding, 37% of children from 0 to 23 months of age breastfed immediately after birth. This percentage was at 30% in 1999; therefore it had improved by more than 23%. The percentage of children from 6 to 23 months exclusively breastfed comes, according to the results of the 2003 survey, to 35% in Upper Guinea, 25% in the Faranah Region and 37% in the region of Kankan. These breastfeeding rates seem

overestimated. Women do not seem to have understood the exclusive breastfeeding means giving nothing to the child outside of breast milk, not even water. The DHS of 1999 does not give rates of exclusive breastfeeding for the regions.

Prevalence and treatment of diarrhea in children. The survey results of 2003 provide a prevalence rate for diarrhea of 27% in children under the age of 5 years in Upper Guinea. Diarrhea is a seasonal disease whose prevalence increases sharply in the rainy season. Having been done in September, an exceptionally rainy month this year, the 2003 survey shows a prevalence rate that is higher than that recorded in 1999 during the DHS, the information of which was collected in May and July (20%). The percentage of children who presented with diarrhea and received Oral Rehydration Therapy continues to be weak: 33% in 1999 for all of Upper Guinea, and 30% in 2003. Stock-outs of medicine in general and of ORS in particular were the causes of this weak level of use.

Family Planning. The usage level of modern contraceptive methods is sharply increased between 1999 and 2003, going from around 3% to 7% in Upper Guinea, an increase of 133% in the space of four years. The new phenomenon in the Family Planning sector in Upper Guinea is the modification of the structure by age of prevalence by the shifting of the modality of the structure in the 15-19 age group. Against all expectations, the prevalence within this age group is clearly more increased than other age groups: 12% as against 7% in the 20-24 age group, and 6% in the 25-29 and 30-34 age groups. This phenomenon is seen regardless of the modern method in use, and notably in condom use. Information campaigns and awareness raising efforts, strongly focused on youth during these last few years, are without doubt at the origin of this fact.

Sexually Transmitted Infections and AIDS. The levels of awareness in the AIDS sector are generally very good; more than 85% of women and men of 15 years or older have heard of AIDS, more than 75% of women and 85% of men are aware of at least one method of transmission and one method of protection against this disease. To the contrary, however, the percentage of those who know that the condom is a method of protection against AIDS is very low: 45% for men, and 21% for women. Moreover, only 7 persons in every 100 who are aware of AIDS declare themselves to be uncomfortable with contacts with persons living with HIV/AIDS.

Health service usage and treatment prices. The results of the 2003 survey indicate a relatively low rate of primary curative consultation and a rate of overpricing of services relatively high. For every 100 persons who fell ill within the last month, only 38 had a consultation in a public health facility (41% in Faranah region, and 40% in the Kankan region). Moreover, the percentage of services in which the patient paid more than the Ministry of Health established maximum price for the service comes to, in Upper Guinea, 39% (42% in Faranah region and 38% in Kankan region). The survey recorded in some sub-prefectures rates of 70% of services rendered at prices over the official price. The survey revealed also that the overpricing is stronger in rural areas than in urban areas.

Comparison of 2003 Results to 2006 Results

Pre-natal consultation and childbirth

The rates of women using pre-natal consultation services continued to grow between the survey of 2003 and that of 2006, going from 84% in 2003 to 90.3% in 2006. This rate represents a slower year-over-year growth (7% per year in 1999-2003, as opposed to 2.1% per year in the period 2003-2006) than the period between 1999 and 2003, arrived close to total acceptance of the practice. The percentage of women who made at least three pre-natal consultations, of which one was in the ninth month of pregnancy, as recommended by the Ministry of Public Health, has however, not progressed as rapidly, going from 42.4% in 2003 to only 43% in 2006 for the Upper Guinea region.

Table 1: Percentage of women who completed three pre-natal consultation of which one was during the ninth month of pregnancy²

Milieu	PNC 3 + 9th month		
	2003	Milieu	2006
Village and hamlet	38.9%	Rural	41.8%
Large village	53.2%		
Prefecture town	51.1%	Urban	50.6%
Large city	70.8%		
Total	42.4%	TOTAL	43.0%

The proportion of deliveries that were assisted by trained personnel (medical personnel or village-level trained birth attendants) went from 62% in 2003 to 68.9%. The proportion of deliveries made in health facilities, however, went down slightly from 29.5% to 27.5% during the same period.

Table 2: Comparison of assisted/non-assisted delivery by point of delivery according to milieu and region

Milieu and Region	At Home without trained personnel		At Home with trained personnel		In Health Facility	
	2003	2006	2003	2006	2003	2006
Rural	*	27.6%	*	42.6%	*	23.2%
Urban	17.9%	8.9%	31.1%	34.3%	51.0%	54.9%
Faranah	38.8%	32.9%	34.1%	42.8%	27.1%	22.0%
Kankan	34.3%	23.1%	35.2%	41.1%	30.4%	28.8%
Total	35.6%	24.3%	34.9%	41.4%	29.5%	27.5%

*2003 survey data not comparable for rural areas

² The 2003 survey divided its sample group into four subgroups (Village/hamlet, large village, prefecture town and large city) whereas the 2006 survey only made distinctions between rural and urban milieux. The two categorizing systems are not directly comparable.

Mother and child vaccination

The survey questions concerning the vaccination of children were addressed to the mothers of children between 12 and 24 months of age (948 children in our sample). The great majority of women (86%) indicated that they had received advice on the vaccination of their children. Three quarters (74.1%) of children had vaccination cards, a marked improvement over the last two surveys (66.3% in 2003 and 41% in 1999). The existence of vaccination cards allows much more confidence in the data concerning vaccination coverage, because depends much less on the declarations of mothers – an information source less reliable than cards.

One of the most important indicators is the number of children in this age group who have completed a full course of vaccinations. This means they have received BCG, DPT3, Polio3 and Measles (this assumes that the intermediary doses of polio and DPT have been received if the third dose has been administered). In 2003, around 51% of children could present vaccination cards showing that they had received the full course of vaccinations. According to the following table, full course vaccination has improved substantially, with 78% of children showing full course vaccination in their cards. If we add the children without cards whose mothers declare that they have received full course vaccination, this number comes down to 61%. This can be compared to the data in the 2005 DHS which calculate the coverage rate, taking into account both sources of information at 39.9% for the region of Upper Guinea in 2005. The difference between the two sources of information is difficult to explain, but it is of note that the regional sample for the DHS is much smaller than for that of the Household Survey 2006.

Table 3: Percentage of Children with full course vaccination (with cards and without cards)

Full course vaccination	Effective/Total	Percentage
With vaccination card	534/688	77.6%
Without vaccination card	33/260	12.7%
Total	567/948	59.8%

For children with vaccination cards, the coverage by type of vaccination is as follows:

Table 4: Percentages of children from 12-23 months who have vaccination cards, and percentages of those who received vaccination (2003, 2006)

	2003 (N=1774) Percentage	2006 (N=688) Percentage
Vaccination cards	66.3%	74.1%
BCG	86.7%	96.7%
DTC1	84.9%	95.4%
DTC2	75.5%	91.6%
DTC3	65.1%	88.7%

Polio1	83.7%	93.9%
Polio2	72.0%	89.0%
Polio3	58.0%	85.3%
Measles	72.4%	81.4%
Total Vaccinations	51.1%	77.6%

It can be seen that the default rate has gone down significantly for the two vaccines with repeated dosage: for the DPT around 7% of children who received the first dose did not return for the third dose (compared to 20% in 2003), and for polio 9% of children who received the first dose did not return for the third dose (compared to 26% in 2003).

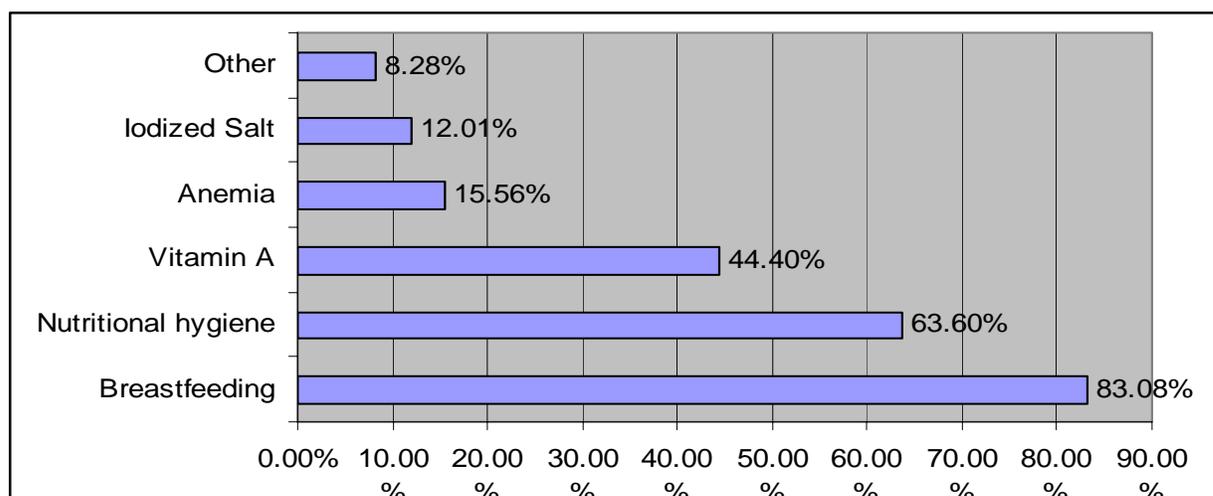
Nutrition and breastfeeding

The target group for nutrition questions was mothers of children from 0 to 23 months of age. 1,734 women responded to these questions. Almost two thirds (63.4%) indicated that they had received information and/or advice on mother and child nutrition since the start of their last pregnancy, as compared with 47% in 2003. Among those who had received information, the subjects that were addressed are as follows:

Table 5: Percentage of mothers of infants less than two years of age having received advice or information in the cited nutritional areas

Nutritional Area	2003	2006
	(N=3525)	(N=1099)
Iodized salt	2.90%	12.01%
Anemia	2.60%	15.56%
Vitamin A	11.30%	44.40%
Nutritional hygiene	18.60%	63.60%
Breastfeeding	30.90%	83.08%
None of above	55.50%	36.30%

Figure 1: Breakdown of subjects addressed in nutritional advice to women with children from 0 to 23 months



As for the source of this information, it is evident that many more women acknowledge having received this information from traditional midwives, community agents or from Health Centers or Posts. This development corresponds to the PRISM project interventions aimed at reinforcing the role of these agents in counseling and community awareness raising.

Table 6: Breakdown of information sources concerning nutrition

Information Source	2003	2006
	N=1528	N=1099
Community Leader	1.70%	1.0%
Others	10.60%	3.1%
Peer Educator	7.20%	4.3%
Friend	7.30%	7.5%
Radio	21.20%	19.6%
Village midwife	5.90%	22.2%
Community Health Agent	13.30%	29.2%
Health Center/Post	66.50%	79.9%

To better understand mothers' knowledge of nutrition, the survey posed a set of questions. Accordingly to the two tables below, there is a clear improvement in knowledge of the nutritional contributions of foods for the improvement of blood energy and vision in children. In spite of these improvements, it should be noted that one quarter (24%) of mothers did not know of any food rich in iron, and more than a third (36%) could not identify a food item rich in Vitamin A.

Table 7: Percentage of mothers of children – to 23 months who were able to cite the names of foods rich in iron and rich in Vitamin A

Foods rich in iron	2003	2006
Don't know	35.90%	24.1%
Liver	9.10%	17.8%
Fish	21.30%	30.4%
Leafy greens	21.00%	32.7%
Eggs	24.50%	39.2%
Meat	52.70%	56.6%

Foods rich in Vitamin A	2003	2006
Eggs	29.80%	68.10%
Sweet potatoes	8.00%	36.50%
Don't know	57.40%	36.00%
Oil	6.50%	35.30%
Leafy Greens	14.40%	29.60%
Mango	6.80%	18.00%
Papaya	8.60%	12.00%

As for the consequences of lack of Vitamin A, there was an improvement in the knowledge of certain consequences, but one of the classic consequences of Vitamin A deficiency remains unrecognized: that of night blindness.

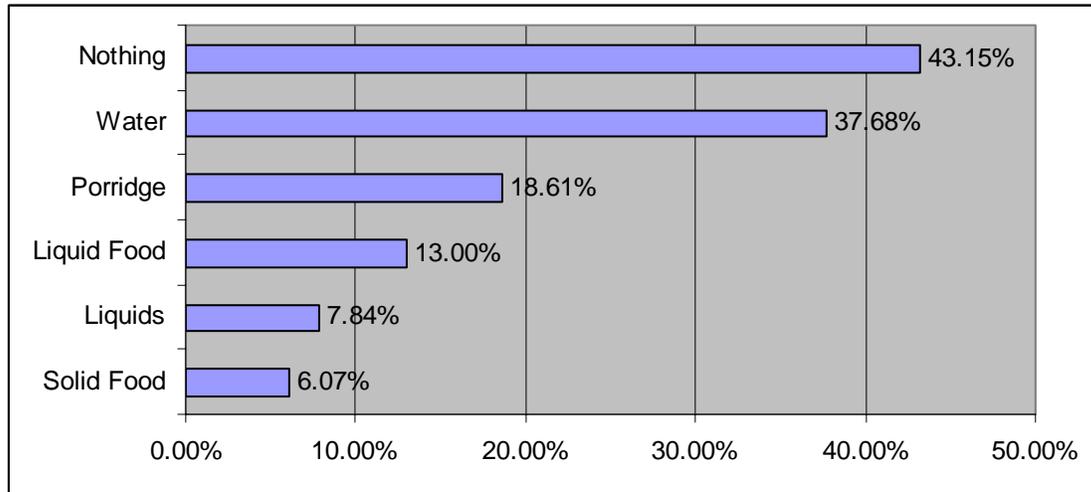
Table 8: Percentages of mothers with children from – to 23 months able to cite the consequences of lack of Vitamin A

Consequence of lack of Vitamin A	2003	2006
Still-birth	3.60%	8.20%
Night blindness	9.90%	9.30%
Infant mortality	5.60%	12.20%
Don't know	39.30%	28.90%
Underweight at birth	13.20%	43.80%
Stunted growth	34.10%	52.90%
Weakened immune defense	35.80%	77.80%

A set of questions was administered as well to mothers of children from 0 to 23 months concerning breastfeeding. The percentage of breastfed infants stood at 96%. This was practically the same figure as in 2003. There has been a slight change in the proportion of children started on breast milk immediately after birth (35.3% as compared to 36.7% in 2003). This change is so small as to possibly be by chance.

Exclusive breastfeeding until the age of 6 months is also an important strategy for the program. It was also asked of the mothers if they had given anything other than breast milk to eat or drink during the first six months. Figure 7 below shows the breakdown of their responses.

Figure 2: Supplementary feeding other than breast milk given to children during the first six months



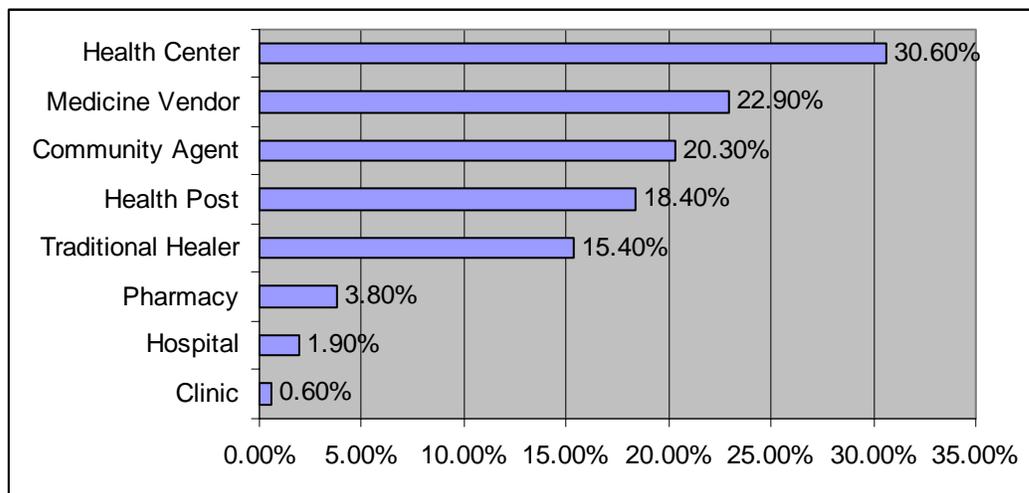
If only these responses are taken into consideration for children aged 6 to 23 months during the survey (n=929), a figure emerges of 49% who were exclusively breastfed. This figure suggests that there was a substantial improvement since the 2003 survey where an average of 34% of children in this group had been exclusively breastfed.

Prevalence and treatment of diarrhea in children

The survey team asked the mothers of children less than 5 years of age if their children had had episodes of diarrhea during the previous two weeks before the survey. Among 4,786 children for whom data are available, 17.3% had had at least one episode of diarrhea – a significant reduction in prevalence since 2003 (28%).

Among sick children, 64.8% had sought advice or treatment outside the home, the sources of which are broken down in Figure 3 below.

Figure 3: Sources of advice/care for children with diarrhea



Among all those who had diarrhea, 34.3% received packets of oral rehydration salts (ORS). This is a slight increase over 2003, when the percentage was 31%.

Family Planning

The questions on family planning were directed to the entire group of women from 15 to 49 years of age. In order to allow comparison with other surveys (DHS), we have also analyzed some of the indicators using the sub-group of married women only.

The percentage of women who use a modern contraception method has almost doubled, from 6.8% in 2003 to 13% in 2006. If we calculate the rate of contraceptive prevalence for married women only, this figure increases to 9.9%. This figure is clearly higher than the prevalence calculated for the region during the 2005 DHS. The 2005 DHS cites a figure of 5.5%, although the size of the DHS sample is much smaller (1,596 married women, compared to 2,522 for the 2006 survey).

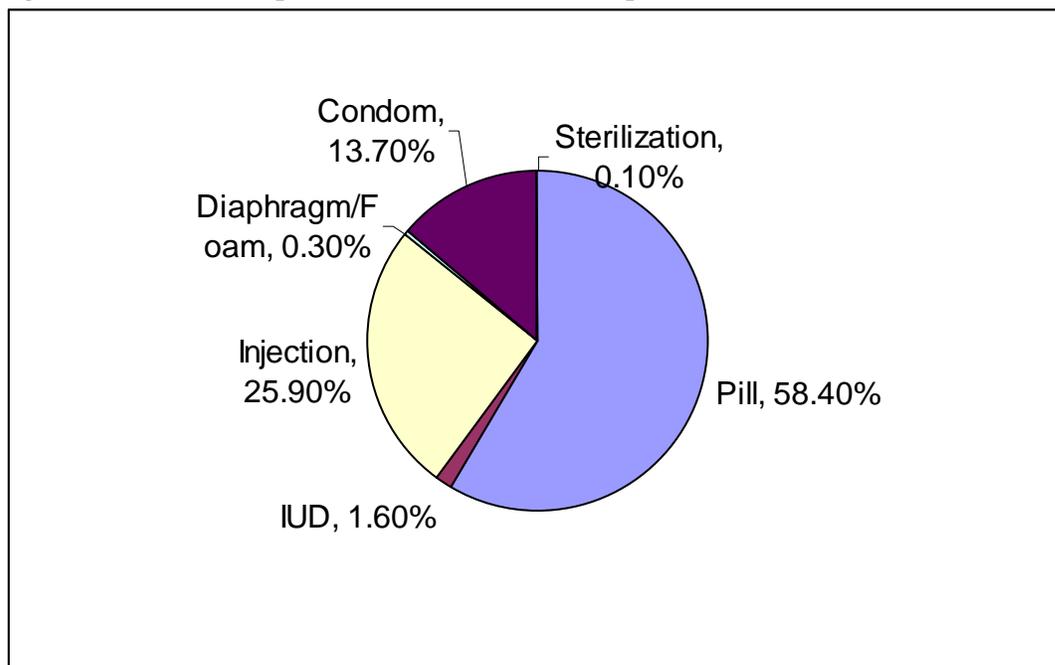
The breakdown of contraceptive prevalence by method is seen below:

Table 9: Breakdown of contraceptive methods used by women from 15 to 49 years of age

Method currently used	2003	2006	Number
1= Pill	3.70%	7.59%	460
2= IUD	0.30%	0.21%	13
3= Injection	2.50%	3.36%	204
4= Diaphragm/Foam	0.10%	0.03%	2
5= Condom	1.00%	1.78%	108
6= Sterilization	0.10%	0.02%	1
7= Abstinence	NA	1.58%	96
8= Withdrawal/continence	0.60%	0.05%	3
9= Amenorrhea	2.10%	2.57%	156
10= Other	0.20%	0.16%	10
Total women 15-49 years			6,064

There have been substantial changes at the level of pill use (105% increase), condom use (78% increase) and injectable use (35% increase).

Figure 4: Breakdown of prevalence of modern contraceptive methods



Generally these figures correspond relatively well to the data concerning Couple Years Protection (CYP) coming from the Family Planning system. Contraceptive prevalence increased around 91% and Couple Years Protection increase around 127% since 2003. In particular, the increase in CYP provided by the pill – that most popular method – was at 112%, and the increase in prevalence provided by this method was 105%.

Table 10: Growth of Couple Years Protection (CYP) by Year

Method	Couple Years of Protection		% Change
	2003	2006 ³	
Pill	4,985	10,551	112%
Depo - provera	2,506	4,655	86%
Spermicide	294	31	-89%
Condom	847	2,859	238%
IUD	1,491	4,334	191%
Tubal Ligature		530	
Total	10,122	22,960	127%

This growth is also a reflection of the rapid expansion of service networks offering family planning services, and the integration between health posts and the training of community FP agents.

³ Couple Year Protection is projected from SIG data for the months January until October 2006 (CYP * 12/10)

Contraceptive prevalence varies from region to region. Kankan has a rate of 13.8%, whereas Faranah has a rate of 10.1% (8% and 4% respectively in 2003). This difference is even more significant between urban and rural milieus, because the prevalence rate in urban milieus is around 17.7% and that of rural areas is at 11.9% (9% and 6% in 2003).

Sexually Transmitted Infections and AIDS

One of the most important sectors of the PRISM project has been support to interventions against sexually transmitted diseases and HIV/AIDS. Consequently a set of questions was posed concerning knowledge and attitudes about the diseases.

The near totality (97%) of the target group for these activities – women 15-49 years of age, and men 15-59 years of age, has heard of AIDS in 2006 (there was no difference noticed between the two sexes). This suggests that there has been a significant improvement, because in 2003 only 92% of men and 89% of women had heard of the disease.

Among those who had heard of AIDS, almost all could cite at least one mode of transmission.

Table 11 : Connaissance des modes de transmission du SIDA.

Mode of transmission	N=4479	N=5368	N=9847
	Men	Women	TOTAL
Sexual relations	93.7%	93.0%	93.3%
Dirty Objects	66.2%	56.6%	60.9%
Blood Transfusion	31.1%	25.6%	28.1%
By the mother	9.8%	9.1%	9.4%
Other	4.2%	4.3%	4.3%
Don't know	0.3%	0.5%	0.4%

95.5% old men and 92.5% of women said that one can do something to avoid AIDS. The table below indicates the methods cited.

Table 12: Ways of protecting against AIDS (Gender disaggregated)

Way to Avoid AIDS	N=4475	N=5378	N=9853
	Men	Women	TOTAL
Faithfulness	72.4%	74.2%	73.4%
Avoid unclean objects	55.7%	48.6%	51.9%
Use a Condom	60.1%	41.3%	49.9%
Avoid prostitutes	15.8%	18.0%	17.0%
Limit sexual activity	5.3%	3.3%	4.2%
Other	2.0%	1.7%	1.8%
Don't Know	0.2%	0.6%	0.4%

It is of note that condom use is the third most popular response, with 50%, but there is still a significant gap between men and women of 60% and 41% (45% and 21.5% in 2003). Nevertheless these figures are much better than in 2003 when only 32% of these groups cited condoms.

Connected to the AIDS questionnaire, the surveyors posed questions about the prevalence of high-risk sexual relations and condom use. Among the 10,761 participants in the study for this set of questions, 13% of men from 15 to 59 years and 4.8% of women from 15 to 49 years stated that they had had sexual relations with someone other than their habitual partner in the previous 12 months (a rate of 10.4% of men and 3.6% of women was recorded in 2003).

In this group, 28% of men, and 48% of women had paid (or received) money for sex (as compared to 31% and 41% in 2003). The more notable observation is that the proportion of those who used a condom during the last commercial sexual encounter had increased (an increase of 63% for women and 42% for men). Clearly the message concerning the danger of AIDS transmission during high-risk sexual relations has begun to influence behavior.

Table 13: Percentages of those who had sexual relations with a non-habitual partner during the last 12 months, those who paid for or received money for sex, and those who used a condom during these sexual encounters.

Indicator/Sex	2003 N=1101	2006 N=906
Had sex with non-habitual partners		
Women	3.6%	4.8%
Men	10.4%	13.0%
Paid for or received money for sex		
Women	41%	47.7%
Men	31.2%	27.9%
Used condom during commercial sex		
Women	48.7%	79.4%
Men	56.7%	80.6%

When the condom was used, this was initiated by the person being questioned in 80% of the cases (as compared to 84% in 2003), and not by the non-habitual partner. In these cases men continue to insist upon the use of the condom relatively more often than women (87% as compared to 63% in 2006; 87% as compared to 77% in 2003).

Another target group for HIV/AIDS prevention activities is that of young adults (15-24 years). The table below compares the results of this study with those of the 2003 Household Survey and those of the DHS 2005. The comparison between the two surveys suggests a significant improvement in the situation of young men and women, but these figures are substantially below those of the demographic health survey. In effect, the data of the DHS for this indicator are not very reliable and the level of Upper Guinea, due to the small sample size taken.

Table 14: Percentage of adolescents and young adults (15 to 24 years) who know that the condom is a way of preventing HIV/AIDS

Sex	HHS 2003		HHS 2006		DHS 2005	
	%	Effective	%	Effective	%	Effective
Men	44.90%	1,215	71.80%	1,286	87.60%	162
Women	22.50%	2,172	49.60%	1,879	82.20%	545

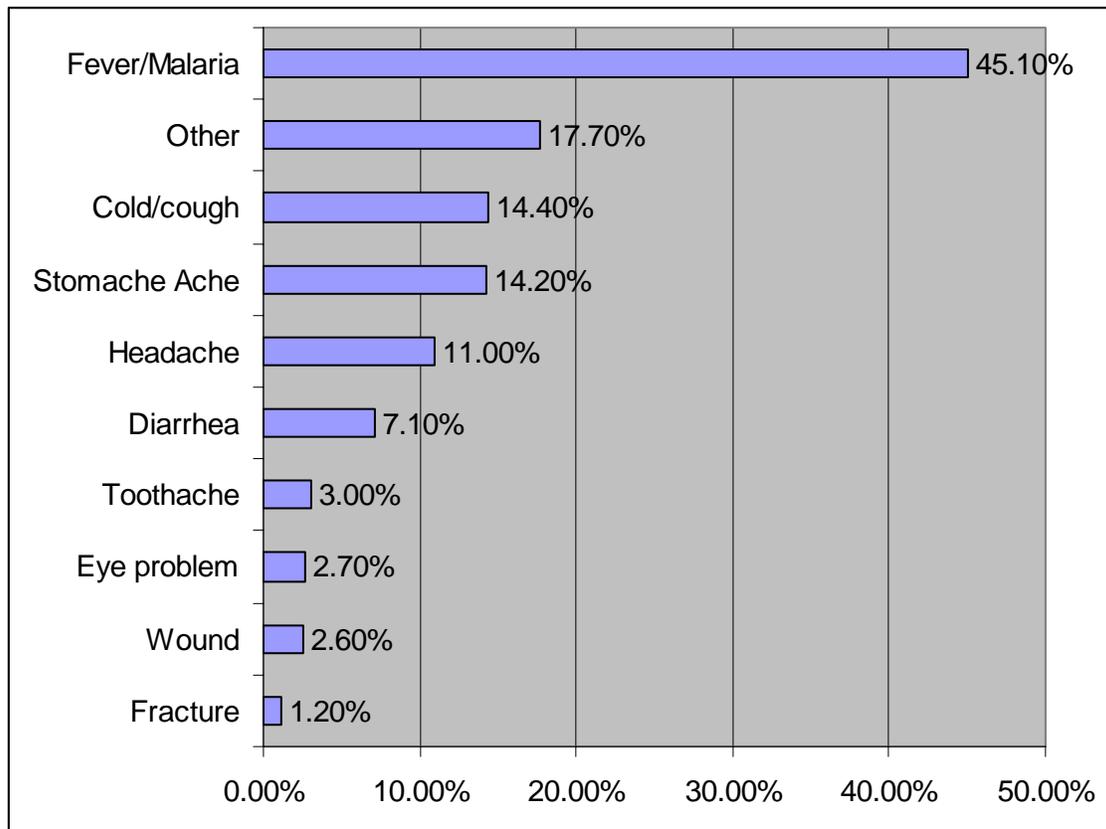
Another challenge for the HIV/AIDS program is to reduce the stigma associated with individuals infected with the disease. In the questionnaire a set of questions was administered to measure with some precision the percentage of people stating that they were not discomforted by contacts with people living with HIV/AIDS.

The percentage responding that they accept any form of contact (be ready to play, sleep or eat) with persons living with HIV/AIDS was on the average 23% in 2006 (28% for men and 18% for women). This figure has improved substantially since 2003, when the average for Upper Guinea was around 7%.

Health service utilization and prices

During the 4 weeks before the survey around 18.5% of people indicated that they had been ill, of which almost half (45.1%) complained of fever or malaria. This observation seems to be normal, given that malaria is the first cause of morbidity in Guinea but also the survey took place in the middle of rainy season.

Figure 5: Breakdown of complaints among those who reported being sick



Among those who reporting being ill, 51% sought help in a health facility for their complaint. Only 3.5% of the individuals declared to have sought help in a health facility for reasons other than illness.

These figures can be translated into prevalence rates by dividing the number of cases by the total population. According to the graphic below, there has been a slight decline in the prevalence rates of several complaints between 2003 and 2006 – in particular in fever and malaria, stomach aches, diarrhea and eye complaints.

Figure 6: Prevalence of illness during the two weeks before the survey

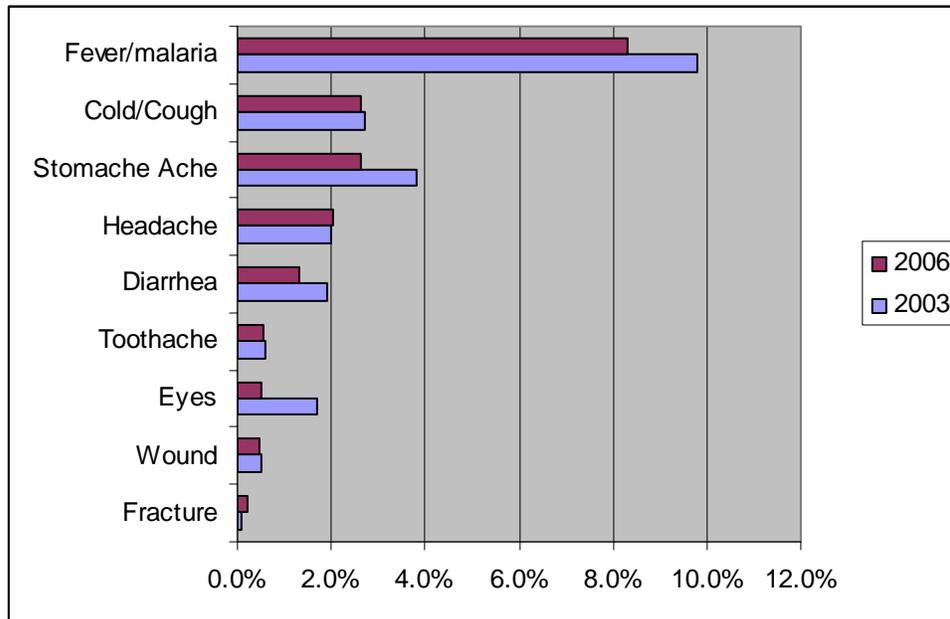
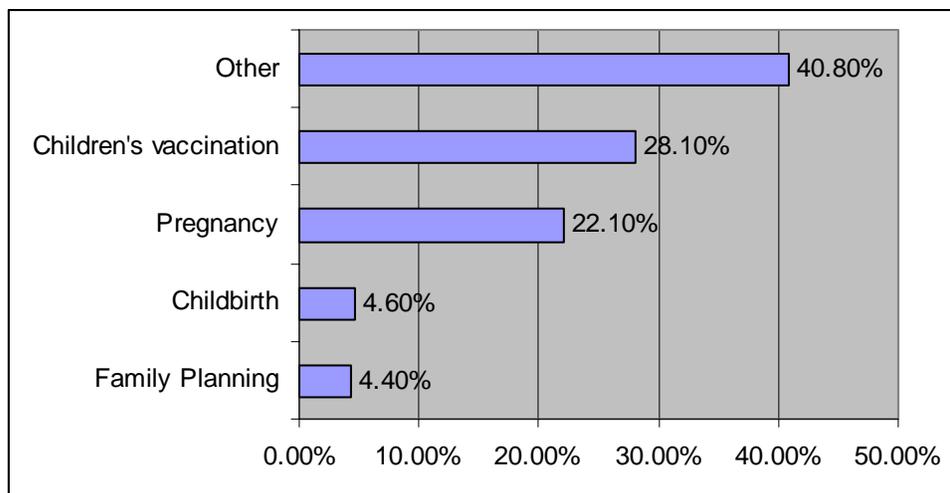


Figure 7: Breakdown of reasons for visits to health facilities other than illness

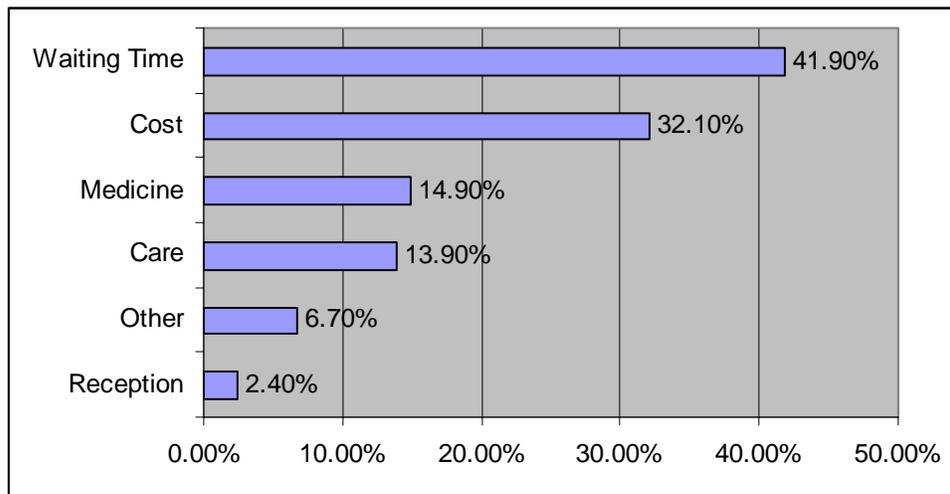


Among those who sought help from any health facility, half (51%) went to a health center, followed by 26% who went to a health post, and 18% who went to public hospitals. Only 7% indicated that they went to other types of service providers, either private or traditional.

In terms of payment, almost a quarter (23%) indicated that they paid nothing for consultation. However, 24% paid 1,000 Guinean Francs or less, 35% paid between 1,500 and 5,000 Guinean Francs, and 9% paid more than 5,000 Guinean Francs. The average cost of service was at around 8,236 Guinean Francs (about USD 1.5 at the moment) – a decline of about 400 francs from figures in 2003. The median cost of 3,190 consultations was at 2,000 Guinean Francs (also a decline of 400 Francs compared to 2003). These changes are due perhaps to the extended coverage of mutual and to efforts of CoGes to promote standardized price lists.

The great majority of people did not experience problems with their consultations (83%), among the 17% who complained of problems. The breakdown of complaints is found below.

Figure 8: Principal problems cited during visits to health facilities among those who expressed complaints



Supplementary indicators and analysis on governance and partner performance

Comités de Gestion (COGES)

In view of the project's growing interest in the improvement of governance and active community participation in the management and financing of health promotion activities, some supplementary modules were added to the 2006 household survey. Since this is the first time that these questions have been posed, there are no comparative data as such. These figures serve rather as an indication of the baseline situation. Nevertheless, a comparison between different project zones where interventions were undertaken in different ways can be instructive.

During the last two years, the PRISM Project undertook several activities to launch and reinforce governance and community mobilization for local management of health services. The targeted institutions of these interventions were: 1) local management committees that go by various names according to the region and the intervening entity (COGES – old model, CPSC – PRISM sub-prefectural level, CSC – PRISM village level, CVS – Africare) and 2) Mutual Health Organizations (Mutuelles).

Three modules of the survey were dedicated to Management Comités. Module 3 was a part of the household survey (3,772 responses) to elicit opinions from the population in general about these institutions. Two other modules were the subject of visits in a limited numbers of Health Centers (25) and targeted members of management committees and the heads of Health Centers to elicit their opinions concerning the functioning of these institutions.

Among all of the households surveys, a little over one third (36%) were familiar with one form or another of the management committee (COGES – old model, CPSC, CSC or CVS –Africare model). It seems that the awareness raising concerning the management committees is a little more advanced in the health districts supported by SCF and ADRA (54% and 42% of households are familiar with these committees) than in the districts supported by Africare and PRISM (34,5 and 26%). Among those who are familiar with these institutions, the large majority are familiar with a person who was a member of the committee (91%).

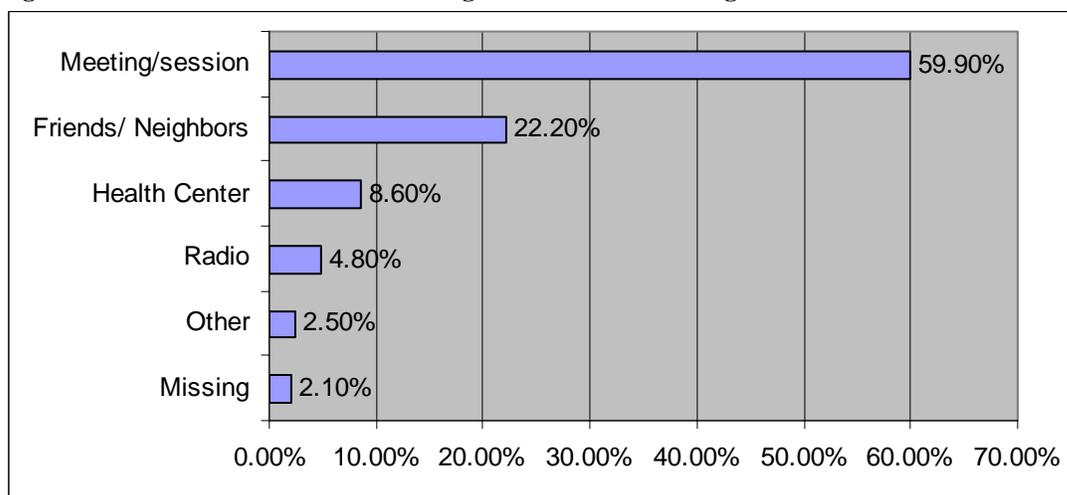
Table 15: Percentages of households that are familiar with different forms of management committee by partner and those among whom know a member of the management committee.

Partner – Health District	% who know of Mgmt. committee	n	% who know members	n
ADRA – Siguiri	42.2%	129	96.9%	125
Africare - Dinguiraye et Dabela	34.0%	177	68.8%	119
PRISM – Faranah, Kankan &	25.7%	414	91.9%	376

Kerouane				
SCF - Kouroussa & Mandiana	54.4%	498	96.6%	477
TOTAL	36.3%	1218	91.0%	1097

The majority of these households (60%) have learned of the existence of the committee through a meeting or community information session. Figure 9 shows the breakdown of the sources of information.

Figure 9: Information Sources concerning the existence of management committees



More than two thirds of households (68%) have attended an event promoting the concept of the management committee.

From 25 Health Centers in the sample, 45 members of management committees were interviewed. The great majority were male (80%) and more than half were farmers (52%). Table 16 lists the breakdown of occupations of the members interviewed. Six interviewees (14%) had previous professional experience in the health sector (or veterinary).

Table 16: Breakdown by occupation of management committee members interviewed

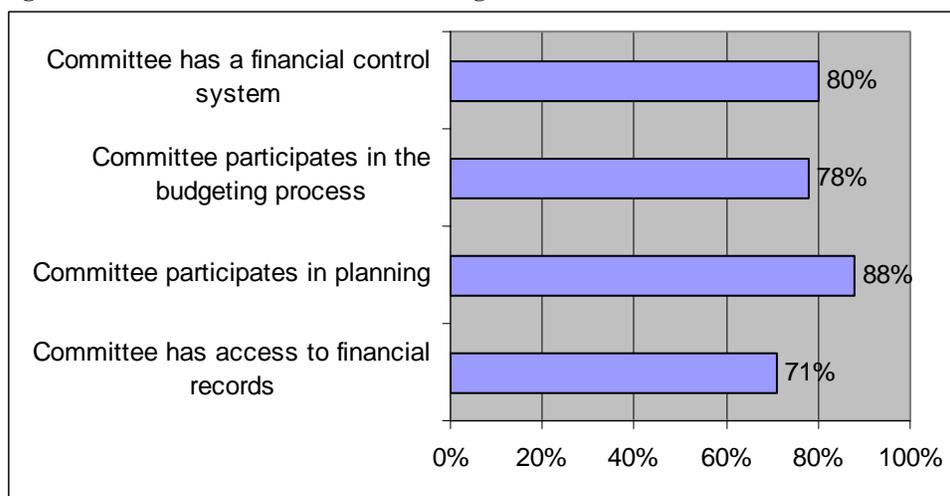
PROFESSION	Number	%
Traditional Birth Attendant	1	2.4%
Community Agent	2	4.8%
Driver	1	2.4%
Counselor to the CRD	1	2.4%
Farmer	22	52.4%
Teacher	4	9.5%
Nurse/retired health assistant	2	4.8%
Shopkeeper	1	2.4%
Housewife	1	2.4%
President (CPSC)	1	2.4%
Tailor	1	2.4%

Technician	1	2.4%
Retailer	3	7.1%
Veterinarian	1	2.4%

The average age of the members was 51 years, and except for one younger person of 18 years, the rest were more or less equally distributed between 32 and 74 years of age. Practically all the members interviewed had served on the committee for more than one year (91%) indicating a certain stability in the group.

In order to determine the level of transparency and the responsibilities of the committee members the surveyors asked them a set of questions on planning, budgeting and financial control. As shown by Figure 10 it seems that access to financial documents of the Health Center is limited in more than one quarter of the cases (29%). The role of the committee in planning is much more recognized (88%).

Figure 10: Roles and functions of the mangement committee



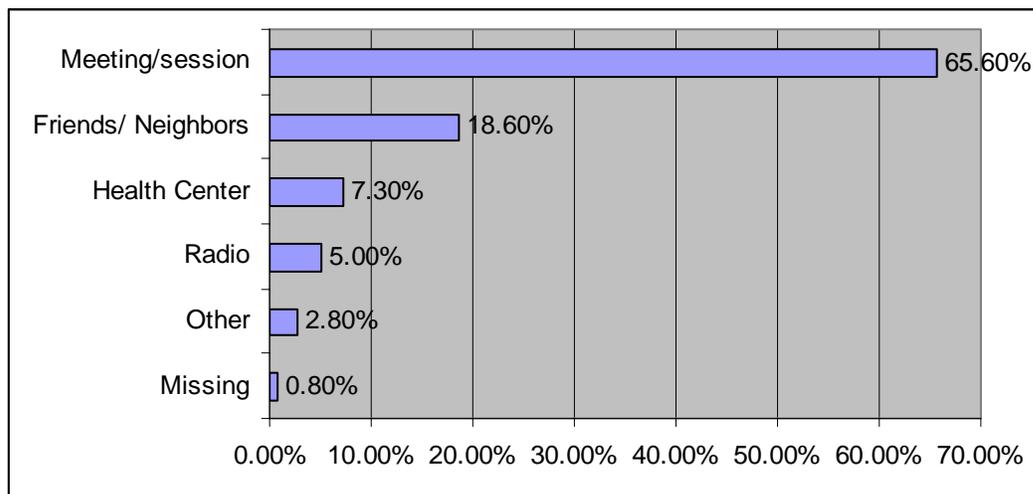
As for the frequency of the meetings: 71% participate in the meetings every two weeks (25%) or each month (46%). Only one person indicated that he has never participated in the meeting but ten percent indicated that their committee met irregularly. For the great majority (87%) their last meeting took place less than 2 months before the date of the investigation. In 61% of the meetings a representative of authority (local or prefectural) attended the meetings.

Mutual Health Organizations

In some zones of Upper Guinea the Project led actions to introduce or re-introduce the concept of mutual health organizations (“mutuelles”). A mutual health organization is a local, voluntary, and nonprofit community-based association that administrates micro-insurance to respond to members’ needs in facing their community’s health problems. This approach is known in Guinea by different names such MURIGA (an acronym for the French phrase for community mutual health organization to cover risks related to pregnancy and childbirth), but more widely by *mutuelle*. These organizations take different forms in

different areas. In the villages where they are identified as “community chests” and in the towns and prefectural and sub-prefectoral cities they are known as “health mutuals”. Across Upper Guinea, 38% of households are aware of the mutual health organization, and among these 88% know a member of a mutual health organization. The information sources on the existence of mutuals are practically the same as those of the management committees.

Figure 11: Information sources on the existence of mutual health organizations



Almost three quarters (74%) of households had attended one event promoting mutual health organizations. Among those who were informed of the existence of the mutual health organization 64% participated as members of mutuals at the time of the survey. If we view the number of households that are members of the organizations as a proportion of total households, we find a coverage rate of around 22% for Upper Guinea.

The affiliation to mutual health organizations is not uniform across the Project zones. ADRA and SCF raise a lot of awareness and in these zones more than two thirds of households are subscribers to mutual health organizations. However, in the districts supported by Africare, the activities have not yet been started. (We suppose that some who are familiar with mutual health organizations have come from elsewhere).

Tableau 17: Percentage of households that are familiar with the mutual health organization and the percentages of those who know members or are members themselves

Partner	% know Mutual	n	% who know members	n	% who are members	n
ADRA – Siguiri	49.0%	150	94.6%	140	66.4%	99
Africare - Dinguiraye et Dabela	0.8%	2	50.0%	1	50.0%	1
PRISM – Faranah, Kankan & Kerouane	31.2%	504	82.9%	417	57.1%	286
SCF - Kouroussa & Mandiana	55.5%	507	91.9%	464	71.0%	358
TOTAL	37.9%	1163	88.3%	1022	64.4%	744

To better understand the barriers and the concerns of the population about mutual health organizations the surveyors requested to non-members to explain to them why they were not members. In 18% of the cases it was because the mutual health organization did not exist in the person's community. 15% were members before, but left the mutual health organization. Only 5% indicated that the barrier was economic ("too expensive").

Among those who were members, less than one quarter (23%) indicated that there were problems in the mutual health organization to which they belonged. In this group, 5% explained that these problems were linked to the fact that the service providers did not accept the coupons from the mutual, and only 2% indicated that the problem was rather linked to the risk that the subscriptions to the mutual could lose their value. Apart from these two categories, the following problems were mentioned:

- Problems of member dues payment/cost recovery, stoppage of members dues payment, low dues payment rates, recovery, payment of monies without having received service,
- Difficulties linked to community understanding of the system,
- Lack of support, problems in mobilizing resources,
- Management problems, follow-up of defaulters, lack of seriousness, misunderstanding, inconsistent functioning of the mutual, "sabotage" of those who submit claims,
- Access Problems : Lack of health posts, lack of functioning of the existing health facilities, lack of time due to agricultural field work,
- Non admittance of those who are not in the immediate nuclear family.

One third (33%, n=277) of households that were members of mutuals had indicated that they had used the services of mutuals. Among them, almost half (46%) had admitted that the provider had demanded the payment of additional money. This observation is disturbing, but may be explained partially by the fact that in 60% of cases the mutual members had not presented the letter from the mutual guaranteeing payment of services.

However, three quarters (74%) had noted that they had found the medicines on their prescriptions easily (3% did not receive prescriptions).

Community Health Mirror

In some prefectures of Upper Guinea the project introduced an advocacy/management/analysis tool called the "community health mirror". PRISM introduced this tool in the areas where it works, as well as in those where ADRA and SCF work. At the time of the survey, Africare had not begun the introduction of the "community health mirror" in its health districts in Dinguiraye and Dabola.

In the health districts supported only by the PRISM team, the idea of the mirror is the best known (18% of households had heard of it compared to 12% in the ADRA and SCF districts). This observation is normal because the tool's introduction began in the zones

covered by the PRISM team only. In the zones supported by ADRA and PRISM only, the majority of these households also participated in the process (around 60%). However, in the SCF zones, only 16% of those who are familiar with the concept had effectively participated in the exercise.

Table 18: Percentage of households that are familiar with the community health mirror by partner and health district and percentage of those who participated in the exercise.

Partners – Health Districts	% familiar with « Health Mirror »		% of those who participated in the exercise	
	%	n	%	n
ADRA – Siguiri	12.0%	30	60.0%	18
PRISM – Faranah, Kankan & Kerouane	18.0%	236	59.7%	141
SCF - Kouroussa & Mandiana	12.0%	93	16.1%	15
TOTAL	14.0%	359	49.0%	174

Radio Broadcasts in the households

There were two modules of the survey that addressed the subject of radio broadcasts. Module 3 of the household survey sought information at the household level concerning the existence of radios and the interests of those who listened to radio.

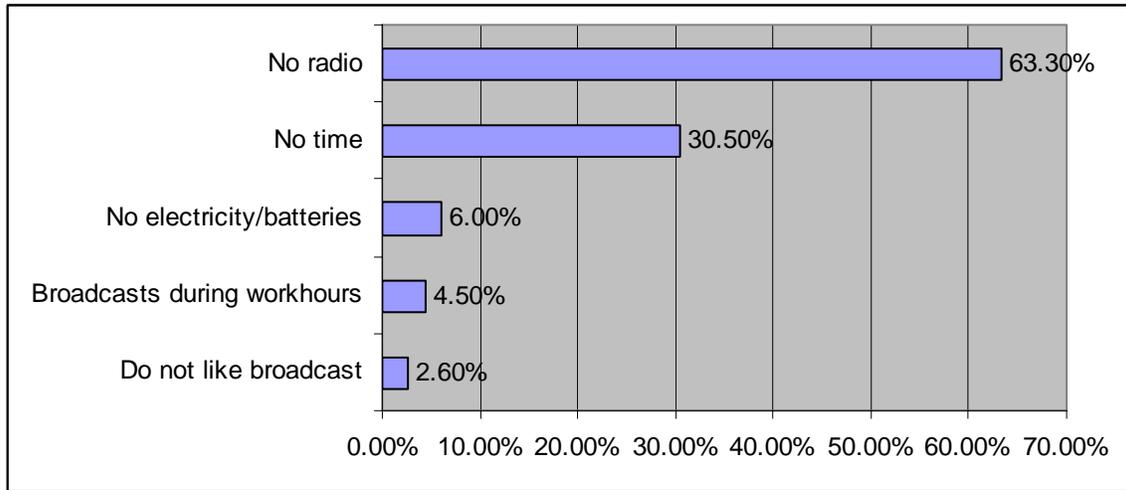
Interest in radio broadcasts varies substantially across the zones supported by the project. In over three quarters of households in Siguiri (85%), Kouroussa and Mandiana (75%) the population listens to radio regularly. The health districts where PRISM operates alone are relatively well covered also, as 68% of households listen to radio. However, in the health districts supported by Africare (Dinguiraye and Dabola) less than half of households listen regularly to radio.

Tableau 19: Percentage of households that listen regularly to radio by intervention zone

Partner	%	n
ADRA – Siguiri	85.0%	306
Africare - Dinguiraye & Dabela	45.3%	523
PRISM – Faranah, Kankan & Kerouane	68.3%	1606
SCF - Kouroussa & Mandiana	75.2%	910
TOTAL	68.1%	3345

In around two thirds (63%) of cases, the reason given for not listening to radio is because the household does not have a radio.

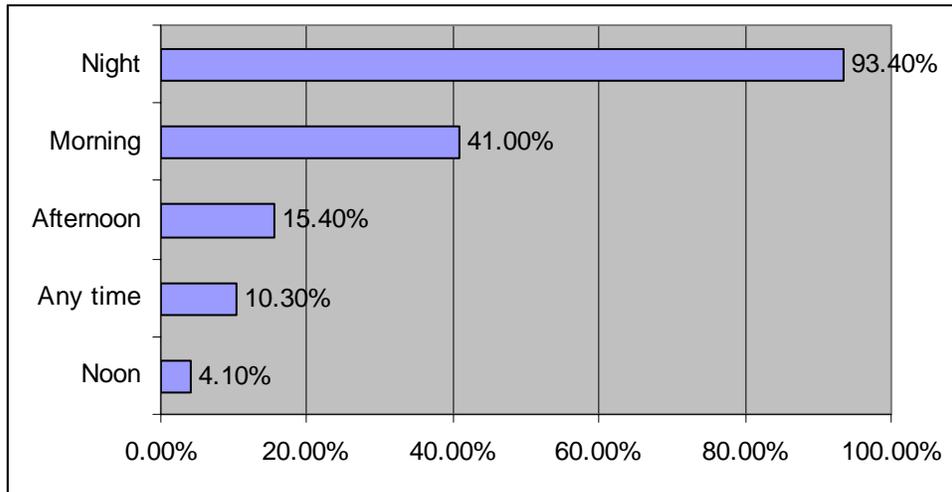
Figure 12: Reasons given for not listening to radio for household that do not listen to radio



A minimal number of households (90) that did not have a radio manage anyway to listen to radio at neighbors' houses (38%), at friends' (34%) or at bars or cafés (30%).

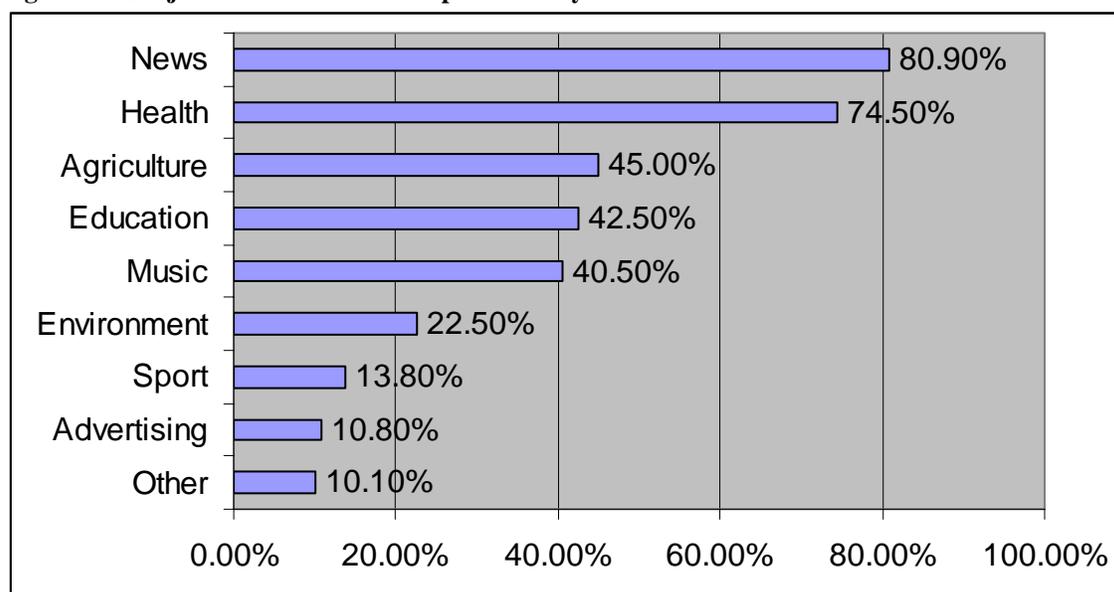
Around two thirds of those who listen to radio (65%) say that they listen every day and the great majority (93%) listen to nightly broadcasts (see Figure 13).

Figure 13: Distribution of preferred times for listening to radio in the household



The great majority of households prefer to listen to news (81%) and health programs (74%). Figure 14 indicates the breakdown of preferred subjects. It is not clear if the preferences correspond to the programs offered, or if they represent real household interests.

Figure 14: Subject of radio broadcasts preferred by households



The last question in the module concerning radio broadcasts asked if there were suggestions for other types of programs that the members of the household would like to listen to. This open question produced almost a thousand different answers, classified here below:

Table 20: Categorization of suggestions for improved radio broadcasts

Theme/Suggestions	Number of references
Health	446
Improve the frequency of broadcasts or the signal strength to rural areas	118
News	82
Agriculture	61
Education	54
Economy	36
Programming in local languages	34
Civic Education	31
Environment	24
Culture, stories & tales	23
Music	14
Death notices	13
Road conditions/traffic	11
Development	9
Religion	8
Sport	4
Fashion	1
Grand Total	969

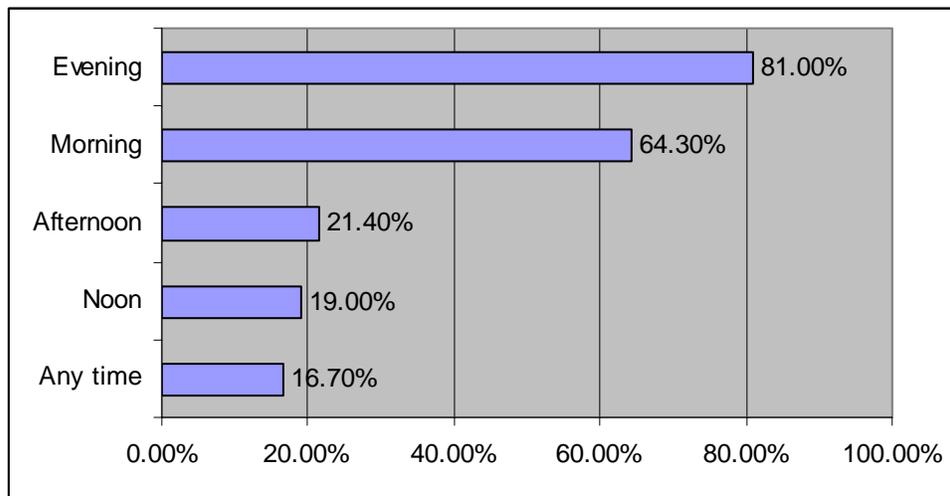
The suggestions the most frequently cited concerned health, news, agriculture and education. On the other hand, a great number asked for boosted signal strength to rural areas.

Broadcasts for health service providers

Module 8 targets health services providers only to evaluate to what degree they have followed and retained the information in two series of broadcasts concerning interpersonal communication and counseling (IPC) and uterine cancer developed by the PRISM project.

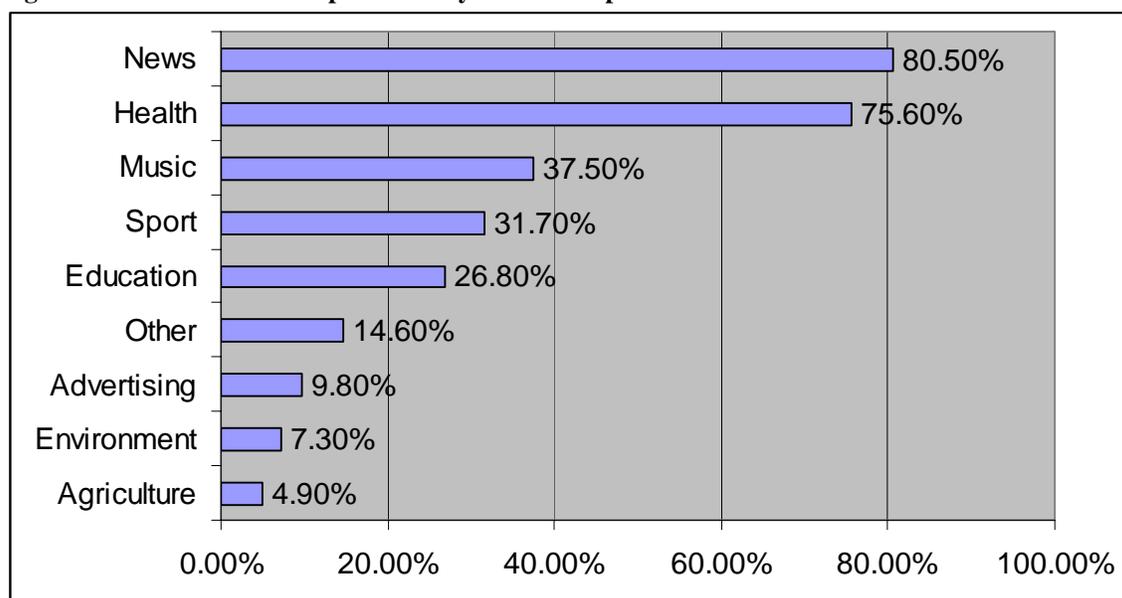
Among the 42 providers interviewed, all indicated that they listened to radio and only one service provider did not own a radio. Almost three quarters (71%) said that they listened to radio every day. The breakdown of preferred hours for listening to the radio are indicated in Figure 15. This distribution is more or less the same as that of the households (Module 2).

Figure 15: Distribution of preferred times to listen to the radio by providers at Health Centers (N=42)



The breakdown of preferred subjects is practically the same as that of the households as well (see Figure 16).

Figure 16: Radio broadcasts preferred by the service providers at Health Centers



Seventy percent of providers had heard at least one of the broadcasts on interpersonal communication & counseling (IPC). One third (32,3%) of the providers knew that the author of the broadcast was the PRISM project (25% said Radio Locale, the station, and 7% said the Ministry of Health).

As for the themes followed, it seems that the providers did not follow the broadcasts regularly. Only one provider indicated that he had followed the first episode – perhaps the advertising for the series had not been broadcasted in time. The themes concerning vaccination (58%), exclusive breastfeeding (46%) and the secondary effects of contraception (42%) were the best followed.

Table 21: Themes heard by providers who follows the broadcasts IPC

Order	Theme	Frequency	Percentage
1	IPC description, importance, overview of program	1	3.80%
2	Techniques and practice of IPC	6	23.10%
3	Exclusive breastfeeding and IPC	12	46.20%
4	Vaccination and IPC	15	57.70%
5	Growth monitoring and feeding after six months	7	26.90%
6	Counseling and secondary effects of contraception	11	42.30%
7	Risks of unattended childbirth/referral in emergency cases and IPC	4	15.40%
8	Pre-natal consultation/Norms and procedures and promotion and IPC	9	34.60%
9	Importance of attended childbirth by educative conversation	7	26.90%
10	Malaria and I.R.A and VAnd IPC	10	38.50%
11	Diarrhea + IPC	6	23.10%

In general service providers enjoyed the broadcasts: 57% cited “very good”, and 43% “good”.

The majority of listeners (80%) said that the series contributed to the improvement of their work, and some cited examples:

- “These broadcasts allowed me to have a very good knowledge of breastfeeding and the protection of infants”
- “These broadcasts allowed me to change my behavior in the exercise of my functions”
- “These broadcasts helped me to know more about childbirth and family planning”
- “This broadcast allows us to get experience”
- “The population comes more often to the Center”
- “The broadcasts allowed me to be much more informed about the exercise of my function”
- “The awareness raising has been very beneficial for the Health Center because the Center is used more frequently by the population”
- “A good knowledge of childbirth and breastfeeding”

In terms of the second series of broadcasts about uterine cancer, only 8 among the 42 service providers interviewed (19%) declared that they had heard at least one broadcast. Among them, no one followed more than one broadcasts; therefore the data are insufficient to analyze further.

Inventory of Health Centers

During the visits to the Health Centers (HCs) the teams of surveyors inventoried key resources essential to the quality provision of health services. These resources were divided into 5 categories: equipment, management tools, IEC material, trained personnel and essential medicines. This module also inventoried the availability of services according to the minimum package of services (MPS). It is of note that the number of health facilities visited during the survey (25 among a total of 110 Health Centers in the two regions) is too small to generalize conclusions across the region of Upper Guinea.

This module posed questions concerning the availability of services planned according to the MPS in each health facility. As could be seen in Table 22, in general the availability of key services is good, but three services in particular are not consistently made available: Post-abortion care (52%), HIV/AIDS consultation (16%) and uterine cancer screening and care. It is notable that this last program (uterine cancer screening and care) has just been introduced into Guinea, so the very low figure is not surprising.

Table 22: Number and percentage of Health Facilities that offer Minimum Package of Services by region

Service	Faranah	8 sites	Kankan	17 sites	Upper Guinea
	service exists	%	service exists	%	
Ante-natal consultation (ANC)	8	100%	17	100%	100%
Child survival (children <5 years)	8	100%	17	100%	100%
Family Planning	8	100%	17	100%	100%
STI Prevention	8	100%	17	100%	100%
Syndromic STI treatment	8	100%	17	100%	100%
Support to community participation	8	100%	17	100%	100%
Obstetric Delivery	7	88%	17	100%	96%
CPC vente ME	8	100%	16	94%	96%
Management of epidemic and endemic diseases	8	100%	16	94%	96%
School health programming	6	75%	13	76%	76%
Post-abortion care	2	25%	11	65%	52%
HIV/AIDS consultation	0	0%	4	24%	16%
Cervical Cancer screening and care	0	0%	2	12%	8%
Overall availability	79	66%	181	71%	

Another question linked to service provision and transparency is the public posting of service prices in the Health Center. Practically all of the Health Facilities in Faranah (7 out of 8) had public posted price tables. However, less than three quarter of the health facilities in the Kankan region had their prices posted (12 out of 17).

In addressing the availability of trained personnel, the surveyors interviewed all the staff in order to determine the trainings or refreshers they had received in the 7 subject areas supported by the PRISM project: LTO, Ante-natal consultation, obstetric delivery, Family Planning/STI prevention, Syndromic management of STIs, Child survival, and Material management. Among the 25 health facilities visited, almost half (48%) lacked personnel trained in at least one of these subjects. As seen in Table 27 the subjects for which training coverage is the most deficient are: management of materials (24%), child survival (12%) and obstetric delivery (12%).

Table 23: Number and percentage of Health Facilities that do not have trained personnel, by subject

Subjet	N=25	%
LTO (Lepre, Tuberculosis, Onchocercose)	0	0%
ANC	2	8%
Obstetric delivery	3	12%
Family Planning	0	0%

STI	2	8%
Child Survival	3	12%
Material management	6	24%

Concerning equipment, the physical inventory of 52 items was implemented in 25 Health Centers visited. The general rate of availability was around 75%. The situation in the Kankan region was slightly better than that of Faranah (74% compared to 77%). The nine items in Table 28 were lacking in half the health facilities. Among this list, only five items (benches, tape measures, plain examination table, birthing table, refrigerator/cold box) existed in all the facilities visited.

Table 24: Equipment missing in over 50% of Health Centers

Equipment	% of sites with equipment
Flashlight	8%
Garrot	16%
Reserve wick glass for cold box	32%
Soup spoon	32%
Syringe 0.1ml	36%
Petrol stove	40%
Mucus extractor (for babies)	44%
Oven timer	44%

Among the 17 management tools inventoried, the treatment ledger and the thinness diagram were lacking in over 50% of the facilities. Only the cold box maintenance log and the account book existed in 100% of the facilities.

Table 25: Availability of IEC materials by subject and by support type

	Faranah	n=8	Kankan	n=17	All
IEC Materials	Flip book	Poster	Flip Book	Poster	Together
Family Planning	87.50%	100.00%	94.12%	94.12%	93.94%
Prevention/Treatment of STI/AIDS	87.50%	100.00%	76.47%	82.35%	86.58%
The Fight against diarrheal diseases	75.00%	87.50%	70.59%	76.47%	77.39%
Ante-Natal Consultation	100.00%	75.00%	41.18%	70.59%	71.69%
Nutrition	87.50%	62.50%	52.94%	52.94%	63.97%
Acute respiratory Infections	50.00%	87.50%	29.41%	76.47%	60.85%
Vitamin A	50.00%	62.50%	35.29%	94.12%	60.48%
Breastfeeding	50.00%	75.00%	41.18%	70.59%	59.19%
Vaccination	37.50%	75.00%	23.53%	82.35%	54.60%
Malaria	25.00%	75.00%	23.53%	70.59%	48.53%
Childbirth	50.00%	25.00%	47.06%	41.18%	40.81%
General Availability	63.64%	75.00%	48.66%	73.80%	

As for IEC material, its availability is also irregular. Among the 11 subject for which support materials were inventoried, more than half of the health facilities did not have the two support materials necessary for childbirth and malaria. In general, the support

materials on family planning, the prevention and treatment of STIs and AIDS, the fight against diarrhea disease, and Ante-natal consultation are the most widely available.

These results suggest that the stock control system should be reinforced and that certain of these items could be placed in reserve at regional pharmaceutical depots to allow health facilities to restock easily. The supervision visits could also include greater control of these items that are often missing entirely.

As for the availability of essential medicines, the surveyors did a physical inventory of 25 products in each Health Center. Table 26 shows the percentage of Health Centers that did not have stockouts, by product, 90 days previous the survey. In general, the situation in the Faranah region seems to be better than that of Kankan. The stock problems in Kankan seem to be long-term in nature, because across all products 23% of the products have been out of stock for more than 100 days (compared to only 3% in Faranah). It is very disturbing to see the availability problem of ORS, Ringer's Lactate (Sodium), doxycycline and ophthalmic tetracycline ointment (OTO) persisting in more than half of the Health Facilities.

Table 26: Percentages of Health Centers without stockout by essential medicine

Medicine	Faranah	n=8	Kankan	N=17	Average 30 days stockout
	0 days stockout	Missing information	0 days stockout	Missing information	
Acetylsalicylic Acide (ASA)	100%	0%	94%	0%	97%
Condoms	100%	0%	94%	0%	97%
Thread for Umbilical Ligature	88%	13%	100%	0%	94%
Depo-Provera	100%	0%	82%	0%	91%
Iron and Folic Acid(IFA)	100%	0%	82%	0%	91%
Kanamycin	100%	0%	76%	0%	88%
Hydrophilic Cotton	88%	13%	88%	6%	88%
Cotrimoxazol	100%	0%	71%	0%	85%
Lo-Femenal	88%	13%	82%	6%	85%
Chloroquine	75%	25%	82%	0%	79%
Syringe	100%	0%	53%	0%	76%
Mebendazole	100%	0%	47%	0%	74%
Metronidazole	88%	0%	59%	0%	73%
Injectable Quinine	100%	0%	41%	0%	71%
Vitamin A	63%	13%	76%	12%	69%
Ergometrin	75%	13%	59%	0%	67%
Glucose Serum (GS)	88%	0%	41%	0%	64%
Ciprofloxacin	88%	0%	29%	6%	58%
Distilled Water	88%	13%	29%	6%	58%
Procaine Fortified Penicillin (PPF)	88%	0%	24%	0%	56%
Erythromycin	63%	13%	41%	6%	52%
Ringer's Lactate (Sodium)	75%	13%	24%	0%	49%
Doxycycline	88%	0%	6%	6%	47%
Ophthalmic tetracycline ointment (OTO)	50%	13%	35%	0%	43%
Oral Rehydration Salts (SRO)	50%	13%	12%	6%	31%
General availability	86%		57%		

been doing social marketing of contraceptives for more than 10 years in Upper Guinea and the forest region.

The interaction between the key partners is one of the preoccupations of the 2006 household survey. We would like to test the hypothesis that the different types of partnerships between the PRISM bilateral project, the Ministry of Health and other international NGO's with a presence on the ground create a synergy that produces better results than a bilateral project working on its own.

Comparing the performance of these partners is somewhat problematic for a couple of reasons. For one thing, the catchments populations of the different zones are very different – resulting in the fact that the number of households sampled in the zones where ADRA and AFRICARE work are not adequate for comparing certain of the low prevalence indicators with the precision we had hoped to achieve. In addition, some of the partners, such as EngenderHealth and Helen Keller International are not geographically isolated, so we cannot attribute their inputs to any specific area.

Nevertheless, comparison between the key players who are geographically isolated, do provide us with some interesting differences that can serve as baselines for future work.

Looking at current performance alone, it appears that the zone where SCF intervenes with PRISM support has the best status for each of 4 key indicators:

1. Fully immunized children
2. 3 or more Prenatal Consultations, with one during the 9th month
3. Contraceptive prevalence rate
4. Assisted deliveries (including home deliveries and those within health facilities)

Although ADRA appears to have a small advantage for the contraceptive prevalence rate (17% vs. 16%), together, the average of all of these indicator scores, the zones where PRISM works alone appear to be in second position, followed by ADRA and AFRICARE.

Figure 17: Comparison of different performance indicators by partner 2006

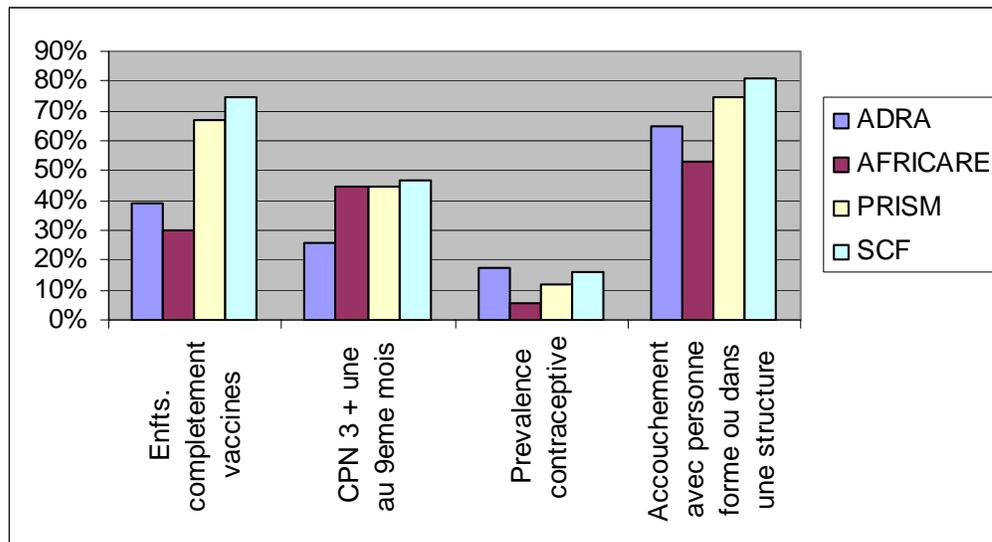


Table 27. Comparison of different performance indicators by partner 2006

Zone	Completely immunized children	CPN 3 + and one during 9th month	Contraceptive Prevalence	Assisted deliveries	Average
ADRA – Siguiri	39%	26%	17%	65%	37%
AFRICARE - Dinguiraye et Dabela	30%	45%	6%	53%	33%
PRISM – Faranah, Kankan & Kerouane	67%	44%	12%	74%	49%
SCF - Kouroussa & Mandiana	75%	46%	16%	81%	54%
TOTAL	63%	43%	13%	73%	48%

To more accurately compare the performance of the partners, we had to re-analyze the data from the 2003 household survey, so that we could take into account the different baseline values for these indicators. This enables us to calculate the percent change over time for each indicator in each intervention zone between 2003 and 2006.

Regarding childhood immunizations, the percentage of children completely vaccinated improved 28% on average, but this progress wasn't uniform. The zones where SCF and PRISM worked evolved twice as fast as the average (49% and 40% respectively) whereas the zones where ADRA and AFRICARE worked saw a decrease of (-25% and -33%).

Table 268: Comparison of the percentage of children 12 - 23 months completely vaccinated, by intervention zone

Zone	2003		2006		% change
	n	%	n	%	
ADRA	99	52.4%	40	39.2%	-25.2%
AFRICARE	60	44.8%	29	30.2%	-32.6%
PRISM	476	48.0%	281	67.1%	39.8%
SCF	232	50.4%	223	74.8%	48.5%
TOTAL	867	48.8%	573	62.6%	28.3%

With respect to contraceptive prevalence, the overall rate nearly doubled (91% increase), but the change was most noticeable in the zones where ADRA, AFRICARE and PRISM worked (177%, 152% and 123% respectively). Note that the baseline from which SCF began was already twice as high as the average – a factor that may have contributed to the relative lack of progress (35% increase only).

Table 27: Comparison of the contraceptive prevalence rate for modern methods (all women 15 -49 years), by intervention zone

Zone	2003		2006		% change
	n	%	N	%	
ADRA	60	6.3%	97	17.5%	177.4%
AFRICARE	20	2.2%	31	5.5%	151.6%
PRISM	250	5.4%	394	12.0%	123.2%
SCF	257	11.8%	266	15.9%	35.1%
TOTAL	587	6.8%	788	13.0%	91.1%

Comparing performance for pre-natal consultations, only the zone covered by ADRA was unable to achieve significant gains (-38% decline), but this observation could be due to the small size of the sample in that zone.

Table 30: Comparison of CPN coverage (% women who received 3 or more Prenatal consultations, of which one was in the 9th month, by intervention zone.

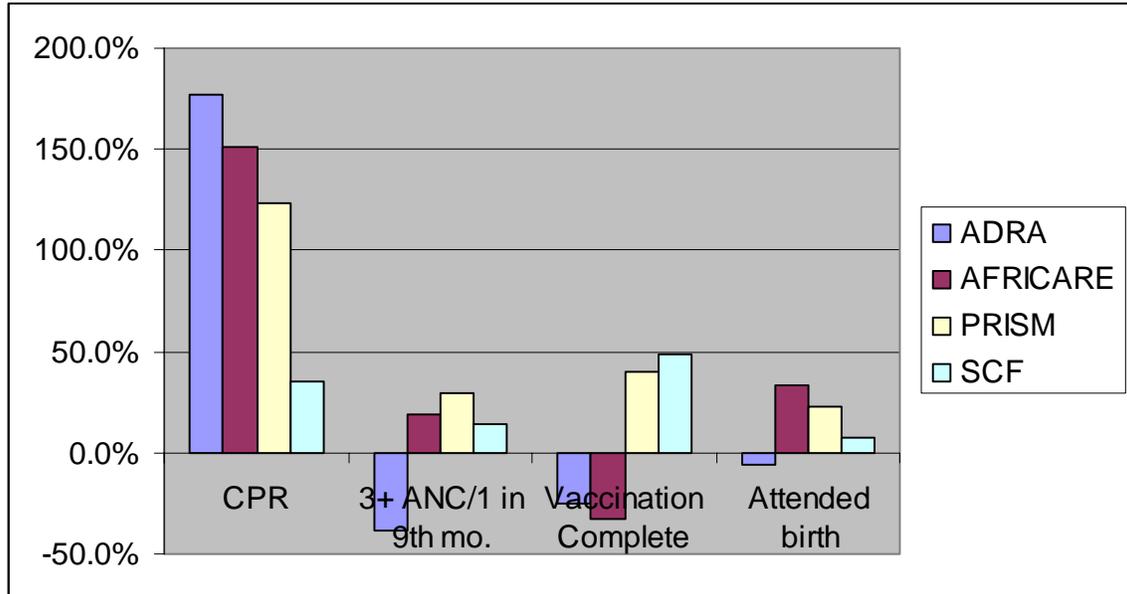
ZONE	2003		2006		% change
	n	%	N	%	
ADRA	167	41.6%	51	25.8%	-38.1%
AFRICARE	97	37.6%	86	44.6%	18.5%
PRISM	690	34.3%	391	44.4%	29.5%
SCF	353	40.7%	250	46.5%	14.2%
TOTAL	1307	36.9%	778	43.0%	16.5%

Another important intervention in the project concerned the training of village midwives and the promotion of assisted deliveries by trained health workers or in health facilities. In this area there appears to have been significant improvement overall. In particular the proportion of women who delivered without the assistance of trained personnel diminished nearly everywhere (except in the ADRA zone). The bulk of the change was due to a shift to home deliveries with trained personnel – rather than to health facilities.

Table 28: Comparison of location of delivery for women delivering within the last 2 years

ZONE	Home delivery without trained assistance			Home delivery with assistance by trained staff			Delivery in a health facility		
	2003	2006	% change	2003	2006	% change	2003	2006	% change
ADRA	29%	31%	6%	32%	29%	-11%	36%	36%	0%
Africare	59%	43%	-28%	12%	40%	244%	24%	13%	-46%
PRISM	41%	23%	-45%	30%	41%	38%	28%	33%	21%
SCF	24%	17%	-29%	45%	48%	8%	30%	33%	8%
TOTAL	35%	24%	-31%	35%	42%	21%	29%	31%	8%

Figure 18: Comparison of change rates for 4 key indicators between 2003 and 2006, by intervention zone.



Taking into account the evolution of all 4 of these indicators by calculating an average change rate, one can note that the zones managed by PRISM and AFRICARE seem in fact to have had the best performance. The ADRA and SCF zones occupy the 3rd and 4th positions (although the difference between them is not statistically significant). Nevertheless, this composite indicator is not very revealing, because there is so much variation between the individual indicators – a fact that renders an average somewhat meaningless as a measurement of central tendency.

Conclusions and Recommendations

The preliminary conclusions were developed during a workshop entitled “Round Table on the Analysis of Data from the PRISM 2006 Survey” held at the PRISM office in Kankan from 18 to 19 October, 2006 (see agenda and list of participants in Annex 1). In group work the participants developed conclusions and prioritized recommendations for each large thematic area of the survey. After the workshop, supplementary analyses proposed during the workshop were done by the PRISM team members. Supplementary conclusions were then added by the team members. The Table 30 below summarizes the priority observations and recommendations by thematic area.

Table 32: Priority Observations and Recommendations for Possible Actions

<i>N°</i>	<i>Observation/Priority Problem</i>	<i>Possible Actions</i>
THEME: Morbidity and Use of Services		
1	Among the frequent causes of illness, fever/malaria is No. 1 (45.10%)	Support the distribution of treated mosquito nets as well as other anti malarial measures : <ul style="list-style-type: none"> - Chemical prophylaxis against malaria - Sanitation - Promotion of targets
2	The prevalence of diarrhea in children has substantially diminished since 2003 (17% compared to 28%), but continues as one of the frequent illnesses during the rainy season. The percentage of children who received ORS packets has not grown significantly (34% compared to 31% in 2003). Problems of ORS supply appear intractable.	<ul style="list-style-type: none"> - Continue awareness raising with mothers on the subject of treatment of diarrhea with ORS - Improve the circuit of ORS production and distribution
3	In general, the population is happy with the quality of services (83%). Nevertheless problems encountered by the minority of patients in the course of consultation are the following: <ul style="list-style-type: none"> - Waiting time - Cost - Medicine 	<ul style="list-style-type: none"> - Contract the health agents - Spread knowledge of the official price list - Order medicines and improve stock management
THEME : Nutrition Awareness		
4	63% of the population surveyed received information and advice on maternal and child feeding during pregnancy as against 47% in 2003,	The situation has improved substantially due to awareness raising activities and social promotion. These strategies should continue.

<i>N°</i>	<i>Observation/Priority Problem</i>	<i>Possible Actions</i>
	therefore the nutrition education coverage has improved substantially.	
5	The subjects of the nutritional component are mainly as follows: <ul style="list-style-type: none"> - Breastfeeding - Food hygiene - Vitamin A 	Reinforce other nutritional messages that are not well-treated now: <ul style="list-style-type: none"> - Preventing Anemia - Importance of iodized salt
6	Despite the close collaboration with Helen Keller International in this project, very few women associate the lack of Vitamin A with problems of blindness (9%)	Reinforce nutritional messages concerning the lack of Vitamin A.
7	Traditional Birth Attendants and Community Agents play a much more important role in the diffusion of nutritional messages in 2006 than in 2003 (51% compared to 19%)	The population recognizes these individuals as important sources of information concerning health. Continue to reinforce this role.
THEME : Family Planning		
8	There still exists a high number of women of reproductive age who are not familiar with any modern method of Family Planning (26%)	Reinforce the awareness raising (through the Community Agents, AV, GPIEC, Radio, etc...) <ul style="list-style-type: none"> Organize discussion groups with flip books and radio
9	The Contraceptive Prevalence Rate (CPR) has almost doubled from 6.8% to 13% in 2006 – this is a remarkable increase in a short space of time that reflects well the expansion of the network of service delivery points (sites and agents) and the increase in the quantity of contraceptives distributed (Couple Years Protection). Nevertheless this rate is relatively low and the efforts must continue if the country is to benefit from birth spacing and population growth reductions.	Continue to improve : <ul style="list-style-type: none"> - The availability of contraceptive products - The quality of service delivery by continuous training of service providers, counseling and awareness raising
THEME : HIV/AIDS		
10	Around 80% of people who maintain commercial extra-conjugal relations report using condoms. Although this figure has greatly improved from that of 2003 (around 53%) research must be done to find a mechanism to reach all groups at high-risk of becoming infected.	Redouble efforts to raise awareness (through various other channels), make condoms available at all levels of the health pyramid, to all of the population and build effective social marketing.

N°	Observation/Priority Problem	Possible Actions
11	The percentage of those who accept any form of contact with individuals living with HIV/SIDA has greatly improved at 23%, as opposed to 7% in 2003. This change took place in the absence of any specific program targeting the stigmatization of people living with HIV/AIDS.	<ul style="list-style-type: none"> - Develop specific IEC material targeting the stigmatization of people living with HIV/AIDS
THEME : Management Committees (CPSC and COGES)		
12	In general, 64% of the population is not aware of the existence of management comités (i.e. : COGES, CPSC, etc..). This situation is worse in the zones where the PRISM project works alone (76%). SCF and ADRA seem to have raise much more awareness in the population on this subject (46% et 58%).	<ul style="list-style-type: none"> - Community Re-mobilization - Organization of free and democratic elections for members of the CPSC - Follow-up contact and reporting to the community by members of the committees - Training of elected members on the function of the CPSC and management of health programs - Monitoring/Evaluation of CPSC activities
THEME : Mutual Health Organizations		
13	Across Upper Guinea only 38% of the population is aware of the existence of mutual health organizations. In the zones supported by SCF and ADRA the percentage is relatively better (56% et 49%). The population's low subscription rate to the mutual health organizations (22%) is probably du to lack of information or unavailability of mutual health organizations in some villages. In villages that do have mutuels, more than two thirds of the population is aware of them.	<ul style="list-style-type: none"> - Stronger emphasis on awareness raising about the function and importance of mutual health organizations - Decentralization of mutual funding bases - Monitoring/Evaluation of the function of the mutual health organization
THEME : Vaccination		
14	The vaccination coverage rate seems to have improved greatly. Taking into account only children from 12 to 24 months with vaccination cards, the percentage of children completely immunized has gone from 51% in 2003 to 78% in 2006. This improvement is consistent for all antigens. There is, as well, a reduction in the default rate for DPT and polio	Continue the good work to maintain this coverage rate. Monitor the functioning of the logistics chain and the cold chain.

N°	Observation/Priority Problem	Possible Actions
	(from 20% to 7%, and from 26% to 9% respectively).	
15	It seems that there has been a slight relaxation of awareness raising activities and informational activities on vaccination (86% in 2006 as opposed to 89% in 2003)	<ul style="list-style-type: none"> - Training/refrechers for health actors (AS, AC, AV, PE, COGES, etc...) in IEC techniques - Supply the health facilities with IEC materials - Reinforcer facilitative supervision Create and motivate an IEC focal point - Stimulate the updating of IEC activities, identify and put in charge a leader from the current pool of agents.
16	There has been a substantial increase in the percentage of children who have immunization cards (74% compared to 66% in 2003), but the number of children without cards is still significant. This makes it harder to control the vaccination status.	<ul style="list-style-type: none"> - Supply Health facilities and Health posts in management tools (health cards, vaccination cards, child health forms) - Intensify the awareness raising of mothers on keeping their children's vaccination cards. - Actively seek out all defaulter cases (see the health facilities and heads of household) - Intensify the awareness raising of vaccinators on the importance of delivery of cards.
THEME : ANC and Childbirth		
17	It seems that there is a stagnation in the coverage rates of pregnant women's complete pre-natal visits (3 ANC of which one occurs in the 9 th month) with 42% in 2003 as opposed to 43% in 2006.	<ul style="list-style-type: none"> - Follow strictly the calendar negotiated with SA - Suplí the Health Centers regularly with VAT according to their target populations - Intensify the awareness raising of pregnant mothers on the importance of three ANC visits and vaccination. - Organize the RA - Supervise the field agents - Supply the Health Centers with logistics equipment - Publicly acknowledge pregnant women who have completed the 9th month visit. - Supply the health centers with medicines

<i>N°</i>	<i>Observation/Priority Problem</i>	<i>Possible Actions</i>
THEME : Health Center Inventory		
18	The variety of services available in all health centers chosen by for the evaluation is somewhat diverse (9 services are available almost everywhere). However, four services are less well established: School Health (76%), Post abortion care (PAC) (52%), HIV/AIDS counseling (16%), cervical cancer care (8%).	- Continue the expansion of these programs in the Health Centers that do not yet offer them.
19	The situation of essential medicine stocks and equipment is not yet well understood.	- Continue training of providers in stock management - Review the logistics chain to identify bottlenecks and seek solutions.
20	Training and refresher coverage of health personnel seems to be good, but one quarter of health centers does not have personnel trained in stock management	Continue the program of refresher training of personnel in stock management, and monitor closely staff transfers to ensure that at least one trained staffer is placed in each health facility.
THEME : Radio Broadcasts		
21	More than two thirds (68%) of households regularly listen to the radio and the broadcasts concerning health are the second most favored subject (after news).	This communication channel should be exploited more for awareness raising.
22	The participation of providers in the radio broadcast series was not adequate. In particular, few providers followed all the episodes.	Consider the options for improving publicity around these broadcasts or incorporate elements of integrated teaching (radio+supervision+ on-the-job training). Establish series with fewer episodes and broadcast them more frequently.