



PRISM

POUR RENFORCER LES INTERVENTIONS EN SANTE
REPRODUCTIVE ET MST/SIDA



MANAGEMENT SCIENCES FOR HEALTH
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END OF PROJECT REPORT

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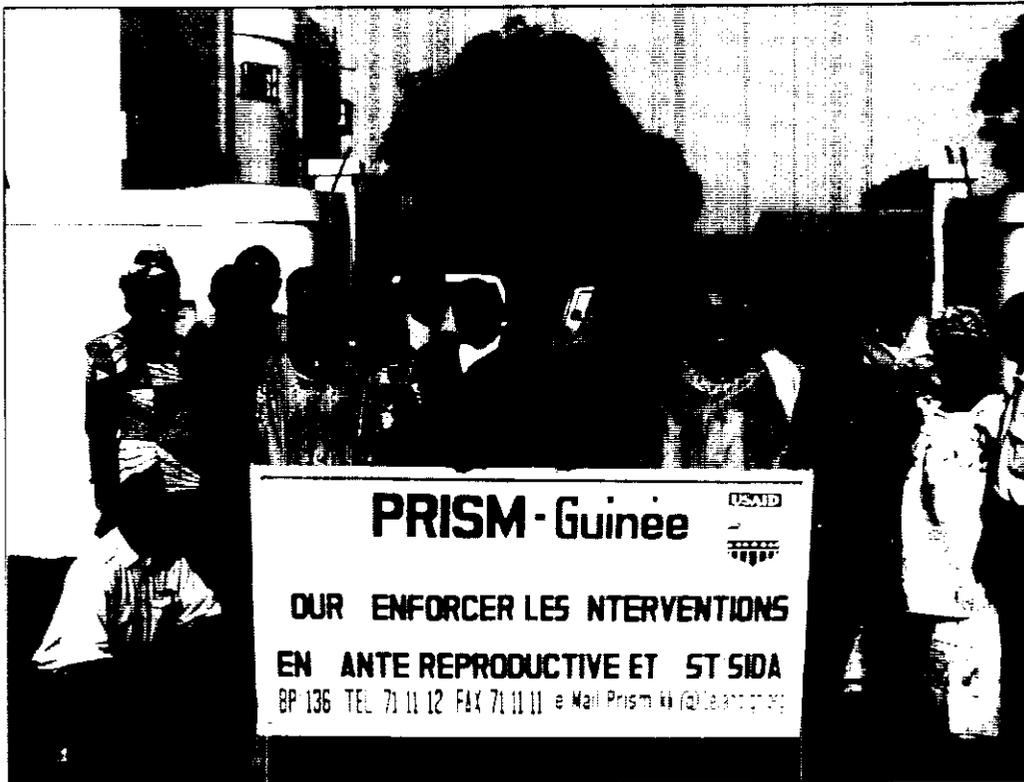
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PRISM End of Project Report



Members of the PRISM team in Kankan in janvier 2002 during the workshop on the finalization of the 2002 annual workplan. Top picture: Support personnel. Bottom picture: Technical personnel.



PRISM End of Project Report



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Acronyms

Acronym		Definition
ENGLISH	FRENCH	
ADRA	ADRA	Adventist Disaster Relief Agency
AGBEF	AGBEF	Association Guinéenne pour le Bien-Être Familial
AIDS	SIDA	Acquired Immune Deficiency Syndrome (Syndrome Immunodéficientaire Acquis)
AMIU	AMIU	Aspiration Manuelle Intra Utérine
AVSC	AVSC	Association for Voluntary Surgical Contraception (now EngenderHealth)
BI	IB	Bamako Initiative (Initiative de Bamako)
CBC	SBC	Community Based Care (Services à Base Communautaires)
CBD	DBC	Community Based Distribution (Distribution à Base Communautaires)
CBS	SBC	Community Based Services (Services à Base Communautaires)
CENAFOD	CENAFOD	Centre National de Formation et de Développement
CERREGUI	CERREGUI	Cellule de Recherche en santé de la Reproduction en Guinée
CNFCS	CNFCS	Centre National de Formation Continue en Santé
CNLS	CNLS	Conseil National de Lutte contre le SIDA
COGES	COGES	HC's Management Committee (Comité de Gestion)
COPE	COPE	Client Oriented Provider Efficient
HC	CS	Health Center (Centre de Santé)
CPN	CPN	Ante natal consultation (Consultation Pré Natale)
CSU	CSU	Urban health center (Centre de Santé Urbain)
CTC	CTC	Technical Coordinating Committee (Comité Technique de Coordination)
CTPS	CTPS	Regional level coordination committee (Comité Technique Préfectoral de la Santé)
CTRS	CTRS	Prefecture level coordination committee (Comité Technique Régional de la Santé)
CYP	CAP	Couple Year of Protection (Couple Année Protection)
DDM	IPD	Data for Decision Making (Information pour la Prise de Décision)
DED	DED	Deutscher - Entwicklungsdienst, German Volunteer Organization
DHP	DivPS	Health Promotion Division (Division Promotion de la Santé)
DMR	DMR	Local initiatives direction (Direction des Micro-Realisations)
DNPL	DNPL	National Direction for Laboratories and Pharmacies (Direction Nationale des Pharmacies et Laboratoires)
DNSP	DNSP	National Direction for Public Health (Direction Nationale de la Santé Publique)
DRS	DRS	Regional Health Direction (Direction Régionale de la Santé - ex IRS)
DPS	DPS	District (Prefecture) Health Direction (Direction Préfectorale de la Santé)
ED&C	ME&C	Essential Drugs and Contraceptives (Médicaments Essentiels et Contraceptifs)
ELCO		Simplified map produced by a community level worker
EMHC	SSME	Essential Maternal Health Care (Soins de Santé Maternels Essentiels)
ERCOSAR	ERCOSAR	Regional RH coordination team (Equipe Régionale de Concertation en SR)
EOP		End of Project date
FP	PF	Family Planning (Planification Familiale)
FS	SF	Facilitative Supervision (Supervision Facilitante)
FY	AF	Fiscal Year (Année Fiscale)
GOG		Government of Guinea
GPIEC	GPIEC	District IEC Working Groups (Groupes Préfectoraux IEC)
GRIEC	GRIEC	Regional IEC Working Groups (Groupes Régionaux IEC)
GTZ	GTZ	German Development Agency
H/MIS	SNIS	Health/Management Information System (Système National d'Information Sanitaire)
HC	CS	Health Center (Centre de Santé)
HG	HG	Haute Guinée
HHC	CSS	Heads of Health Center (Chef de Centre de Santé)

Acronym		Definition
HIV	VIH	Human Immune deficiency Virus (<i>Virus Immunodéficientaire Humain</i>)
HMO	Mutuelles	Health Management Organization (<i>Mutuelles de Santé</i>)
HP	PS	Health Post (<i>Poste de Santé</i>)
ISAD	ISAD	Initiative pour la Santé à Dinguiraye, Afrique
IEC	IEC	Information, Education and Communication
ILO	BIT	International Labor Organization (<i>Bureau International du Travail</i>)
IMAT	IMAT	Inventory Management Assessment Tool (<i>Outil d'Évaluation de la Gestion des Stock</i>)
IMCI	PCIME	Integrated Management of Children's Illnesses (<i>Prise en Charge Intégrée des Maladies de l'Enfant</i>)
IP	PI	Infection Prevention (<i>Prévention des Infections</i>)
IPC/C	CIP/C	Interpersonal Communication/Counseling (<i>Communication Interpersonnelle et Counseling</i>)
IR	RI	Intermediate Result (<i>Résultat Intermédiaire</i>)
ISMI	ISMI	Projet d'Initiative pour la Santé Maternelle à Dabola, Afrique
IUD	DIU	Intra Uterine Device (<i>Dispositif Intra-Utérin</i>)
JHU/CCP	JHU/CCP	Johns Hopkins University, Center for Communication Programs
JHU/JPIEGO	JHU/JPIEGO	Johns Hopkins University, JPIEGO Corporation
KFW	KFW	German Development Bank
MCH	SMI	Maternal and Child Health (<i>Santé Maternelle et Infantile</i>)
M&L	M&L	Management and Leadership Program
MOH	MSP	Ministry of Health (<i>Ministère de la Santé Publique</i>)
MSH	MSH	Management Sciences for Health
MURIGA	MURIGA	Health Mutual focused on pregnant women (<i>Mutuelle de santé consacrée à la référence des femmes lors des accouchements</i>)
NGO	ONG	Non Governmental Organization (<i>Organisation Non Gouvernementale</i>)
N&P	N&P	Norms and Procedures (<i>Normes et Procédures</i>)
ORS	SRO	Oral Rehydration Solution (<i>Sels de Rehydratation Oraux</i>)
PAC	SAA	Post Abortion Care (<i>Soins Après Avortement</i>)
PCG	PCG	Pharmacie Centrale de Guinée
PEV/SSP/ME	PEV/SSP/ME	Primary Health Care System (<i>Prog. Élargie de Vaccination Soins de Santé Primaire Médicaments Essentiels</i>)
PMA	PMA	Paquet Minimum d'Activités
PNMSR	PNMSR	National Program for Safe Motherhood (<i>Programme National de Maternité sans Risques</i>)
PPSG	PPSG	Projet Population et Santé Génésique
RH	SR	Reproductive Health (<i>Santé de la Reproduction</i>)
SBC	SBC	Community Based Distribution (<i>Services à Base Communautaire</i>)
SDP	PPS	Service Delivery Point (<i>Point de Prestation de Services</i>)
SIDA3	SIDA3	Projet de Lutte contre le Sida en Afrique de l'Ouest (2 ^{ème} phase), ACDI/CIDA
SO	OS	Strategic Objective (<i>Objectif Stratégique</i>)
SG	SG	General Secretary (<i>Secrétaire Général</i>)
STEP	STEP	NGO/ONG Stratégies et Techniques contre l'Exclusion sociale et la Pauvreté
STI	IST	Sexually Transmitted Infection (<i>Infection Sexuellement Transmissibles</i>)
TA	AT	Technical Assistant (<i>Assistance Technique</i>)
TB	TB	Tuberculosis (<i>Tuberculose</i>)
TBA	AT	Traditional Birth Attendant (<i>Accoucheuse Traditionnelle</i>)
UN	ONU	United Nations Organization (<i>Organisation des Nations Unies</i>)
UNFPA	FNUAP	United Nations Funds for Population Assistance (<i>Fonds des Nations Unies pour la Population</i>)
USAID	USAID	United States Agency for International Development (<i>Agence Américaine pour le Développement Internationale</i>)

Executive Summary

In November of 1997, Management Sciences for Health (MSH) was awarded the USAID funded "Guinea Family Planning and Health Activity" (FPH) to assist the Government of the West African Republic of Guinea (GOG) in its efforts to improve the health of Guinean families. Known as PRISM (*Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA*)¹, the \$15 million, five year project was implemented by a partnership between MSH and Johns Hopkins University Center for Communications Programs (JHU/CCP). The geographical focus area was the rural administrative regions of Kankan, Faranah and N'Zérékoré. These regions cover 15 of Guinea's 38 health districts and serve a combined population of 3.2 million or 40% of Guinea's total population of 8 million. After the first project year, security considerations stemming from instability in neighboring Liberia and Sierra Leone forced PRISM to reduce its scope and exclude the region of N'Zérékoré and the Kissidougou "prefecture" (district) of Faranah.

This end-of-project report focuses on the interventions that have been conducted in the eight districts that constitute Guinea's natural region of Upper Guinea where a total of 1.6 million people reside. Of these, 289,000 are children under the age of five and 400,000 women between the ages of 15 and 49.

USAID's Health and Family Planning Strategic Objective (SO) under which PRISM operated was: **Increased use of essential FP, MCH, and STI/HIV/AIDS prevention services and practices.**

The four Intermediate Results (IR) associated with this SO are as follows.

- Increased access to FP, MCH, and STI/HIV/AIDS services and products
- Improved quality of FP, MCH, and STI/HIV/AIDS services and products
- Increased behavior change and demand for FP, MCH, and STI/HIV/AIDS prevention services, products and practices
- Effective response among donors, government, community organizations, nongovernmental organizations, and private sector in addressing critical health systems constraints

PRISM has sought to create a positive impact on the quality of life of the Guinean population by, on the one hand, strengthening Guinea's decentralized health care system and service delivery capacity primarily at the district and regional levels, and, on the other hand, building community capacity to participate in health service management and support, thus creating an environment that stimulates demand and favors the use of services. The central vision was to create fully functioning health centers, supported by strong management and community systems.

¹ "to strengthen interventions for reproductive health (RH) and for sexually transmitted infections (STI); Human Immune Deficiency Virus infection (HIV)/ Acquired Immune Deficiency Syndrome (AIDS)"

Using an integrated and systems wide approach, PRISM's primary strategies included support the MOH at each level of the system to:

- **Decentralize** the health program, shifting the responsibility for decision-making to the operational level and focusing the central level on general oversight and the development of policies and national norms and protocols.
- **Streamline & Improve management support systems** to increase efficiency
- **Improve the technical and administrative capacity** of service providers at health centers, maternities and in communities.
- **Stimulate local cost-recovery** systems to ensure sustainability
- **Foster community participation** in managing their local health centers and services to create a feeling of greater ownership and improve equity and fairness in the system.

By addressing these areas, PRISM sought to increase the supply of quality primary health care services and generate more demand for these services. The underlying assumption was that demand and supply would lead to use of basic health services,² which, in turn would result in better community and family health.

The integrated systems approach was implemented by a technical assistance team of international and local experts, who were based at the operational level, namely in the regions themselves. Working side by side with communities, district and regional authorities, while providing limited support to the national MOH, PRISM's systems strengthening and capacity building efforts resulted in improved services, which led to accelerated and steady health improvements.

By the end of 2002, the contraceptive prevalence rate in PRISM's target area was 12.2%. In 1999, the DHS showed this figure to be 2.9% compared to 4.9% nationally. The significant increase in Upper Guinea stems from a more than 3 fold increase in the number of women who began using modern FP and a more than 4 fold increase in the number of women who continued using FP. The results are consistent with now universal access to FP services (by the end of the project, 100% of HC in HG were integrated in FP and all HC had well functioning Community Based Agents networks), improved quality of FP services (71% of FP services were in full compliance with national Norms & Standards) and increased awareness and demand for FP services, in large part due to improved community support for FP (e.g. 96% of religious leaders are actively advocating FP compared to 43% at project start up; 66% of men and 70% of women approve of FP compared to, respectively, 47% and 58% at the start of the project).

Increased access, improved quality and increased demand for services are also at the core of marked improvements in other indicators. The degree by which the quality of services for child survival, maternal health, prenatal care, FP, HIV/AIDS prevention and

² This includes services for: family planning, pre-, peri- and post-natal care, safe motherhood, child survival/IMCI, sexually transmitted infections, HIV/AIDS

STI care, comply with national standards has improved a great deal and has exceeded project targets. In addition, vaccination coverage for BCG in children aged 12-23 months had risen to 88% (compared to 61% in 1999, and 75% nationally). The rate for DTC3 was 46% (exceeding the national level, and an increase in Haute Guinea from 24% in 1997) and for measles, it was 61% (compared to 24% in 1997). These marked improvements are also related to the Child-for-Child (*Enfant pour Enfant*) approach, a strategy involving teachers and older children to "watch over" their younger siblings in order to ensure they get vaccinated. Nevertheless, the number of children under age 2 years who were completely vaccinated remained low at 30% (comparable to the local and national rate in 1999).

The use of oral rehydration solutions for diarrhea in children under 5 years of age was far better in Haute Guinea (54% compared to 35% in 1999) than elsewhere in the country (40%). Likewise, children in Haute Guinea were more often breast fed within an hour after birth (43% in 2002 compared to 30% in 1999) than the national average (26%). Among other factors, this reflects the increase in the number of births that were assisted by a trained health provider, which rose from 48% in 1999 to 56% in 2002. During that same period, the percentage of births that took place in a health structure rose from 17% to 36%. This indicator is consistent with increasing number of pregnant women (81%) who have at least one prenatal consultation and the proportion who have had at least 3 prenatal consultations during their pregnancy (57% in 2002 versus 41% in 1997).

Finally, in the face of the burgeoning HIV/AIDS epidemic, PRISM's efforts in HIV/AIDS and STI prevention and care have resulted in 72% of youth knowing that condom use can help in avoiding HIV infection. In addition, all HC in Haute Guinea are integrated in STI/HIV prevention services, and half of them (53%) now offer STI care (syndromic management). This latter service was not available at any health center in Haute Guinea at project start up.

Nevertheless, these gains, while real and significant, are still fragile and require further consolidation to create sustainability. PRISM's efforts to involve communities in health financing and management, through HMO's and COGES participation, will fall apart without continued external support, even though, with PRISM's help, the fees for services have been updated and are now widely known.

In addition, the "Achilles heel" of service use continues to be the availability of essential drugs at the local level. By the end of the project, only 54% of health centers in Haute Guinea had a sufficient stock of essential drugs (the target was 75%). Though this figure is up from 22% in 1999, it is still much too low. The improvement is likely due to PRISM's intense efforts to standardize drug and commodity management into the one official system and to build the capacity at all levels (HC, district, regional and national depots) to manage essential drugs and commodity stocks. The lesson is that a sole reliance on the public sector for the provision of essential drugs is insufficient and partnerships with the private sector should be established.

Partnerships have also proven critical in PRISM's overall success. PRISM not only leveraged cost sharing (8.2% of the project was financed with other sources than those provided by USAID) but has coordinated efforts with other NGOs, donors, MOH, as well as regional and district authorities at all stages of its implementation. These partnerships have contributed greatly to PRISM's success, allowing results that exceeded PRISM's already ambitious objectives.

Probably the most unique and special value that PRISM has added to Guinea includes its integrated approach, *improving the health system at each level*, ranging from the community, to the district, region and national level; *improving coordination between the levels*, establishing stronger linkages and supports; and *strengthening all management and support systems* within each level (rather than singling out one area). In doing so, PRISM always sought to build local capacity to implement and sustain improvements. The combination of a systems wide approach and local capacity building is at the heart of sustainable programs and services.

Introduction

In November of 1997, Management Sciences for Health (MSH) was awarded the USAID funded "Guinea Family Planning and Health Activity" (FPH) to assist the Government of the West African Republic of Guinea (GOG) in its efforts to improve the health of Guinean families. Known as PRISM (*Pour Renforcer les Interventions en Sante Reproductive et MST/SIDA*), the \$15 million, five year project was a partnership between MSH and Johns Hopkins University Center for Communications Programs (JHU/CCP)

Due to the poor quality of services and dire health conditions in the eastern regions of the country, USAID requested that interventions be focused in the three administrative regions of Kankan, Faranah and N'Zérékoré. These regions cover 15 of Guinea's 38 health districts and serve a combined population of 3.2 million or 40% of Guinea's total population of 8 million. Security considerations early in the project stemming from instability in neighboring Liberia and Sierra Leone forced PRISM to reduce its scope to exclude the region of N'Zérékoré and the Kissidougou "prefecture" (district) of Faranah. This report will focus on the interventions that have been conducted primarily in the eight districts that constitute Guinea's natural region of Upper Guinea, or "Haute-Guinée" (HG), where a total of 1.6 million people reside.

USAID's Health and Family Planning Strategic Objective (SO) is: **Increased use of essential FP, MCH, and STI/HIV/AIDS prevention services and practices.**

The four Intermediate Results (IR) associated with this SO are as follows:

- Increased access to FP, MCH and STI/HIV/AIDS services and products
- Improve quality of FP, MCH and STI/HIV/AIDS services and products
- Increase behavior change and demand for FP, MCH and STI/HIV/AIDS prevention services, products and practices
- Improve coordination for a more effective response among donors, government, community organizations, nongovernmental organizations, and private sector in addressing critical health systems constraints

While working through these four IRs, the PRISM project has sought to create a positive impact on the quality of life of the Guinean population by creating sustainable decentralized health care systems which focus primarily on the district and regional levels. However, several national level interventions were conducted in support of the decentralization process.

PRISM's approach has been to consolidate the activities of numerous partners into a series of coordinated interventions in support of the MOH's attempts to address the development of a fully functional decentralized health care system. This strategic approach is founded upon the MSH model of the Fully Functioning Service Delivery Point (FFSDP). The preliminary success of this approach has led USAID to award MSH (in continued partnership with JHU/CCP) an uncompleted 33 month contract to

consolidate the results of the original PRISM contract, which expired at the end of December 2002.

Throughout the life of the project, PRISM has strived to support the MOH in the creation of reliable information systems to objectively measure project impact and changes in the health status of the population. This final report will draw upon data derived as a result of project activities to provide a summary of the major achievements and strategic approaches undertaken by PRISM during its five year life span. Following the introductory section, which will describe the context of the project, each of the four project's IRs will be addressed individually. The sections describing IR1 and IR2 will detail the processes whereby training, evaluation, and systems building resulted in real improvements in service delivery. The section on IR3 will describe how quality was promoted and the demand for the FFSDPs was not only generated but transformed into real behavior changes among clients and in communities. Finally, the section on IR4 describes how partnerships were a critical part of PRISM's strategy to achieving impact. Indeed, teamwork through partnership with both local and international organizations is one of the cornerstones of PRISM's success for it created a shared vision and shared ownership, as well as a pooling of financial, human and other resources that result in much greater impact than can otherwise be expected from projects of this size. Detailed information from PRISM's monitoring and evaluation (M&E) system will provide evidence of the project's results and impact. The report will then describe the conclusions and lessons learned which were derived from the project implementation.

As noted above, the PRISM project has a stated objective of collaboration with all agencies and projects working for the improvement of the health status of the Guinean population. While this report will outline improvements in the health care system in HG during the project's implementation period, it is important to note that no single agency deserves unique credit for these changes. There have been a large number of partners working in HG over the past five years and attributing results is an arduous and potentially contentious process. PRISM fully recognizes the value of the contributions from all partners during the project implementation period. A more detailed examination of the collaborative process is provided in the section on IR4.

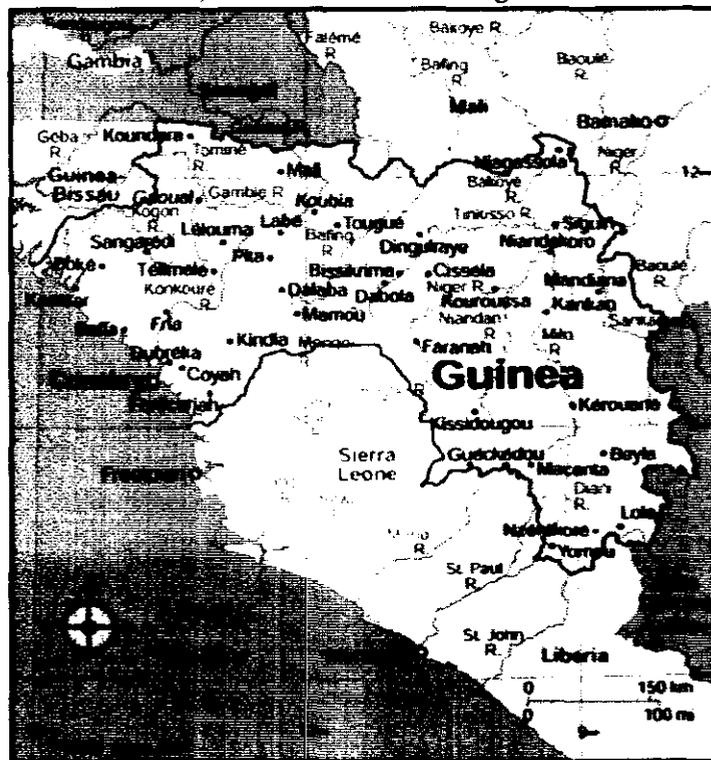
Context and Background

Geography: The Republic of Guinea has a total area of 245,857 sq km, which is slightly smaller than the U.S. state of Oregon. It has a coastline of 320 km on the Atlantic Ocean and is bordered by Guinea-Bissau, Senegal, Mali, Côte d'Ivoire, Liberia, and Sierra Leone. The country consists of four major geographic areas: a humid coastal plain, a hilly to mountainous central region (the Fouta Njalou), a savanna region in the northeast (the upper Niger River basin) and a forest area in the southeast. Guinea's altitude ranges from sea level in the coastal plain (which includes the capital Conakry) to 1,752 meters at the summit of Mount Nimba in the Forest Region. The Niger River and its important tributary the Milo have their sources in the Guinean highlands. Only about 3.5% of its land is arable and only 950 sq km are irrigated. The climate is hot and humid on the coast and grows dryer toward the sahelian area in the eastern part of the country. Guinea has a monsoonal-type rainy season (June to November) with southwesterly winds and a dry season (December to May) with northeasterly harmattan winds. The dusty harmattan and human activities have led to considerable deforestation in the southeast and desertification in the north. The population has inadequate supplies of potable water and the country suffers from soil contamination, erosion and overfishing.

Administratively, the country is divided into eight regions that directly correspond to the health regions. The regions are subdivided into 38 prefectures or districts according to the overall population, with an average of approximately 230,000 people per district. The terms prefecture and district will be used interchangeably throughout this report.

Population: Guinea has a rapidly growing population of 8 million people, with about 70% living in rural areas (see Table 1). The population is young, with approximately 44% under the age of 15 years and 18% under the age of five³. Less than 3% of the population is over 65 years of age and life expectancy at birth is only 54 years. There are slightly more females than males (0.096 males: 1 female)

³ According to the MOH 2000 (the most recent) *Annuaire Statistique* which refers to the 1996 census and the 1999 DHS



The population growth rate is estimated at 2.6% with a total fertility rate of 5.5 children per woman. Estimates of infant mortality range from 95 to 127 deaths per 1,000 live births. Under-five mortality is estimated to be about 177 per 1,000, with 98 per 1,000 for infants under the age of one. Maternal mortality is among the highest in the world at 528 per 100,000 births.

Population density is still low but growing rapidly, with approximately 29 people per square kilometer. High fertility rates and a large influx of refugees from the civil wars and unrest in neighboring Liberia, Sierra Leone and Cote D'Ivoire are placing an increasing strain on the environment, especially in the Forest Region in the east.

The prominent ethnic groups are Peuhl (40%), Malinke (30%) and Soussou (20%). The final 10% is comprised of numerous groups, each with its own language. Although the official language is French, the country has eight national languages: Mandinka (also known as Mandingo and Malinke), Susu, Fulfulde, Kissi, Basari, Loma, Koniagi, and Kpelle. Approximately 85% of the population is Muslim and 5% Christian, with the remainder following local religions. Barely one third of the population is literate, with rates falling to about 22% for women.

Additional information is provided in Table 1 below.

Table 1: Socio-demographic and health indicators for Guinea, 1992-2005 compared with Sub-Saharan Africa

Indicator	2005*	1999	1992	1999 Sub-Saharan Africa
Population (in millions)	9	7.6	4.7	628
Population Density/km ²	36.6	30.9	19	25
% <15 years	44	46	46.9	43
% 15-49 years	45	43	39.7	42
% > 49 years	11	11	13.4	15
% 15-49 year old women	46.2	44.6	-	43
% Female	51	51	51.5	51
% Urban	36.7	31.6	26	33
GNP/capita		540	510	480
TFR	5.2	5.5	5.7	5.3
CPR		4.9	1.5	22
MMR		528	666	1100
IMR	89.9	98	153.1	91
CMR	163.5	177	252.1	144
Women (25-49 years old): Median Age at:				
1 st sex	-	16.0	15.6	-
1 st marriage	-	15.8	15.8	-
1 st birth	-	18.8	18.7	-
HIV prevalence	-	2.1	-	8.6
% Enrolled in primary school	-	51	37	77

Indicator	2005*	1999	1992	1999 Sub-Saharan Africa
Median Birth Spacing (months)	-	-	35.0	-

Sources: DHS 1992, DHS 1999, Guinea MOH *Annuaire Statistique* 2000, World Bank Development Indicators, World Development Report 1994, State of World's Children 2003

* Projections made by the MOH, *Groupe Thématique de la Santé de la Reproduction*, March 1999

Economy: Despite large mineral reserves of gold, diamonds, uranium and bauxite, Guinea remains among the poorest countries in the world. Once ranked last in the UNDP's Human Development Index (HDI, 1996), it has a current ranking of 167th (out of 174 countries). Although the majority Guineans are subsistence farmers and/or pastoralists, a substantial number are also employed by the potentially lucrative mining sector, which accounted for about 75% of exports in 1999 and about 34% of GDP overall. Agriculture, which employs 80% of the population, only accounts for 24% of the total GDP, while the figures for services and manufacturing are 38% and 4% respectively.

Despite significant hydropower potential, only 16% of Guinean households have electricity according to the 1999 DHS survey. This figure actually represented a net decrease from the 26% recorded in the 1992 survey. Only 52% of households have access to potable water, while 37% have no toilet, including pit latrine.

Guinea's external debt for 2001 was \$2.9 billion, while GDP was estimated at \$3 billion. Real growth rate of GDP was 3.3% in 2001, with an inflation rate of about 6%. However population growth rates have kept pace with GDP growth, leaving a per capita GDP growth rate of only 0.1% for the year 2000.

Escalating fighting along the Sierra Leonean and Liberian borders has caused major economic disruptions. Between September 2000 and March 2001, the civil unrest had resulted in the death of over 1,500 Guinean civilians and military personnel. Even today, the borders with Liberia and Sierra Leone remain mostly sealed. In addition to direct defense costs, the violence has led to a sharp decline in investor confidence. However, Guinea has been able to maintain peace within its own borders and has functioned as a stabilizing force in the West Africa region. The country is being assisted by multilateral donors including Heavily Indebted Poor Countries (HIPC) debt relief to counteract inflation and maintain regional stability and peace.

Recent health reforms: With support from the international community, including USAID, the Guinean government has embarked on major health reforms. In 1989, Guinea became one of the first countries to adopt the Bamako Initiative (BI), placing decentralization, local cost-recovery and community participation at the heart of Guinea's health policy. At that time, the Government of Guinea also began formulating its first population policy recognizing that population and family planning issues were intricately linked with high rates of maternal and child mortality. With help from international donors and technical assistance (TA) agencies, the government began constructing health centers throughout the rural areas and improved health services by providing essential

drugs and commodities as well as medical training to service providers. Subtle, encouraging changes in the health of Guinea's population were noted. The total fertility rate dropped from 5.84 in 1983 to 5.67 in 1992, vaccination coverage among children less than 12 months increased, the child mortality rate dropped by 26% from 185 to 136 per 1000, and the infant mortality rate declined by 30% from 153 to 108 per 1000⁴

These trends continued steadily in the years that followed. Yet, progress was extremely slow and mortality, especially among children and mothers, remained among the highest in the world. The downward trends in fertility and mortality masked disturbing disparities and shortcomings.

By 1997, life expectancy at birth remained well below 50 years for the country as a whole and was much lower in rural areas. Guinea's infrastructure remained unreliable. Shortages in basic medical equipment, transportation problems, lack of electricity and running water in most health centers, and inefficient and tardy drug logistics continued to plague the health system. The Ministry of Health (MOH), through its system of regional hospitals, local health centers and community health posts, theoretically provided health care to the entire population. In actuality, only about 25% of the population was using the public health facilities. Guinea's spending on health represented 6.4% of the government budget yet the average household was spending close to 20% on health care – most of it in the informal sector – and an additional 50% on food. The Contraceptive Prevalence Rate (CPR) was only 1.7% for modern methods in 1997 and the maternal and infant mortality rates in Guinea remained among the highest in Africa. PRISM's target zone of Upper Guinea had the worst health indicators in the country, which prompted USAID to focus its efforts in that region.

Health Indicators: Today, Guinea's health indicators remain among the worst in the world, and HG is far below the national average for most essential indicators. The following table, which was extracted from the 1999 DHS, shows the comparison between HG and the rest of the country.

Table 2: Selected Indicators for Guinea and Upper Guinea

Indicator	Guinea	Upper Guinea
Primary school attendance	60.6	38.1
Assisted deliveries	74.7	58.6
VAT 2	59.4	43.1
Home births	69.5	82.9
Measles vaccine	52.1	41.8
Completely vaccinated	32.2	30.0
DTP/Polio 3	46.2	40.2
Malnourished under 5	23.2	24.4
Neonatal mortality	51.6	61.8
Infant mortality	106.6	128.5
Under 5 mortality	195.1	221.9

⁴ DHS 1992

Indicator	Guinea	Upper Guinea
Women having knowledge of condoms	65.3	50.1
Fertility rate	5.5	6.9
Adolescent fertility	37.2	46.2
Women having knowledge of a modern method of contraception	69.1	58.2
Children with diarrhea in previous 2 weeks	21.2	20.2

Neonatal, infant and under five mortality rates are alarming high for the country as a whole and particularly so for HG (61.8, 128.5 and 221.9 respectively). Not surprisingly, vaccination rates in HG are lower than the national average. Measles vaccination coverage is only 41.8% for HG compared to 52.1% for all regions combined. Rates of malnutrition in HG are only slightly higher than the rates for the country as a whole, which is unacceptably high at 23.2%.

Although several variables were not segregated by region, the DHS 1999 depicts a much more serious situation for women in HG than the rest of Guinea. Fertility rates were substantially higher at 6.9 for HG compared to 5.5 for the country. Of those women giving birth, 82.9% in HG delivered at home, compared to a national average of 69.5%. Statistics for the entire country showed that 74.7% of births were assisted, while only 58.6% for HG. Only 43.1% of the women in HG received VAT2 or more, compared to a national average of 59.4%. This is not surprising when one looks at primary school education levels. Only 26.2% of females in HG attend primary school. This is less than the national average of 47.7%. More than 50% of women give birth before the age of 19 and 54% are in polygamous relationships. The median age of marriage is only 16.4 years for girls and 98.6% have been subjected to some form of genital excision.

Health system: The organizational chart for the central level Ministry of Health is presented in Annex 1. The process of decentralization and rapid expansion of the number of service delivery points has created numerous challenges for the departments and programs at the central level. Roles and responsibilities have not evolved in pace with the changing demands and old patterns of behavior continue to persist. PRISM has developed a leadership capacity strengthening program to help the MOH senior staff effectively address these challenges (see IR4).

Despite continued problems with the process of decentralization, the regional and district level have been granted greater authority in planning and decision making. The organizational chart for the regions and districts in PRISM's target zone is presented in Annex 2. Assisting the planning process at these levels has been a primary focus for the project. The general procedure can be summarized as follows: planning for the health system is conducted on a semi-annual basis through a highly defined formal process called "*monitorage*", with the health centers and hospitals serving as the primary planning unit. Once the "*monitorage*" of each site is completed, key personnel attend semi-annual meetings in the district headquarters to review data, discuss problems and set plans for the next period. These meetings are referred to in this report as the CTPS, which is the French acronym for *Comité Technique Préfectoral de la Santé*. The Plans are then

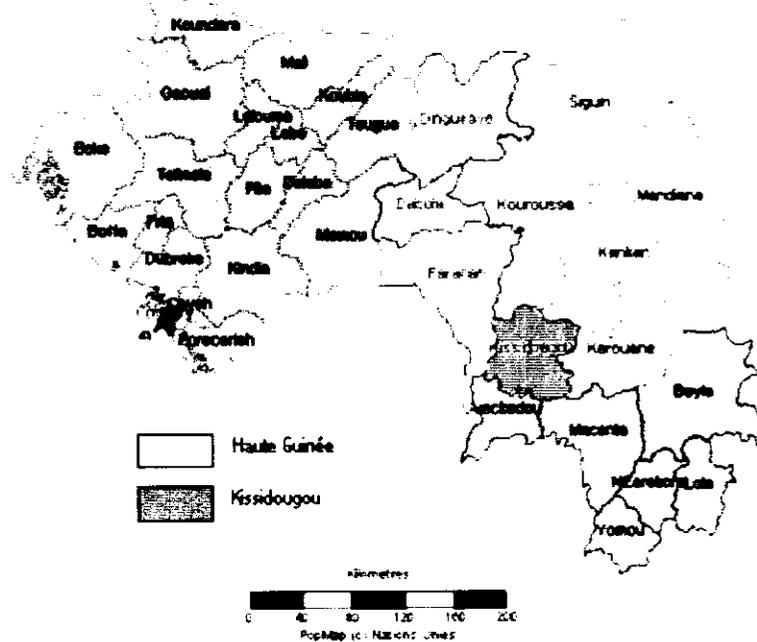
brought to the regional planning meeting for finalization, which is referred to as the CTRS (*Comité Technique Régional de la Santé*). The results and plans from each region are presented and validated at the national level semi-annual meeting called CTC (*Comité Technique de Coordination*). In addition to this, the regional and district health authorities meet annually with key MOH personnel from the central level and representatives from development agencies and projects to review results and issues from the previous year and plan future interventions. This meeting, held during the first quarter of the year, is referred to as the "*Revue Annuelle du Système de Soins de Santé Primaire*" PRISM and numerous other partners in health attend these meetings in order to assure that all activities are incorporated into the MOH workplans for the year. PRISM has been supporting and facilitating the conduct of many of those coordination meetings in the course of its regular technical assistance delivery.

In summary, between the mid-1980's and the mid-1990's, the population of Guinea had almost doubled. Despite declining mortality and fertility rates, the gains in health were at best fragile. The expanding primary health care system, while serving a larger proportion of the population than in the 1980's, was functioning through multiple vertical systems and programs. Lines of authority were often confused and funding was sporadic and insufficient. Many districts functioned only because of the presence of international agencies on the ground. The numerous parallel systems made planning, monitoring and sound decision making difficult. This complex web of problems created deficiencies in all areas of health care, from the availability of essential drugs and medical supplies to service provision and the evaluation of performance and progress. Quality of services, especially at the health center level, declined markedly. It was clear that Guinea had, in fact, failed to effectively operationalize its progressive decentralization policy and translate it into improved health for the population. The MOH realized that its health reforms would not result in improved, much less sustained, health unless the capacity of the public health system itself and of the communities it served were developed so that they themselves would be able to implement the integrated approach prescribed by the Bamako Initiative.

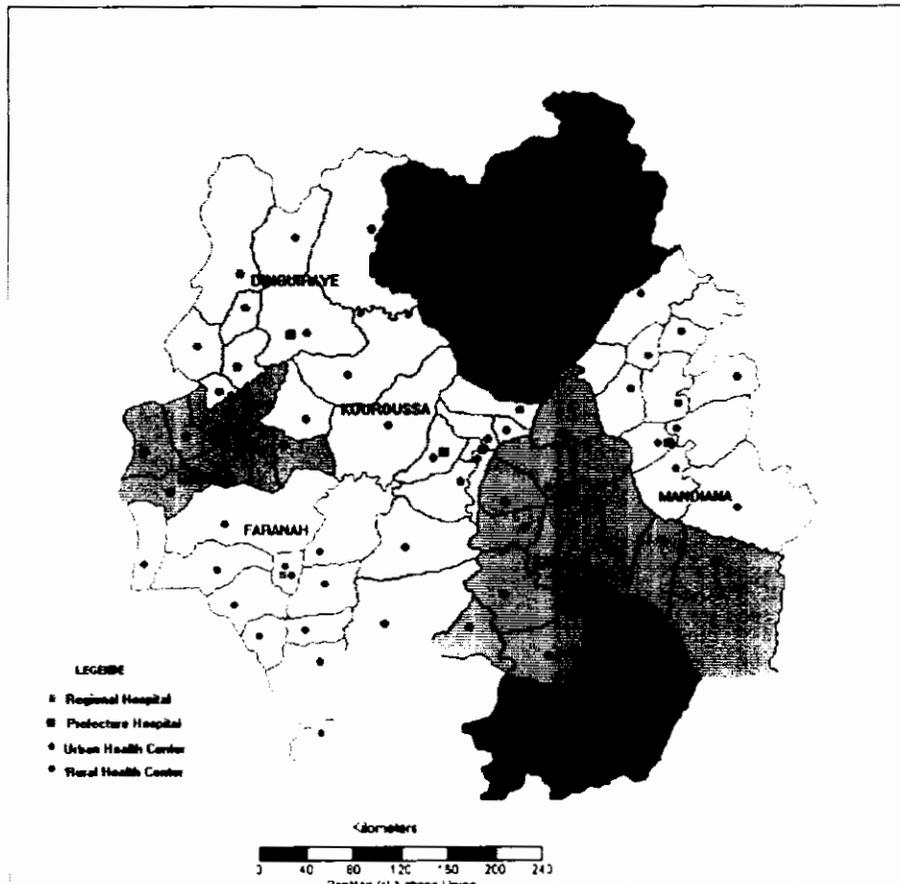
In 1997, this recognition led to USAID's call for specialized TA in strengthening health systems, including community participation. Since January 1998, the MSH/JHU team represented by the PRISM project, has been privileged to be the GoG's and USAID/Guinea's key partner in creating sustainable increases in the use of health services through systems strengthening, local capacity building and fostering community ownership of local health services. This report will underscore the aptness and timeliness of the technical direction that USAID opted for in 1997 by highlighting how it ultimately led to better than anticipated improvements in health today.

Project Strategic Design

As mentioned above, security concerns in some of the original project districts reduced the target zone to the eight districts in the natural region of Haute Guinée (in yellow in the following map). This included the entire administrative region of Kankan and its five districts and three out of four districts in the region of Faranah.



This area which will be referred to as PRISM's target zone, includes 99 health posts, 89 health centers, two regional hospitals and six district hospitals. The next map present the location of service delivery points in the project target zone.



Regions & Prefectures	Health Centers	Health Posts	Prefecture Hospitals	Regional Hospital
RA Faranah	29	22	2	1
Dabola	9	6	1	
Dinguiraye	8	9	1	
Faranah	12	7		1
RA Kankan	60	77	4	1
Kankan	16	30		1
Kerouane	8	6	1	
Kouroussa	11	14	1	
Mandiana	11	11	1	
Siguir	14	16	1	
TOTAL	89	99	6	2

The target population for this focus zone is estimated to be about 1.6 million people, with 289,000 children under the age of five and 400,000 women between the ages of 15 and 49.

PRISM's strategic point of emphasis in the health structure was the 89 health centers and the district and regional directorates that supervise them. Using an integrated and

systems wide approach, PRISM also focused on the communities served by these health centers and the hospitals to which they made referrals. Planning and implementation of activities was conducted in close collaboration with the two regional health directorate teams and the health district directorates they supervised.

Strategic Approach

PRISM's strategic approach was to improve quality and build the capacity of the MOH, with a primary focus on the regional and district level, in order to:

- **Decentralize** the health program by shifting the responsibility for decision-making to the operational level and focusing the central level on general oversight and the development of policies and national norms and protocols
- **Streamline & Improve management support systems** to increase efficiency
- **Improve the technical and administrative capacity** of service providers at health centers, maternities and in communities
- **Stimulate local cost-recovery** systems to ensure sustainability
- **Foster community participation** in managing their local health centers and services to create a feeling of greater ownership and improve equity and fairness in the system

By addressing these areas, PRISM sought to stimulate the supply of quality primary health care services as well as the demand for these services. Improved supply and enhanced demand would result in increased use of these services, while improved service quality would ensure sustainability through continued use. The underlying assumption was that greater use of quality basic health services⁵ would result in better community and family health.

Implementation Strategies

PRISM's implementation strategies focused on developing sustainable systems and were constructed around the previously mentioned IRs. They included interventions to

- **Increased access to FP, MCH and STI/HIV/AIDS services (IR1)**
 - Increase availability of services:
 - Develop a minimum basic package of services
 - Integrate FP, MCH and STI/AIDS services at Health Centers and hospitals
 - Provide basic medical equipment, IEC materials and management tools
 - Strengthen essential drug & contraceptive management
 - Bring services closer to the community by developing networks of CBD agents and TBAs

⁵ This includes services for: family planning, pre-, peri- and post-natal care, safe motherhood, child survival/IMCI, sexually transmitted infections, HIV/AIDS

- Improve affordability of services
 - Promote equitable access to services
 - Strengthen community awareness and ownership
 - Assure compliance with standardized pricing
 - Develop local insurance schemes
 - Improve efficiency of cost recovery systems
- **Improve quality of FP, MCH and STI/HIV/AIDS services (IR2)**
 - Improve quality standards
 - Develop and disseminate RH norms & procedures
 - Strengthen quality improvement support systems
 - In-service training for
 - Family Planning (FP)
 - Emergency Maternal Health Care (EMHC)
 - Safe Motherhood (SM)
 - Child Survival (CS) /Integrated Management of Childhood Illnesses (IMCI)
 - Prevention and treatment of Sexually transmitted infections (STI) and HIV/AIDS
 - Strengthen H/MIS
 - Update Indicators & data collection tools
 - Build capacity in using data for decision making
 - Improve capacity to conduct rapid surveys
- **Increase behavior change and demand for FP, MCH and STI/HIV/AIDS prevention services, products and practices (IR3):**
 - Improve coordination of IEC programs
 - Develop IEC strategy and protocols for action planning
 - Develop IEC working groups
 - Strengthen client-provider interaction
 - Adapt / Reproduce existing IEC materials
 - Produce new IEC materials
 - Train providers in counseling
 - Conduct health promotion interactions
 - IEC campaigns
 - Advocacy
 - Community Mobilization
 - Small grants to NGOs
 - Child to child
 - Peer educators
 - Community based distributors (CBD agents)
 - Improve IEC management and delivery capacity
 - Train IEC managers
- **Improve coordination among partners (IR4):**

- Strengthen MOH capacity to coordinate
- Participate and sponsor coordination activities and processes
- Create new mechanisms for coordination at decentralized level and at institutional level
- Improve coordination within the system through management training

Conceptual Framework

Underlying PRISM's approach to creating a sustainable decentralized PHC system in Guinea was MSH's model of a Fully Functional Service Delivery Point (FFSDP - see Figure 1). By starting with a clear idea of a service delivery point that could fulfill a community's needs for basic health care, the project was able to work backwards through the health care system to identify obstacles to the adequate functioning of that point of contact with the client. Many of these obstacles were identified at the SDP itself. However, numerous other issues were identified at other levels of the health care system, including the community, which needed to be rectified in order for the SDP to function at a satisfactory level of performance. The project's strategies were developed to remove obstacles at each level of the health care system and in the community to enable clients throughout the region to receive the services they deserve.

The fully functional service delivery point is defined to mean that at each point of contact between the client and service provider, the health care worker is able to provide quality services appropriate to his/her level and the client is able to demand and recognize quality services. The SDP can be defined as any recognized point of contact ranging from a hospital or health center to a health worker in the community. For the PRISM project, a health service delivery point was considered fully functional when it had all of the following essential resources:

- A pre-established number of providers who were fully trained and supported in delivering the basic package of services (including prevention, curative or referral services for maternal and child health, family planning, and STI/HIV/AIDS)
- Sufficient supplies of essential drugs, including contraceptives
- Basic medical equipment and supplies, as well as IEC materials and management tools
- Adequate infrastructure to perform the services
- Clients who want the services and who are able to access and use them at affordable rates

This last point is an important one because even the best service cannot be fully functional unless the community it serves perceives it as responding effectively to their health needs. For this reason, PRISM aimed at improving both the availability of quality public health services *and* the community's understanding of their value and relevance to enable demand to emerge and grow. To achieve this, PRISM invested heavily in the management and leadership systems that are needed to enable providers to offer quality

services. The Management and Leadership (M&L) framework used by PRISM was designed by the Management and Leadership project, a USAID centrally funded project being implemented by MSH. Their activities in Guinea provided additional resources and were integrated into the PRISM project to promote project objectives. The Management & Leadership framework used by PRISM is presented in Figure 2

A service delivery point was considered fully functional when it had the adequate infrastructure, at least one qualified provider available for each concerned services and 80% of essential material resources, and delivered services with compliance rates with the *prescribed norms and standards* of 60% and more. The project developed a detailed, yet simple evaluation approach, which became part of the formal supervisory system, to measure improvements in functionality. Training was a combination of adult education methods and on-the-job “learning by doing” while being coached by an expert trainer.

Figure 1: Fully Functional Service Delivery Point Framework

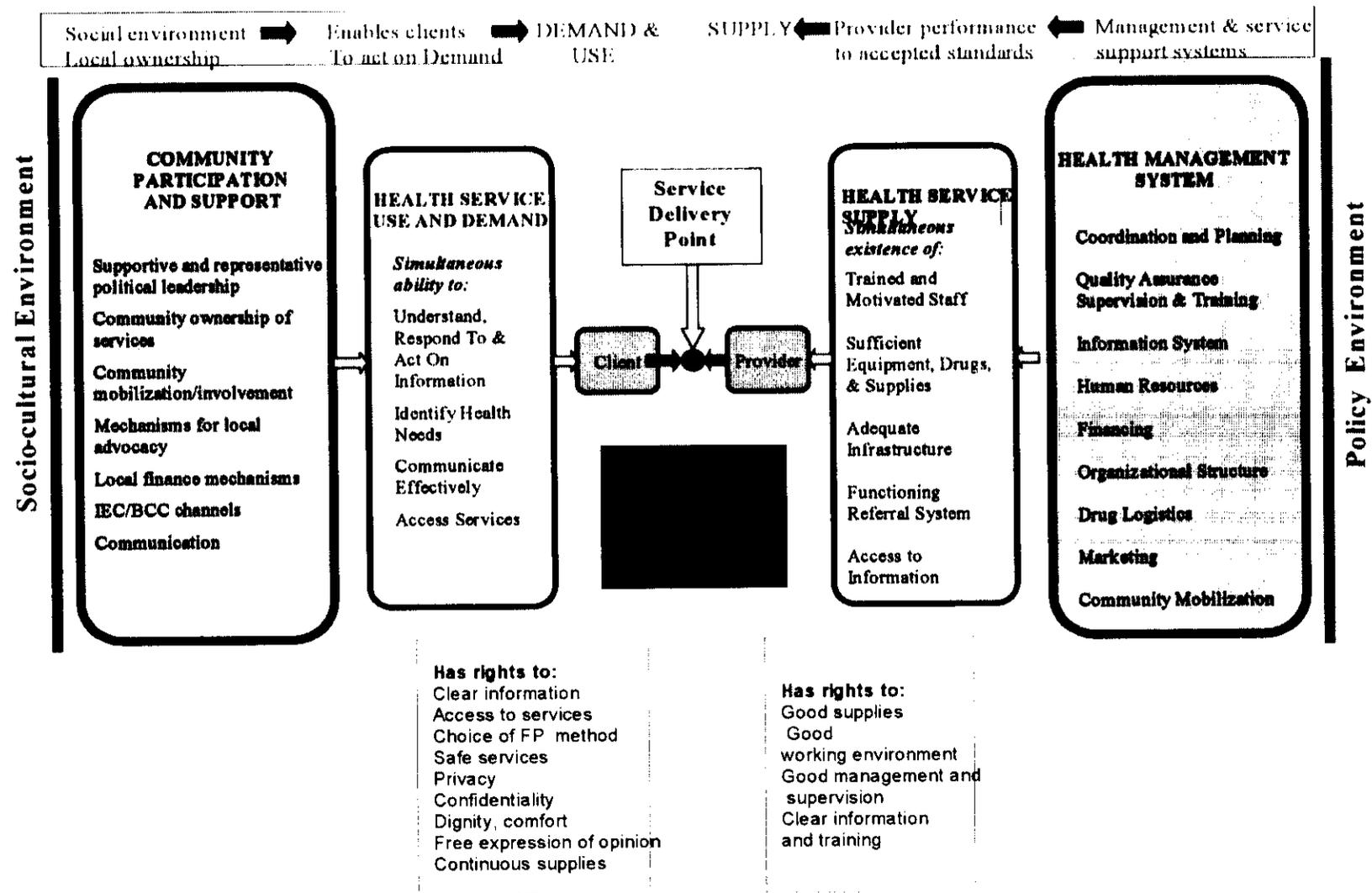


Figure 2:

Framework for building national and regional management & leadership to support local delivery of high impact services

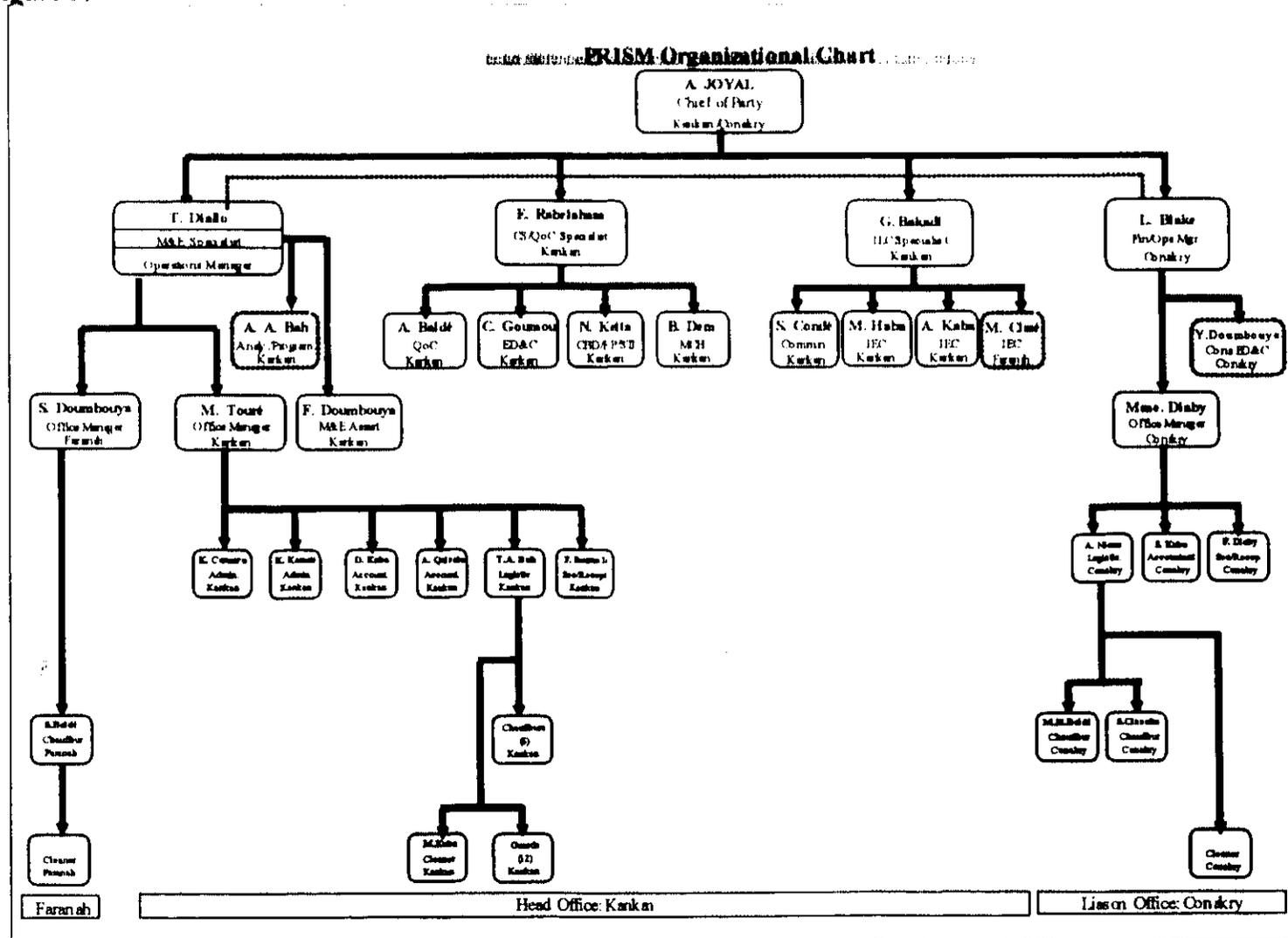
(Adapted from MSH/Management & Leadership Framework, *The Manager* 2002)

Leading and managing: enabling organizations to achieve sustainable results in a complex and ever-changing environment	
LEADING Helping to bring new realities into being	MANAGING Ensuring effective operation within a given reality
<p>SCANNING</p> <ul style="list-style-type: none"> • What are the challenges you are faced with? What do you know (and what more do you need to know) about these challenges? <p>FOCUSING</p> <ul style="list-style-type: none"> • What are the most important challenges now? What is the goal? What are the strategies? What is/are the most important thing(s) to focus on? <p>ALIGNING/ MOBILIZING</p> <ul style="list-style-type: none"> • Whose support do you need? How can you mobilize them as well as other necessary resources? <p>INSPIRING</p> <ul style="list-style-type: none"> • How do you get and keep people engaged? How can you keep people's spirits up when there are obstacles or setbacks? 	<p>PLANNING</p> <ul style="list-style-type: none"> • In the short run, what are your objectives, what activities do you need to undertake, and how much will that cost? <p>ORGANIZING</p> <ul style="list-style-type: none"> • How can you organize the work and the necessary resources so that the plan can be implemented? <p>IMPLEMENTING</p> <ul style="list-style-type: none"> • How can you make sure that the work gets done correctly and within the allotted time and budget? <p>MONITORING & EVALUATING</p> <ul style="list-style-type: none"> • How do you make sure the objectives are met, the desired results produced? How do you learn from experience? How do these learnings inform further work?

Operational Structure

PRISM's operational structure was originally designed to work side by side with regional health authorities in Kankan, N'Zérékoré and Faranah. The project Chief of Party (COP) and senior technical staff were to be based in these regional capitals. However, over the course of the first year, the project's central office was moved from Kankan to Conakry to allow for an initial phase of building central support for regional activities and for strengthening coordination between the regional and central health authorities. By the end of the project's 3rd year, the Conakry office had been reduced and the COP and senior technical staff were relocated to Kankan for the duration of the project. The office in N'Zérékoré was closed and the Faranah office was downsized to one technical and two support staff due to the previously mentioned insecurity in the Forest Region. Figure 3 represents PRISM's organizational chart for the final two years of the project.

Figure 3:



Monitoring and Evaluation System

Monitoring and evaluation is a key element of a successful project. Objectively verifiable indicators developed by the PRISM project have allowed progress to be followed, documented and communicated to USAID and the MOH on a quarterly and annual basis. The documentation of project results has been instrumental in identifying areas of strengths and weaknesses and providing evidence for program design. This has helped the project provide the MOH with clear evidence to evaluate the probability for success of replicating specific project initiatives in other regions of the country and also has helped in the development of clear and feasible standards of practice.

Project indicators reflect USAID's specific indicators for each IR as well as additional indicators developed uniquely for the PRISM project. All project indicators have been reviewed annually and revised where needed in collaboration with USAID/Guinea. This report is based on the data and information collected throughout the first phase of the PRISM project, from January 1998 to December 2002. The data are derived from a variety of tools that PRISM used to monitor and evaluate its progress towards results and its impact. They included:

- Baseline surveys in 1998 (rapid assessment, service statistics and a review of existing research and data)
- Training data base, established in 1998 and used throughout the project
- Equipment data base, established in 1998 and used throughout the project
- Service statistics from health centers, districts, and regions, especially to allow calculation of CYP, on a quarterly basis, throughout the project
- Supervision reports and checklists
- Project mid-term internal evaluation in March 2000
- Project mid-term external evaluation by USAID in February 2001
- Demographic Health Survey results from EDS-III (1999)
- Facilities survey in HG by the Measure Project (January-February 2001)
- Performance indicators (semi-annually) defined and finalized in 1999
- Operations research
- Pre- and post-campaign evaluations (3 campaigns: targeting youth in 1999; men in 2001; and MCH in 2002-3)
- Annual workplans
- End-of-Project household survey in September 2002

All of these data collection instruments were elaborated with the assistance of MOH personnel, and data collection was also a collaborative process with the MOH. The system was designed and implemented in a manner that provided training for MOH staff in the use of data to improve health systems at all levels.

Table 3.a:

Evolution of Performance Indicators

PRISM USAID Grant # 624-A-00-97-00077-00

List of Resulting Indicators corresponding to the R4 Indicators List

Performance Indicators	# PRISM	# R4-USAID	Status at Inception Nov-97	Status as of the end of					Target EOP Dec-02
				FY98	FY99	FY00	FY01	FY02 EOP	
IR 1: Access									
Percentage of health centers (Centre de Santé) having posted user fees for RH Services (including deliveries)	1.1	2.1.2	N/A	N/A	N/A	18% ⁽¹⁾	51%	100%	75%
Percentage of health centers (Centre de Santé) integrated in FP and STI/AIDS prevention services (i.e. having personnel trained in FP and STI/AIDS prevention)	1.2	2.1.3	55%	72%	89%	96%	96%	100%	95%
Percentage of health centers (CS) integrated in syndromic management of STI cases (i.e. having personnel trained in syndromic management of STI)	1.3		0%	0%	0%	9%	22%	53%	60%
Percentage of integrated health centers (CS) that are functional in syndromic management of STI	1.4		N/A	N/A	N/A	N/A	9%	59%	75%
Percentage of health centers (CS) functional at delivering FP and	1.5		N/A	N/A	N/A	N/A	65%	60%	75%

Performance Indicators	# PRISM	# R4-USAID	Status at Inception Nov-97	Status as of the end of					Target EOP Dec-02
				FY98	FY99	FY00	FY01	FY02 EOP	
STI/AIDS prevention services									
Percentage of health centers (CS) functional at delivering prenatal services	1.6		N/A	N/A	N/A	N/A	44%	34%	75%
Percentage of health centers (CS) functional at delivering Child Survival services	1.7		N/A	N/A	N/A	N/A	22%	49%	75%
Number of functional CBD agents in priority prefectures (Faranah, Kankan, Kerouane, Kouroussa and Siguiri)	1.8		N/A	N/A	N/A	115/134 86%	279/316 88%	239/267 90%	75%
In other prefectures			N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percentage of functional traditional birth attendants	1.9		N/A	N/A	N/A	N/A	0/120 0%	39/120 33%	75%
IR 2: Quality									
Percentage of pre-natal service consultations for which the compliance rate with N&P is equal or superior to 60%	2.1	Treatment Counseling Combined	N/A	N/A	N/A	12% ⁽¹⁾ 11% 6%	83% 46% 43%	88% 61% 59%	50% 50% 35%
Percentage of STI service consultations for which compliance rate with N&P is equal or superior to 60%	2.2	Treatment Counseling Combined	N/A	N/A	N/A	28% ⁽¹⁾ 15% 15%	66% 32% 28%	65% 56% 47%	50% 50% 40%
Percentage of CS service consultations for which compliance rate with N&P is equal or superior to 60%	2.3	Treatment Counseling Combined	N/A	N/A	N/A	11% ⁽¹⁾ 11% 8%	37% 50% 27%	72% 73% 62%	50% 50% 35%
Percentage of FP service consultations for which compliance rate with N&P is equal or superior to 60%	2.4	2.2.2	N/A	N/A	N/A	0% ⁽¹⁾	63%	71%	35%
Proportion of CS with essential drug stockouts lower than 10% during the	2.5	2.2.3	N/A	N/A	N/A	N/Disp	55%	54%	75%

Performance Indicators	# PRISM	# R4-USAID	Status at Inception Nov-97	Status as of the end of					Target EOP Dec-02
				FY98	FY99	FY00	FY01	FY02 EOP	
last 3 months									
IR 3: Demand									
CYP	3.1	2.2	4,227	4,468	5,886	6,701	7,084	8,812	10,000
Percentage of births that benefited from at least 3 ante-natal visits	3.2	2.4	41%	N/Disp	44% ⁽²⁾	N/Disp.	49%	57% ⁽⁴⁾	50%
Number of community and religious leaders oriented in FP and STI/AIDS prevention	3.3	2.3.5	0	0	125	250	682	922	650
Immunization coverage rate for DTP/Polio 3	3.4	2.3.2	30.4 ⁽³⁾	N/A	40.2 ⁽²⁾	N/A	N/A	45.8 ⁽⁴⁾	51%
Immunization coverage rate for measles	3.5	2.3	24.0 ⁽³⁾	N/A	41.8 ⁽²⁾	N/A	N/A	61.6 ⁽⁴⁾	56%
Rate of increase for the proportion of young people ages 15-24 who know that condoms that can be used to prevent STI/AIDS	3.6	2.3.6	N/A	N/A	N/A	N/A	N/A	Absolute rates 72% 48%	Rate of increase 50%
IR 4: Coordination									
Percentage of project spending covered by other sources of funding (cost sharing obligation)	4.1	2.4.1	0%	N/Disp	N/Disp.	3.7%	5.0%	8.2%	6.5
Percentage of health districts (DPS) carrying out supervision activities according to the norms	4.2		N/A	N/A	N/A	N/A	88%	100%	100%

⁽¹⁾ According to Measures situational analysis carried out in January 2001

⁽²⁾ ENDS 1999

⁽³⁾ ENDS 1992

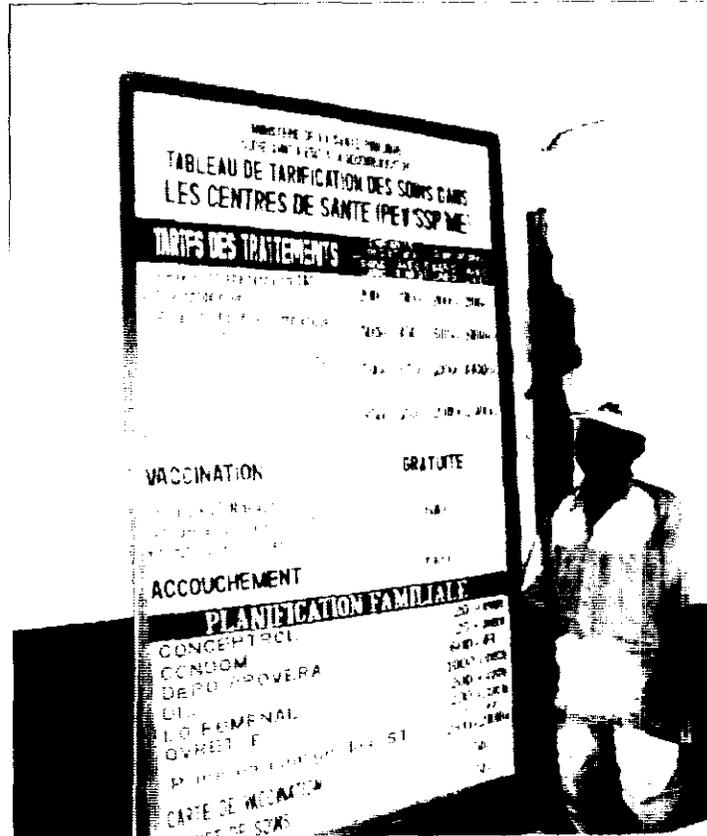
⁽⁴⁾ Enquête ménage PRISM 2002

Table 3.b.: PRISM Household Survey 2002 – Results for Main Indicators

	2002	2002	HOUSEHOLD SURVEY 2002
Ante Natal Care (ANC) Delivery			
1. Percentage of women aged 15-49, mothers of children less than 24 months (less than 60 months for the DHS), who have had at least one ante natal checkup (ANC) during their last pregnancy (3 ANC or more is unfortunately not available in the DHS report)	71	56	81
2. Percentage of women aged 15-49, mothers of children less than 24 months (less than 60 months for the DHS), whose last birth took place in a health facility	29.0	16.8	35.7
2. Percentage of women aged 15-49, mothers of children less than 24 months (less than 60 months for the DHS), whose last birth was attended by a trained person (traditional birth attendant or health personnel)	54.8	48.0	56.1
Vaccination			
1. Percentage of children aged 12-23 months who have received BCG	75.8	61.6	88.3
2. Percentage of children aged 12-23 months who have received DTP 3	46.2	40.2	45.8
3. Percentage of children aged 12-23 months who have received measles vaccination	52.1	41.8	61.6
4. Percentage of children aged 12-23 months who have received all vaccinations	32.2	30.0	30.1
Diarrhea			
1. Percentage of children under 5 years old who had diarrhea in the last two weeks	21.2	20.2	28.6
2. Percentage of children under 5 years old who had diarrhea in the last two weeks and who were brought to a health facility	36.0	27.1	36.5
3. Percentage of children under 5 years old who had diarrhea in the last two weeks and who received packets of ORS	39.9	35.4	53.8
Breastfeeding			
1. Percentage of children less than 24 months (less than 60 months for the DHS) who were breastfed immediately or within an hour of their birth	26.0	29.7	42.8
2. Percentage of children aged 7-23 months who were exclusively breastfed for their first six months	9	Not avail.	10.3
Contraception			
1. Percentage of women aged 15-49 (married women in HG for the DHS) who are not pregnant and are using a modern method of contraceptive	4.9	2.9	12.2
2. Percentage of women aged 15-49 who are not using contraception but are intending to use it in the future	36.3	Not avail.	56.3

WORK TOWARD THE INTERMEDIATE RESULTS (IR)

IR1: Increase ACCESS



Access to reproductive health services depends on (1) the degree to which essential resources are simultaneously available at service delivery points, as well as (2) to the degree to which these services are made affordable to all people. PRISM's strategies for this IR included:

Availability of essential resources at SDPs:

1. Assistance in defining and disseminating the minimum package of integrated services (MPA) of the primary health care system at all levels (including community level);
2. Ensure the integration of FP, MCH and STI/AIDS services at SDPs (fixed sites like HCs and hospitals as well as at the community level via CBD agents and TBAs);
3. Provision of basic reproductive health Medical, IEC and Management material to health centers and to hospitals;
4. Strengthen the management of the Essential Drugs & Contraceptive logistics system at all levels.

Affordability of services at SDPs:

5. Promote equitable access to RH services;
6. Strengthen community ownership, via community level management committees (CoGes), Health Mutual type organizations promotion and support to improve cost-recovery and HCs sustainability.

IR1: Increase Access for Basic Health Services

With 14.2 inhabitants per square km, Haute Guinea has the lowest population density of any region in Guinea and is less than half the national average. This low density creates problems of access to health services for the majority of the rural population. Although specific data are not available for HG, the 1999 DHS reported that the median distance for a rural woman in Guinea to travel to receive FP services was 6.1 km. When one considers the poor transportation system, lack of disposable income and oppressive climate of Guinea, this is a considerable obstacle to seeking health care. Given the low population density in rural HG, it is safe to speculate that the distance is even greater for this region. Equivalent national figures for prenatal care, obstetric care and vaccination services for children are 4.1, 4.5 and 4.6 km respectively.

It must be noted, however, that access to services is restricted by more than just geography. Frequently, access is also limited by the lack of supplies or trained personnel at the closest facility. It can also be restricted by costs that exceed the ability of the population to pay for services they need. PRISM has addressed all of these issues of access during the past five years. Geographic access has been bridged by bringing essential basic services closer to the community through CBD agents, TBAs and peer educators, among others. The availability of services has been addressed through a process defined as "integration". This involves equipping SDPs with minimal drugs and supplies and training relevant staff to a certain minimum standard. The issue of the cost of services has been confronted in several manners, including the promotion of health mutuals at the community level and the promotion and training of local management committees (known as *Comités de Gestion* or COGES).

This section will describe the strategic approach and specific activities used by PRISM to address the crucial issues of access to basic health care services. Although quality standards were observed and promoted during all of the described activities, specific issues related to quality will be addressed in detail in the section on IR2.

The following list provides a summary of activities used to improve the **availability** and **affordability** of services for *each level* of the Guinean health system. These activities will be recounted in greater detail in the following two sub-sections, which will describe activities at all levels of the system according to their focus on either availability or affordability.

At the **community** level, PRISM has expanded access to services by:

- Expanding and strengthening a network of CBD agents
- Promoting the use of TBAs and strengthening their technical capacity
- Increasing the range of services offered by CBD agents
- Promoting and supporting the creation and development of community-based HMOs and MURIGAs to remove economic barriers to health services, especially emergency referrals and transportation for child birth

- Revitalizing community health committees (COGES) to foster community participation and leadership in the management of the health center, and thus ensuring that services respond to real community needs, including the most vulnerable
- Building networks of youth peer educators, safe motherhood promoters, business based IEC educators, religious leaders and others to mobilize and educate their communities about health care and prevention, as well as the communities' rights to health services.

At the level of the **health center**, PRISM increased access to services by:

- Training or re-training providers so HCs are capable of offering the complete range of basic health services
- Integrating basic health services in HCs that were not yet able to offer them (FP and STI care)
- Providing basic medical equipment needed to perform essential services
- Improving the management of:
 - Drug and commodity supplies to reduce stock outs of essential drugs
 - Medical equipment and material essential to service delivery
 - IEC materials to ensure the presence of sufficient tools for education and inter-personal communication between clients and providers
 - Management tools to help providers plan for adequate coverage
- Clearly displaying fee schedules to ensure that clients are aware of official costs for all services and providers adhere to the official rates

At the **DPS and DRS** level, support to increased access was ensured by:

- Training hospital providers at maternal and pediatric divisions so they are capable of providing adequate health services, especially complicated cases and referrals
- Providing hospitals with basic medical equipment, IEC material and management tools needed for RH services
- Enhancing sustainable capacity to produce management tools for service delivery points
- Establishing regional buffer stocks for cold chain spare parts
- Improving the management of drug and commodity supplies at the regional and district warehouses
- Included IEC/BCC interventions in campaigns (see IR3) to educate the target population regarding the availability of new or improved health services

At the **central MOH**, PRISM assisted the MOH to formulate and/or update policies, norms and protocols by:

- Developing and distributing a Basic Package of Primary Health Services, specifying what services must be provided for each level of the health care system
- Standardizing the national drug and commodity management system to eliminate parallel structures

- Strengthening the Central Pharmacy or “*Pharmacie Centrale de la Guinée* (PCG)” in pharmaceutical management to ensure adequate drug supplies at the central level and efficient distribution to regional depots
- Integrating contraceptives into the list of essential drugs
- *Advocating for new or alternative models to implement cost-recovery and COGES*
- Introducing cost recovery on sales of contraceptives, as opposed to the previous policy of free distribution
- Identifying and sharing lessons learned, and integrating them into policy revisions.

Availability of Essential Resources

The absence of essential resources is a key problem in many African countries. However, simple provision of needed resources is at best a short-term response. In order to promote a sustainable solution, many PRISM activities focused on improving systems and institutional capacity within the MOH to identify and resolve problems related to the availability of resources at the point of contact with the client. An important early step was to create consensus around the types of services that should be offered at each level of the health system.

1.1 Basic Package of Activities

When the PRISM project began operations in 1998, Guinea had not yet formally defined the basic package of health services to be delivered by the primary health care system at each of its levels. Without such definition, standardization of services throughout the country was clearly impossible. This affected nearly every aspect of health care delivery from the development of training and CBC materials to the monitoring and evaluation of services at all levels. The absence of such a fundamental policy directive, coupled with weak coordination and integration of partners' inputs, posed a threat to the rational and cohesive development of the national health system. PRISM therefore directed early technical and financial resources to the process of defining a basic package of activities for the primary health care system, resulting in the adoption by the MOH in September 2000 of the “*Paquet Minimum d'Activités pour les Soins de Santé Primaire – Horizon 2005*” (Minimum Package of Activities for Primary Health Care through 2005).

This *Paquet Minimum d'Activités* (PMA) was distributed at the regional health coordination meetings (CTRS) of January 2001 as an integral part of the documentation kit on the National Health System Development Plan, which is Guinea's main strategic document for primary health care implementation. PRISM assisted in disseminating the PMA to the regions of Kankan, Faranah and N'Zérékoré and had been instrumental in mobilizing other TA partners to help the MOH disseminate the PMA in the other regions of the country.

In its target regions, PRISM also disseminated the PMA during the health district coordination meetings (CTPS) of January 2002, thus ensuring that all the Heads of HCs as well as the hospitals' senior staff had access to the document. In 2004, the MOH is planning to update the "PMA - Horizon 2010", and PRISM II will again offer assistance to this effort.

1.2 Integration of RH Services in HCs

At project start-up, fewer than 50% of the 89 HCs in PRISM's target zone were offering FP or STI prevention services, and virtually none provided STI care services. Expanding availability of these services was, therefore, one of PRISM's highest immediate priorities. In collaboration and coordination with the DRS, AGBEF and other TA agencies working in the regions, PRISM embarked on a systematic effort to make quality RH services available throughout the region. By December 2002, all 89 HCs in Upper Guinea were offering FP and STI prevention services, 47 of which were also providing STI care (see Table 4).

Table 4: HC integrated in FP & STI Prevention Services, and in STI care services (%)

Before PRISM inception		45		0
1998	50	72	NIP	NIP
1999	75	92	NIP	NIP
2000	95	95	NIP	9
2001	95	96	35	25
2002	100	100	60	53

NIP = Not in PRISM package of performance indicators at that time

1.2.1 Integration of FP and STI/AIDS prevention services

As shown in the table above, the MOH had already integrated FP and STI prevention services in 49 of the 89 HC in Haute Guinée by the end of 1997. Throughout 1998, PRISM expanded this effort. The primary objective was to train a minimum of two service providers per health center and their respective supervisors at the DPS and DRS in counselling and provision of family planning and STI prevention services and to provide these health centers with a start-up kit including contraceptives, IEC materials, condoms for STI prevention and basic medical equipment. These were the basic criteria that defined an integrated health center.

By the third project year, 95% of all HCs in PRISM's target area were integrated. By the end of PRISM's initial mandate in December 2002, family planning and STI prevention services were available at all 89 HCs and at the 8 hospitals in HG. As new HCs were integrated, PRISM helped the DRS and DPS to inform the population of these services and to promote their use through large-scale campaigns, advocacy by community and religious leaders, and local community events (see IR3).

Despite the success in creating a high prevalence of FP and STI/AIDS preventive services by the end of the project, PRISM personnel realized the dynamic nature of staffing patterns in the health system. It is inevitable that some trained staff will leave the system through retirement, death, transfer or other reasons. In order to maintain a sustainable system, the responsible MOH supervisory staff needed to be trained to identify deficiencies as they arise and then to subsequently train appropriate staff to assure continuity of services. To this end, PRISM supported the DRS by (1) introducing an inventory tool for use by the DRS and DPS to monitor the availability of human resources and thus rationally manage their distribution and deployment at the HC⁶; and (2) training new staff at integrated HCs that have fewer than two trained. To date, PRISM has trained 29 new providers from 27 integrated HCs in order to maintain the availability of FP services.

As defined above, a HC is considered to be integrated in a defined service when it offers that particular service and has met basic criteria, defined in the PMA, relating to the quality of that service. Once a HC is integrated, the initial criteria that were established for its integration must be maintained to be functional. For example, in the case of trained staff as mentioned above, a HC could have been integrated after two staff members were trained. However, if one or both of those staff members left the HC, it would no longer be considered functional even though it is integrated.

The concept of functionality is related to the quality of service provided. Functionality is, however, an indicator of access, not quality. The criteria for functionality pertain to the availability of minimum resources at the SDP so that the service is accessible to the population. Indicators of quality are discussed under IR2. Although the project considers many aspects of quality, the indicators focus primarily on the technical (clinical) quality of the service provided. In other words, for the SDPs that are functional, how did the service provider actually perform the specific techniques required for a successful intervention? The criteria for quality in this case have been established by the MOH and are delineated in the national norms and procedures document.

1.2.2 Integration of STI care services

PRISM anticipated integrating STI care services in 54 of Upper Guinea's 89 HC during the course of the project. The goal was to train two service providers per HC and

⁶ "Fiche d'Inventaire: Disponibilité des Services et Equipement"

their supervisors at the DPS and DRS in the syndromic treatment of STIs and in counseling STI patients. These health centers would receive free start-up kits including a six-month supply of antibiotics, relevant IEC materials, and basic medical equipment

In accordance with MOH policy, training of providers in STI care was initiated only when drugs were available at the SDP. Anti-STI drugs were generally procured by the PEV/SSP/ME through the World Bank PPSG project and the European Union debt-relief special funds. Unfortunately, the PEV (EPI) encountered numerous delays and difficulties in obtaining and then releasing these drugs for free start-up kits. Despite this major constraint, PRISM was eventually able to procure the necessary drugs and supplies from GTZ and the Canadian project Sida3, and still managed to integrate STI care services in 47 of the 89 HCs (53%). A total of 92 providers were trained in the syndromic management of STIs, including six from integrated sites that had lost a previously trained provider. At the end of the project, all 47 HCs (100%) where personnel had been trained were still actively providing this service.

The high level of performance of the HCs integrated in STI care services is largely related to the supervision that they receive. When integrating STI care in HC, PRISM also ensured that supervisors from the DPS, DRS and referral hospitals were adequately trained not only in syndromic management of STIs, but also in post-training monitoring and on-the-job training techniques to continuously improve the capacity of the providers to transform their training into action. In collaboration with Sida3, a Canadian project specializing in syndromic management of STIs, PRISM supported the teams to conduct supervision at the newly integrated HCs.

As STI care services became available, PRISM also organized promotional activities to inform the population of the new services (see IR3). These activities were conducted in all the communities served by 43 of the 47 integrated HCs. STI care promotional activities will be conducted under PRISM II at the remaining four sites, as this intervention is also an integral part of the project's scope of work.

1.2.3 Community based services (CBD/SBC)

The CBD program was among PRISM's most important interventions to improve access to RH services for the rural population of HG. However, the initiative had already begun before the project got under way and PRISM's role evolved into one of revising and expanding a program that was clearly faltering in its early stages.

Historical Overview: The first CBD agents in Guinea were trained in 1997. They included 250 male agents in the eight prefectures of HG and 250 agents, only three of whom were women, in the nine prefectures of the Forest Region. Communities were asked to select their CBD agent using the following criteria. The CBD agent had to be (a) literate, (b) resident in the community, (c) speak a local language, (d) be credible, available and a volunteer to do this work, (e) able to communicate and be discreet, (f) be mobile. Their job was to (1) educate their communities about FP, STI prevention and the

prevention and treatment of diarrheal disease, (2) sell oral rehydration salts (ORS) and FP products, including condoms, spermicides and the contraceptive pill, (3) make referrals to the HC as appropriate and (4) keep track and submit monthly reports of their activities and sales to the HC. CBD agents obtained their products from the HC, and sold them at a marginal, fixed profit. The only restriction was on the sale of contraceptive pills, for which the client required a prescription from a HC.

Performance of CBD program in 1998: A PRISM evaluation of the CBD program in 1998 discovered that, after one year, fewer than 66% of the original 250 CBD agents in Upper Guinea were still operational⁷. Collectively, they had held only 115 IEC sessions, or less than one session per agent. The typical CBD agent had between 5 and 10 clients per month and failed to adequately manage his products, resulting in stock-outs and the distribution of expired products. The actual quantity of sales made by the agents was also unclear, as reporting was often incomplete, varying from 31% to 72%. Further analysis revealed that their low performance was related to a poor understanding of their roles as CBD agents, inadequate training and follow-up, poor motivation, insufficient or complete lack of supervision, low levels of literacy and difficulties in discussing RH issues, especially with women.

PRISM's strategy: In order to address these problems, PRISM worked with the MOH to re-design the CBD strategy and developed a technical assistance approach that linked the CBD services more closely to the health centers, the DPS and DRS. The new strategy also ensured a more careful and realistic process for selecting CBD agents. Other modifications included: the development of a network of five CBD agents per HC; regular monthly meetings at the HC; increased supervision by HC staff; adaptation of data collection and management tools for illiterate CBD agents; revision of selection criteria to allow for illiterate agents; community mobilization to ensure true community participation in selecting CBD agents; work with the community to select female CBD agents; linking performance of CBD agents to performance incentives; appointment of a CBD program associate at the DPS ("*chargé SBC*") and pairing him or her with a technical assistant for capacity building; subsidies to the DPS for supervision and support to HC with CBD networks; use of ELCO mapping; adult education training methods for CBD agents and their supervisors; on the job follow-up training; revision of HMIS indicators for CBD agents; expanding CBD services to include items such as Vitamin A, iodised oil, chloroquine and paracetamol. PRISM's CBD/SBC support strategy was formally approved by the MOH in 1999 and was subsequently used by the central MOH as a model for CBD programs in other regions.

PRISM devised two separate packages of activities according to the presence or absence of another international TA partner in health covering *all* communities in a given prefecture. In prefectures where such a partner was active⁸, PRISM's support was designed to be complementary while ensuring implementation consistent with the national CBD guidelines. In prefectures without another TA partner, PRISM's

⁷ CBD Evaluation Report, 1998

⁸ Such as Dabola and Dinguiraye with Africare and Mandiana with Save the Children

interventions also included assistance to communities in identifying CBD agents, building capacity of selected agents, and providing necessary supervision for them. In these "priority" prefectures, PRISM sub-contracted CENAFOD, a Guinean NGO specialising in community development, to implement the mobilisation activities, and with AGBEF (the Guinean IPPF affiliate) to ensure TA to the DPS. Working with these agencies also enabled PRISM to assist local NGOs in their own institutional capacity development. Table 5 presents results for the two groups of prefectures.

Table 5: Status of the CBD program in Upper Guinea by December 2002

	Priority Prefectures (Kankan, Kouroussa, Kouroum, Faranah, Siguiri)	Prefectures with TA partner (Dabola, Dinguiraye, Mandiana)	Upper Guinea (total)
# HC with network of at least 5 CBD agents	52* (100%)	27 (100%)	79
# CBD agents trained, equipped, & offering RH services	317	292	609
# Female CBD agents (%)	71 (22%)	Not avail.	Not avail.
# CBD supervisors trained	107	74	181
# Prefectures with active "Chargé SBC"	5	3	8

* = Rural HCs only

Performance of CBD program today: As can be seen in Table 5, all 79 of HG's health centers have at least five CBD agents in the field. At the end of the project, there were a total of 609 agents equipped and operating, which means that most zones have more than the minimum of five. In the PRISM priority zones, 22% of the CBD agents are women, compared with a total of only three for the entire region before PRISM. A total of 181 supervisors have been trained. At the end of the project, PRISM assessed the performance of the 267 CBD agents from the Kankan region's priority districts. Performance was measured as the degree to which CBD agents accomplished the main tasks in their scope of work⁹ and the availability level of the products they distribute. The assessment determined that 239 out of the 267 targeted CBD agents (89.5%) obtained a functionality rating equal or superior to 80%. The 267 CBD agents successfully implemented 88% of the expected IEC activities within their community according to the suggested policy standard (1 per month per agent) and they maintained a reporting rate of 89% for their monthly progress report. Finally, they had on average 75% of the products in the CBD package¹⁰ in stock. Nevertheless, maintaining an adequate supply of products with all CBD agents is and will remain one of the biggest challenges of the CBD program.

Table 6 shows the evolution in performance over the life of the project. Substantial improvements were noted in all categories monitored. The total number of

⁹ Score of Work includes attendance to the monthly meeting at the HC during the year, the number of IEC promotion activities carried out and the transmittal to the HC of their monthly progress report.

¹⁰ The products in the package are oral contraceptives, spermicides, condoms and oral rehydration solutions.

contacts increased by over ten fold from 1998 to 2002. This was a result of both the increased number of CBD agents and the number of contacts per agent, which increased by more than 500%. The number of IEC session, which will be discussed in the section on demand (IR3), increased dramatically from only 115 in 1998 to over 10,500 in 2002. PRISM's emphasis on oral rehydration resulted in an increase of over 15,000 packets of ORS being sold per year in the four year span of the project.

Table 6: Performance improvements of CBD program 1998 - 2002

	1998	2001*	2002*	% Change (1998 to 2002)
# New FP contacts	Not monitored	7,522	7,868	-
# Old FP contacts	Not monitored	22,169	30,011	-
# Total contacts	3,629	29,691	37,879	944%
# Contacts /agents	22		119	441%
# Pills sold (cycle)	985	17,002	21,318	2064%
# Condoms sold	1,096	35,686	43,511	3870%
# Spermicides sold	Not avail.	15,254	15,514	-
# ORS units sold	1,548	13,155	16,953	995%
CYP	Not avail.	1,492	1,979	-
# IEC sessions	115	8,378	10,518	9064%

* = the 2001 and 2002 data concerns only the priority prefectures of Kankan, Kouroussa, Kerouane and Siguin. It does not include the data from Mandiana, Dinguiraye, Dabola and Faranah.

Expanding the array of services provided by CBD agents: PRISM conducted an operations research exercise in three sub-prefectures in Kankan to test the feasibility of having CBD agents sell oral contraceptives without the need for a prescription from a HC. A high profile committee of representatives from the MOH, the University Hospital, research centers and PRISM supported this initiative. It involved 21 CBD agents, and was completed at the end of December 2002. Preliminary results indicate that the CBD agents from the three participating sub-prefectures supplied over 400 clients through this approach and did so with a high rate of compliance with national norms and procedures. The results of the test will be reviewed and validated by the MOH steering committee with PRISM II support during FY 2003.

Traditional Birth Attendants: The National Safe Motherhood Policy, developed with PRISM support (see IR2), stipulates that five TBAs (*Accoucheuses Villageoises*) per HC are to be trained, supported and monitored by HCs. PRISM initiated TBA integration activities in the three prefectures of Kankan, Kerouane and Faranah and trained a total of 39 TBAs or 33%. The project fell short of its ambitious goal of training 120 TBAs because the development and implementation of the national safe motherhood policy required major coordination efforts from PRISM and other partners over an extended period of time. Although the training activities had to be postponed while the policy was being developed, the eventual development of uniform norms, procedures and monitoring tools as well as a national training curriculum proved to be a worthwhile trade-off. Future training across the country will certainly benefit from this effort.

1.3 Strengthening of the Essential Drugs and Contraceptive Logistics System

Based on a rapid assessment and diagnosis of the existing drug and commodity management system conducted by the project in 1998¹¹, PRISM's strategy to strengthen the sustainability of Guinea's drugs logistics structures, has been threefold: (1) promote the insertion of contraceptive products into the official list of essential drugs, (2) encourage the establishment of contraceptive sales prices to HCs by the PEV/SSP/ME, and (3) strengthen the drug and commodity management system with improved tools and capacity building.

1.3.1 Integration of contraceptives in essential drugs list & cost recovery system

Following strong lobbying efforts, the MOH integrated contraceptives into the essential drug package in early 1999. PRISM then presented a proposal to the MOH with pricing scenarios outlining how the PEV/SSP/ME could generate sufficient revenues to cover the logistics costs associated with contraceptives. The scenarios highlighted the cost-effectiveness of managing the distribution of paid rather than free contraceptive products. This resulted in the integration of contraceptives into the cost recovery efforts of the public health system in May 2001. All HCs currently acquire contraceptive products at 50% of sale prices to their clients and use the difference (profit) to stock new products and subsidize the center's operating costs.

Despite the addition of contraceptives into the cost recovery system, one of the major challenges confronting HCs remains inadequate cash flow. The current HC fee schedule is ten years old and inflation has rendered it obsolete. This fact is placing enormous stress on the financial viability of the PHC system and the schedule needs to be updated to current price levels. Replenishment of ED&C uses over 65% of an average HCs' revenue, compared to only 40% when PRISM first started. Even for the best managed HC, this severely limits other expenditures essential to providing quality health care.

1.3.2 Capacity Building & Systems Strengthening

Efforts to create sustainable ED&C systems at the SDPs began early in the project. By the end of 2002, 54% of HC in the PRISM focus zone had achieved stockout rates of less than 10%. Some of the primary interventions contributing to this improvement are summarized below:

- *Rationalization and harmonization of forms, tools and procedures:* In 1998, the use of multiple parallel systems led to numerous problems for national and local forecasting and management of stock. PRISM initiated the process of streamlining and unifying these various systems, first at the HC level and later for

¹¹ *Guinea Report on the Logistics and Supply of Family Planning and STI Supplies for the PRISM Project.* Michael Gabra, May/June 1998.

the hospitals. The process engaged stakeholders in reviewing existing forms and tools, selecting an optimal combination, and adapting them for the ED&C Management Manual for HCs. PRISM played a leading role in harmonizing tools and developing the national manual for HCs. This manual was disseminated widely to all DRS and DPS in PRISM's target zone. The ED&C Procedures Manual for Hospitals was later developed in a PRISM-facilitated workshop that was co-financed with WHO. Together, these manuals form the basis for the National Manual on the Essential Drugs and Medical Supplies Integrated Logistics, which was finalized in a joint effort between PRISM, UNFPA and the MOH in late 2002.

- *Introducing IMAT (Inventory Management Assessment Tool)*: Previous to the PRISM project, the MOH had no systematic tool to evaluate their ED&C system. PRISM introduced IMAT into the Guinean MOH to compensate for this shortcoming. IMAT is a tool developed by MSH to allow managers to monitor and evaluate the performance of an ED&C system through four sets of simple indicators that measure (a) the accuracy of records; (b) errors in stock levels; (c) availability of products; and (d) the duration of stock-outs for any given product. IMAT was integrated in the National ED&C Manual and by the end of the project, it had become fully integrated into the supervision protocol of DRS/DPSs.
- *Training of ED&C managers and supervisors at HC, DPS, DRS and PCG-PEV*: Using the newly adopted manuals, updated forms, tools, expired drugs destruction protocol and IMAT, as well as a specially developed ED&C management curriculum (adopted by the MOH), PRISM trained a wide array of ED&C managers. Training began with heads of HCs and eventually expanded to DPS, DRS and central levels. All trainees received extensive documentation on ED&C, including the "Family Planning Management Handbook" and the USAID funded book "Decentralization Management of Health and FP Programs"¹². Table 7 shows the number and cadre of managers who were trained, as well as the resulting improvements in stock availability at HCs.

Table 7: Number of managers, healthcare staff and supervisors trained in ED&C management from 1999 through 2002 & Stock out indicators

	1998	1999*	2000*	2001	2002	Total
# of head of health centers	N/A	41	44	24	6	115
# other health care agents	N/A			33	33	66
# DPS pharmacists	N/A	4				4
# hospital pharmacists/directors	N/A	9				9
# from PCG	N/A	2				2
# from DRS Drug Warehouse	N/A	1				1
# DRS	N/A	1				1
Total	N/A	58	44	57	39	198

¹² MSH/FPMD Publications

	1998	1999*	2000*	2001	2002	Total
Proportion of CS with essential drug stock outs lower than 10% during the last 3 months	Not avail.	Not avail.	Not avail.	55% ¹	54% ²	

* Data includes training in Upper Guinea and the Forest Region, before PRISM left the Forest Region

(1) As of the end of fiscal year 2001

(2) As of the end of fiscal year 2002

- **Contraceptive procurement support to the PCG:** During the first 3 years of the project, PRISM assisted the *Pharmacie Centrale de Guinée's* (PCG) in conducting its annual year-end inventory exercise. PRISM facilitated the computation of annual shipments of the various drugs and medical supplies stocked.
- **Support to DCMI survey:** The Drug Management for Childhood Illness (DMCI) tool is an indicator-based instrument designed to **support successful IMCI implementation**. It provides a rapid assessment of the pharmaceutical and medical supplies management systems in MOH health facilities and drug retail outlets. The main objective of the tool is to generate data on the availability and prescribing practices of drugs used for IMCI, identify ways to improve IMCI drug management (availability, treatment, and cost), and transfer self-assessment technology by creating country-based operations research capacity. In 2002, PRISM collaborated with the USAID funded BASICS II and MSH/RPM-projects to conduct the DMCI survey.
- **Preliminary results of the DMCI survey indicate the following:** Average percentage of stock records that correspond with physical counts for a set of DMCI tracer drugs in MOH storage and health facilities = 90% at HCs and 80% at hospitals. The percentage of median international price paid for a set of DMCI tracer drugs that were part of the last regular MOH procurement = 111%. The average percentage of a set of unexpired DMCI tracer drugs available in MOH storage and health facilities = 51% at HCs and 66% at hospitals; Percentage of encounters diagnosed as no-pneumonia (cough or cold) that are prescribed antibiotics (ideal = 0%) = 91%. The results underscore the importance of intensive TA in this area before implementing IMCI
- **Support to USAID contraceptive procurement:** PRISM regularly supported USAID's SO2 team in the computation of contraceptive needs for Guinea. Throughout the project period, PRISM assisted the USAID mission to clear USAID purchased contraceptives through customs and identify temporary storage in Conakry prior to their transfer to HG. Table 8 shows the USAID contraceptive stock as of the end of project.

Table 8: USAID-procured contraceptives stock at the PCG, September 2002

Products	Quantity	
	Expiration year/month	
Lofemenal (Cycles)	40,800	2005/06
	134,400	2006/02
Ovrette (Cycles)	57,200	2005/11
	39,600	2006/05
Depo-Provera (Doses)	76,800	2004/04
	70,400	2005/05
Conceptrol (Pills)	91,200	2003/05
	67,200	2005/06
IUD (Units)	0	
Condoms (Units)	71,000	2004/12
	198,000	2005/03

1.3.3 The major challenge in ED & C management

Despite the intense levels of training and TA provided by PRISM and other partners, achieving and maintaining low stockout rates of essential drugs and contraceptives at the SDPs remains a difficult goal to attain. Stockout rates have improved, suggesting moderate success and the need for continued TA. However, rates remained unacceptably high at regional supply points and many HCs. Further improvements can be realized through effective community participation, especially through the *Comités de Gestion (COGES)*, as well as revisions in the fee schedule, and improved supervision, monitoring, and leadership at the decentralized level. However, to achieve acceptable and stable levels of drug supplies, Guinea's public health program will most likely need to expand its drug delivery channels to include the private sector. In other countries, this has emerged as an effective strategy for improving local availability of essential drugs.

1.4 Maintaining Functional SDPs: Availability of Basic Medical Equipment, IEC Material & Management Tools

After services have been integrated into a SDP, it is paramount that the momentum created is not lost due to staff movement or logistical and supply problems. Efforts to create demand in the population for services vital to good health will ultimately discourage potential clients if those services are not maintained over the long term. The PRISM project was not satisfied merely to train service providers and leave them to fend for themselves. Health care workers at the local level have little influence over the systems that provide essential drugs and supplies, yet they are subjected daily to the breakdowns of those systems. After providing the essential resources to integrate services into the SDPs, PRISM set out to create the sustainable systems required for health care to be considered truly accessible at the SDP. An example of PRISM's work in creating sustainable systems was the ED&C initiatives discussed above. This sub-section will

outline some of the activities that were conducted to assure the long term availability of other essential, and frequently overlooked, resources to allow service providers to continue to serve the population.

PRISM's focus in this area was to support the DRS and DPS efforts to provide essential materials through the following initiatives: (a) assuring initial procurements of basic medical equipment and IEC materials, (b) building the DRS capacity to monitor needs and ensure availability, and (c) producing and re-producing materials in support of newly integrated or updated services. While these activities were not undertaken systematically and rationally in 1998, DRS and DPS supervisors now assess the availability of essential resources at the HCs during the last three months of the year and during regular supervision visits, using the newly designed "*Fiche d'Inventaire: Disponibilité des Services et Equipement*", a management tool developed with PRISM TA during FY01. Table 9 summarizes the recent impact on the HCs in Upper Guinea.

Table 9: Availability of Essential Resources at HCs in HG & HCs' Functionality Level per RH Service (FY01 and FY02)								
Availability of Resources	FP Services		Ante Natal Consultations		Child Survival Services		STI Care Services	
	FY02	FY01	FY02	FY01	FY02	FY01	FY02	FY01
Trained providers	100%	85%	100%	100%	100%	100%	100%	100%
Medical Material	70%	71%	66%	66%	58%	59%	58%	63%
Essential Drugs	80%	82%	76%	79%	75%	83%	76%	13%
IEC material	91%	89%	58%	55%	92%	25%	84%	82%
Management Tools	64%	76%	67%	72%	65%	69%	54%	73%
Average	81%	81%	73%	74%	78%	67%	79%	66%
% of HC with functionality :	% of HC							
Superior to 80%	60%	65%	34%	44%	50%	22%	59%	9%
Target	75%	75%	75%	50%	75%	50%	75%	50%
Superior to 60%	91%	85%	86%	97%	86%	85%	84%	59%
Inferior to 60%	9%	0%	14%	3%	14%	15%	14%	41%
	Number of HCs							
Integrated HC	89	85	89	89	89	89	38*	22*
HC Evaluated	89	69	89	68	89	68	38*	22*
% of integrated HG evaluated	100%	81%	100%	76%	100%	76%	100%	100%

* Only fully integrated HC were considered

1.4.1 Availability of medical materials

PRISM's goal was to support problem resolution in the area of medical equipment, material and supplies at service delivery points. PRISM conducted annual inventory reviews of basic medical equipment at HCs and hospital maternity services to determine which SDPs required additional materials. PRISM also integrated this inventory exercise and needs analysis into the routine tasks performed by DPS and DRS supervision teams. The subsequent rational procurement and allocation of the materials ensured that, by the end of the project, the majority of health centers and maternity services had the basic materials needed to perform MCH and RH services. Table 9 presents exact figures for the availability of ED&C for HCs in HG. It should be noted that some materials must occasionally be procured by an external source due to their expense and/or lack of local availability. In order to promote sustainable solutions and develop indigenous markets, PRISM worked with local craftsmen whenever possible to design and produce appropriate medical equipment in HG. Certain materials, such as examination tables and birth delivery tables, are now produced locally. Not only does this support local industry, it decreases dependence on foreign goods. This initiative will continue under the PRISM II project.

1.4.2 Availability of management tools

All HCs received an initial kit of management tools when they were launched or integrated into the PEV/SSP/ME system. Cost recovery revenues are used to replenish the tools and forms, which are for sale at regional warehouses. Table 10 provides a list of the current tools and forms. Initial supplies of revised forms have been subsidised by PRISM when the project was directly involved in the revision effort (e.g. for drug logistics forms and SNIGS registers). However, PRISM continued to regularly supply FP and CBD tools throughout the project's life.

Table 10: List of Management Tools and Forms available through the PEV/SSP/ME

<i>Cahier d'entretien du Frigo</i>	<i>Echéancier</i>	<i>Fiche de référence</i>
<i>Carnet de santé</i>	<i>Feuille de relevé de</i>	<i>Fiche de stock</i>
<i>Carnet de soins</i>	<i>température</i>	<i>Fiche Infantile</i>
<i>Carnet de vaccination</i>	<i>Fiche CPN</i>	<i>Livre de caisse</i>
<i>Cartes infantiles</i>	<i>Fiche de consultation PF</i>	<i>Registre de consultation</i>
<i>Diagramme de maigreur</i>	<i>Fiche de croissance infantile</i>	<i>Registre SNIS</i>
	<i>Fiche de partogramme</i>	

Availability of these tools and forms proved to be a weak link in the system and has adversely affected the percentage of SDPs reported as functional. Table 9 indicates that the availability of these forms at the HC level ranged from only 54% to 67% (according to the service) at the end of the project. The performance of the PEV/SSP/ME national program in providing management tools on a regular basis to the regions has

remained problematic. To help resolve this issue, PRISM purchased a large volume copying machine for each of the Kankan and Faranah DRSs to allow them to reproduce management tools and forms locally. However, increased capacity at the DRS had yet to become effective as of the end of 2002. The establishment of a functional and sustainable production unit at the DRS has taken more time than anticipated and will be followed closely in the early stages of PRISM II.

1.4.3 Availability of IEC materials

PRISM produced and distributed new IEC materials and reproduced existing ones on a regular basis, especially for HCs, CBD agents and peer educators. As a result, IEC materials at HCs are becoming increasingly available. Table 9 shows that the availability of these materials increased for all technical focus areas between 2001 and 2002. The greatest difference was for child survival materials, which increased from 25% of facilities in 2001 to 92% in 2002. By the end of PRISM, the major outstanding problem was for ante-natal services.

Functionality of Family Planning Services

As can be seen on Table 9, the availability of resources essential to FP services has generally been high and stable since monitoring began in FY01 (81% in both FY01 and 02). Since inception of the PRISM project, numerous providers were trained in FP, attention to contraceptives management has been continuous and FP-associated IEC material has been made widely available. As stated above, the weakness in the system has been the availability of management tools arriving from the central MOH level, with only 64% of HCs possessing the required forms and tools. Due primarily to this problem, the number of HCs considered to be functional (having a functionality score of 80% or greater) was only 60% by the end of the project. Although this represents major progress over pre-PRISM conditions, it was below project expectations. This issue, discussed above, is being addressed by finding local solutions that decrease dependency on the central level.

Functionality of Antenatal Consultation Services (CPN)

The availability of resources essential for CPN services was at 73% at the end of FY02 compared to 74% last year. Availability of CPN trained staff remained excellent at 100%, but insufficient (although stable) for the other four essential resources categories – 66% for medical material, 76% and 79% respectively for essential drugs, 58% and 55% for IEC material, and only 67% of management tools compared to 72% last year. The number of HCs considered functional at delivering antenatal care actually decreased from 44% last year to only 34% this year. Once again, the weaker showing in the management tools area had a negative overall impact on the overall functionality of HCs in delivering ante-natal services. Solutions have been discussed above.

Functionality of Childcare Consultation Services (CS)

Significant improvements were achieved in this important preventive and clinical care service, especially during the final year of the project. The availability of resources

essential for CS consultation services was at 78% for all categories considered at the end of FY02 compared to 67% at the end of FY01. Availability of CS trained staff remained excellent at 100%, while availability of IEC material progressed substantially from 25% to 92%. Development, production and distribution of these materials were a project priority and the efforts proved successful. However, the availability of the other essential resource categories was insufficient and generally deteriorated between the end of FY01 and end of FY02. For example, availability of essential drugs fell from an acceptable level of 83% to a marginal one of 75%, while management tools fell from a rate of 69% to 65%. Nevertheless, as of the end of the period, 49% of HCs were considered functional for CS consultation services. This is a sharp improvement of the situation assessed at the end of FY01 where only 22% of HCs were considered functional in light of their essential resources availability rates.

Functionality of Sexually Transmittable Illness (STI) Consultation Services

Significant improvements were also achieved in STI care services during the final year, correcting some of the deficiencies previously noted. The availability of resources essential for STI consultation services was found to be at 79% at the end of FY02 compared to 66% at the end of FY01. This is due primarily to the major improvement in the availability of anti-STI drugs that resulted from the various initiatives taken by the health authorities during the period. At the same time, availability of STI-trained staff remained at 100% for integrated SDPs and availability of medical material remained stable, although still unsatisfactory. IEC material related to STIs improved from an already acceptable 82% availability rate to an even better 86% rate. As of the end of the period, 59% of the STI care services at integrated HCs were considered functional for that service compared to only 9% the previous year. If it were not for the deterioration of the management tools availability and the stagnation of the medical material, the proportion of HCs declared functional could have reached its 75% target

Affordability of Services at SDPs

- 100% of HCs in HG have a fee board covering all services and products (including birth delivery services) (89/89);
- 6 HMO/Muriga covering health services costs for their members (target = 36), participative feasibility studies completed and "*instances dirigeantes*" established for an additional group of 18 HMO/Muriga.
- COGES community orientation and mobilization approach tested and the development of local institutional capacity to implement the revitalization strategy ongoing.

1.5 Improved Financial Sustainability of HCs and Equitable Access to RH Services

1.5.1 Promote equitable access to RH services

Advertise Reproductive Health fee schedule

Broadcasting/Advertising of RH fee schedule: PRISM worked with the MOH to establish more realistic and updated fees for services, taking into account the clients' financial capacity and the need for cost recovery in the health system. New fees were agreed upon in 2000, and PRISM supported the MOH and DRS to advertise the new fee structure over the radio as one strategy of informing people in the regions and districts about their rights to services. The radio broadcasting was reinforced by subsequent announcements of the fee schedule at every community event organised in HG with PRISM support. During the "Town Meetings" on access to and quality of MCH services for instance, the fees charged by HCs' providers in comparison to the official schedule is generally at the heart of the debates. This approach continues to this date.

Provision of a revised fee schedule board to HC/HP: PRISM and the Kankan DRS designed and pre-tested a new fee schedule board for services and products to be posted at HCs in HG during FY01. Subsequently, boards were installed at all HCs in the Faranah Region and in the Kankan Region. Upon project completion, every HCs in HG had received its fee board, and had it displayed in a clearly visible location.

Support the revision of HCs services' fees – CORE

PRISM introduced the CORE (Cost and Revenues Analysis) tool to the Kankan DRS and DPS in view of the viability study of the cost recovery model that has been in use at the HC level in Guinea since the early 1990s. The current capacity at the MOH for financial analysis and management is very limited and mostly concentrated at the central level. The project aligned two of its technical staff members as well as a member of the DPS, a former head of HC, to the task and discussions are ongoing with a local health economist to support the exercise.

The results of the initiated simulation will be presented next year to local health and administrative authorities as well as to renovated COGES at selected sites in order to test the most promising services fee structures on a small scale. Actual tests will be accompanied by a procedure approved and monitored by the community to ensure access to services for the poorest elements of the population.

Promotion and support of MURIGA

MURIGAs are health mutual type organizations (HMO) formed by members of a community to facilitate referral of women at risk during birth delivery. They are an integral part of the Guinean Safe Motherhood Promotion Strategy. Effective MURIGAs could be expanded to cover other community health needs beyond referral associated to pregnancies. PRISM interventions to support the national safe motherhood strategy at the

community level focus on three prefectures: Kankan, Faranah and Kerouane. PRISM promoted and supported MURIGA/HMOs creation and operations in six sub-prefectures initially (two per prefecture) and expanded its interventions to 18 additional sub-prefectures during the reporting period (6 per prefectures). Activities were designed to promote the functionality of MURIGA as follows.

- PRISM sponsored the participation of its Community Institutional Development Coordinator and of AGBEF Regional Coordinator for Kankan in two of the UN/ILO one-week courses on health mutual organizations in Africa during the reporting period. These were the course on *Participatory Feasibility Studies* in the context of the creation of health mutual organizations that was held in Benin and the course on *Monitoring & Evaluation of HMO* that was held in Dakar. These training complemented the other UN/ILO course they attended last year on the *Promotion of HMOs*. These public health professionals are spearheading support activities to MURIGA/HMO in the prefectures targeted by PRISM in HG.
- Active partnership with ILO/STEP was established during FY01. Since then, STEP provided regular complementary technical assistance to our program and funding for some of the community assessments and training sessions. ILO funded the tuition of two PRISM participants to the Benin and Dakar courses.
- Management tools for HMOs were printed with co funding from STEP. These are.
 - Member's books (*cartes*)
 - Services registers
 - Subscriptions registers
 - Membership registers
 - Bank journal
 - Petty cash journal
- Management tools kits were delivered to forming MURIGA/HMOs. Each of them received:
 - 500 member's books
 - 1 service delivery register
 - 1 subscriptions register
 - 1 membership register
 - 1 bank journal
 - 1 petty cash journal
- Training curriculum for members of the Comités d'initiatives. PRISM and STEP adapted the training curriculum of the members of the *comités d'initiatives*. These committees are composed of the key community members leading the establishment of the health mutual in their locality.
- Participative Feasibility Studies were performed in a number of communities and the results were shared with the communities. These feasibility studies present the participation costs for various packages of services covered at the local HC and at the local hospital. The General Assemblies of the HMOs identified and adopted their package of services to be covered. As of the end of FY02, participative feasibility studies had been performed in 24 out of the 36 sub-prefectures in the targeted

prefectures of Kerouane, Kankan and Faranah. As a result of these studies and consultations, 12 General Assemblies (50%) decided their HMO would cover the full package of services offered by its HC according to the PMA¹³ of the PHC system, 7 (29%) elected a maternal and child health package and 5 (21%) a safe motherhood package (MURIGA).

- General Assemblies were held in the targeted sub-prefectures and the executive bodies (*Conseil d'Administration, le Comité Exécutif et la Commission de Contrôle*) were established.
- PRISM in partnership with STEP prepared various legal documents important for the functioning of the Mutual and shared them with the forming MURIGA/HMOs. These are the "*règlements intérieurs*", the internal status and the convention between the mutual and the health service delivery points.
- By the end of the project, 6 MURIGA/HMO were receiving contributions from their members (*adhérents*) and were providing coverage (*prise en charge*).

Continued partnership with ILO/STEP and active mobilization of the prefecture *Directeur des Micro-Réalisations* will be necessary to consolidate the success and expand it more widely. This will ensure quality of interventions and complete coverage.

1.5.2 Increase community participation in the management of the HCs

Support activities to strengthening COGES

The presence of a functioning COGES or a similar body is a central component of the Bamako initiative allowing community participation and capacity for action, behavior change, and ultimately increased use of the services.

The strengthening of the community participation in the management of their HC strategy is one of the main "*mesures d'accompagnement*" of the reform of the PHC system of a prefecture engaged during the period by the DRS with PRISM support. The in-depth evaluation of the prefecture's health system and the remobilization of the health personnel in the system that it leads to is the initial step in the reform and precedes the package of interventions aimed at strengthening the community participation in the management of the system. The strategy simultaneously targets all HCs of a prefecture and requires the consultation and involvement of the population of all rural administrative districts (a small group of villages) and urban "*quartiers*". The COGES will be revitalized and supported concurrently in all HCs of a prefecture. It will count in its ranks one representative member coming from each of these rural or urban units. The training needs of the revitalized COGES members will be assessed and a training program designed and put in place. The technical needs required for the adequate functioning of the renovated COGES will also be assessed and a TA plan designed and put in place.

PRISM therefore developed an initiative to revitalize HCs COGES in its focus zone started. Main activities conducted and results achieved include:

¹³ Minus a few chronic diseases like diabetes and hypertension.

- ▶ The development of a PRISM TA strategy package including strengthening communities in choosing members for COGES, building the members capacity in their role as community representatives on the COGES, and a scope of work for local NGO's ("*Organisations Relais*") to be sub-contracted by PRISM to ensure community participation and other implementation activities to strengthen COGES.
- ▶ Development of a partnership with CLUSA: Efforts were made at developing a partnership with CLUSA in support of the participation of communities into the management of their HC. CLUSA is currently starting community institutional strengthening activities in six localities in HG. These activities focus on agriculture, natural resource management and other revenue generating activities as well as on community health issues. PRISM has offered to pool resources with CLUSA in these sub prefectures and initiate joint interventions in the health area. CLUSA submitted PRISM a costly proposal that requires further discussions during PRISM II.
- ▶ Development of the COGES revitalization strategy: Building up on the results of a COGES survey conducted by PRISM in FY01, PRISM and the Kankan DRS enhanced the definition of the Strategy to Strengthen the Community Participation in the Management of the Primary Health Care System in HG. The strategy, and its draft document, has reached the clarity level required to provide strong guidelines to all concerned parties in HG involved in the implementation and/or monitoring of this critical activity for the future of the PHC system of Guinea. The strategy document, still a work in progress, is being completed and finalized during the deployment of the strengthening activities in Kerouane and Kankan – the first two prefectures benefiting from PRISM in this critical area.
- ▶ Community orientation and mobilization:
 - PRISM, CENAFOD and the Kankan DRS jointly developed reports' template for community mobilization and orientation activities on community participation to the management of the primary health care system. A specific report has been designed for the village/*quartier* level, the sub-prefecture level and for the prefecture level.
 - 11 CENAFOD field agents (*animateurs communautaires*) and 2 supervisors oriented in the community mobilization approach and tools.
 - Community mobilization approach and tools tested with success in Balandou sub prefecture in Kankan prefecture. 11 community members selected by their village to represent them in the HC's COGES. CENAFOD tested the community orientation/mobilization protocols and tools in the Balandou sub-prefecture near Kankan. The NGO's eleven community facilitators and two supervisors who were trained by PRISM to implement the activity in full scale in the Kerouane prefecture used the test in Balandou to gain field experience. CENAFOD and PRISM technical staff presented results of the test to the health regional authorities and the other stakeholders in the Kankan region. The reporting templates and community intervention protocol were adjusted in light

of the experience gained in Balandou. CENAFOD will implement the activity in Kerouane and in half of Kankan's 16 sub-prefectures under PRISM II

As a result of PRISM activities in this critical aspect of the primary health system, the path for community management of HC revival is now defined, democratic elections of members that truly represent the community have been initiated and local institutional capacity to implement the revitalization strategy is being build up. However, most COGES continue to exist on paper only, while in areas where new elections have taken place, and membership is active, members still need to be trained, or retrained, in management skills such as accounting, planning, use of data and information for decision-making, and resource allocation. With local capacity being developed, the COGES revitalization strategy will become preminent in PRISM package of interventions and will remain so during the whole of the second phase of the project.

WORK TOWARD THE INTERMEDIATE RESULTS (IR)

IR2: Improve QUALITY



PRISM built quality through (1) the development, dissemination, and implementation of quality standards, and (2) the strengthening of the health and management information systems (H/MIS). Specifically, the PRISM team provided:

Quality Standards and Services:

1. Assistance to the MOH technical committee in refining and disseminating the national RH Norms and Procedures, including the development of referral guidelines, job descriptions, service delivery guidelines, and performance assessment tools;
2. Strengthening quality improvement support systems to the service delivery points;
3. Training in clinical RH services (FP, EMHC, CS, STI/AIDS).

H/MIS:

4. Strengthening/improving the HMIS system to capture appropriate, sufficient, or adequate information useful for management and quality improvement needs. This includes assistance and training to the central level MOH, to the DRS, and the DPS in collecting and using data for decision making, and in developing periodic HIS reports.

IR2: Improve Quality for Basic Health Services

Defective quality assurance mechanisms and resulting poor quality of services delivered cannot only be dangerous to the clients, but will rapidly cancel investments made in increasing demand and improving access. Thus the strategic relevance of PRISM's design requires addressing the supply side of services in tandem with the demand side. This section presents PRISM interventions and achievements at strengthening the capacity of Guinea's PHC at delivering improved quality RH services. The first part focuses on norms and procedures, the system basis to assess quality, while the second and final sections cover respectively the SDPs support units and the service providers.

RH Quality Standards, Support Systems and Services

2.1 Reproductive Health Norms & Procedures

At the inception of PRISM in 1998, national RH Norms & Procedures were in the process of being developed by the Guinean MOH and its partners. PRISM accelerated the process by helping the MOH mobilize TA, offering direct TA and funding the production and dissemination of the RH N&P document. The document was co-funded by other partners and distributed by PRISM to the regional and district health authorities in PRISM's target regions. The N&P document subsequently formed the basis for updating training modules and for training providers and managers in its focus zone. Since the document was distributed, PRISM has monitored its use and validity, anticipating future needs for updates and other revisions. In 2002, PRISM initiated plans with UNFPA and the World Bank to assist the MOH in updating the RH N&P. Revisions are being planned for 2004.

2.2 Strengthening Quality Improvement Support System

Good quality of care and preventive services require full functionality at the service delivery points and at the organisational units created to support them – the DRS and DPS. A key element to achieve full functionality is effective personnel management at those various sites. Good management practices are of particular importance for evaluation, supervisory and leadership functions. Maintaining adequate infrastructures and the availability of essential drugs, medical equipment and supplies can only be ensured in a sustainable fashion when Human Resource (HR) management is strong. Convinced that competent HR management is at the core of good quality of care and services, PRISM has been dedicated to introducing counterparts to performance improvement approaches, techniques and tools and at integrating them in the Guinean primary health care system. Some key results are highlighted in the following table and will be discussed in more detail below.

- 63 heads of HCs and 37 managers from HG's DPSs and Hospitals trained in Team Management
- 34 DRS/DPS supervisors trained in COPE facilitation
- 41 DRS/DPS supervisors trained in clinical supervision skills (including Facilitative Supervision)
- COPE was integrated in 35 sites including 5 maternity services, 6 pediatric services and 24 HCs.
- A new tool for monitoring HC's quality of services delivery is being used routinely by all health districts allowing to determine provider compliance with N&P

2.2.1 Train Human Resources Managers in Team Management

Training in HR management: PRISM trained a total of 63 heads of health centers (HHC) and 41 hospital and DRS/DPS managers in HG in Team Management. Among hospital and DRS/DPS managers the project goal was to have two managers trained in Team Management at each of these units – for a total of 36 in HG. Over the life of the project, 41 hospitals and DRS/DPS managers received this training. As of the end of the project, 34 of them were still at post in HG and the goal was largely achieved. This course was developed in 1998-99 as a response to what was identified early on by the MOH senior staff at all levels as one of the two priority management areas of the PHC system to strengthen¹⁴. The six-day course covered the following topics: meetings management, personnel supervision, learning styles and interpersonal skills and group development stages. By the end of the project, the training program had become so popular that the DRS requested to include heads of hospital maternity services and paediatric services in future training sessions.

Improving Supervisory Capabilities with COPE and Facilitative Supervision (FS):

PRISM introduced facilitative supervision approaches in collaboration with EngenderHealth by training DRS/DPS team members in COPE facilitation and Facilitative Supervision (see box below). The objective of this activity was to provide supervisors within the DRS and DPS with the knowledge and practices required to implement interventions at the HC that effectively support and complement the local efforts to improve the facility's services. PRISM's vision, which is shared by key staff at the DRS level and the MOH central level, is to transform the supervisors at the DPS level into technical assets and permanent trainers for the HC's staff. Every supervisory visit is a training opportunity to enhance the skills of the service providers. The supervisors must also become authentic team members with the HC, COGES and other community stakeholders in assuring the facilities' overall success. The supervisors were trained through a rational sequence of formal training sessions and guided fieldwork interventions. Following the initial training, the DRS and DPS teams received regular on-the-job training from PRISM's technical assistants during routine supervisory visits.

¹⁴ The other priority area was essential drugs management.



Although COPE is designed as a tool to be used autonomously at the service delivery point, the initial stages of its introduction at a site require regular outside facilitation from a qualified supervisor – a key role played by the DPS's technical staff. Although solid progress has been made, integration has been slower than hoped due to the serious technical absorptive capacity limitations¹⁵ at the DPS level. Completion of this integration throughout HG will require two or three additional years of sustained external technical assistance. Ultimately, the DPS's technical limitations will have to be overcome structurally¹⁶ if they ever are to monitor and support adequately the COPE process at their SDPs in the future.

Support DRS/DPSs' Capacity to Implement Supervision Activities:

Strengthening the supervision capacity of the MOH decentralized support units was a core element of PRISM's strategy to improve the quality of reproductive health services

¹⁵ Technical absorptive capacity of the DPS as a unit is constrained by its limited number of available and active public health professionals. Typically, a health district director has too few personnel to whom to allocate the workload and each health professional is being asked to do too many things. As a result of this situation, focus and quality suffer, routine support functions are not properly assured, prevention actions are not identified and crisis management mode is the norm.

¹⁶ Under PRISM II, MSH will provide technical support to the MOH at better aligning staffing configuration at the regional and district directorates with their mission, roles and responsibilities

at the HC level. Following a series of coordination meetings to strengthen the DPSs' management of supervision activities, PRISM signed a *Convention de Partenariat* for supervision support with HG's eight DPSs and the two DRSs. Since then, the DPSs have had continuous access to PRISM specialized TA in facilitative supervision as well as occasional logistics support and modest budgetary assistance for the implementation of supervision visits to HCs, especially in remote areas. PRISM's package of interventions for improving the DPS capacity to supervise includes:

- Adapting and testing supervision technical and managerial tools
- Orienting the DPS staff in the use of the various supervision planning and reporting forms and supervision checklists
- Assistance to the DPS to define the profile of the members of the supervision team
- Training of supervision team members in facilitative supervision
- Facilitating some of the DPS's quarterly planning exercises of its supervision program (on average twice during the year at each of the DPSs)
- Training the eight DPS directors and their accountants in small grant financial management
- Financial assistance to the DPSs for one quarterly facilitative supervision visit per HC
- On the job training of DRS/DPSs' staff during facilitative supervision visits to build DRS/DPS capacity in the job training and post-training monitoring

Improve RH supervision checklists and other integrated tools: PRISM developed, tested and introduced two new tools for the public health supervision system. These include:

- o **Service Delivery Observation Form:** This checklist helps determine the degree to which providers comply with N&S when delivering services at HCs. These services included CPN consultations, STI care, childcare and preventive health services, and FP consultations. The observation forms are based on the Guinean national RH norms and procedures with the exception of childcare services, which are based on the national IMCI guidelines. The observation form, entitled "*Fiche d'Observation Client-Prestataire*"¹⁷ has been routinely used at all of HG's DPSs since their introduction in 2001.
- o **Facilitative Supervision Observation Form:** The FS Observation Tool is designed to assess the progress of an individual supervisor's performance. It is a checklist to help the supervisor prepare and implement an intervention at a service delivery point. DPS supervisors use the tool to observe and provide feedback to a teammate. (The form was designed to allow a DPS supervisor to observe and provide feedback to a colleague). The DRSs used the tool to assess performance of the DPSs facilitative supervision teams.

¹⁷ The service delivery observation form "*Fiche d'Observation Client - Prestataire*"

Impact on the Supervisory system:

The interventions described above have resulted in more frequent and higher quality supervision visits. PRISM measured progress according to targets established by MOH policy, which maintains that at least one FS visit should be effectuated to each HC per quarter. According to this standard, the best performing prefecture was Kankan at 52% of the goal, followed closely by Dinguiraye at 47%. During FY02, 88 of HG's 89 HCs received at least one facilitative supervision visit and 36 of them were visited twice or more (40.4%). Other districts reported progress, but still managed to achieve only 25-33% of the target, as can be seen in the table below.

Region/Prefecture		# of CS	# of FS Visits		% of Achiev.	FS Coverage per HC
			Target	Achiev.		
Kankan	Kankan	16	64	33	52%	2 HC visited three times 13 HC visited twice 1 HC visited once
	Kérouane	8	32	8	25%	1 HC visited twice 6 HC visited once 1 HC not visited
	Siguiri	14	56	21	38%	1 HC visited three times 5 HC visited twice 8 HC visited once
	Kouroussa	12	48	13	27%	1 HC visited twice 11 HC visited once
	Mandiana	10	40	15	38%	5 HC visited twice 5 HC visited once
Faranah	Faranah	12	48	14	29%	2 HC visited twice 10 HC visited once
	Dabola	9	36	9	25%	9 HC visited once
	Dinguiraye	8	32	15	47%	1 HC visited three times 5 HC visited twice 2 HC visited once
Total		89	356	128	36%	<i>Overall level of achievement Out of HG's 89 HC: 4 received three visits 32 were visited twice 52 were visited once 1 HC was not visited</i>

FS visits have now become a core element of DPSs' workplans, which is important for sustainability of the intervention. It is also clear that a greater degree of rationality has been followed in prioritizing supervision visits; the DPS tended to

distribute their FS efforts equitably between HCs. Health Centers received their second FS visit only after *all* the prefecture's HCs had been visited once. Considering the plethora of problems that confront the HCs, it is critical that all of them receive at least one visit since none are functioning sufficiently well as to be able to forego supervision. After the first round of visits was completed, the second visits were then prioritized among those HCs that were in the greatest need of assistance. Another positive note is that HG achieved a reporting rate for these activities of nearly 100%.

Despite notable progress, by the final year of the project, only four HCs had received three visits and 52 were visited only once. Issues that impeded progress in these districts are the following:

- The Kankan DRS performed a special evaluation of the PHC system in each of the region's health districts during the final project year. This exhaustive evaluation provided valuable insights into the functioning of the health care system but proved to be time consuming. In an attempt to create consensus around the problems and priority issues, many of the DPS's high-ranking personnel served on the evaluation team, thus rendering them temporarily unavailable for routine duties, including FS.
- Despite assistance from PRISM, the financial resources available to the DPSs for supervision activities are still insufficient and often disbursed late. This is a chronic problem that renders rational work-planning extremely difficult. With only one exception (Dinguiraye), no DPS performed any FS supervision activities until funds were received either from PRISM or another source.
- During the years prior to 2001, supervision was infrequent, hierarchical and administrative in nature. More time and technical assistance is required to change this culture of supervision into a more supportive and sustainable endeavor.

The promotion and organization of facilitative supervision visits became a major PRISM focus only during the penultimate year of the project. A disciplined and lengthy series of activities were required before the initial visits could be effectuated according to project and MOH standards. The final year of the project brought notable progress and encouraging results that will provide momentum for this intervention as PRISM II moves forward. However, sustained attention and leadership on the part of the DRS and a regular source of funding from the central level will be critical to the sustainability of good quality supervision services provided for the SDPs.

2.3 Improve the Quality of RH Services Delivered

Improving Quality of Child Survival Services

105 HCs PEV agents received refresher-training in PEV services and child growth monitoring. By the end of the project, 96% of HG's HC had retrained

agents

- CPC agents for 71 HCs (80%) received refresher-training in Child Illness Case Management;
- Compliance with N&P in child survival services improved steadily and significantly. 62% of child survival services observed during the last year of the project complied with MOH N&P compared to only 27% the previous year.

Improving Quality of Maternal Health Services

- CPN agents for 87 HCs received refresher training in CPN-Partogramme (98% coverage of HG's HC) in partnership with DED¹⁸
- Compliance with N&P in CPN consultation services improved steadily and significantly. During the last year of the project, 59% of CPN consultation services observed complied with N&P compared to 43% the previous year
- 87 providers from HG's 8 hospital maternity services trained in infection prevention
- 30 providers from HG's hospital maternity services updated in contraceptive technology (FP)
- PAC services currently being integrated at 7 facilities (HG's 2 regional hospitals, 4 of the 6 prefecture hospitals and Banankoro HC)
- Essential Maternal and Child Health training curriculum for TBAs developed and in use. 39 TBAs trained in PRISM targeted prefectures for MSR

Improving Quality of STI Care Services

- 92 providers were trained in STI syndromic care and management. Today, 47 out of HG's 89 HCs offer STI care services
- 24 STI care supervisors received refresher-training in STI syndromic care and intensive supervision activities in progress
- 47% of STI care consultations observed during the final year complied with N&P compared to 28% the previous year

Improving Quality of FP Services

- All HCs in HG fully integrated in FP and STI Prevention
- Compliance with N&P in consultations improved steadily and significantly. During the last year of the project, 71% of CPN consultation services observed complied with N&P compared to 63% the previous year

2.3.1 Improving Child Survival / IMCI services at HC

The following table shows the improvement in the quality of child survival services delivered at the SDPs during the final two years of the project. Observations were performed using a checklist to record compliance with national norms and procedures (N&P) and tallies were completed to calculate the number of client contacts

¹⁸ DED is a German volunteer organization that implemented a clinical RH project in the Kankan region during many years until December of 2000.

in which an accepted minimum standard of 60% (referred to as the green zone) was attained.

Table 12: Percent of Children treated at Health Centers in HG for which the compliance rate to National Norms and Procedures is equal or greater than 60%

(SO2 indicator = 2.2.1 & 2, PRISM = 2.3)

Category of Observation		Sept. 2001 ⁽¹⁾	Sept. 2002 ⁽²⁾
Clinical aspects	Target	15%	50%
	Actual	37%	72%
Counseling	Target	15%	50%
	Actual	50%	73%
Clinical and counseling combined	Target	10%	35%
	Actual	27%	62%

(1) Results for September 2001 are based on data collected at HCs by 7 health districts' supervision teams during the three preceding months. A total of 126 CS observed consultations coming from 45 of the 89 HCs in HG (51%) were retained.

(2) The methodology used to compute the results for FY02 is similar to the methodology described in note 1 but with one exception. Results for FY02 are based on the data collected during the whole year as opposed to the last quarter only for FY01. A total of 406 CS observed consultations were retained. They come from 89 HCs out of the 89 HCs in the 8 health districts of HG (100%).

The percentage of children falling within the green zone more than doubled between fiscal year 2001 and 2002, progressing from 27% to 62%. It is important to note that these are the observed services for which compliance rates were in the green zone for *both* the clinical *and* the counseling aspects. When considered separately, the rates for clinical aspects and counseling improved from 37% to 72% and from 50% to 73% respectively. This represents a sharp increase in the proportion of child survival (CS) services delivered in PRISM's target zone that meet minimum national standards.

The PRISM strategy for improving child survival services at HCs has been twofold: (1) improve the performance of EPI and Child CPC providers in accordance with Guinean National N&P, including *formal training for providers*, improved supervision and on-the-job follow-up training; and (2) support the adaptation and progressive introduction of clinical IMCI in Guinea. The usual interval between the national orientation workshop and the actual delivery of childcare services using the IMCI approach is two years. In Guinea, the process is proving to be slower than average. Therefore, PRISM secured the agreement of USAID and the MOH to launch interventions for improving compliance rates with N&P of childcare services at HCs while still supporting and preparing the ground for the implementation of IMCI activities. These interventions focused primarily on training and monitoring activities that could have immediate impact without contradicting the future IMCI program.

Specific activities included:

- **Adapt Management of Child Illness training curriculum for HC agents.** This curriculum was adapted from the PEV/SSP/ME training modules and covers the management of the eight main illnesses at the core of child mortality in Guinea. Seventeen themes are covered in the following nine modules, namely (1) Basics in the management of child illnesses including infection prevention, counseling targeting mothers, IV solution preparation, etc.; (2) Malnutrition case management; (3) Anemia case management; (4) Acute Respiratory Infection; (5) Measles (epidemiology, prevention); (6) Malaria; (7) Meningitis; (8) HIV/AIDS; (9) Diarrhea
- **Conduct refresher training of HCs' CPC providers in Management of Child Illness.** Staff at all of the HCs targeted for CS/IMCI received refresher training based on the above curriculum. The CPC agents originated from the Dinguiraye prefecture (8 out of 8 HCs), Faranah (12/12 HCs), Kankan (16/16 HCs), Kerouane (8/8 HCs), Siguiri (15/15) and Kouroussa prefectures (12/12 HCs). The two remaining prefectures (Dabola and Mandiana), have been selected as the pilot health districts selected for the integration of IMCI and will receive the official IMCI clinical training during the first half of 2003.
- **Conduct refresher training of HCs' PEV providers in child survival: EPI agents** from 85 out of the 89 HCs received refresher-training in CS with a special focus on building the skills and knowledge needed by the EPI agents to fulfill their main responsibilities in the area of Child Survival. Specific items included: (1) EPI targeted diseases; (2) Immunization norms and standards (calendar, delivery, infection prevention); (3) Cold chain management (vaccines and supplies management, equipment maintenance); (4) Growth monitoring of children 0-5 years old and exclusive breastfeeding.
- **Establish post-training monitoring visits** at the providers' sites by the prefectures' supervision teams. During these supportive visits, supervisors worked with providers and the DRS to correct service delivery practices when needed. Key findings during initial visits include:
 - Nearly a third of the clients did not receive key counseling messages on the importance of immunizing the child.
 - Clients received counseling on breastfeeding at only two thirds of the HCs
 - Over 50% of EPI agents were unable to estimate the HC's target population for immunization, leading to inaccurate EPI coverage rate computations and thus stockouts or overstocking.
 - 18 out of the 50 HCs (36%) faced critical problems associated with infection prevention including absence of chlorine concentrate solution and the inappropriate application of sterilization protocols.
 - The cold chain was well managed at over 80% of the sites
 - At the time of the visit, few HCs had all their vaccines and supplies (such as ice packs, freeze watch and salt water bottles) arranged in the refrigerators in

accordance with N&P. Most sites were making minimal errors that were corrected on the spot with explanations provided.

- EPI management forms are correctly completed and reports properly prepared at most facilities.
- 40% of HCs required further strengthening in counseling practices for child growth monitoring.

2.3.2 Improving Maternal Health Services

The following table shows the improvement in the quality of CPN services from February 2001 to September 2002. As with the assessment of CS services described above, a checklist was used to determine the number of consultations in which the national N&P attained a minimum score of 60%. All scores falling above this minimum standard are considered to be in the "green zone".

Table 13: Percent of CPN consultation at Health Centers in Haute Guinée for which the compliance rate to National Norms and Procedures is equal or greater than 60%

Category of Observation	Feb. 2001 ⁽¹⁾	Sep. 2001 ⁽²⁾	Sep. 2002 ⁽³⁾
Clinical aspects	Target		50%
	Actual	12%	88%
Counseling	Target		50%
	Actual	11% ⁽³⁾	61%
Clinical and counseling combined	Target		35%
	Actual	6%	59%

(1) Measure Situational Analysis, January and February of 2001, 424 CPN consultations observed in Haute-Guinée.

(2) Results as of the end of FY01 are based on the data collected at HCs by 7 health districts' supervision teams during the three preceding months. A total of 127 CS observed consultations were retained. They come from 47 out of the 89 HCs in HG (53%).

(3) The methodology used to compute the results for FY02 is similar to the methodology described in note 1 but with one exception. Results for FY02 are based on the data collected during the whole year as opposed to the last quarter only for FY01. A total of 396 CS observed consultations were retained. They come from 89 out of the 89 HCs in the 8 health districts of HG (100%).

As can be seen from the above table, there was a dramatic increase in the quality of CPN services provided during the course of the project. Scores in the green zone improved from 6% in February 2001 to 59% only 18 months later. Improvement in individual scores was the most striking for clinical aspects, which improved from 12% to 88%. However, the counseling component of the visit also improved significantly from 11% to 61%.

The PRISM strategy for improving maternal health services included (1) improving the performance of CPN providers in antenatal care and birth delivery in accordance with Guinean National N&P via formal training, improved supervision, and on-the-job training; (2) improving community based services in relation to maternal health care by training traditional birth attendants; (3) integrating PAC/AMU services into hospital maternity services while simultaneously addressing weaknesses and deficiencies in key areas such as infection prevention, counseling and the availability of equipment and material; and (4) improving provider performance by improved supervision (including on-the-job training) and intensive post-training and post-integration monitoring activities.

Specific activities included:

- **Adapt EMCH training curricula for HC – CPN/Partogramme curriculum:** With the support of PRISM, a panel of regional trainers adapted the CPN agents' refresher-training curriculum from the PEV/SSP/ME training modules. The curriculum covers ante- and post-natal consultation and the use of the *partogramme* (WHO birth delivery algorithm) for safe delivery practice. The curriculum covers the following 11 themes, grouped into 6 modules:
 1. Communication for behavior change in maternal health
 2. Antenatal consultation
 - 2.1. Risk factors associated to pregnancy
 - 2.2. Preventive care during pregnancy
 3. Birth delivery
 - 3.1. The algorithm, including referral practices as necessary
 - 3.2. Neonatal care
 - 3.3. Post delivery complications
 4. Postnatal consultation and referral
 5. Maternal health and infection prevention (IP)
 - 5.1. IP and the provider
 - 5.2. IP and the client
 - 5.3. Sterilization of medical equipment and material
 6. Supervision of the Traditional Birth Attendant

- **Retrain/Update HC staff in CPN-Partogramme MH:** During the second half of FY01, the DRSs organized, with PRISM, the *refresher training sessions* of 37 HC's CPN providers in CPN/Partogramme described above. All the CPN agents from the 29 HCs in the Faranah region as well as 8 of 10 from the region of Kankan who had not been previously covered by DED before their project activities terminated in HG were included. As of the end of the PRISM's mandate, only 2 CPN agents from Kankan prefecture remained to be updated in CPN/Partogramme in HG.

- **Adapt the EMCH training curricula for Traditional Birth Attendant training:** The TBA curriculum was adapted primarily from TBA training courses

used by UNICEF and Save the Children as well as the new PMA and TBA supervision checklist. The RH Norms and Procedures were followed closely to ensure that educational objectives were properly aligned with the TBA's job description. As most TBAs are illiterate, images were elaborated to insert in the training material to support acquisition of knowledge. By the end of the project, PRISM had sponsored and supported the training of 39 TBAs in its three safe motherhood priority prefectures.

- **Train Community Health Promoters in Safe Motherhood:** PRISM supported the development of the training curriculum for Community Health Promoters in Safe Motherhood and trained 13 regional trainers. By the end of the project, a total of 90 promoters had attended the course (see IR3).
- **Integrate PAC/AMIU services in Maternity services in 3 MSR prefectures:** The MOH/DSR, in partnership with PRISM and JHPIEGO, strengthened Post Abortion Care (PAC) - *Aspiration Manuelle Intra Utérine (AMIU)* – at 7 facilities in HG. In addition to training 24 providers in PAC/AMIU at Donka University Hospital in Conakry, this involved updating 30 providers in FP technology and over 60 in infection prevention. As of the end of PRISM (December 2002), the hospitals of Kankan, Faranah, Kerouane, Dabola, Suiguiri and Mandiana and the Banankoro HC were offering PAC services. The three sites in which PAC services were integrated during FY01 reported a caseload of 394 women benefiting these services during FY02 – of which 30% are less than 20 years old and 83% are adopting a FP method after the intervention. These are very encouraging numbers in relation to the reduction of maternal mortality and morbidity in HG.

2.3.3 Improving FP and STI Prevention and Care

Interventions to improve these services were described in detail above and in the section on IR1 Improving Access to Services. The impact of PRISM's training and TA is best reflected by the degree to which providers improve their compliance with national N&P when offering the services. PRISM assessed this via the new tools introduced in the supervision system ("*fiche d'observation*"). As shown by Table 14, the compliance rates for both treatment and counseling services improved dramatically for STI care consultations, and they exceeded PRISM's targets. The compliance rate for clinical aspects was 65% and the rate for counseling was observed to be 56%. The combined scores from these results yielded a total of 47% of observed consultations that conformed to the 60% minimum standard. This compares to only 28% for the previous year. Likewise, Table 15 below shows significant improvement in the quality of FP consultation services delivered. The percentage of FP consultations for which the compliance rate is acceptable or better progressed from 63% in FY01 to 70% in FY02. These major improvements in the quality of these two important RH services are largely attributable to PRISM's integrated approach of strengthening the technical/clinical skills of providers at the same time as improving supervisory skills of the DPS. The combined

approach resulted in systematic follow up and on the job training. The continued implementation of the FS program promises to produce even greater improvements in the future.

Table 14: Percentage of STI care consultations at Health Centers in HG for which the compliance rate to National Norms and Procedures is equal or greater than 60%

Category of Observation		Sept. 2001 ⁽¹⁾	Sept. 2002 ⁽²⁾
Clinical aspects	Target	35%	50%
	Actual	66%	65%
Counseling	Target	25%	50%
	Actual	32%	56%
Clinical and counseling combined	Target	20%	40%
	Actual	28%	47%

(1) Results as of the end of FY01 are based on the data collected at HCs by the 7 health districts' supervision teams of HG during the three preceding months. There was no STI care observations reported in Dabola's HCs. A total of 47 STI care consultations were retained. They come from 28 HCs out of the 89 HCs in HG (31%). The consultations were observed and reported on with the form "Fiche d'Observation: Consultation pour les IST/SIDA". The form is closely based on Guinea's STI Norms and Procedures and represents a simplified version of the Measure's questionnaire. The selection of questions was made with the DRS's and DPS's staff on the basis of what was considered critical for quality of service in both the clinical and counseling aspects.

(2) The methodology used to compute the results for FY02 is similar to the methodology described in note 1 but with one exception. Results for FY02 are based on the data collected during the whole year as opposed to the last quarter only for FY01. A total of 151 observed STI care consultations were retained for FY02. They come from 71 HCs out of the 89 HCs in the 8 health districts of HG (80%).

Table 15: Percentage of FP consultations at Health Centers in HG for which the compliance rate to National Norms and Procedures is equal or greater than 60%

Category of Observation	Sept. 2001 ⁽¹⁾	Sept. 2002 ⁽²⁾
Target	15%	50%
Actual	63%	70%

(1) Results as of the end of FY01 are based on the data collected at HCs by 6 health districts' supervision teams of HG during the three preceding months. A total of 38 FP observed consultations were retained. They come from 21 HCs out of the 89 HCs in HG (24%). The consultations were observed and reported on with the form "Fiche d'Observation: Planification Familiale (PF). The form is closely based on the MOH's Norms and Procedures and represents a simplified version of the Measure's situational analysis questionnaire. The selection of questions was made with the DRSS and DPSs staff on the basis of what was considered critical for quality of service in both the clinical and counseling aspects.

(2) The methodology used to compute the results for FY02 is similar to the methodology described in note 1 but with one exception. Results for FY02 are based on the data collected during the whole year as opposed to the last quarter only for FY01. A total of 110 observed FP consultations were retained. They come from 44 HCs out of the 89 HCs in HG (49%).

Health Management Information System (H/MIS)

2.4 Strengthening the National Health Management Information System

PRISM worked mainly at three levels to improve the HMIS and the capacity of health managers to use the system to achieve practical results: (1) integrate the RH indicators package into the national H/MIS, (2) decentralize computerized data processing of the updated HMIS to the DRS and (3) improve the use of data for decision making at all levels.

- ☞* RH indicators integrated into the National H/MIS
- ☞* Updated H/MIS monthly report forms for DPSs, HCs and hospitals disseminated nationwide
- ☞* Updated computerized H/MIS installed and functional at DRSs
- ☞* Basic computer skills training conducted for the DRSs' staff in HG

2.4.1 Integrate the RH indicator package into the National H/MIS

A rapid assessment of the Guinean H/MIS conducted during the early stages of the project revealed that data for key RH indicators were not being routinely collected. PRISM provided regular and focused technical assistance to the MOH at the central level to correct this situation: RH indicators were selected, proposed and, finally, validated during a workshop held in Kindia in December 2000. The following year PRISM brought in a consultant from EpiConcept, the firm that had been developing the computerized H/MIS system since the early 1990s, to integrate the RH indicators into the national system and train key personnel in the use of the modified version. The new data collection forms were tested and finalized and the MOH determined that their dissemination to all facilities nationwide would occur during the January 2002 CTPS meetings. As a result of PRISM support, the following results have been achieved to improve RH reporting in the Guinean H/MIS:

1. Selected RH indicators were integrated into the H/MIS system
2. Computerized H/MIS tools were adapted to integrate the new indicators
3. Key MOH staff members were trained to collect and analyze information from the RH indicators
4. Monthly data collection forms for HCs, Hospitals and Health Districts (DPS) were updated, printed and disseminated to SDPs nationwide
5. The H/MIS has been producing more comprehensive data about reproductive health technical areas since January 2002

2.4.2 Decentralization of the National HMIS to the DRS Level

The computerized H/MIS application for data entry and analysis was adapted for use at the regional level following a pilot test at the DRS of Kindia. Subsequently, PRISM installed the updated computerized application at the DRSs in Kankan and Faranah and conducted training for key DRS personnel to ensure that data from monthly reports were entered regularly, beginning with January 2002. PRISM offered several training activities in basic computer use (Windows, Outlook Express, Explorer, Word and Excel) targeting MOH staff at the decentralized level (mainly at the DRSs) as well as the staff of the MOH's central units directly involved with RH and responsible for supporting the decentralized level.

PRISM also provided TA to the DRS in health data processing beyond the core H/MIS. The CBD/SBC database designed by PRISM and maintained initially by project staff has been transferred successfully to the DRSs. The following data processing and reporting systems have been developed and are at varying stages of transfer to the DRSs: Training database; Essential Resources at SDPs database; Compliance Rates of Observed RH Services Delivered at SDP database; Supervision database; and Service Delivery Points Management Performance Assessment database (in development). The work plan for PRISM II includes the complete devolution of these H/MIS to the DRS (and in some cases to the DPS) level by the end of FY05.

2.4.3 Strengthen RH Managers' Skills in Data for Decision-Making (DDM)

A PRISM supported evaluation of the PHC system in 2002 revealed that most providers and numerous HC supervisors were incapable of using data to make simple calculations that could improve the quality of the services they were providing. For example, the majority could not correctly calculate the target population of their site and had very limited understanding of how service statistics, demographic and other survey data could be used to optimize the use of their scarce resources. The capacity of the district level supervision personnel was also insufficient in the important areas of basic health statistics, PHC monitoring and evaluation (*système de monitoring*) and the use of data for management purposes. PRISM has been improving their skills through on-the-job training during the evaluation visits. The experience demonstrated that the main obstacle to improving the quality of data and the DDM capacity is the low level of technical competence of district supervision personnel and HHCs in the aforementioned areas. Although on-the-job training of this personnel will continue during DRS/PRISM supervision visits, a more systematic training program targeting district supervisors and HHCs is planned for PRISM II.

WORK TOWARD THE INTERMEDIATE RESULTS (IR)

IR3 Increase DEMAND



PRISM 's approach to increasing demand for RH services in HG has been to improve the coordination of IEC programs, strengthen provider-client interaction, conduct health promotion interventions, and improve IEC management, delivery capacity and sustainability. Specifically, this included:

1. Improve Coordination of IEC Programs

- Assistance to MOH and DRS in developing national and regional IEC strategies and protocols, action plans and IEC working groups.

2. Strengthen Provider-Client Interaction

- Evaluate, reproduce and distribute existing IEC materials.
- Develop, produce and distribute new IEC materials for provider-client settings, and
- Train service providers in counseling.

3. Conduct Health Promotion Interactions

- Hold large and highly visible IEC campaigns.
- Carry out advocacy efforts at the community level and community mobilization, and
- Award small IEC grants to local NGOs.

4. Improve IEC Management and Delivery Capacity

- Train IEC managers & providers and provide them with regular technical assistance.

IR3. Increase Demand for Basic Health Services

At the advent of the PRISM project in 1997, IEC/BCC activities in Guinea were typically donor driven, sporadically conducted (e.g. in response to an epidemic) and not fully evaluated for impact. IEC/BCC strategies and measurable objectives were notably absent from most reproductive health and health promotion guidelines. In the absence of national guidelines, projects often developed competing or conflicting messages, and resources were not optimally used. PRISM therefore began the institutional building process of working with national, regional and district partners to develop strategies and implementation plans that included all actors, were research-based, focused on measurable objectives, and included an evaluation component. At the end of the first five years of the PRISM project, a noticeable air of collaboration has emerged, particularly among two disparate but equally important groups: community leaders and the MOH/PRISM personnel, and among the large donor projects (World Bank, UNFPA, USAID). PRISM has clearly played an important role in fostering "win-win" situations at central and local levels.

Demand generation interventions were designed 1) to increase the use of essential health services (FP, STD/AIDS, maternal and child health) and 2) to promote positive health behaviors. Communication interventions were research-driven, strategically designed, implemented with strong community support, and carried out in combination with other PRISM components -- towards the end of improving the health of Guinean families. The IEC/BCC strategic axes included:

- Improved IEC/BCC Coordination
- Strengthened Client-Provider Interaction
- Increased Demand for RH Information and Services and Encourage Health Promotion
- Improved IEC Management, Delivery Capacity and Sustainability

Improve Coordination of IEC Programs

3.1 IEC Coordination at the Central Level

Within the Ministry of Health, the Division of Health Promotion (DHP) has the responsibility for IEC/BCC coordination at the central level. PRISM worked closely with the Division to strengthen its capacity to respond to this mandate. Specifically, PRISM provided technical, logistical, and equipment (e.g. computer) support to the Division. Among the activities carried out with the DHP were:

- Design of message and strategies for youth campaign (discussed below)
- Finalization of the National IEC RH Strategy document
- Launch of men and youth campaigns

- Design of IEC messages and strategies for MCH campaign
- Facilitation of an IMCI/community workshop (in collaboration with BASICS)

3.1.1 IEC coordination at the regional and district levels: Groupes Régionaux (Préfectoraux) IEC (GRIEC/GPIEC)

IEC/BCC activities cut across public and private sectors; therefore, both sectors need to be included in the development, implementation and evaluation of activities. At the beginning of the project, PRISM supported a workshop that included representatives from private and public sector IEC/BCC entities from all 15 districts. The representatives, who had not previously met to discuss IEC/BCC activities, formed themselves into three regional IEC working groups (IEC WGs, known more popularly by their French acronym *GRIEC*). Each working group produced regional workplans of all IEC/BCC activities, an organization secretariat, and a scope of work for their group. The regional workplans, featuring activities of all IEC/BCC players in the region, was an innovation for Guinea. This workplan and the entire inclusionary process were greatly appreciated by the Regional Inspectorates, who felt that their ability to manage IEC/BCC activities in their regions was greatly enhanced.

The *GRIEC* members, and their district-level equivalent, *GPIEC*, have taken on increasingly important roles over the five project years. For example, during the Youth campaign, *GRIEC* members carried out the following activities: (i) identification, training and supervision of peer educators, (ii) negotiation with and mobilization of community leaders; (iii) review and recommendation of small grants proposals; (iv) training and supervision of small business partners (e.g., hair salon owners), and (vii) coordination of campaign launching.

Selected *GRIEC* members received local and third-country training to improve their IEC/BCC capabilities. PRISM, while funding the majority of the *GRIEC* quarterly meetings, successfully negotiated with other funding agencies (e.g. GTZ) to support *GRIEC* activities. The success of the *GRIEC* model has led the Division of Health Promotion to consider establishing a similar organ at the national level, an idea strongly supported by PRISM and USAID.

3.2 Strengthen Client-Provider Interaction

The IEC/BCC component assured that providers were adequately trained and equipped to offer high quality services to the populations motivated by the project's demand generation activities. Specifically, PRISM carried out the following activities.

3.2.1 IEC/BCC Job Aids

PRISM reproduced and distributed the following materials for providers at health centers (HCs) and Community Health Agents (CHAs):

- Flipcharts for FP (350), AIDS (350), diarrhea, (375) and adolescent health (660)
- Posters for AIDS prevention (500); 100 copies each of five different posters
- Brochures for MCH (3,000), FP (55,000), AIDS (70,000), CDD (50,000) and model wooden penises (200).
- BERCER poster for improved counseling (1,100)
- Infection prevention poster in French and English; also distributed to refugee sites (600).
- Contraceptive display cases placed in FP consultation rooms, with FP method names, samples and prices (200).

3.2.2 Training curriculum for health workers and Peace Corps Volunteers

PRISM modified the MOH training curriculum to assure emphasis on interpersonal communication/counseling (IPC/C) for health providers and community health workers. PRISM also provided technical assistance to the U.S. Peace Corps to train 18 Volunteers and their MOH counterparts in IPC/C. PRISM reinforced the interpersonal skills of 22 agents to offer youth-friendly health services.

3.2.3 IEC/BCC materials for Community Health Agents (CHAs)

PRISM produced and distributed *paghes* and shirts featuring the CBD logo. This logo was finalized with MOH input and will serve to create a sense of unity among the community health agents, as well as clearly mark CBD actors for potential clients. Assistance was provided to develop CBD training curricula, as well as 6 reproductive health training "aprons" for CBD trainings. These aprons provide a realistic and convincing display of key reproductive organs and functions, such as fertilization and development of the fetus. All CBD agents also received brochures, flipcharts, model penises and other job aids that PRISM provided to health centers.

3.2.4 Distance learning radio program *Agents de Santé, Amis des Clients (Health Agents, Friends of the Clients)*

PRISM developed 13 episodes of a distance learning radio program to reinforce health workers' interpersonal communication skills.¹⁹ Themes covered included: (1) The definition of interpersonal communication; (2) Techniques of good interpersonal communication; (3) Conditions contributing to a positive health worker-client partnership; (4) The promotion of exclusive breastfeeding; (5) Immunization; (6) Growth monitoring and feeding after six months; (7) Counseling and the side effects of contraception; (8) Prenatal care; (9) Promotion of assisted childbirth; (10) Sexually transmitted infections; and (11) Home visits to prevent and treat malaria and acute respiratory infection.

¹⁹ The 13 episodes were developed during PRISM. production and broadcast took place after the completion of PRISM (i.e. during PRISM II).

3.3 Increase Demand for RH Services and Conduct Health Promotion Activities

The driving force behind demand generation in the project area was the development and implementation of carefully targeted multimedia behavior change campaigns. Each campaign followed a similar development path, viz. (i) strategies were developed based on qualitative and quantitative research; (ii) members of the target audience helped to identify activities and materials; (iii) the GRIEC members played a key role in management and supervision; (iv) community-based and individual efforts (e.g. IPC/C) were complemented by mass media; and (v) a final evaluation determined campaign impact. In addition to these campaigns, the project supported child-to-child (EPE) and small grants for health promotion activities.

3.3.1 Mini campaign

One of the first tasks for PRISM was to integrate 30 health centers with RH/FP services. An integral part of the integration was the development of a "mini" (denoting its limited geographical scope) campaign that consisted of:

- Three regional religious leaders' conferences with representatives from 30 newly integrated (with RH/FP services) Health Centers
- Briefing and equipping Health Centers with IEC materials (posters, flipcharts, brochures)
- Ten rural radio programs in 4 languages to promote the 30 newly integrated sites
- Community mobilization activities around each of the 30 health centers

The campaign was successful in motivating clients to go to the health centers for the new services. Lessons learned during the mini-campaign proved valuable for future IEC/BCC efforts.

3.3.2 Male motivation campaign

Research showed that Guinea was a pro-natalist society and that men traditionally made household decisions related to health care, fertility and sexuality. It also confirmed that the supposed opposition of men to family planning was based on erroneous assumptions and information, such as confusing contraception with permanent sterility. Based on priorities identified with national, regional and local partners, PRISM launched the Male Motivation campaign to achieve the following **objectives**:

Among religious leaders:

- Increase knowledge about modern contraceptive methods, and
- Increase the frequency of talking about family planning during sermons

Among married men and women:

- Increase the proportion of married men capable of citing at least one modern contraceptive method,
- Increase the proportion of men who discuss family planning with their spouses,
- Increase attitudes that are favorable toward small family size and contraceptive use, and
- Increase contraceptive use in the study regions.

To achieve these objectives, PRISM and its partners carried out the following activities:

- 15 Religious Leaders Conferences (reaching ~ 450 leaders)
- Production and distribution of Religious Leaders Print Materials
 - Brochures (French and Malinke), 275,000 and 180,000 copies, respectively
 - Poster (in French and Malinke), 5,000 copies
- Religious Leaders Video
- Christian Leaders Conference
- 3 Regional, 1 National and 12 District Campaign Launches
- 15 Traditional music contests (~ 22,500 attendees)
- 30 Community mobilization events (~ 30,000 attendees)
- Production and distribution of print materials:
 - Posters: 4,500 copies of two posters (French/Malinke languages)
 - Brochure: 200,000 copies
- Comic Cassette *La Vie N'est Pas Compliquée*: 3,000 cassettes (French/Malinke)
- Rural radio programs: 10 programs in 4 languages
- Radio spots: 10 spots in five languages
- 26 episodes of the radio drama *La Vie N'est Pas Compliquée*
- Publicity materials w/ logo: T-shirts (3,200), plastic market bags (20,000), cloth bags (120), hats (3,200), stickers (1,600), water pots (800), key chains (1,600), pens (1,600), cloth wraps (*pagnes*) (1,000)

Results: The campaign had significant impact on the knowledge, attitudes and practices of religious leaders and married men. Selected impact results include the following²⁰:

- Percentage of religious leaders aware of 3 or more modern methods increased from 73 percent (baseline) to 99 percent (final evaluation).
- 77 percent of men and 68 percent of women were exposed to at least one campaign material.

²⁰ For complete evaluation results, see *Impact of a Male Motivation Campaign*. JHUCCP Field Report Number 13, April 2002.

- The proportion of women who were either using a modern method or intending to use one in the future increased significantly from 33 percent at baseline to 39 percent at follow-up.
- Higher exposure to campaign activities/materials significantly increased likelihood of several indicators, including women who reported personal advocacy of family planning and men who approve of family planning (increased from 55 percent at baseline to 69 percent at follow-up).

3.3.3 Youth Campaign

PRISM, in collaboration with the Ministry of Health, representatives from NGOs, Peace Corps and donors, including the World Bank and other development groups launched a youth campaign to increase young people's awareness of HIV/AIDS and pregnancy prevention, and to reinforce and provide young people with the skills they need to make healthy decisions. Community-based support from parents, service providers and teachers, combined with youth-driven peer education interventions and youth-network were the driving forces behind the campaign. All campaign materials featured the logo and slogan *My Right—Information; My Duty—Abstinence or Condom Use*.

Specific **objectives** for the campaign were as follows:

Young People:

- Increase the percentage of youth that consider the Health Center a viable source of information, as well as condoms and other contraceptive methods.
- Increase the percentage of youth who know how to protect themselves against STIs, including HIV/AIDS; increase the percentage who have chosen abstinence or regular condom use, to personally prevent HIV/AIDS.
- Increase the number of young IST patients who have encouraged their partner(s) to visit a Health Center for STI treatment.
- Increase the percentage of young girls who use modern methods.
- Increase the percentage of youth that use condoms during the last sexual intercourse

Parents:

- Increase the percentage of parents who have spoken to their children about issues related to growing up, including sexuality and HIV/AIDS prevention.

Health Center Personnel:

- Increase the percentage of Health Centers who provide youth friendly services including: welcome reception, counseling, HIV/AIDS and pregnancy prevention messages and referrals.

To accomplish these objectives, PRISM and its partners carried out the following **activities**:

- 9 district launches
- More than 200 peer educators selected and trained (equal numbers between boys and girls)
- 150 businesses oriented to HIV/AIDS and implicated in the campaign
- District IEC Committees (GPIEC) managed campaign activities in their districts
- 20 "youth friendly" health centers identified, and 22 providers trained
- Community mobilization events held, including video and slide shows, street shows, in-school Q&A sessions, sporting events, and gala evenings
- Selection and training of 15 members of the "Press Club" from area schools
- 16 interactive rural radio shows produced and aired (French/Malinke)
- 5 spots produced and aired (French/Malinke)
- 8 districts theatre groups produced plays (*Si Je Savais, If I Knew*) and discussion for youth and community members
- Brochures produced and distributed on STI/AIDS (40,000), abstinence (30,000), pregnancy (30,000).
- Posters produced and distributed on condom use (2,295), parent-child communication (1,500).
- Promotional materials w/ logo: T-shirts (2,500), caps (2,500), stickers (1,900), pins (1,000), pens (4,650), shirts (900), commemorative cloths (950), balloons (4,800), flags (1,500), handbags (500), bags (100), combs (2,000)

Results: In April 2002, researchers conducted an impact evaluation of the youth campaign and found significant impact based on the degree of exposure to activities compared to control sites. Selected findings include the following²¹:

- Significantly higher proportion of young men and women in the intervention area ever using a condom or using a condom at last sex, when compared to the control site
- Significant association ($p < 0.01$) between the level of campaign exposure and condom use at last sex.
- 83 percent of men and 63 percent of women reported participating in at least one campaign activity.
- 60 percent of males in the intervention area reported more openness (to discussing publicly sexual matters) in the intervention area as compared to 33 percent in the control area.
- Youth reported significant changes in sexual behavior in response to campaign exposure.

3.3.4 Maternal and Child Health Campaign

The maternal health and child immunization statistics in Guinea are among the worst in the world, with an estimated 528 women dying for every 100,000 live births and

²¹ For a complete set of impact evaluation results, contact Stella Babalola, JHU Senior Research Officer, or Carol Sienche, Senior Program Officer, 111 Market Place, Suite 310, Baltimore, MD 21202

only 30% of the children in Haute Guinea completely immunized. To address this alarming situation, PRISM and its partners launched a maternal and child health campaign (known by its local name *Den Ba Nyuma Timin Nan Di*—A Good Mother Who Knows How To Take Care of Her Child), which involved 107 health centers covering a population of 2 million people

The **objectives** of the campaign were to increase the percentage of

- Women who know that pregnant women should make a birth plan covering pregnancy, labor, delivery and post-natal health care
- Women who can correctly list 3 components of a birth plan
- Men and women who understand and have joined a local MURIGA
- Women who can correctly list two danger signs for a woman who is pregnant or in labor and two for a post-partum woman indicating that she should seek help from a trained health care provider
- Women who can correctly list two risk factors for pregnant women
- Women who are currently using a modern family planning method
- Community members who state they believe that health center and community accountability has increased since the campaign began
- Children aged 0-12 months who have an immunization card and are fully vaccinated against the six major childhood diseases

To achieve these objectives, PRISM and its partners carried out the following **activities**:

- “Community Dialogue” meetings of health center workers and members of the community to discuss current maternal health problems and services available (in 40 sub-districts)
- 200 peer educators and 10 CBD agents trained
- Orientation to campaign activities for more than 400 women’s groups
- 20 district campaign launches
- Promotional materials produced including commemorative cloths (600), pins (3,000), and t-shirts (1,200)

Results: The MCH campaign is in progress at the time of the writing of this report, therefore, impact evaluation data are not yet available.

3.3.5 Small grants

To encourage and build on local initiatives, PRISM awarded small grants to local NGOs and organizations to carry out reproductive health activities. The objective of the small grants was to enable local NGOs to conduct activities designed to expand the impact of PRISM’s IEC/BCC component on increased use of health centers and the practice of preventive health behaviors. The GRIEC also served as funding channels for

community based interventions. Over 20 grants were distributed to small, local groups, as summarized below:

Table 16: Small Grants distributed to local groups to promote IEC activities:

Group	Intervention Focus
Prefecture IEC WG (8)	RH Action Plans
CPTAFE	Awareness of consequences of female genital mutilation (FGM)
APROFIG/Kankan	Youth and reproductive health conferences
AFFAAV/Faranah	Training of traditional mid-wives in reproductive health
Assoc. Promo. 70/Siguiri	Reproductive health awareness conferences
CPTAFE/Faranah	Awareness of consequences of FGM
CENAFOD/Dabola	Awareness of reproductive health issues at village level
CPTAFE	Awareness of consequences of FGM
ASTRAG/Guekedou	Training of traditional healers in STI/AIDS
AED/Nzerekore	Awareness of RH issues among school-aged youth
Peace Corps Volunteers (6)	Awareness of local RH problems and solutions

3.3.6 Child to Child strategy (*Enfant pour Enfant: EPE*)

Given the high child mortality rate, the low percentage of children completely immunized by age 2 and the high illiteracy rate among women, PRISM launched the EPE strategy in 1999 in the Faranah district. The EPE approach seeks to increase the immunization coverage of children from birth to 5 years of age by involving older children and their teachers in keeping up with the vaccination schedule of younger children. Concretely, the EPE strategy mobilizes students in the fifth class (eighth grade) and their teachers to reach and encourage mothers, in particular, to complete the full course of immunization for their infants.

The EPE strategy was introduced in 20 schools in the urban centers of Dabola and Kankan during the third quarter of 2001. Eighty-four teachers and eight health workers from Kankan, and 14 teachers and three health workers from Dabola attended the EPE workshop, where they received training and promotional and technical materials to take back to their schools.

The EPE strategy resulted in a significant decrease in the drop out rate for follow up vaccinations, namely from 28% in December 1999 to only 15% in June 2001. In addition, 41% of all children under 1 year of age who were completely immunized were part of the EPE program.

3.4 Improve IEC Management and Delivery Capacity

Improving local capacity to design, implement, manage and evaluate communication interventions was a major focus of the IEC/BCC/Demand Generation interventions. PRISM has supported capacity development through the following activities:

- **IEC Working Groups.** Members of the IEC Working Groups have been strengthened through: (i) training, and (ii) opportunities for expanded leadership and responsibility in the ongoing communication interventions and campaigns under PRISM (“learning by doing”). This hands-on experience proved valuable to increasing their capacity and motivation to conduct IEC/BCC interventions. At least ten of the Working Group members have benefited from third-country training, supported by PRISM.
- **PRISM Regional IEC Coordinators.** PRISM has supported the professional development of its Regional IEC Coordinators by carefully identifying pertinent training and conference opportunities in Guinea and the region, providing mentoring and career guidance, and allowing the Coordinators to assume gradually increasing responsibility and leadership for IEC/BCC activities in their regions.
- **SCOPE.** PRISM prepared Strategic Communication Planning and Evaluation (SCOPE) workshop materials and made a presentation of SCOPE to MOH and USAID. SCOPE is a process of discovery, assimilation of information, creativity, and learning by doing. Through an interactive software interface SCOPE allows people to design, implement, and evaluate effective health communication projects directly on the computer.

WORK TOWARD THE INTERMEDIATE RESULTS (IR)

IR4 Improve COORDINATION



PRISM 's approach to improve coordination of RH interventions has been to strengthen the MOH's managerial and communication capacities, to participate actively and support existing coordination processes, and to promote when needed the creation of new but sustainable mechanism, especially at the decentralised level. Specifically, this included:

At the decentralised level

- Support the establishment, functioning and actions of RH Regional Working Groups;
- Support the preparation and participate into the CTPS and CTRS meetings;
- Strengthen the managerial capacity of DRS/DPS, especially of their supervision activities.

At the institutional level

- Review project's activities, results and achievements with the MOH and USAID
- Participate to the extend possible in the development of health related policies at the central level;
- Improve electronic communication capacities of MOH at the central level and at the DRS level;
- Plan and implement interventions with RH partners in the field.

IR 4: Improve Coordination

Throughout the implementation of PRISM, coordination among partners and donors has been a strategic requirement to secure efficient resource allocation toward the achievement of common goals, to share information for effective management, to support communication and to build on lessons learned. It has been important to consider and plan for collaboration at the local level, strengthen capacities and partnerships at the central and regional levels and to build linkages and mechanisms to support communication and exchange and to root the health program in Guinea into the larger social and economic fabric.

Effective coordination depends on the quality of the information being shared and disseminated and on a consultative planning process to align goals and target resources where they will have the most positive impact. PRISM has included collaborating and cost-sharing partners both in our work planning and program implementation and made joint efforts to monitor program progress.

The PRISM Project, through MSH* and its subcontracting partners, JHU/CCP* and JHPEIGO*, developed strong collaborative relationships across a broad range of partners:

- the Ministry of Health at the central, regional (DRS Kankan*) and local levels
- the Ministry of Decentralization and Micro-realization
- the Ministry of Education
- multilateral international organizations including WHO*, UNICEF*, UNHCR, IPPF, ILO*, WFP*, the European Union*, and the World Bank
- bilateral donors development agencies such as USAID, CIDA (Canada) *and GTZ* and KFW* (Germany)
- international NGOs such as PSI, EngenderHealth, Helen Keller International, Africare, Adra and Save the Children
- regional projects such as SIDA3 and STEP
- local NGOs, such as AGBEF*and CENAFOD
- health services run by mining companies
- educational institutions (e.g., the University of Kankan, technical schools)
- all health centers managed by local *COGES*

* Partners that participated in achieving PRISM goals through the cost share program. Additional cost share partners were the Hewlett Foundation (CERREGUI and F4060), the Gates Foundation (SEAM), and numerous individuals who committed time and services.

Regional-Prefecture level:

The primary counterparts for the project were MOH employees within the DRS and DPS. Much effort was extended to assure that these levels were able to function

autonomously and effectively in their ability to manage services under their supervision. At the local level, PRISM supported the DRS and DPS by expanding their leadership capacity and through project participation in the CTRS and CTPS, which served as an anchor to provision of technical assistance for decentralization. This report has highlighted ways in which the project worked to build the DRS capacity to coordinate and support (1) its own staff and (2) donors and technical agencies (3) the community and other partners working in health, and to leverage inputs and to maximize the potential of collaborating with other sectors.

Fostering electronic communications between the regional and prefecture levels has been another strategy to improve coordination and reinforce decentralization. PRISM introduced e-mail and trained staff in its use within the DRS and within the DPS when the opportunity arose. E-mail communications for purposes of coordination and management were promoted between the regional and national levels.

PRISM supported the two IEC regional working groups (GRIEC) and the IEC prefecture working groups (GPIEC). The regional IEC group (GRIEC) is the strategic overview body for demand generation and behavior change activities and programs in a region, while the prefecture IEC working group (GPIEC) is the operational coordination body through which most community based IEC/BCC interventions, especially campaigns, are implemented. PRISM provided technical assistance to the GPIEC and monitored both the quality of their work and the use of the funds allocated to them by the project.

Reproductive health regional working groups (respectively ERCOSAR and CORASAR in Kankan and in Faranah) had been established with PRISM support during the past years to address specific issues in relation to project implementation. The functions of these working groups were fully integrated into the coordinating bodies of the PHC system in the final year of the project. Continuous PRISM participation and support to the CTRS and CTPS and integration of the work groups' operational plans into the overall regional and prefecture health plans insured effective implementation without the need to maintain these special regional RH work groups. It is expected that the GRIEC and GPIEC will follow a similar integration process within the coordinating bodies of the PHC system. PRISM has established channels for addressing these needs with the MOH at both the central and decentralised levels.

Supporting the annual review of the PEV/SSP/ME program: PRISM attended and participated actively in the annual review and programmatic meetings of the PEV/SSP/ME which led to clarifying and authorising an increased role for community participation in the management of the health centres. PRISM's advocacy was significant in promoting this liberalisation to enable enhanced community participation and revitalization of the COGES as a critical element of the system.

PRISM Operation Plan Review: PRISM support strategies and operational plan were reviewed in depth with the Kankan and Faranah DRS personnel following the

change at numerous key managerial positions in these organizational units. Training activities were rescheduled to cover new needs and to avoid training health personnel that were scheduled to play different roles in the near future.

Regional-national coordination: Central-level support was provided to reinforce policy, norms and standards guidance to the peripheral level to allow effective implementation and adherence to the decentralization policy. In collaboration with other international donors, PRISM developed and promoted mechanisms to coordinate with government health authorities and with other governmental units. At the national level, PRISM participated in CTCs and in the annual review of the PHC system. The project supported the development of national policy and strategy for cost-recovery, essential drug management (including contraceptives), H/MIS reform, policy in SM, IMCI, HIV/AIDS/STI, articulating Guinea's proposal for funding from the Global Fund for HIV/AIDS, TB and Malaria (GFATM), national IEC strategy, and updating the PMA, RH guidelines, and referral protocols.

The project facilitated field visits by central-level authorities to the regions and prefecture levels to share lessons learned, present new tools and approaches, and communicate monitoring and evaluation results. PRISM's results and new successes at the regional level were shared regularly with larger audiences at the national level (with the DRS represented at such debriefings).

Support to MOH at the central level: Although PRISM was a decentralised project with a focus on the regional and district levels, its experts, advisors, consultants and coordinators supported, as much as was feasible, collaborative health-related policy development.

- PRISM supported the development of IMCI in Guinea and served as a member of the National IMCI "*Groupe Technique*"
- PRISM supported the development of the Safe Motherhood National Policy and its coordination unit at the central level, the "*Programme National de Maternité sans Risques*" (PNMSR), as well as its implementation at the regional level
- PRISM participated in STI/AIDS related coordination meetings in support of the CNLS
- PRISM participated in the country coordinating group for the Global Fund to fight AIDS, Malaria and TB
- PRISM was a leader in the development of one major component of the National Health Development Plan – the Minimum Package of Activities for the primary health care system of Guinea
- PRISM supported the "*Comité National de Formation Continue en Santé*" (CNFCS)

Strengthening MOH electronic communication capacity: To strengthen the MOH managerial capability, PRISM allocated computers to various units involved in coordinating RH activities (SG, DNSP, DNPL, SSEI, Dips, DRSs, etc). The goal was to ensure that the MOH organisational units have better access to data and other information and have improved communication capacity through the regular use of email and the

Internet. A local network (LAN) serving key units at the central level was installed and PRISM contracted with a Conakry-based computer service firm to ensure maintenance and training.

Leadership Strengthening Program for the MOH's Senior Staff: Strengthening leadership skills of managers at all levels of the health system has become increasingly critical during the last few years as the MOH has been actively pursuing its decentralization policies. These skills are essential for assuring a coordinated response for the progressive changes being pursued. The Minister of Health and his General Secretary actively encouraged the development of a leadership strengthening program for the MOH. The program was designed with the MOH's senior staff and built around MSH's M&L framework. Participants included the MOH's 6 national directors, 8 regional directors, political, economic, and international advisors to the Minister of Health as well as his Cabinet Chief, the Inspector General, and the Secretary General. PRISM is currently discussing with the Health Minister and the General Secretary approaches to follow to complete the training of the ten cohort members who were unable to participate in all the training modules and on the extension of the program to the lower tiers of the ministry.

Supporting the MOH's training program management (CNFCS): In recognition of the need to strengthen the quality of in-service training delivered at various levels in the health care system and in order to improve coordination among partners, the MOH established the *Comité National de Formation Continue en Santé* during 2001. PRISM was a dynamic factor of change in the approaches used throughout the country to train health providers and managers and contributed to the evolution towards methods compatible with the needs of adult trainees (andragogic approaches). Other technical agencies have also been moving in the same direction, thus creating a "critical mass" of partners sharing a similar vision of in-service and pre-service training. PRISM supported the development of a cadre of regional trainers in PHC/RH through a Training of Trainers (ToT) program for public health professionals with the MOH. With this ToT, the health sector in HG currently has at its disposal a total of 17 certified trainers at the basic level and eight certified trainers at the advanced level.

Support to the National Safe Motherhood Policy development and coordination:

Coordination with the PNMSR on MURIGAs: The PRISM Advisor in Quality of Care continued to coordinate closely the development of PRISM's Safe Motherhood activities with the MOH Head of the *Programme National de Maternité sans Risques* (PNMSR).

Post Abortion Care (PAC): PRISM assists the MOH to coordinate the implementation of standardized services for PAC and supports the analysis of service statistics for PAC. The project actively supported the MOH in the various tasks leading to the participation of the Guinea delegation to the regional conference held in Dakar on PA.

Emergency Maternal and Neonatal Care National Guide: PRISM technical staff participated in the coordination and consensus building workshop held in Conakry.

sponsored by WHO in February 2002 to review the Emergency Maternal and Neonatal Care National Guide. During the workshop the draft of the guide was reviewed and recommendations formulated.

Support to the adaptation and coordination of the Integrated Management of Child Illnesses (IMCI) approach in Guinea: In collaboration with WHO, UNICEF and others, the GoG adopted the IMCI approach to child survival in 1999. PRISM participated in the support offered to the MOH to implement IMCI activities. The integration of IMCI has followed the WHO guidelines, building the program in a step wise fashion. It involved broad based partnerships and coordination at the national level and between the national and regional levels. PRISM supported the MOH in these coordination efforts and in implementing the approach. In particular, PRISM has spearheaded the application of IMCI in pilot sites in HG and at the community level (see IR2).

Support to the National IMCI Technical Group: PRISM maintained regular participation in the activities of the National IMCI Technical Group that spearheaded the integration of IMCI in Guinea. The scope of work of the Steering Committee and Technical Committee for IMCI were reviewed and corrected and the IMCI operational workplan was integrated into the workplan of the national primary health care program (PEV/SSP/ME). Coordination of activities with the BASICS II project contributed to overall program efficiency and effectiveness.

DCMI/GMME survey preparation and coordination: PRISM participated closely in the preparation and coordination of the DCMI/GMME survey which was successfully completed with assistance from the Rational Pharmaceutical Management project (RPM+), a USAID centrally funded project being implemented by MSH. PRISM was the management partner for the survey and coordinated field activities. Numerous coordination meetings and work sessions were conducted in Guinea with the MOH and with BASICS II to ensure the success of this activity.

Support the Management of DRS/DPS Supervision Activities: The strengthening of the DRS/DPS supervision system was a high priority for the project. PRISM staff guided the review of supervision concepts and the system for implementing them during the CTPS and CTRS meetings. PRISM technical staff also worked directly on site at each DPS in its focus zone on the development and update of operational plans for facilitative supervision.

National Immunization Days (NIDs): PRISM was actively involved in the supervision and coordination of the NIDS in HG for each year they were conducted. Technical personnel and logistical resources were allocated to the two DRSs as well as the prefectures of Siguiri, Kerouane, Kouroussa and Faranah.

Collaboration with Mining Companies: In addition to collaborating with groups in the public sector, PRISM also worked with private mining companies in Siguiri, Kerouane.

and Banankoro to promote better health practices. These mining companies participated in PRISM's training program, and received new and updated management tools and IEC materials.

Coordination with USAID: PRISM was supported by a capable and committed SO2 team and by the USAID mission in general. Communication and collaboration were strong throughout the implementation of the project. This open and straightforward guidance and support assisted the project team to identify issues that arose in time to make appropriate changes and has been integral in the process of managing resources efficiently. In the consolidation phase, this teamwork was critical for continued results.

PRISM recognized the essential need to coordinate with other health CAs. Ensuring close collaboration and synergies with all other USAID implementing partners and donors such as GTZ and the World Bank, has been a central PRISM contribution to the effectiveness of the health program. Regular PRISM partners included CLUSA, PSI, HKI, BASICS, and JHPIEGO, as well as other PVOs, including Save the Children, ADRA and Africare, Peace Corps Volunteers. This coordination included facilitation of regular meetings for joint planning and strategic review, primarily in the regions but also at the central level, and has involved teamwork in sharing lessons learned both within Guinea and internationally. The USAID/SO2 team, in its workshop on performance indicators for CAs (held at the PRISM headquarters in Kankan) used the PRISM package of performance indicators as a model in designing and assessing program goals.

Leveraging Costs and Shared Planning: MSH and its partner JHU/CCP have managed an important cost-share program under PRISM to bring stakeholders and institutional actors (other donors, CAs, and local NGOs) together around common objectives. This program achieved a cost share level of 8.2% of federal funds (exceeding the indicator target by 26%) and has achieved its goals related to operational efficiency, stakeholder buy-in, and sustainable results.

The following partnerships were developed and are ongoing in PRISM II:

- With ADRA to develop and support CBD/SBC and IEC/BCC activities in Siguin prefecture
- With AFRICARE to develop and support CBD/SBC in Dinguiraye prefecture
- with AGBEF to support districts at managing their CBD program and IEC activities
- with BASICS II to adapt and integrate clinical IMCI in Guinea, conduct pilot studies in selected prefectures for the implementation of community IMCI and to improve EPI performance
- with the Guinean national NGO CENAFOD to revitalise HC management committees and community participation in the management of the health system
- with Engender Health to integrate COPE and Facilitative Supervision in HG
- with the UN affiliated ILO/STEP West Africa project to promote the creation and support the development of HMO/MURIGAs risk-sharing schemes
- with JHPIEGO to integrate Post Abortion Care at hospitals in the project target zone

- With USAID centrally funded project Management & Leadership Project (M&L) on the design and implementation of a leadership strengthening program targeting the MOH's senior staff
- With USAID centrally funded project Rational Pharmaceutical Management (RPM+) on the implementation of the DCMI/GMME survey in Guinea in support to the IMCI program
- With Save The Children to develop and support CBD/SBC and IEC/BCC activities in Mandiana prefecture
- With the Canadian funded SIDA III project to integrate STI syndromic case management in the health care system

Partnership discussions are under way with the following agencies:

- With Helen Keller International to integrate micro-nutrient supplementation into the PMA of the PHC system
- With the World Bank on a future HIV/AIDS project in Guinea
- With CLUSA on strengthening community participation in the management of the health system

Main Results
<ul style="list-style-type: none"> • GRIEC and GPIEC meetings organized and supported • CTPS and CTRS meetings supported and attended • PRISM operational plan fully integrated into the MOH PEV/SSP ME at the central level and into the DRS/DPS work plans. • MOH-MCH/FP Section's workplan for calendar year 2002 and 2003 developed with PRISM assistance. • Management of supervision activities supported at the 2 DRSs and at the 8 DPSs in HG; all 8 DPSs implemented supervision activities in accordance with agreed on managerial guidelines. • Development and coordination of national health policies supported: IMCI, Safe Motherhood, STI/AIDS, H/MIS, Essential Drugs, PMA and Norms & Procedures • Computer network and email capacity installed and maintained at MOH central level units and at HG's DRSs. • Program to enhance leadership capacity completed for MOH's senior staff • Continued active collaboration sustained with nine international technical agencies/projects and with two Guinean national NGOs. • Comprehensive results and data on performance indicators for the project submitted to USAID on a timely fashion. • Target of 6.5% cost sharing surpassed.

One of the salient lessons of the PRISM experience has been the confirmation that collaboration, coordination, joint planning of resource allocations, and the sharing of key data enhance health program quality, efficiency, impact and sustainability. No project or agency is sufficiently diversified to be able to address all issues involved in such a complex undertaking without having recourse to external expertise to ensure that the

highest level expertise and best practices have been summoned to aid the common good. A project's ability to enlist that expertise around common objectives is a prerequisite for success, especially for a project as complex and multi-dimensional as PRISM.

The PRISM project clearly gained momentum each year in recruiting local and international agencies and incorporating their perspectives into common goals. Collaboration with the MOH and the communities also improved steadily and PRISM enjoys a high level of trust at all levels. These multiple levels of coordination and collaboration certainly improved efficiency and impact. They also supported the establishment of ownership stakes in the standards, mechanisms, and processes that were jointly developed and allowed communities and service delivery staff, as well as MOH officials and CA staff, to draw value from and realize rewards as a result of their joint efforts.

Conclusions & Lessons Learned

Has PRISM made a difference?

PRISM's collaborative focus, which simultaneously addressed issues at all levels of the health system, has led to encouraging decreases in fertility and mortality. The results of PRISM's technical assistance underscore the value of the systems approach previously identified by the GoG and USAID. This approach emphasized impact at the decentralized level while identifying obstacles to service delivery that arise elsewhere in the health care system. A further emphasis on community mobilization contributed crucial elements of self-reliance and sustainability through community empowerment. Major improvements resulting from the efforts of the PRISM project and partners in the field include the following:

- Services for family planning, HIV/AIDS prevention, MCH, and STI care and prevention have become widely available and extensive numbers of service providers have received training.
- CBD services have been revitalized through identification and training of CBD agents. All rural health centers currently have a functioning network of CBD agents.
- Over 50% of all new CBD agents in Haute Guinée are women (whereas in 1997, only 3 of 500 were women).
- CBD agents distribute oral contraceptives without the need for a prescription from a health center provider.
- Essential drugs and commodities are no longer procured through multiple, parallel systems but rather through the national system. Fewer stock-outs occur at health centers.
- A significantly higher number of prenatal, FP, STI care, and child survival consultations conform to national standards.
- Quality supervision is conducted with greater frequency and regularity at the SDPs.
- Supervision visits have been transformed from an administrative and punitive orientation to one of support and continuing education.
- Communities have become more aware of health needs and are more engaged in demanding quality services, taking appropriate action and managing local health centers. Community and religious leaders, youth, teachers, schoolchildren and mothers in all districts in HG actively participate in health promotion and advocacy, promoting FP, STI prevention, and vaccination coverage.
- International and local partners have come together in a strengthened collaboration across a wide range of activities.
- National policy documents, IEC materials and training curriculum have been elaborated and widely distributed.
- Information systems have steadily improved and are producing comprehensive data on reproductive health.

During PRISM's short life, increased systems capacity has resulted in improved services, which, in turn, have led to accelerated and steady health improvements

- The percentage of non-pregnant women using a modern contraceptive method increased from 3% to 12%
- The percentage of women attending at least one prenatal clinic during her last pregnancy increased from 56% to 81%
- The percentage of women giving birth in a health facility increased from 17% to 36%
- The percentage of mothers who breastfed their newborns within one hour of delivery increased from 30% to 43%
- Measles vaccination coverage increased from 42% to 62%
- Coverage for DTC3 increased from 40% to 46%
- Use of oral rehydration solution (ORS) for diarrheal disease in children increased from 35% to 54% (among infants with diarrhea in the two weeks preceding the survey).
- The use of condoms for HIV/AIDS and STI prevention increased

Despite these encouraging results, the improvements are recent and their sustainability fragile. Even by impoverished sub-Saharan African standards, Guinea's health indicators remain weak. Life expectancy at birth remains well below 50 years for both men and women. The IMR of 98, CMR of 177, and MMR of 528 show that too many children and mothers continue to die of easily preventable causes such as malaria, dehydration, and respiratory infections (DHS 1999). Fertility remains high (TFR= 5.5) and modern contraceptive use remains low (CPR = 4.9). Even though improvements over the past five years were greater than elsewhere, the health situation in HG still tends to be worse than in any other part of the country. The primary exception is STI/HIV/AIDS, which has higher prevalence in the Forest Region and Conakry. In order to continue to improve the health indicators and prevent HG from becoming more affected by HIV/AIDS and other STIs, many of the interventions initiated during the past five years must be maintained, while others need to evolve to meet the challenges of changing circumstances.

Improvements in health are heavily influenced by the accessibility, quality and demand for services, as well as the efficacy of collaboration and coordination between partners and donors in both the public and private sectors. These four areas are represented in USAID's results framework by the intermediate results (IRs). Achieving the IRs is contingent upon enabling service providers to offer better services and enabling (potential) clients to seek them in a timely fashion. However, to achieve sustainable results, improvements at the client-provider level must be supported by improvements at the community and the policy level, and vice versa. These are long-term investments that underscore the need for continued governmental involvement in creating and maintaining a supportive policy environment to continue to ameliorate the health of the Guinean people.

Policy: Over the past few years, PRISM has supported all levels of the decentralized health system, including assistance at the central level to define, validate, and disseminate policies and initiatives pertaining directly to the decentralized level. Significant priority activities included the elaboration and dissemination of the minimum package of activities, the "PMA à l'horizon 2005," and assistance in updating and disseminating the RH Norms and Procedures (N&P). These efforts have provided the policy framework for HG's health service managers and providers. Using the new national guidelines, PRISM collaborated in training health managers as well as health providers and their supervisors to implement and adhere to the PMA and conform to national norms and procedures.

Despite the progress already attained, these documents need to be continually updated to reflect current standards of best practice. PRISM is particularly concerned with revising and improving these documents in the areas of CS/MCI, safe motherhood, emergency obstetric care and HIV/AIDS. Another area of concern is that job descriptions were never fully revised to reflect certain important elements of the policy framework. Aligning staffing configurations and job descriptions with PMA and the national N&P is essential for rational management of resources at all levels of the health system. While revisions of the job descriptions have begun, the national-level MOH has not yet been able to finalize them for dissemination throughout the country.

Quality improvements: While the PMA clearly defines services required at every level of the health care system, the referral system and other linkages between levels remain weak. Quality improvements at referral centers such as prefecture and regional hospitals have been inadequate and referral between the community and the HP or HC also remains tenuous. PRISM has contributed to improving maternity and pediatric wards at the hospitals, and invested substantial resources in enabling community-based service providers to recognize individuals in need of referral and the appropriate referral center. However, efforts to date have not sufficiently addressed deficiencies in the system. The current referral guidelines must be reviewed and updated to meet quality standards and respond to the updated PMA and RH N&P.

Financial management: One of the most pressing needs in HG is that of better management of financial resources to adequately cover the costs of services and, therefore, improve their sustainability. As USAID's midterm evaluation underscored, a critical area in understanding Guinea's health needs is that of decentralization in general and cost recovery in particular. Critical conditions for full and effective implementation of these pillars of the Bamako Initiative must be met at two levels: demand and supply. At the "demand" level, community participation is essential to improve transparent management of the health centers and make services more responsive to needs. At the "supply" level, mechanisms for obtaining adequate drugs, tools, and equipment must be operational and directives regarding national standards and the PMA must be clearly articulated and effectively communicated. Decentralization thus requires strong management capacity at these two levels.

Fee structure: PRISM support to the MOH has ensured that fees are clearly posted on billboards in front of every health center. PRISM also assisted in broadcasting the service fees over the rural radio. However, the current fees, in use since 1992, must be further revised to reflect both the real, changing costs of service delivery, including the new essential drug list, and performance incentives for service providers

Community participation: the strengthening of community participation in the management of the health system has focused on (1) community mobilization through community events, including town meetings attended by providers, community members, and political leaders, and communication via radio; (2) revitalization of COGES in managing health services; (3) promotion and support of local community-owned insurance schemes (mutualism) and Marinas.

Community events and radio broadcasting have done a great deal to raise awareness of the official fees for services. They have already sparked debates over official versus actual tariffs and have held providers more accountable for adhering to the official fee schedule. However, overcharging does continue, and further behavior change on the part of providers and supervisors is still necessary

The revitalization of COGES and the democratic elections of community representatives have increased community interest and participation. This participation has been further enhanced through a series of PRISM-initiated COPE exercises. However, progress has proven to be sporadic and sustained support, including continuous training, is needed for these important changes to take root. Principle areas identified for further training include basic management skills in accounting, planning, use of data and information for decision-making and resource allocation, as well as governance of community-based associations.

Motivation of service providers: A major challenge in Guinea's decentralized health system is enhancing the job satisfaction of providers. While many providers are recognized by their community for their contributions, most struggle financially. Their salaries, provided directly by the central government, are generally not commensurate with basic subsistence needs and the current management mechanisms of the PHC system does not financially reward good performance. Limited resources in the public sector preclude a major upward revision of salary scales. However, interventions at the local level were identified and need to be pursued and supported over time. Examples include introducing performance-based benefits (primes de performance) for health center workers, using the principle of shared success in group practice, and adjusting the cost recovery potential by updating fees for services (see above). Of critical importance in such adjustments is the introduction of a merit-based system which links remuneration and performance. As was noted in USAID's midterm evaluation of the PRISM project, the low salaries and lack of financial performance incentives for individual providers or health centers remains one of the major underlying causes of overcharging for services and medicines. Overcharging helps compensate care providers for services, but undermines the official system and creates disparities in the quality of care. The result is

that clients end up paying substantially more for health services than the official fee structure requires and the HCs "capture" even less of the revenues. This dissonance discourages the use of the health services and compromises their integrity and sustainability.

Essential Drugs: PRISM has worked with the MOH and the national level PCG and PEV/CME to standardize the ED&C logistics management system, integrate family planning products into the list of essential drugs, and establish contraceptive sale prices in HCs. By supporting the GoG, PRISM focused its interventions at the regional and district levels, as well as the health centers. This approach has resulted in notable improvements in the management of ED&C. Better monitoring instruments have been adopted and used throughout the logistics system leading to significant improvement in the accuracy of record keeping. By the end of the PRISM contract period, over half of the HG's HCs were reporting very low stockout rates. Nevertheless, many challenges continue to beset the drug and commodity management system. Stockout rates remain unacceptably high at several of the regional supply points and at an unacceptably high number of HCs, suggesting that a sole reliance on the public sector supply system is insufficient.

One of the major challenges to the ED&C system is cash flow, as has been underscored by PRISM's reports to USAID. Hospitals, using a substantially higher fee schedule than HCs, tend to have sufficient cash to resupply drug stocks. On the other hand, the current ten year old HC fee schedule is putting enormous stress on the viability of the PHC system and needs to be updated to keep pace with the changing financial realities in the country (see IR 1). Replenishment of ED&C now represents, on average, over 65% of HCs' revenue (compared to 40% some years ago). Even the most efficient and well-attended HCs generate precious few resources beyond what is required to replace ED&C. This acts to the detriment of all other activities essential to the provision of adequate quality of care and to the implementation of health prevention activities. Poorly managed facilities face an even more precarious situation. To make matters worse, by the time most health centers have sufficient funds, the regional pharmacy is frequently out of stock for one or more of the needed drugs. This situation could be corrected through further strengthening of leadership and managerial capacity and improvements of the logistics system and key PHC policies. Effective community participation, especially through the COGES, is critical for achieving this goal, along with establishment of a revised fee schedule, improved supervision, monitoring, and leadership at the decentralized level.

H/MIS: PRISM has worked extensively with national, regional and district authorities and staff to prioritize and update indicators, revise and disseminate improved HMIS tools, decentralize the system, and increase the capacity for decision-making based on data and information. However, the health management information system remains underused for the purposes of decision-making, especially at the peripheral levels of HC and CBD services. While these levels have made improvements in collecting and reporting the data, they have not yet begun to actively use them for local decision-making and action.

Epidemiological and Demographic Considerations for Guinea's Future:

The current mortality and fertility situation in Guinea still warrants continued investments in improving systems, stimulating awareness and behavior change among both clients and providers, and increasing community participation at the decentralized level so that current gains will lead to long-term sustainable increases in the use of RH services. If everything else remains constant, such consolidation will ensure that Upper Guinea families will have easier access to higher-quality services with noticeable improvements in health by 2005: more children will be vaccinated and live beyond five years of age, they will grow up with a greater ability to avoid unwanted pregnancies and prevent sexually transmitted infections, and, as adults, many more mothers will survive their childbearing years.

Unfortunately, the specter of the HIV/AIDS epidemic threatens to reverse many of the advances of recent years. Until 2002, HIV/AIDS prevalence was thought to be around 1% in the general population, inspiring hope that Guinea might succeed in fending off a generalized epidemic. However, recent evidence indicates the prevalence to be about 5% (MOH 2002), while the incidence of other STIs and TB is rising rapidly. Intensifying HIV/AIDS prevention and care is rapidly becoming a top priority. However, the current infrastructure and health system do not have the capacity required to mount an effective response, which would require establishing a VCT program, introducing PMTCT services, developing home-based care programs, offering more prompt STI treatment, improving care for opportunistic infections, providing comprehensive care to HIV-positive people and their loved ones, and enabling HIV-negative people to stay negative. The current efforts of the GoG indicate that Guinea is seeking to build this capacity rapidly. Meanwhile, the GoG continues to rely heavily on existing activities to ensure condom distribution, raise public awareness, and break the stigma surrounding HIV/AIDS, as well prevent and control opportunistic infections and emerging diseases such as TB by integrating TB management into primary health care.

Given the profile and importance of HIV/AIDS on the global political agenda, Guinea will need to manage the increasing pressures and opportunities from international HIV/AIDS donors and advocacy groups to maintain its focus on a well-balanced, integrated health program. Indeed, in many countries, the HIV/AIDS problem has obscured the importance of the high infant, child, and maternal mortality due to non-HIV/AIDS related causes. Verticalization of HIV/AIDS programs has often taken away resources from other RH needs such as FP, mother and child health, and malaria control, as well as from local systems-building to increase capacity to adequately respond to HIV/AIDS in this and future generations. While Guinea will pay increasing attention to HIV/AIDS, the gains in other RH and CS areas risk suffering major setbacks, which could result in increasing mortality from both HIV/AIDS and other preventable causes which are currently on the decline.

Guinea's continuing high mortality and morbidity from preventable conditions must continue to be aggressively addressed despite the competing demands placed on

limited resources by HIV/AIDS. Guinea's success will be nested in its long-standing, ongoing commitment to decentralization and integrated health programs and in its openness to collaborating with national and international partners

Lessons Learned from PRISM

Decentralized Project Design

The PRISM experience has reinforced previous evidence that substantial improvements of a decentralized health system can be achieved through the support of a project that has a **strong emphasis on the peripheral level** in a limited and well-aligned geographic zone, a **broad technical mandate**, and systematic **technical assistance delivery embracing all levels of the system**. By focusing its attention at the decentralized level, the PRISM design made it possible to identify the weaknesses throughout the entire system that most affected the quality of services provided to the population. By working intimately with the communities that the SDPs serve, it was possible to increase awareness and participation in the health development process. The success of numerous interventions at the peripheral level led to greater interest at regional and national levels. This interest increased participation in the decentralization process and resulted in numerous requests for training, technical approaches and tools from other levels of the system as well as from other geographical regions. The existence of a broad technical mandate in PRISM design created important synergy between programs and activities as demonstrated by the extensive network of partnerships established in the project focus zone with numerous organizations active in reproductive health. Finally, in addition to being fiscally rational and responsible, the focus of the technical assistance on a limited and well-aligned geographic zone allowed the project to establish very strong and active relationships with the health managers and service providers in specific health regional directorates, districts, and in their service delivery points

Project Deployment, Implementation and Management

PRISM experience demonstrates that it is critical for the central level of the health system to be engaged early on in the project in supporting implementation at the periphery. During the first years of the project, the maintenance of a strong PRISM presence in the capital, Conakry, was a necessity and an essential factor in the overall success of the project. During the later stages of the project, maintenance of a reduced but well-adapted PRISM presence in Conakry was critical to the successful transfer of experience and technology from the periphery to the center of the health system and to their integration into the overall system. Activities successfully implemented at the peripheral levels of the MOH can be effective in creating demand for similar activities at "higher" levels, e.g. M&L, drug logistics, training in team management. Higher, more centralized levels of the health system (central MOH, regional offices) nevertheless need to be engaged early on in the project to support implementation at the periphery

The technical assistance design of having technical staff located in the regions proved very appropriate and effective. However, the PRISM experience has underscored the difficulties associated with opening multiple offices at the same time. A step-wise approach is more appropriate as this will allow the team to first build technical expertise among Guinean colleagues, and then expand the project “products” to other regions with Guinean colleagues taking the implementation lead. In other words, in project design, like in implementation strategy, investing in quality before expanding coverage is a slower but more sustainable approach.

Over the life of the PRISM project, the emergence of civil unrest in the Forest Region and the occurrence of other potentially disruptive events highlighted the importance of a flexible programmatic and management style, allowing for strategic, structural and operational adjustments in order to ensure momentum maintenance and minimize health improvement losses.

A good M&E system is crucial for any project and especially so for a decentralized project with a broad technical scope of work like PRISM. It not only allows interventions to be measured and evaluated, it also provides clear evidence to be used for advocacy purposes to influence national policies, norms and practices, and as a management tool for project decision-making. Clear evidence of success is also useful for building partnerships with counterparts and other technical assistance agencies. The information must be generated in a timely manner and presented in a format that is clear,

comprehensible and consistent with the needs of the MOH and partner agencies. The objectivity of documenting both successes and standoffs is instrumental in generating trust and a collaborative, problem-solving environment.

Partnering is a key element of success, and not merely a formal mandate for implementation. PRISM has managed an important cost-share program to bring stakeholders and institutional actors (other donors, CAs, and local NGOs) together around common objectives. This program has met the contractual target and has achieved its goals related to operational efficiency, stakeholder buy-in, and sustainable results. It is MSH’s approach to integrate cost sharing and donor leveraging into all work planning and to carefully track success and opportunities in this regard. For these reasons, cost-share programs should be maintained but shifted to the same standing as other technical performance objectives. By specifying cost-leveraging as a technical performance target rather than an adjunct contractual obligation that is formally labeled ‘cost share’, implementing agencies can consolidate coordination efforts and focus on sustainable results rather than distorting activities in pursuit of cost sharing as a goal in itself.

Intermediate Result 1: Increased access to RH services

Implementation of a CBD program needs to be done carefully, systematically and incrementally to create sustainable models. It is important to monitor its progress, integrate it into the formal health system, create an internal mechanism for motivation, take the time that is needed (dependant upon the local capacity to absorb and integrate), start cautiously with close monitoring of progress and expand as depth of knowledge

increases and the program matures (tools, training manuals, supervisory staff understanding/technical competence). It is also necessary to have a clearly articulated plan and procedures to demonstrate progress along the way in order to allay donor pressure for rapid results. Impact will be demonstrated after the program has gained the momentum that comes with community trust and awareness

Illiterate (or literate only partially and in the local language) individuals can be successful promoters of FP and health. They are capable of distributing contraceptives when given appropriate tools, training and above all, supervision and supportive structure.

Women can be very effective CBD agents, even in a society where public jobs are traditionally reserved for men. Educating communities and identifying culturally acceptable ways of bringing women to health promotion activities (e.g. pairing male and female CBD agents) are key.

Reliance on a single government provider for ED&C is insufficient. Other channels, especially through the private sector, must be developed to mutually reinforce availability of essential drugs at the community and health center level. This was underscored by PRISM's experience in standardizing the multiple public channels for commodities and drugs supply that existed in 1998. "Dismantling" of parallel systems allowed for more systematic and streamlined approaches throughout the regions and districts, and it substantially improved local (health center) capacity to manage, monitor, and order new stocks. However, despite improvements in drug and commodity management, drugs were frequently unavailable due to either complications at the central pharmacy or lack of financial resources at the health centers to allow them to purchase supplies in a timely manner.

Exclusive reliance on the central level as a supply source leads to stockouts of essential resources at health facilities. Availability at the SDPs of spare parts for the cold chain, small medical equipment, IEC materials and management tools can be significantly improved when buffer stocks are established, maintained and actively managed at the regional level.

Civil society is only now emerging in Guinea after a long colonial period followed by a generation-long authoritarian regime. As a result of these profound historical factors, individual and group initiatives are manifest but remain modest compared to what is needed to ensure dynamic private and public institution building. The necessity of a vibrant civil society is widely accepted in principle in Guinea and PRISM encountered no resistance at implementing interventions aimed at increasing community members' participation in health promotion activities and even in the management of important segments of the PHC system. Everyone in and outside of the health profession in Guinea agree that this is at the core of a sustainable health system. PRISM and any agency promoting community participation in the PHC system have been confronted with a shortage of qualified facilitators and trainers in technical areas critical

to enhanced community participation. This has constituted a major constraint in the development of sustainable health insurance schemes and of health management committees (COGES). Continued investment and support from donors and international agencies is required and will be required for many years to come in order to establish enough local capacity to develop community facilitators, animators and trainers qualified in the various subjects relevant to the development of community participation and local democracy.

Intermediate Result 2: Improved quality of RH services

Routine facilitative supervision and on-the-job training improve the quality of service delivery, especially when combined with adequate support to the supervisory teams themselves.

But no matter the amount of in-service training and facilitative supervision, providers' capacities are limited by the quality of pre-service training received. Deficiencies in the Guinean professional education system for healthcare workers, including the admission selection process, greatly limit their capacity to deliver quality services to the population when they reach SPDs and to improve their performance through in-service support. To help counter this problem, the donor community, in collaboration with technical agencies, needs to systematically channel more resources to technical and professional schools (for midwives, nurses, ATS, etc.) in order to strengthen this pool of providers and DRS/DPS support unit staff members at the source. Sustained improvement in the quality of health services delivered needs more than support in the development of clinical skills, including counseling, and in the development of management capacity. Leadership capacity development of health managers at all levels of the system is required to induce behavior changes in favor of practices (clinical and managerial) compatible with responsive and responsible health services.

Intermediate Result 3: Increased demand for RH services

The BCC campaigns used proven behavior change strategies that helped ensure their effectiveness. Peer to peer approaches were at the core of the campaign design. Use of formative research to identify barriers to desired behaviors allowed project staff to design activities and materials that appropriately addressed the information and motivational needs of the intended audiences.

Religious leaders either became active RH promotion agents or ended their opposition to FP once they understood that child spacing was not against the teachings of Islam. Project staff worked with religious leaders to identify passages in the Koran or Hadith that favored family planning. These verses provided the background for campaign messages and served to encourage religious leaders to talk to their followers about family planning. The majority of the leaders interviewed at follow-up reported awareness of at least one verse of the Koran or Hadith that favored family planning. Capitalizing on the

favorable relationship thus established, PRISM continued work with the religious leaders for youth and MCH campaigns.

The use of multiple channels of communication helped ensure the wide reach of campaign messages. Formative research helped identify relevant communication channels. The use of a variety of channels to disseminate the messages helped ensure that the majority of the intended audience was exposed to the campaign, and that many people heard the same messages from multiple channels. If it is verified that multiple exposures to campaign messages was a key factor in behaviour change among the targeted audiences, additional evidence coming from PRISM experience in Guinea indicates a strong relationship between behaviour change among targeted groups and the intensity of peer-to-peer activities.

IEC stakeholders at the decentralized level can be engaged in a cohesive and effective intervention plan. PRISM supported the creation of regional IEC working groups composed of representatives from the public and private sectors. The working groups successfully integrated their workplans to provide the regional health inspectorate with a cohesive, coordinated regional workplan of IEC activities. The working groups actively participated in the planning and development of the programs and were key players in their implementation. This collaboration continues to be an important tool for carrying out PRISM IEC activities.

Youth (boys and girls) can be very effective participants in every stage of a youth campaign, from the conception of the program, (slogan/logo development, etc.) to the identification of the activities, leadership in the initiatives, etc. The program worked to build their capacity and self-efficacy as well as address them as an audience. Supporting youth, rather than directing them, helped to confer interest and "ownership" of campaign activities.

The selection, training and supervision of the peer educators are some of the main factors contributing to the success of the youth campaign. Involving girls in the youth initiative gave them more self-confidence (a critical aspect to the adoption of positive behaviors). The fact that these peer educators were chosen by their communities meant that the communities felt responsible for facilitating their work, and helped to assure the selection of positive and responsible role models.

Community dialogue proved to be one of the most important activities of the MCH campaign in particular, providing insight into the causes of low birth attendance at health centers and opening up channels of communication through which community members could share ideas on how to tackle the problems raised. Since, during the town meetings, community members had unanimously expressed the need to improve their knowledge of maternal care, PRISM offered special sessions to women's association leaders and to male leaders. Through the orientation, messages were introduced into the social network, making them more accessible. A typical orientation lasted about two hours and covered the following topics: EPI diseases, the immunisation calendar, birth

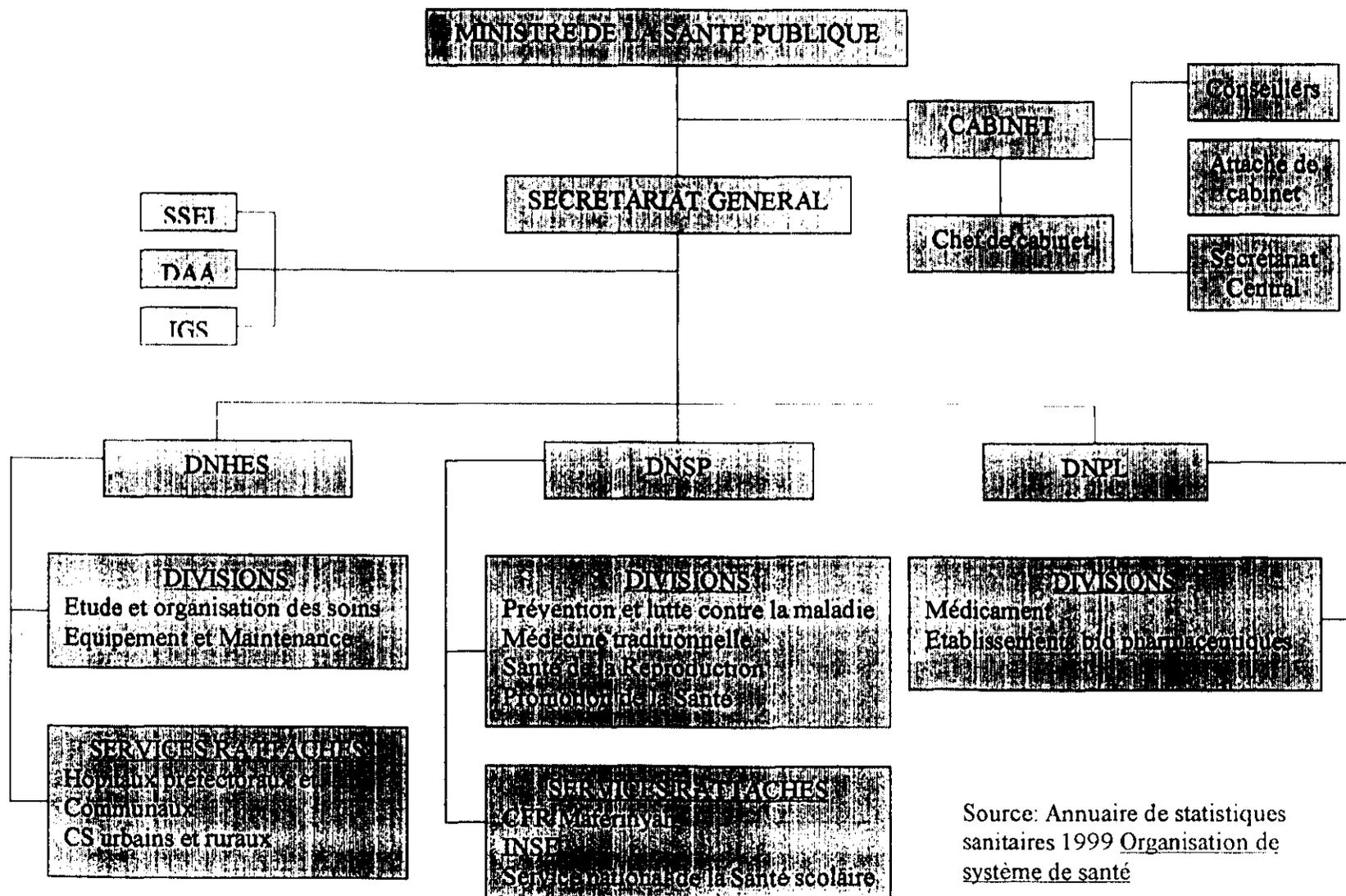
plans, danger signs during pregnancy and childbirth, and service fees. The last theme was by far the most interesting because people learned that the health centers did not respect the posted rates.

Intermediate Result 4: Better coordinated response among RH partners

As noted above, partnering is a key component of a successful project, especially one as complex as PRISM. However, collaboration is very time-consuming and requires effective and efficient channels of communication. Joint planning and evaluation sessions are important for aligning goals, targets and joint activities.

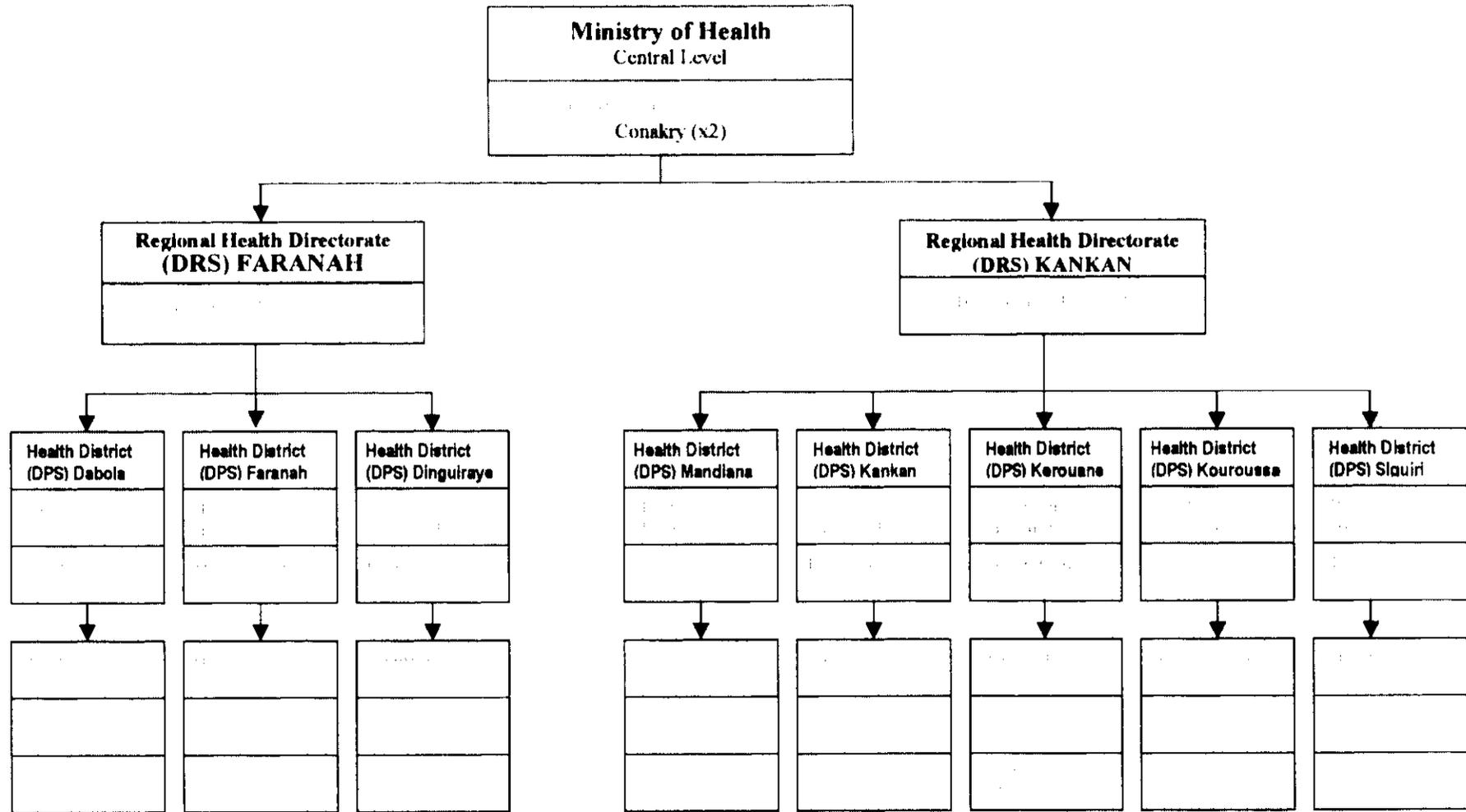
Continued high mortality and morbidity, despite major improvements over the project implementation period, dictate the need for continued and additional public, private and community support to the health sector. In particular, the relative performance of health indicators in Upper Guinea compared to other parts of the country confirms the need for consolidating and replicating a comprehensive, integrated TA package throughout Guinea, focusing on all levels of the health system.

Annex 1: ORGANIGRAMME DU MINISTRE DE LA SANTE PUBLIQUE



Source: Annuaire de statistiques sanitaires 1999 Organisation de système de santé

Annex 2 Public Health System in Haute Guinée



Legend

Support Units

Support Unit