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GUINEA PRISM II Annual Progress Report 2006



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Guinea PRISM II Annual Report
October 2005 – September 2006

About the Guinea PRISM II Project

Since 1997 the PRISM project has worked to make quality primary health care and reproductive health services available at the peripheral levels of Guinea's national health care system. Its principal objectives are to increase the quality and use of family planning and MCH services and to help prevent the spread of sexually transmitted infections and HIV/AIDS. Throughout the project, MSH has implemented activities in partnership with Johns Hopkins University Center for Communication Programs, EngenderHealth, and several local Guinean organizations (including CENAFOD and IPPF/AGBEF).

The PRISM project works principally with regional authorities and district-level health centers in two remote, rural regions of Upper Guinea. Key activities have included training for service providers (hospital workers, health center staff, and community-based distribution agents), community mobilization through the formation of local health committees and health insurance schemes, and technical assistance to improve management and logistics practices. PRISM has also conducted a series of leadership workshops with high-level officials in the Ministry of Health.

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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Acronyms

Please note that for all acronyms in the text, the French acronym will be used where applicable.

English	French	
ADRA		Adventist Development and Relief Agency
AGBEF	AGBEF	Association Guinéenne pour le Bien-être Familial
	AMIU	aspiration manuelle intra utérin (intra-uterine manual aspiration)
AT	AT	assistant technique
CBD Agent	Agent SBC	community agent (<i>Agent Communautaire</i>)
CBD	SBC	community-based services (<i>services à base communautaire</i>)
CENAFOD	CENAFOD	Centre National de Formation et de Développement
CIP/Counseling	CIP/Counseling	communication inter personnelle et counseling
CNLS	CNLS	Comité National de Lutte contre le Sida
CoGes	CoGes	Comité de Gestion
CPS	CPS	Chef de Poste de Santé
CPSC	CPSC	Comité de Promotion de la Santé
CPR		contraceptive prevalence rate
CSC	CSC	Comité de Santé Communautaire
CSU	CSU	Urban Health Center (<i>Centre de Santé Urbain</i>)
CTPS	CTPS	Comité Technique Préfectoral de la Santé
CTRS	CTRS	Comité Technique Régional de la Santé
CYP	CAP	couple-years of protection (<i>couple année protection</i>)
DDM	IPD	data for decision-making (<i>information pour la prise de décisions</i>)
DPS	DPS	District (Prefecture) Health Directorate (<i>Direction Préfectorale de la Santé</i>)
DRS	DRS	Regional Health Directorate (<i>Direction Régionale de la Santé – ex-IRS</i>)
DSR	DSR	Division de la Santé de la Reproduction
ED&C	ME&C	essential drugs and contraceptives (<i>médicaments essentiels et contraceptifs</i>)
FP	FP	family planning (<i>planification familiale</i>)
FY	AF	fiscal year (<i>année fiscale</i>)
GPIEC	GPIEC	Groupe Préfectoral IEC
GRIEC	GRIEC	Groupe Régional IEC
GTZ	GTZ	Agence de Développement Allemande
HC	CS	health center (<i>centre de santé</i>)
HHC	CCS	Head of Health Center (<i>Chef de Centre de Santé</i>)
HMIS	SNIS	National Health Management Information System (<i>Système National d'Information Sanitaire</i>)
HP	PS	poste de santé
IEC	IEC	information, education et communication
IP	PI	infection prevention (<i>prévention des infections</i>)
IR	RI	intermediate result (<i>résultat intermédiaire</i>)
IST/SIDA	STI/AIDS	Infections Sexuellement Transmissibles/SIDA
IUD	DIU	intra-uterine device (<i>dispositif intra-utérin</i>)
JNV	JNV	Journée Nationale de Vaccination
MOPH	MOPH	Ministry of Public Health (<i>Ministère de la Santé Publique</i>)
MSH	MSH	Management Sciences for Health

MURIGA	MURIGA	mutuelle de santé consacrée à la référence des femmes lors des accouchements
NGO	ONG	nongovernmental organization (<i>organisation non gouvernementale</i>)
OC	CO	oral contraceptives (<i>contraceptifs oraux</i>)
PAC	SAA	postabortion care (<i>soins après avortement</i>)
PEV/SSP/ME	EPI/PHC/ED	Programme Elargi de Vaccination/Soins de Santé Primaires/Médicaments Essentiels
RAMCES	RAMCES	rapport mensuel des centres de santé
RH	SR	reproductive health (<i>santé de la reproduction</i>)
SDP	PPS	service delivery point (<i>point de prestation de services</i>)
SF	SF	facilitative supervision
SMI	MCH	maternal and child health
STI	IST	sexually transmitted infection (<i>infection sexuellement transmissible</i>)
UG	HG	Upper Guinea (<i>Haute Guinée</i>)
USAID	USAID	United States Agency for International Development
WHO		World Health Organization

Executive Summary

USAID/Guinea Strategic Objective #2

Increased use of essential family planning and maternal-child health services and prevention of sexually transmitted infections and AIDS.

PRISM II Vision

By the year 2006, Guinean families and individuals will have access to high-quality services and information that meet their reproductive health needs.

The PRISM (Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA) project is an initiative of the Republic of Guinea as part of its bilateral cooperation with the United States of America, designed to increase the utilization of quality reproductive health services¹. The project is funded by the United States Agency for International Development (USAID) and is implemented by Management Sciences for Health (MSH).

The project's intervention zones correspond to the natural region of Upper Guinea as well as Kissidougou prefecture in the Forest Zone, thus covering all of the nine prefectures of Kankan and Faranah administrative regions.

This annual report covers the activities and results of MSH/PRISM over the fiscal year (FY) 2006, October 1, 2005 to September 30, 2006. Like all of MSH/PRISM's activity reports, the present report is structured according to the project's four intermediate result (IR) areas: 1) increased access to reproductive health services and products, 2) improved quality of services at health facilities, 3) increased demand for reproductive health services and products, and 4) improved coordination of health interventions.

In August 2005, USAID requested that MSH develop a work plan for the extension of some of the PRISM project activities that were considered essential for FY06. After a series of exchanges, the proposal for an extension of the PRISM project for an additional year was approved by USAID and was signed by MSH on September 29, 2005, right before the last day of the project.

This extension covers the following elements of the previous terms of reference of the PRISM project:

- expansion of SBC program;
- health mutuals;
- community participation in the management of health centers (CoGes);
- family planning (FP) services in the health centers and hospital maternities as well as integration in the health posts;
- strengthening of contraceptive logistics;
- cervical cancer screening activities.

¹ This also responds to the Strategic Objective #2 from USAID's program in Guinea, "Increased Use of Essential Family Planning, Maternal and Child Health and STI/AIDS Prevention Services and Practices."

This is an overall reduction of activities in comparison with the previous scope of work. As a result, the reduction in budget necessitated an important reduction of project personnel. The project terminated the employment of over half the project employees and closed the Faranah regional office.

In August 2006, USAID requested that MSH develop a further work plan for the extension of the PRISM project activities to the end of the second quarter of USAID's FY07. After a series of exchanges, the proposal for an extension of the PRISM project for six months was approved by USAID and was signed by MSH on September 30, 2006.

This extension covers, in addition to the regular activities implemented in 2006, two new technical topics:

- the extension of voluntary counseling and testing (VCT) activities in three prefectures in Upper Guinea;
- testing a new performance-based budgeting approach

In May 2006, the USAID mission director, accompanied by the mission's health team, visited the Kankan region and MSH/PRISM activities in the field. He visited various villages, health posts, and health centers with the Kankan region governor and held discussions with various community leaders. The results of this trip included recognition of the project's efforts in reinforcing equity in access to and financial stability of community health centers as a form of local governance and accountability.

This report consists of three parts. The first part presents the introduction, an executive summary, and a synthesis of principal results attained over the year. The second part presents in detail the project's strategies and approaches for each IR, the activities implemented, and results attained over the year. The conclusion includes a review and update of principal indicators. A full list of the indicators updated to reflect the situation as of September 2006 is presented at the end of the report.

The project's principle achievements for FY2006 are described below, by intermediate result, and major task area under each intermediate result.

IR1: Increased access to reproductive health services

- In FY2006, carry out and consolidate the integration of FP and STI prevention at the facility and community levels.

Result: The PRISM project organized the training of 157 health providers from health centers and health posts in the project's zone. Because of those trainings, 100% of the 109 health centers in Kankan and Faranah regions and all the 131 health posts in the same regions now have at least one provider trained in providing FP and STI/AIDS prevention services.

Result: MSH/PRISM has trained 1,507 community-based distribution (CBD) agents across the Upper Guinea region in the distribution of oral contraceptives and Vitamin A in their villages. Thus, over the fiscal year, MSH/PRISM ensured that each village

in Upper Guinea has one CBD worker trained to locally distribute FP services and Vitamin A.

- In FY2006, integrate cervical cancer screening services into 14 health facilities.

Result: 42 service providers trained and provided with basic technical equipment, commodities, management tools, and information, education, and communication (IEC) materials for cervical cancer screening in 14 sites in Upper Guinea

Result: 4,149 clients screened for cervical cancer at project supported health facilities.

- Ensure a sustainable supply of medical equipment, IEC materials, and management tools for the health facilities

Result: MSH/PRISM provided health facilities and CBD workers a nine-month supply of contraceptives and Vitamin A.

Result: MSH/PRISM provided adequate management tools and IEC materials to 9 maternities, 109 health centers, 131 health posts, and 1,507 CBD workers to maintain the continuous availability of services.

- Carry out and consolidate the distribution of oral contraceptive and Vitamin A at the community level (CBD program).
- Ensure the availability of contraceptives at all service delivery points and strengthen the management of contraceptives.

Result: MSH/PRISM supported the recruitment of 83,521 new users of family planning.

Result: MSH/PRISM obtained 22,247 couple-years of protection (CYP) during the fiscal year, an increase of over 30% from last year.

- Strengthen community ownership through 1) health mutual insurance and other associations interested in community self-reliance, and 2) management committees of health centers that represent the community and are interested in improving the cost recovery system at the facility level.

Result: MSH/PRISM supported the creation of 107 *caisses communautaires*, recruiting thousands of new mutual members and collecting more than 17 million Guinean francs in Kankan, Kerouane, and Faranah prefectures.

Result: MSH/PRISM supported the reinforcement of 329 community health committees (CSC) in the prefectures of Kankan, Faranah, and Kérouané in the local management of health issues. These CSCs established 38 community health promotional committees (CPSC) (previously called management committees).

IR2: Improved quality of services

- Strengthening quality services at service delivery points through the supervision and adaptation of RH curricula, when necessary.

Result: Each health center in the project zone received at least one joint PRISM/Regional Health Directorate (DRS) supervision visit during the course of the year. A total of 109 health centers were visited to monitor the availability of essential drugs as well as the quality of their management.

Result: On average over the year, the project supported four supervisory visits per health center and health post by the Prefectoral Health Directorate (DPS), the DRS, and MSH/PRISM staff. Each service delivery point was supervised at least once a quarter. When necessary, the supervisors provided on-the-job training to facility staff.

Result: MSH/PRISM supported quality in the national tuberculosis program through the development of the training curriculum for the community DOTS.

- Follow-up postabortion care (PAC) activities.

Result: MSH/PRISM supported 761 clients with PAC services; 561 of these clients accepted FP methods postabortion.

- Devolution of the management information system (MIS). This includes assistance to and training for the central level of the MOH, the DRS, and the DPS in collecting and using data for decision-making, and in developing periodic MIS reports.

Result: 9 DPSs using MSH/PRISM-packaged applications of the management information system (MIS), consisting of the *Rapport Mensuel des Centres de Santé* (RAMCES) and a geographical information system.

IR3 : Increased demand for services

- Improving coordination of IEC programs through assistance in developing national and regional IEC strategies and protocols, action plans, and IEC working groups.

Result: MSH/PRISM oriented 100% of members of 38 *Comités de Promotion de la Santé* (CPSCs) in the efficient use of the “community mirror” tool. The project organized activities to promote mutual health organizations (MURIGAs) in 120 villages, as well as hundreds of events to mark the integration of family planning and STI prevention services in health posts, and to present newly trained CBD agents.

- Strengthening client-provider interactions by developing, producing, and distributing new or existing IEC materials, and training service providers in counseling.

Result: MSH/PRISM produced an educational video on HIV and undesired pregnancies, for use in mining zones. In parallel, the survey report on impact of project activities targeting religious and community leaders was finalized

Result: MSH/PRISM produced and distributed 2,000 brochures on HIV/AIDS, 200 brochures “*Pour Aider à espacer les Naissances*,” (Help in Birth Spacing), and 200 on “*Famille planifiée, Famille heureuse*” (Planned Family, Happy Family).

- Conducting health promotion interactions by holding large and highly visible IEC activities, carrying out advocacy efforts at the community level, community mobilization, and awarding small IEC grants to local nongovernmental organizations (NGOs).

Result: MSH/PRISM supported the broadcast of more than 45 episodes of the cervical cancer screening roundtables. In parallel, the project organized 70 meetings with potential clients of the cervical cancer screening program in Kankan, Siguiri, and Faranah.

- Improving IEC management and delivery capacity by training IEC managers/providers and providing them with regular technical assistance.

Result: MSH/PRISM supported the nine IEC prefectoral groups in developing their own work plan, and in implementing, monitoring and reporting on their activities. In this way, local IEC groups performed various activities to support the promotion of RH in the target area.

Result: MSH/PRISM organized one workshop to develop messages and approaches to increase community knowledge of FP and STI prevention. Message effectiveness was then tested and confirmed at community level.

IR4 Improved coordination

- At the decentralized level, support the establishment, functioning, and actions of RH regional working groups; support the preparation of and participate in the *Comité Technique Préfectoral de la Santé* (CTPS) and *Comité Technique Régional de la Santé* (CTRS) meetings; and strengthen the managerial capacity of DRS/DPS, with an emphasis on their supervision activities.

Result: During the fiscal year, MSH/PRISM participated actively in the dissemination of the National Health Development Program (PNDS) and supported the development of the two regional work plans in Kankan and Faranah.

Result: MSH/PRISM supported all four CTRS and 18 CTPS organized in the regions of Kankan and Faranah during the fiscal year.

- At the institutional level, review the project’s activities, results, and achievements with the MOH and USAID; participate in the development of health-related policies at the central level; and plan and implement interventions with RH partners in the field.

Result: The MSH/PRISM project participated in a national workshop on the “Programme National d’Assurance de la Qualité des Soins.” (National Program for the Assurance of Quality of Care).

Result: MSH/PRISM collaborated with various partners on the ground, notably with EngenderHealth, Helen Keller International (HKI), Africare, ADRA, and Save the Children.

Result: MSH/PRISM signed three memoranda of agreement with Save the Children, Africare, and ADRA for the extension of the CBD program in Upper Guinea.

Overarching Achievement: Strengthening Grassroots Democracy and Governance

Although organized within USAID/Guinea's Intermediate Result #1 (increased access to reproductive health services), the project's support for local democracy and governance has fast become a common thread throughout the entire MSH/PRISM project. The project has developed a new integrated local governance strategy that unites access, quality, demand, and coordination to reinforce the principle of local control and accountability for services. The project has developed mechanisms at the community level that have begun to create more sustainable health facilities and change beneficiaries into partners. In these last few months of PRISM, the project is providing its partners with the tools and support to improve, manage, and sustain their health system to support their needs.

IR1: Increased access to reproductive health services

This part of the report presents the progress achieved during FY06 in terms of improving access to RH services. It is organized into two sections, each one corresponding to a strategy by which the PRISM project worked to improve access: the first part concerns the availability of essential resources and second, equity and sustainability in accessing these services. The table below summarizes progress in these areas.

IR1: Increased access to RH services				
Task area	Activity	Target	Actual	Percent
Section I: Availability of essential resources at health facilities				
Carry out and consolidate the integration of FP and STI prevention at the facility and community levels	# of health center providers trained in family planning and STI/AIDS prevention	104	109	104%
	# of health post providers trained in offering family planning and STI/AIDS prevention services	119	131	110%
	# of CBD agents trained in offering oral contraceptive at the community level	443	1,507	340%
Integration of cervical cancer screening services into 14 health facilities	# of providers trained to offer cervical cancer screenings	44	48	109%
	# of clients screened for the cervical cancer	No target set	4,149	NA
Ensure a sustainable supply of medical equipment, IEC materials, and management tools for the health facilities	# of birthing centers (BC), health centers, and posts provided with medical equipment, including cervical cancer equipment and consumables.	119 HC 104 HP 9 BC	131 HC 109 HP 9 BC	110% 104% 100%
	# of birthing centers, health centers, and posts provided with IEC materials and management tools	119 HC 104 HP 9 BC 443 CBDs	131 HC 109 HP 9 BC 1,507 CBDs	110% 104% 100% 340%
Carry out and consolidate the distribution of oral contraceptive and Vitamin A at the community level (CBD program)	# of new FP users recruited	No target set	83,521	NA
	# of CYP obtained	20,000	22,247	111%
Section II: Equity in access and sustainability in the provision of services at the facility level				
Strengthen community ownership through health mutual insurance organizations, management committees of health centers that represent the community and other associations interested in community self-reliance	# of "caisses communautaires" created	269	107	39.7%
	# of community health committees	329	329	100%
	# of community health promotional committees	38	38	100%

Section I: Availability of essential resources at the facility level

For a service to be available, a service delivery point (SDP) has to be functional at delivering it to its clients. To be fully functional at delivering services, a SDP needs to have simultaneously the following essential resources: trained providers, drugs, medical equipment, and supplies, as well as IEC and management tools. The SDP is functional for a specific service once it has at its disposal trained providers for that service and most² of essential material resources required for delivering it. During FY06, MSH/PRISM undertook the following activities to assure that all facilities benefited from adequate resources and training to offer quality services.

Carry out and consolidate the integration of family planning services and STI/AIDS prevention

The table below indicates the percentage of facilities in Upper Guinea (UG) and Kissidougou in which FP and STIs/AIDS prevention are integrated.

Number of facilities in UG and Kissidougou in which FP and STIs/AIDS prevention are integrated

Type of Service Delivery Point	FY03		FY04		FY05		Results FY 06	
	Target	Result	Target	Result	Target	Result	Target	Result
Birthing centers (9)	9 (100%)	9 (100%)	Maint.	9 (100%)	Maint.	9 (100%)	9 (100%)	9 (100%)
Health centers (104)	104 (100%)	100 (96%)	Maint.	100 (96%)	104	104 (100%)	104 (100%)	109 (105%)
Health posts (119)	30	16 (13%)	30	56 (47%)	Maint.	56 (47%)	119 (100%)	131 (110%)

Note: Absolute figures are cumulative; % figures are percentage of life of project target.

Already at the end of the last fiscal year, all targeted health centers and birthing centers were integrated in family planning and STI/AIDS prevention. Because some trained providers will retire or be transferred to another facility, and new health centers are created, the challenge for health authorities in Upper Guinea and MSH/PRISM is to ensure the continuity and preserve the integration and service availability of FP and STI/AIDS prevention services despite changes in personnel.

All birthing centers, health centers, and health posts in Upper Guinea and in the Kissidougou prefecture are now integrated in FP services and prevention of STIs/AIDS.

–109 health center providers were trained in FP and STI/AIDS prevention–

MSH/PRISM supports the regional and prefectural health authorities in this constant effort by periodically conducting complementary training. During the year, the project trained 38 new providers from 38 health centers in the Kankan and Faranah regions. With this training, all health centers and birthing centers in the target zone have at least one provider in FP and STI prevention.

² A minimum of 80% of essential materials must be available to consider a facility "functional."

–131 health post providers were trained in FP and STI/AIDS prevention services–

While health centers are in a maintenance phase in this year of the project, MSH/PRISM has been working at the next level to ensure that village health posts, the next level down in the Guinean health infrastructure, also offer integrated FP and STI/AIDS prevention services. This year the project supported the integration of FP and STI prevention services into 119 health posts in nine prefectures. This represents 100% of all health posts in the project zone.

Integration means training providers, supplying contraceptives as well as management tools and IEC materials, and ensuring post-training follow-up. The project provided training to one provider from each of the 131 health posts, and gave the provider a nine-month supply of contraceptives, management tools, and IEC materials.

All birthing centers and health centers in Upper Guinea and in the Kissidougou prefecture are now integrated in FP services and prevention of STIs/AIDS. Over the course of the project, five new health centers and 22 new health posts were recognized by the *Programme Elargi de Vaccination/Soins de Santé Primaires/Médicaments Essentiels*. The project immediately integrated FP and STI prevention into its package of services for training to the providers at these new facilities.

During FY06, all the health posts integrated in FP/STI prevention benefited from at least one post-integration follow-up visit. During these visits, different aspects of service provision were assessed: availability of equipment and management tools, provider performance, and counseling. The results obtained during these visits show that in more than 73% of health posts, the availability of equipment and management tools is equal to or higher than 80%. Furthermore, in 90% of facilities, providers strictly follow established norms and procedures when offering FP services.

The project added seven new sites to the 21 sites already integrated with services for insertion and removal of intra-uterine devices (IUDs). Project and collaborating agency staff conducted needs assessments and trained two health providers per site. They equipped the facilities with IUD kits, IEC materials, and IUD case management tools, and conducted post-training follow-up. The project integrated facilities at Kinièran and Kondianakoro in Mandiana in partnership with Save the Children, and five health centers in the Siguiri Prefecture through EngenderHealth: Bolibana, Siguiri Koura, Doko, Kintinian and Franwalia.

Finally, during the fiscal year all sites offering IUD services in benefited from four post-integration follow-up/supervisions. During this activity, the project systematically collected data on new clients. The results summarized for the fiscal year are in the following table.

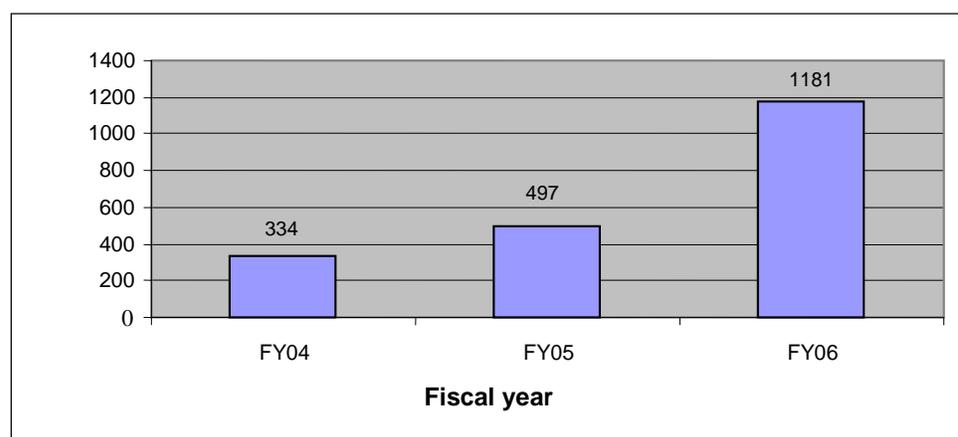
Number of clients recruited for IUDs from FY04 to FY06

Facilities	FY 04 (Oct. '03–Sept. '04)	FY 05 (Oct. '04–Sept. '05)	FY 06 (Oct. '05–Sept. '06)
Hop. Kankan & AGBEF	39	91	176
CSU Salamani	20	63	67
CSU Dabola Sekou	—	—	40
Hop. Kérouané	23	27	42
CSU Kérouané	25	40	65

Banankoro SCA	14	19	76
Hop. Mandiana	38	30	42
CSU Mandiana	1	26	33
CSR Koundianakoro	—	—	49
CSR Kinieran	—	—	33
Hop. Kouroussa	8	14	20
CSU Kouroussa	—	18	29
Hop Pref. Siguiri	16	30	101
CSU Siguiri Koro	18	43	117
CSU Bolibana	—	—	48
CSU Siguiri Koura	—	—	52
CSR Kintignan	—	—	48
CSR Doko	—	—	15
CSR Franwalia	—	—	28
Hop. Reg. Faranah	37	39	30
CSU Abattoir	28	14	24
Hop. Kissidougou	20	19	18
CSU Hérémakono	3	6	3
CSU Madina	9	2	4
Hop. Dinguiraye	23	5	2
CSU Dinguiraye	9	4	10
Hop. Préf. Dabola	3	1	5
CSU Dabola	0	2	4
Total	334	497	1181

The table shows that recruitment of new clients in FY2006 increased to almost three times the number in FY2004. In fact the number of IUDs distributed during the first half of the FY2006 (498) was almost equal to the total distributed during the entire fiscal year in 2005. This trend was accelerated during the second half of 2006, bringing the number of new IUD clients in Upper Guinea for FY06 to be largely more than double of what was observed in 2005 (2.4 times). This rapid increase in the number of IUD users is illustrated by the graph below. The availability and better management of IUDs explain this rapid increase.

Number of IUD clients recruited, FY04–FY06



During the last three years, the project, in partnership with EngenderHealth, has integrated tubal ligation services in 100% of the nine birthing centers within the project zone. Minilaparotomy (minilap) services are only available in seven of the nine centers, but tubal ligation during Caesarean-section (C-section) is available in all nine facilities.

Number of new tubal ligation clients from FY04 to FY06, by method

Hospital birthing centers	Tubal ligation under minilaparotomy			Tubal ligation during C-section		
	FY04	FY05	FY06	FY04	FY05	FY06
Kankan	0	0	0	8	16	8
Kérouané	0	0	0	4	4	8
Mandiana	1	1	2	0	3	4
Kouroussa	NA	NA	NA	2	13	4
Siguiri	2	3	0*	21	7	6
Faranah	7	5	7	27	13	32
Kissidougou	1	0	0	13	6	16
Dinguiraye	NA	NA	NA	5	3	3
Dabola	4	1	1	10	13	18
Total	15	10	10	90	78	99

* The provider trained was moved from the service delivery point.

The table above shows that after a period of unpopularity, C-section services rebounded in FY2006 with a 26.9% increase from FY2005. This is due to better information dissemination on the reversibility of the procedure. There is a clear contrast in the difference between minilap services, the use of which is flat from FY2005 to FY2006, and the more popular ligation during C-section, which has bested its FY2004 high of 90 in FY2006 with a total of 99. Note that the prefectural hospitals of Dinguiraye and Kouroussa were excluded from the minilap program because there was not a high demand for the service. The project is pleased by the up-tick in service trends in a difficult rural area. It will continue to support this trend through IEC activities in the context of a lack of interest by the Ministry of Public Health (MOPH).

–1,507 CBD agents were trained in offering oral contraceptives at the community level–

The strengthening and expansion of community-based services constitutes one of the principal components of PRISM's interventions in support of increasing the population's

access to health services. These interventions are focused toward two goals: 1) training former CBD agents to directly distribute oral contraceptives, and 2) recruiting, training, and deploying new CBD agents, with an emphasis on female agents, as planned in the current strategy. During FY2006, the project maintained the expansion of direct oral contraceptive distribution to ensure complete coverage of prefectures in UG. As a result the project trained a total of 1,507 CBD agents in eight of the nine prefectures covered by the project (see table below for breakdown). Among these agents, 718 or 47.6% are female. This percentage confirms the “feminization” of the program. Each rural subprefecture in Upper Guineanow has a full network of CBD agents in the area of each project-supported health center. Please note that in Dabola and Dinguiraye training was carried out in partnership with Africare, in Kouroussa and Mandiana, PRISM partnered with Save the Children; and in Siguiiri, ADRA was the partner.

Number of CBD agents trained in the direct distribution of oral contraceptives

Prefecture and partner(s)	Number of trained agents				Total trained agents		
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Female	Male
Kerouane PRISM	47	0	0	61	108	46	62
Kankan PRISM	21	63	30	67	181	86	95
Siguiiri PRISM PRISM & ADRA	0 0	41 73	0 0	42 144	300	147	153
Kouroussa PRISM PRISM, Save the Children	0 0	53 76	0 0	0 43	172	65	107
Faranah PRISM	0	49	0	102	151	83	68
Dabola PRISM PRISM & Africare	0 0	0 0	12 117	0 0	129	63	66
Mandiana PRISM PRISM, Save the Children	0	0	0	266	266	133	133
Dinguiraye PRISM PRISM, Africare	0 0	0 0	50 150	0 0	200	95	105
Total	68	355	359	725	1,507	718	789

The CBD agents’ activities show a remarkable increase in the number of new clients in all of the prefectures. In total, the CBD agents recruited 47,067 new clients during the fiscal year compared to 5,011 during FY05. This number is impressive, in that at least half of these agents started their activities only during the last three months of the fiscal year. See also the analysis of the CYP below.

These positive results clearly demonstrate an urgent need to make the services available as close as possible to the potential users’ communities. The challenge will be to maintain the increase in the number of permanent users through a durable provision mechanism for contraceptives (and others consumables) as well as a system for monitoring the quality of services offered.

To maintain and strengthen the program, MSH/PRISM focused on motivation, follow-up, and supervision visits for the CBD agents. MSH/PRISM organized community meetings with religious and community leaders in seven subprefectures (three in Kankan, three in Kérouané, and one in Faranah) to learn how to better motivate CBD agents. These contacts resulted in initiatives to provide seed, volunteer field labor, and plowing resources to CBD agents in exchange for their work. Also, MSH/PRISM ordered about 800 bicycles to be distributed to the CBD agents. The project also organized three roundtables with representatives from rural radio stations to highlight the achievements of the 28 highest-performing CBD agents. These events allowed CBD agents to share their experiences, which motivated their colleagues to improve their performance.

Through a subagreement with the project, Association Guinéenne pour le Bien-être Familial (AGBEF) supervised all CBD agents. At the prefectural level, MSH/PRISM will continue to encourage CBD chargés to take control of the oversight of the CBD program. The CBD chargé is appointed by the Government of Guinea and is normally in charge of the IEC program at the DPS level. As a result of the project's CBD activities, the MOPH agreed to redeploy the chargés to manage the CBD program. This is an important element in sustaining the quality of the CBD program after the closing of the project. The reporting rate of CBD agents is improving, but PRISM expects that the increased involvement of CBD chargés will improve the CBD agents' reporting rate.

Integration of the cervical cancer screening services into 14 health facilities

According to data, the incidence rate of cervical cancer in Guinea is 51/100,000 (0.051%). However, a 1999 pilot project undertaken by the World Health Organization (WHO) and Donka Hospital in Conakry identified about 200 cervical cancer cases out of 10,000 women (2%). A higher incidence level was suspected in UG, based on the fact that many clients identified during the pilot were from that region. Despite its inclusion in the national health policies, the administration of screening has not benefited from a structured national program. As treatment services for advanced cervical cancer are very limited, screening and treatment at the early stages is extremely important.

–42 providers were trained to offer cervical cancer screening services–

In collaboration with the maternity service of the national hospital of Donka (Conakry), MSH/PRISM deployed a cervical cancer screening program modeled on the WHO/Donka pilot to the prefectures of Kankan, Siguiri, and Faranah in order to reduce the cervical cancer morbidity and mortality in UG. The program covered three hospitals and 11 urban health centers in Kankan, Siguiri, and Faranah. It uses Donka hospital for referrals of advanced cases. Professeur Namory Keita, who managed the pilot program in Donka, leads the project intervention in this area.

A team of MSH/PRISM and Donka hospital staff visited the two regional health directorates as well as three prefectural health directorates and the heads of three birthing centers and 11 health centers. They oriented health authorities and providers at the SDP level about the cervical cancer screening program and its implementation.

The team visited 14 service delivery points to assess the availability of basic equipment and identify the target population for the program. Based on the needs assessment, MSH/PRISM procured basic equipment to support training and the implementation of the program. In

parallel, the team procured certain locally produced equipment such as regular and gynecological exam tables.

The team trained a total of 42 providers from Siguiri (13), Kankan (19), and Faranah (10) in offering screening services. Among them, 24 came from health centers and 18 from hospitals. The training focused on cervical cancer screening techniques of visual inspection with acetic acid application and visual inspection with application of Lugol's solution. In addition to the training, the team provided basic equipment (multitip freezer, halogen fiber optics, cervical biopsy curettes, an electrosurgical generator, bottles of Monsel's solution, etc.), IEC materials, and management tools to the facilities.

–4,149 clients were screened for cervical cancer–

During the training, the team organized community mobilization activities in Kankan, Faranah, and Siguiri to promote the use of these new services. These activities enabled the population to access services during their integration (immediately after the training), facilitating the practical training of the service providers.

During and immediately after the integration, 4,149 patients were screened: 720 in Siguiri, 1,234 in Faranah, and 2,195 in Kankan. Among them, 249 patients tested positive (6% of total screened), 87 received biopsy, five patients presented invasive cancer, and eight received therapeutic treatment. As this is the first screening program in the area, the demand was higher than expected. All invasive cancer patients were referred to Donka Hospital for specialized care.

Ensure a sustainable supply of medical equipment, IEC materials, and management tools for the health facilities

–9 birthing centers, 104 health centers, and 131 health posts were provided with medical equipment, including cervical cancer equipment and consumables–

The accessibility of family planning services depends upon, among other things, the continuous availability of products. During the FY06, PRISM received from USAID various contraceptives to be distributed in UG. The table below shows the quantity and type of contraceptives received.

Contraceptives received from USAID and distributed during the fiscal year

Contraceptive	Units	Quantity	Expiring date	Distributed
Lo-femenal	Cycle	717,500	11/2009	330,400
Ovrette	Cycle	127,000	08/2010	90,300
Dépo-provera	FI	132,000	05/2009	46,475
IUD	Piece	1,400	04/2012	850
Condom	Piece	442,600	12/2009	230,000

The project continued the direct management of contraceptives, thus ensuring the availability of contraceptives to all SDPs in Upper Guinea and Kissidougou.

In November 2005, MSH/PRISM inventoried the regional warehouses and all the SDPs to examine the situation of contraceptives at all levels. This close follow-up revealed that the

availability of contraceptives at the SDP level was continuously deteriorating. This resulted in stockouts at the CBD agent level and the paralysis of the CBD program. To resolve this situation, MSH/PRISM set up a parallel system of directly ensuring contraceptive distribution to SDPs and CBD agents. All SDPs that are integrated with FP and STI/AIDS prevention services in the project zone received a minimum 12-month supply of contraceptives. This activity was carried out by the project staff to make sure that the contraceptives arrived at their final destination. Note that this stock is given free of charge. It contributes, although modestly, to the recapitalization of the health centers.

Also, MSH/PRISM agreed to stock contraceptives in N'Zérékoré (Forest Region) to ensure the continuity of FP service delivery in this region not currently covered by the project but still targeted by USAID.



Two male members of CPSC

During the fiscal year, MSH/PRISM also provided new integrated health posts with a one-year supply of contraceptives. In parallel, the project supported the adaptation of several management tools to allow health centers to predict the contraceptive needs of the health posts and integrate this data into its overall projections. In November 2005 MSH/PRISM subcontracted AGBEF, a local NGO, to provide a technical assistant for each of the nine prefectures covered by the project to monitor stocks and perform a monthly analysis of the real contraceptive needs. These technical assistants report back to MSH/PRISM and the MOPH on the quality of contraceptive management for CBD agents, health centers, health posts, and birthing centers. Additionally, they support the regional depots with the direct provisioning of health centers, health posts, and birthing centers, taking into account the needs of the CBD agents.

PRISM's objective for the end of the fiscal year was to ensure that 100% of health facilities in Upper Guinea have at least a six-month supply of contraceptives and have created sustainable systems to more effectively manage them.

Since PRISM has been in-country, the project has provided contraceptive logistics support to Kankan, Faranah, and N'Zérékoré regions by assuring the availability and accessibility of products at the regional and district levels. Since PRISM will be closing, there is concern about how to transfer this provisioning task and assure its sustainability within the limited resources of the MOPH. To this end, the project engaged a short-term technical assistant to review the current contraceptive logistics system and make recommendations for the future.

The consultant's main recommendation to implement a circuit based on the national structure, the *Pharmacie Centrale de Guinée* (PCG), which will supply the SDPs according to their needs. This physical flow of contraceptives is supported by a financial flow that allows the system to make a profit. In addition, an MIS system will have to be installed to trace consumption, determine needs, and monitor product availability. There will be no more external intervention (of NGOs, for instance); the PCG and regional authorities will be fully responsible vis-à-vis the system. The PCG will ensure the receipt, storage, and transfer of the contraceptives to the regions; regional authorities will be responsible for onward distribution to SDPs. The challenge is significant, taking into account the collapse of the official system due to the lack of other essential drugs (see past reports). However, the proposed system appears feasible, based on indications that both PCG and the DRS are ready to prove their capacities and responsibilities.

To set up such a system, in agreement with the MOPH, it is recommended that two MOUs be established: one between USAID and the PCG, and one between USAID and the DRS. The terms of these MOUs should clearly specify expectations such as financial requirements, performance benchmarks, support expected from USAID, mobilization of resources by PCG, and supervision of the regional system by the DRS. The full report of the consultant was transmitted to USAID and to the MOPH for decision.

–9 birthing centers, 104 health centers, and 131 health posts were provided with IEC materials and management tools–

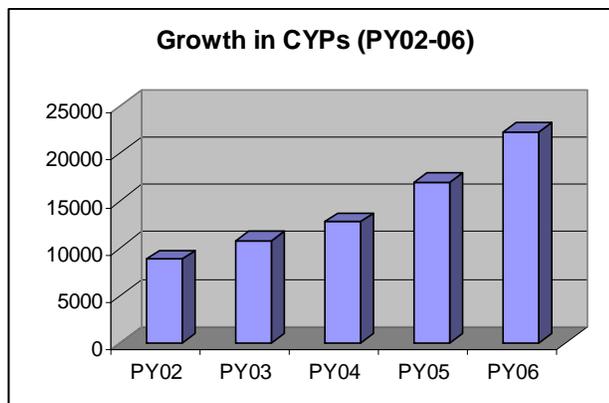
One of the project's objectives is to support the MOPH in the identification and implementation of sustainable mechanisms to assure the availability of equipment, material, and medical supplies at all facilities where health services are provided, so that health care providers are able to offer quality services to the population. However, it became necessary to directly supply certain articles because of shortages. During FY06, the project procured and delivered locally produced or imported medical equipment to nine birthing centers, 109 health centers, and 131 health posts. These materials include consumables and equipment related to the diagnosis and treatment of cervical cancer.

During FY06, the project produced and distributed thousands of copies of brochures in the project zone. These materials focus on the promotion of FP services, cervical cancer screening services, and the consequences of undesired pregnancies, STIs/AIDS, and the "*Foudoukoudounin*" (the "short marriage" practice of the taking of young girls for temporary sexual arrangements). Brochures are the educational material most valued by both the health providers and the target populations. The project distributed brochures specifically focusing

on youth in the schools, at community events, and in health centers during consultations.

Carry out and consolidate contraceptive use in Upper Guinea

Remarkable progress can be observed by the rise of the number of couple-years of protection (CYP) in this region. Indeed, the number of CYP in Upper Guinea has achieved an average annual increase of 26.2% year over the year. The total CYP achieved in FY2006 is 22,247, 111% of the annual target of 20,000 (which was thought to be a very ambitious target when set in FY2005).



The contraceptive prevalence rate (CPR) is the proportion of women of reproductive age using a modern method of FP among those (in this age) in the sample. In 2005, using the provisional data of the Demographic Health Survey 2005 (DHS-05), this indicator was at 6.5% for Upper Guinea. The MSH/PRISM Household Survey of 2006 (HH2006) indicates that the CPR in Upper Guinea stands at 13.0%. Compared to the MSH/PRISM Household Survey 2003, the CPR in Upper Guinea has almost doubled in 2006 compared to 2003, from 6.6% to 13%.³ Thus, the results in Upper Guinea in 2006 go beyond the target fixed for MSH/PRISM for FY 2006 (10%).

³ It should be noted that provisional results of the DHS-05 only considered the use of modern FP methods among married women. Performing the same analysis, the HH2006 shows that the CPR among women of reproductive age and in union is 9.9% in 2006 compared to 5.5% in 2005 (DHS, 2005). It should be noted that in 2003 and 2006, MSH/PRISM followed exactly the same method of sampling and used the same questionnaires as of the DHS, ensuring that the results are comparable.

Section 2: Equity in access and financial sustainability

Strengthen community ownership through health mutual insurance organizations, management committees of health centers that represent the community, and other associations interested in community self-reliance

Despite efforts, health centers almost everywhere in Guinea are not fully functional. Low motivation of health service providers, lack of supervision, and a lack of drugs and financial, human, and material resources limit the services offered. Most health centers are not able to break even financially because the fees for service, which have not been changed in over ten years, are too low. Throughout Guinea, community members commonly feel alienated from the health care system and do not feel that they have the ability to improve the health centers. There is generally weak participation by communities in the management of the health system. The MSH/PRISM project supports the Guinean MOPH in this area by promoting community co-management of the health system, including the promotion of local financing. During FY06, MSH/PRISM supported a series of activities at the community level to improve local governance.

Efforts made in service integration are only sustainable if the populations have the financial means to access these services. Financial accessibility to health care could be improved in several ways, such as installation of community solidarity mechanisms (mutual health organizations), and through substantial involvement of communities in the management of health services. The PRISM project supports the MOPH in each of these strategic areas.

At the Hospital in Kankan



–107 “caisses communautaires” (mutual health organizations) were created–

One of the most important ways to increase access to health services in situations where the national governance is weak (as in Guinea) is to give communities the experience of managing an institution that responds directly to their needs. In such a situation, local governance becomes increasingly important. PRISM has tested different approaches to reinforce local governance in the management of health systems. One of the approaches is the promotion of mutual health organizations.

A mutual health organization is a local, voluntary, and nonprofit community-based association that administrates micro-insurance to respond to members' needs in facing their community's health problems. This approach is known in Guinea by different names such MURIGA (an acronym for the French phrase for community mutual health organization to cover risks related to pregnancy and childbirth), but more widely by *mutuelle*.

The project supported pilots in Kankan, Kérouane, and Faranah prefectures. The pilot approach creates a community organization that covers a complete range of health services including child survival, in addition to services related to pregnancy and childbirth. A *mutuelle* is a community-based group that receives service from a health facility. Community members subscribe to the *mutuelle* and pay a regular premium into a central community fund (*caisse communautaire*) that acts as an insurance fund to pay for the costs of health service at the health facility. This fund is administrated by a committee that negotiates prices for member services with the health facility and pays the health facility upon receipt of a monthly service invoice. Members are treated at the facility without having to pay costs up front for an agreed-upon set of services.

Mutual health organizations have existed at the subprefecture level for a long time, but had lost much of their dynamism. The project decentralized the *mutuelle* system to the village level to revitalize the process by placing it as close as possible to the communities. Over the fiscal year the project initiated a process of decentralizing the collection of participation fees at the village level by creating 248 *caisses communautaires*, recruiting thousands of new members in Kankan, Kerouane, and Faranah, and collecting about GNF 17 million—a very significant sum of money in the context of the Guinean rural population.

The idea of the *mutuelle* has grown to include the management of supplies. With the frequent stock-out of medicines, communities have expressed interest in using their *caisse communautaire* funds to subsidize the purchase and transport of pharmaceuticals for their health facilities system in order to better meet their communities' needs. MSH/PRISM has assisted communities and health authorities in setting up basic management systems to secure the community funds and ensure they are used for the good of the community.

Membership in the *mutuelles* has increased primarily due to the efforts of MSH/PRISM to decentralize the their financial management down to the village level. With village management of the funds, community members are willing to trust the management of their investments. Those that manage the mutual investments are elected by the community and are generally individuals who are already well respected and trusted. This approach has significantly improved the perception and security of the *mutuelle* system.

–329 community health committees and 38 community health promotional committees have been established–

When communities lack the training, tools, and local coordination mechanisms they need to govern their associations, the new committees and their *mutuelles* have a hard time succeeding. The MSH/PRISM experience in Faranah drove this point home when MSH/PRISM assisted the community and health authorities to implement a *mutuelle* but without promoting or reinforcing additional governance activities. The *mutuelles* in this prefecture lost many members. Each month, fewer “enrolled” people pay their membership fees. It is clear that successfully increasing demand for health services while maintaining a balanced supply of resources to support them requires an integrated and comprehensive approach. Select, stand-alone activities have limited success when conducted independently. MSH/PRISM has demonstrated the potential for greater impact when all these program elements are developed in unison with strengthened transparency, accountability, and community empowerment.

Since January 2006, MSH/PRISM piloted an approach in 38 health centers to ensure sustained access to health services in Kankan, Faranah, and Kerouane by developing integrated structures that empower the community to promote transparency and accountability. The project has done this by revitalizing the previous *comité de gestion* (CoGes), or management committee, model into a new committee called *comité pour la promotion de santé communautaire* (CPSC), or committee for community health promotion. This CPSC is composed of representatives of village-level health committees, *comités de santé communautaires* (CSC). CSC members are democratically elected by their communities, and the CSCs internally select the person to represent them at the CPSC.

The project then facilitates the connection of the village-based *mutuelles* to their respective CSCs and CPSCs, to enable organizing of meetings, renegotiation of tariffs, and to help ensure the availability of drugs, among other important management activities. As the *caisses communautaires* provide financial support to the village health system, their representation at the CSC and CPSC levels energizes the committees to demand real accountability from health facilities and take effective action to manage health resources.

The development of this system has strengthened local governance by fostering a strong relationship with the MOPH and building upon previous community development experience in Upper Guinea. The MOPH has given MSH/PRISM the necessary authorization to test these approaches. The result is that they are driving a revival of quality health services owing to the direct investment of community resources to reinforce and improve the system.

Baté Nafadji Health Center system data from June 2006 show that the health center and health posts of Baté Nafadji had required drugs and supplies for 84% of clients seeking prenatal care services and for 95% of clients seeking immunizations and family planning services.

The increased access to (and demand for) effective services is due primarily to the availability of critical medicines. The local governance structure in Baté Nafadji pooled financial resources with the local community and drew the support of regional authorities to purchase 12 months of medicine for the health center, surrounding health posts and two other health centers located in Missamana and Balandou.

Through increased community participation in the *mutuelle*, Baté Nafadji now has accumulated approximately 4.3 million GNF in reserves, as compared to only 0.2 million GNF accumulated over the previous six-month period.

–Focus on results: local governance–

The project first implemented this strategy in the subprefecture of Baté Nafadji and then expanded to Balandou and Missamana. After just a few months of implementation, this new approach started to produce solid results. With the village-based *mutuelle* and the management committee structure in place, the health center at Baté Nafadji achieved 84% drug and supply availability per quarter, whereas other health centers around it barely achieved 60% (see box below).

Local governance, solid results

- 100% increase in health facility revenue
- community-negotiated price lists
- 63% increase in facility use
- shared health costs
- communities participate in developing health budgets
- CSCs organize dissemination meetings
- performance-based payment for health providers

The results presented during the last semi-annual *Comité Technique Préfectoral de la Santé* (CTPS) prove that local governance also works to support the financial requirements of health facilities. The total revenue generated in the first six months of 2006 by the Missamana health center reached 5.2 million GNF⁴, while the revenue generated by the Balandou Health Center reached 4.6 million GNF in that time period, almost double what had typically been generated in the past.

Another result produced by the local governance approach is negotiated rates for services offered by the facilities. It is public knowledge that revenues generated through official service fees at almost all the health centers in Guinea do not cover the cost of services provided. The more services the health center offers, therefore, the greater its probability of going bankrupt. This business model is clearly flawed, but this handicap has not been well understood by the communities that the health centers serve. The new local governance approach has provided an opportunity, for the first time, to openly discuss this issue and to dissipate the distrust bred throughout nearby communities by provider-initiated coping mechanisms. By way of the CSC and CPSC community meetings, representatives from the 14 villages of the Baté Nafadji subprefecture and various political, administrative, and health authorities came together to identify simple solutions to a rather complex challenge. The group determined that the priority action to address the problem would be to renegotiate service pricing to reflect reasonable costs for the users that would also cover the health system's direct operating costs. Ultimately, the committees determined new rates and the health authorities have posted them at each health center and health post in the area. This transparency has successfully reduced overcharging of services. After learning about the new rates, many community members showed enthusiasm when they realized that the rates were often less than what they had previously been paying to health providers through "informal" pricing.

The use of health services in Baté Nafadji and its health posts has dramatically increased during this pilot phase, as reflected in the revenue generated by the health center. The June 2006 data show that Baté Nafadji and its health posts realized total revenue of 8.5 million GNF from services in six months compared to 5.2 million GNF during the previous six-month period—the highest total revenue of all the health centers in Kankan Prefecture⁵. This increase is due to a combination of factors. Health facilities now have drugs and other

⁴ The Missamana health center, with a rather small population, generated as much money from services as the nearby Tokounou health center (5.1 million GNF), with twice the population.

⁵ This includes the busy urban health centers of Salamani (7.1 million GNF) and Kabada (6.2 million GNF).

material resources available. Through the *mutuelle* fee structure, key financial barriers have been reduced. Client confidence has increased because know they will not be overcharged.



Dr. Camera, health center director at Bata Nafadji, interviewed by local radio

The collaborative framework of the strategy has resulted in increased collaboration between the health infrastructure and other government authorities. During one of the monthly CPSC meetings, the chief of the health center expressed the intention to recruit one more *matronne* (nurse matron) as well as a guard for the health center. Based on the discussions, the elected president of the Baté Nafadji *Communauté Rurale de Développement* (CRD) or rural development community, and his board members, including the *Sous-Prefet* (sub-prefect), decided to cover the salaries of the *matronne* as well as the guard from CRD reserves, thus reducing the health center's need for increased service-fee revenue. This sharing of operating expenses is a notable illustration that demonstrates the potential of direct involvement of the local authorities in the management of the health center. Following receipt of performance data, the governor of the region visited numerous villages, talking to people and expressing his enthusiastic support for the initiative.

The local governance framework has yielded increased community engagement. Community members of Baté Nafadji actively participated in the analysis and development of their health center budgets. Each month, representatives from each village, alongside health and administrative authorities, review the health centers' revenue and budgets and then recommend budgetary allocations to program elements. This has fostered more transparent and effective management of the health centers.

The local governance structure has opened new avenues of community mobilization for services and outreach activities. In Baté Nafadji and its villages, community-elected representatives (CSC presidents) have organized community meetings to discuss methods of

motivating their CBD workers to disseminate information about and expand access to FP services throughout their communities.

The local governance structure has resulted in greater support for fixed personnel costs at the health facility. During one of the first community meetings, the committee decided to tie health providers' financial incentives to health center revenue. The base system design stipulates that total revenue should cover total operating costs (drugs, gasoline, supplies, and management tools). In some cases, the revenue has fully covered costs and has resulted in a surplus. Community members decided that part of this surplus (that would otherwise have gone into "reserves") should go to cover depreciation of the GNF (for both procurement and salary payment) and that the remaining amount should go to the health providers based on personal performance. The monthly CPSC meeting sets performance objectives for each service and for the health providers, reviews performance results at month's end, and pays incentives based on the results. Health providers in Baté Nafadji and its health posts make more money than before and, within limits, can earn even more as the health centers improve performance and results.

IR2: Improvement in the quality of reproductive health services

During the FY06, MSH/PRISM's support to strengthen the quality of RH services focused on two themes: 1) supervision/post-training activities, including the management of PAC services, and 2) the devolution of the national health management information system (SNIS) developed since project inception.

IR2: Improved in the quality of RH services				
Task area	Activity	Target	Actual	Percent
Strengthen quality services at the service delivery points through the supervision and adaptation of RH curricula when necessary	# of supervisory visits made to each health center per year	4	4	100%
	# of curricula revised and adapted	1	1	100%
Follow up on PAC activities	# of clients served	No target set	761	Not known
	# of post abortion clients which accepted family planning	761	561	76%
Devolution of the MIS system	# of DPS utilize RAMCES for collecting and analyzing the health service data	9	9	100%

Strengthen quality services and update the family planning training curricula

–4 supervisory visits per year were made to each health center–

The project regularly gives technical, financial, and logistical support to the DPS and DRS to support facilitative supervision. Project staff and/or the health authorities directly supervised all 109 health centers, the nine birthing centers, and 131 health posts in the target area. During the supervision visits, supervisees and supervisors implement a joint review to discuss progress and identify problems. These elements are contained in the form “Monitoring and Supervision of SDP,” a structured format with the summary statement of the problems, the concrete actions to solve them, the name of the person responsible for completion of each action, and the deadline. MSH/PRISM helped develop this document to act as a problem resolution plan for SDPs. It represents the principal supervision monitoring tool in Upper Guinea.

–1 curriculum was revised and adapted–

Integration of FP and STI/AIDS prevention services requires training of the providers at the health post level. The official training curriculum in FP and STI prevention requires a 2–3 week workshop, and the displacement of providers from their sites during this period. In Guinea, the health posts usually have only one provider, making it ineffective and counterproductive to remove this agent for 2–3 weeks for training and close the site. MSH/PRISM, therefore, decided to re-examine the training curriculum in collaboration with regional and prefectural health authorities, making it less disruptive while not lessening the quality. In January 2006, MSH/PRISM organized a large curriculum review workshop in Kankan targeting the main decision-makers, users, and technical staff at the regional and prefectural directorates. The workshop participants prioritized key topics (prevention of infections, the ICP/counseling, etc.) and reduced the training to six days. Workshop

participants developed and tested session plans and submitted them to the regional and prefectural health authorities for validation. Copies of the new curriculum as well as the session plans were available at the DRS and DPS levels in Upper Guinea. After the sign-off, these copies were then shared with others partners and used for all the subsequent trainings.

Follow-up on postabortion care activities

–761 clients served–

Since 2001, in collaboration with JHPIEGO, the PRISM project has gradually integrated a PAC program in the birthing centers of the nine hospitals in the project’s intervention zones and in the health center of Banankoro. The program aims to improve the quality of PAC for women, resulting in reduced maternal deaths and prevention of repeated cases. The project supported four supervision and post-training monitoring visits in the 10 health facilities offering these services, to monitor the availability, quality, and use of services. The data collected during these follow-up visits show that the facilities received 761 clients for PAC services in the target SPDs. Among these clients, 68 (8.9%) presented complications on arrival and eight complications occurred after “*aspiration manuelle Intra utérin*” (AMIU) (1.05%). Also, 561 of 761 women who received PAC accepted a FP method (74%). The maternities of Dabola and Dinguiraye have the weakest FP acceptance rates, 32% and 50% respectively. MSH/PRISM will make efforts to correct this situation in those facilities.

Postabortion care services, FY06

Facilities	# Cases	# Complications on arrival	Types of complications	Complications on leaving	# Acceptors of FP	%
Hop. Kankan	155	2	1 infection 1 hemorrhage	0	98	63
Hop. Kérouané	23	2	1 infection 1 hemorrhage	0	23	100
CSA Banankoro	45	1	1 hemorrhage	0	43	96
Hop. Mandiana	46	5	3 hemorrhage 2 infections	0	46	100
Hop. Kouroussa	38	7	2 infections 5 hemorrhages	0	26	68
Hop. Siguiri	63	2	hemorrhage	1 hemorrhage	44	69
Hop. Faranah	209	23	9 hemorrhages 14 infections	4 infections 1 hemorrhage	193	92
Hop. Kissidougou	80	0	—	0	50	63
Hop. Dinguiraye	34	17	17 hemorrhages	2 infections	17	50
Hop. Dabola	68	9	5 hemorrhages 4 infections	0	21	32
TOTAL	761	68	—	8	561	74%

Upon USAID’s official request, MSH/PRISM supported JHPIEGO technically and logistically for the implementation/extension of PAC services in N’Zérékoré. MSH/PRISM organized JHPIEGO training for 36 service providers from the hospitals of Yomou, Beyla, Macenta, Gueckedou, Lola, and Zérékoré in infection prevention (IP). In the same way, the project supported 15 other service providers trained during the fiscal year in AMIU. Also

during this fiscal year, MSH/PRISM provided each of these hospitals with basic medical equipment as well as initial consumable stocks.

–561 postabortion clients accepted family planning–

In total during FY06, among the 761 women who received PAC services, 561 (74%) had accepted a FM method after AMIU. This is almost the same rate as for FY05 (72%). It should be noted, however, that during FY05, 565 clients received PAC services, and 406 had accepted a FP method after AMIU.

Devolution of the National Health Management Information System

–9 DPSs utilize RAMCES for collecting and analyzing health service data–

After installation of the application developed for managing a health facility's routine information (RAMCES) in the nine DPS in the intervention zones, the project developed and tested a user's guide, training curriculum, and "read me first" document with the DPS team members. The project packaged and transferred the geographical information system developed by the PRISM project at the end of the year 2004 to the health authorities and USAID for countrywide dissemination.

IR3: Increased demand for reproductive health services

To increase demand for RH services in Upper Guinea, MSH/PRISM implemented a three-pronged approach. Through interpersonal communication training and round-table activities, the project improved and increased the effectiveness of the client-provider interface. Through conducting focused awareness-raising activities at the village level, the project increased knowledge of FP and the resources available at the health facility. Through constant improvement of IEC materials and training of facility and CBD staff in how to use them, the project ensured that providers were vectors for positive health messages at the facility and in the community.

IR3: Increased demand for services				
Task area	Activity	Target	Actual	Percent
Improved coordination of IEC services	# of villages using “community mirror”	320	320	100%
Strengthening client-provider interactions	# of round tables organized in relation to cancer screening	No target set	45	Not known
	# of meetings organized with potential cancer screening clients	80	70	87.5%
	# of radio broadcasts made focusing on providers’ interpersonal communication	40	13	32.5%
	# of IEC materials produced and distributed in project zone	2,400 brochures; 1,200 books	2,400 brochures; 1,200 books	100% 100%
Conducting health promotion interactions	# of villages covered to raise awareness about <i>caisses communautaires</i>	279	320	115%
	# of events organized to raise the general public’s awareness of family planning and STIs/HIV/ AIDS prevention	No target set	131	Not known
Improving IEC management and delivery capacity	# of supported IEC prefectural groups	9	9	100%
	# of supported IEC regional groups	2	2	100%

Improved coordination of IEC services

–320 villages used the “community mirror”–

The “community mirror” helps communities prioritize needs, identify responsibilities, and summarize information on addressing local health problems. The community can use it like a visual organizer to monitor the progress of interventions and make mid-course changes when necessary. As with the promotion of *caisses communautaires*, MSH/PRISM oriented and supported CPSC members to popularize the use of “community mirrors.”

Strengthening client-provider interactions

–45 round tables were organized to promote cancer screening–

To advocate and inform the public about cervical cancer screening, MSH/PRISM helped to initiate a community mobilization program. This program focused on encouraging more women to be proactive and get tested early for human papilloma virus. The project carried out a series of radio broadcasts in collaboration with the rural radio stations in Kankan, Siguiri, and Faranah. In these broadcasts, people who were already diagnosed or successfully treated told their stories and invited other women to follow their example. Over the course of the year, the project recorded and broadcast 45 “*Tables Rondes*” and organized 70 meetings with potential cancer screening clients.

–13 radio broadcasts were made focusing on providers’ interpersonal communication–

Many health professionals consider one of the biggest obstacles in rural Guinea to be that of interpersonal communication between health providers and clients. In response to this problem, MSH/PRISM provided continuous reinforcement and skills building to providers in interpersonal communication and counseling. Effective training in this area will help foster positive communication between health providers and clients.

MSH/PRISM developed such radio messages as “long distance training” to strengthen health provider’s skills in how to be discrete with clients, how to help a potential client choose a family planning method, and how to help regular users encourage nonusers to take advantage of FP and STI prevention services.

Regional and prefectural health authorities tested and approved the training curriculum. Immediately after the review, MSH/PRISM organized the diffusion of 13 radio messages through six community radio stations in Upper Guinea.

Also, in order to evaluate the impact of such training, MSH/PRISM developed and distributed a simple tool to all SDPs to measure the new recruitment rate based on information heard from the rural radio program.

–3,600 copies of IEC materials produced and distributed in the project zone–

To keep IEC materials fresh and effective, it is crucial to review all messages and materials on a regular basis. In this vein, MSH/PRISM organized a workshop in November 2005 in Dabola to review and improve the performance of IEC materials. Other partner organizations also helped develop new strategies and messages.

The main goals of the workshop were to:

- review survey results (e.g., DHS, PRISM HH survey) and identify obstacles to the wide diffusion of FP and STI/AIDS prevention services;
- prioritize problems and identify primary, secondary, and tertiary targets of interventions;
- define the communications objectives;
- elaborate messages, taking into account identified obstacles.

During the workshop, participants from different organizations agreed on a list of 24 key messages. The main targets were women of child-bearing age, couples, health providers, community leaders (religious and administrative), and school teachers. This meeting also produced a complex communication strategy that included new and more effective approaches to training and community mobilization.



CBD worker and member of CPSC

The project helped to diffuse the communication strategy and messages coming from this workshop throughout the project zone. The result was improved demand for FP and STI/AIDS prevention services, as described before (see pages related to the use of FP). In total, 83,521 new clients were recruited for FP services in FY06 compared to 21,510 during FY05.

To support IEC activities, MSH/PRISM also produced and distributed brochures and posters to the health providers and their present or future clients. The project produced 2,000 “*VIH/SIDA*” (HIV/AIDS) brochures, 200 “*Pour Aider à Espacer les Naissances*” (Helping in Birth Spacing) brochures, and 200 “*Famille Planifiée, Famille Heureuse*” (Planned Family, Happy Family) brochures and distributed them to health centers, health posts, and birthing centers, as well as to other potential clients of FP and STI prevention services in Upper Guinea. As part of these activities, PRISM also distributed 1,200 books on modern methods of contraception to SDPs in Upper Guinea.

At the beginning of the fiscal year the subcontractor JHU/CCP submitted the following deliverables: 1) a video on HIV and undesired pregnancies in the mining zones, and 2) the results of the survey on the project’s impact on community and religious leaders since its inception. MSH/PRISM shared copies of these materials with USAID and the Government of Guinea. Also, as part of communications strategy in the mining zones, PRISM duplicated and distributed the video to counterparts in the field.

Conducting health promotion interactions

–Awareness about “caisses communautaires” was raised in 320 villages–

The decentralization of the “*caisses communautaires*” (see IR1, Section 2 on page 17) from the subprefectoral level to the village level is a recent project strategy. MSH/PRISM promoted this approach to rural populations in the target areas before implementing the pilot program. The project organized an orientation session for 27 CPSC members in Faranah Prefecture to help them promote the approach in their communities. Trained and equipped, these CPSC members visited a significant number of villages and mobilized communities to promote *caisses communautaires*. The positive reaction encouraged MSH/PRISM to expand this strategy to cover the rest of the project area. The project introduced the *caisse communautaire* approach to all CPSCs formed in Kankan, Faranah, and Kerouane prefectures, covering 320 villages.

–131 events were organized to raise the public’s awareness of FP and STI/HIV/AIDS prevention–

PRISM chose to organize IEC events to promote the integration of FP and STI/AIDS prevention services at the health post level. These mobilization activities informed the target population about the services available at the health post. The project organized promotional events in the project zone, covering 131 integrated health posts. Most of the promotional materials were translated into Malinke, the local language, in an effort to reach the entire target audience.

To support CBD agents, MSH/PRISM organized a series of activities to present the newly trained community-based agents to their villages. The events publicly recognized the new agents and facilitated their official insertion into the community. They also provided a chance for community leaders to fully accept and support CBD workers.

During FY06, MSH/PRISM supported actions through the *Group Régional IEC* in favor of various target populations, including youth, sex workers, miners, and women of reproductive age. The involvement of the opinion leaders allowed the project to overcome any pockets of resistance to the dissemination of the HIV/AIDS messages. To this end, the PRISM project oriented hundreds of religious and community leaders to support the HIV/AIDS prevention activities. Currently, religious leaders regularly take part in message dissemination in their communities.

Improving IEC management and delivery capacity

–9 IEC prefectoral groups were supported–

The main IEC group activities include the organization of community events (such as football games and films related to the consequences of STI/AIDS) and technical support to the DPS in Upper Guinea. During the past year, MSH/PRISM provided continuous technical assistance to nine prefectoral IEC groups to ensure the sustainability of IEC activities after the project ends. The project developed work plans to support the integration of RH services.

These groups will become autonomous through solicitation of activity funding and support from other partners operating in Upper Guinea.

–2 IEC regional groups were supported –

MSH/PRISM provided continuous technical assistance to two regional and nine prefectural IEC groups to ensure the sustainability of IEC activities after the project ends. These groups coordinate IEC activities, organize regional events, and provide technical support to the prefectural groups in Upper Guinea. These groups will become autonomous through solicitation of activity funding and support from other partners operating in Upper Guinea.

Focus on Results: Behavior Change

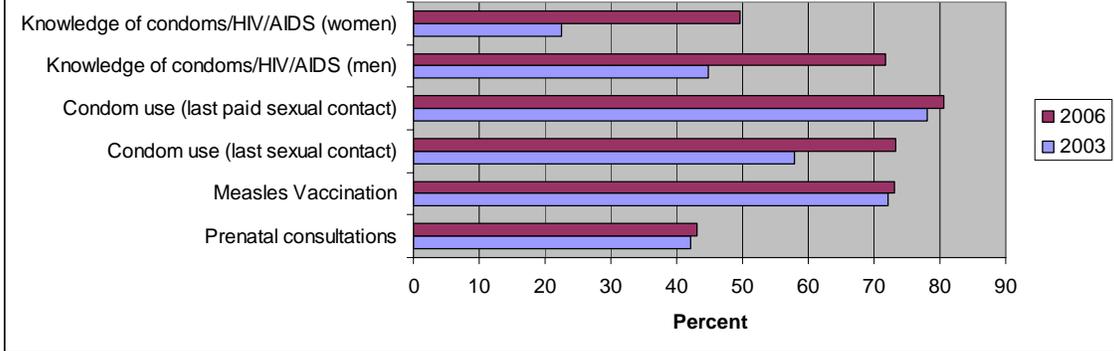
In the last quarter of the reporting period, MSH/PRISM initiated a household survey to capture the measurable impacts of the project on the target population. This survey measures the same indicators as the 2003 survey of the same type. As the survey was ongoing at the close of this fiscal year, and will be analyzed and published in the next period, the numbers presented are not definitive. The preliminary figures do indicate progress since 2003. A sampling of results shows the following:

- 43% of pregnant women had three prenatal consultations, including one in the ninth month, as compared with 42.2% in 2003. This represents a 1.8% increase.
- 73% of children received the measles vaccine before their first birthday, as compared with 72.1% in 2003. This represents a 1.2% increase.

During the same survey MSH/PRISM noted improvement in general population's knowledge about FP and STI/AIDS prevention:

- 73.3% of men reported that they used a condom during their last sexual contact with a non-regular partner, as compared with 57.8% in 2003. This represents a 26.8% increase.
- 80.6% of men stated that they used a condom during the last paid sexual contact, as compared with 78% in 2003. This represents a 3.3% increase.
- 71.8% of young men (15–24 years old) reported that they knew condoms are a means of preventing HIV/AIDS, while only 49.6% young girls (15–24 years old) stated the same, as compared to 44.9% young men and 22.5% young women in 2003. This represents increases of 59.9% and 120.4% respectively.

Behavior Change Results 2003-2006



IR4: Improvement of coordination

PRISM's approach to improving coordination of RH interventions is to participate actively in support of the existing coordination processes and mechanisms, and to promote, when necessary, the creation of new, sustainable mechanisms at the decentralized level. These activities are not quantified in the workplan, but remain a priority for the project.

IR4: Improved coordination				
Task area	Activities	Target	Actual	Percent
Provide support to and strengthen managerial capacity at the decentralized level	Support the establishment, functioning, and actions of RH regional working groups	N/A	N/A	N/A
	Support the preparation of and participate in the CTPS and CTRS meetings	N/A	N/A	N/A
	Strengthen the managerial capacity of DRS/DPS, with an emphasis on their supervision activities	N/A	N/A	N/A
Provide support to and strengthen managerial capacity at the institutional level	Review the project's activities, results, and achievements with the MOH and USAID	N/A	N/A	N/A
	Participate (to the extent possible) in the development of health-related policies at the central level	N/A	N/A	N/A
	Plan and implement interventions with RH partners in the field	N/A	N/A	N/A

Provide support to and strengthen managerial capacity at the decentralized level

–Supported the establishment, functioning and actions of RH regional working groups–

The MSH/PRISM project actively participated in the preparation and implementation of the national review of the Programme Elargi de Vaccination/Soins de Santé Primaires/ Médicaments Essentiels. The project presented its approaches to community mobilization and innovations regarding local governance. Participants learned about MSH/PRISM's approaches and requested more information about the project's activities and results.

–Supported the preparation of and participated in the CTPS and CTRS meetings–

To support the decentralized health system, the PRISM project actively participated in all prefectoral coordination structures, with particular emphasis on the CTPS. CTPS and CTRS are opportunities to review the plans for the previous six months and also to define plans for the upcoming semester. In 18 CTPS meetings, MSH/PRISM contributed to the analysis of the health facilities' results by identifying possible solutions to the outstanding problems. The project also shared information with participants about PRISM activities and on how to identify well performing health providers and CBD agents in the field. Participants also reviewed the project's supervision tools and strategies.

The DRS organized four semiannual sessions of the CTRS at which MSH/PRISM staff took advantage of the opportunity to adjust the project's scheduled activities in light of schedules

DRS and NGO partner schedules. The project also used these sessions to examine the data collected in the health centers and to propose solutions to the obstacles found after data analysis. The participants approved PRISM's solution to distribute oral contraceptives through CBD agents. During the CTPS and CTRS sessions, PRISM staff also presented the results achieved through the CBD and local governance programs.

–Managerial capacity of DRS/DPS activities was strengthened–

MSH/PRISM provided ongoing support to regional and prefectural health authorities in organizing and financing joint supervision visits to the SDPs. Health authorities received information on the quality of different MSH/PRISM programs related to RH and developed a better understanding of the limitations on health resources.

In addition to providing technical and logistical support to the regional directorates of Kankan and Faranah, the MSH/PRISM project also supervised the National Vaccination Campaign initiated by the MOPH. After various preparatory meetings, PRISM established supervision teams in the health districts and supported the regional directorates in monitoring the campaign. Even the “community mirrors” assisted health authorities in tracking immunization activities in the region (even in the regularly underserved areas).

Supported and strengthened managerial capacity at the institutional level

–Reviewed the project's activities, results, and achievements with the MOPH and USAID–

This activity was done throughout the year with both offices.

–Participated in the development of health-related policies at the central level–

MSH/PRISM supported the meeting organized by the National Tuberculosis Control Program (PNLT) to share information about the current health policy, especially regarding the distribution of the DOTS at the community level.

The project participated in the WHO-financed workshop for the adoption of the “*Programme National d'Assurance de la Qualité des soins et services*” (National Program for Quality of Care and Service) that was held in Kankan, December 27–30, 2005. Various executive officers at the central, regional, and prefectural levels of the MOPH, as well as partners in the field, participated in this workshop. MSH/PRISM provided technical support and made recommendations on the preparation and finalization processes.

One of the principal MOH activities over the course of the year was to organize the dissemination of the “*Plan National de Développement Sanitaire - PNDS*” (National Plan for Health Development) and to develop the work plans for 2006 for Kankan and Faranah regions. For this purpose the PRISM project, a key partner of the regional Directorates, brought in technical support to efficiently develop the annual work plans for each regional directorate including the overall activities deployed by various partners in the field.

–Planned and implemented interventions with RH partners in the field–

MSH/PRISM continued close collaboration with other intervention partners in the health sector over the course of this year.

With Africare, PRISM staff prepared and discussed an MOU for the implementation of CBD of oral contraceptives in Dabola and Dinguiraye. The parties agreed on the MOU; after signing the agreement, PRISM organized trainings in Dinguiraye and Dabola for Africare's employees as well as community agents.

Helen Keller International continued to maintain its regional representation in Kankan in the PRISM office.

MSH/PRISM made agreements with Save the Children to expand CBD of oral contraceptives in Kouroussa and Mandiana. In relation to these activities, the project organized trainings for Save the Children's field supervisors, Mandiana DPS's staff, and CBD workers in these prefectures.

MSH/PRISM participated in a workshop organized by ADRA at which the organization presented its health work plan in Siguiri for FY06. MSH/PRISM supported ADRA in the implementation of these health activities.

–Focus on results: Cost-sharing activities with other organizations–

Over the course of the year, the PRISM project carried out many activities in partnership with other organizations that were not funded by USAID. These interventions accounted for 5.1% of the total annual budget in cost share. The specific activities carried out without USAID support are summarized in the paragraphs below:

The German development agency (GTZ) and Plan/Guinea provided necessary drugs to health centers in the Faranah region (Kissidougou for Plan/Guinea) in relation to their integration into the RH service. PRISM's role was to provide training, IEC materials, and management tools to these providers.

In collaboration with the PASSIP (a European Union project), PRISM took responsibility for many activities in the region: trainings, supervision, and certain direct interventions, to improve vaccination coverage (in particular, supplied fuel for refrigerators housing vaccines).

With UNFPA, the PRISM project supported the revision of the RH indicators, allowing the health centers generate monthly reports more easily.

With GTZ and the Coopération Française, PRISM helped establish a network and Intranet at the MOPH.

With UNICEF, the PRISM project supported the functioning of the *mutuelles* in Kissidougou.