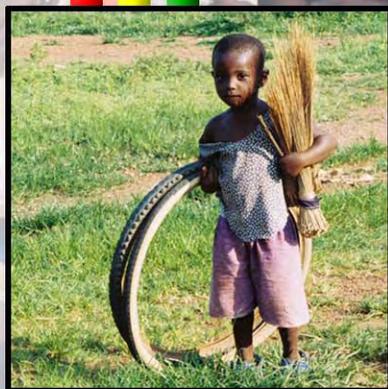
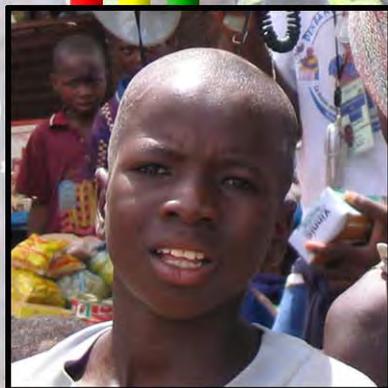




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# Guinea PRISM Final Report 2003-2007





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## Acronyms

BCG - Bacillus Calmette-Guérin ( <i>tuberculosis vaccine</i> )	FSDP - Functional Service Delivery Point
CBD - Community-based distribution	HHS - Household survey
CPS – <i>Comité de Promotion de la Santé</i> (committee to promote health services)	IEC - Information, education, and communication
CRD - <i>Communauté Rurale de Développement</i> (rural development community)	IMCI - Integrated management of childhood illness
CPR - Contraceptive prevalence rate	IUD - Intra-uterine device
CSC - <i>Comité de Santé Communautaire</i> (community based health committee)	LDP - Leadership development program
CTPS - <i>Comité Technique Préfectoral de la Santé</i> (committee of health at the district level)	MOH - Ministry of Health
CYP - couple years of protection	MSH - Management Sciences for Health
DPS - <i>Direction Préfectorale de la Santé</i> (District [Prefecture] Health Directorate)	PRISM - <i>Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA</i>
DRS - <i>Direction Régionale de la Santé</i> (Regional Health Directorate)	SDP - Service delivery point
	SF - Facilitative supervision
	STI - Sexually transmitted infection
	TBA - Traditional birth attendant
	VCT - Voluntary counseling and testing
	USAID - United States Agency for International Development

This publication was produced for review by the United States Agency for International Development. It was prepared by Management Sciences for Health.

Project Name: GUINEA PRISM II Contract Number: 675-A-03-00037-00

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

## GUINEA OVERVIEW

A healthy population is one of the most fundamental pillars of society. In the developing world, it can determine the long-term economic and political success of a country. Guinea's government has endeavored to provide such a platform for long-term development. The majority of Guinea's population consists of rural farming families, whose continual struggle is focused on surviving from one day to the next. At this basic level of living, good health becomes one of the most important priorities for any family. As one religious leader from the village of Balandou in rural Upper Guinea stated, "Without your health, you have nothing. If you are not well, you cannot work, you cannot rest and you cannot eat. Health is the most important thing in life."

Even compared with its conflict-ridden neighbors of Sierra Leone, Liberia, and Côte d'Ivoire, Guinea's health statistics remain among the worst in the world. In 2005, Guinea was ranked 156 of 177 in the United Nations Human Development Index report. For an average Guinean, common health issues such as pregnancy, malaria, malnutrition, and lack of basic health services are the difference between life and death. A government that cannot provide such basic health systems and services is a government that loses its most valuable asset: its people's trust.

Access to quality health services brings stability to families and communities. This access plays an important role in arresting the decline of vulnerable states and bringing legitimacy to government. In Guinea, efforts to improve the health care system had been crippled by disorganized infrastructure, corruption, and dependence on international donors. The people of Guinea lost their confidence in their health

care system and services became dangerously underutilized. Only 40% of people who were ill went to the local health clinic for consultation. The reasons for this are clear: upon visiting the facility, many people found empty medicine cabinets, exploitative, and overpriced health services, and weak or nonexistent management by authorities. These realities sowed deep seeds of distrust and doubt that the status quo could ever be changed.

## PROJECT SUMMARY

Today, with support from the United States Agency for International Development (USAID), that reality has begun to change in Guinea. As this final report documents, through the USAID-funded PRISM project managed by Management Sciences for Health (MSH), a new local governance strategy has taken shape to reinvigorate and restore people's trust in their health care system. By creating connections between the health facilities and the communities they serve, the project has empowered the communities themselves to make a positive difference in their health and well-being, through the creation of the region's first "fully functional service delivery points" for public health.

A recent USAID assessment cited poor governance in Guinea as one of the principal sources of the country's vulnerability. After years of development investment, the Government of Guinea determined that the foundation of good governance must be achieved before results can be realized in any one sector. With support from USAID and others, Guinea is refocusing its efforts to improve governance throughout the country. MSH, a long-time partner in Guinea, started at the community level. MSH found that the most powerful

### Community Health: USAID and MSH's Ten-Year Commitment

1997: Baseline assessments and priority setting

2000: PRISM—Reinforcing quality of care at regional and health center levels

2003: PRISM II—Reinforcing quality of care at the health post and community levels

2006: PRISM II Extension—Expanding PRISM's mission to include HIV/AIDS testing

and committed champions could be found within the local governance structures at the village level. With the most to gain, communities were ready to step up to the challenge.

Ten years ago, the Ministry of Health (MOH) and MSH conducted baseline assessments and engaged stakeholders throughout the country in determining the most important priorities in improving Guinea's health system. Armed with this input, the MOH determined that improvements to access, quality, and demand for primary and reproductive health services for all Guineans were the critical priorities. To help Guinea achieve these goals, MSH and its partners have spent much of the past decade focused on improving access, quality, demand, and coordination of country-wide health efforts while also refocusing resources at the community level to build a foundation of governance and systems that can support long-term improvements.

## **MSH/PRISM IN GUINEA: MAKING HEALTH CARE FULLY FUNCTIONAL**

The story of the two PRISM projects has been the story of creating a model regional health system that engenders fully “functional service delivery points” (FSDP) at all levels. The fully functional service delivery point is a facility that matches a well-trained, well-informed, and well-supervised clinical provider with a well-informed, motivated client to create good health care at its most basic level: the individual contact between the provider and client. This creates quality experiences at the in-

dividual level that translate into quality health coverage at the macro level.

For many years, the principal approach to improving the quality and expansion of services has been to train health staff. Evaluations from many countries have shown that these interventions often lead to improvements in service delivery but do not consistently lead to significantly sustained use of services. The main reason for this lack of sustained use is that these interventions have focused on inputs (such as conducting training) and outputs (providers trained in growth monitoring, or health facilities equipped with a stethoscope, scale, and examination table), rather than the outcomes that will result from the inputs and outputs.

In Guinea, the problem was not only the absence of appropriate inputs and outputs, but the degree to which all of these components of service delivery were simultaneously present at the service delivery point (SDP), where the client and provider interact. For the provider, these key components include (1) an adequate number of trained and motivated staff with access to good information; (2) adequate space and infrastructure; (3) sufficient equipment, drugs, and other supplies; and (4) a good referral system. It is necessary to have clients who (1) understand and act on health information; (2) can identify their health needs; (3) have access to services; and (4) can communicate effectively with service providers and demand quality services. To achieve functionality, the SDP must be supported by management systems tailored to the environment, disease profile, and service delivery



package for the SDP, as well as by community participation. The result is a functional service delivery point (FSDP), supported and used by its community.

This final report shows the application and results of this framework in Guinea through the PRISM II project, from January 2003 to April 2007. The project was a continuation and evolution of the USAID-funded PRISM I project (1997–2002) with the goal of increasing the use of services for essential family planning, maternal and child health, and prevention and treatment of sexually transmitted infections (STIs) and HIV/AIDS. The two projects effectively created a 10-year presence for integrated health systems development in Upper Guinea.

The PRISM II project covered the Upper Guinea region plus the prefecture of Kissidougou (Forest Region), which together have a population of 2.1 million (Guinea's total population is nearly 10 million) and included 9 of Guinea's 38 health districts. Almost 1 in 5 people is a child under the age of 5 years and 1 in 4 is a woman between the ages of 15 and 49 years. This population is served by 119 health posts, 109 health centers, 7 district hospitals, and 2 regional hospitals. When the project began, health indicators for this impoverished rural area were far below the national average because of lack of access to high-quality health care and education.

The project had two main strategies: (1) to strengthen Guinea's decentralized health care system and service delivery capacity, primarily at the district and regional levels, and (2) to build community capacity to participate in health service management and support. Together these strategies create an environment that enables providers to offer higher-quality services and stimulates demand for and use of services.

The project's approach is based on a partnership whereby the MOH and other implementing agencies foster coordination of activities to develop a well-functioning decentralized primary health care system. Local and in-

ternational experts provide technical assistance to support the MOH at each level (national, regional, district, community) of the system. Our assumption was that better access, quality, and demand would produce more and better client-provider interactions at the SDP, and thus lead to improved supply of and demand for services.

**This approach rests on a limited number of key activities, which include:**

- community mobilization through formation of local health committees and health insurance schemes;
- technical assistance to improve drug management and logistics practices;
- integration of antenatal care, family planning, STI management, and child survival interventions into health centers, health posts, and community-based distribution (CBD) networks; and
- leadership development at the district, regional, and national levels of the MOH.

**The major results of this approach include:**

- a doubling of the contraceptive prevalence rate in the target areas;
- all health centers and health posts in the target area now offer services for STI and HIV/AIDS prevention and family planning;
- contraceptives are now part of the national essential drug logistics system, leading to dramatic increases in the number of contraceptives sold;
- standards for reproductive health services are now defined and disseminated to all health facilities in the target area;
- a network of over 1,500 CBD agents is meeting the family planning needs of populations in the target areas; and
- vaccination rates, antenatal visits, attended births, and facility use have all increased in the target areas.

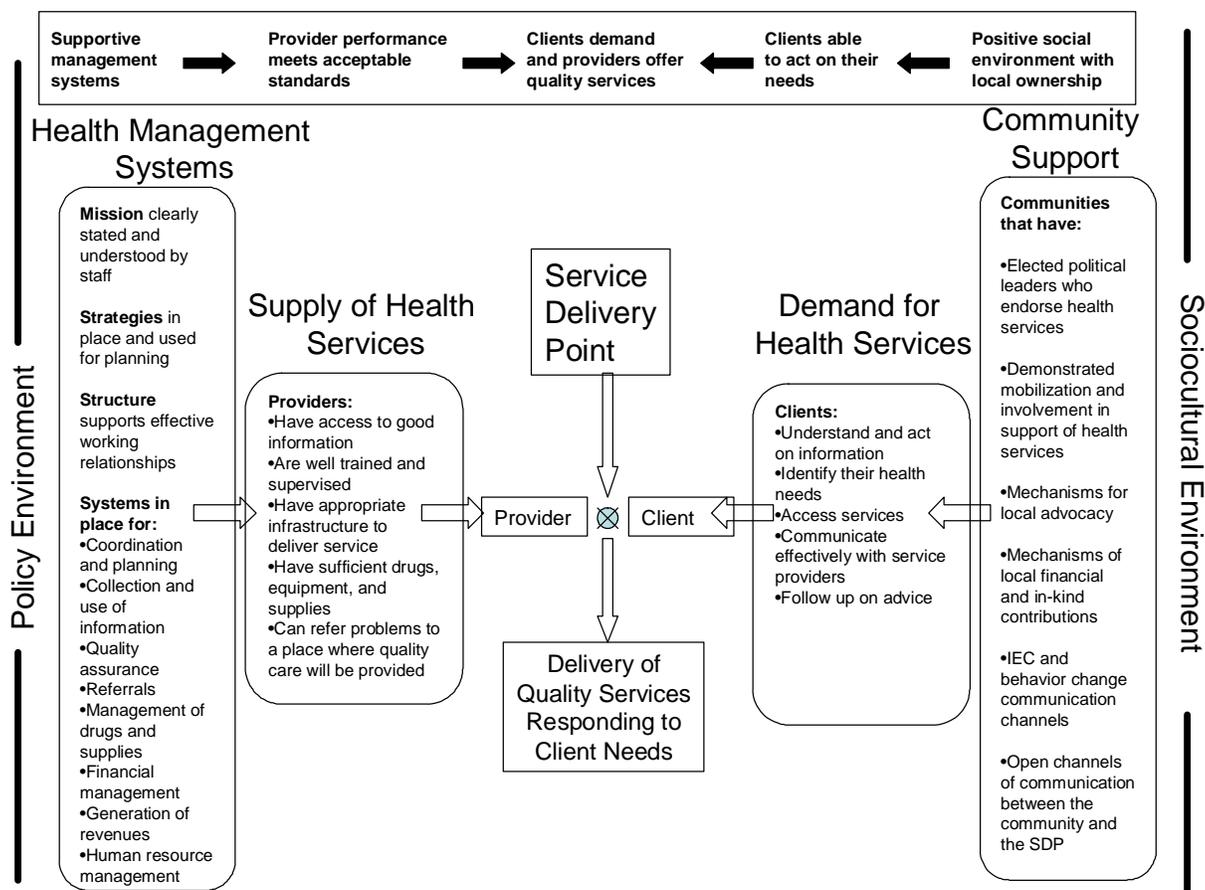
## FUNCTIONAL SERVICE DELIVERY POINT

The fully functional service delivery point framework outlines the components necessary to fulfill a community's needs for basic health care. Figure 1 reflects how we put this concept into practice by (1) mobilizing stakeholders in Guinea to identify health problems and analyze their causes; (2) agreeing on what health outcomes should be improved, and the package of services to reach these targets; (3) rapidly assessing services to identify gaps; and (4) planning interventions. The FSDP helped health care managers provide communities with facilities that provided key components of basic health services to achieve the access, quality, and demand goals which the MOH put forward:

- trained and motivated personnel
- equipment, drugs, and supplies
- adequate infrastructure
- a referral system
- clients who can identify and act on their health needs
- information for providers and clients

This simple tool helped managers identify critical services for their communities; plan, implement, and monitor those services; and manage for continual change by identifying gaps and addressing opportunities for improvement.

Figure 1: Functional Service Delivery Point



## FROM FRAMEWORK TO RESULTS

To operationalize the FSDP approach, the PRISM project was organized into four key intermediate result areas:

(1) **Increasing Access to Health Care**—ensuring that services are being provided to clients at a reasonable level of cost and convenience.

(2) **Improving the Quality of Health Care**—ensuring that the health care provided meets MOH standards.

(3) **Increasing Demand for Health Care**—ensuring that the community has adequate information about services available at the health facility and is proactive in seeking care there.

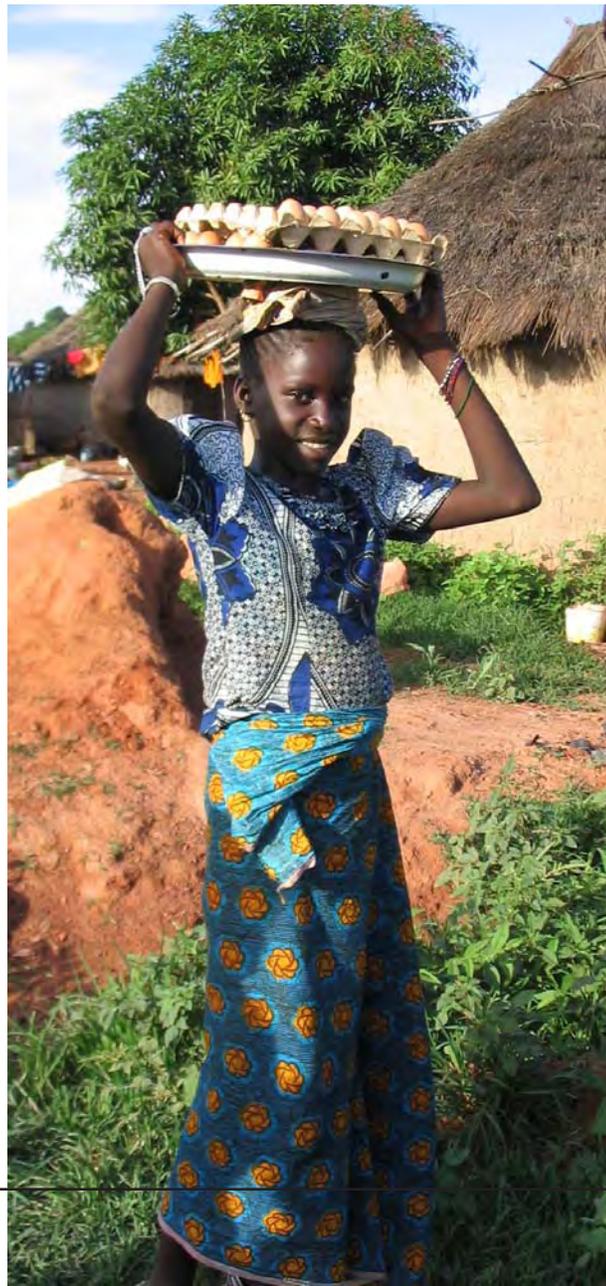
(4) **Coordination of Health Care Provision**—ensuring that all governmental and non-governmental resources for health care are working together to support the good health of the population.

The following section provides an overview of each of these areas, the interventions carried out, the results, and the impact health programs have had since 2003.

## INCREASING ACCESS

The FSDP brings comprehensive health resources within reach of the community. This reach may be physical, in terms of locating a health center where a population can reach it. It may be social access, in terms of putting trained, organized, competent staff in a health center to carry out health activities. Access may be logistical, ensuring that medicines, supplies, and equipment are available at the health center for service providers to use in treating community members. It may also be economic, by making services available at a price that the community can afford, and creating ways for those who cannot afford treatment to access them. Increasing access to the FSDP is not only the responsibility of the health provider. It is also the responsibility of the community being served, as is demonstrated in Figure 1 in the simple community/SDP governance structures pioneered by the project.

PRISM II used three key strategies for increasing access to health services. It increased social access through intensive training of health facility staff in family planning and STI prevention procedures, cervical cancer screening, and post-abortion care, ensuring that at least two fully trained staff be located in each of the target area's health facilities. To increase logistical access to medicines and reproductive



health commodities, PRISM worked with the national, regional, and local health authorities to build strong logistics systems for drugs and reproductive health commodities from the national level to the community level, with a robust program of direct supply of reproductive commodities to community-based distributors in Upper Guinea. To increase economic access, PRISM worked with the local health authorities to build strong community health committees to support expanded use of health facilities, and mutual health organizations to ensure that communities could afford quality services and had a say in how those services are provided.

### Increasing Social Access

PRISM II built on PRISM I's success in increasing social access to health care at the health center level by pushing integration of services out to Upper Guinea's 131 health posts. The project and the MOH identified the elements lacking in the list of basic services offered by health posts, when compared against the needs of the service populations. The project then assisted the regional and district health offices to shape intensive training courses for health post staff in family planning and STI prevention. The project continued to ensure that integrated access at the health center level was maintained through refresher courses for staff, as well as the introduction of new services. In 2004, the project trained

new health center service providers in intra-uterine device (IUD) insertion and removal. In 2006, the project trained service providers in cervical cancer screening and referral. The project reached its target of two trained service providers in each health facility in Kankan and Faranah administrative regions.

Access at the community level increased through the project as well. The project continued its work in training traditional birth attendants, adding—from 2003 to 2005—68 new birth attendants practicing safe, sanitary delivery. From 2005 to 2006, the project assisted in the creation of a dynamic corps of community-based distributors of family planning products. By the end of 2006, the project had trained and supplied 1,507 distributors to ensure that family planning methods were available at the community level in safe and culturally acceptable ways.

### Increasing Logistical Access

In 2005 and 2006, the project supported a logistics system that provided direct distribution of family planning commodities to health centers, health posts, and community-based distributors, so that stock-outs were minimized at all levels of the system. This system underpinned the confidence clients have in the service providers at all levels.

To render the supply of contraceptives sustainable, the project worked with its corps of community-based distributors to create a system of supply at the local level fueled by incentives for distribution. Community-based distributors received up to 30 percent of the value of what they were able to sell. This money was, in turn, deposited into a bank account to fund community development activities for their communities. At the end of the project, almost 24 percent of the value of the contraceptive products sold at the community level went back to the communities through this performance-based mechanism.

### Increasing Economic Access

Throughout the project life, the technical



team has striven to build a model for sustainable community involvement and management of its health resources. This is the element of the FSDP framework that develops the community's responsibility for its own health care, and puts it into a close accountability relationship with the health facility. Several elements of the model came together over the project life to culminate in the Baté Nafadji model. This model places *Comité de Promotion de la Santé* (CPS) in the role of representing the community's *mutuelle* health organizations, in negotiation with the health facility. Representing the collective capital the community has raised to finance the health services, the CPS is able to negotiate the prices for services—which have always before been set by the MOH—and types of service the community most needs. This dialogue has become a form of local governance.

The results presented during the 2006 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 GNF<sup>1</sup>, while the revenue generated by the Balandou Health Center reached 4.6 million GNF in the same 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 a 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 which 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. In *Comité de Santé Communautaire* (CSC) and *Comité de Promotion de la Santé* (CPS) community meetings, representatives from the 14 villages of the Baté Nafadji subpre-fecture and various political, administrative, and health authorities met and identified 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. Ulti-

<sup>1</sup>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) that has twice the population.

mately, 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 for 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 collaborative framework of the strategy has resulted in increased collaboration between the health infrastructure and other government authorities. During one of the monthly CPS 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), and his board members, including the *sous-préfet* (subprefect), decided to cover the salaries of the *matronne* as well as the guard from CRD reserves, reducing the health center's need for increased service-fee revenue. This sharing of operating expenses is a notable demonstration of 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 total support for the initiative.



The local governance framework has yielded increased community engagement. Community members in Baté Nafadji actively participated in the analysis and development of their health center budgets. Each month, representatives from each village, with 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 family planning 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 the 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. The community members decided that part of this surplus (that would otherwise have gone into "reserves") should go to cover depreciation of the Guinean franc (for both procurement and salary payment)

and that the remaining amount should go to the health providers, based on personal performance. The monthly CPS meeting sets performance objectives for each service and 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. This successful experience was then scaled up to cover a total of 38 health centers (almost 380 villages) in three prefectures (Kankan, Faranah, and Kerouane).

## Results



The recently completed 2006 Household Survey (HHS) showed that the work on access has paid off. Due to the intensive concentration of access-increasing activities in family planning, the HHS shows an increase of 91% (from 6.8% in 2003 to 13% in 2006) in modern method contraceptive prevalence in Upper Guinea. This surpasses the national average contraceptive prevalence rate (CPR) of 5.7% (DHS, 2005).

Couple years of protection (CYP)—an indicator of the availability of family planning products, as well as public willingness to use them—also increased throughout the period. Figure 2 shows a steady increase in CYP in Upper Guinea throughout the project period. This is due to the ready availability of contraceptive methods through health facilities and the community distribution network, as well as the trained community agents who are able to answer questions about family planning.

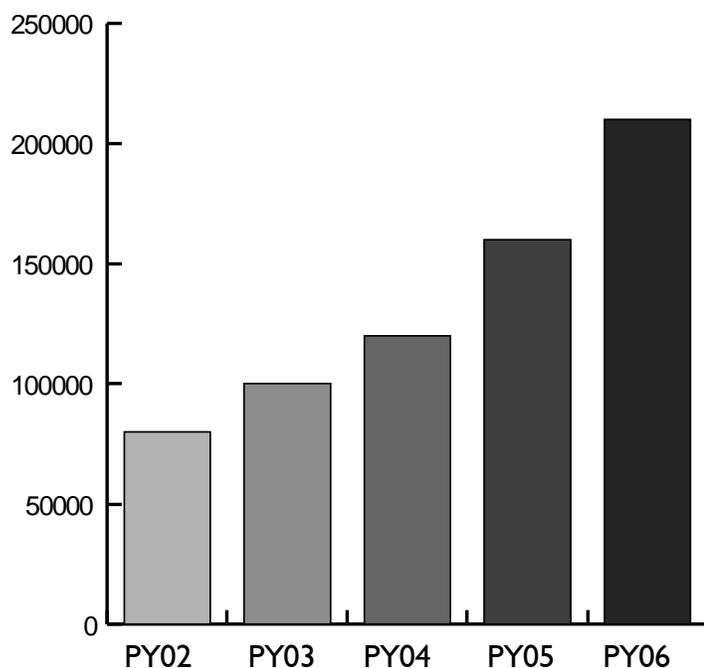
The rate of children aged 12–23 months who received full-course *Bacillus Calmette-Guérin* (BCG) vaccination for tuberculosis rose from 61.6% in 2003 to 78.5% in 2005. This shows the effect of having quality vaccination services and a working cold chain at the health center and health post levels.

A testament to the project's continuing work in monitoring the gains from PRISM I

training at the health centers is that the number of women having at least one antenatal consultation continued to rise in the health centers from 84.0% in 2003 to 90.3% in 2006.

The work done in community-level governance in health resources is well represented in the pilot community where the CPS/*mutuelle* model was tested. 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 Bate 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 prefecture<sup>2</sup>. This increase is due to a combination of factors. Health facilities now have drugs and other material resources available. Through the *mutuelle* fee structure, key financial barriers have been reduced. People's confidence has increased because know they will not be overcharged.

Figure 2: Growth in CYPs (PY02-06)



<sup>2</sup>This includes the busy urban health centers of Salamani (7.1 million GNF) and Kabada (6.2 million GNF).

## Lessons Learned



- Efforts made to reinforce government health care services are only sustainable if the beneficiary communities are fully involved and buy into the effort. In practice this means that project management must give communities the knowledge and experience of managing an institution that responds directly to their needs. By empowering communities through this process, the project ensures that the equipment, materials, and other supplies used by the health facilities are well managed and maintained.

- Select, stand-alone activities have limited success when conducted independently of one another. 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. This often means that efforts to integrate new services are conducted in tandem with efforts to improve service quality and increase demand. This can be a complicated process, and requires particular attention to prior planning and gaining community and facility buy-in for the entire program.

- The common understanding that rural populations in the developing countries do not have adequate resources to access social

services and health services is largely not true. In reality, in Guinea, even with limited financial resources, communities are willing to pay for services that respond to their “real” needs. Communities find ways to cover their costs but also develop their own mechanisms to support those in need. This was shown in the self-financing schemes that grew up around the project.

The common understanding that family planning is not a priority for the rural population in Upper Guinea should be revised. In reality, Guineans felt they had no real access to these services because the services were perceived as external to their communities. After the communities chose their own CBD agents, defining scopes of work and systems of motivation, they have begun widely using contraceptives. Even religious leaders have agreed to discuss and promote modern methods within their communities.

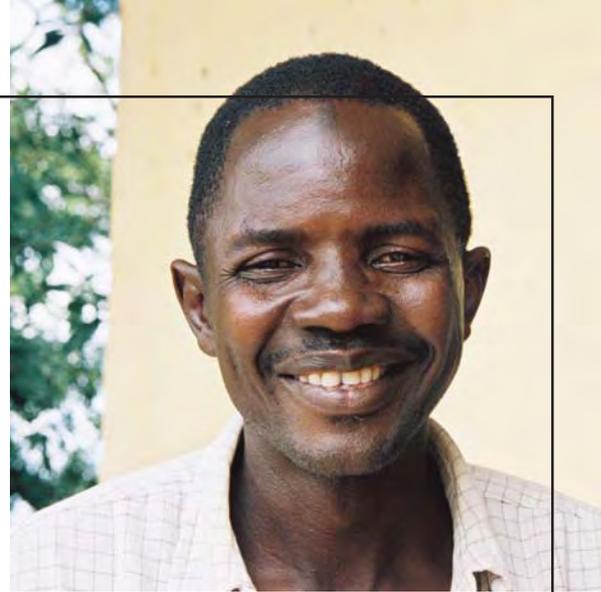
## INCREASING DEMAND

In the FSDP framework, the provider and the client stand together, each responsible for producing a high-quality health encounter. While the provider is largely—but not uniquely—responsible for making health care accessible, the client is primarily responsible for ensuring that there is an acceptable level of demand. If access brings health services to the community, demand-promotion activities

## CERVICAL CANCER SCREENING PROGRAM

In 2006, the PRISM project implemented its first organized cancer screening program in the country in three major cities across Upper Guinea. To date, 42 service providers have been trained in visual cervical cancer screening methods. Since February 2006 eleven health centers and three regional hospitals have been providing screening to every woman who comes in for services.

While service providers are being trained in detecting cervical cancer, rural radio stations and word of mouth are also being used to raise awareness among women about the risks and how to get screened. The integration of cervical cancer screening with other women’s health services will have an enormous impact on the health of women in Guinea and provides hope of decreasing the incidence rate.



bring the community to the health services. Increasing demand means making more people aware of what services are available. It is also means promoting the importance of regular use of health services so that community members can effectively manage their health and that of their family. Ultimately, increasing demand will result in strong advocacy for good health in the community, and position the health center as the focal point of maintaining and increasing health and well-being.

MSH/PRISM's strategy for achieving increased demand for health services at the community level rests on four pillars: (1) leveraging community influence, so that the community can effectively advocate for its own health; (2) providing tools for the community to analyze its own health needs; (3) providing mass communication tools to better inform the community about its health resources; and (4) support to those working in information, education, and communication (IEC)—individuals, groups, and committees—to ensure the quality of IEC messaging throughout the project area. Working at the community level is an important tool in increasing the efficiency and effectiveness of the entire system to respond to the communities' needs.

### Leveraging Community Influence

During its initial period, the project identified influential people in villages—people who were in contact with high-risk groups for HIV/AIDS and STIs. It sought out moral leaders of

the community and provided them with a steady stream of information on responsible behaviors, the availability of help at the health facility level and of products for family planning. The project worked with youth educators and football players at schools to access youth with reproductive health messages. The project concentrated on providing mining communities with information on the risk of *foudoukouni*, or “short-marriage,” in the spread of STIs and HIV/AIDS. The project worked with religious leaders, orienting them and their spouses in family planning methods and prevention of STIs. Looked up to in communities, these individuals are especially important in the dissemination of behavioral messages.

The project engaged with teachers and students in a peer-education program to inform students about services available to them at the health centers and posts, as well as behaviors to avoid STIs. The project also worked with bartenders and commercial sex workers to give them vital information to share with their clients on the dangers and prevention of STIs and HIV/AIDS. In specific prefectures the supervision of community peer educators was conducted, allowing the project to evaluate the communities' capacity to support local health services. Peer education training was emphasized in mining communities, where a new approach was launched to involve the *bureaux des ressortissants* (groups of people coming from the same village, city, or country) in the effort to prevent the spread of HIV/AIDS.

In addition, the initiative aimed at health governance at the community level also leveraged community leadership to advocate for better health. By championing a rights-based approach to health in community-based health committees, MSH/PRISM empowered community members to understand their rights regarding the management of health centers and strengthening community ownership of health services.

### Providing Community Tools for Self-analysis

In the latter years of the project, PRISM developed an effective tool for communities to begin the conversation on health problems and needs, in preparation for the role the CPSC would play in negotiating services with health



facilities. This was the “Community Mirror.” The Community Mirror provided a framework and a process for communities to assess their health needs by displaying community problems in a visual manner so that they could be talked about in a coordinated fashion. Thirty-eight communities went through the process of using the Community Mirror to define their health advocacy agendas.

### Providing Mass Communication Tools

The project also produced educational videos and episodic radio shows to foster an environment wherein positive health messages were the subject of everyday discourse. The radio shows promoting early cervical cancer screening and educational videos on HIV/AIDS and pregnancy provided a constant and entertaining way for individuals to learn about services available at the health facility they might not otherwise have known about.

In addition to radio and video, the project produced messaging brochures and stickers with reproductive health messages and HIV/AIDS messages to further saturate the area with information on positive behavior.

### Support to IEC Individuals, Groups, and Committees

To enhance the impact of the mass information campaign and those activities targeted at the community level, the project provided support to a variety of IEC groups at the village, district, and regional levels. The project provided technical and financial support necessary to carry out community mobilization activities. These groups conducted public meetings and awareness-raising events around family planning, STI and HIV/AIDS prevention, vaccination, and maternal and child health, to link directly with the service upgrades in the health facilities.

### Results

In the area of knowledge, attitudes, and practice, it is clear that attitudes cannot

change without a solid knowledge base. The PRISM project has established this base in STI and HIV/AIDS prevention. At the end of 2006, 73.3% of men reported that they used a condom during their last sexual contact with a nonregular partner, as compared with 57.8% in 2003. This represents a 26.8% increase.

Almost 81% of the concerned male population stated that they used a condom during the last paid sexual contact, as compared with 78.0% in 2003, a 3.3% increase. Among young men (15–24 years old), 71.8% reported that they knew condoms are a means of protection against HIV/AIDS, and 49.6% of young girls (the same age group) 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. Figure 3 illustrates the knowledge and behavior change results in a number of areas.

This increase in knowledge translates into an increase in health facility utilization once the population is aware that services and products are available in the health facility, helping prevent STIs, HIV/AIDS, and other health risks.

Progress is evident in health-seeking behavior as well. The 2003 HHS reported that 40.0% of those surveyed said they had used the

health facility in their area. This figure increased to 51.0% in the 2006 survey.

### Lessons Learned

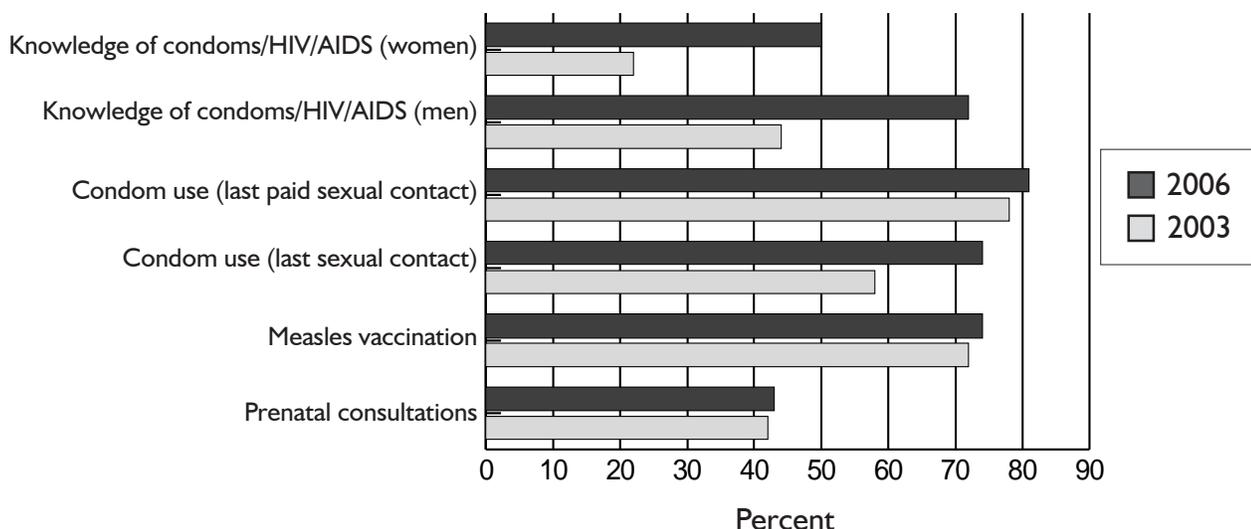


- In Upper Guinea, interpersonal direct IEC messages are better accepted and effective than the usual IEC materials (posters, t-shirts, etc.). Using person-to-person communication (peer educators, local association members, etc.) the project made significant results in behavior change, while maintaining the sustainability of these results.

- When messages address the real needs of the community and when communicators use traditional means and channels of communication, IEC is more efficient and effective. This was especially evident in the use of the Community Mirror. Based on traditional gatherings in the community, this tool helped communities prioritize their chief health concerns, and monitor progress in addressing them.

- Use of the Community Mirror changed the way communities were dealing with their health. Now able to monitor their own local progress, communities have been trained to reorient their IEC strategies and themes. Us-

**Figure 3: Behavior Change Results 2003-2006**





ing the example of vaccination, in one village it was a common misunderstanding that vaccinations should be given only in the morning. The agent/vaccinator who arrived later in the day would find the mothers gone to the fields. Using the Community Mirror, community leaders were able to analyze the problem in a structured way, give the right message to the community, and negotiate the right time for both the agent and the population to implement the vaccination sessions.

## IMPROVING QUALITY

Access and demand create the basic foundation of the FSDP model, representing the service provider on the access side and the clients of those services on the demand side. Each side has a role to play in both, however. Overarching access and demand, the issue of quality of health services creates the framework in which the provider-client interface produces consistently good health interactions. In the context of the PRISM project, quality is defined as the principle that services provided and demanded meet quality standards set by the MOH. Adherence to quality standards creates consistency and reliability in health services, deepening the bond between the government and its citizens. Quality can mean making sure that all providers are trained according to treatment protocols mandated by the MOH. Quality can also mean the provision of consistent supervision of health facilities to ensure that staff members are adhering to standards, and that all staff feel that they are managed in a productive and positive way.

MSH/PRISM's activities in quality promotion rest upon the intersection of three mutually supportive activity areas: (1) providing technical expertise in the development of Ministry-approved curriculums; (2) providing equipment and material essential to meeting quality-of-care standards at the health facility; (3) providing systems and structure for effective supervision of the quality of health staff service provision at the facility level.

## Developing and Updating Curriculums

For quality to be established at all levels of the health system, the project started with a general review of the curriculums used to train health system operatives. It is essential that the plans for training health service providers be in accordance with the latest practices in all health sectors. Therefore, early in the project, the technical staff assisted the Ministry officials in undertaking a general review of all health training curriculums. This resulted in the finalization of the TBA special training curriculum, the curriculum and training guide for management of neonatal obstetrical emergency, the on-the-job training guide of syndromic management of STIs, and the updating of referral protocols. Later in the project, technical staff assisted the Ministry in updating the curriculum for community DOTS. Community and clinical integrated management of childhood illness (IMCI) curricula were also updated, with the results of test trainings done. In addition, a suite of tools for monitoring the quality of IMCI at the clinical and community levels was developed.

## Providing Equipment and Material for Quality of Care

As part of the review and revision of the curricula, the project assisted in the development and distribution of tools and materials to ensure that the skills learned through the curricula could be implemented at the health facility level. The project provided assistance in distribution and orientation of the new STI algorithms on plastic supports.

The project also integrated the clinical and community version of COPE, a powerful process to bring the community and the health facility together to discuss and solve service provision problems. This set of tools provides exercises designed to analyze service provision elements, isolating the obstacles to ser-

vice provision and resolving them within the structure of community and health facility collaboration. Ninety-one health facilities participated in this exercise.

The project helped the *Direction Régionale de la Santé* (DRS) and *Direction Préfectorale de la Santé* (DPS)—respectively, the regional and district health directorates—to successfully advocate for radios to link the disparate elements of the health system in the region, and for all-terrain ambulances for the Faranah, Kankan, and Kerouane hospitals to handle emergency referrals from the health centers. Finally, the project provided generators to the hospitals in Faranah, Kankan, Kerouane, and Mandiana, to ensure at least minimum functionality.

## VOLUNTARY COUNSELING AND TESTING CENTERS

In its extension phase, USAID requested that the project undertake the establishment of Voluntary Counseling and Testing (VCT) to provide support to at-risk populations and people living with HIV/AIDS. This increased access to essential services in Upper Guinea. By following basic principles of voluntary service, providing accurate information to clients, ensuring client confidentiality, and procuring referral services, the project worked with Family Health International (FHI) to implement a multitrack process to establish VCT services.

Initially, a coordination workshop was organized to gain the essential support of the social and health infrastructure for the establishment of the VCT services. Through a review of standards and expected results, the project informed the stakeholders of the services, which generated a great deal of enthusiasm in the community.

Intensive training was required to ensure that clinic staff could safely and effectively provide the VCT services. A laboratory specialist at the Kankan Regional Hospital was trained to operate the CD4 machine, which processes blood samples for HIV. Staff at the clinic level were trained in laboratory techniques of sample processing in Nzerekoré, where FHI had already established VCT services. Staff were also taught infection prevention in an HIV/AIDS context through the use of similar training materials for post-abortion care. In addition, four midwives and social assistants were trained in counseling support in pre- and post-test counseling to ensure that clients received quality psychosocial treatment throughout the service. Each VCT center employee also went through training sessions on confidentiality and information management, to ensure that the privacy and dignity of the client is always maintained.

The procurement and installation of testing equipment is an integral part of establishing VCT services. In addition to the CD4 machine at the Kankan level, each VCT site received a solar refrigerator, an incinerator, two exam tables, autoclaves, plastic covers, and IEC materials to support counseling efforts. MSH/PRISM also developed solar panel systems to ensure the conservation of laboratory reagents to be used in testing.

MSH/PRISM used three types of community mobilization activities to ensure that client villages were informed about the new services and motivated to get tested. Community animation sessions encouraged communities and individuals to take responsibility for their own health and get tested to know one's status. Rural radio programs provided another avenue to inform people. The project held roundtable discussions with local animators on radio broadcasts throughout the region to bring the message to radio listeners in multiple communities. MSH/PRISM also organized community events to advertise the theme of "Stop AIDS: Keep the Promise". These events centered around World AIDS Day, and closely implicated all project partners.

Since these activities were initiated in the final six months of the project, it is too early to derive any concrete results on the health of the population, but the infrastructure is now in place to test for, as well as counsel for, HIV in Upper Guinea.

## Providing Systems and Structure for Effective Supervision

At the regional level, the project hosted a leadership development program (LDP) to act as a forum for the leaders at all levels to learn a process of leadership that would give them a common language to discuss common issues and solve common problems. Sixty-five DRS and DPS, and regional hospital staff participated in this exercise, as well as participants from three partner organizations. Through this experience, a cadre of LDP facilitators was oriented to be able to continue the LDP process after the project ends.

The exercise of leadership in terms of the health infrastructure in the region is expressed through supervision of the health facilities. The project supported the regional office to en-

sure that supervision was done on a cyclical and consistent basis for all health facilities in Upper Guinea. This process began with the signing of supervision support protocols between the project and the regional office that would allow the project and the government to operate jointly with regard to supervision. The project assisted the regional office in developing a set of supervision tools that could be deployed in each supervision visit. Fourteen supervisory staff at the prefectural and regional levels went through a comprehensive training in facilitative supervision. Due to the emphasis on consistent supervision, the level of supervisory visits went from 352 in 2004 to 960 in 2006, an increase of 172% over three years. This translates to an average of four visits per health facility per year, to assure adequate supervisory presence.

The output of adequate supervision is that reporting from the health center is accurate and timely. To administrate the receipt and analysis of health center reporting, the project developed a database to archive and serve as a platform for analysis of incoming data from the health centers. This system has been installed in nine DPSs. The system is also aided by a geographic information system that creates visual interpretations of the health system and its activities.

## Results

At the beginning of the project, the technical staff created an instrument for assessing quality or adherence to government standards of each of the key areas of service delivery treated by the project. To be considered functional by the FSDP model, a facility had to reach a score of over 60% on the instrument. After the quality standards were introduced and integrated into the health system in the region, the percentage of health services conforming to at least 60% of the norms and procedures has reached 78% for the prenatal consultations, 90% for family planning, 73% for syndromic management of STIs, and 79% for child survival, all generally at or above the project goal of 75%.



## Lessons Learned



- Supervision is key to ensuring the quality of services. It has been shown many times that quality of services is a prime barrier to facility use. Systematic supervision by authorities in charge is possible if a clear system is designed and well understood. By making the regional authorities accountable for their responsibilities and by supporting logistic arrangements for supervision, the project made it possible for the first time in Guinea to guarantee that each site (health center, health post, maternity workers, and CBD workers) would benefit from at least one formative supervision visit per quarter. Note that each supervision visit covers two working days on the site. This requires organizational will on the part of the regional health authorities as much as it does on that of local service providers. A great deal of time and effort goes into securing this will.

- By developing a clear monitoring and evaluation system that allows providers and their supervisors to monitor their progress in the provision of technical services and supervision, the project provides to authorities the opportunity to challenge themselves through a process of self-evaluation. This process made possible the ongoing performance improvements of health providers and supervisors, as well as the strengthening of the whole health system.

## INCREASING COORDINATION



Once access, demand, and quality are ensured, it is important that the health system be shared among all partners and that partners share the same essential vision for health outcomes. PRISM therefore worked to provide an environment in which coordination of all actors in the health sector in the region is facilitated, connecting national, regional, and local levels in a network of communication and dialogue about how health is provided.



MSH/PRISM's approach to coordination rested essentially on the principle of searching for and exploiting existing opportunities for communication and coordination at multiple levels of the health system. The aim of this approach was to create vital vertical links between the local, regional, and national levels on issues of access, demand creation, and quality in health provision. MSH/PRISM also implemented many of its activities through partners already on the ground, making use of established relationships to create more effective interventions through collaboration than could be achieved through unilateral actions.

## Exploiting Existing Opportunities

Much of what the project has been able to accomplish is based on the building and leveraging of a strong relationship with the MOH and building on previous community development experience in Upper Guinea. Early in the project's life, the MOH gave PRISM the necessary authorization to test approaches that have led to the revitalization of health services through the reinforcement of local governance. Subsequently, the mechanisms put in place have led to direct investment of community resources to reinforce and improve the system. The level of trust that allowed the MOH to vest MSH/PRISM with this authorization is evidence of MSH's collaborative approach, both appropriate and effective in a difficult political environment. It also represents a key building block upon which future programming can be based.

Another important result of the positive relationship between the MOH and PRISM has been the establishment, through operations research, of the principle that CBD agents can safely prescribe oral contraceptives in their program activities. The project was responsible for changing government policy to allow CBD agents to prescribe and distribute oral contraceptives.

The project leveraged other important relationships to make its interventions successful. It worked with a variety of IEC groups at the regional and prefectural levels in Kankan and Faranah to assist in coordinating and delivering clear and consistent IEC messages to underpin project work on demand promotion.

The project also regularly gave technical support to regional and prefectural technical committees (CTRS/CTPS) to assist them in their technical review of public health policy and protocol based on data from the health facilities.

At the national level, the project hosted a

quality of care workshop to better define what that term means in the context of the health centers and health posts. This workshop has had impact beyond the project's target areas.

Some of the most important coordination work was done at the prefectural level with partner organizations in implementing project activities through previously established structures. The project worked with EngenderHealth, Helen Keller International, as well as ADRA, Africare, and Save the Children, to implement training and technical interventions in a consistent manner throughout the project areas.

## Results

The primary result of coordination has been in leveraging the resources of other organizational structures to enhance the achievement of the project. This is seen in the overall achievement in the indicators (CPR, CYP) that go beyond the targets set for the project. Without the strong relationships with the MOH and partners, the results achieved would not have surpassed the goals. Without these important relationships, the project could not have had the impact that it has had on the populations of Upper Guinea.

## Lessons Learned

- By ensuring the full involvement of the MOH and partners, the project ensured that resources are used effectively, and that activities are sustained even after the project ends. The project staff always remembered that they were working through the MOH, assisting the Ministry in carrying out its plans instead of creating parallel structures to gain quick but unsustainable results.

- Coordination actually headed off problems before they became too large to deal with. The curricula for health training were shared, avoiding issues of mixed or uneven



messaging to the services providers. Tools were shared among all partners so that the same level of understanding was developed in all areas. Results were regularly communicated to all partners and communities, so that all partners had incentive to excel in their activities.

- Cost sharing is an effective gauge of coordination among different actors in the project. The project's performance in negotiating cost share was an ongoing exercise of

interagency coordination. The fact that cost share always surpassed its target in the project is testament to the project's ability to develop and motivate partners around a dynamic model and program.

Coordination has an additional benefit: communicating the project's technical strategies and results on a consistent basis among partners helped other MOH and USAID-funded projects in other sectors better calibrate their activities to complement and extend the success of the PRISM project.

## CASE STUDY: BRINGING IT ALL TOGETHER IN BATÉ NAFADJI

The following case study presents MSH's program to bring each area of intervention (access, demand, quality, and coordination) together in one setting. The case study of the health center at Baté Nafadji demonstrates how an integrated approach to improved health care can make a significant difference in a short period of time.

### Communities in Guinea Empowered to Manage a Health Care System That Works for Them

In a small classroom, men and women are busy shuffling around the room, squeezing into chairs one by one to begin the meeting. Nearly 40 men and women have gathered from 14 different villages throughout the region or subpréfecture to represent their community's health. These men and women are not professional health workers. Primarily poor, rural farmers who have never had any formal education, they are committed volunteers selected by their villages to play a very important role in governing their health care system. They are proud to be advocates and stewards of their villages. Each month they come together to meet with local and regional health authorities to determine what health services, drugs, management, and resources are needed in their communities.

Today, with support from USAID, that reality is slowly changing in Guinea. Through the USAID-funded PRISM project, managed by Management Sciences for Health, a new local governance





strategy is taking shape with a renewed focus on reinvigorating and restoring people's trust in their health care system. Since February 2006, in conjunction with regional health authorities and health providers, PRISM staff have worked closely with the communities of Baté Nafadji, Missamana, and Balandou to pilot a new approach that is changing business as usual.

For the first time, communities, providers, and regional authorities are being supported to work together to confront a broken, neglected system and rebuild one that works for all. Already, positive changes are being realized. As communities are getting involved in improving their health services in their areas, services are being used more than ever. This is a hopeful sign in a country where health indicators are still one of the lowest in the region.

### Changing Business as Usual

A new strategy was needed to close the gap between Guinea's health care system and the communities that it serves, and to empower communities to mobilize and invest in their own health. To ensure this, PRISM and its partners designed a new local governance structure that focuses on engaging communities to be part of the problem solving and create solutions that work for them. In doing so, a spotlight has been focused on the health system. Increased transparency and newly defined roles and responsibilities from the village level to the regional health authority level have created a truly collaborative atmosphere to change business as usual.

In this model, roles and responsibilities are defined collaboratively for each level of the health system, including the village representatives, health post staff, health center staff, regional health facility staff, and finally, the regional health authorities. At each level, a democratic process has taken shape to elect community representatives who are each responsible for managing one area of the health care system. For example, at the village level, communities elect representatives to manage their village's health insurance funds, family planning activities, or vaccination efforts. Everyone has a stake.

Each community works together to improve the health of its people. To bring it all together, there is a monthly health meeting where representatives from all villages in the region meet to discuss health trends. The meeting provides an opportunity to identify similar challenges and share innovative ideas for how to improve the health care system. The monthly health meetings, or the community health promotion committee (CPSC), allows doctors, nurses, and regional health authorities to hear firsthand what health problems people are facing. It gives the people and the health providers a chance to talk together to figure out how to best allocate services.

Now that reasonable prices have been set, the health center in Baté Nafadji has been able to purchase a year's supply of essential drugs. Already the health center is seeing more patients than it had before. Word travels fast. People in other communities are coming to the health center in Baté Nafadji because they heard that the health center has medicines in stock.

### Restoring Trust

With drugs now available at the health center and services offered at reasonable rates, there has been a renewed focus on restoring the community's trust in the health care system that

many had abandoned. A major goal has been to revitalize the underutilized health insurance, or *mutuelle* program, which has been present in Guinea for a number of years. To revive the program, the health committee decided to move the financial management of the program to the village level from the local health facilities where it had been managed for years. In this way, community members can readily track the money they are investing and choose people they know in their community to manage it. Community members use a democratic process of electing a person in the village to manage their insurance program.

### Community Empowerment Making Lasting Change

Already, health districts and health posts are starting to see a difference. Health centers are busy, and waiting rooms are crowded. With more patients to see, more services are getting to the people who need them. The health center and health posts of Baté Nafadji have reported a significant 25% increase in polio and DCT vaccinations. Ninety-five percent of all family planning clients now have access to required medicines and supplies. Through increased community participation, the health insurance program in Baté Nafadji has now accumulated approximately 4.3 million GNF in reserves available to members when they need it. This is a dramatic increase from only 0.2 million GNF in reserves just six months ago. Hard work is beginning to pay off.

## PRISM'S LEGACY

The best projects are judged not by what they have done but by what they leave behind as permanent changes upon which to build new initiatives. These elements constitute the project's legacy.

PRISM has achieved a lasting legacy in the new skills in family planning, cancer screening, postabortion care, and vaccination now practiced at almost all the health facilities in Upper Guinea. These are skills that professionals at every level of the Guinean health care structure now possess. They cannot easily be taken away, and will serve to benefit populations well into the future.

The system of monitoring and evaluation, as seated now in the coordination bodies in the region, the CTPS and the CTRS, is a permanent fixture, and it provides a new way of thinking about how health activities succeed in the region.

The governance strategy, built up

over years of incremental improvements, has proven to be an effective tool for putting the community in the driver's seat of managing its own health care. It has led to a revolution in the pricing of health services, the effects of which are yet to be fully seen throughout the country.

The communities that participated in the PRISM project are now able to effectively analyze their own health needs through the use of the Community Mirror, a tool for identifying, discussing, and addressing critical health needs.

Already the project has seen a shift in orientation of the MOH to greater involvement of communities in managing their health needs. With a network of fully functional service delivery points able to meet communities' demand, the future of health care in Upper Guinea will be one of increasing responsiveness and increasing trust.



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This publication was made possible through financial assistance from the United States Agency of International Development under the PRISM Program, contract number 675-A-03-00037-00.