



PRISM

POUR RENFORCER LES INTERVENTIONS EN SANTÉ REPRODUCTIVE ET MST/SIDA

ANNUAL PROGRESS REPORT

End of Year 4 (October 2001)



Management Sciences for Health
(MSH)

In partnership with

The John Hopkins University,
Center for Communication Programs
(JHU/CCP)

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LIST OF ACRONYMS

Acronym		Definition
ENGLISH	FRENCH	
ADRA		Adventist Disaster Relief Agency
AGBEF		<i>Association Guinéenne pour le Bien-Etre Familial</i>
AIDS	<i>SIDA</i>	Acquired Immune Deficiency Syndrome
AMIU		<i>Aspiration Manuelle Intra Utérine</i>
AVSC		Association for Voluntary Surgical Contraception (now EngenderHealth)
CBD	<i>DBC</i>	Community Based Distribution
CBS	<i>SBC</i>	Community Based Services
CENAFOD		<i>Centre National de Formation et de Développement</i>
CERREGUI		<i>Cellule de Recherche en santé de la Reproduction en Guinée</i>
CIDA	<i>ACDI</i>	Canadian International Development Agency
COGES	<i>COGES</i>	HC's Management committee (<i>Comité de Gestion</i>)
COPE	<i>COPE</i>	Client Oriented Provider Efficient
CPN		Ante natal consultation (<i>Consultation Pré Natale</i>)
CSU		Urban health center (<i>Centre de Santé Urbain</i>)
CTPS		Regional level coordination committee (<i>Comité Technique Préfectoral de la Santé</i>)
CTRS		Prefecture level coordination committee (<i>Comité Technique Régional de la Santé</i>)
CYP	<i>CAP</i>	Couple Year of Protection
DDM	<i>IPD</i>	Data for Decision Making
DED		Deutscher – Entwicklungsdienst, German Volunteer Organization
DivPS		Health Promotion Division (<i>Division Promotion de la Santé</i>)
DMR		Local initiatives direction (<i>Direction des Micro-Réalisations</i>)
DNPL		National Direction for Laboratories and Pharmacies (<i>Direction Nationale des Pharmacies et Laboratoires</i>)
DNSP		National Direction for Public Health (<i>Direction Nationale de la Santé Publique</i>)
DRS		Regional Health Direction (<i>Direction Régionale de la Santé - ex IRS</i>)
DPS		Prefecture Health Direction (<i>Direction Préfectorale de la Santé</i>)
ED&C	<i>ME&C</i>	Essential Drugs and Contraceptives
ELCO		Simplified map produced by a community level worker
EMHC	<i>SSSM</i>	Essential Maternal Health Care
ERCOSAR		Regional RH coordination team (<i>Equipe Régionale de Concertation en Santé Reproductive</i>)
EOP		End of Project date
FP	<i>PF</i>	Family Planning
FS	<i>SF</i>	Facilitative Supervision
FY		Fiscal Year
GF		<i>Guinée Forestière</i>
GOG		Government of Guinea
GTZ		German Development Agency
H		Hospital
H/MIS	<i>SNIS</i>	Health/Management Information System
HC	<i>CS</i>	Health Center
HG		<i>Haute Guinée</i>
HHC	<i>CSS</i>	Heads of Health Center
HIV	<i>VIH</i>	Human Immune deficiency Virus
H/MIS	<i>SIG/S</i>	Health Management Information System
HMO		Health Management Organization
HP	<i>PS</i>	Health Post
ISAD		Initiative pour la Santé à Dinguiraye, Africare
IEC	<i>IEC</i>	Information, Education and Communication
ILO		International Labor Organization
IMAT		Inventory Management Assessment Tool
IMCI	<i>PCIME</i>	Integrated Management of Children's Illnesses
IP	<i>PI</i>	Infection Prevention
IR	<i>RI</i>	Intermediate Result
IRS		<i>Inspection Régionale de la Santé (now DRS)</i>

Acronym		
ISMI		<i>Projet d'Initiative pour la Santé Maternelle à Dabola, Africare</i>
IUD	<i>DIU</i>	Intra Uterine Device
JHU/CCP		Johns Hopkins University, Center for Communication Programs
JHU/JHPIEGO		Johns Hopkins University, JHPIEGO Corporation
KFW		German Development Bank
MEASURE		USAID centrally funded project
MCH	<i>SMI</i>	Maternal and Child Health
MIS	<i>SIG</i>	Management Information System
MOH	<i>MSP</i>	Ministry of Health
MPA	<i>PMA</i>	Minimum Package of Activities
MSH		Management Sciences for Health
MURIGA		<i>Mutuelle de santé consacré à la référence des femmes lors des accouchement</i>
NGO	<i>ONG</i>	Non Governmental Organization
N&P		<i>Normes et Procédures</i>
ORS	<i>SRO</i>	Oral Rehydration Solution
PAC	<i>SAA</i>	Post Abortion Care
PCG		<i>Pharmacie Centrale de Guinée</i>
PEV/SSP/ME		<i>Prog. Elargie de Vaccination/Soins de Santé Primaire/Médicaments Essentiels</i>
PMA		<i>Paquet Minimum d'Activités</i>
PNLS		<i>Programme National de Lutte Contre les IST le SIDA</i>
PPSG		<i>Projet Population et Santé Génésique</i>
PSR		<i>Projet Santé Rurale (GTZ)</i>
PRISM		<i>Pour Renforcer les Interventions en Santé Reproductive et MST/Sida</i>
QoC	<i>QSS</i>	Quality of Care
RH	<i>SR</i>	Reproductive Health
SA	<i>AS</i>	Situational Analysis
SBC		<i>Services à Base Communautaire</i>
SDP	<i>PPS</i>	Service Delivery Point
SIDA2		<i>Projet de Lutte contre le Sida en Afrique de l'Ouest (2nd phase), ACDI/CIDA</i>
SOW	<i>TdRéf</i>	Scope of Work
SO#2		Strategic Objective # 2
TBA	<i>AT</i>	Traditional Birth Attendant
SG		<i>Secrétaire Général</i>
STEP		<i>ONG Stratégies et Techniques contre l'Exclusion sociale et la Pauvreté</i>
STI	<i>IST</i>	Sexually Transmitted Infection
STTA	<i>ATCD</i>	Short Term Technical Assistance
TA	<i>AT</i>	Technical Assistant (Assistance)
TB		<i>Tableau de Bord</i>
ToT	<i>FdF</i>	Training of Trainers
UN	<i>ONU</i>	United Nations Organization
UNFPA	<i>FNUAP</i>	United Nations Funds for Population Assistance
USAID		United States Agency for International Development
WB	<i>BM</i>	The World Bank

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Addendum

Summary of Principal Activities and Results (July to September 2001)

Executive Summary

Increasing the use of reproductive health (RH) services by strengthening the client-provider interaction has been a central theme of PRISM's assistance to the people and the Government of Guinea. Accordingly, PRISM's TA strategy has been one of strengthening communities and the formal health system to better support clients to access and demand quality services, and providers to offer them. In order to not only increase but to also sustain the use of RH services, PRISM has been working with community leaders and groups and with the formal health authorities and their partners to foster local ownership, management and leadership. This approach tends to be very effective for long term sustainability, even though it is often a long, slow process, requiring major efforts in relationship building, creating trust and team work, and putting in place a firm foundation to generate and sustain results.

PRISM's 4th project year (ending October 2001) is bearing the fruits of these investments, as shown by the results reported in this annual progress report. The results reflect the contributions of PRISM toward achieving the intermediate results of increased access to, improved quality of, increased demand of RH services and improved coordination of RH interventions in Guinea. While continuing to consolidate the interventions of the previous 3 years, PRISM's focus in FY01 was on service quality improvements and on community based interventions, leading to results that often exceeded the set targets (see Table 1).

In the area of service improvement, much effort was directed at improving human resource management, supervision systems, and strengthening the quality of MH and CS services delivered, including infection prevention, which remains one of the biggest challenges in the public health sector, and emergency maternal health care. The underlying principles of these interventions is that efficient human resource management and supervision, as well as "learning by doing" are the key to translating improved knowledge into improved practices, thus creating durable improvements. The ultimate goal is to have in place sufficiently strong support systems at all levels of the public health program for quality service delivery. This means that (a) service delivery must comply with national RH norms and standards, and (b) for any one service, the service delivery point has to be functional, i.e. have all of the following elements simultaneously present.

- (1) Trained staff,
- (2) Relevant IEC information,
- (3) Appropriate management tools,
- (4) Adequate medical material,
- (5) Sufficient stock of essential drugs and contraceptives.

Monitoring and evaluating services delivery against RH Norms and Protocols on a regular basis is essential to rational decision making in relation to interventions to improve compliance. During year 4, PRISM helped the DPS integrate the assessment of compliance rates into standard supervisory checklists. The supervisory visits by the DPS using the new checklist and observation tools are also prime opportunities for the supervisors to offer vital feedback to providers on the preventive and curative services they delivery. PRISM is encouraged by the compliance rates obtained for observations made during the last three months of the year (see Table 1, IR2). These results testify to the importance of follow-up on-the-job training integrated in facilitative supervision visits to sites.

Functionality by service was also measured at the end of the year (see Table 2) and showed that a majority of HC had functionality scores, defined by the presence of the five elements

mentioned above, of 60% or higher for FP, CPN, Child Care and STI care services. However, the target of reaching functionality scores of at least 80% was not met for any of those services. The main reasons included a lack of certain basic medical equipment for FP services, a lack of essential IEC materials for CPN and Child Care, and the chronic shortage of drugs for STI treatment. While PRISM will continue to provide medical and IEC materials during the coming year, supporting the MOH at all levels in improving the supply of STI drugs will be a priority.

Table 1: Main results of the PRISM project by IR, as of the end of FY01

Indicator	Target	Result
IR 1: Increased Access		
% HC with fee schedule for RH services clearly posted	50	51
% HC integrated in FP & HIV/STI prevention services	95	96
% HC integrated in syndromic management of STI cases	35	25
# CBD agents who are <i>functional</i>	500	308 ¹
IR 2: Improved Quality		
Compliance Rate ² for Prenatal Care treatment & counseling Services (CPN)	10	43
Compliance Rate for STI care treatment and counseling Services	20	28
Compliance Rate for Child Survival treatment and counseling Services	10	27
Compliance Rate for FP & STI/HIV prevention services	15	63
% HC with mean duration of stock-outs of ED&C smaller than 10%	50	55
IR 3: Increased Demand		
CYP	8000	7084
% Births that benefited from at least 3 prenatal visits	47	49
# Community leaders oriented toward promoting FP and STI/AIDS prevention	450	682
IR 4: Improved Coordination		
The ratio of resources from non USAID expenses on health activities to the total of USAID expenses on health activities (in %)	5.1	5

Table 2: % of integrated HC functional in specified services, by functionality score

Functionality Score	FP	CPN	Childcare	STI care
Target: % of HC functional 80% or more	75%	50%	50%	50%
% of HC functional at 80% or more	65%	44%	22%	9%
% of HC functional at 60% or more	85%	97%	85%	59%

PRISM's community focus has been critical to complement the service delivery improvements. During year 4, PRISM continued to expand the reach of RH services through the CBD program. To date, all 52 rural HC in our 5 priority prefectures¹ have a network of 5 to 7 CBD agents, HC based CBD supervisors, and a DPS "*Chargé SBC*". This is a key achievement since it not only makes services more readily accessible to the people, but it allows community members direct involvement in their health related issues.

Another major component of PRISM's community focus during its 4th year of existence has been the youth campaign, which included community members and groups from its planning stages all the way through its implementation and evaluation. The youth campaign launches highlighted the importance of combining strategic advocacy, community mobilization, along

¹ In 5 of the HG's 8 prefectures (Faranah, Kankan, Sigui, Kerouane and Kouroussa). Functionality of CBD agents in Mandiana and in Dabola will be assessed with partner international agencies active there. These two prefectures had a total of 150 CBD agents as of the end of the year.

² % of consultations with compliance rates of 60% or more with national RH Norms & Protocols

with media and interpersonal communication interventions to bring about behavior change. During its culmination period, the youth campaign in Haute Guinée was featured in media reports on national television, national and rural radio and in local newspapers. The campaign was also reinforced with the recognition of 20 HCs where special training had been offered as being "youth friendly".

Finally, PRISM worked closely with teachers and school children to strengthen the Child-to-Child (EPE) program in HG to improve immunization coverage. This effort resulted in improved vaccination coverage, with a decrease of 28% to 15% in dropouts from follow-up vaccinations.

The progress made by PRISM during FY01 forms a promising basis to reach the end-of-project targets specified in PRISM's workplan, which was approved by USAID this past year. The results are significant and very real, given the Guinean context and the stage of development of its RH program. They are pointing towards improved access, quality and demand, and concomitantly, increased use of modern FP, decreased maternal and child mortality, and improved practices for STI/HIV prevention. However, the results are also fragile and will require continued TA to bring them to a level where increased use of RH services in rural Guinea will become sustainable.

The results reported and reviewed in this report must also be understood against the background of a rapidly changing environment, which caused PRISM to shift its geographical focus from two natural regions to one (HG only) because of security problems in the Forest Region. The project's technical developments also required a shift in the location of PRISM's technical staff, reducing the Conakry office to a liaison role, while the Kankan office expanded to include the project direction as well as most technical staff. Much of the technical and managerial improvements made over the past year, and documented in detail in PRISM's approved re-application document, were guided by the course of the project itself, but also by a very useful evaluation of the project commissioned by USAID/Guinea. On-going collaboration with both USAID/Guinea and the MOH has proven to be very valuable to PRISM and the project team expects to complete its fifth project year in full continued partnership with those institutions.

INTRODUCTION

SO # 2

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

Vision

By the year 2002, Guinean families and individuals will have good access to high quality services and information that meet their reproductive health needs.

This progress report covers PRISM activities and achievements during year 4 of the project ending in October 2001. The report also presents the last quarter of USAID's fiscal year 2001 for the purpose of completeness and continuity in quarterly reporting. Like other progress reports, this report is structured around PRISM's four implementing strategies to fulfill USAID's strategic objective # 2. The implementing strategies are designed to achieve the four intermediate results (IR) linked to the SO#2: (1) Increased access to RH services; (2) Improved quality of services; (3) Increased demand for services; and (4) Improved coordination between the MOH, donors and other partners.

Following a review of important events that have impacted on PRISM during the past year, the report presents the results with performance and process indicators for each IR. The document also offers a discussion of these results with regard to PRISM activities during year 5 of the current contract. The report concludes with a synthesis of PRISM's highlights to date and their implications for Guinea's public health program and system in the long term.

Events affecting PRISM implementation during year 4

PRISM's 4th project implementation year represents both some of the greatest challenges and the greatest results to date. A number of important events have had a major influence on PRISM implementation and operations. These events are summarized here, while further details can be found in PRISM's previous quarterly reports.

1. Security situation in the Forest Region

When the rebel invasions from Liberia and Sierra Leone started in September 2000, the security situation in GF worsened. PRISM suspended all project activities in the Forest Region (7 prefectures) in compliance with U.S. Embassy restrictions on working and traveling in the Forest and took all appropriate measures to secure the safety of the project staff and assets, transferring equipment, supplies, technical staff, and some administrative staff to Kankan.

Initially, PRISM had put in place a contingency plan for the quick resumption of technical activities in GF in case the situation should improve. However, in November 2000, PRISM was advised by USAID that the Embassy would most likely continue to prohibit work in the Forest Region for another year. Eventually, PRISM closed its office in N'Zérékoré.

⇒ At present, PRISM operates in *Haute Guinée* only, through a major presence based in Kankan (see below), and a reduced presence based in Faranah. PRISM's current target population is close to 2 million.

2. Continuation Application for Year 4 and Year 5

PRISM's re-application for the continuation of the contract for years 4 and 5 was approved by USAID in June 2001. The approved reapplication included a thoroughly revised technical and operational plan addressing all major concerns raised by USAID in relation to the initial submission in October 2000. The plan continues to focus on strengthening the decentralized health system, has a strong technical focus on maternal and child health, and includes a restructuring of PRISM staff and project operations following the withdrawal from the Forest Region. PRISM's restructuring responds also to a reduction in PRISM's overall budget, PRISM's technical needs and priorities, and to USAID's mid-term evaluation recommendations (see below). While the re-application process took longer than anticipated, it provided an opportunity for close teamwork with USAID/SO2. The process of re-working the technical application for years 4 and 5 and thus aligning technical and management priorities with budget constraints became a very productive and positive experience in which PRISM felt well supported by the USAID/SO2 Team and the MOH. Another important result of the process was a major reworking of PRISM's performance indicators package.

⇒ PRISM and USAID continue to work in Guinea with a major focus on MCH for years 4 and 5.

3. USAID mid term evaluation

In April 2001, USAID released its mid-term evaluation of the PRISM project and worked with PRISM to implement the recommendations made by the team of experts, who visited Guinea in February 2001. Some of the evaluation's main recommendations came as reassurance to orientations already taken by PRISM and well covered in its revised operating plan, submitted in March 2001. Examples of these are: the necessity to strengthen the MOH's decentralized supervision, especially post-training supervision; re-deploying PRISM's Direction and the Monitoring & Evaluation unit to the field (as presented in the March 7 Management Plan); and maintaining the CoGes strengthening component in the project's SOW. Innovative recommendations, like installing some of the PRISM technical staff at the Kankan IRS office, allowed PRISM to improve further its ability to transfer technology to its clients and deliver high quality interventions. PRISM, the USAID Mission and the MOH agreed on the set of recommendation to retain and implement.

⇒ PRISM implemented most of the mid-term evaluation recommendations and thus consolidated its technical and management efficacy.

4. Funding situation

During year 4, PRISM reduced the monthly burn rate to remain within the budget limitations communicated to MSH by USAID. This was done while maintaining expenses at a level compatible with the achievement of project results. The efforts to reduce the burn rate had an important auxiliary effect in permitting PRISM to continue to fund implementation of activities from the end of April, when another obligation for FY 2001 was due, until July, when the obligation was actually made. As additional measures to achieve savings during the

period of May and June, PRISM put on hold all TDYs, all equipment procurement, as well as youth campaign promotional material procurement. These measures were still in force at the end of June 2001. All activities were suspended during the first 10 days of July. Some activities were postponed as a result of the funding situation but PRISM, in consultation with USAID and the MOH, is adjusting when required its operational plan implementation to allow achievement of results. MSH greatly appreciates the special efforts the Mission deployed to ensure rapid funding of PRISM as soon as Congress released the money allocated to the Agency¹.

⇒ PRISM's cost saving and restructuring now ensure maximum technical output within current budgetary constraints

5. PRISM restructuring

In response to project needs, and confirmed in its validity by USAID's mid term evaluation, PRISM underwent a major restructuring during year 4. The most important change is that the project's Direction and Monitoring & Evaluation functions and staff are now based in Kankan. The Kankan office has become the central office of the project while the Conakry office transitioned from that role to a liaison and coordination role at the central level. This important change is at the core of PRISM's current management plan. An additional important change was the installation of some of PRISM technical staff in the Kankan Health Regional Direction: PRISM's Child Survival Specialist and Quality of Care Advisor, as well as its Coordinator for Medical Material and Supplies. A "*Convention de Partenariat*" describing the responsibilities of PRISM and the IRS in that regard was developed and signed.

⇒ The efficacy of PRISM's decentralized technical assistance is fully maximized; the new structure and project's central location in Kankan ensure optimal results, and minimize the burden of central level demands.

1. MSH received the Grant Amendment providing incremental funding for PRISM on the 10th of July 2001.

SUMMARY OF MAIN RESULTS

IR1. Increase of ACCESS to RH Services

Availability of Essential Resources at SDPs

- 1.a) PMA document adopted by the MOH and disseminated.
- 1.b) FP and STI/AIDS prevention services have been integrated in nearly all of HG's HCs as of the end of FY01 (96% or 85 out of 89). Of these, 85% have at least one trained staff available and 65% are functional at delivering the service.
- 1.c) 44% of HCs are functional at delivering ante natal consultation services (CPN).
- 1.d) 22% of HCs are fully functional at delivering childcare services in HG.
- 1.e) STI care services have been integrated in 25% of HCs of HG (22 out of 89). Of these, 9% are fully functional at delivering the service (2/22).
- 1.f) 55% of HCs experienced less than 10% ED&C stockouts duration during the last 3 months.
- 1.g) Critical medical material delivered to HCs and hospitals leading to close to 100% coverage for those items.
- 1.h) 51% of HCs in HG have a fee board posted covering all services and products (including birth delivery services).

CBD Program

- 1.i) All 52 rural HCs of priority prefectures have a network of at least 5 CBD Agents they supervise, replenish and support (26 added during FY01).
- 1.j) 317 trained and equipped CBD Agents offering RH products and services are deployed in priority prefectures (183 added during FY01).
- 1.k) Among them, 70 are female CBD Agents (compared to 0 prior to 1998).
- 1.l) 1,713 CYP gained by CBD agents during FY01 – 25% of total CYP gained in HG.

IR2. Improve QUALITY of RH Services

RH Quality Standards, Support Systems and Services

- 2.a) Training of 22 HHCs in Team (Human Resources) Management, bringing the total to 62 trained HHC out of 89 in HG.
- 2.b) 28 DRS/DPS supervisors trained in COPE facilitation, and 17 trained in Facilitative Supervision.
- 2.c) COPE integrated in 19 facilities: 4 maternity & 5 pediatric services and 10 HCs.
- 2.d) Integrated HC services delivery monitoring tool developed and in use at all HG's DRS/DPSs.
- 2.e) 338 consultations observed at 62 HCs and reported on by DRS/DPS supervisors during last quarter.
- 2.f) 62 PEV agents refresher-trained in PEV services and child growth monitoring (83% coverage of HG);
- 2.g) 27% of child survival services observed during last three months complies with N&P (target was 10%);
- 2.h) 37 CPN agents refresher-trained in ante natal services (CPN) and use of Partogramme (98% coverage of HG);

- 2.i) 43% of CPN consultation services observed during last three months complies with N&P (target was 10%);
- 2.j) 28% of STI care consultations observed during last three months complies with N&P (target was 20%);
- 2.k) 63% of FP consultations observed during last three months complies with N&P (target was 15%);
- 2.l) 49 providers from hospital maternity services trained in infection prevention;
- 2.m) PAC services integrated at 3 hospitals in HG (12 hospital maternity providers trained in PAC);

Strengthening of the National H/MIS

- 2.n) RH indicators integrated in the National H/MIS;
- 2.o) Monthly reporting H/MIS forms updated and tested for DPSs, HCs and hospitals;
- 2.p) MOH computerized H/MIS system updated with new RH indicators;
- 2.q) Training in basic computer uses of DRSS' staff in HG (decentralization of H/MIS)

IR3. Increase DEMAND of RH Services

- 4a) A youth campaign targeting HIV/STI prevention and prevention of unwanted pregnancy is successfully being implemented in all of the 8 prefectures and in one high risk sub prefecture;
- 4b) 682 community leaders oriented and participate in RH promotion (432 during FY01);
- 4c) 49% of births in HG benefited from at least three pre natal visits to a HC;
- 4d) CYP for FY01 is 7084, reflecting a 6% increase compared to the previous FY and a 59% increase compared to FY98
- 4e) Regional and prefecture IEC working groups reached out to communities and community leaders, establishing joint work planning and IEC activity implementation
- 4f) 20 HC in HG are recognized as 'youth friendly'; their staff were trained in special IEC and IPC/C skills to meet the needs of youth
- 4g) New IEC/BCC materials and job aids were developed, tested and distributed to HCs, communities and IEC promoters, and messages were passed at social events including sports, theater and social clubs
- 4h) The EPE program improved immunization coverage in Faranah (pilot prefecture) and resulted in diminished drop out from follow up vaccinations from 28% in 1999 to 15% in FY01

IR4. Improve COORDINATION of Interventions in RH

- 4a) Management of supervision activities supported at the 2 DRSS and at the 8 DPSs of HG; 4 DPSs performed supervision activities in accordance with agreed guidelines.
- 4b) Computer network installed and operational at MOH; email capacity established at MOH central level units and at HG's DRSSs.
- 4c) 8 Regional Working Group meetings held.
- 4i) Participation and technical support to 12 CTPS meetings and to 4 CTRS meetings.
- 4j) 5.0% cost sharing attained as of the end of FY01 (target = 5.1%).
- 4k) 3 quarterly review meetings held with MOH and USAID

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WORK TOWARD THE INTERMEDIATE RESULTS (IR)

IR1: Increased ACCESS

MINISTRE DE LA SANTE PUBLIQUE
SECRETARIAT D'ETAT A LA MODERNISATION
TABLEAU DE TARIFICATION DES SOINS DANS
LES CENTRES DE SANTE (PEV/SSP/ME)

TARIFS DES TRAITEMENTS	PEV	SSP	ME
Parasitisme et traitement local SRO	200	200	200
contraception orale	300	450	600
Tout traitement oral sans antibiotique (sauf progestatif)	300	450	600
Tout traitement oral avec antibiotique (sauf progestatif)	500	650	1000
Tout traitement injectable (sauf contraceptif injectable)	1500	2000	2500
Pratiquentel			
VACCINATION	GRATUITE		
Consultation PNI pendant toute la durée de la grossesse jusque à l'accouchement y compris la carte de santé			1000
ACCOUCHEMENT			10000
PLANIFICATION FAMILIALE			20000
CONCEPTROL			25000
CONDOM			6000
DEPO-PROVERA			10000
DIU			2000
LO-FEMENAL			2000
OVRETTE			2500
Prise en charge des IST			200
CARTE DE VACCINATION			500
ACTE DE SOINS			

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

Availability of essential resources at SDPs:

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

Affordability of services at SDPs:

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

AVAILABILITY OF ESSENTIAL RESOURCES AT SDPs

PRISM assists the MOH at ensuring the availability of reproductive health (RH) services at service delivery point (SDP)¹ in *Haute Guinée* (HG) as required by the Minimum Package of Activities (PMA). For a service to be available, a SDP has to be functional at delivering it to its clients. To be fully functional at delivering services to its clients, a service delivery point (SDP) needs to have simultaneously at its disposal the following essential resources: trained providers and support staff, drugs (including contraceptives), medical equipment and supplies as well as IEC material and management tools. The SDP is functional for a specific service once it has at its disposal trained providers for that service and most² essential material resources required for delivering it.

Main Results:

- 65% of assessed integrated HCs are functional at delivering FP and STI/AIDS prevention services in HG according to the DRS/DPSSs' monitoring activities (45/69);
- 44% of HCs are functional at delivering ante natal consultation services (CPN) in HG (30/68);
- 22% of HCs are functional at delivering childcare services (CPN) in HG (15/68);
- 9% of integrated HCs are functional at delivering STI care services in HG (2/22).

* These results are presented in detail and discussed at the Monitoring & Evaluation section immediately following section 1.4.

1.1 Minimum package of Activities (PMA)

Main Results

- PMA document adopted by the MOH
- PMA document disseminated at the national and regional levels

The PMA document "*Paquet Minimum d'Activités pour les Soins de Santé Primaire – Horizon 2005*" was disseminated at the regional level during the January 2001 CTRS meetings. It was an integral part of the documentation kit on the National Health System Development Plan presented during the CTRSs by MOH central level senior staff. The PMA was developed with PRISM technical and financial assistance during FY99 & 00 and validated by the MOH in September 2000. PRISM will support the DRS to disseminate the PMA during the upcoming coordination meetings at the Prefecture level - or CTPS - routinely held at the end of each calendar year. The Heads of HCs as well as the hospitals' senior staff attend the CTPS meetings.

1. SDP's targeted by PRIM are health centers, hospitals and community agents like CBD agents and TBAs.
2. The threshold is defined at 80% of required items available.

1.2 Integration of RH Services in HCs

1.2.1 Integration of Family Planning and STI/AIDS Prevention Services³

Main results	End of Year 3 (Oct. 2000)	End of Year 4 (Oct. 2001)	End of Year 5 (Oct. 2002)
% of HCs in project area where FP and STI/AIDS prevention services have been integrated			
Target		95%	95%
Actual	95%	96%	
% of integrated HCs in project area providing FP and STI prevention services ⁽¹⁾			
Actual		85%	

(1) Integrated HCs with at least one recognized trained staff in FP & STI/AIDS prevention services.

During FY01, FP was integrated in one of the last remaining non-integrated HCs in HG. This was CS Konso in Dabola. The integration was accomplished through the assignment of 2 trained staff in FP by the DRS and by the allocation of an initial stock of contraceptive products. This brings the total number of HCs integrated in FP services to 85⁴, leaving 4 to be integrated during FY02. These are CS Konindo and CS Kindoye in Dabola Prefecture and CSU Kankan Koura and CS Boula in Kankan Prefecture. At integrated HCs, PRISM will also ensure that new, untrained providers will be trained to preserve availability of FP services there.

In the normal course of action, and over time, some trained providers retire or are transferred to another facility. Once the service is integrated at a site, the challenge for the regional health authorities is to preserve its availability despite changes in personnel. PRISM has supported this constant effort by various means. One has been to provide the DRS/DPSs with an adequate inventory tool to monitor the availability of human resources at service delivery points⁵. PRISM has also continued to include untrained staff assigned to integrated HCs with less than two trained providers in FP integration training activities. To date, PRISM has trained 14 such providers coming from 12 HCs. As a result, at the end of FY01, 85%⁶ of integrated HCs still have trained personnel in FP on their staff. This encouraging result underscores the importance for the DRS to manage pro actively the region's health system human resources.

3. PRISM performance indicator 1.2. See annex 1.1 for additional details on the indicator. See detailed list of integrated HCs at annex 1.7.

4. Of these, 36 were integrated by PRISM after inception of the project in 1998.

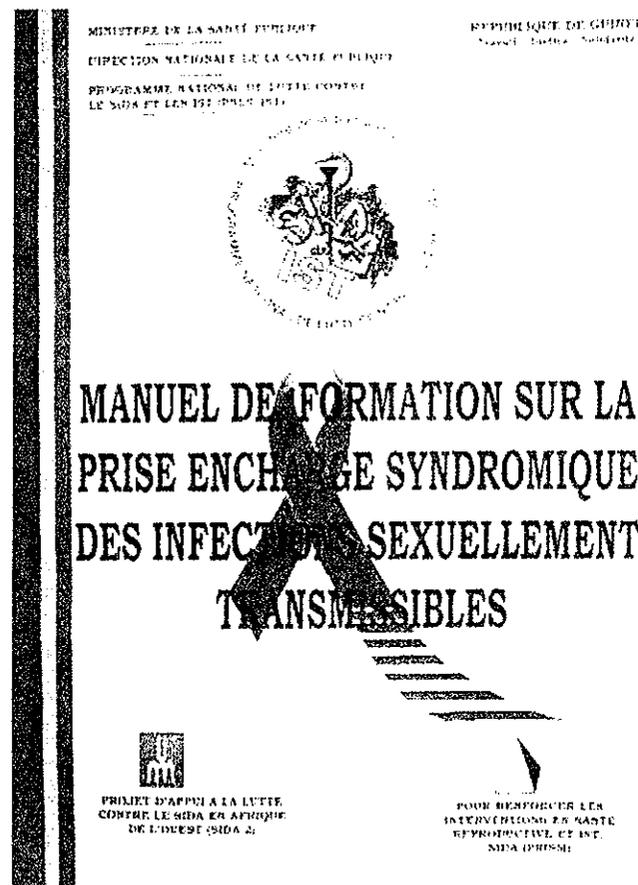
5. See "Fiche d'Inventaire: Disponibilité des Services et Equipement" at annex 1.3.

6. Out of 73 HCs inventoried recently, 62 have at least 1 confirmed trained provider.

1.2.2 Integration of STI Care Services⁷

*STI Syndromic Case Management
Integration Steps (MOH/PNLS)*

- Selection of priority HCs to integrate based on following criteria set:
 - Urban HCs
 - HCs located in STI high risks zones like mining areas, truck stop villages
- Train DRS/DPS supervision staff in STI syndromic case management
- Secure anti STI drugs necessary to prepare HCs start up kits worth 3-6 months of service
- Train all Heads of selected HCs in STI syndromic case management
- Train a 2nd provider for each selected HC
- Deliver start up kits including:
 - STI drugs
 - Medical equipment and supplies
 - IEC material
 - Management tools
- Promote the service within communities served by the HCs
- Perform post-training monitoring during a period of up to 6 months
- Monitor regularly the quality of STI care service delivered and perform On-The-Job training as required



Main results	End of Year 3 (Oct. 2000)	End of Year 4 (Oct. 2001)	End of Year 5 (Oct. 2002)
% of HCs in project area where STI care services have been integrated			
Target		35%	60%
Actual	9%	25%	
% of integrated HCs in project area providing STI care services ⁽¹⁾			
Actual		100%	

(1) Integrated HCs with at least one recognized trained staff in the syndromic management of STI cases.

During FY01, PRISM integrated STI syndromic care in 14 HCs, all located in the Kankan Administrative Region, bringing the total number of HC with integrated STI care in HG to 22⁸ (i.e. 25% of all HCs). The target was to reach a total of 31 (35%) by the end of the project's year 4 but non-availability of anti-STI drugs precluded PRISM from reaching this target. The PNLS policy, supported by PRISM, is to initiate training of providers in STI care only when drugs are

7. PRISM performance indicator 1.3. See annex 1.1 for additional details on the indicator. See detailed list of integrated HCs at annex 1.7.

8. 8 HCs from the Faranah Region were integrated during FY00.

available. Each targeted HC is to be provided with a 3 to 6 months start up kit of anti-STI drugs immediately following the training of its providers in the syndromic management of STI. As in the previous year, long delays in deliveries of STI pharmaceuticals from the World Bank project PPSG motivated PRISM to identify other sources. PRISM negotiated successfully with the Canadian SIDA2 project which agreed to provide pharmaceuticals for the 14 targeted HCs from the Kankan Region and integration activities proceeded. PRISM interventions in this integration activity included the training of supervisors and providers, post-training monitoring visits at HCs, and, in coordination with IEC prefecture groups, the promotion of the newly available STI care services in the 14 sub-prefectures served by integrated HCs (1.2.2.3).

Training of providers in the syndromic case management of STI (1.2.2.1). A total of 44 providers were trained in STI care during FY01 (target = 48). They included 27 providers from the 14 integrated HCs mentioned above and 17 providers from the next group of HCs that PRISM will integrate in FY02.

Training of Supervisors in Syndromic management of STI Cases (1.2.2.2): PRISM trained 20 supervisors from the 5 prefectures of the Kankan Region in the Syndromic case management of STI (target = 13). They included 16 health professionals from the DPSs and 4 from the hospitals. The supervision teams performed qualified post-training monitoring site visits at integrated HCs as a result of this training. At the hospital, the supervisor who has regular clinical duties at the hospital now applies the syndromic approach for 1st contact clients, and uses the etiologic approach for referred cases (cases for which the syndromic approach failed).

1.2.3 Integration/Extension of Community Based Services with Health Centers

1.2.3.1 Community Based Distribution (CBD/SBC) Agents Integration/Extension



The CBD program is one of PRISM's main interventions aimed at improving access to RH services for the rural population of Haute Guinée.

PRISM CBD/SBC support strategy, developed and approved by the MOH in 1999, presents two different packages of activities, depending on the presence or absence of another international technical agency active in health at the community level in a prefecture. In prefectures where such a partner is active, PRISM support is designed to be complementary while ensuring compliant implementation with the national CBD policy. PRISM's interventions and results are presented in the following lines separately for each of the two groups of prefectures.

CBD Program in Prefectures with no international agency active at the community level⁹

<p>KANKAN SIGUIRI KOUROUSSA KEROUANE FARANAH</p>	<p><u>Main results of the CBD program in the 5 priority prefectures during FY01¹⁰</u></p>
	<p>☞ All 52 rural HCs have a network of at least 5 CBD agents they supervise, replenish and support (26 added during FY01).</p>
	<p>☞ 317 trained and equipped CBD agents offering RH products and services are deployed (183 added during FY01).</p>
	<p>☞ Among them, 70 are female CBD agents (compared to 0 prior to 1998).</p>
	<p>☞ 1,713 CYP gained by CBD agents during FY01 – 25% of total CYP gained in all of HG.</p>
	<p>☞ 22,797 contacts generating sales made with contraceptive users during FY01, of which 7,860 are new contacts.</p>
	<p>☞ 14,470 ORS units sold during same period.</p>
	<p>☞ 8,378 IEC activities performed by CBD agents</p>

Mobilise rural communities and train CBD agents and their supervisors (1.2.3.1.1): As of the end of FY01, all 52 rural sub prefectures located in PRISM's priority prefectures have a CBD agent network linked to their HC and providing RH products and services to the population (26 integrated during FY01). Community mobilisation activities, performed in 130 villages during FY00, were extended to 182 more villages this year. As in previous years, PRISM worked with CENAFOD, a Guinean NGO specialising in community development, to implement the mobilisation activities. A total of 317 CBD agents have been trained, equipped and are now active in the priority prefectures (183 trained and equipped during FY01). The table on the next page presents the mobilisation results in detail.

Interventions at Sub Prefectures with Established CBD Activities

Interventions at Established CBD Villages: Community mobilisation activities took place at 165 villages where CBD activities had been integrated prior to 1998 (at 35 during FY01). The main goal of these remobilization activities was to have the communities determine whether to keep their CBD agents or to select a new one. A total of 100 villages decided to maintain their existing CBD agent, 4 villages decided to maintain their agent and pair him with a female CBD agent and 61 villages decided to select a new agent altogether¹¹. As a result, PRISM trained and equipped 169 agents coming from established villages (35 agents during FY01), linked to 26 rural HCs (7 covered during FY01).

Interventions at New Villages: One of PRISM's CBD expansion strategies is to add CBD agents coming from villages not covered in sub prefectures with large rural populations – therefore increasing the number of CBD agents in those sub prefectures. The standard sub prefecture (HC) network has 5 CBD agents. At sub prefectures with a larger population, CBD networks were expanded from 5 to 7 CBD agents. A total of 52 CBD agents coming from 26 such sub prefectures were trained and deployed by PRISM under this strategy – all during FY01.

9. These prefectures are referred to as "priority prefectures" for PRISM in the CBD program context because PRISM is the only international technical agency offering support to CBD initiatives there.

10. See results of the CBD program in the priority prefectures as of the end of September 2001 at annex 1.4.

11. The main reasons for the changes are unsatisfactory services, old age or retirement, and agents that had moved to another district.

Interventions at Sub Prefectures with No Past CBD Activities

Since 1998, FP services continued to be integrated in rural HCs in HG – primarily by PRISM in conjunction with AGBEF. A total of 19 such rural HCs that were not offering FP services in 1997 do so now. It is PRISM's strategy to increase access of rural populations to RH services and products by creating the CBD network in sub prefectures served by these HCs. During FY01, PRISM integrated CBD networks in all of these sub prefectures. Community mobilisation activities took place at 95 villages and 96 new CBD agents were trained.

Community (Re)Mobilisation Activities October 1999 – September 2001									
Prefecture	# of villages new to the program (mobilisation)			# of villages integrated in the past (remobilization)			Total number of rural villages (re)mobilised		
	FY00	FY01	Total	FY00	FY01	Total	FY00	FY01	Total
Kankan		28	28	45	5	50	45	33	78
Kerouane		17	17	30	0	30	30	17	47
Siguiri		42	42	30	0	30	30	42	72
Kouroussa		40	40	25	0	25	25	40	65
Faranah		20	20	0	30	30	0	50	50
Total	0 ^(*)	147	147	130	35	165	130	182	312
Communities' Decisions Confirmed or New Agents – Female or Male Agents									
Confirmed				82	22	104	82	22	104
<i>Female</i>				0	0	0	0	0	0
<i>Male</i>				82	22	104	82	22	104
Newly recruited		148	148	52	13	65	52	161	213
<i>Female</i>		41	41	24	5	29	24	46	70
<i>Male</i>		107	107	28	8	36	28	115	143
Total^(**)	0 ^(*)	148	148	134	35	169	134	183	317
<i>Female</i>		41	41	24	5	29	24	46	70
<i>Male</i>		107	107	110	30	140	110	137	247

(*) No new villages were integrated in the program during the initial stage of implementation (FY00). Priority was given to the remobilization of villages for which CBD activities had been integrated in the past (prior to PRISM's inception in 1998).

(**) Number of CBD agents is larger than number of mobilised villages for some categories because some villages decided to have more than one agent: 5 of them in fact. This explains why we have 317 agents based in 312 villages.

CBD Program and the Gender Issue

PRISM evaluation of the CBD program set up in HG prior to 1998 drew attention to the fact that all of the 165 CBD agents deployed were men. On the basis of the widely shared conviction that the lack of female CBD agents was limiting the reach and efficacy of the CBD program, PRISM, with the backing of key MOH officials and the enthusiasm of its local partners, adapted the approaches and tools to ensure that no discriminating obstacle would prevent women from becoming CBD agents. For instance, the developed mobilisation protocol ensures that a community could select one of its members as their CBD agent on the basis of merit regardless of gender. CBD order forms, monthly reports and other management tools were modified to

become usable by individuals who are illiterate or literate only in the local language, which often is the case for women. As a result of these measures, one third of the newly recruited CBD agents are women (70 out of 231). Female CBD agents thus constitute 22% (70 out of 317) of all agents currently operational in the 5 priority prefectures of HG. PRISM, with its partners, will continue to promote a better gender balance in the CBD program to ensure better access to RH products and services to all segments of the population.

Train Supervisors of CBD agents with MOH/PRISM developed curriculum (1.2.3.1.2)

In FY01 PRISM trained 56 HCs staff in supervising CBD agents, bringing to 107 the number of HC staff trained in CBD supervision in the priority prefectures of HG. The policy is to have two qualified CBD supervisors per HC, generally the Head of the HC and the PEV agent. However, at 4 of the 52 HCs with a CBD network there is only one qualified CBD supervisor due to changes in personnel. PRISM will continue during FY02 to assist the DRS/DPSs in monitoring the availability of CBD supervisors at integrated HCs.

Support DPSs in managing the prefecture's CBD program

Technical Assistance provided to DPSs through AGBEF

AGBEF continued to provide technical assistance to the priority prefectures of HG under a subcontract awarded by PRISM in May 2000. The AGBEF technical assistant is assigned to the DPS to support the prefecture's CBD program and IEC activities and transfer skills. At the launch stage of the CBD program (initial 6 months) the TA devotes 100% of his time to the CBD program. Over the following 6 months, his time is progressively dedicated toward IEC activities. At the end of the first year of support to the DPS, the TA uses 25% of his time for CBD and 75% for IEC activities.

Support to the DPS's "Chargé SBC" function

In FY01, PRISM completed the training of all 5 DPSs' "Chargé SBC" (1 during FY01) and provided one motorcycle per prefecture for that function. PRISM allocates also, on a decreasing rate basis¹², fuel for the CBD/IEC work-related uses of the motorcycles. The allocation of fuel is down to 50% of estimated needs for 4 of the 5 prefectures now.

Monitoring & Evaluation of CBD agents' performance

Evaluation of CBD agents trained during FY00

The performance of the CBD agents trained during FY00 was assessed during the first quarter of 2001 by the DPSs' *Chargé SBC*, with the assistance of their AGBEF technical assistants and the PRISM CBD Coordinator. Performance was measured against objectives such as attendance at monthly meeting at the HC, the use of the ELCO map to monitor clients, referral practices and the number of IEC promotion activities delivered. Performance was equal or exceeded the set goals for 115 of the 134 CBD agents trained in FY00 (86%). The 115 performing CBD agents received a bicycle in recognition of their efforts during locally organised ceremonies with the DPS sub prefecture or village level.

12. The allocation of fuel is decreased to 50% of estimated needs after 6 months, to 25% after 12 months and is cancelled altogether 18 months after the allocation of the motorcycle.

CBD Program in Prefectures with an international agency active in the health sector at the community level¹³

<p>MANDIANA¹⁴ DABOLA DINGUIRAYE</p>	<p><u>FY01 results shared with partners</u></p> <p>In Mandiana, in support of Save the Children-managed CBD interventions:</p> <ul style="list-style-type: none"> ☐ 73 trained and equipped CBD agents offering RH products and services are deployed. <p>In Dabola, in support of ISMI-managed CBD interventions:</p> <ul style="list-style-type: none"> ☐ All 9 HCs have a network of at least 5 CBD agents they supervise, replenish and support. ☐ 74 trained and equipped CBD agents offering RH products and services are deployed. <p>In Dinguiraye: no intervention yet</p>
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Support to the CBD program implementation in Dabola Prefecture with Africare/ISMI

- Delivery of CBD material to Africare/ISMI: PRISM delivered materiel for 74 CBD agents and 18 supervisors. The materials delivered for CBD agents included IEC material (IEC picture box, pagnes), CBD material bags, CBD *armoirettes*, and contraceptives products. Materiel delivered for CBD supervisors included the following items: CBD *pagnes*, blackboard and calculator, CBD material bags.
- During regular visits to Dabola, the PRISM CBD Coordinator provided technical assistance to the CBD training activities implemented by ISMI (9 supervisors and 74 CBD agents) and to the integration of immunisation and fever references into the CBD MIS forms and reports. He provided also liaison assistance between the prefecture level and the regional level for the identification and assignment of qualified regional MOH CBD trainers.
- Allocation of one motorcycle to the Dabola DPS "*Chargé SBC*" to support the CBD supervision activities in the prefecture.
- Training of the 2nd CBD supervisors of the 9 HCs in the Dabola Prefecture. ISMI had trained only one supervisor per HC while the official norm is two.

Support to the CBD program implementation in Mandiana Prefecture with Save the Children

- Delivery of CBD material to Save the Children: PRISM delivered material for 146 CBD agents and 24 supervisors in Mandiana prefecture. They included the same type of items that PRISM provided to ISMI (see previous sub section).
- Allocation of one motorcycle to the Mandiana "*Chargé SBC*" to support the CBD supervision activities in the prefecture.

13. These are Mandiana where Save the Children is active and Dabola and Dinguiraye where Africare is active.

14. Interventions in Dinguiraye were limited to consultation and planning sessions with ISAD and the DPS. Active support to CBD activities will start during last quarter of 2001, in accordance with ISAD implementation plans.

Other CBD Related Interventions

Increase access to oral contraceptive (1.2.3.1.5): The MOH authorised PRISM to pilot test the use of a checklist by CBD agents, allowing them to prescribe oral contraceptives to clients. The PRISM CBD Coordinator met with the Head of the MOH's RH Division, the Director of the "Centre National de Recherche et de Formation en Santé Rurale de Maferinya" and the Head of the Maternity Service at the Donka University Hospital in Conakry, who are members of the special steering committee that the MOH is setting up to monitor the pilot test. The test protocol has been drafted by PRISM as well as the monitoring tools and the CBD agent's checklist for oral contraceptive prescription. A review session of this material is planned for the last quarter of 2001 and the 6 months test period will start in January 2002.

Implementation of the computerised CBD monitoring system at the DRSs: PRISM completed the development of the computerised CBD monitoring system and finalised the users guide document. The system captures CBD service statistics and produces reports tailored to the needs of each level of the CBD program (sub-prefecture, prefecture, regional and national). The application has been installed at the Faranah DRS. The Kankan DRS is transferring one staff from a HC to their data entry/process function. PRISM will install the CBD monitoring application there when they are ready.

1.2.3.2 Traditional Birth Attendant (TBA) Integration

Strengthening (training) of Traditional Birth Attendant (TBA) (1.2.3.2.1): According to the National Safe Motherhood Policy, 5 TBA (*Accoucheuses Villageoises*) per HC are to be supported and monitored by HCs. PRISM is supporting the implementation of this policy in three prefectures in HG. Those are Kankan, Kerouane and Faranah. PRISM requested and received from the DPSs the list of TBAs that are to be trained and supported in those prefectures. The training of at least 120 of the TBAs will start during the last quarter of 2001. It will focus on maternal and infant life saving skills - going beyond basic birth delivery skills by aiming at improving the TBAs' capabilities to recognize early on signs of labor-associated risks. The main goals are to prevent infection, improve referral practices and postpartum care, provide better assistance to birth delivery, and promote preventive practices (FP, immunization and breast-feeding). It is important also to note that the refresher course in CPN/Partogramme for the HCs' CPN agents, which was updated with PRISM TA, includes a module on TBA supervision.

1.3 Strengthen the Essential Drugs and Contraceptives (ED&C) logistics system

Main Results

- 55% of assessed health centers (26 out of 47 HCs) experienced less than 10% ED&C stockouts duration during the last 3 months¹⁵ (target was 50%).
- 22 HHCs trained in ED&C management during FY01; cumulative for HG = 62 (70% of HCs in HG).

15. PRISM performance indicator 2.5. See annex 1.2 for additional detail on indicator. See detailed list of assessed HCs and results at annex 1.5.

Main Results

- On-the-job training of sales point agents done at 36 HCs, all during FY01 (EOP target = 64 HCs).
- 15 new trainers certified at basic level (cumulative & EOP target = 20), 8 trainers certified for advanced level (EOP target = 8).
- Sales prices of contraceptives to HCs are established by the MOH.
- ED&C management curricula are adopted by the MOH at the regional level in Kankan and Faranah.
- Hospital logistics forms/tools are harmonized; forms/tools package ready for integration in Hospital Logistics Manual.

1.3.1 Training in ED&C logistics management

Training of Heads of Health Centers in ED&C Management (1.3.1.1): During FY01, PRISM trained 22 Heads of Health Center in management of essential drugs and contraceptives during FY01. The course was directed by a senior staff member of the Kankan IRS, Dr Oumar Diakité, who is an advanced trainer since the October 2000 ToT training session. As a result of the training session, 62 out of the 89 HHC in *Haute Guinée* have been trained in ED&C Management. The goal of having all 89 HHC trained by the end of FY01 was not achieved because of the temporary funding shortage from May to early July. When funds became available again, PRISM emphasis had to be on the scheduled monitoring activities to strengthen the DPSs' supervision teams' tools and performance¹⁶.

On-the-Job Training of 2nd Managers at HCs (1.3.1.4, 5 & 6): PRISM and the DRSs conducted on-the-job training of the 2nd managers of ED&C at 36 HCs. The 2nd manager of ED&C is the **Sales Point Attendant**. He/she works under the supervision of the HHC and handles the direct delivery of ED&C to the clients. The HCs covered include 14 of the 19 HCs targeted for IMCI (10/10 in Mandiana; 4/9 in Dabola), 13 of the 36 HCs targeted for MSR (5/12 in Faranah; 5/16 in Kankan; 3/8 in Kerouane) and at least 3 HCs per prefecture in the remaining ones (9 HCs). Qualified and experienced regional trainers from the MOH have implemented this on-the-job training activity at most covered HCs.

1.3.2 Training of regional trainers (ToT)¹⁷

It is critical to the successful decentralization of the MOH, that RH training capabilities are increased at the regional level. PRISM started its support in this area during the very first year of the project. At the beginning of FY01, PRISM conducted one additional Basic Level ToT session resulting in 15 newly certified trainers and a first Advanced Level ToT session leading to the advanced certification of 8 formerly trained professionals. The participants came from various clinical and managerial specialties and are active in RH support activities – not just in ED&C management. The ToT curricula for both the Basic and the Advanced Levels have been finalized and will be formally transmitted to the MOH.

16. For the same reasons, the training of DRS/DPSs and hospital cadres in ED&C management (1.3.1.2 & 3) has been postponed to the last quarter of 2001.

17. The code for this activity comes from the code structure in force before the approval of the Y4 and 5 Continuation Operational Plan on 17 July 2001.

1.3.2 Support the development of ED&C logistics policies, procedures, tools and curriculum

Promote the establishment of contraceptive sales prices to HC (1.3.2.1): PRISM's policy is to promote the sustainability of the Guinean logistic structure by transferring technology, systems and approaches to it. We noticed early in the project's life that contraceptives were supplied for free to all HCs by the PEV/SSP/ME despite the fact that family planning services had been integrated for more than 2 years in many of these facilities. This practice was in contradiction with PEV/SSP/ME's own policy of providing essential drugs for free only during the initial 2 years of a HC creation and/or new services integration. It was also counterproductive in terms of sustainability of the logistics system since no revenues were generated out of the contraceptives by the entity responsible for acquiring, storing (at the central level), and distributing the contraceptives to all the regions. All the while, the contraceptives are being sold to the HCs' clients at very low prices, but sold nevertheless.

PRISM's strategy to strengthen the sustainability of Guinea's drugs logistics structures has been twofold: (1) promote the insertion of contraceptive products into the official list of essential drugs, and (2), encourage the establishment of contraceptive sales prices to HCs by the PEV/SSP/ME. PRISM, in concert with most major technical agencies involved in reproductive health in Guinea, lobbied actively with the public health authorities for the insertion of contraceptives into the official list of essential drugs for HCs. The decision was made in early 1999 by the MOH to do so. Immediately following this important step, PRISM presented to the Minister of Health a mechanism that would allow the PEV/SSP/ME to generate enough revenues to cover the logistics costs associated with contraceptives while continuing to charge the same contraceptive sales prices to the clients. The proposal stipulates that one fourth of their final sales price be charged by the logistics system to the HCs. We estimated that the remaining 75% of the value of contraceptives would still represent a very significant "grant" element to the health center. This proposal was not retained then because rules to which the PEV/SSP/ME was subjected forbid it to sell to HCs products it acquired for free. PRISM nevertheless continued to lobby the MOH authorities at all levels for the proposed sustainability strategy. PRISM's lobbying highlighted that the management of paid contraceptive products proves to be more cost-effective than the management of products acquired for free. In May 2001, the MOH established sales prices for contraceptive products delivered to HCs. They are defined at 50% of sale prices to users – a rate twice as high as PRISM had proposed but nevertheless very viable for HCs.

PRISM is currently monitoring the HCs' management of contraceptives with special attention to any adversarial impact the establishment of sales prices might have on availability of the products to clients. Although still early to draw a definite conclusion, we have noticed no negative impact thus far. PRISM will facilitate a special session covering contraceptives procurement during the December CTPS meetings¹⁸ and close attention to contraceptive management will be maintained during the following months.

Support the harmonization of hospitals' logistics tools and forms (1.3.2.2): PRISM co-facilitated the workshop (funded by WHO) during which the logistics tools and forms for the hospitals were harmonized, making the development and adoption of a national manual/guide for hospital management of drugs possible. Contrary to the HC level for which PRISM has been the leading force in harmonizing tools and developing the national manual, for hospital

¹⁸. The HHCs finalize their semester order of essential drugs and contraceptives during the CTPS meetings.

level tools/manual development, PRISM is simply assisting the process.

ED&C Management Manual for HCs finalization and dissemination (1.3.2.3&4): PRISM provided assistance to the MOH "Direction Nationale des Pharmacies et Laboratoires" in developing the National Manual on HC ED&C logistics. The manual is now officially adopted by the MOH and includes a preface signed by the Minister. It is ready for printing and dissemination planned now for the December 2001 CTRS and CTPS meetings. Dissemination was initially planned to occur during the June CTRS/CTPS meetings but was delayed because of funding constraints experienced during that period.

National ED&C management curriculum (1.3.2.5): The Essential Drugs & Contraceptives Management training curriculum has been finalized in its various versions targeting specific groups: Heads of Health Centers, Pharmacists and Managers of IRS/DPS, hospitals, and the regional depots (PEV and PCG). They are ready to be formally submitted to the National Coordination of PEV/SSP/ME (for HCs) and to the *Direction Nationale des Pharmacies et Laboratoires* (for the other managerial levels). The submission of the curricula is rescheduled to the 1st quarter of FY02.

1.3.3 Improve availability of products: Other Interventions and results

- /r/ The ED&C monitoring and evaluation tool IMAT (Inventory Management Assessment Tool), introduced in Guinea by PRISM, is now fully integrated into the supervision protocol of DRS/DPSs (1.3.3.4).
- /r/ PRISM provides technical and financial assistance to DRS/DPSs for improved supervision of ED&C management at HCs (1.3.3.1). PRISM supported over 175 such visits during FY01.
- /r/ Duplicopier supplied to Kankan¹⁹ DRS to reproduce ED&C logistics tools and forms (1.3.3.2).
- /r/ Support to USAID and the Guinean national logistic units in contraceptives management (1.3.3.3&6): PRISM continued to handle all port clearances, reception and storage of the contraceptive products shipped to Guinea by USAID. The full integration of contraceptives in the Guinean logistic system, completed at all levels with the exception of the central level, is ongoing. PRISM also regularly supports USAID's SO2 team in the computation of contraceptive needs for Guinea.
- /r/ Expired drugs destruction protocol is integrated in the MOH's ED&C Management Manual for HCs.

19. Faranah's DRS needs in terms of document copying were already covered. It declined the duplicopier.

IR1.3 Strengthening of ED&C Logistics System: Monitoring and Evaluation

(SO2 # 2.2.3 ; PRISM # 2.5)

<u>% of Health Centers in HG for which the average duration rate of stockouts of ED&C is smaller than 10%⁽⁰⁾.</u>	<u>Sept. 2000</u>	<u>Sept. 2001</u>	<u>Sept. 2002</u>
<u>Target</u>		50%	75%
<u>Actual</u>	Not available ⁽¹⁾	55% ⁽²⁾	

- (0) Assessment based on cumulative number of days with stockouts for 25 essential drugs during the preceding 100 days (standard IMAT protocol).
- (1) The present indicator was adopted on 15 June 2001. It is based on the ED&C monitoring tool IMAT introduced by PRISM and used by the MOH supervision teams.
- (2) Data on availability of essential drugs during the last quarter of FY01 is available for 47 out of the 89 HCs of the focus zone. Of the 47 HCs assessed, 26 had average stockouts of less than 10% during the 100 days period preceding the date of the assessment.

The distribution of average stockouts rates between quintiles is as follow:

Quintile 1 (0 – 20%)	=	79%	(37/47)
Quintile 2 (21 – 40%)	=	15%	(7/47)
Quintile 3 (41 – 60%)	=	6%	(3/47)
Quintile 4 (61 – 80%)	=	0%	(0/47)
Quintile 5 (81 – 100%)	=	0%	(0/47)

Stockouts at HCs versus training status of HHCs

While 55% assessed HCs experienced duration rates of stockouts lower than 10%, 63% did so where the HHCs have been trained in ED&C management by PRISM (24 out of 38) compared to only 22% of the other HCs (2 out of 9)²⁰. This suggests strongly that PRISM's course material in ED&C management and training methodology is making a significant difference at the HC level.

Stockouts vs availability of STI care drugs

The average availability rate of STI care drugs at the end of the period was only at about 13% at HCs. Stockouts are unfortunately frequent and long in duration for this category of drugs. More HCs would have experienced lower than 10% stockout duration rates if anti-STI drugs were as available as other drugs. One fourth of assessed HCs had stockout duration rates between 10 and 20%. Some of them would have moved up into the best performing HC category.

20. See stockout rates table at annex 1.5 for details.

1.4 Availability of Basic Medical Equipment, IEC Material and Management Tools

Main Results

- 60% of HCs assessed during previous three months have 60%+ of required medical material available according to N&P (53 out of 88 HCs).
- Critical medical material delivered to HCs and hospitals leading to close to 100% coverage for those items.
- 58% of HCs assessed (32 out of 55) during the previous three months have IEC material available for 60%+ of the RH services considered (Birth Delivery, CPN, FP, STI/AIDS and Child Care); 31% of them have IEC material available for 80%+ of the services.
- 82% of HCs assessed during previous three months have 60%+ of required management tools and forms available (45 out of 55); 27% of them have 80%+ of the management tools and forms available.

1.4.1 Availability of Medical Material

PRISM's goal is to support problem resolution in the area of medical equipment, material and supplies at service delivery points. Delivery of such material by an external source is sometimes the only practical solution. This is so either because the items are expensive and/or difficult to find and the facility has too limited resources or is in outright deficit. To address these difficulties, PRISM is progressively providing HCs and hospitals the material considered indispensable to the delivery of quality services but difficult for the facilities to acquire out of their own resources and means. The managerial situation at the service delivery points is also being assessed and addressed in order to identify the factors explaining the lack of materials and supplies that should be present at the site but are not. Replacement of consumable supplies (gloves, chlorine solution, etc) by the facilities should generally be possible through a combination of cost recovery and community based contributions. PRISM is promoting sustainable solutions whenever and wherever they are realistically achievable.

Acquisition and distribution of medical materials and supplies for SDPs in focus zone (1.4.1.4 & 5): During FY01, PRISM purchased and received from the USA \$42,612 worth of medical materials and supplies for the service delivery points of its focus zone. PRISM delivered during the period medical material and supplies to HCs and hospitals in all of the 8 prefectures²¹ on the basis of recent inventories completed in the facilities²². The medical materials were delivered and installed with PRISM assistance via the DRS and DPS administrative channel and, every time feasible, in the presence of representatives of the HC's COGES or of the hospitals' *Comité Consultatif*. With the exception of wicks for kerosene refrigerators, current availability rates are at 100% (or close to) at sites for items supplied by PRISM during the period. Spare wick distribution was ongoing at the end of the period at HCs, especially at those in deficit.

21. Siguiri Prefecture was covered during October 2001.

22. PRISM/MOH inventoried medical equipment, material and supplies at 86 of the 89 HCs (97%) and at the maternity and pediatric services at all 8 hospitals in HG. The three missing HCs' inventories are Hermakono and Kobikoro in Faranah Prefecture (locations near the border with Sierra Leone) and at Babila in Kouroussa Prefecture.

Medical Material Received and Distributed to Facilities in HG October 2000 – September 2001			
Items	Received	Distributed*	Availability at HCs**
IUD Insertion Kits (for hospitals)	0	7	100%
Scales, Salter type (for children)	150	90	100%
Scales, Adult type	25	23	99%
Specula, Vaginal	450	283	100%
Sphygmomanometers	150	99	100%
Stainless steel "haricots" (kits of 3 units)	150	125	100%
Stethoscopes, Medical	150	97	100%
Stethoscopes, Obstetrical	150	115	100%
Surgical gloves (pairs)	15,200	9,800	98%
Thermometers	150	181	100%
Wicks for petrol refrigerators (spare)	75	35	56%

* Some items were already in stock at PRISM prior to the arrival of the medical material was received.

** According to consolidated inventories during last 3 months of the period

Inventory of medical material and analysis of needs (1.4.1.1 to 3): Inventory and situational analysis activities of medical material (including the cold chain) at HCs and at hospitals in HG has been very intense since the beginning of 2001. The results are helping PRISM and the health authorities in the region to address some of the problems identified. These monitoring activities included:

- The inventory of medical material at HCs performed by Measures in January and February 2001;
- The situational analysis of medical material and of the cold chain at HCs and hospitals done by PRISM from March to October 2001;
- Routine inventory of resources at HCs (including medical material and cold chain elements) performed by the prefectures' supervision teams from August to October 2001.

PRISM/MOH recent inventories and situational analysis at HCs Main Findings and Interventions	
<u>Maternal health-related medical equipment/material</u>	
<ul style="list-style-type: none"> - Prior to PRISM delivery of material, more than 60% of HCs did not have vaginal specula, and in-working-condition sphygmomanometer, stethoscope and medical thermometer. After PRISM deliveries, close to 100% of HCs have these material available; - Small surgical instruments (scalpel, scissors, needles, etc) and their boxes are generally missing at HCs. Most maternity kits are incomplete at HCs and at hospitals; - <i>Pelvimètres</i> are missing at 35% of HCs; - Urethra catheter are missing at 71% of HCs; - Most HCs have a gynecological examination table but many don't have a birth delivery table (<i>table d'accouchement</i>). 	
<u>Child care-related medical equipment/material</u>	
<ul style="list-style-type: none"> - 65% of HCs don't have a nasal mucus extractor for new born; 	

PRISM/MOH recent inventories and situational analysis at HCs
Main Findings and Interventions

- Close to half (48%) of HCs don't have the weight/height table for growth monitoring and most (92%) don't have the infant height measuring table;
- After PRISM deliveries, all HCs have at least one child weight scale (salter type).

Infection prevention-related items

- 12 HCs are reported to have no sterilizing equipment (*stérilisateur à vapeur ou cocotte*);
- Most HCs had examination gloves prior to PRISM deliveries – 100% of them do so now;
- Only one third of HCs have chlorinated solution in stock;
- Most HCs don't have a minimal kit of cleaning and maintenance supplies and equipment.

Vaccination and cold chain items

- Spare parts for refrigerator are not always in stock at HCs: 56% of HCs had one wick, 27% had a burner and 25% had a flame protection glass; only 13% had a full kit of spare parts;
- All HCs have ice packs and box to carry them for outreach vaccination activities (68% of them have the RDW25 boxes);
- Only half (53%) of HCs have the required 3 types of syringes but one third of HCs have no syringes at all for vaccination. All 8 prefectures have some HCs with no syringes;
- 8 HCs don't have a refrigerator. Some of the refrigerators are in poor shape and require repair or replacement. Most are not properly installed and as a consequence burn more fuel than necessary;
- One third of the HCs do not maintain a petrol reserve on site for their refrigerator. They purchase it on a daily/weekly basis – making their cold chain extremely vulnerable to fuel stockouts at certified supply points and inferior quality fuel.

PRISM Interventions and Contributions to Logistics Problem Resolutions:

- **Coordination meetings and work sessions held with IRS/DRSs and facilitated by PRISM to resolve medical equipment and supplies and cold chain/vaccination material (1.4.1.3).** The goals of the meetings/work sessions were to share information and agree on PRISM contributions, HCs' autonomous contributions via use of cost recovery revenues, other projects/agencies' contributions and communities' potential contributions. Meetings held in Kankan's prefectures and at the regional level in Faranah.
- PRISM has delivered medical material received during FY01 (1.4.1.5) and is preparing another medical material overseas procurement on the basis of the situation analysis to meet uncovered needs (ex.: *pelvimètres*, surgical instruments, maternal kits, mucus extractors, re-usable syringes and sterilizers).
- Birth delivery table prototype has been developed locally in Kankan and will be produced locally in required number.
- PRISM is currently distributing wicks to deficit HCs and is establishing with the DRSs a sustainable mechanism to facilitate re-supply for HCs. This mechanism will cover burners and glasses.
- PRISM is supporting the integration of COPE in facilities (2.2.2). COPE contributes to resolve logistics problems that can effectively be addressed at the site level and with the community served by the HC.
- PRISM has tailored its PEV refresher course to address the most damaging deficiencies observed. All HCs' PEV agents attended the refresher course²³

23. With the exception of HCs in Siguiiri prefecture where ADRA has trained PEV agents.

1.4.1 Availability of IEC material and Management Tools at HCs

Management tools and forms: The PEV/SSP/ME provides on a routine basis most of the following management tools and forms to HCs through its regional depots. HCs are given an initial kit when they are launched or integrated into the PEV/SSP/ME system. As a general rule, HCs replenish their tools by purchasing them at the PEV/SSP/ME depots. PRISM intervenes regularly at ensuring that forms are available in the system and supplies FP as well as CBD tools. Initial supplies of revised forms have been procured by PRISM when the project is directly involved in the revision effort, as in the case of the revised logistics forms, or will be as in the case of the SNIS registers.

List of Management Tools and Forms Inventoried		
August-September-October 2001		
<i>Cahier d'entretien du Frigo</i>	<i>Echéancier</i>	<i>Fiche de référence</i>
<i>Carnet de santé</i>	<i>Feuille de relevé de température</i>	<i>Fiche de stock</i>
<i>Carnet de soins</i>	<i>Fiche CPN</i>	<i>Fiche Infantile</i>
<i>Carnet de vaccination</i>	<i>Fiche de consultation PF</i>	<i>Livre de caisse</i>
<i>Cartes infantiles</i>	<i>Fiche de croissance infantile</i>	<i>Registre de consultation</i>
<i>Diagramme de maigreur</i>	<i>Fiche de partogramme</i>	<i>Registre SNIS</i>

Management tools and forms are now quite generally available at HCs. About 82% of assessed sites HCs (55) had 60% or more of the tools and forms available while 27% had 80% or more. The only tools missing in most HCs are the *Diagramme de maigreur* and the *Fiche CPN* - both items essential for adequate MCH care services. The SNIS register was available at only half of the HCs. The HCs that had less than 50% of the 18 forms available (6 in the recently assessed HCs) will receive special attention from the DPSs supervision teams.

IEC Material (posters, boîtes à image, leaflets, etc.): PRISM produces and distributes on a regular basis to service delivery points IEC material that it designed or that other agencies and projects have designed. PRISM coordinators assess and correct on an on-going fashion the situation at HCs and with CBD agents and peer educators. IEC material at HCs is becoming more and more available as attested by the fact that 80% and more of HCs have IEC material in FP and STI/AIDS while more than 50% of them have IEC material covering CPN. More work remains to be done as only around 25% of HCs have IEC material on Child Care and on Assisted Birth Delivery, and 42% of HCs are covered in only 2 of the 5 assessed RH services.

Availability of Essential Resources: Monitoring and Evaluation

The availability of essential resources at the HCs was assessed by the DRS/DPS supervisors during the last three months of the year. They were able to inventory resources at most sites, doing so during regular supervision visits. A total of 62 out of 89 HCs were assessed this way²⁴. The supervisors performed the assessment of essential resources using the newly designed "*Fiche*

24. To the information provided by the DRS/DPSs' supervisors, PRISM added recent data from other sources, often internal to PRISM, like IMAT results, trained staff availability, inventories of medical material. This is how the recent situation with essential resources is known for some additional sites in addition to the 62 inventoried by the DRS/DPSs' supervisors.

*d'Inventaire: Disponibilité des Services et Equipement*²⁵, a management tool developed by PRISM during FY01. The results of the inventory of essential resources are summarised in the following table as well as the impact of their availability on the levels of functionality of HCs.

Availability of Essential Resources and HCs' Functionality Level per RH Service (end of October 2001)				
	FP	CPN	Childcare	STI care
Availability of Essential Resources				
Trained staff	85%	100%	100%	100%
Medical material	71%	66%	59%	63%
Drugs	82%	79%	83%	13%
IEC material	89%	55%	25%	82%
Management tools	76%	72%	69%	73%
Average	81%	74%	67%	66%
Functionality Level				
	At % of HCs			
Over 80%: achieved	65%	44%	22%	9%
Target	75%	50%	50%	50%
Over 60%	85%	97%	85%	59%
Less than 60%	0%	3%	15%	41%
Non Functional*	15%	0%	0%	0%
Number of HCs				
Integrated HCs	85	89	89	22
Assessed HCs	69	68	68	22
% of HCs assessed	81%	76%	76%	100%

* non functional because of the non-availability of trained staff (functionality level at those sites = 0%)

Family Planing Services Functionality

The availability of resources essential for FP services was generally high (81%). Over time, especially during the first few years of the project, PRISM has trained numerous providers in FP. Attention to contraceptives management has been continuous and FP-associated IEC material has been made widely available by PRISM. These efforts are reflected in the high rate of availability found for those resources. But the availability of a trained provider at the HC is an absolute functionality criteria. 15% of integrated HCs did not have trained staff at the time of the assessment and, therefore, are not considered functional in FP services. Moreover, only 71% of the essential medical materials were available on average. Infection prevention material and supplies like sterilizers, brushes and chlorinated solution are needed at most sites (a problem for all services, not just FP). Nonetheless, as of the end of the period, a large contingent of HCs (65%) was considered functional in FP services. They had at least one trained provider and an overall availability score of at least 80% for essential resources. 24% are considered only marginally functional and 15% not functional at all. Better management of HR by the DRS and the resolution of key medical material issues, many with PRISM support, will bring the functionality level even higher and increase the number of HCs considered functional for FP

25. See a specimen of the "Fiche d'Inventaire: Disponibilité des Services et Equipement" at annex 1.3.

services.

Pre Natal Consultation Services (CPN):

The availability of resources essential for CPN consultation services was at 74% overall. Availability of CPN trained staff is excellent (100%) while availability of drugs is good (79%). But availability of the other essential resource categories was insufficient, especially for the CPN-associated IEC material (55%). As of the end of the period, 44% of HCs assessed were considered functional for CPN consultation services, while over half of them (56%) were only marginally functional. The distribution of CPN-related IEC material will receive priority attention during year 5 of the project. PRISM will be selecting and developing such material for printing and distribution – this in the context of its upcoming MCH promotional campaign.

Childcare Consultation Services (CS):

The availability of resources essential for CS consultation services was at 67% overall. Availability of CS trained staff is excellent (100%) while availability of drugs is good (83%). But availability of the other essential resource categories was insufficient, especially for the CS-associated IEC material (25%). As of the end of the period, only 22% of HCs assessed were considered functional for CS consultation services, while the rest of them (78%) were marginally functional. As for CPN services, the distribution of CS-related IEC material will receive priority attention during year 5 of the project. That type of material is missing in 3 out of 4 HCs assessed. PRISM will be selecting and developing such material for printing and distribution – this in the context of its upcoming MCH promotional campaign.

Sexually Transmittable Illness (STI) Consultation Services:

The availability of resources essential for STI consultation services was at 66% overall. This is so despite disastrous lack of any STI-related essential drugs at 2/3 of the integrated sites assessed. Moreover, no site had its full contingent of STI drugs. Availability of STI-trained staff was perfect and availability of material and tools was from good to decent. As of the end of the period, only 2 of the 22 integrated HCs (9%) were functional for STI care services. The lack of STI drugs indicates that most HCs had used up the products they received as part of their start-up kits at the time they were integrated. Drugs were not replaced due to a combination of two main factors: their non availability at the regional depots and their replacement cost. PRISM will assist the DRS in implementing a sustainable solution to these problems. On the other hand, 14 of the 22 integrated HCs (64%) are functional, when one considers all essential resources with the exception of drugs. This reflects the fact that with the exception of the essential drugs, all other essential resources were widely available.

AFFORDABILITY OF SERVICES AT SDPs

Main Results

- /v 51% of HCs in HG have a fee board covering all services and products (including birth delivery services) (45/89);
- /v HC's fee broadcast on rural radio in HG;
- /v COGES survey completed and results presented.

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

1.5.1 Promote Equitable access to RH services

Advertise Reproductive Health fee schedule (1.5.1.1)

Radio broadcasting of RH fee schedule: The complete HC services and products fee schedule was presented and explained by the Kankan DRS on rural radio. This interview-type radio presentation will be used again from time to time to advertise the fee schedule.

Provision of a revised fee schedule board to HC/HP: PRISM and the Kankan DRS designed and pre-tested a new fee schedule board for services and products to be posted at HCs in HG. A total of 45 of them were installed at HCs by the end of the year26.

Promotion and support of MURIGA (1.5.1.3)

MURIGAs are mutual type organizations formed by members of a community to facilitate referral of women at risk during birth labor. They are an integral part of the Guinean Safe Motherhood Promotion Strategy. Effective MURIGAs could be expanded to cover other community health needs beyond referral associated to pregnancies. PRISM interventions to support the national safe motherhood strategy at the community level focus on three prefectures: Kankan, Faranah and Kerouane. Here is the description of activities and interventions in favor of the creation of MURIGAs completed or initiated during FY 01:

- PRISM sponsored the participation of 2 of its coordinators (one Community Institutional Development and one IEC) and 2 AGBEF technical staff (including the Kankan regional coordinator) in the UN/ILO 1 week course in Dakar, Senegal, on the promotion of mutual health organizations. Since then, these public health professionals have been leading the support activities to the creation of Murigas in Haute Guinée, especially in the three prefectures targeted by PRISM. They started this effort by presenting the concepts, current structure and experiences learned associated with mutual health organization in the African context to key government staff in HG responsible for promoting, supporting and monitoring such organizations in the three targeted prefectures.
- Inventory of HMOs in existence in HG (1.5.1.3.1): PRISM Coordinator visited Dabola and Mandiana prefectures where such activities have been initiated for some time already.

26. PRISM performance indicator 1.1. See annex 1.1 for additional details on the indicator. See detailed list of HCs with the new fee schedule board at annex 1.6.

- The Kerouane and Kankan "Directeurs des Micro-Réalisations (DMR) accompanied him.
- Establishment of an active partnership with ILO/STEP: Support activities in favor of Muriga are implemented in partnership with the International Labor Organization unit focusing on HMOs, called STEP, recently established in Guinea. STEP is providing regular complementary technical assistance to our program and is funding some of the community assessments and training sessions.
 - Selection of 6 "sous-préfectures" (with their HC) for the first cohort of Muriga to promote and support: CSU Salamani and CS Titioulen in Kankan; CSU Marché and CS Marella in Faranah; CSU Kerouane and CS Konsankoro in Kerouane.
 - Organization of an "Information Day" on HMO/Muriga at 5 of the 6 selected sites²⁷. During these special presentations, the members of the "*Comité d'Initiative*" were identified as well as other local resources. Local plans were also drawn.
 - Training of the Muriga promoters (members of the *Comité d'Initiatives*) from 5 of the 6 selected sites and from the 3 prefectures in HMO governance, monitoring and management. PRISM, STEP, and the prefecture's DMRs performed the training session.

During the coming year, PRISM will first facilitate community-based decision making regarding funding approaches and levels, the control mechanism, and on the services covered. This will lead to the launch of the Murigas' governing and monitoring bodies, the start of participation fees collection (cotisation) from members, and the initial maternal referral activities. We expect to see the first Murigas in operation before the end of March 2002.

1.5.2 Increase community participation in the management of the HCs

Support activities to strengthening COGES (1.5.2.1):

PRISM Survey of COGES: The COGES survey was completed at 24 HCs in the Faranah and Kankan regions at the beginning of FY01. The data was analysed and presented for review to a panel of 12 professionals involved in community-based initiatives promotion. The DMRs of each of HG's 8 prefectures were present. The main goal of the review was to define/validate a set of strategies and approaches to strengthen COGES. Here are the COGES survey's main findings over and beyond what was expected:

- 52% of COGES members were trained in relation to their role usually at the launch of the HC serving their community – sometimes more than 10 years ago.
- 28% of the members were never trained at all in relation to their role on the COGES.
- Respondents indicated that youth and women need to be represented in the COGES and that their active participation in its activities is critical to the success of the HC.
- All DPS staff believe that it is essential to renew the COGES membership at all concerned HCs.
- 55% of the community members said they don't know what the COGES is.
- 56% of COGES members have a good understanding of the "*indigent*" (a non-seasonal

27. It has not been possible to organize specific promotional activities concerning the Muriga creation around the CSU Salamani in Kankan. PRISM with Kankan DRS/DPS decided to remove Salamani from the current cohort and replace it with Batenafadji, also in Kankan prefecture. Promotion of a Muriga appears to present problems in a large urban center like Kankan, where Salamani is located.

IR1. Increase ACCESS: Affordability of Services at SDP

poor person) notion and who they are in their community.

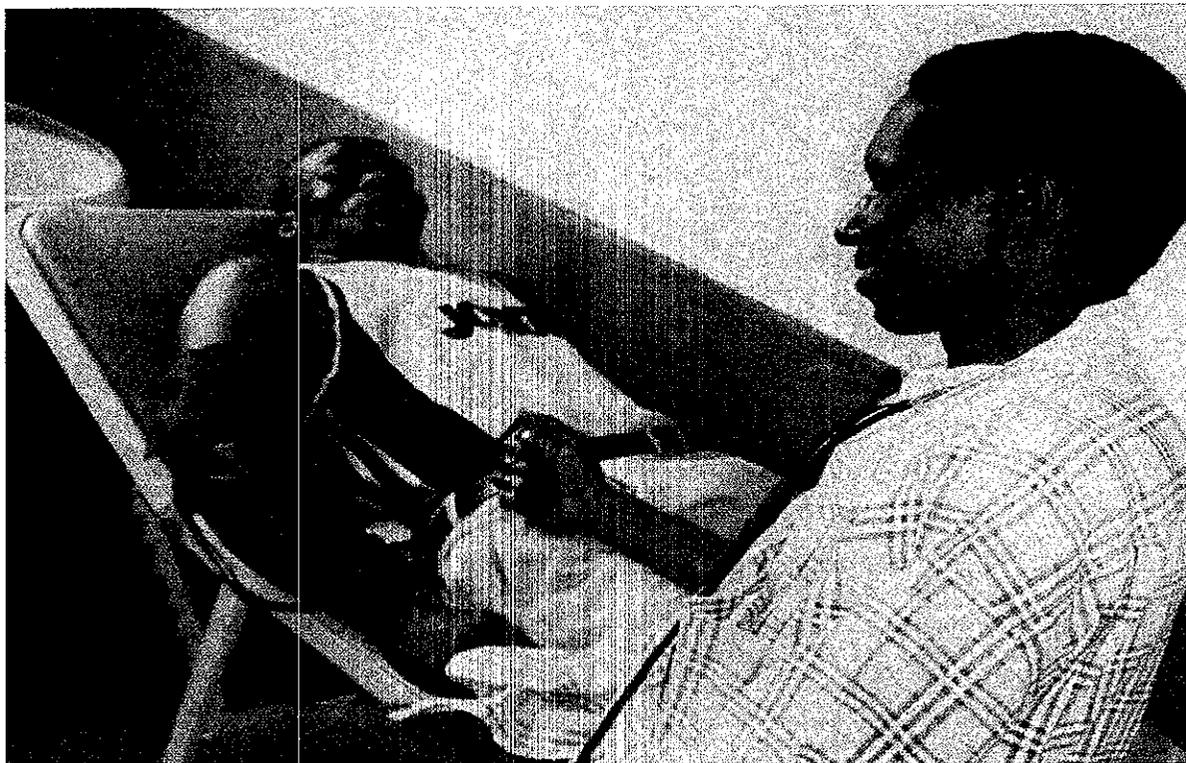
The panel members identified and discussed the results and devised strategies to address the needs. The following table presents selected items.

<p><u>COGES Strengths</u></p> <ul style="list-style-type: none"> ▪ Membership on the COGES is positively perceived by the community ▪ Scope of work (SOW), roles and responsibilities are formally described for each position on the COGES ▪ Unanimity on the active participation of youth and women representatives 	<p><u>Strategies to preserve and use Strengths</u></p> <ul style="list-style-type: none"> ▪ Improve COGES members capabilities via training in relevant subjects and facilitative supervision ▪ Inform community members on COGES position SOWs, roles and responsibilities via promotional and mobilization activities ▪ Support community decision making processes leading to selection of representatives for youths and women
<p><u>COGES Weaknesses</u></p> <ul style="list-style-type: none"> ▪ Members' lack of motivation ▪ Lack of COGES monitoring and supervision ▪ Lack of effective internal planning and monitoring tools at HC/COGES 	<p><u>Strategies to surmount weaknesses</u></p> <ul style="list-style-type: none"> ▪ Renew COGES membership on clear basis to avoid false expectations and disappointments ▪ Specific training of members; host members from other COGES; public recognition locally and on rural/national radio; mini grants to HCs with effective COGES ▪ Mobilize the supervision units already in place at the prefecture and sub prefecture levels to support and monitor COGES. ▪ Integration of COPE at the HC and insertion of COGES members on the COPE team.
<p><u>Opportunities</u></p> <ul style="list-style-type: none"> ▪ Existence of a national policy on community participation in the HC management ▪ Community members' motivation toward achieving better health 	<p><u>Strategies to capitalize on opportunities</u></p> <ul style="list-style-type: none"> ▪ Test adaptations to the policy in action and provide recommendations to policy makers ▪ Facilitating true community participation via tested mobilization approaches
<p><u>Threats against COGES</u></p> <ul style="list-style-type: none"> ▪ HCs belong de facto to HHC instead of belonging to the community ▪ Disinterest of supervision units at prefecture and sub prefecture level 	<p><u>Strategies to overcome threats</u></p> <ul style="list-style-type: none"> ▪ Facilitate processes leading to COGES with legitimate and credible membership in the view of community members ▪ Accompany COGES in its functions and demonstrate benefits to all parties ▪ Train and assist DMRs and sub pref.staff

During the 1st quarter of FY02, feedback sessions on survey results at the community level will be part of PRISM's community mobilisation activities in favour of their HC's COGES "redynamisation" interventions. The development of the scope of work for local NGOs' "Organisation Relais" to strengthen COGES and the subcontract(s) award will be implemented by the end of 2001.

WORK TOWARD THE INTERMEDIATE RESULTS (IR)

IR2: Improve QUALITY



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

Quality Standards and Services:

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

H/MIS:

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

RH QUALITY STANDARDS, SUPPORT SYSTEMS and SERVICES

2.1 Reproductive Health (RH) Norms & Procedures (N&P)

During FY01, PRISM continued to work with the framework of the national RH Norms & Procedures. Earlier, PRISM had participated in updating and distributing this document and training regional and prefecture staff as well as HHCs in its use. No new activities were planned for the 4th year of the project.

PRISM will join other partners, like the UNFPA and the World Bank project PPSG, during 2002 in updating with the MOH the 1998 version of the reproductive health Norms and Procedures. We expect this exercise to be completed by mid year and the new version of the N&P document to be available for dissemination at the June-July CTPS/CTRS meetings. In parallel, PRISM will update when necessary the various training modules on the basis of the revised RH N&P. However, in many instances the modules already include many of the anticipated changes. The training modules will in fact serve to support the N&P updates.

2.2 Strengthening Quality Improvement Support Systems

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

Main Results
<ul style="list-style-type: none"> /▫ Training of 22 HHCs in Team (Human Resources) Management, bringing the total to 62 trained HHC out of 89 in HG. /▫ 28 DRS/DPS supervisors trained in COPE facilitation. /▫ 17 DRS/DPS supervisors trained in Facilitative Supervision. /▫ COPE integrated in 19 facilities: 4 maternity services, 5 pediatric services and 10 HCs. /▫ Integrated HC services delivery monitoring tool developed and in use at all HG DRS/DPSs. /▫ 338 consultations observed at 62 HCs and reported on by DRS/DPS supervisors during last quarter.

2.2.1 Train Human Resource (HR) managers in Team Management

Training of Heads of HCs in HR management (2.2.1.1): PRISM and the MOH trained 22 Heads of HC in human resources management (team management) during the year. This brings

the total number of HHCs trained in Team Management to 62 out of 89 (70%) in HG. PRISM will train all the remaining 27 HHCs before the end of year 2001 if possible. The training session planned for early November has been cancelled because of the November 11 referendum on the constitution. The training in Team Management is done through a session during which ED&C is also covered. For additional details on the activity, please refer to section 1.1.1 of this report.

Training of hospital and of DRS/DPSs' managers in HR management (2.2.1.2): By the beginning of FY01, PRISM had already trained 12 hospital and DRS/DPS managers in HR management. Plans to train an additional group of managers during FY01 had to be postponed because of budgetary constraints in mid 2001, the limited availability of these managers later in the year and other factors like the "*Journées Nationales de Vaccination*" in October. Training will be completed as early as possible during FY02. In addition to having 2 trained senior staff per hospital and DRS/DPS, PRISM will ensure also that all heads of hospital maternity services and paediatric services are trained in HR management.

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

COPE (Client Oriented Provider Efficient) is a simple process used on a continuous basis by site staff to improve the quality of services through self-assessment. COPE is used jointly by all levels of staff and supervisors to identify and solve problems related to the quality of services at a given site. COPE includes self-assessment guides, medical records review tools, client interviews, community interviews, and client flow analysis to identify problems and develop an action plan with solutions to the problems identified. Experience has shown that COPE works best when used as part of a quality improvement package rather than in isolation. Site or service supervisors are the most appropriate persons to introduce COPE, and it is best done using a facilitative supervision approach. In general, staff members are capable of resolving 60-70% of the problems identified without need for additional outside resources. However, some of the problems identified do require additional resources to resolve. Facilitative supervision is needed to assist staff in resolving these kinds of problems.

Facilitative supervision is a managerial approach whereby supervisors at all levels of a system focus on the needs of the staff they oversee. Supervisors consider staff as their primary customers. Their most important role is to enable staff to manage the quality improvement process to meet the needs of their own clients, and to implement institutional goals. This approach emphasizes mentoring, joint problem solving and two-way communication between supervisors and those being supervised. The supervisor serves as liaison between the staff and sources of external support.

Train DRS/DPSs team members in COPE facilitation and Facilitative Supervision (2.2.2.1 & 2): The objective of this activity is to provide DRS/DPS's supervisors with the knowledge and practices required to implement interventions at the HC that effectively support and complement the local efforts at improving the facility's services. PRISM's vision, shared with several key staff at the DRS level and at the MOH central level, is that the supervisors of the DPSs truly become technical assets for and team members with the HCs' staff as well as with the COGES and other community stakeholders in the facility's overall success. The supervisors are trained through a rational sequence of formal training sessions and guided fieldwork interventions.

COPE integration, monitoring and support at DRS/DPS levels: PRISM, in collaboration with AVSC/EngenderHealth, launched early in FY01 its support activities for the integration of COPE in its target zone, developing in the process a regional cadre of COPE facilitators. A total of 28 supervisors were initiated to COPE integration and facilitation techniques (15 from the Faranah region and 13 from Kankan). The supervisors were trained in COPE facilitation through COPE integration at sites and, during the following quarters, through COPE monitoring at integrated sites and COPE integration at additional sites (learning by doing). Importantly, each COPE facilitator developed his/her own COPE monitoring workplan and integrated it into the supervision program of the DRS/DPS concerned.

Training and Support in Facilitative Supervision: PRISM, again in collaboration with AVSC/EngenderHealth, trained 17 IRS/DPS supervisors coming from the 8 prefectures of HG in Facilitative Supervision (FS) techniques and practices. The training helps supervisors implement supportive interventions, especially on-the-job training, during their visits to SDPs in their region or prefecture. The FS training session is a 1-week course covering the following topics:

- *FS and quality of services*
- *Motivation of the SDP staff*
- *Characteristics and skills of a competent supervisor*
- *Counseling in the context of the client's rights*
- *Whole-site training approach*
- *Medical/clinical supervision*
- *Constraints on supervision activities*
- *Introduction to COPE*

PRISM and EngenderHealth technical assistants provided regular on-the-job training in Facilitative Supervision to DPS supervisors during the period. This process will continue during year 5 of the project.

Integration of COPE in HCs and hospital services (2.2.2.3): The DRS/DPS supervision teams integrated COPE into the following facilities with the help of PRISM and EngenderHealth technical assistance. All COPE integration activities occurred during FY01.

COPE INTEGRATION	
Where	When
<u>Faranah Region</u>	
1. CSU Faranah (Marché)	FY01 – 1 st quarter (4 th quarter of 2000)
2. CS Dialakoro in Dinguiraye	FY01 – 1 st quarter (4 th quarter of 2000)
3. CS Bissikrima in Dabola	FY01 – 1 st quarter (4 th quarter of 2000)
4. Maternity Service at Faranah Hospital	FY01 – 1 st quarter (4 th quarter of 2000)
5. Pediatric Service at Dabola Hospital	FY01 – 1 st quarter (4 th quarter of 2000)
<u>Kankan Region</u>	
6. CSU Kankan (Salamani)	FY01 – 2 nd quarter (1 st quarter of 2001)
7. CSU Kouroussa	FY01 – 2 nd quarter (1 st quarter of 2001)
8. CS Titoulin in Kankan	FY01 – 2 nd quarter (1 st quarter of 2001)
9. CSU Mandiana	FY01 – 4 th quarter (3 rd quarter of 2001)
10. CS Koumana in Kouroussa	FY01 – 4 th quarter (3 rd quarter of 2001)
11. CS Konsankoro in Kerouane	FY01 – 4 th quarter (3 rd quarter of 2001)
12. CS Kitinian in Siguiri	FY01 – 4 th quarter (3 rd quarter of 2001)
13. Maternity Service at Kankan Hospital	FY01 – 2 nd quarter (1 st quarter of 2001)

COPE INTEGRATION	
Where	When
14. Pediatric Service at Kankan Hospital	FY01 – 2 nd quarter (1 st quarter of 2001)
15. Maternity Service at Mandiana Hospital	FY01 – 4 th quarter (3 rd quarter of 2001)
16. Pediatric Service at Mandiana Hospital	FY01 – 4 th quarter (3 rd quarter of 2001)
17. Maternity Service at Kouroussa Hospital	FY01 – 4 th quarter (3 rd quarter of 2001)
18. Pediatric Service at Kouroussa Hospital	FY01 – 4 th quarter (3 rd quarter of 2001)
19. Pediatric Service at Kerouane Hospital	FY01 – 4 th quarter (3 rd quarter of 2001)

Each of the targeted facilities established their COPE team in which all staff members are encouraged to participate. The COPE teams developed an internal problem resolution workplan aimed primarily at improving client rights compliance and quality of services delivered. We were pleased that key members of the communities served by these facilities, whether they were COGES members or not, chose at most sites to participate actively in the COPE team process. This is something PRISM has been encouraging, as we believe this kind of participation is crucial in strengthening the links between the facility's workers and the population served.

As of the end of the year, COPE had been introduced in a total of 19 service delivery points: at 4 of the 8 hospital maternity services, in 5 of the 8 hospital pediatric services and in 10 HCs. The end of next year target is to have COPE integrated in the remaining 4 maternity services, the 3 remaining pediatric services and in at least 2 HCs per prefecture (6 remaining HCs). These targets are achievable as DPSs can sustain integration of COPE at 13 facilities with PRISM support (compared to 19 in FY01). The challenge for the DPS supervision teams will be to monitor and support adequately the COPE process at all integrated facilities. Performance range is already wide in that regard. Some DPS are doing very well and have become committed to COPE. But some other DPSs have a rather inconsistent or low performance level. These various situations are currently being addressed by PRISM with the DRSs. PRISM, in agreement with USAID and the DRSs will proceed with further integration of COPE at a rhythm compatible with the individual DPSs' capacity.

Support DRS/DPSs Supervision Activities Delivery (2.2.2.4): Strengthening supervision capacity of the MOH decentralized support units is a core element of PRISM's strategy to improve the quality of reproductive health services at HCs. PRISM organized with both DRSs a series of coordination meetings dedicated to the DPSs' supervision activities management and support. By the end of the third quarter of the year the process had been engaged with all 8 DPSs of HG. The main objectives of these supervision review meetings with DPSs were to:

- Clarify the various supervision concepts and approaches (FS, SIF, On-the-job training, post-training monitoring, *monitorage*);
- Define the profile of the DPS supervision team;
- Identify the team's strengths and weaknesses;
- Define the facilities priority needs in term of support and supervision;
- Develop an initial 3 months supervision plan and budget.

As a result of these discussions PRISM has now negotiated and signed a *Convention de Partenariat* for supervision support with the 8 DPSs of HG. Via these conventions, the DPSs have access to PRISM specialized technical assistance in facilitative supervision, to occasional

logistics assistance and to modest budgetary assistance for the implementation of meaningful supervision visits to HCs, especially remote ones. It is understood that the performance of the supervisory team and the DPS in implementing supervision activities will condition future support from PRISM. During the last quarter of the fiscal year, all 8 DPSs were engaged in facilitative supervision and monitoring and evaluation visits at their HCs.

Improve RH supervision checklists and other integrated tools (2.2.2.5):

Service Delivery Observation Form: During the second half of FY01, PRISM developed and tested, in collaboration with the Kankan DRS, an observation form for four of the main reproductive health services delivered at HCs. These are CPN consultations, STI care, childcare and preventive health services, and FP consultations. The design of the observation form allows it to be used by providers as a checklist of what should occur according to N&P during a consultation. With the exception of childcare services for which the observation form is based on IMCI guidelines, the observation forms are hence based on the Guinean national RH norms and procedures. The questionnaires developed by MEASURE for the January 2001 situational analysis were also a major source of inspiration for this exercise. The resulting observation form, called "*Fiche d'Observation Client-Prestataire*"¹ was presented and explained to all the DPSs during the July CTRS meetings. PRISM collected the inputs, finalized the draft and sent the observation form to all DPSs. The Service Delivery Observation forms were in uses at all of HG's DPSs during the last three months of the period.

Facilitative Supervision Observation Form: As part of the training of supervisors in Facilitative Supervision, PRISM introduced a monitoring tool to assess the situation and progress over time of the individual supervisor's performance. The FS Observation Tool² is designed to be used also as a checklist to help the supervisor prepare and implement an intervention at a HC or at another type of service delivery point. DPS supervisors can use the tool to observe and provide feedback to a teammate. PRISM and DRSs are using the tool to assess performance of the DPSs in supervision.

Monitoring & Evaluation: Improving supervisory capability

Observations by supervisors of service delivered at HCs: The number of consultations observed and reported by the DPSs over time represents a clear indicator on the regularity of facilitative supervision activities. The service delivery observation form was introduced recently by PRISM and the DRS and we have data on the last three months of the project's 4th year (August to October 2001). This data is presented in the following table.

A total of 338 observations were made at 62 HCs by the DPSs' supervision teams since the Service Delivery Observation Form was introduced in July 2001 (see following table). Most DPSs were able to perform between 30 to 49 observations. The Kouroussa DPS made a total of 99 observations, covering in the process 11 out of its 12 HCs during the quarter. The Dabola DPS supervision team made only 8 observations during the same period, at 6 of its 9 HCs. This is a very modest number indicating that time spent at each site was too limited. The situation calls for

1. See the service delivery observation form "*Fiche d'Observation Client – Prestataire*" at annex 2.1.
2. See the facilitative supervision observation form at annex 2.2.

the Faranah's DRS to review it with the DPS. PRISM anticipates that the number of observations will stabilize at a certain level, yet to be determined, with annual peaks around the end of the FY and also, hopefully, at the end of calendar year.

**Number of Observed Consultations Processed for FY01 Compliance Rate
Computation**

Observation made during period July-October 2001*

Region	Prefecture (# of HCs)	CPN	IST	Child Survival	PF	Total
Kankan	Kankan (6/16)	16	6	13	7	42
	Kérouane (6/8)	14	7	17	9	47
	Siguiri (7/14)	17	2	16	0	35
	Kouroussa 11/12)	38	15	35	11	99
	Mandiana (4/10)	9	7	8	4	28
Faranah	Faranah (6/12)	14	8	14	6	42
	Dabola (6/9)	8	0	0	0	8
	Dinguiraye (6/8)	11	2	23	1	37
Total	(at 62 out of 89 HCs)	127	47	126	38	338
		38%	14%	37%	11%	100%

* A few observations were made during July 2001.

STI and FP services represent a modest percentage of the services observed at HCs. This was not unexpected though for two reasons. The small number of integrated HCs (22 out of 89) explains in itself the limited number of observation made of STI care services. We know for a fact that STI care services are also delivered at certain non-integrated HCs (observations were made at 19 of these) but many HCs don't offer this service at all (no observations were made at 26 HCs). One revealing fact is that, on average, close to 2 STI care observations were at integrated HCs – a rate close to the average for CPN and CS observations. On the other hand, when one considers the fact that FP services are integrated in almost all HCs in HG, one has to conclude that the modest number of observations made for FP services has to be explained by the modest use of that service at HCs by the population. The modest number of observation is in line with the number obtained during other monitoring and evaluation activities³.

PRISM has clear indications and partial confirmation that supervisors provided ample feedback to providers during their visits to HCs and shared the form/checklist with them. Analysis of results shows steady progress in compliance rates for multiple observations made of the same service at the same site. This aspect will be more systematically assessed during coming quarters, while the monitoring tool will become more firmly established.

Post training monitoring of DPS staff in Facilitative Supervision: Post training monitoring of supervisors in Facilitative Supervision was initiated by PRISM immediately after the completion

3. As an example of this, the January 2001 Measure survey was able to observe only 49 FP consultations at 89 HCs visited – this while the evaluators spent 2 days at each sites.

of the training session in February 2001. Supervisors from Dabola, Dinguiraye and Faranah prefectures were monitored during the weeks immediately following the training. Due to the funding problems during the period May to July, post training monitoring of FS was done at a modest level compared to what was planned. Monitoring visits planned for the Kankan region's prefectures had to be cancelled with the exception of Siguiiri. Good FS is key to better quality of services at the HC. Post-training monitoring in FS will continue during year 5 of the project.

Results from the FS monitoring interventions point in the right direction as demonstrated in the following table. The PRISM Coordinator for Supervision Activities and Systems provided feedback to DPS supervisors during post-training monitoring in Infection Prevention with providers.

Supervisor*	Prefecture	Site supervised	Compliance rate of supervisor	Compliance rate of site in IP
Supervisor #1	Faranah	CS Marella	50%	23%
		Hosp. Maternity Svce.	50%	56%
Supervisor #2	Dinguiraye	CS Selouma	55%	26%
		CS Dialakoro	85%	13%
Supervisor #3	Dabola	CS Kindoye	50%	22%
Supervisor #4		CSU Dabola	45%	32%
Supervisor #5	Siguiiri	Hosp. Maternity Svce	90%	68%

* Identity of supervisors observed is available on request at PRISM and at Faranah DRS.

We note the remarkable progress made by supervisor #2, after he received feedback from the observer following his supervision at CS Selouma. But compliance rates in FS are often low and still need to improve. Additional post-training monitoring activities will be necessary to obtain adequate compliance rates. Infection Prevention observed compliance rates are discussed in section 2.3.3.

2.3 Improve the Quality of RH Services Delivered

Main Results

- 62 PEV agents refresher-trained in PEV services and child growth monitoring (83% coverage of HG);
- 27% of child survival services observed during last three months complies with N&P (target was 10%);
- 37 CPN agents refresher-trained in CPN-Partogramme (98% coverage of HG);
- 43% of CPN consultation services observed during last three months complies with N&P (target was 10%);
- 49 providers from hospital maternity services trained in infection prevention;
- PAC services integrated at 3 hospitals in HG (12 hospital maternity providers trained in PAC);
- 28% of STI care consultations observed during last three months complies with N&P (target was 20%);
- 63% of FP consultations observed during last three months complies with N&P (target was 15%).

2.3.1 Strengthening Child Survival (CS) Services at SDPs

The PRISM strategy for improving child survival services at service delivery points, especially at HCs, is twofold: improve HCs' PEV providers and Child CPC providers practices according to Guinean National N&P and support the adaptation and progressive introduction of clinical IMCI in Guinea. IMCI implementation in a country generally takes on average about 2 years from the national orientation workshop to the first delivery of childcare services using the approach. The process in Guinea is proving to be longer than that average. Accordingly, PRISM with the agreement of USAID and the MOH, launched during FY01 a series of interventions tailored at improving compliance rates with N&P of childcare services at HCs while supporting and preparing the ground for clinical IMCI.

Update the PEV/SSP/ME training modules for HCs' childcare services: PEV providers (2.3.1.5.3): A panel of regional trainers and PRISM technical staff updated the PEV agents' training modules that have been in use for many years by the PEV/SSP/ME. The material was then organized as a refresher-training course. The refresher-training curriculum focuses on the skills and knowledge needed by the PEV agents to fulfill their main responsibilities in the area of Child Survival. These are:

- i) The PEV targeted diseases;
- ii) The immunization norms and standards;
- iii) The implementation of immunization activities in situ and during outreach activities (advance strategy);
- iv) Cold chain management (monitoring and maintenance);
- v) Growth monitoring of children 0-5 years old.

Refresher training of HCs' PEV providers in child survival (2.3.1.2.1): Refresher training

courses targeting PEV providers started in March and were completed by the end of the project's 4th year. A total of 62 PEV agents attended the course offered by PRISM, representing a coverage of 83% of all the HCs in HG with the exception of Siguiri prefecture, where another partner performed a similar training. The participants came from the HCs of Keroune (8 out of 8), Kankan (15 out of 16), Dinguiraye (8 out of 8), Kouroussa (12 out of 12), Mandiana (8 out of 10), Faranah (11 out of 12) and none from Dabola⁴. The refresher courses were followed by port-training monitoring visits done by the prefectures' supervision teams, sometimes accompanied by PRISM technical staff (2.3.1.4.3).

During the next period, PRISM will refresher-train the CPC providers of all HG's HCs in child illness care. We will use an updated version of the PEV/SSP/ME module as the basis of the course in all prefectures with the exception of Dabola and Mandiana, where IMCI is to be introduced in early 2002. A radio distance learning series is in development and broadcasts on HG's rural radios will start during the 1st quarter of 2002. Some of the series episodes will cover child survival topics. Finally, facilitative supervision of providers by the DRS/DPS in child survival skills will continue as well as monitoring of compliance rates of services delivered.

Monitoring and Evaluation: Compliance rates for Child Survival services delivered at HCs

Child Survival services delivered at the HCs in HG were observed and reported on by the DRS/DPS supervisors during intense monitoring activities deployed during the last three months of the period. A total of 126 observations were made during that time in 42 HCs located in 7 prefectures. Here are the main findings of these monitoring activities⁵.

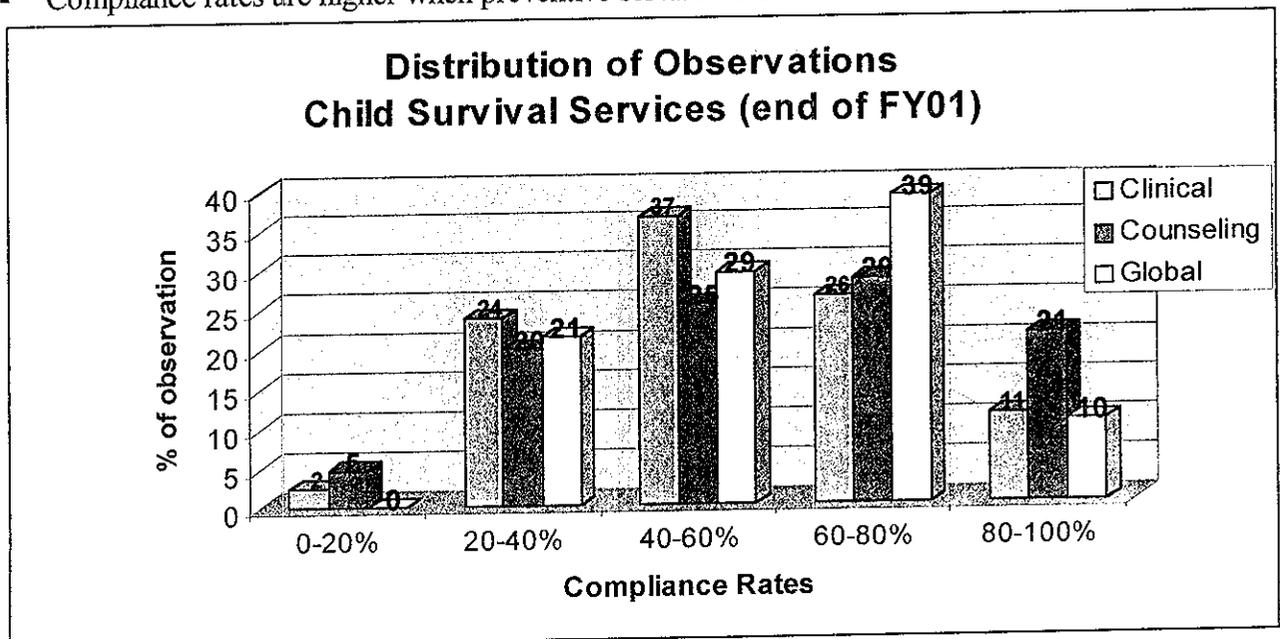
- The % of children treated at HCs in HG for which the compliance rate to the National N&P was equal or greater than 60% - the so-called "green zone"- has progressed from 8% in early 2001⁶ to 27% during the last 3 months of the year. It is important to note that these are the services for which compliance rates were in the green zone for both the clinical and the counseling aspects. While 49% of CS service observed at the end of FY01 had a compliance rate equal or superior to 60% (see following chart), a little over one fourth of Child Survival services observed were considered in compliance with the N&P.
- Compliance rates are higher for the counseling components of the CS services compared to the clinical components: 50% in the green zone compared to 37% (see following chart). This was expected as the refresher course for the PEV providers was attended by most of them already and counseling represents a major part of it.

4. PEV providers from HCs of the Dabola prefecture were not available at the time the refresher course was held. They will be trained as early as possible during year 5 of the project.

5. PRISM performance indicator n° 2.3. See annex 1.2 for additional details.

6. According to our secondary analysis of the data collected by Measure during the Situational Analysis performed in January 2001.

- Compliance rates are higher when preventive service observations are isolated from curative



service ones. 43% of observed children received preventive care in compliance with N&P while only 33% of observed children did so when treated for illness (curative care). PRISM anticipates progress with child curative care services' compliance rates after the launch of the refresher courses in November-December 2001.

2.3.2 Strengthening Maternal Health Services at SDPs

Adapt EMCH training curricula for HC – CPN/Partogramme curriculum (2.3.2.5.2)

With the support of PRISM, a panel of regional trainers prepared the CPN agents' refresher-training curriculum. The panel included the Head of Training of the 2 DRSSs, the Kankan Regional Hospital gynecologist, the midwife in charge of training at the "Centre de Formation en Santé Communautaire de Kankan", and the PRISM MCH Coordinator and QoC Advisor. The PEV/SSP/ME training modules were used as the basis for the adaptation of the refresher curriculum. The curriculum covers ante- and postnatal consultation and the use of the *partogramme* (WHO birth delivery algorithm) for safe delivery practice. Altogether, the curriculum covers the following 11 themes, grouped into 6 modules:

1. Communication for behavior change in maternal health
2. Antenatal consultation
 - 2.1. Risk factors associated to pregnancy
 - 2.2. Preventive care during pregnancy
3. Birth delivery
 - 3.1. The algorithm, including referral practices as necessary
 - 3.2. Neonatal care
 - 3.3. Post delivery complications
4. Postnatal consultation and referral
5. Maternal health and infection prevention (IP)
 - 5.1. IP and the provider

- 5.2. IP and the client
- 5.3. Sterilization of medical equipment and material
6. Supervision of the Traditional Birth Attendant

The curriculum was tested during the 1st refresher training session of CPN agents and finalized in time for the second session.

Retrain/ Update HC staff in CPN-Partogramme MH (2.3.2.2.1)

During the second half of FY01, the DRSS organized, with PRISM, the refresher training sessions of 37 HC's CPN providers in *CPN/Partogramme*. The participants came from the HCs of Dabola (9 out of 9 HCs), Faranah (12 out of 12 HCs), Dinguiraye (8 out of 8 HCs) and Kankan (8 out of 10). As of the end of FY01 only 2 CPN agents from Kankan prefecture remain to be updated in *CPN/Partogramme* in HG. PRISM has covered 100% of the Faranah Region's needs and conducted refresher training with 8 out of the 10 CPN agents that had not been retrained recently by the DED⁷ in the Kankan Region.

Training of Maternity Staff in Infection Prevention (2.3.2.2.1 & 3): During FY01, PRISM implemented three training sessions in Infection Prevention (IP) for HG's hospital maternity services staff. A total of 49 providers, mostly obstetricians/gynecologists and midwives, were trained in IP. As of now, every maternity service in PRISM's intervention zone has trained staff members in IP. This has been achieved through the partnership with JHPIEGO for the Post Abortion Care services integration in HG and through the subcontract with EngenderHealth for strengthening supervisors' capacities⁸. They are expected to correct inadequate situations and implement better practices at their maternity services as well as helping out the HCs staff to do likewise via the facilitative supervision visits which they participate in. The IP training session was a 1-week course covering the following topics:

- i) Critical importance of IP for the health of the clients and providers
- ii) Aseptic practices and products
- iii) Management of pointed and sharp instruments
- iv) Sterilization techniques
- v) Decontamination
- vi) Waste management
- vii) Regular and basic cleaning of the facility

Infection cases are a major problem at SDPs in Guinea and IP is weak throughout the primary health care system. The IP course was and continues to be urgent. However, it is only a first step in the process of ensuring that IP knowledge is translated into better practice. IP practice will gradually improve over time, provided that training is followed up with sustained quality supervision. The importance of supervision is underscored by the post-training monitoring⁹ data captured by the project during FY01. The data shows that, despite the large-scale training in IP, improvements are inadequate at the two maternity services assessed. The compliance rates in IP

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

8. Hospital maternity services' staff members are part of the prefecture's health supervision team that visits HCs.

9. For details, see data in the table included in the second part of the monitoring sub section of section 2.2.

at HCs range from 13% to 32% only, while the rates for the maternity services are respectively 56% and 68% for Faranah and Siguiri. PRISM will continue to participate in and support on-the-job training activities and facilitative supervision to improve compliance rates in this important aspect of quality of care.

Adapt EMCH training curricula for HC – Community Health Promoters in Safe Motherhood & Training of Trainers (ToT) (2.3.2.3.2)

With the support of PRISM's technical staff, a group of community health specialist from the project's target zone developed the Community Health Promoter in Safe Motherhood training curriculum. This group included three DPS's "Chargé SBC", the Kankan Regional Hospital principal midwife, the "Chargé SR" from the Faranah DPS and PRISM staff. The main goal of the course is to educate the promoter in informing the members of their community on best practices to reduce maternal mortality and morbidity. Their role is threefold: 1) encourage pregnant women to visit the HC for the three recommended antenatal consultations, 2) stress the importance of utilizing a trained health agent during delivery/birth, and 3) support community mobilization in favor of referrals for women at risk during labor. The curriculum is designed for illiterate promoters – an important step in allowing more rural women to become effective maternal health promoters. It will be tested during the 1st quarter of FY02.

The course designers also initiated the group of 13 trainers who will be responsible for training the promoters. They are 5 Heads of HCs, the "Chargé SBC" from Faranah, Kankan and Kerouane, the IRS officer in charge of promotion in Faranah, the DPS officer in charge of traditional medicine in Faranah, the DPS officer in charge of health education in schools, and 2 HCs PEV agents.

Training of promoters will start during the next period. The promoters will come from the three prefectures targeted by PRISM in support of the implementation of the National Policy for Safe Motherhood - Kerouane, Faranah and Kankan.

Integrate PAC services in Maternity services in 3 MSR prefectures (2.3.2.2.5)

During FY01, the MOH/DSR, PRISM and JHPIEGO initiated the joint implementation of a program aimed at strengthening Post Abortion Care (PAC) at three Hospitals in the PRISM target zone: the regional hospitals in Faranah and Kankan and the prefecture hospital in Kerouane. The activities included in the program are:

- Needs assessment at the three hospitals (completed);
- Training in Infection Prevention (IP) of the maternity services staff (see description in subsection covering IP training on the previous page);
- Update in Contraceptive Technology (completed for 9 out of 15 providers);
- Post training monitoring in IP and in FP (on-going);
- AMIU (*Aspiration Manuelle Intra Utérine*) training at Donka University Hospital (completed for 12 out of the 15 targeted providers);
- Post training monitoring in AMIU (1st quarter of FY02).

The **needs assessment at the 3 hospitals** and the training in IP were performed during the 3rd quarter of FY01. The main findings of the needs assessment are as follows:

- ◆ Insufficient staff at 2 of the 3 maternity services. There is no gynecologist or

midwife in Kerouane. The hospital surgeon acts as the gynecologist and a health assistant acts as a midwife. In Faranah there is only one midwife. The DSR decided to assign a gynecologist/obstetrician to the Kerouane maternity service with budgetary help of PPSG as soon as feasible.

- ◆ Insufficient maternal health medical equipment, material and supplies in all three hospitals. For instance, the Kerouane surgery theater does not have an operating table, medical instrument kits are non-existent, very incomplete or too few depending on the hospital, and no IP supplies and materials were present at the sites. PRISM is currently addressing these needs with the hospitals in coordination with the DRS/DPSs through its IR1 package of interventions.
- ◆ Kerouane hospital has no electricity and water. PRISM is currently addressing this situation with the health and administrative authorities of the Kankan region and the Kerouane prefecture.
- ◆ 23 providers need training in IP (need covered during FY01).

Update in Contraceptive Technology (CTU): The partners identified 5 providers per maternity services targeted to be updated in contraceptive technology. This was done for 9 of the 15 providers during the CTU course implemented during the last quarter of FY01. The remaining 6 providers will be trained during the next period. The training was delivered by the Head of the Maternity Service of the Donka University Hospital and by the PRISM Coordinator for FP activities.

AMIU (*Aspiration Manuelle Intra Utérine*) training: The training of the targeted providers in AMIU is held at the Donka University Hospital in Conakry. The trainees come from the three targeted hospitals' maternity services and are MDs, midwives and health technicians. 12 of the 15 providers completed their AMIU training during FY01. At the conclusion of the training session, an AMIU kit is delivered to each of the providers. Monitoring visits at each of the three hospitals revealed that the AMIU service installation is progressing well in Faranah where rooms have been prepared for the service, small material and furniture purchased or allocated, and IP practices upgraded. Unfortunately, the situation in Kankan and Kerouane has not been moving forward much. The lack of senior management leadership is an issue at both maternity services and is currently being addressed by the MOH.

Monitoring and Evaluation: Compliance rates for CPN services delivered at HCs

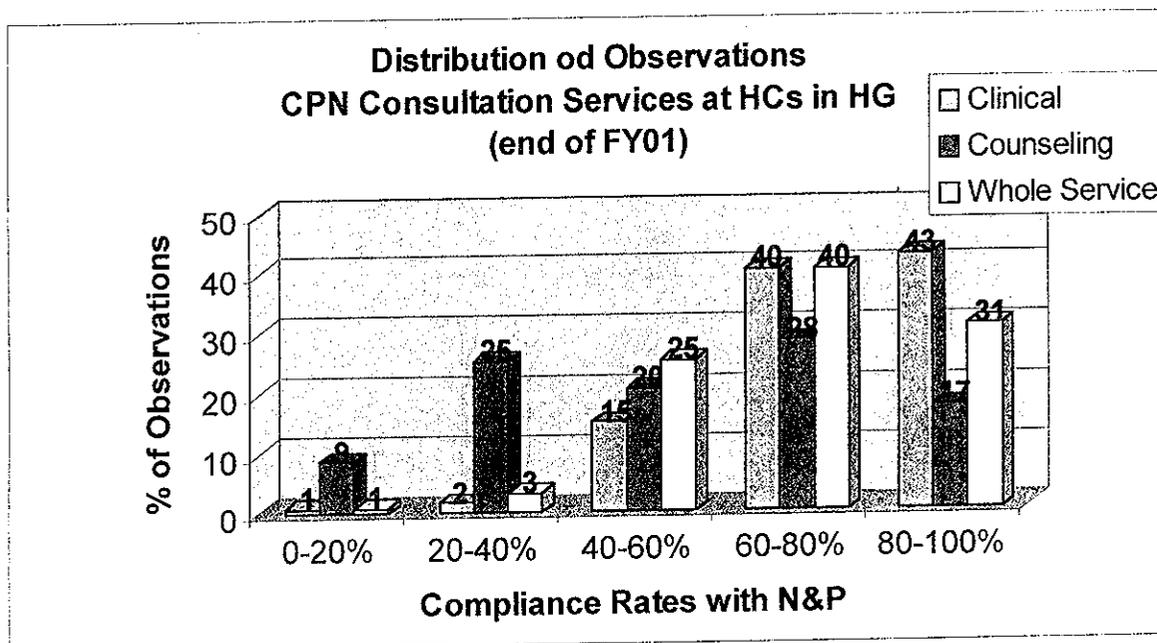
Antenatal consultation (CPN) services delivered at the HCs in HG were observed and reported on by the DRS/DPS supervisors during intense monitoring activities over the last three months of the period. A total of 127 observations were made during that time in 47 HCs located in HG's 8 prefectures. Here are the main findings of these monitoring activities¹⁰:

- The % of CPN consultations at HCs in HG for which the compliance rate to the National N&P was equal to or greater than 60% - the so-called "green zone"- has progressed from 6% in early 2001¹¹ to 43% during the last 3 months of the year. It is important to note that these

10. PRISM performance indicator n° 2.1. See annex 1.2 for additional details.

11. According to our secondary analysis of the data collected by Measure during the Situational Analysis performed in January 2001.

are the consultations for which compliance rates were in the green zone for both the clinical and the counseling aspects. 71% of CPN consultations observed at the end of FY01 had a compliance rate equal or superior to 60% (see following chart). Compliance rates for clinical treatment are much stronger than the compliance rates for counseling.



- Contrary to Child Survival services, compliance rates for clinical aspects of CPN consultations are stronger than for counseling aspects. 83% of CPN consultations had a compliance rate in the green zone for clinical aspects compared to 46% for counseling aspects. This indicates that almost all providers have a good to excellent knowledge of and practice level for CPN clinical aspects but much progress remains to be made in the counseling offered to pregnant women who visit the HC for a CPN consultation. Counseling was very weak (compliance rates 40% and lower) for more than a third of the observations made (34%).

Monitoring and Evaluation: Compliance rates for STI care services delivered at HCs

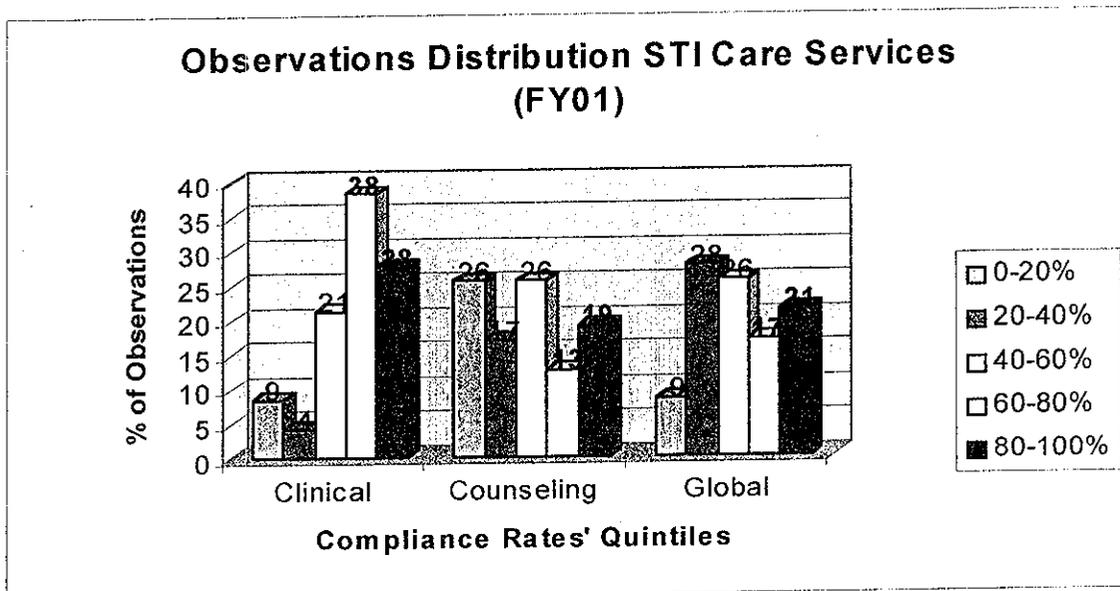
STI care consultations delivered at HCs in HG have been observed and reported by the DRS/DPS supervisors during the last three months of the period. A total of 47 observations were made during that time at 28 HCs located in 7 prefectures of HG (Dabola didn't report any). Of these observations, 16 were made at 9 HCs where STI care had been integrated by PRISM (7 during FY01 and 2 during FY00), and 31 were made at 19 non-integrated HCs. Here are the main findings of these monitoring activities¹².

- The % of STI care consultations observed for which the compliance rate to the National N&P was equal to or greater than 60% has progressed from 13% in early 2001¹³ to 28% during the last 3 months of FY01. It is important to note that these are the consultations for which

12. See PRISM performance indicator n° 2.2. See annex 1.2 for additional details.

13. According to our secondary analysis of the data collected by Measure during the Situational Analysis performed in January 2001.

compliance rates were in the green zone for both the clinical and the counseling aspects. 38% of STI care consultations observed at the end of FY01 had a compliance rate equal or superior to 60% (see following chart).

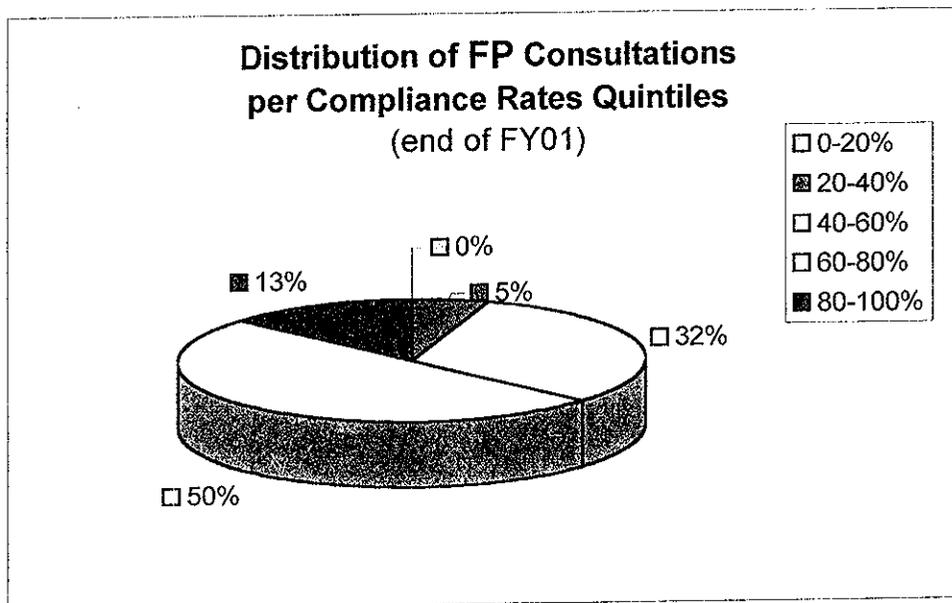


- While 28% of all the observed STI consultation were in compliance with national N&P, 44% were in compliance at HCs where the service had been integrated formally by PRISM. Non-integrated sites where supervisors observed STI care consultations had only 19% of them in compliance with the N&P. PRISM's integration process is making a significant difference in the quality level of STI care services delivered. But 44% still represents a modest fraction of services in compliance and further Facilitative Supervision during which on-the-job training is done is required. PRISM will support such interventions during year 5 of the project.
- Treatment aspects of the service are more in compliance with N&P than counseling aspects: 66% of consultations compared to 32%. Counseling in the context of STI care services is weak and will require special attention. When we compare treatment and counseling aspects at integrated sites with non-integrated sites we note a significant difference with counseling. Counseling aspects are in compliance with N&P for only 25% of the consultations observed at non-integrated sites compared to 43% at integrated sites. On the other hand, the difference is modest between the two groups when we compare clinical aspects: 69% and 64% in compliance respectively. The providers' training activities we implemented made a difference especially with counseling, although this part needs to be strengthened.

Monitoring and Evaluation: Compliance rates for FP services delivered at HCs

FP consultations delivered at HCs in HG have been observed and reported by the DRS/DPS supervisors during the last three months of the period. A total of 38 observations were made during that time at 21 HCs located in 6 prefectures of HG (Dabola and Siguiri did not report any

observations)¹⁴. As mentioned earlier, the number of observation is modest but in line with numbers obtained during other monitoring and evaluation activities. This reflects the fact that FP consultations represent a small percentage of services delivered at HCs.



- The 63% of FP consultations observed during the last 3 months of FY01 were in compliance with the National N&P (compliance rates equal to or greater than 60%). Our target for the end of FY01 was 15%. But the modest number of observations made coupled with the small number of HCs concerned by these observations (in comparison with the large number of integrated HCs) requires utmost prudence in interpreting this result. It appears that providers can obtain fairly good compliance rates according to N&P when delivering FP services while knowing the evaluation criteria (which was generally the case), and while observed by a supervisor able and allowed to provide feedback (which was always the case). Additional FP observations over time and at more HCs will allow us to draw firmer conclusions on the providers' effective level of knowledge and practice.

14. PRISM performance indicator n° 2.4. See annex 1.2 for additional details.

2.4 Strengthening the National Health Management Information System (H/MIS)

Main Results

- /b/ RH indicators integrated in the National H/MIS
- /b/ Monthly report forms updated and tested for DPSs, HCs and hospitals
- /b/ MOH computerized H/MIS system updated with new RH indicators
- /b/ Training in basic computer use of DRSs' staff in HG

2.4.1 Integrate the RH indicators package in the H/MIS

At the end of FY01, the dissemination of the new H/MIS data collection form (2.4.1.4) is the only intervention remaining to complete the integration of the RH indicators package in the national H/MIS. The MOH decided that the dissemination of the data collection forms to all facilities would take place during the January 2002 CTPS/CTRS meetings.

PRISM has been the MOH's main partner in supporting the integration of the RH indicators in the national H/MIS. In December 2000, the MOH held a very important workshop for the reform of the Health Management Information System in Guinea. The objective of the workshop was twofold: validate the new reproductive health indicators package developed the previous year with the support of PRISM and to develop the integration plan of these indicators in the H/MIS at all levels. PRISM co-organized and co-facilitated the RH validation workshop with the MOH/SSEI, the UNFPA and the WB/PSPG project (2.4.1.2). Immediately after the workshop, PRISM updated the monthly report forms for the HCs, the hospitals and the DPSs to include the RH indicators and produced the Users' Guide for each form (2.4.1.3). The new forms were submitted to the MOH authorities for final approval by the SSEI after it tested them successfully in the field.

A consultant from EpiConcept, the firm which has been developing the MOH H/MIS computerized system since the early 90s, came to Guinea sponsored by PRISM to integrate the RH indicators package into the national computerized system and train key personnel in the uses of the modified version. The integration of the indicator package was successful and 4 MOH staff members from the central level were trained in the use of the modified version

2.4.2 Decentralize computerized data processing at the IRS level

Part of the EpiConcept consultant's assignment was to adapt the computerized H/MIS application for use at the regional level (2.4.2.1). This was done and tested at the DRS in Kindia. PRISM will support the training of the Faranah and Kankan IRS staff in its use (2.4.2.2) in early 2002 when the data collection forms are disseminated and beginning to be used. Meanwhile, PRISM ensured that both DRSs in its target zone received the software application.

PRISM launched its training program in basic computer use targeting MOH units directly involved with RH and responsible for RH support at the decentralized level (2.4.2.3). The following key personnel received on-the-job computer training in the basic use of computers (Windows, Outlook Express, Explorer, Word and Excel):

- The Kankan DRS's director and the officer in charge of training, monitoring and evaluation;
- The same staff at the Faranah DRS;

2.4.3 Strengthen RH managers' skills in Data for Decision-Making (DDM)

Adapt existing DDM curriculum to H/MIS system in Guinea (2.4.3.1): A consultant from MSH came during the period to assist the MOH and PRISM at adapting existing DDM training modules and tools to the H/MIS of Guinea. In addition to improving managerial performance, one of the hoped for result of the project's DDM "*volet*" is to render the national H/MIS data more accurate and credible in an effort to re validate the much needed MOH's "*Système de Monitoring*".

PRISM held a workshop in Kankan grouping key managers from the MOH central level, the DRS, DPS and SDPs to develop the DDM training curriculum. The participants agreed upon the necessity for the heads of each facility/unit (HC, H, DPS, IRS) to maintain a monitoring tool called a "*Tableau de bord (TB)*" presenting monthly key indicators over a sliding period of 6 months. The group identified the indicators to be included that would make the TB significant in terms of the facility/unit needs and situation. The four TBs were tested through simulation and adjusted as needed. Filling out the TB requires the manager to analyze relevant epidemiological data as well as service statistics. The group prepared the "*guide de remplissage*" and the indicators interpretation guide. The MOH/SSEI presented the results of the workshop at the central level (MOH and partners) and the MOH authorities provided the approvals necessary to implement the next steps in the process. The TB will be field tested and disseminated during year 5 of the project.

WORK TOWARD THE INTERMEDIATE RESULTS (IR)

IR3 Increase DEMAND



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

1. Improve Coordination of IEC Programs

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

2. Strengthen Provider-Client Interaction

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

3. Conduct Health Promotion Interactions

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

4. Improve IEC Management and Delivery Capacity

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

Main Results

- A youth campaign targeting HIV/STI prevention and prevention of unwanted pregnancy was successfully launched in all of the 8 prefectures and in one high-risk sub prefecture. These youth launches highlighted what can be achieved through a combination of strategic advocacy, community mobilization, media and interpersonal communication interventions.
- A cumulative total of 682 community leaders are oriented and participate in RH promotion; 432 of them were oriented during FY01.
- 49% of births in HG benefited from at least three pre natal visits to a HC.
- CYP for FY01 is 7,084, reflecting a 6% increase compared to the previous FY and a 59% increase compared to FY98.
- Regional and prefectural IEC working groups reached out to communities and community leaders and established joint work plans and IEC activity implementation.
- 20 HC in HG are recognized as 'youth friendly'; their staff were trained in special IEC and IPC/C skills to meet the needs of youth.
- Community mobilization activities took place in all prefectures, with the active participation of trained peer educators, community leaders and small businesses.
- New IEC/BCC materials and job aids were developed, tested and distributed to communities and IEC promoters, and messages were passed at social events including sports, theater and social clubs.
- The EPE program improved immunization coverage in Faranah (pilot prefecture) and resulted in diminished drop out from follow up vaccinations from 28% in 1999 to 15% in FY01.

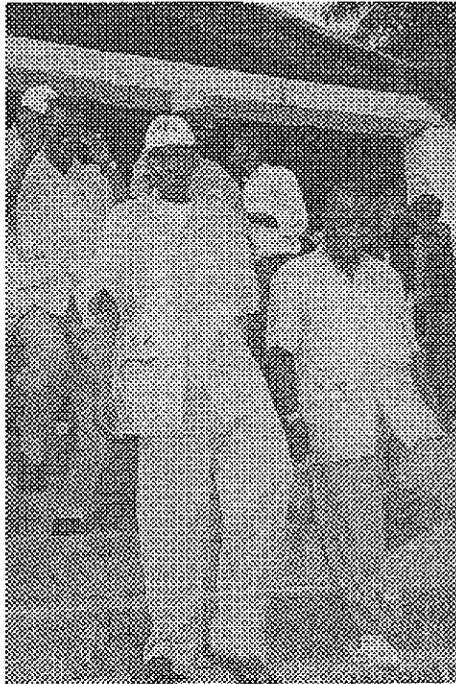
3.1. Improve Coordination of IEC Programs**3.1.1 IEC COORDINATION AT THE CENTRAL LEVEL (activity #3.1.2 in the OpPlan)**

IEC coordination at the central level is assumed by the Division of Health Promotion (DHP). This year, PRISM has looked to the DHP for policy and guidance on the youth campaign, and has, in the process, worked closely with the DHP to assume central leadership in fully supporting regional program implementation. In this capacity, the DHP has organized, with PRISM support and participation, a Conakry-based workshop to finalize the National IEC Reproductive Health Strategy. The Strategy will serve as a basis for all organizations working on IEC/BCC throughout Guinea and thus ensure in a more structured and formal way that local, decentralized activities take place within the framework of national policy and objectives. The workshop was initially scheduled for the end of PRISM's FY01. At that time, many key representatives from the regions were not able to participate. To ensure the efficacy of the workshop, the MOH has postponed the timing until all key participants from the regions and prefectures can attend.

3.1.2 IEC COORDINATION AT THE REGIONAL LEVEL: GROUPES REGIONAUX IEC (GRIEC) (activity #3.1.1.)

At the regional level, the IEC working groups in Kankan and Faranah continued to meet on a quarterly basis and move the regional action plans forward. They played a lead role in planning and carrying out the adolescent reproductive health campaign. The youth campaign was launched in July and August 2001 in each of the eight préfectures.

The launch included large IEC events, for youth and by youth, and was accompanied by wide broadcasting on rural radio. The activities included members of the regional and prefecture working groups, local health workers, government officials, members of rural development committees, school teachers and principals, and parent associations, as well as representatives from the target group. They identified young people of their communities to be trained as peer educators and to meet with parents to discuss participation of youth in the campaign activities. The IEC activities in general, and the youth campaign in specific, have, through the coordination of the regional IEC working groups, been publicly endorsed by local and regional political and religious leaders representing all the communities of HG. The following Table indicates the high number of such community leaders oriented by PRISM since the beginning of the project.



Here is Mr Hady Thiam, the Dinguiraye Prefect, on youth launching day in Dinguiraye (July 29, 2001). He is known to be a very strong religious leader.

Youth, Community Leaders and Administrative Authorities Oriented by PRISM

Youth and Community Leaders	Number
Youth peer educators	200
Religious leaders (FY00)	250
Coalition members in Siguiri	50
Coalition members in Kerouané/Banankoro	30
Members of <i>Associations des Parents d'Élèves et Amis de l'École</i> in all 8 prefectures	64
Sub-total:	594
Administrative Authorities (*)	
Both of the Regional Governors and staff	2
All the <i>Préfets and staff</i>	8
All of the <i>Sous-Préfets</i> and their staff	60
All members of the <i>Comités Régionaux de Développement (CRD)</i>	
All Health Préfectoral Directors	8
All Youth Préfectoral Directors	2
All Education Préfectoral Directors	8
All Health Center Chiefs	
Sub-total:	88
Grand total	682

(*) Please note that numbers presented for administrative authorities are very conservative and most probably underestimate the real number of people in these sub categories oriented by PRISM. Our monitoring system will capture complete data for this indicator during the coming period.

Following the campaign launches, IEC regional meetings were held to review the youth launches, and to stimulate youth to develop action plans of activities to build upon, and strengthen the initial impact of the launches. The review indicated that (i) there was full involvement of youth and community leaders (political, administrative and religious in the campaign launches, (ii) community groups were fully mobilized, (iii) local material and financial contributions from the community leaders were substantial, and (iv) there was national television and radio coverage. (More details on the campaign launches can be found in Section 3.3.1.)

3.1.3 PREFECTURE IEC WORKING GROUPS AND COMMUNITY LIAISONS

At the prefecture level, IEC groups formed with PRISM support in previous years, continued to be instrumental in planning, implementing and monitoring the youth campaign activities. Prior to the launch, PRISM assisted the prefecture IEC groups to meet for campaign orientation and organization with community leaders. The main objective was to involve communities from the start, thus ensuring that community leaders shared responsibility and ownership for the campaign. The meetings included: *Préfets*, Officials at the *Directions Préfectorales de l'Éducation (DPE)* and at the *Directions de la Jeunesse et du Sport*, Village Development/Health Committees, members of local *Associations des Parents et Amis de l'École (APEAE)*, youth organizations, businesses where youth gather, and representatives from local NGOs. During the meetings, the participants identified their respective roles in the campaign, and developed plans to assure that the health needs of youth in their region were addressed. The active participation of the DPS proved particularly important to stimulate action among the stakeholders with regards to HIV prevention. A recent report presented by the DPS of Siguiri showed that 13 cases had been detected among adolescents less than 18 years old at Siguiri hospital within the span of one week.



Mrs. Doussou Kaba stand near a sign board made to identify her store as a partner in the youth campaign. She has been oriented and had received a wooden penis model and condoms for demonstrations. We asked what her husband's reaction when he found that she is now educating clients about HIV/AIDS. She replied that in the past he would have gotten upset but now he jokes about PRISM reaching even the hair salons.

The community meetings led to the formation of special committees that organized, implemented and oversaw the youth campaign activities at the local level. PRISM supported the IEC prefecture group members in following up and supervising these committees. Interventions organized by the committees included sports and soccer games that delivered key campaign messages, HIV/STI and FP education sessions in sewing and hair houses, street shows, theatre activities, and promotional evenings. The committees also identified and mobilized community resources that could support the youth campaign.

Based on the locally identified intervention/ activity package, each IEC prefecture group developed, with PRISM's assistance, a workplan and a budget necessary to implement the plan. With PRISM financial support, the activities were launched in the following prefectures during the months of July and August: Mandiana, Faranah, Dabola, Dinguiraye, Kouroussa, Siguiri, Kerouane, Bananko and Kankan.

3.1.4 DEVELOPMENT AND IMPLEMENTATION OF ACTION PLANS

As mentioned earlier, all prefecture IEC groups submitted budgeted action plans and received funding from PRISM for key activities (3.1.1.5). The activities included video/film projections, support to peer educators' action plans, youth and adult theatre group tours, and the use of cultural and sport events as vehicles to disseminate key campaign messages.

In addition to the Prefecture IEC groups, the GRIEC received proposals from eight NGO's in the Kankan region and one in Faranah. The participation of local NGOs fostered public-private sector collaboration and thus a broad-based community participation.

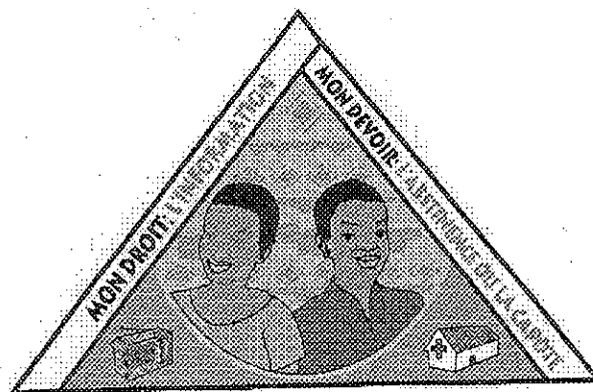
Following a request from the government instructing the MOH to focus International Population Day (July 11) activities on HIV, PRISM supported the prefectural IEC groups in organizing community events, including sports events, contests, theater productions, and to distribute IEC materials aimed at HIV prevention and awareness. Faranah and Kankan

received small grants to support *mamaya*¹ activities on Women's Day and other activities on International Youth Day. Peer educators took a lead role in disseminating messages and leading discussions following video projections.

3.2. Improve Provider-Client Interaction

3.2.1 DISTRIBUTION OF EXISTING IEC MATERIALS (2.3.2.1)

During FY01, PRISM continued to reproduce existing materials to improve the communications between providers and clients. This year, the materials were selected to increase HIV/STI awareness and included framed HIV posters, AIDS brochures, penis models and the Guide de Counseling Population Reports that were distributed to the University of Kankan, schools, health centers and youth centers. Penis models were also distributed to the *Service National de Production et de Vulgarisation*, and Guide de Counseling Population Reports were distributed to the DPS and various training and orientation workshops.



3.2.2 PRODUCTION AND DISTRIBUTION OF NEW MATERIALS (2.3.2.1 & 3.2.3.9)

In FY01, PRISM facilitated national and regional workshops to develop and test new campaign messages and materials. The workshop participants included both service providers and (potential) clients. They ranged from decision-makers, parents, and adolescents (15-24 years) to MOH representatives and health care providers from hospitals and health centers. Together, they developed and finalized the campaign slogan: *Mon droit: l'information, Mon devoir: abstinence ou la capote* and an accompanying logo which appears on all campaign materials.

New materials include three brochures (abstinence, HIV/AIDS prevention, and unintentional pregnancies), two posters, one comic-style book and a question-and-answer book. (These last two are in final stages of production.) There was also a wide range of promotional materials produced that carry the campaign's messages and logo.

¹ A community event, often organized by women's *seres*, in which women get together to dance.

The logo has been placed on "youth friendly" health centers, as well as cooperating hair salons, sewing centers, and garages, which are serving as sources of referral to the health centers. Details of the new materials are provided in section 3.3.1 below.

3.2.3 TRAINING OF SERVICE PROVIDERS

Skills building for both counseling (IPC/C) and for conducting IEC/BCC educational sessions was an integral part of PRISM's provider training for each of the targeted services: FP and STI prevention, Child Survival, STI care, Maternal Health, and CBD services (see activity 2.3.2.3 in Operational Plan).

In addition to the activities already described under IR1 and 2, PRISM conducted a special orientation session for the heads of 20 health centers to strengthen their ability to respond to the special needs of young people and to deliver "youth friendly" services. Topics included communication and counseling skills, greeting skills, and technical health education information. These health centers and their service providers are an integral part of the youth campaign activities and work closely with peer educators.

During the third quarter of FY01, PRISM also trained twelve Peace Corps Volunteers and their health care co-workers in interpersonal communication and counseling (IPC/C) for reproductive health issues.

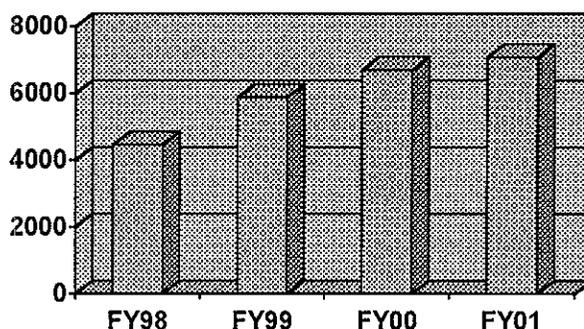
3.3. Increase Demand for Reproductive Health Services and Conduct Health Promotion Activities

PRISM's TA to increase demand and improve health behavior ultimately aims at increasing the use of RH services. The DHS and other surveys are the ultimate validation of success. However, the CYP and the number of new and returning FP clients, as well as the number of births that benefited from at least 3 prenatal visits, are also good indicators of increased use, as the likely combined effect of improved access and quality (especially for returning clients) and of increased demand and behavior change (especially for new clients).

In FY01, the three indicators (CYP, new, and old contacts) continued the positive trend they had begun to show in project years 2 and 3. **The CYP in HG for FY01 is 7,084.** This is a 6% increase compared to FY00 and a 59% increase compared to the first project year, FY98 (see Figure a). **New contacts** numbered **11,646** this year, compared to only 4,561 in FY98 (see Figure b), and thus suggest increased new demand for services. In FY01, **old contacts** numbered **32,512** compared to 8,394 in FY98, which suggest increases in continued demand².

² See detailed FP data at annex 3.1

Figure a: CYP in HG FY98 - FY01



The % of births that had benefited from at least 3 prenatal visits was 49% (target had been 47%), which is up from 44% at the end of FY00. This indicator suggests improved awareness of the importance of prenatal consultations and improved quality of these services.

Even though PRISM cannot entirely or solely claim credit for the positive trends in these indicators, the project's contributions are likely to be significant. For example, an analysis of the CYP demonstrates significant increases following specific interventions in the integration of new or re-integration of old HCs in FP. It also showed that recent increases in CYP due to increased condom use in the last quarter of FY01 occurred immediately following the launch of the youth campaign, while drops in CYP with IUDs are consistent with the interruption of IUD services at 3 hospitals. The condom sales rose from approximately 2,500 condoms in June to more than 8,000 in September 2001 at the health centers.

The sharp increase in both new and old contacts suggests that FP and the use of RH services is moving into a new phase where people, especially youth but also mothers, are increasingly aware of the services, where to get them, and of their benefits. These results are encouraging, especially since FP is well-known to be not only a crucial intervention for social and economic development, but the most important intervention to reduce both maternal and child mortality. PRISM will work to maintain this trend during year 5.

The upward trend in the % of births that benefited from at least 3 prenatal visits is likely the result of both continued IEC activities, especially at the community level, and of the beginning of improved MH/CS services described under IR2. Through its technical focus on MH and CS (see IR2), PRISM will continue to consolidate these trends in FY02.

3.3.1 MULTIMEDIA ADOLESCENT REPRODUCTIVE HEALTH CAMPAIGN

The above-mentioned adolescent multi-media campaign, launched in all eight prefectures, was also launched in the Banankoro sous prefecture and in the regions of Kankan and Faranah, during the months of July and August 2001. Banankoro was chosen because it is an area with diamond mines, and thus attracts a mobile population of migrant male laborers and of sex workers. The area is known for its high sexual promiscuity. Even though the campaign intended to help influence social norms, its main goal was to equip young people with the knowledge and skills they need to prevent unhealthy and unwanted consequences of their sexual behavior. Therefore, the campaign aimed at improving: (i) dialogue about issues related to sexuality and HIV/AIDS prevention and (ii) practices of either abstinence or

condom use. The message strategy was to raise a realistic sense of risk and vulnerability, but not fear, and to enable youth to protect themselves from HIV/AIDS and unintended pregnancies.

Three key strategies used to reach this goal were:

Peer education (3.2.3.1 & 2): Reach, engage and mobilize youth with the information and skills they need to prevent themselves and their friends from HIV infection and unintended pregnancies. Work through *grains* and *seres* to disseminate messages.

Community involvement and advocacy: Increase community-wide dialogue about HIV/AIDS and strengthen social support for the discussion of sexuality, including HIV/AIDS and pregnancy prevention measures.

Strengthen and "brand" health centers as "youth friendly" (3.2.3.3): Listen to, train and identify local health centers where young people can receive appropriate counseling and services for unintended pregnancy prevention, as well as the prevention of STIs, including HIV/AIDS.

During FY01, these interventions resulted in the following:

- 105 male and 105 female youth educators were trained and equipped to inform their peers about how to prevent unwanted pregnancy and HIV/STIs, and refer them to health centers.
- Over 150 youth serving businesses (hair salons, sewing centers, and garages) in eight préfectures have become information dissemination and referral points.
- The youth theater troupe of HG has begun performing a participatory play entitled *Si je le savais* ("If only I had known"), in each of the eight campaign préfectures.
- Three adult theater troupes (Mandiana, Dinguiraye and Banankoro) have begun programs that highlight the importance of dialogue between parents and their children on reproductive health. Many of the women in these troupes are skilled *griots* (traditional story tellers) and create accompanying songs.
- Two traditional social networks – the grains and seres - have become actively involved in disseminating reproductive health information among youth. They have been supported by PRISM through their peer educators who have received a small quantity of sugar and tea to encourage them to gather and reach their friends through these *grains*. The *seres* are more structured groups of women born in the same year who maintain their ties of friendship over a lifetime. They help each other and raise money for various activities. Women's *seres* were prominent in all the launch festivities, where they participated in the organization of events and show up to dance wearing colorful, matching dresses and head wraps.

- Campaign materials and programs produced in FY01 include the following:

Campaign Materials and Programs	Quantity
Print Materials	
Brochure on STI/AIDS	40,000
Brochure on abstinence	30,000
Brochure on pregnancy	30,000
Poster on the condom	2,295
Poster on parent-child communication	1,500
Mass Media Programs	
Interactive Rural Radio Programs (to air twice monthly in three local languages)*	16
Radio "micro-programs" [†]	7
Promotional Items with Youth Logo and Slogan	
T-shirts	2,500
Caps	2,500
Large stickers	400
Small stickers	1,500
Pins	1,000
Pens	4,650
Men's shirts	900
Commemorative cloths	950
Air balloons	4,800
Flags	1,500
Women's hand bags	500
Bags for peer educators' IEC materials	100
Combs	2,000

Other print materials still in production include a question and answer booklet on reproductive health topics and a comic book designed to serve as a memory aid for the peer educators.

Several key lessons learned to date:

- Real Community Dialogue is key to changing behavior. While PRISM's TA in IEC/BCC activities has continued at all levels of the health system, in FY01 PRISM fully shifted its priority focus to the grass roots level, i.e. the community. This TA is truly community-based and not only community-oriented.
- Identify Strong Leaders: The success of community-based interventions depends on the active participation of the IEC préfectoral group. PRISM has continued to strengthen the DPS and the sous-préfectures to identify and select strong members for this group.
- Use a Network of Supporters: PRISM has assisted the DPSs and communities not only to identify and work closely with "resource people" in the community but to link them to each other and to the prefecture IEC groups. The network thus becomes a support to the

* The Kankan station of Radio Rurale de Guinée is working with members of the press clubs from secondary schools in the Kankan and Faranah regions to produce 16 interactive radio programs discussing and sharing information about HIV/AIDS and unintended pregnancies. Each 60-minute program will air twice a month in three local languages.

† Seven two-minute "micro-programs" have been produced in two local languages and are about to go on the air on rural radio stations.

resource people and a framework for reference to both community members and health providers.

- Empower with Support and Tools: materials, educational tools, job aids and technical and management skills are integrated parts of PRISM's skills building and IEC/BCC interventions at all levels of the health system but especially in the community.

Monitoring and evaluation:

IEC/BCC activities and interventions are part of PRISM's routine monitoring, as highlighted under IR1 and IR2. Data are collected through the standardized forms that PRISM has developed and helped integrate into the national H/MIS for both health centers and for CBD agents. Data are also collected through PRISM's special assessments and facilitative supervision checklists described earlier.

In addition, PRISM has developed special monitoring forms to measure the reach of its mass media campaigns. For the youth campaign, forms are tailored to capture the activities and impact of peer educators, health centers, and hair/sewing houses. The youth campaign that is currently under way will be evaluated in early 2002. The evaluation will be uniquely designed to capture the impact of the campaign messages on community norms and behavior, as well as on referrals to and increased attendance at health centers.

Meantime, routine monitoring and supervisory activities by the DRSs and DPSs point to preliminary results of the youth campaign. In Siguiri, Mandiana, and Faranah, more than 100 young people visited the health centers to inquire about services within one week of campaign activities. The health center staff in Kankan have anecdotally reported an increase in new young clients when peer educators conduct IEC activities in the community. In Banrous prefecture in Kouroussa, 27 youth went to see health workers for IST and PF as a result of peer education.

The inclusion of youth in intervention activities that aim at youth has also been welcomed by the DPS. Some DPS now integrate youth in their health teams, and they invite peer educators to participate in supervisory visits. The participation of youth in these activities has been reflected in routine reporting, which indicates that most of the girl peer educators hold a weekly session on family planning/STD in the health clinic for women attending prenatal care, and that the reach of many peer educators extends to adults.

3.3.2 ADVOCACY AT THE COMMUNITY LEVEL

See 3.3.1 above.

3.3.3 COMMUNITY MOBILIZATION ACTIVITIES

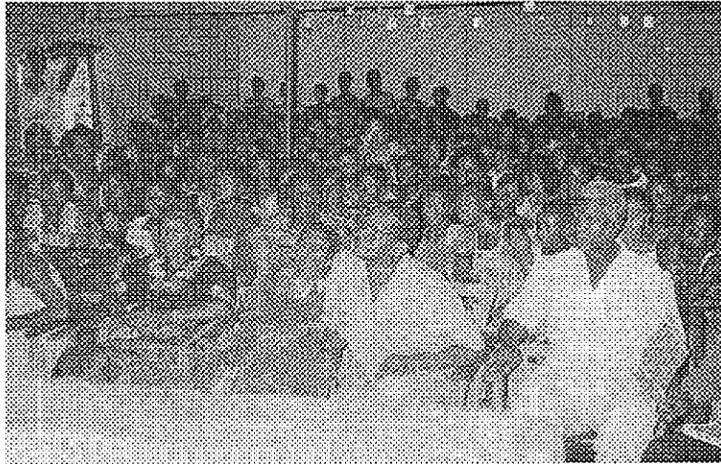
In addition to the community mobilization activities in the context of the CBD program described under IR1, PRISM has worked with the prefecture or sub-prefecture IEC working groups to support community mobilization activities with youth peer education leaders. Detailed descriptions and quotes from these activities can be found in the July – September 2001 quarterly report. Highlights of peer education activities include the following:



Mama Koita, a peer educator from Siguiri, explains to peers the importance of condom and how to use it.

“Standing Youth” are peer educators who, because of their excellent performance became part of the health center health team. Like other peer educators, they were trained by PRISM to reach and/or refer youth with information about HIV/AIDS prevention, as well as prevention of unintended pregnancies. The standing youth reach peer through:

- Health center outreach activities, supervised by the head of the health center and conducted in close collaboration with other HC staff.
- Organized community events (soccer and street shows) which capitalize on community gatherings that attract large numbers of youth. Messages are disseminated through announcers at the soccer games and teams have been nicknamed “Abstinence” and “Capote” for example. Street shows include entertainment such as music that incorporates key campaign messages.
- Grains: trained peer educators work through these groups of friends that meet almost daily to drink tea to introduce and discuss key campaign message including abstinence and condom use.
- Seres: trained peer educators take advantage of these groups that bring together youth of the same age to share and discuss issues related to HIV/AIDS and pregnancy prevention.
- Small planned meetings: rather informal educational gatherings at the request of the peer educators’ friends, or at his/her own initiative, held with a few people.
- Large planned meetings: organized meetings or events, often planned with other peer educators to show video projections or hold organized discussions with soldiers, for example. Peer educators conducted video projections and discussions in all eight prefectures. The three videos shown were: *Les visages du SIDA*, *Ce n'est pas facile*, and *Les conséquences de la grossesse non désirée*. People were reached in public squares, through schools, at sewing and hair salons, at youth centers, and in amphitheatres. Numbers reached ranged from 3,800 in Siguiri to 650 in Dinguiraye; most averaged crowds of around 2,000 for total attendance at the various venues.



Girls watching a video on unwanted pregnancy led by peer educator leaders in Kerouane. Sitting in front are Dr. Sow (with glasses), the health prefecture director, and his wife plus Mr. Jules Fara, the urban head of the health center.

- Individual contacts: these are generally one-on-one discussions that are held by peer educators; contacts range from 3 to 9 times a day.
- Field work: in some *sous-préfectures* many youth work in the field and peer educators have brought messages to these sites.

“Sitting Youth” (3.2.3.6): More than 150 sewing and hair houses, as well as several cafés and garages have been strengthened to serve as youth campaign message dissemination points. Owners have been oriented and these sites have been decorated with campaign materials. Signboards identify them as sources of information and/or referrals for pregnancy and HIV/AIDS prevention.

Mobile populations: 50 leaders of a coalition of residents of Conakry who had migrated from Siguiiri received a basic orientation to family planning and reproductive health issues from PRISM. This included the distribution of video and print materials to use during the Muslim holiday season of Tabaski, when many former Siguiiri residents returned to their hometown. Approximately 17,000 people were reached during the Tabaski season. The Coalition’s IEC activities contributed to the sale of 20,000 condoms by PSI/OSFAM.

3.3.4 SMALL GRANTS

PRISM issued small grants to each of the 8 prefecture IEC working groups. Details are given above in 3.1.4.

3.3.5 THE CHILD-TO-CHILD STRATEGY

Given the high child mortality rate (176/1000), the low % of children completely immunized by age 2 (32%), and the high illiteracy rate among women (80%), PRISM launched the *Enfant pour Enfant* (EPE—Child-to-Child) strategy in 1999 in Faranah prefecture. The EPE approach seeks to increase the immunization coverage of children from birth to five years of age by involving older children and their teachers in keeping up with the vaccination schedule of younger children. Concretely, the EPE strategy mobilizes students in the fifth class (eighth grade) and their teachers -- to reach and encourage mothers, in particular, to complete the full course of immunization for their infants.

PRISM assisted the DRSs in introducing the EPE strategy in schools in the urban centers of Dabola and Kankan during the third quarter of this year. Eighty-four teachers and 8 health workers from Kankan, and 14 teachers and 3 health workers from Dabola attended the EPE workshop, where they received training and promotional and technical materials to take back to their schools.

Today, 123 teachers at more than 30 schools, as well as staff from the three involved DPSs and Prefecture Direction for Education have been introduced to the EPE approach and are managing the activities with 5th graders in their localities. The program was evaluated in Faranah at the end of the year after more than 12 months of activities. 20 teachers and 1001 children are actively participating in the EPE program there. This represents 39% of all fifth graders who function as god-sister/brother. A total of 41% of all fully immunized infants have such a god-sister/brother and the drop out rate for vaccinations necessary in the child's 2nd year, has decreased from 28% to 15%.

The success of the EPE program in the targeted prefectures of HG is largely due to the increased commitment and ability of the DRSs and DPSs to motivate health centers, schools and teachers to participate in the EPE program. Incentives such as rewards at school and community ceremonies for participating teachers, children, and compliant mothers are important ways that PRISM helps to recognize their efforts. However, the key to success really lies with the supervisory capacity and participation of the DPSs and the health centers, and with community participation. This has been PRISM's TA focus to promote the EPE strategy. The district health and education authorities have fully integrated EPE, they provide follow up, and they offer the focal point. PRISM will continue its support to the EPE program in 2002 throughout HG.

3.4. Improve IEC Management and Delivery Capacity

In FY01, PRISM sponsored four people's attendance at IEC-related international workshops and conferences. Mme Kadiatou Camara, DPS/IEC officer and member of an IEC Regional group, attended a workshop on message design held in Ouagadougou, Burkina Faso. Mrs. Aminata Camara, Centre de Santé Urbain/Kerouané, and Cissé Mamady, DPS/Kouroussa, attended a CAFS workshop in Togo on communicating with adolescents. Mr. Mohamed Cissé, one of the PRISM IEC Coordinators, attended a 5-day workshop in Dakar on distance learning.

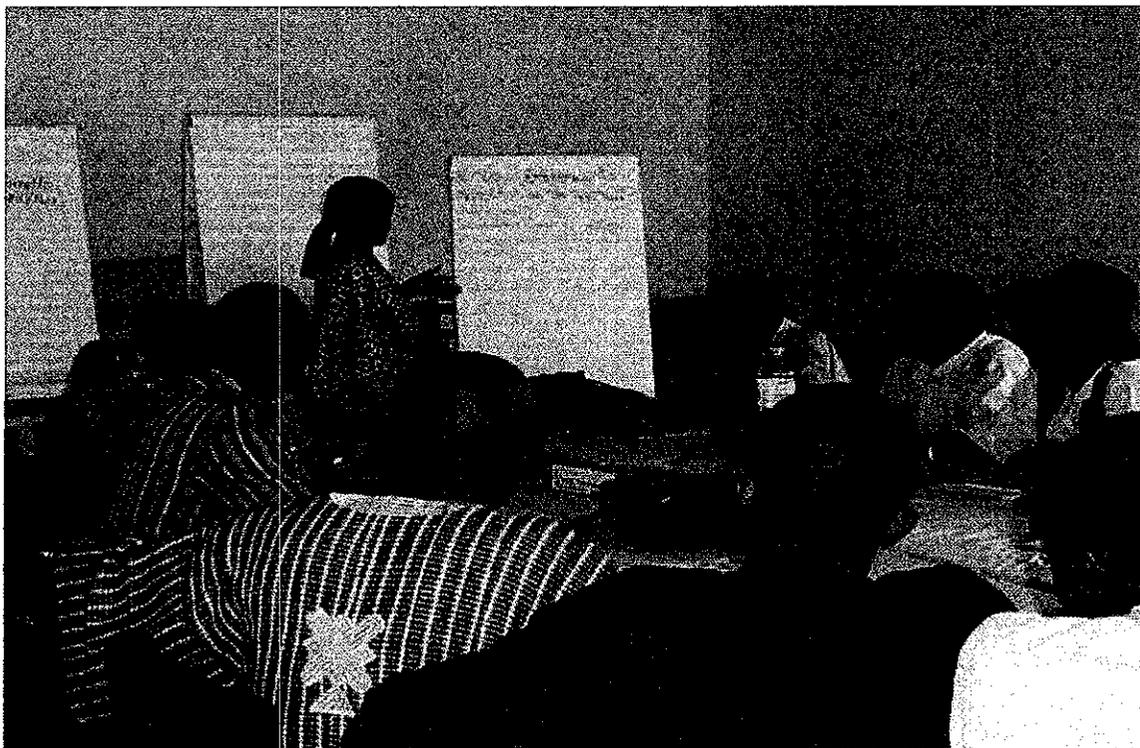
Narrative research on youth perception of sexuality resulted in the report, *Guinée: La Sexualité des Adolescents dans les Régions Administratives de Faranah, Kankan et N'Zérékoré—Résultats d'une Recherche Narrative* (JHU/CCP Special Publication #18, November 2000), also came out this year.



Mandiana peer educators lining up for a long carnival (July 23, 2001).

WORK TOWARD THE INTERMEDIATE RESULTS (IR)

IR4 Improve COORDINATION



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

At the decentralised level

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

At the institutional level

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

Main Results

- ✓ Management of supervision activities supported at the 2 DRSs and at the 8 DPSs of HG; 4 DPSs performed supervision activities in accordance with agreed guidelines.
- ✓ Computer network installed and operational at MOH; email capacity established at MOH central level units and at HG's DRSs.
- ✓ 8 Regional Working Group meetings held.
- ✓ Participation and technical support to 12 CTPS meetings and to 4 CTRS meetings.
- ✓ 5.0% cost sharing attained as of the end of FY01 (target = 5.1%).
- ✓ 3 quarterly review meetings held with MOH and USAID

4.1 Improve Coordination at the Local Level

Regional Work Groups (4.1.1)

The RH and IEC regional work groups (respectively ERCOSAR and GRIEC) met regularly during FY01. The first regional working groups quarterly session main task was to redefine PRISM and other partners' targets in *Haute Guinée* following the close down of PRISM activities in the Forest Region. The following regional groups' meetings focused as usual on coordination and integration of RH interventions with partners. The main theme of all GRIEC meetings this year has been the youth campaign. PRISM with the DRS and their RH partners organised a total of 8 regional working group meetings during the year. Contrary to previous years, now that the DED project in Kankan and the GTZ's PSR project in Faranah have closed down, PRISM funded all the meetings during FY01.

Participate in CTPSs and CTRSs (4.1.2)

PRISM participated actively in **12 of the 16 CTPS** meetings that occurred in its zone during the year and in **all 4 of the CTRS meetings**.

One important decision made by the Faranah DRS and the Kankan DRS during the CTRS meetings was to authorise in their respective regions new sales prices for ORS units. The sale of ORS unit to community agents by HCs was authorised at 150 Gfr per unit and at 200 Gfr for sale to the clients by the community agents. PRISM has been lobbying the MOH at the central level for more than a year for such a decision to be made nationally but without success. The increasing ORS stockouts at HCs following the sharp increase of ORS per unit cost (from 55 Gfr to 136 Gfr) motivated PRISM to plead for a revision of the sales price. It is noteworthy that the DRSs in our focus zone made this decision while the central level has not revised the sale price nationally.

PRISM sponsored and co-facilitated with the Faranah IRS a special session during Faranah's June CTRS meeting on the ED&C and vaccines logistics, the findings of the medical materials inventory and of the cold chain situational analysis made in the region by PRISM. PRISM and other partners' planned support in strengthening logistics was discussed.

Support the Management of DRS/DPSs' Supervision Activities

The strengthening of the supervision system was one of PRISM's top priorities during the whole of FY01 and will remain so during FY02. Under PRISM guidance, the supervision system and supervision concepts were discussed in detail during the June and July CTPS and CTRS meetings. The *Convention de Partenariat* template as well as the new monitoring

forms¹ were reviewed and approved. By the end of FY01, PRISM had signed and implemented a *Convention de Partenariat* on supervision support with each of the 8 DPSs and each of the 2 DRSs of its focus zone. The DRS/DPSs have their supervision plan made for the next 3 to 6 months and these plans tend to be better adjusted to the HCs' needs and better aligned to the capacity of the unit and to the profile of the supervision team. On-the-job training, COPE facilitating and facilitative supervision visits at HCs are progressively becoming more regular. Quality monitoring and evaluation visits at HCs were made at many HCs during the last three months of the period (62). Over 300 client consultations were observed during these visits. Performance level varies from one DRS/DPS to the other. PRISM is configuring its technical resources deployment in order to provide regular and intensive support to all DRS/DPSs during the coming 6 months period, and will lower intensity of technical support to performing units after that.

4.2 Improve Coordination at the Institutional level

PRISM proposed operational plan for MCH for project's Y4 and Y5 was reviewed with USAID/SO2 and with the MOH during two important joint meetings in December. After that, PRISM's achievements and results were presented and discussed on a regular basis during MOH/USAID/PRISM quarterly joint review sessions. The sessions were presided over by a MOH senior officer. Planned activities for the coming periods were also presented and discussed. Many key senior staff from the MOH and from USAID's Health Team (SO#2) were present at these review meetings.

Support MOH coordination at the central level (4.2.1)

Although PRISM is a decentralised project with a focus on the regional level, its experts, advisors, consultants and coordinators support, as much as feasible, health-related policy development.

- PRISM supports the development of IMCI in Guinea. PRISM is a member of the National IMCI "*Groupe Technique*";
- PRISM supports the development of the Safe Motherhood National Policy at the central level and its implementation at the regional level;
- PRISM participates in STI/AIDS related coordination meetings in support of the PNLs;
- PRISM has been a leader in the development of one major part of the National Health Development Plan – the Minimum Package of Activities for the primary health care system of Guinea.

Electronic communication capacity at the MOH units involved in RH (4.2.1.2): To strengthen the MOH managerial capability, PRISM allocated computers to various units involved in coordinating RH activities (SG, DNSP, DNPL, SSEI, DivPS, DRSs, etc.). The goal is to ensure that the MOH organisational units have better access and use of data and have improved communication capacity through the regular use of email and the Internet. One major step at increasing the MOH's coordination capacity was the installation by PRISM during the last quarter of the period of a local network serving key units at the central level².

1. The "*Fiche d'Inventaire : Disponibilité des Services et Equipement*" and the "*Fiche d'Observation : Client – Prestataire*"

2. See the consultant report on the installation of the network and the feasibility study at annex 4.1

PRISM has hired a Conakry based computer service firm to ensure that the computers supplied by PRISM are maintained, that the network at the MOH is functional and that adequate training in computer skills is provided to admissible users in Conakry and in HG. One technician from the firm is assigned to the users and network needs in Conakry and another one is assigned to Kankan to cover the same needs. Training activities started in April 2001 and are currently ongoing. As of the end of FY01, the network at the MOH is functional, and colleagues at the MOH central level and at the DRSs are using email to communicate.

Assist MOH in managing the Hewlett funded research (4.2.1.3): PRISM supported the MOH and it's implementing agency - CERREGUI – in the organisation of the National Coordination Committee meetings. The Committee monitored progress and conclusion of the adolescent sexuality research. The research reached its final stage and initial results are available.

Developing collaboration with RH partners (4.2.2)

PAC Integration in three hospitals in HG: The MOH/DSR, PRISM and JHPIEGO developed a partnership for integrating Post Abortion Care at three Hospitals in HG: the regional hospitals in Faranah and Kankan and the prefecture hospital in Kerouane. A memorandum of understanding was developed and signed and implementation has progressed according to plan. JHPIEGO is providing international and national technical assistance, training curriculum, assessment and monitoring checklists and specialised medical equipment. PRISM is providing regional technical assistance, covers local costs and provides the administrative and logistics support to implement the activities and coordinate interventions in the target zone.

Promotion of Muriga: Active and fruitful collaboration is established with STEP/ILO for the promotion of Muriga in HG and their support (see section 1.5 for details). ILO shared with PRISM the cost of the attendance of two Guinean professionals (one Coordinator from PRISM and AGBEF's Kankan Coordinator) at the course in Benin on the promotion and support of HMO type organisations.

CBD Program: CBD collaboration conventions were signed with Africare for the Dabola prefecture and with Save the Children for the Mandiana prefecture.

STI care integration in the Kankan region: A partnership convention was developed and signed for strengthening of STI care in the Kankan Region. The partners involved with PRISM, in addition to the Kankan IRS, are the PNLs, the SIDA2 project, the PPSG project and the GTZ. The partnership focuses on the STI syndromic case management integration in HCs in Kankan.

KFW and IEC radio material: KFW co funded the production of the RH Radio Drama "*La Vie n'est pas Compliquée*" with PRISM for a value of \$20,000.

Logistics support to the DRSs: PRISM has employees based at Kankan and at Faranah's DRS offices. In order to clarify PRISM's participation in the operating and maintenance costs of these offices, a "*Convention de Partenariat*" was developed and signed with both DRSs.

Each partner's responsibilities and rights are described. PRISM, for instance, committed to cover part of the fuel consumption and maintenance costs of the power generator at the IRSs.

Coordination with partners: Other interventions and activities

- In addition to regular coordination consultations with **ADRA**, PRISM participated in the planning workshop of the SMIS project in Siguiri held in January 2001.
- Likewise, PRISM participated in October of 2001 in the planning workshop held by **Save the Children** on the continuation of their interventions in the Kankan region after October 2002.
- Regular coordination meetings are held with the **Africare ISAD** project in Dinguiraye. Regular coordination meeting were held with **Africare ISMI** project in Dabola until its closedown.
- One of PRISM technical coordinator participated in the PNLs situational analysis sponsored by the **World Bank PPSG project**.
- Active and effective collaboration was maintained with **AVSC/Engender Health** (COPE and Facilitative Supervision integration) with **AGBEF** (CBD program, IEC activities, promotion of Murigas) and with **CENAFOD** (community mobilisation).

Coordination with USAID (4.2.2)

Consultation and coordination with the SO2 team has been very dynamic and productive during FY01.

- PRISM consulted regularly with the USAID/SO2 team in order to finalize the project's operational plan and budget for years 4 and 5 after realigning them to the reduced geographic focus zone.
- The main results of the mid term evaluation of the project were presented to PRISM staff and to the Kankan IRS in April 2001 by USAID's SO2 team members with PRISM COP and M&E Specialist.
- Regular consultations with the USAID CTO and M&E Specialist helped PRISM complete its revised performance indicators package.
- On January 11th USAID/SO2 team and PRISM organised a workshop on HIV/AIDS prevention where USAID related interested parties participated (USAID and USAID funded organisations in Guinea). A total of 10 projects/NGOs and 6 units of USAID-Guinea were represented at the workshop.

Conclusion

Guinea's decentralized health system continues to grow stronger and expand and is beginning to move toward sustainable use of RH services, as for instance shown by the recent increase in CPR (DHS, 1999). However, by any standards, fertility remains high, and maternal and child mortality continue to be unacceptable. Those children that do survive are likely to grow up facing yet another health calamity, namely HIV/AIDS. Yet, despite the daunting health indicators, there is very good reason to believe that these trends can be reversed, and that Guinea may be able to fend off a major HIV crisis. As both the GoG and USAID have correctly recognized, the key to sustainable success lies largely with local and national ownership and capacity to deliver the needed health services.

Over the past 4 years, PRISM has been supporting the GoG in building and strengthening its decentralized health system in rural Guinea. The collaboration has been one of true partnership at all levels, but most so at the regional and district level, where PRISM staff are based and work side by side with local health authorities and the beneficiaries of the health system, namely the communities themselves.

This report has shown that PRISM's approach of improving systems and community participation from within the local Guinean structures leads to important improvements locally, in terms of use of health services as underscored by the continued increase in CYP and CPN services. The approach, albeit somewhat slow at start up, is now leading to results that are real and sustainable and providing continued TA would consolidate the gains made to date. The success is underscored by the encouraging improvements at the service delivery points. Compliance with RH Norms & Protocols has increased beyond expectation, and the CBD program is contributing 25% to increased CYP. However, the functionality of health center services, while improved, will continue to require special attention. Key interventions in FY02 will therefore focus on ensuring that all medical and IEC materials are available at HCs while continuing to ensure that management tools and trained human resources remain available. Perhaps two of the biggest challenges faced by the Guinean health system are those of drugs, especially drugs to treat STIs and to treat childhood illnesses, and of instituting durable supervision systems and approaches leading to sustained quality of care and service improvement. While management systems and tools are steadily improving and becoming streamlined, as demonstrated by the process indicators and follow-up visits by DPS supervisors, the availability of drugs remains dependent on the central level, where stockouts of long duration continue to hamper the full implementation of service delivery. At the same time, the supervision model in place in Guinea remains very hierarchical and still focuses very much on control functions rather than on supportive functions leading to improved performance at SDPs.

During its 5th project year, PRISM will continue to focus on improving maternal and child health, while working with communities and health authorities, to put in place the interventions needed to fend off HIV infection, especially among the younger generation. Lobbying with other donors and the GoG and finding a solution to the chronic shortage of drugs will continue to be part of PRISM's efforts to improve the health system and the health of Guinean families. The FY01 results indicate that PRISM is well on its way to achieve the end-of-project targets, and is likely to even exceed those. The results will be important and real, yet fragile. After 5 years of systems strengthening, the GoG and the Guinean people will continue to need seamless support both to consolidate the gains and to continue the trend of

health improvements. The partnerships fostered over the past 5 years will be key to the long-term success.

SUMMARY OF PRINCIPAL ACTIVITIES AND RESULTS

(July to September 2001)

This section presents PRISM's principal activities and results for the last quarter of USAID's fiscal year 2001 for the purpose of completeness and continuity in quarterly reporting. PRISM end-of-year 4 progress report presents the details on the various interventions and achievements listed hereunder.

IR1. Increase of ACCESS to RH Services

Availability of Essential Resources at SDPs

- Assessment of medical material and cold chain situation in Dinguiraye, Kankan and Kouroussa prefectures.
- Delivery of medical material and supplies to HCs of same prefectures.
- Inventory tool for availability of essential resources at HC in use in HG.
- Assessment of availability of resources at HCs ongoing in HG – performed by DPS supervision teams.
- Fee schedule board for HC's services and products designed, produced and installed at 45 HCs.
- COGES survey results reviewed and presented.
- Training of 15 Murigas promoters.

CBD Program

- Training of 21 CBD agents.
- Evaluation of performance of recently integrated CBD agents and distribution of bicycles in accordance with policy.
- One AGBEF Technical Assistant for CBD/IEC support assigned to the Faranah DPS.
- Performance of AGBEF TAs for CBD/IEC assessed.
- Computerised monitoring application installed at the Faranah DRS and staff trained in its use.

IR2. Improve QUALITY of RH Services

RH Quality Standards, Support Systems and Services

- COPE integrated in 9 facilities, monitored at sites where integrated during previous periods.
- Quality of service observation tools developed for FP, CPN, Childcare and STI care, and in use in HG.
- Assessment of facilitative supervision performed in Siguiri prefecture.
- Post training monitoring of maternity services trained staff performed in Kankan, Kouroussa and Mandiana.
- Training of 18 CPN agents in CPN partogramme.
- PAC services integrated at 3 hospitals in HG (12 hospital maternity providers trained in PAC);
- Contraceptive Technology

Strengthening of the National H/MIS

- Training in basic computer uses of DRSS' staff in HG (decentralization of H/MIS)

IR3. Increase DEMAND of RH Services

- Youth campaign targeting HIV/STI prevention and prevention of unwanted pregnancy is successfully being implemented in all of the 8 prefectures and in one high risk sub prefecture;
- Youth campaign in HG advertised on national news and on national and rural radios.
- Regional and prefecture IEC working groups reached out to communities and community leaders, establishing joint work planning and IEC activity implementation
- 20 HC in HG are recognized as 'youth friendly'; their staff were trained in special IEC and IPC/C skills to meet the needs of youth
- New IEC/BCC materials and job aids were distributed to HCs, communities and IEC promoters, and messages were passed at social events including sports, theater and social clubs
- The EPE program improved immunization coverage in Faranah (pilot prefecture) was evaluated and resulted in diminished drop out from follow up vaccinations from 28% in 1999 to 15% in FY01.
- Participation of PRISM to the IEC Consensus Building Workshop organized by the MOH and held in Conakry.

IR4. Improve COORDINATION of Interventions in RH

- Management of supervision activities supported at the 2 DRSs and at the 8 DPSs of HG; 4 DPSs performed supervision activities in accordance with agreed guidelines.
- Computer network installed and operational at MOH; email capacity established at MOH central level units and at HG's DRSs.
- Participation and technical support to 8 CTPS meetings and to 2 CTRS meetings.