A Snapshot of PRIME II

Addressing Global Priorities for Improving the Performance of Primary Providers

At the three-year mark, the PRIME II Project is implementing over 40 activities in 21 countries worldwide. Eighteen of the activities are core-funded (USAID Office of Population), 14 are financed by USAID missions (Field Support), and 9 are enabled by core special initiatives funds (USAID Office of Health). In general, core funds support innovation in learning strategies or service delivery improvement;[1] sometimes core interventions lead to findings and achieve results that are subsequently expanded with missions' Field Support funds.[2] PRIME II Field Support interventions are typically highly focused and complementary to other USAID-financed activities in a country, although the Project has also proven to be an effective, flexible mechanism for carrying out a wider spectrum of reproductive health activities of the range often seen in smaller scale bilateral projects.[3]

Reviewing Results in PRIME II
Oct. 2001–Sept. 2002

Case Studies:

- Kenya PAC
- Bangladesh RTL
- Dominican Republic RTL
- Ghana PI
- Rwanda HIV/AIDS
- India CPSM
- Dominican Republic CDQ
- Ghana RTL
- Benin RTL
- Rwanda PI
- Mali FGC
- Francophone PAC/Nigeria MAQ

An Effective Partnership for Targeted FP/RH Services

In all cases, PRIME II country activities respond to the daily challenges faced by primary health care workers by providing them with innovative and culturally appropriate solutions derived from the substantial field experience of the PRIME II consortium (Intrah, Abt, EngenderHealth, PATH, TRG, ACNM, Save the Children). The vast majority of PRIME II activities are designed to address unmet family planning needs. In addition, PRIME II plays a leadership role in identifying and testing innovative strategies and practices to enable frontline health workers to respond effectively to a range of reproductive health challenges in very low resource settings. These challenges include adolescent reproductive health, maternal health, postabortion care, postpartum hemorrhage, sexually transmitted infections, HIV/AIDS and female genital cutting. Furthermore, a few USAID missions have requested PRIME II assistance to improve performance by increasing providers' capacity to plan, allocate resources, develop and manage services.

PRIME II Technical Leadership Areas

In 2002, PRIME II used a Performance Improvement (PI) approach within all of its activities, whether they involved family planning, postabortion care (PAC) or responsive training and learning (RTL)—from core-funded studies in Armenia to Field Support programs in Ghana. Although the PRIME II

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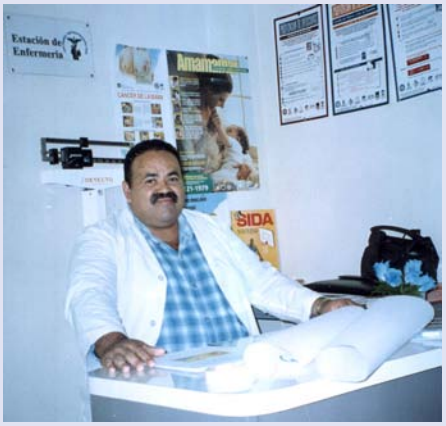
Consumer-Driven Quality initiative was still being conceptualized in 2001, by the end of 2002 providers in all the PRIME II regions were soliciting input from and listening to clients and communities, to ensure that services provided coincided with consumers' expectations. PRIME II PAC activities go beyond technical and state-of-the art medical techniques to incorporate PI, RTL and CDQ approaches into the design, improvement and expansion of PAC services by expertly trained nurse-midwives.

Global Responsiveness and Sharing of Best Practices

With strategically located regional and country offices worldwide, PRIME II is able to implement effective FP/RH service delivery solutions quickly. Experiences and best practices learned in one region are assimilated and applied in other countries and regions. Behavior change techniques found to be effective in addressing safe motherhood issues in India and female genital cutting in Mali are currently being studied as PRIME II develops a postpartum hemorrhage strategy for three countries in Africa. Results with non-training interventions—such as provider peer support networks in Kenya—have shown that there are viable alternatives to costly traditional supervision systems for maintaining high levels of knowledge and skills long after a training event has ended. PRIME II has learned much about hard-to-reach populations, experimenting successfully with different strategies in several countries (e.g., self-paced learning, use of different media, or a combination of methods).



Prospects for 2003-2004

As new data become available from other core and Field Support activities, PRIME II continues to adjust and orient its interventions and initiatives in an evidence-based manner. PRIME II will explore the concept of rapid performance needs assessments (PNAs) for situations where lack of funds or a heightened sense of urgency require program planners to quickly evaluate performance needs and act accordingly. This thoughtful exploration will take into account both the desire for quick results and the need for careful planning, monitoring and evaluation of programs. Innovative learning approaches require considerable lead time for development and reach the implementation stage later than traditional training programs. PRIME II will continue to develop and test alternative learning strategies for situations where opportunity costs preclude standard classroom training.

The PRIME II PAC model will be expanded to other countries to address maternal mortality and morbidity in areas where access to hospital and health center services is severely limited. Ongoing challenges include addressing the sensitivities associated with abortion and PAC, promoting a more comprehensive and community-based approach to PAC, and strengthening linkages between emergency care, family planning and other

RH services. Finally, new CDQ tools will enable providers to elicit their clients' perspectives and use this feedback to improve services. As health workers' attitudes and practices evolve to match consumer-defined needs and expectations, the use of FP/RH services, especially by underserved groups such as men and adolescents, will increase.

Selected Year-Three Results

The facts and figures in the following pages speak for themselves, showing how PRIME II strategies have:

- Linked more than half of postabortion Kenyan women with family planning methods
- Attracted nearly five times the clients to facilities with trained paramedics in Bangladesh and built the capacity of local training organizations for long-term sustainability
- Adapted two excellent training approaches to the needs of volunteer community health promoters working in extremely poor and marginalized communities in the Dominican Republic
- Established reliable unit cost data for starting and maintaining community-based health planning and services zones for better planning and coordination of support by the Ghana Health Services and partners

- Counseled more than 2,000 prenatal women in voluntary HIV/AIDS testing, tested 86% of them, and treated 49 HIV-positive women and 57 infants with nevirapine in Rwanda
- Quadrupled the percentage of women who accepted family planning methods 6-weeks postpartum and who were prepared to deal with complications during delivery in 40 villages and hamlets of rural Uttar Pradesh, India
- Doubled the number of clients attending a Dominican peri-urban clinic and tripled the number who pay for their services
- Posted significantly improved skills among private Ghanaian midwives in the scale-up of a self-directed learning program to strengthen counseling and interaction with adolescent clients
- Tutored primary providers in Benin, 94% of whom identified appropriate protocols and described the correct process of care after their training in new national health protocols developed with PRIME II assistance
- Developed community-based prepayment schemes to strengthen the links between primary providers and the communities they serve, with a focus on increasing access (more than fourfold increase in access to services) and improving quality
- Worked in Mali with the Ministry of Health and NGOs to develop a national performance-based curriculum to eliminate FGC by improving the counseling and interactive skills of primary providers
- Facilitated two important events (Francophone PAC and Nigeria MAQ) that generated action plans, which country teams have already begun to implement.

[1] Self-paced Learning in Ghana, PAC in Kenya and Senegal.
[2] Auxiliary Nurse-Midwives Project in India.
[3] E.g., Rwanda and Paraguay.

PRIME II

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