



Reviewing Results in PRIME II

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

Knowledge Advancing Best Practices

- PMTCT
- Scaling-Up PI
- Costing
- Supportive Supervision

Support to the Field

- Nicaragua: EONC
- Philippines: HIV/AIDS
- Paraguay: FP/RH Quality
- Mali: FGC
- Senegal: PAC
- Dominican Republic: RTL
- Mali, Benin, Ethiopia: PPPH
- Bangladesh: RTL

PRIME II

IntraHealth International, Inc.
6340 Quadrangle Drive, Suite 200
Chapel Hill, North Carolina 27517
intrahealth@intrahealth.org
www.prime2.org www.intrahealth.org

PRIME II Results Review

Since the PRIME II Project is in its fifth and final year of implementation, a group of senior headquarters and field staff, partner representatives and USAID officials gathered in July 2003 to review available and expected results and determine the key messages and lessons learned emerging from the Project. A spin-off from this group has continued the effort to develop a comprehensive communications strategy for the final year of the Project to ensure that these lessons and messages are widely shared. This year's Results Review submission includes an overview of the key messages that emerged from the July workshop and a series of Pages highlighting key results areas from 2002-2003.

Key Messages

The Overarching Message:

PRIME II has improved primary provider performance by applying and scaling-up Performance Improvement and supporting approaches.

Primary Care Providers

PRIME II has helped expand service delivery and reach more people with critical FP/RH services (including HIV/AIDS) by identifying and building the capacity of a wider range of primary providers who respond effectively to growing health care needs.

Consumers

PRIME II has increased the quality, accessibility and use of FP/RH services by integrating consumer perspectives and by fostering consumer-provider partnerships.

Blended Learning

PRIME II has improved primary provider performance by developing and implementing practical, cost-effective blended learning approaches.

Non-training Interventions

PRIME II is discovering effective ways to improve provider performance through a range of non-training interventions.

PRIME II Project Management

PRIME II has demonstrated strong technical leadership and produced impressive results in primary provider performance; successfully managed a large, complex project with significant field support contributions using a decentralized management model; maintained strong and supportive working relationships with USAID/Washington and missions; and pioneered a successful partnership model.



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Improving Performance through Clear Expectations

Linking National Reproductive Health Policy and Primary Provider Performance

Family planning and reproductive health (FP/RH) service policies and protocols can be a powerful facilitating factor in creating clear performance expectations for primary providers. This makes policy and protocols development and revision a natural and critical component of the performance improvement process.

Interventions and Results

PRIME II has had significant success in the policy arena. Key results from 2002-2003 include:

In *Rwanda*, the Ministry of Health (MOH) asked PRIME to help draft the first national RH policy since the country's civil war. To identify national RH priorities PRIME organized a round-table conference in 2000, which launched a collaborative process with key RH stakeholders. PRIME facilitated this process and helped to finalize the RH policy, which was signed by the minister of health in July 2003. With assistance from PRIME, the Rwandan MOH is now drafting new RH guidelines to ensure effective implementation of the national policy.

In *Armenia*, PRIME organized a national forum, held in September 2002, in which over 100 national and international experts reached consensus on the most important actions needed to improve FP/RH access and quality using WHO guidelines. These recommendations served as the foundation for RH legislation passed by the Armenian parliament in December 2002 after significant technical review and support from PRIME, UNFPA and the NGO community. The legislation provides a framework for expanded access to quality FP/RH services and guidance on women's reproductive and sexual rights. Early on in its work in Armenia, PRIME also organized a Ministry of Health working group to draft a national RH policy. After the working group prioritized RH needs and services, PRIME defined roles and responsibilities for FP/RH providers at all levels of the health care system to match these priorities. While not yet officially approved, the draft policy is serving as a guide for additional policy work to support PRIME's assistance in expanding the role of primary-level nurses and midwives. Among these efforts are new RH protocols, which were more easily developed and approved because they were based on the draft national policy.



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In *Paraguay*, PRIME designed and implemented the evaluation of the Ministry of Health's five-year National RH Plan (1997-2001). The evaluation was presented in November 2002 to the National Reproductive Health Council, a major policy body presided over by the MOH. This was a landmark event for Paraguay and Latin America, marking one of the few instances when implementation of a national RH plan has been comprehensively evaluated. The methodology included stakeholder interviews ranging from rural clients to high-level government officials, observation of providers in various settings, and focus groups with clients of different gender and age groups. The results revealed particular problems in the area of dissemination of the National Plan. PRIME is assisting the MOH in designing a new National Plan for 2003-2007, through a highly participatory process that includes stakeholder workshops in 17 geographic departments. PRIME has also been asked to provide training and assist in disseminating the new plan throughout the country.

In *Zambia*, PRIME gathered input from consumers on their expectations for quality nursing services. The Zambia General Nursing Council then built this consumer feedback into revised nursing and midwifery practice standards based on the East, Central and Southern African College of Nursing draft professional regulatory framework. This is one of the first examples of provider standards or protocols that reflect consumer input and promote consumer-oriented care.

Key lessons from these experiences include:

- While necessitating an in-depth and sometimes lengthy process, a participatory approach that ensures the involvement and buy-in of local stakeholders and partners as well as government officials is essential for developing policy and protocols that are most likely to be implemented and used
- Clearly stated policies and related protocols should form the basis for clear provider performance expectations, and are a part of the Performance Improvement approach
- It may be useful to gather feedback from consumers on their expectations for quality care as a part of the process of developing protocols
- In order to improve implementation, it is important to focus on wide dissemination of policies and translation of policies into protocols and clear provider performance expectations.



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Kristin Cooney



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Prioritizing the Common Good The Effective PRIME II Partnership Model



Like many large USAID global projects, PRIME II is designed for implementation by a consortium of partners who bring a broad set of complementary skills and capacities rarely available from a single organization. This is a strategy with many advantages, but it creates a complex structure to lead and manage. From the earliest stages of forming a partnership, responding to the Request for Application and the startup of operations, the five PRIME partner organizations have shared a powerful vision of the partnership in action. The resulting collaboration has proven unusually rewarding, and a review of its successes and lessons learned is provided here.

Partner Leadership Group

Composed of two senior leaders from each partner organization, the Partner Leadership Group (PLG) provides a stable and consistent mechanism for direct participation in the Project's strategic direction and technical leadership. This tight-knit group meets four times a year, rotating venues among partner offices. These leaders must set the example of a willingness to prioritize the common good of the Project and to seek win-win decisions.

Memorandum of Understanding

At the outset of the Project, members of the PLG collaborated to develop the PRIME II Partnership Memorandum of Understanding. This document, signed by each organization, provides transparent and practical guidance on topics such as partnership structure and process, annual planning and subcontracting processes, responding to new work opportunities, credit and recognition, representation, and strategic prioritization of technical assistance requests.

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Seconded Staff

The PRIME II partnership operates daily, in a very straightforward way, through seconded staff from the partner organizations based in the Chapel Hill headquarters. In addition, a number of partner staff are based in PRIME field offices. Many seconded staff hold key decision-making positions on the Project such as Unit Director and Regional Director. Seconded staff are so fully integrated into the Project that it is often not readily apparent to staff or outsiders which partner is their home organization.

Partnership Collaboration in the Field

The same collaborative relationship established among the US offices of partner organizations extends to the partners' regional and country offices. These relationships were purposefully built at the field level. In the beginning of the Project the organizations came together in the field to plan how they would work together. This collaboration frequently proves valuable in identifying new opportunities, helping start new country programs (e.g., in Honduras, Rwanda and Armenia) and sharing experiences and resources (e.g., in Kenya and Ghana).

Challenges of Partnering

Naturally, there have been challenges in building and maintaining the PRIME II partnership. Among the Project's accomplishments and lessons learned:

- Establishing and sustaining a trusting, synergistic partnership requires leadership commitment and resources. This level of commitment from all PRIME partner organizations, including USAID, has been exceptional.
- PRIME II has two supporting institutions, the American College of Nurse-Midwives and Save the Children. These affiliations were based on the need for specific, project-by-project technical assistance, and the organizations have not been PLG members. Consequently, the supporting institution relationship has not been as well defined as the partnership model and has proven more challenging to manage.
- The PLG structure has helped to ensure that communication channels are open and that appropriate staff from each partner organization stay informed about Project developments, aware of each partner's capabilities, and ready to access these competencies to meet the Project's needs.
- While the PLG has resulted in effective communications among partners, a more regular and formal feedback mechanism would enable partners to continuously monitor and improve partner relationships and performance.

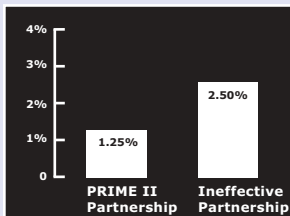


- Each partner organization expects their technical resources to be utilized as fully as possible. PRIME's twin goals have been to assign the most appropriate technical resources to the job at hand, and to share the work so that each partner organization contributes to the Project's success. Decisions on work distribution have been guided by technical needs, not a predetermined portion of the work.
- Partners that initiated or led in developing new project opportunities, especially in the field, generally received larger portions of the work on those projects. This strategy has contributed to the large number of field support projects under PRIME.

Advantages of the Partnership

PRIME's success in creating a model of partner collaboration has resulted in significant benefits:

- The Project has maintained easy access to the partners' diversity, complementary strengths, technical expertise and management know-how.
- A sense of common purpose and shared commitment has encouraged partners to define together the Project's technical leadership areas and cutting-edge technical agendas in a collaborative and technically synergistic manner.
- PRIME has drawn from all partner organizations to constitute its interdisciplinary global teams, developing strategies to move technical agendas forward. This has helped to scale-up new initiatives faster and more successfully.
- The partnership helped the Project expand to new countries faster, bringing more depth of technical expertise, management experience, understanding of the context, and leveraging of other agency and donor contributions.
- Because the PRIME II partnership is effective, USAID has been less taxed to engage in fostering collaboration, solving problems and negotiating among partners. The partnership has played the role of ensuring that the technical competencies of the various agencies are considered and used to the fullest extent possible.



Costs of Partnership
As percentage of
annual project budget

Value of the Partnership

Building and maintaining partnerships requires leadership attention and resources. PRIME estimates that the annual cost of the partnership is approximately \$210,000, which when annualized over the first four years of the Project is about 1.25% of the Project budget. As one way to gauge the value of effective partnering, PRIME estimated the cost of an ineffective partnership using both real examples of the costs of problem-solving and hypothetical examples of missed opportunities. PRIME estimates that annual costs of lost

productivity due to chronic ineffective partnership in a global project the size of PRIME II would be around \$500,000, or about 2.5% of the budget. As this exercise shows, the investment of time and resources in creating an effective partnership has paid off in the Project's overall productivity. However, the successes of the PRIME II Project in technical leadership, field support, producing results, and meeting performance expectations offer the best proof of the strength of this partnership.



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Photo Credit:
Marc Luoma



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Voluntary Counseling, Testing and Treatment Scaling-Up Services to Prevent Mother-to-Child Transmission of HIV



Prevention of mother-to-child transmission (PMTCT) of HIV services at the Byumba and Kibuye district hospitals in Rwanda, launched with assistance from PRIME II in March 2002, have been successfully sustained, with increasing percentages of women and their partners agreeing to receive HIV testing. Scale-up to a third facility, Kigoma Health Center, beginning in December 2002, has produced similar achievements. Building on results and lessons learned from this work, PRIME is taking a leadership role in the new presidential initiative PMTCT program in Ethiopia and developing approaches other projects can use to integrate family planning into PMTCT services.

Background

PRIME's PMTCT activities in Rwanda, carried out in collaboration with the Ministry of Health (MOH), IMPACT/Family Health International (FHI) and the Treatment and Research AIDS Center, have striven to build a foundation for improved prenatal, obstetric and postpartum care, better outcomes for seropositive women and their children, and open dialogue about HIV/AIDS. The PMTCT sites where PRIME is working were identified in conjunction with government and USAID partners in districts where the Project already had an active presence.

Lessons learned and implementation challenges from PMTCT activities in Rwanda are being incorporated into the design of the five-year Ethiopia initiative, the *Hareg* Project, launched in September 2003. PRIME is serving as the overall coordinator of *Hareg* activities for USAID and the Centers for Disease Control, who will collaborate with UNICEF, the MOH and Ethiopia's HIV/AIDS Prevention Control Office

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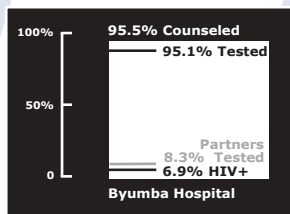
(HAPCO). PRIME's Ethiopia country director and a MOH counterpart will travel to Rwanda late this year to observe PMTCT service delivery and better understand how PRIME's approach in Rwanda is integrated into national FP/RH services.

Interventions

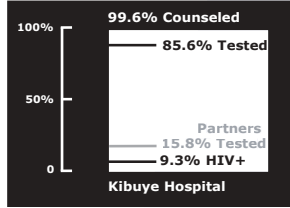
At the Rwanda sites, PMTCT activities include group and individual counseling during prenatal care; voluntary counseling and testing (VCT); administration of nevirapine to HIV-positive delivering mothers and their newborns; prenatal, obstetrical and postnatal care; breastfeeding counseling; and family planning counseling and services. PRIME has trained more than 100 providers in VCT skills and nevirapine administration, and supported the training of eight laboratory technician in rapid HIV confirmation tests. To promote PMTCT services and encourage partner involvement and testing, PRIME has also carried out IEC/BCC activities at the community level. In July 2003, PRIME initiated PMTCT services at two additional sites, Mugonero Hospital and Rubengera Health Center, and will expand to two more sites in the remaining implementation year.

Building on existing PMTCT programs in Ethiopia and targeting health facility-linked prenatal care as an entry point for women's services, the *Hareg* Project will expand PMTCT to 15 medical centers and their catchment sites. In a country where two thirds of mothers have no access to prenatal care services, PRIME and partners will use the Performance Improvement approach to integrate PMTCT services with broader efforts to improve safe motherhood. Priorities include strengthening family planning linkages with PMTCT and enhancing prenatal, intrapartum and postnatal care by including services such as voluntary HIV/AIDS counseling and testing, PMTCT and nutritional support and birth preparedness.

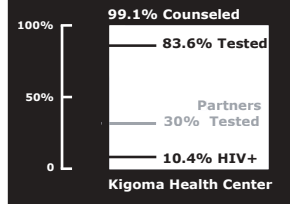




March '02 - August '03



March '02 - August '03



December '02 - August '03
Prenatal HIV Testing
and Counseling
at Rwanda Sites

Results

Rwanda: From March 2002 through August 2003, 95.5% of the over 3,000 women attending Byumba Hospital for initial prenatal visits were counseled about HIV/AIDS and PMTCT and 2,912 (95.1%) agreed to be tested for HIV. Of those women, 190 (or 6.9%) tested positive for HIV, with 142 (74.7%) returning for their test results. Providers have accelerated interventions to follow-up with mothers who have tested positive but have not returned for their results through infant vaccination activities, which are highly attended. Community sensitization activities on partner involvement may have contributed to the 8.3% of male partners who agreed to be tested, a jump from just 1% from March to September 2002. During 1,601 deliveries recorded by Byumba Hospital over the intervention period, 75 HIV-positive women received nevirapine during labor and all newborns were also treated with the drug.

At Kibuye Hospital, 99.6% of the 1,286 women visiting the hospital for prenatal care over the 17 months ending in August 2003 were also counseled about HIV/AIDS and PMTCT and 1,096 (85.6%) received HIV testing. This is significantly higher than for March through September 2002 during which only 64% agreed to be tested. Of the women tested, 82.4% returned for their test results and 9.3% were HIV positive. Following intensive community sensitization activities, testing of women's sexual partners has also significantly increased, from 4% as of September 2002 to 15.8% in August 2003. Of the 1,390 deliveries recorded at the hospital during the 17 months, 61 HIV-positive women received nevirapine during labor and 59 out of those 61 newborns were also treated with the drug.

Kigoma Health Center also reported strong results for the period from December 2002-August 2003: 99.1% of 683 women attending prenatal consultations were counseled about HIV/AIDS and PMTCT and 83.6% agreed to receive testing, with 10.4% HIV positive. Partner involvement has been especially encouraging, with 30% tested, of which 12.3% were HIV-positive. Out of 189 deliveries at the center, 14 HIV-positive women received nevirapine during labor and 12 newborns were also treated.



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Photo Credit:
Amanda Huber

*Applying and Scaling-Up
Performance Improvement***Lessons Learned in Improving
Provider Performance**

To ensure intervention packages address provider needs holistically, PRIME II has conducted 28 performance needs assessments (PNAs) in 18 countries. The findings have demonstrated that some form of PNA is an essential step that should be taken even when the initial client request is for training only. When presented with PNA results, clients quickly appreciate the value gained from the exercise. PNAs need not take a long time, nor cost much money. Based on the scope of the situation to be assessed, PRIME's PNAs have been completed in as little as two or three days, with costs as low as less than 1% of a total project budget. Based on these experiences, PRIME II is able to make recommendations to other organizations on using and scaling-up the Performance Improvement (PI) approach.

**Recommendations for
Implementing Successful PI Projects**

It is possible and necessary to convince even those clients with a one-intervention mindset to use PI. Prior to the widespread use of PI, project designers often attempted to solve provider performance issues with a single favorite intervention, usually training. Because USAID missions and ministries of health are used to training-only solutions, requests for assistance typically still arrive as a request for training. At times, it is appropriate to explain the benefits of PI as a way to address problems affecting performance that are unlikely to be solved through training. In other instances, clients may be resistant and insist on training only. In such cases, PRIME has found it useful to agree to the request but gain permission to ask additional questions to “make sure the training

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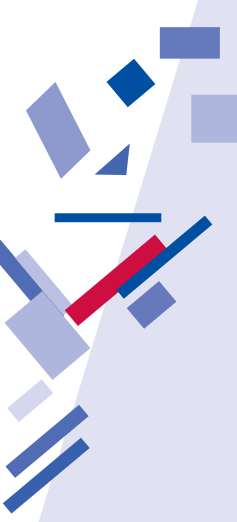
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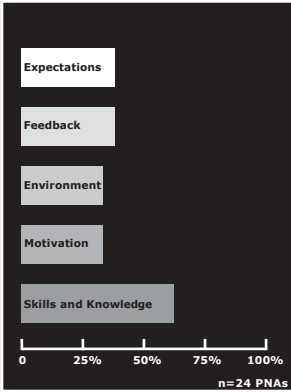
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sticks.” In this way, other performance factors may be addressed and providers can get the additional support they need. Once this tactic has been used to show the non-training-related needs of providers, such as motivation or policy changes that set clear performance expectations, clients usually see the value of the assessment and often ask for PNAs in future collaborations.

The approach must be tailored for each situation: PI has been applied in numerous ways and in many content areas, including family planning, maternal health, postabortion care and preventing postpartum hemorrhage. While the approach consists of a clear, step-by-step methodology, PRIME has found that the process needs to be tailored for each unique situation. In most cases it makes sense to set desired performance before examining actual performance. In other cases the reverse order is used (e.g., India ISMP project). Depending on the rigor needed for the expected results, one may gather data from an exhaustive sample (800+ providers in the performance factors special study) or from only a few knowledgeable stakeholders (the 2001 Armenia PNA). Where target audiences are very large and the scope of performance is wide, more effort and money will be required. Still, even when time is short and budgets constrained, completing a PNA before selecting interventions is a critical investment that cannot be omitted. Moving in quickly with a misguided intervention that fails to improve performance only wastes much more time and money.



Performance Factors Found to be Missing

Multiple interventions are necessary: Over the 28 PNAs, seldom has one intervention been sufficient to meet the needs of providers. The graph on the left summarizes the percentage of needs assessments that found each performance factor missing. Performance results take time to emerge: Training-only projects have typically presented “results” that consist of the number of people trained along with pre- and post-training knowledge test scores. Measuring workplace performance demands more evaluation rigor (and budget). In addition, workplace performance changes take longer to emerge. For example, performance improvements brought on by holistic changes in the supervision system in northern Ghana have taken two years to become fully evident. Where results have been gathered quickly, because of programmatic time constraints, they have been far less compelling (e.g., Honduras PI project). Along with careful interim monitoring, programs should allow the time and space for interventions to be effective.

To build capacity in PI, train and then partner: As a method of scaling-up PI, PRIME has built capacity in using the approach. In internal and external capacity building efforts, the greatest success has come from initial skill-building and then partnering during a PI project. Skill-building has taken many forms, including one-on-one introductions,

public instructor-led courses and self-paced learning using PRIME's online materials. Partnering during an initial project has taken the form of side-by-side work in the field as well as assistance from afar. PRIME's work with MOH staff in Tanzania offers a successful example of PRIME's PI capacity building. After attending a PI short course sponsored by PRIME and the Regional Centre for Quality of Health Care in Uganda, staff members redesigned several RH programs to use the PI approach. PRIME now works with MOH staff to support implementation of these programs.



Future Directions

While significant progress has been made in determining better practices in applying PI, much remains to be learned and tried:

- Broadening the application of PI to offer critical support to the human capacity development challenges posed by the HIV pandemic.
- Taking the PI approach to the next level, which includes developing and documenting additional experience in non-training interventions such as motivation, supportive supervision, human resource allocation, job satisfaction and employee retention.
- Scaling-up the use of approaches that make training more effective and cost-efficient, beginning with performance needs assessments (PNAs) and including approaches such as implementing complementary training and non-training interventions as indicated by PNAs, applying the performance learning methodology, use of innovative and blended learning, and improved use of information technology.



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*Informing Policy Decisions***Costing and Cost & Results
Analysis for Effective Approaches
and Interventions****Reviewing Results in PRIME II**

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PRIME II's work in Ghana demonstrates the Project's ability to help policy-makers and managers better understand the costs and cost-effectiveness of alternative approaches for improving provider performance. PRIME assisted the Ghana Health Service (GHS) to analyze costs of scaling-up the Community-Based Health Planning and Services (CHPS) initiative from a successful pilot activity to a nationwide strategy to reach underserved populations with family planning and reproductive health care. The results of this costing study are being used by the Ministry of Health to determine scale-up options and advocate for resources with partners. PRIME is also helping GHS assess the financial and opportunity costs of two alternative approaches for training primary providers of Safe Motherhood services: an innovative self-paced learning (SPL) approach and a more traditional classroom-based approach.

Background

Cost and results are key factors in determining whether to adopt an innovative training or non-training intervention for wider scale-up. Results are determined by whether an intervention achieves its intended intermediate (e.g., improved supervision, better learning) and end indicators (e.g., improved provider performance, increased service volume). PRIME II developed a Cost and Results Analysis (CRA)

Strategy and Toolkit to guide analyses of whether alternatives achieve desired results at costs equal to or less than existing approaches. The two experiences in Ghana are described below.

Intervention: CHPS District Cost Analysis

The Ghana Health Service and USAID/Ghana requested that PRIME II assess CHPS scale-up costs and produce financial information that had not previously been available for policy dialogue and implementation planning. GHS asked PRIME II to work in a sample of 16 CHPS zones from five of the country's ten regions. The sample zones encompassed 140 communities with a combined population of about 110,000. The PRIME II/GHS team collaborated with stakeholders to develop four data collection tools. Teams of data collectors from the regions gathered cost data on start-up activities and placement of Community Health Officers (CHOs) that occurred in 2000, and costs of service delivery by CHOs in 2001, the last full year for which data were available.



Results

The cost data produced by this analysis provided the basis for serious and overdue policy dialogue on issues related to the level of CHPS implementation the MOH/GHS and its partners can afford. The data will assist MOH/GHS in formulating policy decisions such as the need to downsize implementation goals or encourage adoption of lower cost scale-up strategies (e.g., renovation of buildings versus new construction). The team found the average annual operating cost from the sample zones to be inadequate and made recommendations accordingly.

In the absence of financial figures (which are based on averages from the 16 sample zones), previous plans for scale-up and numbers of CHOs to be deployed were not financially sound. MOH/GHS had never prepared an overall CHPS budget because CHPS is seen as an initiative under decentralized health service delivery and not a “program.” These figures have served as a “reality check” to MOH/GHS planners and partners, leading to increased recognition that

better coordination, logistical support and resource mobilization are needed to enable decentralized CHPS implementation to succeed and approach scale-up targets.

Intervention: Safe Motherhood Operations Research (OR) on Self-Paced Learning (SPL)

PRIME II collaborated with the FRONTIERS Project and the GHS Health Research Unit on the pilot study comparing the SPL and classroom-based approaches. The team measured the financial and opportunity costs of the two approaches based on a sample of 80 learners, 40 for SPL and 40 for the traditional approach, from the Northern and Upper West regions. The two approaches were implemented over 18 months in 2002-2003. Data collected included hours of time required by the learners and persons involved in implementing the two approaches, along with direct costs of activities such as travel, per diem, and other allowances and direct costs. These cost data are being linked with baseline and final evaluation results to assess the cost-results relationships of the two approaches.



Average Financial Cost Per Learner

Results

The financial costs of SPL are about 60% of the cost per learner of the traditional classroom-based approach. SPL takes more learner time, by a factor of about 3 to 1, but much of the time used by SPL learners is personal time or time when they are not seeing clients. Also, the “opportunity cost” of the SPL learners’ time does not have financial impact since their salaries and benefits are already being paid by the Government of Ghana. Programmatic (effectiveness) results will be available soon through an evaluation conducted by FRONTIERS.





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PRIME II

Suggested citation:
Killian R, Nelson D.
Costing and Cost &
Results Analysis for
Effective Approaches
and Interventions
11/2003
(PRIME PAGES: RR-29)

Photo Credit:
Richard Killian

Capacity Building to Support Primary Providers

Strengthening Traditional and Peer Supervision



Reviewing Results in PRIME II

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

Knowledge Advancing Best Practices

- PMTCT
- Scaling-Up PI
- Costing
- **Supportive Supervision**

Support to the Field

- Nicaragua: EONC
- Philippines: HIV/AIDS
- Paraguay: FP/RH Quality
- Mali: FGC
- Senegal: PAC
- Dominican Republic: RTL
- Mali, Benin, Ethiopia: PPPH
- Bangladesh: RTL

PRIME II

IntraHealth International, Inc.
6340 Quadrangle Drive, Suite 200
Chapel Hill, North Carolina 27517
intrahealth@intrahealth.org
www.prime2.org www.intrahealth.org

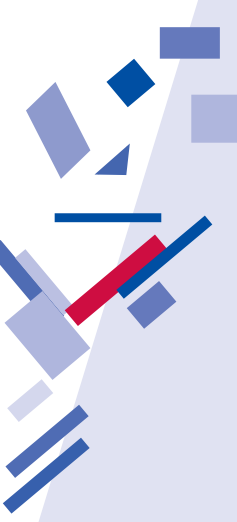
PRIME II seeks to support an enabling work environment for primary providers of family planning and reproductive health services to deliver quality care to their clients. These efforts include helping supervisors become more effective, particularly in the areas of setting clear work expectations and offering performance feedback. In addition, PRIME has encouraged peer networks among providers to create support when formal supervision is insufficient or unavailable.

Background

Performance needs assessments and other studies conducted worldwide often find weaknesses in supervision systems, which are frequently overburdened and understaffed. When supervisors adopt supportive approaches and other support systems are strengthened, the potential to affect a variety of factors influencing provider performance is high.

Interventions

Senegal: PRIME II provided technical assistance to ten direct supervisors of approximately 70 community health workers and their district-level supervisors in Kebemer district (population 150,000). The assistance included workshops, development of a guide and supervisory tools, and follow-up

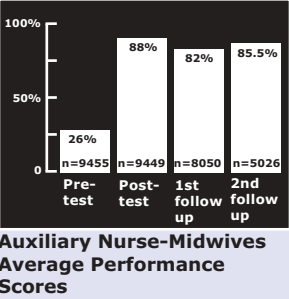
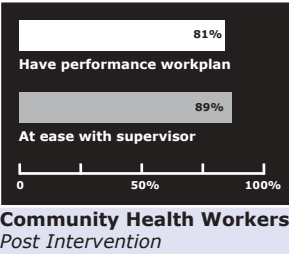


visits to support the supervisors. The intervention complemented a study by the Ministry of Health and the Population Council to explore alternative ways of providing community-based services.

Honduras: In the Olancho health region, PRIME trained 38 supervisors of public-sector primary health care workers in supportive supervision as well as 122 providers and supervisors in peer support. PRIME identified supportive supervision as an important intervention area following a performance needs assessment (PNA) that revealed poor provider performance in prenatal care and FP service delivery.

India: Through a cascade of master and lead trainers, PRIME has trained and supported more than 1,000 Lady Health Visitors (LHVs) in 37 districts of Uttar Pradesh. The LHVs offer supportive supervision to more than 9,500 Auxiliary Nurse-Midwives (ANMs), primary providers offering a range of FP services including IUDs.

Kenya: In Nairobi, Central and Rift Valley provinces, PRIME II has collaborated with the POLICY Project and local partners to strengthen four peer support clusters, formal groups that enable private nurse-midwives trained by PRIME in post-abortion care to supplement the limited support they receive from their formal supervisors, District Public Health Nurses. Workshops on peer support and performance improvement were attended by 46 participating providers.



Results

Senegal: All direct supervisors improved their performance, as indicated by the finding that 8 of 10 supervisors now plan and execute supervisory activities in accordance with the guide, prepare a plan for conducting supervision every two months, and use the checklist included with the supervisory tools; all of these are new performances. After the intervention, 81% of the 60 community health workers sampled had a performance workplan (compared to none prior to the intervention) and 89% felt at ease with their supervisors (no baseline is available since the providers are new to these positions). Preliminary data show improved performance by community health workers in both intervention and control areas.

India: A database on ANM performance reveals that while scores dropped slightly during an initial follow-up assessment a few months after training, they improved at the time of a second follow-up assessment. This return to higher-level performance seems to be due to the support ANMs received from the trained LHVs. All target districts achieved the supervision indicator; a minimum of 50% of supervisors performing at least two interactions per month with their super-



visees. Qualitative data indicate agreement among LHVs and ANMs that supervision has improved as a result of the intervention, with more coaching and emphasis on quality taking place during interactions.

Honduras: Supervisors' performance was measured through provider performance; some areas of performance improved while others did not, but the improvement was not statistically significant. There was no difference between the group with traditional supervision and the group with traditional supervision plus peer support. This lack of effect is most likely due to expecting results and conducting the evaluation too quickly after the intervention.

Kenya: Private nurse-midwives report that learning from peers, problem identification with peers and financial collaboration are among the primary benefits of peer support. Two of the peer-support clusters have become registered associations, with two others in the process of registering. All the clusters have established bank accounts and three are collecting fees from members. The members have either initiated or increased outreach activities in their communities, including visits to schools to discuss FP, STI/HIV prevention and postabortion care services with adolescents. Adolescents had not always been welcome in the private facilities, but peer group discussions helped convince providers to encourage adolescents to access their services and make their facilities more adolescent-friendly. While the final evaluation has yet to be carried out, preliminary data indicate that peer support has been beneficial and that providers see more FP clients because services have improved.

Lessons Learned

Key lessons learned from PRIME II's work in supportive supervision include:

- Many supervision options are available to ensure providers get the support they need. However, several systems need to be in place for supervision and support-related interventions to be successful.
- Consistent follow-up and a minimum investment of time to support the supervisors are required before changes in supervisory practices "trickle down" and affect provider performance.
- While PRIME has explored a variety of supervision alternatives, much work remains to be done, especially in field-testing additional forms of non-traditional supervision.
- Peer support appears to be a viable alternative in situations where traditional supervision is not available, such as with private providers.



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PRIME II

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Dohlie MB, Nelson D.
Strengthening
Traditional and Peer
Supervision
11/2003
(PRIME PAGES: RR-30)

Photo Credit:
Maj-Britt Dohlie

Linking Primary Providers and Communities Improved Responses to Obstetric and Neonatal Emergencies

The PRIME II Project's efforts to address maternal health in low-resource environments often depend not only on improving primary provider performance but also on strengthening community responsiveness to obstetric and neonatal emergencies and ensuring that services at referral facilities are up to standard. A PRIME II-assisted pilot project in rural Nicaragua has successfully integrated community members, volunteers and several cadres of providers to improve emergency obstetric and neonatal care (EONC).



Reviewing Results in PRIME II

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

Knowledge Advancing Best Practices

- PMTCT
- Scaling-Up PI
- Costing
- Supportive Supervision

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- Mali, Benin, Ethiopia: PPPH
- Bangladesh: RTL

PRIME II

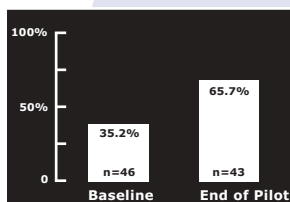
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6340 Quadrangle Drive, Suite 200
Chapel Hill, North Carolina 27517
intrahealth@intrahealth.org
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Background

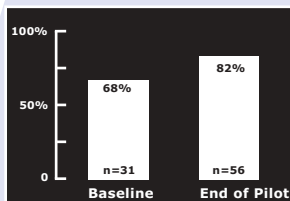
Nicaragua has among the highest maternal mortality ratios in Latin America and the Caribbean. Over a third of births are attended at home, frequently by a traditional birth attendant (TBA). To help the Ministry of Health (MOH) link communities, TBAs and health centers in the mountainous Jinotega region, PRIME II collaborated with the NicaSalud consortium of NGOs/PVOs: Project Concern International, Project Hope, Wisconsin-Partners of the Americas and Catholic Relief Services.

Interventions

The goal of the consortium's EONC strategy was building and reinforcing linkages among community-based providers, facility-based providers and community members to raise awareness of the danger signs of complicated pregnancies, the consequences of delays in seeking care and the importance of a prompt response to postpartum bleeding. TBAs and other primary providers received training in community-based life-saving skills (adapted from the American College of Nurse-Midwives' Home-Based Life-Saving Skills model). Community mobilizers and TBAs from the communities of Wiwili and Pantasma learned immediate first-aid for safe delivery requiring little or no medical equipment and supplies. Providers from Jinotega Hospital were trained in basic emergency skills including administration of drugs and intravenous fluids. Community mobilization activities focused on setting up EONC committees, pooling emergency funds, and establishing transportation plans to ensure women and newborns reach referral facilities quickly in the event of an emergency. Complementing these community organizing efforts, PRIME facilitated an ongoing census of pregnant women in the region. PRIME II staff also participated in a national commission to develop emergency obstetric and neonatal care protocols, which are



Care of Immediate Postpartum Women
Traditional Birth Attendants



Management of Postpartum Hemorrhage
Hospital Providers

undergoing evidence-based validation from the national referral hospital, regional and departmental hospitals and health centers.

Results

The final evaluation demonstrated significant improvement in provider performance. As defined by a quality index score, care of immediate postpartum women by TBAs improved by 87%. Management of postpartum hemorrhage by physicians, nurses and auxiliary nurses improved from 68% to 82%. These positive results for providers have been matched by community efforts. Of the 32 project communities, 78% reported the establishment of committees for emergency obstetric and neonatal care. Emergency transportation systems have been established in 56% of communities and emergency funds set aside in a quarter. In one illustrative example, emergency funds in the community of Venecia are being administered by a committee, and a community member with a vehicle is now on call to transport women to the nearest hospital in cases of emergency at any hour. A census of pregnant women is available in 81% of the communities, and nearly half have implemented birth and complications readiness plans.

PRIME II also conducted a qualitative evaluation to assess the integration of NicaSalud consortium partners in project implementation. The strengths of the partnership were many, with organizations sharing resources, time, funds and objectives to conduct a successful project. Those interviewed agreed that a principal strength was demonstrating to themselves and the MOH that a united group brought added credibility in developing and implementing this pilot at the institutional and community levels.



PRIME II

Suggested citation:
Coleman AL, Nelson D.
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11/2003
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Photo credit:
Alfredo Fort



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*Encouraging Condoms
and Dual Protection***Improving Sexual Behaviors
among High-Risk Youth**

Working through non-traditional providers, PRIME II built on a successful STI/HIV prevention project in the Philippines to improve contraceptive use among youth engaging in high-risk behaviors. Youth exposed to the intervention were significantly more likely to report using condoms and other contraceptive methods during high-risk behaviors than those who were not exposed.

Background

Through the USAID-funded AIDS Surveillance and Education Program (ASEP) in the Philippines, PRIME II partner PATH has been promoting safer reproductive health behaviors among groups identified at high risk of exposure to STIs and HIV. In July 2002, PRIME began working to improve access to family planning information and counseling for adolescent commercial sex workers, their clients/partners, and other adolescents who engage in risky sexual behavior. The intervention focused on encouraging adolescents to use dual protection, but especially to use condoms, through strengthening the capacity of ASEP partner NGOs to deliver information and counseling on STI/HIV prevention, reproductive health and dual protection, with an emphasis on pregnancy prevention, at four ASEP sites: Angeles, Cebu, Iloilo and Zamboanga. Because high-risk youth said they depended on Community Health Outreach Workers (CHOWs) and ASEP peer educators for information and counseling on STI/HIV prevention and treatment, these non-traditional providers were galvanized to expand outreach to high-risk individuals. Youth (the “consumers”), CHOWs and peer educators offered input into the design and implementation of the intervention.

Interventions

Qualitative research conducted with adolescent sex workers and their clients/partners indicated that the sex workers knew little about contraception and were reluctant to access government-run health clinics. Because of the instrumental role that CHOWs play with this elusive and hard-to-reach group, PRIME II provided refresher training to CHOWs from the four project sites on pregnancy prevention and reproductive health needs of adolescents and strengthened the CHOWs skills for dual protection outreach. Together with ASEP partner NGOs and their CHOWs, PRIME developed a job aid on dual protection that standardized messages to use when talking to youth.

**Reviewing Results in PRIME II**

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

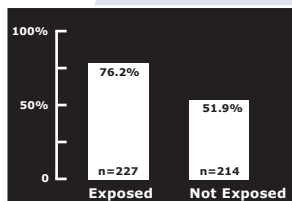
Knowledge Advancing Best Practices

- PMTCT
- Scaling-Up PI
- Costing
- Supportive Supervision

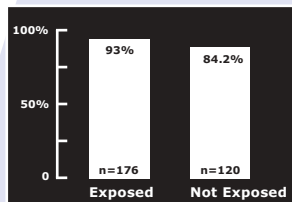
Support to the Field

- Nicaragua: EONC
- **Philippines: HIV/AIDS**
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- Mali, Benin, Ethiopia: PPPH
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PRIME II



Condom Use, Last Sex



Modern Contraception, Last Sex

Pocket-size educational materials were also designed specifically for youth to convey facts about dual protection and how to locate ASEP's youth-friendly pharmacists for select forms of contraception, including condoms.

Results

In May 2003, PATH/Philippines and the ASEP partner NGOs conducted a Behavior Monitoring Survey (BMS) among the adolescent target groups in the four project sites. Findings from the BMS study indicate that young female sex workers who were exposed to the PRIME-assisted intervention were significantly more likely to report condom use (76% versus 52%) and overall modern contraceptive use (93% versus 84%), and to seek appropriate treatment for STI symptoms (76% versus 55%) than those with no exposure to the intervention. The project shows that with clear written expectations for health workers and simple, targeted messages for clients, non-traditional providers can positively affect health-seeking behavior and practice in young female sex workers.



PRIME II

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Photo Credit:
PATH/Philippines



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Improved Performance, Better Quality Strengthening Family Planning and Reproductive Health Services



In Paraguay, PRIME II helped to develop and implement a comprehensive provider performance package with the Ministry of Health (MOH), leading to significant improvements in the quality of family planning (FP) and other reproductive health (RH) services. The components of quality that improved include client-provider interaction, counseling, informed consent, technical competence and availability of contraceptive methods.

Background

Paraguay has among the lowest contraceptive prevalence rates in Latin America and the Caribbean, a hard-to-access rural population, and a comparatively low level of donor and international NGO involvement in the FP/RH arena. The need to strengthen overall systems and services in FP/RH with assistance from PRIME II is a high priority for the MOH and USAID/Paraguay.

Interventions

The objective of the project is to improve the quality of five components of FP services: effective and appropriate client-provider interaction, effective counseling, informed consent, technical competence and availability of contraceptive methods. After an initial needs assessment, PRIME II worked with the MOH to design and implement a quality improvement model that included addressing many of the key factors known to improve provider performance: augmenting provider knowledge and skills in a number of technical areas, creating clear expectations for providers offering FP services, developing systems to incorporate client feedback, reinforcing the supervision systems, and maintaining needed supplies and equipment (e.g., sharp disposal receptacles,

Reviewing Results in PRIME II

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

Knowledge Advancing Best Practices

- PMTCT
- Scaling-Up PI
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- Supportive Supervision

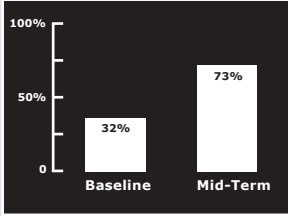
Support to the Field

- Nicaragua: EONC
- Philippines: HIV/AIDS
- **Paraguay: FP/RH Quality**
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- Mali, Benin, Ethiopia: PPPH
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IntraHealth International, Inc.
6340 Quadrangle Drive, Suite 200
Chapel Hill, North Carolina 27517
intrahealth@intrahealth.org
www.prime2.org www.intrahealth.org

privacy curtains, a clean water source). The project was designed to gradually phase up to working in 23 service delivery sites in five geographic regions of Paraguay.



Quality Score
11 Service Delivery Sites

Results

To measure changes in quality, PRIME started with a baseline survey with multiple indicators for each category. The questions required a yes or no answer and the total score for a site was a composite number based on the answer for each question. After up to six months of intervention time, a mid-term evaluation used a similar survey to measure improvements in quality in 11 sites where the interventions were in place (the project is still phasing into the other sites). The survey found that the clinics had realized a more than two-fold increase in their quality score, from 32% to 73%.

Other key results from the mid-term assessment include:

- All sites had established separate FP exam rooms with full-time dedicated staff attending to FP clients; had clear signs directing people to the FP counseling area and/or exam rooms, which were clean, offered privacy for clients and had educational materials available, including FP posters and flipcharts.
- All FP staff appeared enthusiastic, motivated and had a sense of empowerment to provide FP services. Providers who attended a PRIME II workshop or on-the-job training were eager to discuss their new knowledge and skills. As one nurse-midwife stated, “PRIME has been very important for my work. I am very happy and more secure...”
- All FP staff were conversant in FP methods and able to describe properly how they counsel on the pros and cons of each method. All sites properly stored and tracked FP methods (although a few sites depended on other depots for certain methods, so this information was not available for those methods).

- All sites implemented consistent standards of infection control during FP activities, with demonstrable changes in behavior as well as infrastructure. All sites had separate containers with a narrow opening for the disposal of sharp materials. Many sites had created a separate, closed fresh water container with a spigot, with special soap, towel and bucket for hand washing. All sites have separate containers with a narrow opening for disposal of sharp materials. Hydrochlorate solution and instrument buckets were available in the examining room and the providers understood how to mix the solution properly.
- Dramatic changes occurred in interpersonal relations between providers and their clients. Many providers related how they treat their clients differently, using phrases like “we take the time to talk to them and get to know them,” “we put ourselves in their shoes,” “we greet the clients in the hallway when we see them” or “when we send our clients to other departments on-site, we walk with them.”
- Counseling skills and techniques improved, with all sites providing each client with individualized counseling on available methods, presenting the pros and cons of each method before the client makes a choice. All staff used available IEC materials in counseling. In most sites, staff wore name tags and in some sites staff were reorganized to allow for a fulltime FP counselor.
- All of those sites that have received the appropriate provider training offered postpartum/postabortion FP methods on-site.





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PRIME II

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Strengthening Family
Planning and
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11/2003
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Photo Credit:
Juan Britos

Training Providers, Reaching Communities Counseling and Advocacy to Abandon Female Genital Cutting

In Mali, where 92% of women undergo female genital cutting (FGC), a PRIME II-assisted intervention has made encouraging gains in the effort to eliminate the harmful traditional practice through counseling and advocacy. Relying on outreach within and outside of health centers, the intervention was designed to improve primary providers' knowledge, skills and awareness related to FGC so that they could both serve as resource persons and better identify and manage complications from FGC.



Reviewing Results in PRIME II

Oct. 2002–Sept. 2003

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- **Mali: FGC**
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PRIME II

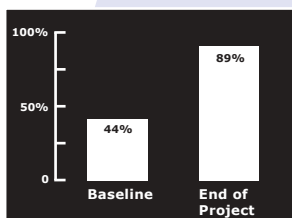
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6340 Quadrangle Drive, Suite 200
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Background

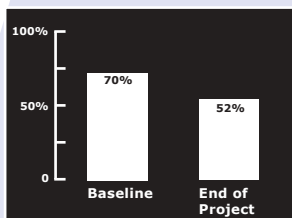
Female genital cutting in Mali typically occurs before girls reach the age of five, following the cultural belief that excising the clitoris and sometimes other parts of the female genitalia will keep a young woman chaste and improve her chances of marrying a good husband. FGC is associated with immediate and long-term health consequences including hemorrhage, HIV infection, complications during birth, infertility and even death. Attempts to persuade traditional practitioners, usually older women, to abandon the practice have not been very successful, and campaigns focused only on the health consequences of FGC have not only been ineffective but have led to increased “medicalization” of the practice by health providers. Targeting men in community campaigns against FGC is essential as they often have the final say in decisions about whether their daughters will be cut.

Interventions

PRIME II assisted a Ministry of Health (MOH) and local NGO technical working group in developing and field-testing a national FGC curriculum, which was used to train 120 reproductive health (RH) providers in Koulikoro and Bougouni districts and Bamako Commune I. Written knowledge tests administered six weeks after training showed significant improvement in provider knowledge about prevention and management of FGC complications. The curriculum is part of a FGC resource package for providers, which includes job aids and a 35-minute video that helps providers understand and identify complications from FGC. Produced with support from PRIME II, the video has also been distributed to government ministers, members of parliament and mayors. In addition to increasing primary providers' knowledge and skills, PRIME has worked with the MOH and NGOs to expand the providers' role as leaders for community campaigns to eliminate FGC.



Clients in Favor of Eliminating FGC



Clients who Intended to Excise Daughters

Results

At the 27 health centers in the three PRIME II implementation areas, providers are now three times more likely to ask pregnant women if they have FGC complications that might affect birthing. The mean number of FGC complications treated on-site has increased by 26%. While counseling on FGC was virtually nonexistent at baseline, an end-of-project review of health center registers showed that 414 female prenatal care clients received private counseling about abandoning the practice. Nearly three quarters of providers passed the counseling skills performance test, up from 12% at baseline. Providers facilitated 473 educational sessions in the health centers on the negative effects of FGC and 958 men who had come for consultation or to accompany a woman or child participated in waiting-room talks about the practice. At the end of the intervention, the percentage of clients who said they were in favor of eliminating FGC rose to 89% from 44%, and the percentage of clients who intended to excise their daughters declined to 52% from 70% at baseline.

Training providers to prevent and manage complications of FGC helped to increase the quality of other RH services in the health centers, as providers improved their skills in patient reception, counseling and screening. Improved counseling skills and provider comfort level in conducting RH talks paid off in a dramatic increase in educational sessions on general reproductive health topics, from 153 at baseline to 2,074 at the end-of-project review. Health information systems at the target sites were also strengthened as a result of tools put in place to monitor FGC-related visits, complications and referrals. Such monitoring activities were nonexistent at baseline.

Of the 1,187 community outreach sessions supported by the intervention, providers were present as resource persons at 714 (60%). Due to the intervention's success, PRIME has received additional funding to extend FGC abandonment efforts through strengthened provider-community partnerships.



PRIME II

Suggested citation:
Newman C, Nelson D.
*Counseling and
Advocacy to Abandon
Female Genital Cutting*
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Photo Credit:
Amanda Huber



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*Increasing Access,
Emphasizing Family Planning*
**A Community Model for
Postabortion Care Services**

**Reviewing Results in PRIME II**

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

Knowledge Advancing Best Practices

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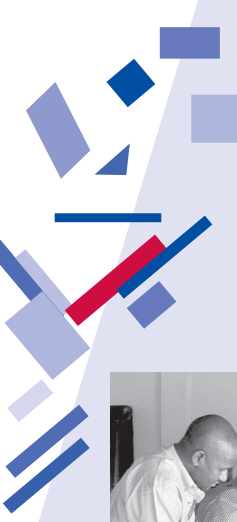
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IntraHealth International, Inc.
6340 Quadrangle Drive, Suite 200
Chapel Hill, North Carolina 27517
intrahealth@intrahealth.org
www.prime2.org www.intrahealth.org

In Sokone district, Senegal, PRIME II has implemented a model to expand postabortion care (PAC) services beyond facilities providing manual vacuum aspiration (MVA) to the community level where many women and adolescent girls live and work. The model relies on high-quality family planning (FP) services to help prevent unintended pregnancies and repeat abortion. This care meshes with fully functional referral and counter-referral systems among rural health huts and health posts and the district health center where women needing treatment for complications from unsafe or incomplete abortion can receive MVA.

Background

WHO has estimated that unsafe abortion is responsible for 30% of maternal deaths in sub-Saharan Africa. With a contraceptive prevalence rate of 8% and an estimated 33% of married women of childbearing age wanting to delay or avoid another pregnancy but not using contraception (DHS, 1997), the situation in Senegal necessitates innovative approaches to reducing the number and minimizing the consequences of unsafe abortion. Sokone, a rural district of 100,000 people about 200 kilometers from Dakar, was



selected by the Ministry of Health (MOH) for the PRIME II intervention because PAC/MVA services are available at the Sokone health center, which serves as a district hospital. There are 14 health posts in Sokone, each staffed by a nurse (mostly male), and 34 health huts where a matron or traditional birth attendant serves clients. Health post nurses supervise the health huts, with an average of two to three health huts linked to each health post.



Interventions

PRIME II used the Performance Improvement approach to target gaps in provider performance and access to services, including lack of knowledge about PAC/FP and infection prevention, no supervision, and limited community involvement for emergency care. Matrons and community members working at health huts have been trained to inform women where to obtain FP, identify danger signs of obstetric emergencies, and activate transportation and referral networks. Health post nurses have been trained in FP and to stabilize women with postabortion complications for transport to the health center. Job descriptions and performance expectations of providers and supervisors, including members of the District Health Management Team (DHMT), have been clarified; training curricula, job aids and supervision checklists are in use during training and supervision; and monitoring and data collection forms are in place.

Organizational support from the DHMT has also been strengthened to clarify task distribution among providers and improve the organization of services; ensure the availability of basic equipment, supplies and FP commodities; and establish the functional referral and counter-referral systems. Community-provider partnerships established and supported with assistance from the Center for Polyvalent Expansion, a program of the Senegalese Ministry of the Interior, play a major role in rallying local communities to maintain transportation plans and funds for obstetric emergencies and helping health post nurses convey effective, community-supported messages about FP. In addition, the Sokone district medical officer and his team have demonstrated their commitment to addressing the problem of unsafe abortion by actively advocating for PAC at the primary and community levels and for increased use of FP to prevent unintended pregnancies.



Results

Monitoring data collected and analyzed on a quarterly basis by the district MOH and PRIME are showing exciting results as women with obstetric emergencies begin, for the first time, to be referred from health huts to health posts for stabilization, treatment as possible, and referral to the Sokone health center for treatment as needed. From May to September 2003, 85 women with postabortion complications were seen at the health posts; of these, 11 were referred from matrons in health huts. Of the 85 PAC clients, 39 (45.9%) were treated by the nurse at the health post, using curage, and 36 (42.3%) were referred to the health center for MVA, 7 after stabilization at the health post. All 39 women treated at the health posts were counseled for postabortion FP and 22 (56.4%) left the health post with a FP method. In addition, 74 matrons at health huts and health posts now understand that they can and should re-supply FP clients using contraceptive pills, a task in Senegal's national FP service policy that matrons were reluctant to perform before a PRIME intervention in August 2003.

Reflecting improved provider performance, these preliminary data offer encouraging signs of what can be accomplished when PAC services are made more available and accessible to those who can benefit most from them. The MOH expects to replicate this approach in other districts in Senegal, and lessons learned and recommendations from the pilot initiative in Sokone district will have implications beyond Senegal for better practices in increasing the availability and use of PAC services to reach more women and adolescent girls who suffer the consequences of unsafe and incomplete abortion.





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PRIME II

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Corbett M, Nelson D.
A Community Model
for Postabortion
Care Services
11/2003
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Photo Credit:
Maureen Corbett

*Improved Provider Performance, Better Health-Seeking Behavior***Volunteer Promoters Increase Family Planning Knowledge and Use in the Bateyes**

While almost all PRIME II interventions measure changes in provider performance, the Project's work to improve the knowledge and skills of volunteer health promoters in seven of the Dominican Republic's *bateyes* also included a community survey of women's family planning and reproductive health (FP/RH) knowledge, attitudes and practices. The survey results reveal encouraging gains in accessibility and use of contraception.

Background

The most alarming health statistics in the Dominican Republic are found in the *bateyes*, isolated communities that were originally established to house the Dominican and Haitian migrant workers who toiled in state-run sugarcane fields and refineries. Due to the privatization of the sugar industry, the *bateyes* endure a high rate of unemployment; housing and sanitation are poor and health care suffers from lack of infrastructure, supplies and trained providers. In collaboration with the Dominican Institute for Community Action (IDAC), an NGO with 15 years' experience working in the *bateyes*, PRIME implemented a year-long intervention to compare two learning approaches, self-directed learning and classroom-based training, for 35 volunteer health promoters.

Interventions

Each learning approach was supported by a reference manual and client education materials, community radio broadcasts, a revolving fund for contraceptive supplies, creation of simple referral systems, community talks and home visits, and facilitated supervision. While the promoters did not necessarily learn in the manner project designers

Reviewing Results in PRIME II

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

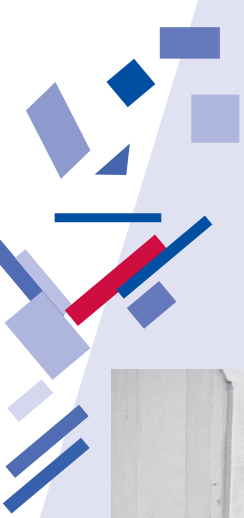
Knowledge Advancing Best Practices

- PMTCT
- Scaling-Up PI
- Costing
- Supportive Supervision

Support to the Field

- Nicaragua: EONC
- Philippines: HIV/AIDS
- Paraguay: FP/RH Quality
- Mali: FGC
- Senegal: PAC
- **Dominican Republic: RTL**
- Mali, Benin, Ethiopia: PPPH
- Bangladesh: RTL

PRIME II



had envisioned, a substantial amount of learning took place among promoters in each approach. Increased promoter knowledge and skills and improved performance have been documented in the 2002 PRIME II Results Review and other reporting, including a *PRIME Dispatch* (Number 6, June 2003) that captures findings and recommendations from the dynamic process of monitoring and revising the project design. To examine the effects of the intervention on health-seeking behavior in the *bateyes*, PRIME carried out a community survey among 390 women of fertile age both before and after the intervention. The random household surveys included 62 FP/RH-related questions. The first challenge in conducting the baseline survey was attempting to identify households in the *bateyes*: none had traditional address numbers and no neighborhood maps existed, even from the census bureau.

To proceed, promoters and PRIME staff drew maps of each *batey* by hand. The mapping exercise became a mini-intervention itself—community members were active in the effort and are using the maps to negotiate expanded municipal services from mayors and community officers. The post-intervention survey was conducted using the same interview instrument and methodology.



Results

The table below highlights findings from the baseline and post-intervention community surveys. Particularly noteworthy are the percentage of women finding contraceptives easy to access (from 19% at baseline to 60% post-intervention) and the percentage of women using contraception (from 69% to 81%). Though these results are positive, one limitation of the survey design is that it did not include measuring women's behavior in "control" areas, which would have provided demonstration of the net effects of the intervention. While the post-intervention survey indicates that improving health promoter performance in the context of a community-based intervention positively affected FP/RH practices, it is plausible that concomitant interventions in the *bateyes* may have contributed to the changes in women's behavior. However, the project staff is not aware of any major government or NGO programs that would have appreciably influenced FP/RH behavior in these communities.

| Question | Baseline (1/02) n = 390 | Final (3/03) n = 391 |
|---|----------------------------|-------------------------|
| Can get contraceptives from promoters | 59% | 79%** |
| Are using contraception | 69 | 81%** |
| -Injection | 1.4 | 5.4 |
| -Condoms | 1.4 | 4.3 |
| Know where to get EC (of 100% of sources) -From Promoter | 9.5 27 | 26** 84 |
| Had PAP smear in last 12 months | 48 | 58** |
| Contraception easy to access | 19 | 60** |
| Am missing info on contraception | 71 | 52** |
| Have attended community talk | 40 | 64** |
| - By promoter | 22 | 60 |
| - About contraception | 57 | 81 |
| Promoter provides good or excellent quality of care | 61 | 70** |

** difference significant at $p < 0.01$

Responses to Questions by Women of Reproductive Age (in percentages)





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Increase Family
Planning Knowledge
and Use in the Bateyes
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Photo Credits:
Alfredo Fort, Lucy Harber

*Reducing Stress, Improving Services***Preventing Postpartum Hemorrhage with Active Management of the Third Stage of Labor****Reviewing Results in PRIME II**

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

Knowledge Advancing Best Practices

- PMTCT
- Scaling-Up PI
- Costing
- Supportive Supervision

Support to the Field

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- Philippines: HIV/AIDS
- Paraguay: FP/RH Quality
- Mali: FGC
- Senegal: PAC
- Dominican Republic: RTL
- **Mali, Benin, Ethiopia: PPPH**
- Bangladesh: RTL

PRIME II

IntraHealth International, Inc.
6340 Quadrangle Drive, Suite 200
Chapel Hill, North Carolina 27517
intrahealth@intrahealth.org
www.prime2.org www.intrahealth.org

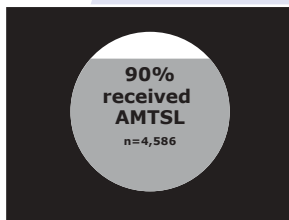
Replacing existing practices for delivery of the placenta with an evidence-based new protocol, PRIME II has trained providers in three African countries in prevention of postpartum hemorrhage (PPH) through active management of the third stage of labor (AMTSL). Providers working at all levels of the health care systems in Benin, Ethiopia and Mali are demonstrating their ability to perform AMTSL. In addition to its value in averting maternal death and morbidity, providers have found AMTSL to be safer, cleaner, faster and often less expensive than previous practices for both the client and the facility.

Background

Postpartum hemorrhage is the single most significant cause of maternal mortality worldwide, accounting for half of all maternal deaths that occur after childbirth and 24% of maternal deaths overall, approximately 130,000 women each year. Half of the women who suffer from PPH have no risk factors, and 99% of women who die from PPH are in developing countries. If a woman survives PPH she may be left severely anemic or with other ongoing health problems. Most cases of PPH occur during the third stage of labor after the baby has been delivered. Recommended by WHO as a best practice for all vaginal deliveries, AMTSL has three main components: 1) administration of an uterotonic drug (like oxytocin) within one minute of birth of the newborn to induce a strong contraction, 2) controlled cord traction of the umbilical cord, which is clamped and cut early, with counter-traction to the uterus, and 3) massage of the uterine fundus through the abdomen. AMTSL shortens the time it takes to deliver the placenta and leads to a decrease in uterine relaxation, which is associated with 90% of PPH.

Intervention

In collaboration with ministries of health and professional associations, PRIME began implementing the PPPH special initiative in 2003 in partnership with the American College of Nurse-Midwives, Management Sciences for Health/Rapid Pharmaceutical Management Plus and JHPIEGO. The project is under way at seven pilot sites in Benin, 24 in Ethiopia (located in five regions), and 8 in Mali, with more than 250 providers trained in AMTSL and related areas including patient counseling, infection prevention and oxytocics storage.



Vaginal Births
24 Pilot Sites, Ethiopia

Results

Monitoring data from Ethiopia and Mali show promising results. At the 24 sites in Ethiopia, AMTSL has been applied to 4,138 of the 4,586 vaginal births since training. Few complications have been reported in women who received AMTSL (41, or about 1%) and no maternal deaths, with only one case of PPH serious enough to warrant a transfusion. In Mali, 3,190 women have received AMTSL out of 3,933 vaginal births. Three complications have been reported, including one death, which was not attributed to AMTSL. While data from Benin are not yet available, a clear improvement has been noted at the community health center in Akassato, where the head midwife states with pride that they have had no cases of PPH in the four months since AMTSL training as compared to nine cases of PPH, including two resulting in death, in the six months prior to training.

Qualitative data from providers indicate that they are being exposed to less blood (thus reducing risk of HIV infection), do not have as many bloodstained materials to throw away or clean, are using less oxytocin and other supplies than would be required by a case of PPH, and do not have to spend as much time waiting for delivery of the placenta—leaving them more time to attend to the newborn and other clients, and for the mother to rest and hold her baby immediately after the birth.

Because of such positive results, the Benin Department of Family Health has already indicated its interest in scaling-up the program nationally, even before final evaluation results are available in early 2004. Both the Ethiopian Society of Obstetricians and Gynecologists and the Ethiopian Midwives Association have highlighted PPH prevention and AMTSL in their annual meetings. In addition, USAID/Mali has included PPH prevention as a high-impact service in its new bilateral projects.



PRIME II

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Creating Change from Within

The Health and Population Sector Programme (HPSP)

At the request of USAID/Dhaka, the PRIME II Project worked with the Bangladesh Ministry of Health and Family Welfare to implement a national in-service training strategy for the essential services package (ESP). The PRIME I Project had been instrumental in drafting Bangladesh's national strategy, so the follow-on PRIME II Project was ideally positioned for this activity and established an office within the Technical Training Unit (TTU) of the Ministry, which worked side-by-side with the TTU staff for three years (2000-2003).



Reviewing Results in PRIME II

Oct. 2002–Sept. 2003

Policy, Advocacy and Services

- National RH Policy
- Partnership

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PRIME II

IntraHealth International, Inc.
6340 Quadrangle Drive, Suite 200
Chapel Hill, North Carolina 27517
intrahealth@intrahealth.org
www.prime2.org www.intrahealth.org

Background

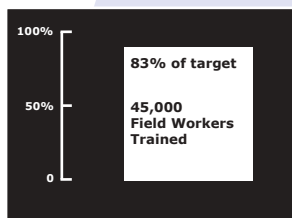
PRIME's goals were to help the TTU operationalize the national in-service training strategy and to create a decentralized national system to train 54,000 primary providers. Key objectives included:

- Strengthen central-level management capacity
- Standardize in-service planning, implementation and follow-up
- Strengthen lead training organization (LTO) capacity
- Strengthen district and sub-district (*upazila*) capacity to plan and monitor training
- Conduct training and follow-up
- Develop monitoring and evaluation capability at the central level, including a Training Management Information System.

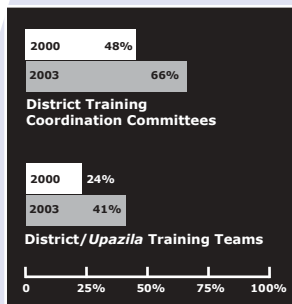
Interventions

Recognizing that a national training program requires standardization of training quality, PRIME led the process of drafting National Training Standards, which the government adopted. Building on these standards, PRIME led in developing training guidelines for the ESP course, and organizing details of all the steps needed to implement an effective training program for field workers. Both the standards and guidelines documents contributed to the development of a quality checklist tool that was used by the Central Monitoring Team to assess the quality of the training they monitored during visits to districts and sub-districts.

With PRIME's assistance, the TTU established a decentralized network of 64 district training coordination committees (DTCCs) and 460 district/*upazila* training teams (DUTTs). Through interventions identified during a performance needs assessment, the PRIME-TTU team strengthened three of the governmental LTOs. The team worked closely with three local NGOs that supported the logistics and administrative management of the training.



Basic Essential Services Package Training



Decentralized Training Responsibility

Results

At the end of the three-year intervention period, the project produced the following key results:

- 45,000 providers were trained in the basic ESP course (83% of the target)
- Data collected at worksites using stringent observation scoring criteria for a sample of providers at baseline and end-line showed a threefold increase in average performance scores on selected tasks
- A national-level computerized Training Management Information System was established, improving the TTUs' ability to plan, monitor and follow-up training
- PRIME developed and piloted a District Management Information System to facilitate supportive supervision and decision-making at the district level
- All six LTOs met the quality standards established in the national training standards
- All sample district/*upazila* training teams reported receiving and using the ESP training guidelines, and 83% of DUTT members received follow-up support during the 21-day basic ESP training at the *upazila*, compared to 52% at baseline
- 66% of DTCC members and 41% of DUTT members recognized training as one of their major responsibilities, compared with a baseline of 48% and 24%, respectively
- PRIME assisted the Line Director for In-Service Training to incorporate Performance Improvement as a strategic approach in the conceptual framework of the IST section in the Ministry's 2002-2003 Annual Operational Plan.

Conclusion

The HPSP represented the first time PRIME II had played a pivotal role in operationalizing a national in-service training program on such a large scale and developing a nationwide framework for human capacity development. Having PRIME staff "embedded" in the Ministry offices facilitated the process of standardizing and ensuring the quality of training throughout the country, and the staff worked constructively and collegially with their counterparts to increase the capacity of the TTU.



PRIME II

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McMahan J, Rabb M.

The Health and

Population Sector

Programme (HPSP)

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Photo Credit:

Lorraine Bell



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