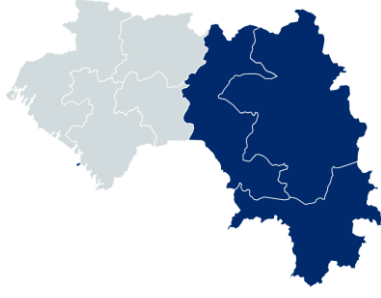


# Guinea RMNCH and Gender-Based Violence EOP Summary & Results



### Geographic Implementation Areas

**Regions**

- 4/8 (38%)—Kankan, Faranah, N'zérékoré, and Conakry

**Prefectures**

- 14/38 (37% of country total)

**Facilities**

- 150/461 (32% of country total)

### Population

**Country**

- 12.4 million

**MCSP-supported areas**

- 4.6 million

**Technical Areas**



**Program Dates**  
January 1, 2015–February 28, 2017

**Total Funding through Life of Project**  
\$1,500,000

**Demographic and Health Indicators**

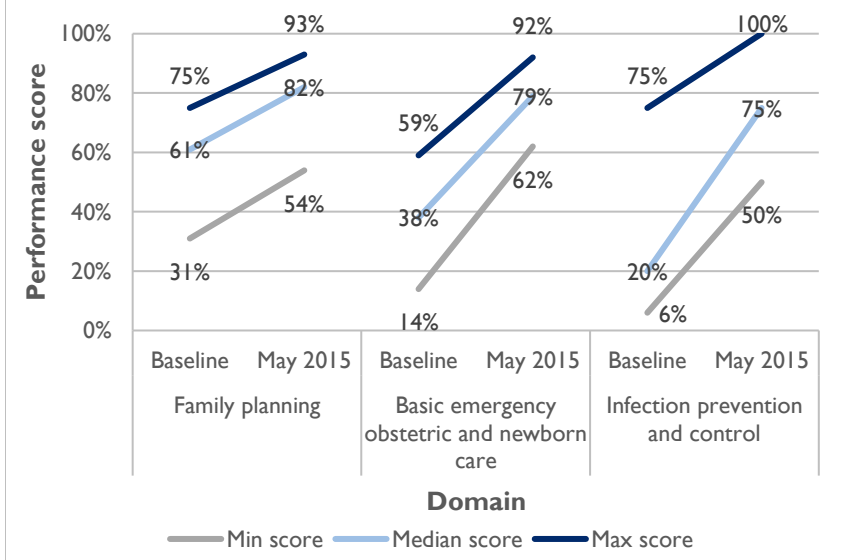
Indicator	# or %
Live births/year <sup>1</sup>	447,000
MMR (per 100,000 live births) <sup>2</sup>	550
NMR (per 1,000 live births) <sup>2</sup>	20
SBA <sup>2</sup>	62.7%
CPR (modern and traditional methods) <sup>2</sup>	8.7%

Sources: [1] 2016, Countdown to 2030 [country profile, GIN](#); [2] MICS 2016.

- Strategic Objectives through the Life of Project**
- Improve and sustain the quality of RMNCAH services in supported health care facilities within the project's targeted area (January 2015 to March 2016).
  - Improve the quality of midwifery PSE at the National Public Health School in Kindia and medical education at the School of Medicine in Conakry (January 2015 to March 2016).
  - Integrate activities and services for the prevention and management of gender-based violence (GBV) within RMNCAH services at the facility and community levels in Conakry (January 2015 to February 2017).

- Highlights through the Life of Project**
- Trained 41 providers (34 women) on integration of GBV prevention, detection, and management into the daily activities and services of health providers. Seven facilities managed and treated 110 cases of GBV and referred 65 of those cases to legal assistance.
  - Conducted quarterly monitoring of FP service statistics, which showed that availability and voluntary use of FP services remained steady even in the face of the evolving EVD epidemic, including 7,808 adopters of long-acting methods.

**Figure 1. Evolution of performance scores for three domains of Standards-Based Management and Recognition among 11 health facilities from baseline to May 2015**



# Guinea—Reproductive, Maternal, Newborn and Child Health and Gender-Based Violence

## Background

The work requested under MCSP was designed to support the accomplishments of MCHIP in Guinea (October 2010 to March 2014), which increased the capacity of health care workers in facilities and in the community to offer quality FP and MNCH services. Also under MCHIP, in 2013, the USAID Mission in Guinea successfully applied for incentive funding for a 3-year project to address GBV reduction. In collaboration with the USAID-funded legal assistance partner, the American Bar Association, MCHIP initiated the first year of activities during the final MCHIP project year to better understand the scope of the problem and what resources exist to prepare for a comprehensive intervention that addresses the health, social support, and legal aspects of victims of GBV, as well as communications to increase community awareness and prevention efforts. MCSP's work in Guinea was originally planned as a 1-year bridge to the Mission's preparations for a bilateral health project, with additional GBV funding added to extend this component of the project.

As the EVD epidemic evolved and spread, MCSP adapted the timeline and activities to the situation at hand. Access to Nzérékoré Region, the epicenter of the epidemic, varied over the life of the project, as the number of cases was high at the beginning but well controlled by late 2015.

## Key Accomplishments

### *Strengthened QI Methodology to Achieve Improved RMNCAH Outcomes*

MCSP reinforced the use of the SBM-R QI tool at 48 facilities that were using the methodology as of the end of the MCHIP project. This included supportive supervision to follow up on SBM-R performance at 29 facilities (60%) that were accessible as the epidemic evolved, which allowed mentors to check on the functioning of SBM-R teams and suggest ways to address gaps in performance. For a few facilities with more dramatic drops in performance, particularly in Conakry, MCSP advised facility managers and staff to work on improving gaps in performance or risk losing their recognition star. MCSP also supported the development and initiation of a monitoring plan for the MOH's implementation of SBM-R in an effort to support its ownership of the system. The plan and corresponding budget were forwarded to the regional directors of health by the National Directorate for Family Health and Nutrition for integration into the 2015–2017 regional and prefectural (district) health development plans.

An analysis of service delivery data for the 48 facilities using SBM-R for January–September 2015 (Q2–Q4 of PY1) showed high levels of performance of lifesaving skills in RMNCAH:

- 98% of 263 recorded cases of pre-eclampsia/eclampsia were treated with magnesium sulfate.
- 95% of women received active management of the third stage of labor.
- 87% of newborns were put to the breast within the first hour after delivery.
- In total, 2,997 cases of obstetric and newborn complications were treated.

Ongoing follow-up of many of these facilities using SBM-R to monitor performance continued under MCSP's Restoration of Health Services scope of work in Guinea.

### *Conducted Routine Supportive Supervision Resulting in Increased FP Uptake and Continued Use*

To sustain the quality of services and training of providers under MCHIP, MCSP clinical advisors worked closely with national-, regional-, and district-level supervisors to identify facilities needing support and to provide constructive feedback and support to improve performance during supervision visits. During the visits, clinical advisors assessed provider performance and checked on the availability of critical supplies and equipment needed to perform services. MCSP supported supervision visits to 191 facilities, reaching 572

providers and 238 CHWs. The project was able to add supervision visits in Nzérékoré as the EVD epidemic came under control there, thus exceeding the target of 150 facilities.

MCSP's analysis of quarterly service delivery indicators at its supported facilities demonstrated the following achievements:

- Active management of the third stage of labor using a uterotonic remained a routine practice for 90–96% of all vaginal deliveries (n = 33,136).
- 9,425 complications were managed among 26,033 deliveries assisted by an SBA.
- Of 966 cases of pre-eclampsia/eclampsia, treatment with magnesium sulfate was provided 98–100% of the time over the five quarters of the project.
- Breastfeeding was initiated within an hour of delivery 87% of the time.

Looking specifically at FP services, about one-quarter of the 500 providers who were previously trained on long-acting and postpartum methods were not present at the time of supervision visits due to transfers and extended absences. Nevertheless, quarterly monitoring of FP service statistics (Table 1) showed that availability and voluntary use of FP services remained fairly steady even in the face of the evolving EVD epidemic, including 7,808 adopters of long-acting methods, with implants chosen approximately twice as often as IUDs. The slight decline in community distribution of FP methods, such as the pill and condoms, can be attributed to engagement of CHWs in Ebola outreach and detection activities, taking them away from their usual activities.

**Table 1. FP service delivery indicators by quarter, April 2015–March 2016**

	April–June 2015	July–September 2015	October–December 2015	January–March 2016
New FP users	32,692	30,714	36,385	40,450
Percentage of new users from community distribution	30%	17%	16%	22%
Continuing FP users	28,270	27,620	30,133	32,548
Percentage of continuing users from community distribution	35%	21%	20%	27%
LARC adopters	1,325	1,194	1,931	3,358
Couple years of protection	20,308	18,370	25,000	27,066

### *Improved the Quality of PSE at the National Public Health School in Kindia and the Medical Education at the Faculty of Medicine in Conakry*

MCSP followed up on MCHIP's PSE interventions, which included support for the development of skills labs as well as close collaboration with the National Public Health School in Kindia and the Ministry of Professional Education and Technical Training to revise the midwifery training curriculum in accordance with recommendations from the West African Health Organization and the International Confederation of Midwives to ensure a competency-based approach to education.

MCSP conducted quarterly supportive supervision visits at the National Public Health School in Kindia. These visits were an opportunity to monitor preceptors' and students' use of the skills labs, follow up on implementation of improved reproductive health and teaching skills, and follow up on implementation of SBM-R for PSE. During MCHIP, skills labs were set up to offer students hands-on experience using anatomic models and simulators to develop clinical competencies. Faculty and preceptors received training on effective teaching skills, assessing student performance, and clinical training and mentoring skills for MNH. The hospitals and health centers that serve as internship sites were also visited to review their efforts to support student learning. Among the SBM-R components for PSE, the school was doing better with

theoretical and practical teaching, whereas equipment and infrastructure issues remained persistent challenges. During each visit, MCSP staff reviewed observations and provided suggestions for key actions to address persistent challenges and reinforce what was going well. The increased capacity to provide practical experience to students through the skills labs and use of anatomic models became even more important during the EVD epidemic as the MOH prohibited student trainees from going to health facilities for practical sessions for a period during 2015.

MCSP conducted several visits to the Faculty of Medicine to review progress made on implementation of SBM-R for PSE and to engage the dean and department heads in overseeing the action plans to improve student learning. It was particularly challenging to engage with the faculty at this time, as many were pulled into Ebola response activities. An assessment of SBM-R standards and comparison with results from 2011 found a general decline in quality from 55% to 32% across the five performance areas. MCSP helped to focus attention on the quality of education by providing feedback on the performance evaluation and using that feedback to develop action plans to address gaps in performance.

### *Increased Treatment of GBV Cases or Referrals to Legal Aid*

Under the project's GBV component, MCSP worked closely with the Ministry of Social Affairs and the Advancement of Women and Children to target communities in the five districts of Conakry, and partnered with two national hospitals and five communal health centers to integrate screening and care for suspected GBV and promotion of related resources. MCSP worked with the American Bar Association's Rule of Law Initiative to support the legal and rights components of the project, training legal aids and community liaisons, operating a legal assistance clinic, and supporting the development of communications materials to increase awareness of both prevention and access to resources for survivors of violence.

MCSP disseminated the findings of the GBV assessment conducted under MCHIP in all five communes of Conakry and one urban commune of Kankan. This assessment informed the development of a set of curricular materials for training health care workers and community educators on detection, management, and prevention of GBV, which began under MCHIP and was finalized and validated with MCSP's support.

Forty-one providers (34 women) from seven facilities across Conakry completed the training workshop to integrate GBV prevention, detection, and management initiatives into the daily activities and services of health providers. Due to the EVD epidemic, the training workshop could not be held until November 2015. Following the training of selected providers, orientations were also provided to the broader facility staff to increase awareness of the services/resources available and promote referral within the facility for suspected GBV cases. At the community level, MCSP trained 123 community and peer educators from the five communes, several secondary and professional schools, and two universities. MCSP, in consultation with local authorities and the Ministry of Social Affairs and the Advancement of Women and Children, set up GBV committees in each of the five communes, and MCSP provided supportive supervision following trainings. At the national level, MCSP worked with the Ministry of Social Affairs and the Advancement of Women and Children to establish an interministerial steering committee to address GBV.

Community educators and paralegals held 707 information and awareness-building sessions, including a door-to-door campaign, to reach 30,787 people. MCSP engaged local stations and provided inputs to produce five radio spots and one TV segment; 10 radio broadcasts and two television broadcasts were aired by the end of the program. Journalists—many of whom had participated in the community orientations—produced 33 articles or communications on GBV (22 on radio and 11 televised). MCSP also put in place a network of mobile phones among community committees; the Office of the Protection of Gender, Children, and Minors; paralegals; and health facilities to facilitate communication and referrals. This system tied into an existing network of phones among health care providers and managers, and MCSP covered the cost of voice calls.

As a result of these community outreach activities, seven facilities managed and treated 110 cases of GBV. In total, facilities referred 65 GBV cases for legal assistance, and 54 cases, including all 27 cases of rape, were pursued. The majority of domestic violence and family abandonment cases, on the other hand, were settled through mediation. Forty-four percent of GBV cases were reported to and managed at the national hospital.

Some of the communal health centers reported few to no cases (zero to four). The reasons for this are unclear, although self-referral by the family to seek assistance outside of their own neighborhood might partially explain this pattern.

At the end of the program, MCSP assessed stakeholder satisfaction with the program’s efforts to address GBV prevention and management. MCSP held 19 individual interviews and eight focus groups with those involved in the project. Providers and health educators appreciated the training course and tools, particularly the flipbook. One provider commented, “Before, I really could not manage a case of GBV, and now I can, and I know who I should call.” A common suggestion for further improving the available tools was to develop videos on the subject in multiple languages.

## Recommendations for the Future

Despite significant challenges due to the EVD epidemic, MCSP’s support enabled many facilities to maintain the important gains in availability and quality of RMNCAH services that they had achieved under MCHIP. USAID’s continued flexibility also allowed MCSP to implement planned activities when it was safe and appropriate to do so given demands on MOH counterparts. Following MCSP’s RMNCAH and GBV work in Guinea, MCSP continued to serve as a mechanism for multiple programs in support of the epidemic response and post-epidemic recovery in Guinea. Recommendations for these programs included:

- **Continue to support SBM-R efforts.** The MOH and donors should continue to support efforts such as SBM-R for QI and quality assurance. The investment during MCHIP and follow-up during MCSP showed promising results in maintaining quality of services, even in the face of the EVD epidemic. Where performance declined, particularly in areas most affected by Ebola, the SBM-R standards served as the reference point to recall what providers and managers should expect of themselves in providing care to the community.
- **Strengthen PSE.** USAID and other donors should continue to support efforts to strengthen PSE. MCSP was able to follow up on some important gains of MCHIP in revising the midwifery curriculum and reinforcing teaching and learning capacity, but more work remains to be done to reap the benefits of the new skilled midwives who are ready to enter the workforce.
- **Integrate GBV prevention and services.** The Ministry of Social Affairs and the Advancement of Women and Children and the MOH should continue to scale up the integration of GBV prevention and services into health facilities and communities, with a focus on geographic areas with high rates of interpersonal violence and GBV, as well as those with increased risk factors, such as internal migration for employment (e.g., mining) and early marriage. Donor support for this will be needed.

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	Achievement (Target)
Number of women receiving individual counseling sessions in immediate postpartum or postabortion care for FP/reproductive health as a result of USG assistance	33,271 (target: 29,053; target exceeded)
Number of new acceptors of modern contraceptive methods as a result of USG assistance	174,246 (target: 225,000; 77% achieved)
Number of women delivering with assistance of an SBA	38,294 (target: 37,500; target exceeded)
Number of women receiving active management of the third stage of labor <sup>1</sup>	30,732 (31,250; 98% achieved)

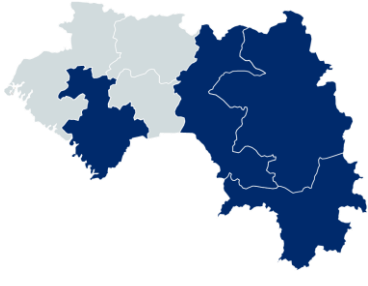
<sup>1</sup> One of the three regions, Conakry, saw a significant decline in overall health service use, including maternity care and FP services, during the EVD epidemic. Kankan and Faranah in the northern part of the country were far less affected by the epidemic.

For a list of technical products developed by MCSP related to this country, please click [here](#).



# Guinea Ebola Response Phase I

## EOP Summary & Results



### Geographic Implementation Areas

**Regions**

- 4/8 (50%)—Conakry, Faranah, Kankan, Kindia, N'zérékoré

**Prefectures**

- 8/38 (21% of country total)—Beyla, Forécariyah, Kissidougou, Kouroussa, and five communes of Conakry

**Facilities**

- 55/461 (12% of country total)

### Population

**Country**

- 12.4 million

**MCSP-supported areas**

- 2.81 million

### Technical Areas:

#### Program Dates

November 17, 2014–August 16, 2015

#### Total Funding through Life of Project

\$3,482,000

#### Demographic and Health Indicators

Indicator	# or %
Live births (per year) <sup>1</sup>	447,000
MMR (per 100,000 live births) <sup>2</sup>	550
NMR (per 1,000 live births) <sup>2</sup>	20
U5MR (per 1,000 live births) <sup>2</sup>	88
Births with SBA <sup>2</sup>	62.7%
CPR (modern and traditional methods) <sup>2</sup>	8.7%

Sources: [1] Countdown to 2030 country profile, 2016; [2] Multiple Indicator Cluster Survey 2016

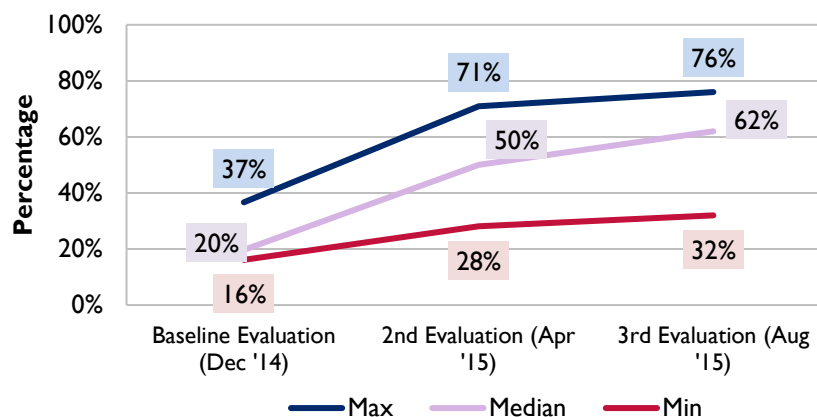
#### Strategic Objectives through the Life of Project

- Support health care workers and facilities to continue to offer high-quality health services in a safe environment by strengthening IPC practices through training, supportive supervision, and complementary M&E.
- Support communities and their local leaders to combat disease transmission through improved contact tracing, intensified social mobilization, and improved technical assistance to district health teams.

#### Key Accomplishment Highlights through the Life of Project

- Contributed to the creation of an IPC Technical Committee to oversee facility-level interventions. MCSP's IPC training curriculum was adopted as the national standard for provider training.
- Trained 2,985 providers from 55 facilities, including three national hospitals, and oriented 447 auxiliary staff on IPC on site. Ninety-one percent of trained health care providers and auxiliary staff at all targeted facilities received supervisory support during the project period.
- Observed steady improvement in the short project period through a series of three IPC performance assessments. At 42 health centers supported by the project, the median performance score rose from 19% (baseline) to 42% (second evaluation) to 67% (third evaluation).
- Reached 1,596 members of civil society associations, women's groups, and two police brigades with EVD sensitization. Trained 228 CHWs to carry out contact tracing, successfully following 92% of 3,195 contacts.

**Figure 1. Evolution of IPC performance scores in the seven medical centers and three prefectural hospitals in Beyla, Forécariyah, and Kissidougou (December 2014–August 2015)**



# Guinea—Ebola Response Phase I

## Background

In response to the EVD epidemic in Guinea and the severe effects it had on the country's health services, including increased risk of EVD for health care providers, USAID Washington and the Mission requested that MCSP develop a program to address IPC practices in facilities and communities to prevent disease transmission. The geographic areas of focus were determined in collaboration with the National Ebola Response Coordinating Committee, CDC, Office of US Foreign Disaster Assistance, and other USG implementing partners.

## Key Accomplishments

### *Participated in the National Ebola Response Coordinating Committee*

Throughout the project period, MCSP provided technical support to the National Ebola Response Coordinating Committee, particularly in the effort to improve national protocols for EVD treatment centers, manage community transit centers, and promote safe burial practices. MCSP also participated in the development of a set of community-focused EVD prevention educational materials (health education messages, posters, and visual aids) that the Ministry of Public Health validated; 500,000 copies were distributed with support from donors.

MCSP led the advocacy for the creation of an IPC Technical Committee under the National Ebola Response Coordinating Committee in collaboration with USAID, the Office of US Foreign Disaster Assistance's Disaster Assistance Response Team, the CDC, and WHO. The technical committee, which became an important source of technical support within the National Ebola Response Coordinating Committee, comprised 15 national and international organizations, and led the standardization of IPC training documents and establishment of triage units across the country. Jhpiego's IPC training curriculum, with updates specific to EVD done under MCSP, was adopted as the national standard. This demonstrated that MCSP's work was valued for its technical quality. The Ministry of Public Health wanted to use these materials to guide all partner work in this area.

### *Trained/Updated Trainers*

MCSP initiated the Ebola Response Project with an IPC update for 27 trainers who were previously trained as trainers under MCHIP. In February 2015, five additional MCHIP-trained trainers joined 18 new candidate trainers, who were selected from a group of providers who had completed the IPC training and demonstrated initiative in improving IPC. This group was trained in clinical training skills, resulting in 50 qualified IPC trainers to support the Ministry of Public Health and the National Ebola Response Coordinating Committee's IPC response to EVD.

### *Conducted Trainings and Provided Routine Quality Assurance Visits and Additional Follow-Up Support*

In collaboration with health facility administrators, MCSP trained 2,985 providers in 121 5-day training sessions from December 2014 to March 2015—139% of the initial project target of 2,150. The training sessions targeted all health care personnel working in 55 health facilities located in some of the areas hardest hit by the EVD epidemic. MCSP also conducted 1-day IPC trainings for 447 support staff members (e.g., janitors and orderlies) at seven health facilities using materials developed by the Ministry of Public Health. Using the local language to ensure comprehension, the trainers taught a broad range of fundamental IPC skills, including preparation of chlorine solution and proper waste collection and disposal.

Within 1 month after the training, the trainers conducted follow-up visits to review implementation of IPC practices and assist staff to address challenges. Coaching sessions were organized at least twice a month in Conakry and once a month in prefectures (due to travel time required). As a result, 91% (3,132/3,441) of trained health care providers and auxiliary staff at all 55 targeted facilities received supervisory support during the project period.

In December 2014, April 2015, and August 2015, MCSP conducted performance evaluations using the Standards-Based Management and Recognition (SBM-R®) process to assess the implementation of IPC performance standards at each of the 55 health facilities.<sup>18</sup> SBM-R is a QI methodology that uses checklists of clearly defined clinical and organizational standards to assess performance, establish the level of functionality, and guide corrections toward improved performance and quality. An analysis of performance scores at baseline (December 2014), second (April 2015), and third evaluations (August 2015) revealed the following progress:

- At the national hospitals of Donka, Ignace Deen, and Sino-Guinéen, 66 services were evaluated. The median performance score rose from 24% (baseline) to 50% (second evaluation) to 68% (third evaluation).
- At seven communal medical centers in Conakry and Beyla and at three prefectural hospitals in Beyla, Forécariah, and Kissidougou, the median performance score rose from 20% (baseline) to 50% (second evaluation) to 62% (third evaluation).
- At the remaining 42 health centers supported by the project, the median performance score rose from 19% (baseline) to 42% (second evaluation) to 67% (third evaluation).

### *Conducted Behavior Change Communication and Sensitization*

MCSP carried out a variety of communication activities, including 249 group talks; orientation of members of civil society, women's groups, and police brigades; theatrical performances; and a soccer match, to share information with community members on Ebola prevention and active surveillance. Social and behavior change communication activities targeted the prefectures of Kouroussa, Beyla, and Kankan, and the communes of Conakry. Radio broadcasts on local radio stations and in local languages were used as a way to disseminate information and messages through pre-recorded messages, discussion roundtables, and call-in shows. In-person communications are estimated to have reached 39,500 people and the radio broadcasts another 53,000 community members.

### *Provided Contact Training and Surveillance*

MCSP trained 228 CHWs to carry out contact tracing, successfully following 92% of 3,195 known contacts through the full 21-day period. MCSP also organized orientations for 1,463 people who work as pharmacists, private health care providers, and traditional healers. This approach was developed to address the challenge of declining community confidence in public health facilities, with people seeking care from alternative sources. This training helped to address myths about EVD and reinforce case detection, personal protection, and timely referral.

## **Recommendations for the Future**

The implementation activities of the MCSP Ebola Response Project helped save the lives of service providers; strengthen IPC practices, standards, and protocols in health facilities; and provide a foundation for the restoration of MNCH services post-Ebola. MCSP further implemented a second IPC-focused project and two projects on post-Ebola recovery.

Crucial lessons for epidemic response and preparing health systems to be more resilient to such shocks include:

- **The Ministry of Public Health and partners should include a focus on IPC in routine health services in the initial response to disease outbreaks and as a matter of quality of care more broadly.** Attention to IPC is an essential component of health systems strengthening (HSS) and the

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<sup>18</sup> Among the 55 health facilities included in the target for this project, three are national hospitals with many separate services and units. During evaluations, smaller hospitals and health centers were assessed as a whole and received a single score (n = 52), but for the national hospitals, each service was assessed individually and results reported for each of 66 services or units of those three hospitals.



initial response to an infectious disease outbreak. IPC in routine health services was not initially a high priority in the epidemic response until the formation of the IPC Technical Committee.

- **The Ministry of Public Health and partners should emphasize that IPC is an issue not only for epidemic response but also for routine quality of care.** Training and skills development needs to be practical and set in a broader context of patient and provider safety and quality. The IPC committee observed that in areas where short trainings were very focused on EVD, improved practices were not maintained. Providers viewed these skills as specific to EVD, so if there were no longer cases in their area, they were no longer considered necessary. In addition, post-training follow-up is an integral aspect of ensuring continuing success in changing behaviors and improving IPC or any clinical domain.
- **The Ministry of Public Health should maintain a census of health care facility staff.** The ministry did not have an accurate census of the number of staff working in health facilities, so when the project began to provide training in some facilities, it was discovered that there were many more providers working there than initially reported.
- **IPC materials need to be considered in supply chain management.** Lack of materials for IPC puts providers and patients at risk when they are unable to put the existing guidelines into practice. Routine availability of IPC supplies was poor before the onset of the epidemic, and the limited supplies and donations that were coming in were prioritized for EVD treatment centers.

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	Achievement (Target)
Number of staff in health facility who received IPC training	2,985 (target: 2,150; target exceeded)
Number of trained staff who received post-training follow-up supervision at 6 weeks and 3 months	2,582 providers received follow-up at their work sites. 86% of those trained (target: 2,150; target exceeded)
Percentage of staff trained on IPC who achieved a score of 85% or higher on knowledge tests during post-training follow-up supervision visits	91% (target: 100%; 91% achieved)

For a list of technical products developed by MCSP related to this country, please click [here](#).

# Guinea Ebola Response Phase II

## EOP Summary & Results



### Geographic Implementation Areas

#### Regions

- 3/8 (50%)—Boké, Faranah, Kankan

#### Prefectures

- 5/38 (13% of country total)- Boke, Dabola, Dinguiraye, Faranah, and Mandiana

#### Facilities

- 59/461 hospitals and health centers (13% of country total)
- 140 health posts and 50 private facilities

### Population

#### Country

- 12.4 million

#### MCSP-supported areas

- 2.81 million

### Technical Areas:



#### Program Dates

June 2, 2015–May 31, 2016

#### Total Funding through Life of Project

\$2,400,000 (OFDA funding)

#### Demographic and Health Indicators

Indicator	# or %
Live births/year <sup>1</sup>	447,000
MMR (per 100,000 live births) <sup>2</sup>	550
NMR (per 1,000 live births) <sup>2</sup>	20
U5MR (per 1,000 live births) <sup>2</sup>	88
Births with SBA <sup>2</sup>	62.7%
CPR (modern and traditional methods) <sup>2</sup>	8.7%

Sources: [1] Countdown to 2030 country profile, 2016; [2] Guinea MICS 2016

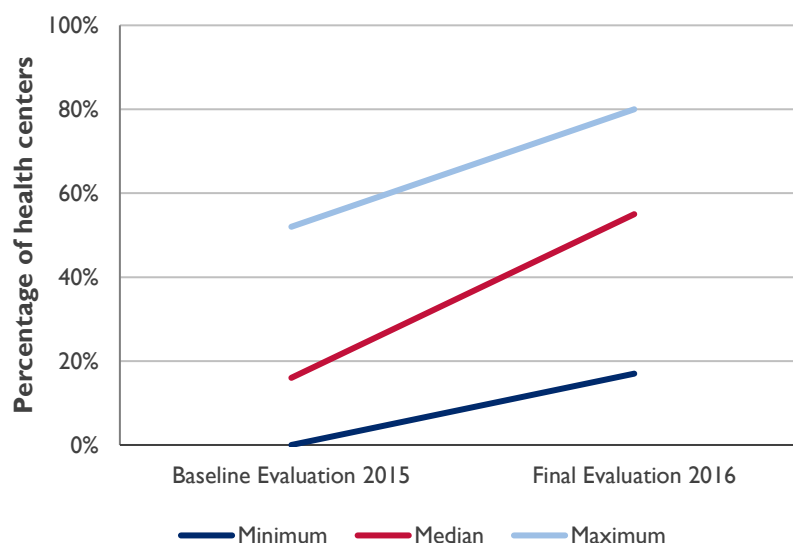
#### Strategic Objectives through the Life of Project

- Support health care workers and facilities to continue to offer high-quality health services in a safe environment by strengthening IPC practices through training, supportive supervision, materials donation, and monitoring.

#### Accomplishment Highlights through the Life of Project

- Provided IPC training to 1,345 staff in 249 health facilities in target prefectures.
- Donated IPC materials and consumables to the Ministry of Public Health facilities to support correct and consistent practice of IPC skills. This includes 29 autoclaves and seven incinerators, which were purchased and installed to support instrument processing and waste management.
- Ninety-four percent of health centers (51/54) improved IPC scores from baseline to final assessment (improving by at least one quartile), and six (11%) reached the 75% threshold of desired minimum performance. Among five hospitals that were assessed by service area, 36/48 of services improved IPC scores and 11 (23%) reached or exceeded the 75% threshold.

**Figure I. Evolution of IPC performance at health centers from baseline to final evaluation in Boké, Faranah, Dabola, Dinguiraye, and Mandiana**



# Guinea—Ebola Response Phase II

## Background

The goal of the MCSP Ebola Response Project Phase II in Guinea was to scale up efforts to prevent and control the spread of the EVD and its effect on the quality of RMNCAH services. As requested by USAID Washington and the Mission, this work built on MCSP's previous Ebola Response Project Phase I, which focused on supporting health care workers and facilities to continue to offer high-quality health services in a safe environment by strengthening IPC practices through training, supportive supervision, and complementary M&E. A similar series of activities as the first project was laid out for this US Office of Foreign Disaster Assistance-funded project to increase knowledge and skills, improve service delivery conditions for correct and consistent IPC, and provide coaching and monitoring to help sustain improved practices. For more information on MCSP's response to Ebola, please see the project's [brief](#).

## Key Accomplishments

### *Provided Intensive IPC Training*

Before initiating IPC training in a prefecture, MCSP conducted an assessment of IPC performance and the availability of key materials for IPC in each of its public hospitals and health centers. The assessment tool for IPC was based on a set of 32 performance standards that originate from the SBM-R methodology for QI. These same performance standards were used throughout the IPC training and for supportive supervision/coaching visits following training.

The MCSP Ebola Response Project Phase II provided intensive IPC training to 1,345 health care providers from 249 health care facilities across the five prefectures. Sixty-two providers also benefited from a 3-day training specifically on setting up and managing triage of patients seeking care at health facilities in Boké. Supervision and coaching visits to support continued IPC performance were conducted at all facilities and reached 78% of trained providers. In addition, 67 staff who were posted to the focus facilities after the training sessions received onsite orientations on IPC during supervision visits. MCSP also provided IPC orientation and coaching in local languages for 271 support staff members.

### *Procured and Supplied Necessary IPC and Sanitation/Waste Management Equipment and Training*

The availability and utilization of IPC inputs is one of the key pillars of an effective IPC program. As part of the support to these prefectures, MCSP donated IPC materials and consumables to the Ministry of Public Health facilities to support correct and consistent practice of the skills learned and reinforced during the IPC training. The donations included IPC products, personal protective equipment, and consumables, such as examination and sterile gloves, soap, masks, goggles, noncontact thermometers, and handwashing stations, as well as waste management materials, such as buckets for separating waste and used instruments, sharps boxes, trashcans and trash bags, mops, brooms, and chlorine powder. MCSP used these donations to advocate with the Ministry of Public Health and partners to ensure availability of IPC materials through the Ministry of Public Health supply chain so that providers would be able to continue good-quality IPC practice.

Based on the experience of the first phase of this project, waste management and sterilization of instruments were identified as clear gaps in improving IPC in many of the hospitals and high-volume health centers. Often, facilities have old autoclaves that no longer function or are too large for their electrical capacity. MCSP intentionally purchased smaller-capacity autoclaves of 24 L and 39 L that could be operated in these facilities. Nonelectric autoclaves that can be operated by heating them on a propane or compressed natural gas burner were provided to facilities where consistent electrical power is not available. Twenty-nine autoclaves were purchased and distributed to facilities supported by the first and second phases of this project. Nine of the autoclaves were donated to facilities targeted in this project specifically, including all of the public regional or prefectural hospitals.

## Organized Routine Quality Assurance Visits and Coaching

For each health district in the project area, six to eight quality assurance coaches were selected from district management teams and health facilities based on their performance in IPC and their availability to monitor the application of hygiene measures. The organization of the coaching activities was coordinated by IPC focal points in larger facilities, department heads, health facility administrators, and members of the health and safety committee of each facility, with monitoring of implementation ensured by the pool of Ministry of Public Health trainers, MCSP staff, and local supervisors. Each facility received an average of two to three supervision visits during the 9-month project period to follow up on coaching activities, provide an external assessment of IPC performance, and give feedback on coaching and performance.

## Conducted IPC Performance Assessments

MCSP conducted baseline assessments in targeted health facilities using the Ministry of Public Health-approved performance standards for IPC to identify the current level of IPC performance and identify gaps to be addressed via training and onsite supportive supervision. The same performance standards were also used during supervision and coaching visits, and for final assessment of all sites. For hospitals, each service was assessed separately and a score generated per service, rather than for the facility as a whole.

Almost all health facilities (51/54, 94%) improved their IPC scores from baseline to final assessment (improving by at least 25 points on a 100-point scale), and six (11%) reached the 75% threshold of desired minimum performance. Among five hospitals that were assessed by service area, 36/48 of services improved IPC scores, and 11 (23%) reached or exceeded the 75% threshold. Several factors likely contributed to the variance in scores among different facilities and why some improved while others did not. The project was implemented in a compressed period, which did not allow for more than two to three coaching visits per facility, particularly in the four eastern prefectures. Training alone may not be sufficient to bring about the behavior change required for correct and consistent IPC performance, given previously poor habits, without additional onsite coaching to reinforce performance over time. Continual challenges with the availability of basic IPC materials, such as gloves and bleach for cleaning surfaces and instruments, are another possible contributing factor; facility managers did not necessarily have the habit or tools to assess IPC needs, and stocks at regional depots were often inadequate for demand.

**Table 1. Summary of IPC scores by quartile for baseline and final assessments in health centers and hospital services**

	Health Centers				Hospital Services			
	Baseline IPC Assessment		Final IPC Assessment		Baseline IPC Assessment		Final IPC Assessment	
	N = 54	%	N	%	N = 48	%	N	%
Score of 75% or higher	0	0%	6	11%	1	2%	11	23%
Score of 50–74%	1	2%	28	52%	7	15%	13	27%
Score of 25–49%	13	24%	19	35%	11	23%	17	35%
Score of 0–24%	39	72%	1	2%	28	58%	3	6%
Missing Data <sup>1</sup>	1	2%	0	0%	1	2%	4	8%

<sup>1</sup> Missing data due to inaccessibility of a health center because of impassable roads or no staff from a given service available during the assessment team's visit.

## Recommendations for the Future

- **The Ministry of Public Health and partners must recognize that training alone is not sufficient and must be accompanied by the materials needed for service provision and onsite support for putting new skills into practice.** Training alone may not be sufficient to bring about the behavior change required for correct and consistent IPC performance, given previously poor habits and continual challenges with the availability of basic IPC materials, such as gloves and bleach for cleaning surfaces and

instruments. While the project was able to reach many providers and facilities in a short period of time, the behavior change for improved IPC appears to require ongoing coaching and supervision to bring about consistent improvement.

- **USAID should consider longer implementation timeframes, even in emergency response.** The project was unable to reach all trained providers with coaching visits due to the short implementation period and resources relative to the number of prefectures covered. If a provider was not present at the time of the visit, there may not have been another opportunity to follow up with him/her. (This project was originally planned for 6 months, which was the timeline used for training and coaching activities. The 6-month extension was requested to complete the installation of incinerators.)
- **The Ministry of Public Health should strengthen accountability at the health facility level.** This experience of working to strengthen IPC in health facilities highlights the need to identify measures to hold health personnel and managers accountable for basic health service functioning, with IPC as one of those basic elements. The project’s efforts to train prefectural and facility managers as IPC coaches and feedback on results for managers are steps in this direction, but a formalized system of accountability is recommended to systematize these roles and responsibilities, promote readiness to prevent and respond to future epidemic diseases, and improve routine attention to quality of care in all health care facilities.

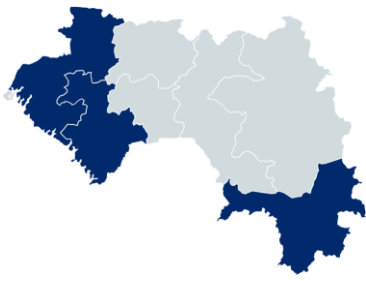
Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	Achievement
Number/percentage of staff in health facility who receive IPC training	1,345 (100% of staff in 60 public facilities, target: 100%; target achieved)
Number of supportive supervision visits conducted on site	421 (target: 400; target exceeded)
Number/percentage of health facilities that have access to disinfecting agents (and sufficient quantity for at least 1 month)	95% in health centers, 76% in hospitals, (target: 100%; 95% and 76% achieved, respectively)

For a list of technical products developed by MCSP related to this country, please click [here](#).



# Guinea Health Systems Strengthening

## EOP Summary & Results



### Geographic Implementation Areas

#### Regions

- 4/8 regions total (50%)—Boké, Conakry, Kindia, and Nzérékoré

#### Districts

- 20/38 total (53% of country total)

### Population

#### Country

- 12.4 million

#### MCSP-supported areas

- 7.65 million

### Technical Areas



### Program Dates

March 1, 2016–June 30, 2018

### Total Funding through Life of Project

\$2,750,000 (Ebola funds—Pillar II)

### Demographic and Health Indicators

Indicator	# or %
Live births/year <sup>1</sup>	447,000
MMR (per 100,000 live births) <sup>2</sup>	550
NMR (per 1,000 live births) <sup>2</sup>	20
SBA <sup>2</sup>	62.7%
CPR (modern and traditional) <sup>2</sup>	8.7%

Sources: [1] 2016, Countdown to 2030 [country profile](#), GIN; [2] MICS 2016.

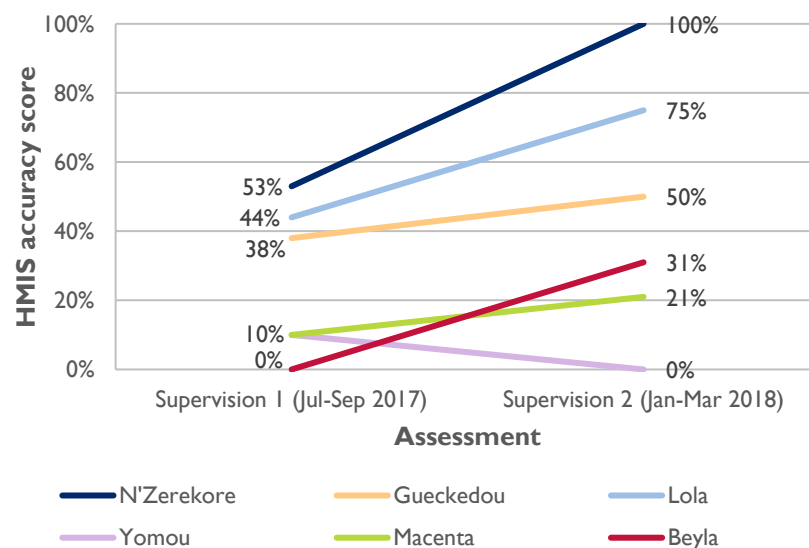
### Strategic Objectives through the Life of Project

- Increase coverage and use of high-impact RMNCAH interventions and innovative new approaches.
- Strengthen MOH capacity to manage and scale up high-impact RMNCAH interventions.
- Institutionalize and integrate IPC protocols into the routine RMNCAH package.

### Highlights through the Life of Project

- Supported the MOH to complete a census of and improve the functioning of incinerators. Fifty-one hospitals (81%) had a functioning incinerator at the end of the project, compared to 49% at the time of the census.
- Trained district management teams on stakeholder engagement, communication, and resource mobilization, resulting in 104 funding requests drafted, 84 submitted, and 43 funded across all districts.
- Supported 35 facilities using the QI methodology SBM-R, with eight facilities qualifying for recognition. By the end of the project, 50% of facilities were performing at the minimum desired level of 80% on EmONC, FP, and IPC standards.

**Figure 1. HMIS data accuracy scores by prefecture in Nzérékoré**



# Guinea—Health Systems Strengthening

## Key Accomplishments

The Ebola outbreak of 2014–2015 had a devastating effect on routine health services in Guinea, especially those related to RMNCAH. Guinea’s already weak health system was at a near standstill due to a lack of regular monitoring and supervision, a devastating loss of health workers, and fear by the community to seek services in health facilities. Per the request of USAID Washington and the Mission in Guinea, MCSP’s HSS program was the fourth and final Ebola-related project funded through the project and the second country program to focus specifically on post-epidemic recovery and building resilience. The HSS program, which started in March 2016 with Pillar II Ebola Response and Recovery<sup>19</sup> funding, was designed to link the facility-level achievements of the earlier Restoration of Health Services program with health systems-level efforts to reinforce and sustain the management and coordination of improved RMNCAH services. These two programs were planned and monitored in close coordination with USAID’s Global Health Ebola Team, which was tasked with overseeing the implementation of the health components of the Ebola Response and Recovery funding.

### *Improved IPC and Waste Management*

To continue the momentum toward strengthening IPC that was created by the EVD epidemic and post-epidemic recovery, MCSP supported printing costs and orientation sessions for the dissemination of IPC policy documents, which included standards and procedures and a monitoring framework. The policy documents were updated and validated under the Restoration of Health Services project and with funds from the CDC, with this project completing the final step of dissemination. To assist health schools and the faculty of medicine to integrate the new IPC policy, the project supported the development of the IPC curriculum and detailed plans to integrate IPC into PSE for nurses, midwives, and doctors. The project also successfully advocated for the integration of IPC specifications in the revised and validated reproductive health norms and protocols in late 2016. Under the auspices of the MOH, MCSP’s HSS program in Guinea provided technical support to the IPC cluster (WHO, MCSP, Expertise France, Catholic Relief Services, and others) to reinvigorate its functioning for continued coordination of IPC and waste management inputs. As a result of these policy- and coordination-level activities, MOH priorities are well articulated and can help to generate financial and technical partner contributions. The IPC standards and procedures also serve to clarify expectations of health care providers as a means to promote accountability for correct and consistent IPC.

Several months into the project, funds were added to focus on improving waste management in MOH facilities. MCSP, in collaboration with IPC cluster partners and the MOH, mapped existing incinerators and their current functioning across the country. Of 63 incinerators identified primarily at hospitals and a few urban health centers, 31 (49%) were in good, working condition. This included seven that were donated and installed by the Office of Foreign Disaster Assistance-funded MCSP IPC 2 project. Among incinerators not functioning at the time of the assessment, some only had minor, repairable problems and/or lacked maintenance. Twelve incinerators donated by another donor during the Ebola epidemic were found at hospitals but had never been installed or put into service. Based on these findings, WHO led a program to repair nonfunctional incinerators with partner support. With MCSP’s support, three incinerators that had been donated but never installed were made functional at Mamou Regional Hospital, Labe Regional Hospital, and the temporary annex to the Donka National Hospital at Camp Boiro in Conakry. By the end of the project, 51 hospitals (81%) had functioning incinerators.

Further, MCSP revitalized 23 hygiene and safety committees in three regional hospitals, 14 prefectural hospitals, and six communal medical centers. On average, the project oriented 20 members per health care facility on their roles and responsibilities in overseeing IPC, and developed action plans to implement routine monitoring and formulate corrective actions for performance gaps. By the end of the project, 65% of hygiene and safety committees were meeting regularly to review IPC performance and implementation of their action

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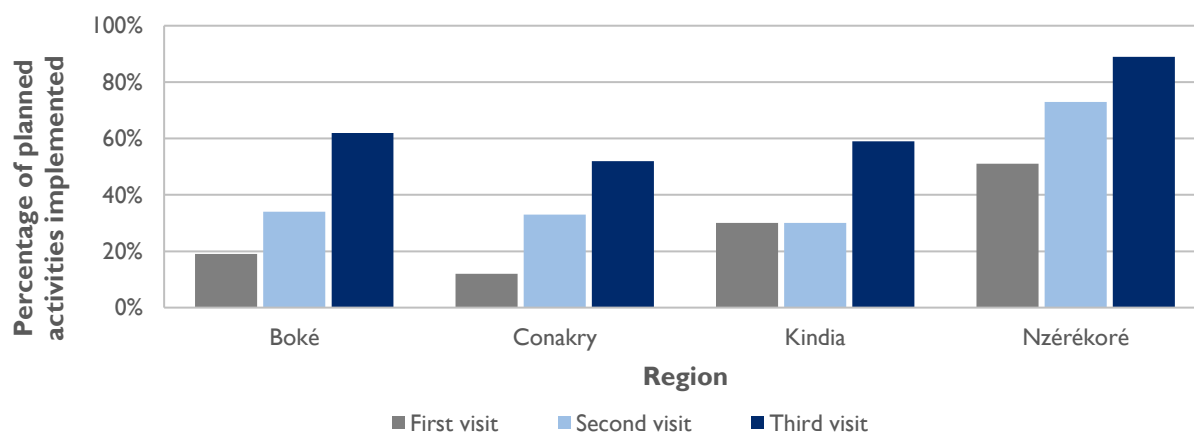
<sup>19</sup> In response to the epidemic, USAID developed a four-pillar strategy to address EVD: Pillar I – Control the outbreak; Pillar II – Recover from second-order impacts of EVD; Pillar III – Build coherent leadership and operations; and Pillar IV – Strengthen global health security in sub-Saharan Africa.

plans. This included reviewing budgets, establishing IPC focal points in each service, monitoring biomedical waste collection and incineration, orienting trainees on IPC procedures, and preparing IPC procurement requests for different departments within the facility. MCSP and other partners funded requests received from the hygiene and safety committees, such as to clean out the septic tanks at four hospitals in Nzérékoré so that toilet and wastewater management could be made functional again.

### *Implemented a Comprehensive Approach to Health Systems Management*

A rapid situational analysis according to the six determinants of the health care system helped to identify strengths and limitations to tailor capacity-building of health managers. This was followed by implementation of the Comprehensive Approach to Health Systems Management for 20 district health teams to identify and analyze challenges, their root causes, and local resources to leverage, and to integrate corrective actions into district teams’ annual work plans. Building on the districts’ action plans, MCSP built the capacity of 22 district health teams on stakeholder engagement, communication, and resource mobilization, resulting in 104 funding requests drafted, 84 submitted, and 43 funded by a range of local resources and development partners across all districts. Further, during the three quarterly visits that were made during the project, the teams noticed a strong improvement in the implementation of planned activities to solve the priority problems. Overall, the rate of achievement of activities and that of the resolution of priority problems increased from 36% at the first visit to 76% at the third visit. Figure 2 shows the scores by region.

**Figure 2. Evolution of the implementation rate of planned Comprehensive Approach to Health Systems Management activities per region**



MCSP was able to institutionalize the Comprehensive Approach to Health Systems Management by integrating the tools into the national guidance for annual planning at all levels of the health system (national, regional, district, and facility). MCSP did this at the request of and in close collaboration with the MOH’s Bureau of Strategy and Development. As a result of these efforts, prefecture health management teams are now able to better analyze and prioritize local needs in their annual plans.

### *Provided Quality Assurance Using the Standards-Based Management and Recognition Approach*

Since 2012, following a review of the QI processes in Guinea at the time, the MOH expressed its wish to implement the SBM-R methodology nationally. At the end of MCHIP in 2014, 48 health care facilities were using the SBM-R process. MCSP’s activities were designed to continue supporting 35 health facilities in the project area (three of the four regions; SBM-R was not previously introduced in Boké) that had been using the process and to reinforce its use in the post-Ebola service restoration period. Building on the Restoration of Health Services work to reinvigorate this QI approach in facilities, MCSP worked at the national and regional levels in Guinea to reinvigorate the external monitoring components of SBM-R. As a result of monitoring the 35 SBM-R sites in the focus regions along with nine validation assessments, eight facilities were successfully validated for recognition of good-quality performance, and three earned a second recognition level developed by the project. The performance level for recognition is 80% across the three core domains of EmONC, FP, and IPC. For the second recognition level, the global score must be above

85%, including some additional service delivery indicators that were added to the performance standards. Financial and technical support (including obtaining donations from partners and communities) for six recognition ceremonies was provided. The recognition ceremonies are a valuable step to engage communities and local government to acknowledge the work of health care providers and motivate providers to maintain quality care. Overall, of the 30 facilities assessed at the end of the project, 50% were performing at the minimum desired level according to the MOH (75–85% depending on domain).

Similar to facilities, whose performance declined during the EVD epidemic, the national SBM-R committee was not functioning well by the end of the epidemic. MCSP advocated with the MOH to reinvigorate the functioning of the national SBM-R committee and also engaged at the national level on the review and prioritization of quality assurance methods and tools in use in Guinea. The issue of the national committee was not entirely resolved by the end of the project, but was an ongoing point of discussion with all partners engaged in QI/quality assurance. Similarly, to reinvigorate regional and prefectural supervisors' use of SBM-R, 21 supervisors were trained on coaching and monitoring using the approach. These trainers/supervisors later went on to support the extension of SBM-R to new facilities under the new bilateral USAID Health Service Delivery project.

### *Provided Support to Strengthen the HIS*

MCSP provided technical assistance to the Bureau of Strategy and Development in collaboration with partners (i.e., MEASURE Evaluation and Catholic Relief Services) for configuration of the new DHIS2 platform, including a data validation manual. MCSP contributed a service delivery-level perspective to the revision of data collection tools and the development of training modules for dissemination of new indicators and tools. The project also supported the management and analysis of data through joint periodic supervision visits by the district management teams and regional-level data reviews. As a result of these efforts, data reporting rates were high for three of four quarters but were beginning to slip at the end of the project while some new configuration was underway. Data accuracy assessments for the six prefectures of Nzérékoré saw good improvements in accuracy among the health centers in five of the six prefectures (see Figure 1).

### **Recommendations for the Future**

Despite the limited timeframe, MCSP was able to contribute to several national- and health manager-level initiatives in support of post-Ebola recovery and to establishing a health system that is better prepared to respond to shocks. MCSP's recommendations to the MOH, USAID, and partners include:

- **Continue to support the Comprehensive Approach to strengthen district health management.** Integration of the methodology and tools into the guidance for annual planning has set this up to continue. Since the end of MCSP, the in-country staff who led this work have been asked on several occasions to provide technical assistance to orient national managers on the tools and facilitate the training in new regions. The MOH and partners should encourage the ongoing use of the improved annual planning tools.
- **Provide support for supply chain management and/or installation and maintenance.** The assessment of incinerators highlighted the ongoing development challenge of donating goods without ensuring they are functional and can be maintained. MCSP worked with the MOH and IPC partners to provide support for installation and repairs, and to develop technical resources for incinerator maintenance. There is still a need to develop guidance on planning and budgeting for recurring costs of waste management, as well as to advocate with national-level authorities to include these costs in national budgeting and requests to donors.
- **Prioritize IPC for future projects with longer implementation times.** The short project periods for post-Ebola recovery were not always conducive to sustained change. Behavior change for improved IPC practices remains challenging, as does enlisting managers and hygiene and safety committees to play a role in monitoring IPC and holding staff accountable. MCSP tried to work at many different levels, from policy to skills updates and coaching of providers and managers, to change this behavior, but the results are still difficult to see in terms of sustained performance. The series of short MCSP projects addressing Ebola response and post-Ebola recovery were not always able to link support for IPC performance to

tackle the issues of ongoing monitoring and accountability. It was fortunate that MCSP was an active award across both acute response and post-epidemic, and was able to call on the same group of technical experts, but the short-term nature of epidemic response and recovery funding did not always prioritize synergies from one project to the next. IPC should continue to be a priority for health development assistance beyond immediate epidemic response and post-epidemic recovery, as it is a foundational element of quality care and of health system functioning.

- **Foster collaboration and opportunities to link USG-funded initiatives and projects.** The opportunity for MCSP to collaborate with MEASURE Evaluation on the DHIS2 rollout is an example of an important link between two USG-funded initiatives. MEASURE’s mandate was largely at the national level, and MCSP was able to facilitate the rollout to regions and districts. As a global award focused on RMNCAH, and experienced with documentation and data use at the service delivery level, MCSP had much to contribute to the discussions of indicators and challenges with data quality and reporting that originated at the facility level.

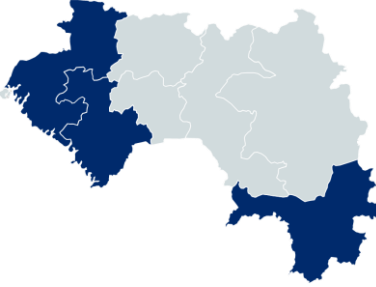
Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	Achievement (Target)
Percentage of SBM-R facilities achieving the minimum standards of performance as defined by the MOH	50% (target: 60%; 83% achieved)
Number of health districts implementing the Comprehensive Approach to Health Systems Management	22 (target: 20; target exceeded)
Percentage of health districts that have resolved at least 50% of problems identified with the Comprehensive Approach to Health Systems Management	77% (target: 80%; 96% achieved)
Number of health facilities that have functioning incinerators or waste pit	84 (51 incinerators and 33 waste pits; target: 55; target exceeded)

For a list of technical products developed by MCSP related to this country, please click [here](#).



# Guinea Restoration of Health Services

## EOP Summary & Results



**Geographic Implementation Areas**

*Regions*

- 4/8 (50% of country total)—Boké, Conakry, Kindia, Nzérékoré

*Prefectures*

- 20/38 (53%)

*Facilities*

- 26/44 (59%) hospitals
- 195/404 (48%) health centers

**Population**

*Country*

- 12.4 million

*MCSP-supported areas*

- 7.65 million

**Technical Areas:** 

### Program Dates

July 1, 2015–December 31, 2016

### Total Funding through Life of Project

\$4,000,000 (Ebola funds—Pillar II)

### Demographic and Health Indicators

Indicator	# or %
Live births/year <sup>1</sup>	447,000
MMR (per 100,000 live births) <sup>2</sup>	550
NMR (per 1,000 live births) <sup>2</sup>	20
U5MR (per 1,000 live births) <sup>2</sup>	88
SBA <sup>2</sup>	62.7%
CPR (modern and traditional methods) <sup>2</sup>	8.7%

Source: [1] Countdown to 2030 country profile, 2016; [2] Guinea MICS 2016

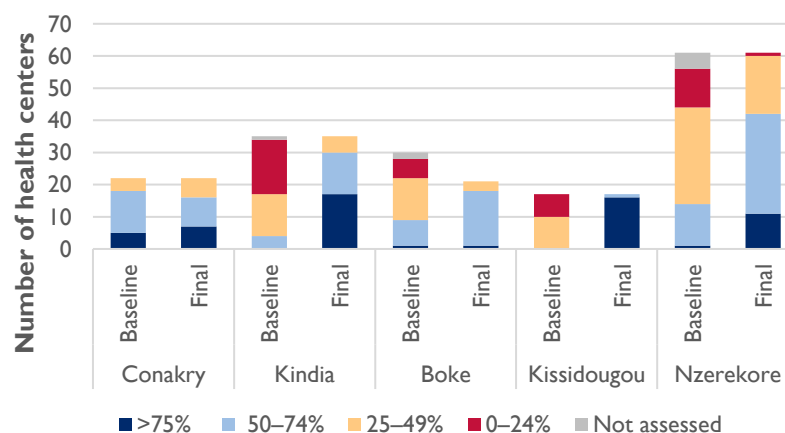
### Strategic Objectives through the Life of Project

- Expand integrated and high-quality MNCH services to additional health facilities and communities, building upon the platform of previous USAID-supported work through MCSP and MCHIP, and responding to the impact of the Ebola outbreak.
- Strengthen service delivery for quality EmONC, FP, and IMNCI.
- Create a favorable health care environment and demand in collaboration with the Health Communication Capacity Collaborative.
- Facilitate community engagement in collaboration with the Health Communication Capacity Collaborative.

### Highlights through the Life of Project

- Helped providers and managers to improve IPC in almost all facilities, with 46% of health facilities/services meeting the desired minimum performance of 75% of IPC standards, compared to only 5% at baseline.
- Contributed to improved treatment of severe pre-eclampsia and eclampsia with magnesium sulfate from 79% in the first quarter to 97% in the last quarter, and an increase in the monthly average of deliveries from 2,487 before the project to 6,242 in the last quarter of 2016.
- Reinforced the management of childhood illness by providers and CHWs in three districts, contributing to an increase in cases of pneumonia treated from an average of 328 per month to 2,052 per month.
- Reinvigorated community-based service delivery by training/refreshing 692 CHWs in collaboration with their supervisors, contributing 100,831 group educational sessions that reached 528,728 people.

**Figure 1. IPC score distribution for health centers at baseline and final assessment by region**



# Guinea—Restoration of Health Services

## Background

MCSP was requested by USAID Washington and the Mission to develop and implement several projects to reinforce IPC in health care facilities and to assist the MOH to restore confidence in and use of health services as a means to contribute to the response to the EVD epidemic in Guinea and the severe effects on health services, including increased risks for health care providers. This report presents the Restoration of Health Services project, which operated from July 2015 to December 2016 and was designed to address the second-order impacts of the EVD epidemic in Guinea (Pillar 2), specifically the restoration of critical non-Ebola health services. The project was funded with resources from the Ebola Response and Preparedness Fund, and the support of the Global Health Ebola Team.

Interventions were concentrated in geographic areas most impacted by the EVD epidemic. These impacts included high numbers of EVD cases and deaths; loss of health care workers to EVD, transfers, and mobilization for the EVD response; and dramatic reductions in health service utilization for routine preventive care and treatment, such as ANC and delivery for pregnant women, FP, and treatment of diarrheal disease, malaria, and other communicable diseases. Community-based health information and services were also impacted by the mobilization of CHWs to support EVD surveillance, contact tracing, and monitoring, and community awareness building.

## Key Accomplishments

### *Supported Consistent and Correct IPC Practices*

MCSP provided institutional support for updating policies, delivering supportive supervision and coaching for sustained performance of IPC, training health care providers on IPC, providing IPC materials and supplies, rehabilitating facility infrastructure, building the capacity of health and safety committees, and monitoring IPC performance on an ongoing basis. Key accomplishments include training 49 supervisors and coaches on IPC, who, along with IPC trainers, carried out 519 facility visits for IPC coaching across the 221 facilities in the project zone. These visits allowed for 9,468 coaching contacts with health care workers and 1,366 contacts with support staff. Ninety-nine health care providers from 26 facilities received training on IPC in Dubreka district, which was fortunate not to have experienced cases of EVD but also had not received prior support to strengthen IPC.

MCSP worked with 143 health and safety committee members across 10 hospitals to reinforce their capacity to monitor and manage IPC performance. The project also supported minor rehabilitation at three hospitals in the project zone, based on findings from a baseline assessment of service functioning. Repairs focused on access to and storage of water; repair of toilets; and backup solar electricity for labor and delivery rooms, postpartum observation, and operating rooms, where maintaining IPC practices is essential for 24-hour availability of lifesaving services. The three hospitals included the regional hospitals in Kindia and Boké and the prefectural hospital in Dubreka.

Periodic assessments were conducted over the life of the project with feedback provided to staff. MCSP observed a decrease in IPC performance at the end of 2015, when the end of the EVD epidemic was declared in Guinea. Supervision and coaching visits helped address some of the fluctuation in performance levels, but changing behavior in IPC practices remains a fundamental challenge for health systems due to the challenges in changing behavior and ensuring consistent availability of IPC supplies, water, and power for instrument sterilization and waste management. Performance rates improved in almost all health facilities, with 46% of health facilities/services meeting the desired minimum performance of 75% of IPC standards, compared to only 5% at baseline. In addition, 34% of facilities were performing between 50% and 74% versus 22% at baseline. The percentage of health facilities/services with less than 50% achievement of IPC performance standards decreased from 70% to 19% between the initial and final evaluation (see Figure 1).

## *Improved Quality of RMNCAH Using the Standards-Based Management and Recognition Methodology*

MCSP worked to reinvigorate and maintain the use of the nationally adopted SBM-R QI methodology. Focusing on facilities where this process had been introduced by previous USAID-funded projects—ACCESS-FP and MCHIP—MCSP carried out a review of current performance and presence of trained SBM-R team members to determine needs. Forty-five providers and supervisors from 15 facilities received orientations on the process to reinvigorate the SBM-R teams. Fifty supervision visits were carried out to support SBM-R reaching each of the 35 targeted facilities at least once. MCSP worked closely with the Health Communication Capacity Collaborative project, also funded by the USAID Global Health Ebola Team, and focused on communications and behavior change activities to integrate its Shining Star QI model with SBM-R. In particular, Shining Star's communication tools increased information available to communities surrounding the facilities receiving recognition.

The target of 80% of the sites achieving or maintaining overall performance was not reached, as only 21 of 35 health facilities (60%) were able to improve or sustain performance with the support of the project. Of these 21 SBM-R sites, eight are at the level of recognition with an average score of 80% across the three core domains of IPC, FP, and maternity care. Thirteen sites improved their performance from baseline to the end of the project, while 14 did not register improvements in the overall score. This was an ambitious target for 18 months, given the sharp decline in quality and utilization compared to before the epidemic and the multitude of activities taking place in these prefectures post-Ebola to attempt to restore health care services and community trust. Competing activities, from protests against the government to national vaccination days, disrupted planned activities multiple times throughout the project.

## *Increased Availability and Improved Quality of MNH Services*

Activities to strengthen the availability of MNH services focused on training, post-training follow-up, and supervision, as well as the provision of medical materials, such as instruments and minor equipment, to focus facilities. A total of 19 of 25 hospitals (76%) and 195 of 195 health centers (100%) benefited from MCSP support to improve the availability of services for pregnant women and newborns. Basic and comprehensive EmONC trainings were offered depending on the level of the facility, with 239 providers completing the competency-based trainings. MCSP adapted the traditional 12-day BEmONC course into a series of three shorter modules for providers from rural health centers. This adaptation was designed to reduce the extended absence of staff from the facility and allow for more practice between modules for skills mastery. The baseline skills of many providers in rural health centers was lower than that of staff in hospitals and urban health centers. To validate skills acquisition and help providers transfer learning to implementation at their work sites, trainers conducted post-training follow-up 1–2 months after training, reaching 84% of trained providers in their work sites.

Using the skills acquired and reinforced during training and post-training follow-up visit and supervision, treatment of severe pre-eclampsia and eclampsia with magnesium sulfate increased from 79% in the first quarter of the project period to 97% in the last quarter. The number of assisted deliveries increased from a monthly average of 2,487 deliveries in the project area (before interventions) to 6,242 in the last quarter of 2016. Improved application of active management of the third stage labor with oxytocin likely contributed to the reduction in cases of PPH from 2.3% in January–March 2016 to 0.8% in October–December 2016, even as the number of deliveries in facilities was increasing.

In addition to the focus on BEmONC, MCSP developed a new training approach to expand the number of providers capable of providing counseling on FP and voluntary access to methods in the immediate postpartum period. Building on efforts to expand access to PPF under MCHIP, MCSP adapted training materials into a series of smaller modules that can be completed on the job with support of a trainer. The self-directed course consisted of 28 modules and could be completed in a minimum of 1 month, but it often extended out over an average of 3 months. While traditional training programs pick a few staff per facility to be trained, this approach trained all staff in large-volume facilities to offer PPF counseling across ANC and maternity services. Trainers were selected from trained staff working in the facility and oriented on the individualized, onsite training approach. Twenty-eight trainers at 18 facilities guided 150 providers through

the course, and by December 2016, 129 (86%) had completed all course modules, and 111 (74%) providers had been qualified by an external assessment.

### *Increased Availability and Improved Quality of Integrated Management of Childhood Illness Services in Facilities*

MCSP also worked to reinforce the management of childhood illness beginning with training of a pool of 17 IMCI trainers, who went on to train 177 providers from health centers and health posts in three districts. Trained providers were provided with job aids, management tools/monthly report templates, and the IMCI reference booklet for the care of the sick child. MCSP also responded to a request from the national IMCI program to support supervision in three districts that did not have support of other partners.

Cases of treated pneumonia increased from an average of 328 per month in October–December 2015 to 2,052 per month during the same period in 2016. Treatment for diarrhea also increased, from an average of 114 cases per month in the last quarter of 2015 to 191 cases per month for the last quarter of 2016. In all, 97% of all reported cases of pneumonia and 96% of cases of diarrhea were treated in health facilities.

### *Reinvigorated CHW Performance through Community-Focused Interventions*

MCSP and MOH trainers trained 682 CHWs in the project area (97% of target), 561 of whom were trained on the integrated curriculum of community services and health messages, and 121 on the dissemination of MNCH/FP/IMNCI/postabortion care messages alone. MCSP worked closely with the district-level community health supervisors and community educators of local NGOs to strengthen their capacity to facilitate CHW monitoring and supervision. Training on supportive supervision of CHWs reached 106 district-level community health supervisors and NGO educators, with 21 trained as trainers for the CHW curriculum. Eighty-five percent (579/682) of new CHWs were reached during post-training visits across all prefectures. CHWs contributed to the conduct of 100,831 group educational sessions that reached 528,728 people (not disaggregated by CHW and provider-led sessions).

Also at the community level, MCSP introduced the community action cycle to assist communities to better understand beliefs and practices related to Ebola and health care seeking. Twenty-four facilitators, including regional health managers and members of community organizations, were trained on the community action cycle and knowledge of community health policies, strategies, and protocols in order to align with national priorities. MCSP was able to provide only the first step in the development of community mobilization teams, in part due to the fact the USAID-funded Health Communication Capacity Collaborative project was also engaged with communities. MCSP therefore put more effort into coordinating with the Health Communication Capacity Collaborative than implementing this process as originally planned. At the national level, MCSP provided technical support to several meetings to review the revised community mobilization strategy document and prepare it for submission to the MOH for validation.

## **Recommendations for the Future**

Based on the lessons learned from the Restoration of Health Services program, MCSP recommends the following for future HSS, IPC, and other projects in Guinea:

- **Carefully consider the timing of post-epidemic recovery interventions supported by USAID and other donors.** Integration of Restoration of Health Services and HSS funding can provide an opportunity for better results/impact than implementation of sequential/independent activities. Restoration of services following an epidemic or emergency depends strongly on functional health systems, while system improvements can result in improvements in health care services when program linkages exist.
- **Prioritize IPC as a fundamental determinant of the quality and safety of health services.** Weaknesses in IPC in health facilities were quickly exploited and exposed by the Ebola virus, and they help to clarify that we should not wait until a potentially epidemic disease is upon us to address fundamental aspects of health care safety and quality. Investments from the MOH and other partners toward improving IPC from the policy level to the lowest-level facility during an epidemic presents an

opportunity to improve attention given to this aspect of health care quality, from protocols and practices of providers and support staff, to consistent budgeting and logistics to ensure supply of commodities.

- **Do not cease behavior change efforts to improve IPC with the post-Ebola response.** Training is not enough, and repeated coaching and supervision were not always enough either. Changing norms and expectations among providers and managers is needed to achieve sustained high-quality IPC performance. Accountability and provider perception of risk remain weak and in need of further exploration of how to improve this in low-resource settings. This was evidenced by the decline in IPC performance after the end of the outbreak (e.g., hand hygiene, triage) because of reduced perception of risk and inconsistent availability of IPC supplies as partner support for materials ended.

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	Achievement (Target)
Number of people trained (health care workers, CHWs)	701 health care workers (target: 350; target exceeded) <sup>1</sup> 682 CHWs (target: 700; 97% achieved)
Number of group educational sessions conducted	100,831 (target: 16,000; target exceeded) <sup>2</sup>
Number of people reached by education sessions	528,728 (target: 128,000; target exceeded)
Number of consultations at health facilities	January–June 2016: 795,495 (5% increase from same period in 2015; no target identified)  July–December 2016: 777,026 (16% increase from same period in 2015; no target identified)
Number of women delivering with assistance of a SBA	118,279 (target: 60,000; target exceeded)

<sup>1</sup> The number of health care workers trained was higher than expected because of change in target for IMNCI training and modular BEmONC training for rural health center staff.

<sup>2</sup> Underestimate of original target, as presence of CHWs unknown before project start and access to communities was rapidly changing as the EVD epidemic neared its end.

For a list of technical products developed by MCSP related to this country, please click [here](#).