



Improving the Performance of Primary Providers in Family Planning and Reproductive Health

*Results and Lessons Learned
from the PRIME II Project,
1999-2004*

Includes a CD-ROM of PRIME II's publications,
resources and interactive tools

PRIME II



Table of Contents

List of Acronyms	3
1.0 Global Results and Lessons Learned	5
2.0 Overview of Results	11
2.1 Performance Improvement	11
2.2 Postabortion Care	15
2.3 Responsive Training and Learning	18
2.4 Integrating Consumer Perspectives	21
2.5 Family Planning and HIV/AIDS Integration	23
2.6 Policy and Protocols	25
2.7 Preventing Postpartum Hemorrhage	26
2.8 Safe Motherhood	28
2.9 Female Genital Cutting	30
2.10 Adolescent Reproductive Health	32
2.11 Gender	33
2.12 Maximizing Access and Quality	35
3.0 Management and Partnership	37
4.0 Monitoring and Evaluation and Communications Strategies	41
5.0 Looking Ahead	45
Annex A PRIME II Projects by Region and Country	47
Annex B PRIME II Performance Monitoring Plan	51
Annex C Funding Overview	53
Annex D PRIME II Website CD-ROM	

List of Acronyms

AIDS	Acquired immune deficiency syndrome
AMTSL	Active management of the third stage of labor
ANM	Auxiliary nurse-midwife (India)
ASEP	AIDS Surveillance and Education Project (Philippines)
CBLSS	Community-based life-saving skills
CDQ	Community-driven quality
CMW	Community midwife (India)
COPE	Client-oriented, provider-efficient services
CPE	Clear performance expectations
CPI	Client-provider interaction
CPSM	Community partnerships for safe motherhood
DVD	Digital video disk
EONC	Emergency obstetric and neonatal care
ESOG	Ethiopian Society of Obstetricians and Gynecologists
ESP	Essential Services Package (Bangladesh)
FGC	Female genital cutting
FHI	Family Health International
FLASOG	<i>Federacion Latinoamericana de Sociedades de Ginecologia</i>
FP	Family planning
GHS	Ghana Health Services
GNC	General Nursing Council (Zambia)
HBLSS	Home-based life-saving skills
HIV	Human immunodeficiency virus
ICP	Integrating Consumer Perspectives
ISMP	Indigenous Systems of Medicine practitioner (India)
IUD	Intrauterine device
LHV	Lady health visitor (India)
LSS	Life-saving skills
LTO	Lead training organization (Bangladesh)
M&E	Monitoring and evaluation
MAQ	Maximizing Access and Quality
MOH	Ministry of Health
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
PAC	Postabortion care
PAFP	Postabortion family planning
PATH	Program for Appropriate Technology in Health
PDQ	Partnership-defined quality
PI	Performance Improvement
PLG	Partner Leadership Group
PLM	Performance Learning Methodology
PMTCT	Prevention of mother-to-child transmission of HIV
PNA	Performance needs assessment
PPH	Postpartum hemorrhage
RCHS	Reproductive and Child Health Section (Tanzania)
RH	Reproductive health
RRT	Regional Resource Team (Ghana)
RTL	Responsive Training and Learning
SALSA	<i>Salvadoreños Saludables</i>
SDL	Self-directed learning
SPL	Self-paced learning
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TLA	Technical leadership area
TRG	Training Resources Group, Inc.
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VAW	Violence against women
VCT	Voluntary counseling and testing
WHO	World Health Organization



1.0 Global Results and Lessons Learned

A foundation of collaborative partnership, strong technical staff and field presence, and practical monitoring and evaluation anchored the PRIME II Project's successful efforts to improve the performance of primary providers of family planning and reproductive health (FP/RH) services. PRIME II's global achievements and lessons learned are summarized in this section; an overview of project results in each technical leadership and focus area is presented in Chapter 2.

Background

The PRIME II Project began in September 1999 as a follow-on to PRIME, a five-year contract with the United States Agency for International Development (USAID) implemented from 1994 to 1999. When PRIME was originally conceived in the early 1990s, USAID's intention was to create a ten-year program focused on training and support to primary health care providers in the developing world. PRIME was one of the first global projects USAID established after the 1994 Cairo International Conference on Population and Development, and the first to focus on integrated reproductive health care.

Intrah, a program of the School of Medicine at the University of North Carolina at Chapel Hill, won the PRIME contract in 1994, leading a consortium of agencies well equipped to handle the challenges of provider training and support around the world. The partnership model that evolved during PRIME was successful in contributing to both country priorities and USAID mission strategic objectives, and the project reached its ceiling of \$45 million and had to turn down Field Support funding in its final year. PRIME pioneered technical approaches, including the Performance Improvement (PI) methodology, and strategies for bringing important services like postabortion care (PAC) to the primary level of service delivery.

For PRIME II, a more refined and comprehensive strategy was developed to address human capacity issues and reproductive health. Building on lessons learned during the introduction of the Performance Improvement approach in PRIME, the project's mandate evolved from a focus on the training of primary health care providers to the improvement of provider performance and sustainable systems for training and education.

Like its predecessor, PRIME II was designed to cover a variety of health issues managed at the primary level of service delivery. Although principally funded and managed by the Office of Population, PRIME II also received support from other sectors of USAID's health portfolio, in maternal health, HIV/AIDS and child health. PRIME II proved to be adaptable and effective as a mechanism for USAID missions seeking to custom design more integrated programs in their countries.

Project Description

PRIME II was implemented under a five-year cooperative agreement with a ceiling of \$88 million awarded to Intrah (now IntraHealth International) in 1999. The original PRIME II partnership included Abt Associates, Inc., AVSC (now EngenderHealth), Intrah, Ipas, Program for Appropriate Technology in Health (PATH), and Training Resources Group, Inc. (TRG), along with two supporting institutions: the American College of Nurse-Midwives and Save the Children. Ipas withdrew from the partnership in 2001 after deciding not to accept USAID funding under the reinstated "Mexico City policy" for population funding.

Over the course of five years, PRIME II implemented projects in 25 countries in six regions: Asia, East and Southern Africa, Europe and Eurasia, Latin America and the Caribbean, the Middle East and North Africa, and West and Central Africa. (For summaries of PRIME II's work in each country, access the PRIME II website, available with this report on CD-ROM.) Project activities were coordinated and supported by IntraHealth's headquarters in Chapel Hill, North Carolina and through regional offices in Dakar, Senegal; Nairobi, Kenya; New Delhi, India (later Bangkok, Thailand); and Santo Domingo, Dominican Republic. To support intensive country-level efforts, PRIME II also



opened offices in Armenia, Bangladesh, Benin, El Salvador, Ethiopia, Ghana, Honduras, Mali, Nicaragua, Paraguay and Rwanda.

To accomplish PRIME II's mission and provide a structure for core-funded innovation, the project was organized by four technical leadership areas (TLAs): 1) Performance Improvement, 2) Responsive Training and Learning, 3) Postabortion Care, and 4) Consumer-Driven Quality (later called Integrating Consumer Perspectives). The TLAs were not specified as part of PRIME II's original design but were added in the first year of the project to help focus its overall effort to improve primary provider performance. For each TLA, two co-chairs led a global (or virtual) team that included representation from headquarters, partner and field offices. Although the working styles of the teams varied, most met face-to-face once a year and held monthly or bimonthly telephone meetings to review major issues and challenges as well as share state-of-the-art thinking in their TLA. At times new approaches recently tested and proven in developed countries were considered and adapted for low-resource settings.

In July 2003, the PRIME II partners decided to merge Integrating Consumer Perspectives activities into the Performance Improvement TLA to continue work in this area as part of the PI approach. At the same time a new TLA was created to guide an area of increasing emphasis for PRIME II: Family Planning and HIV/AIDS Integration. In addition to the TLAs, PRIME II's scope included projects in adolescent reproductive health, elimination of female genital cutting, gender, HIV/AIDS, safe motherhood and preventing postpartum hemorrhage, as well as participation in USAID's Maximizing Access and Quality (MAQ) initiative.

A goal of PRIME II's TLAs was to use core funds to introduce or test new approaches and tools. Core funds were used to start activities that were then expanded with Field Support funding, for example scale-up of postabortion care (Kenya) and prevention of postpartum hemorrhage (Benin, Mali) pilots, and integration of FP into prevention of mother-to-child transmission of HIV services (Rwanda).

Primary Providers

PRIME II's focus on primary providers was appropriate and important. The evidence is clear that both a broader definition of primary providers and an expanded role for these providers contributes significantly to the growing demand for quality health care services caused by pressures such as the HIV/AIDS pandemic and the burgeoning cohort of youth entering reproductive age. PRIME II helped a wider range of primary providers reach more people with critical FP/RH services by:

- Building the capacity of non-traditional cadres such as volunteer health promoters, youth peer educators and pharmacy agents to provide FP/RH counseling and services and community outreach
- Expanding needed services by training primary providers in procedures such as active management of the third stage of labor, postabortion care, and the integration of voluntary counseling and testing for HIV with other FP/RH services
- Incorporating consumer perspectives on quality services and fostering consumer-provider partnerships
- Supporting and strengthening providers through national policies and protocols, curriculum development, and assistance to large-scale in-service training and pre-service education programs.

Lessons Learned

- Community members prefer to visit primary providers who are easily accessible and well entrenched within the local social infrastructure, and who offer services that meet their expectations for quality.
- Status within the community is an essential ingredient in sustaining primary providers' motivation; well-designed interventions that meet community needs and expectations can serve to boost community respect and recognition for providers.

- Clearly stated, widely disseminated FP/RH service policies and protocols are a powerful facilitating factor in creating clear performance expectations for primary providers. The primary provider's perspective and involvement is a necessary starting point for effective policy and protocols analysis and revision.
- Active management of the third stage of labor (AMTSL) by skilled primary providers to prevent postpartum hemorrhage is feasible in the service delivery systems of developing countries.
- Primary providers can deliver high quality postabortion care (PAC) services, and return to fertility, FP, and HIV/AIDS prevention are essential messages for postabortion women. Postabortion care remains sensitive, however, and providers are concerned about PAC being perceived of as providing abortion. To render PAC services more acceptable, it is important to advocate for PAC in the context of safe motherhood and reproductive health and to work closely with committed national counterparts.
- To reach many of those most in need, health care systems and organizations must expand their definition of who can provide critical FP/RH services at the primary level. Non-traditional cadres can often be identified, prepared and promoted where there is unmet need.
- Changing providers' behaviors and attitudes toward adolescents is possible even when there are conflicts between providers' personal beliefs and professional obligations. However, levels of knowledge and skills related to adolescent RH continue to be lower than optimal for many providers and continued attention to improvement is necessary.



Performance Improvement

The Performance Improvement (PI) methodology used in the majority of PRIME II projects proved to be a dependable, user-friendly approach for identifying gaps in health care worker performance and designing and selecting training and non-training interventions to strengthen performance and improve service delivery. The PI approach is content neutral and PRIME II applied it broadly across technical areas (such as family planning, postabortion care and safe motherhood) and regional and country contexts. Use of the approach produced substantial interest and involvement from ministries of health and other partners.

Through PI efforts, PRIME II successfully fostered many linkages among professional schools, associations and providers. In addition to mentoring providers, these connections help to establish the framework through which providers understand job expectations and related performance standards. PRIME also applied PI to address management support by focusing on what providers need to perform to standard and analyzing organizations and systems to determine the best sources of such support. Results of PRIME II's application of PI throughout the world—and products such as the *PI Stages, Steps and Tools*—have been widely disseminated through short courses, publications and conferences, equipping clients and colleagues with guidance and resources to apply the PI approach in their own organizations, systems and projects.

Lessons Learned

- PI is a powerful and transferable approach for improving performance as well as service quality and use in low-resource health care settings.
- A performance needs assessment (PNA) to identify all of the factors affecting performance 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 of the exercise. PNAs need not take a long time, nor cost much money. Based on the situation, PRIME II completed PNAs in as little as two or three days, with costs as low as less than 1% of a total project budget.

- Human performance is a system of interdependent factors, and an intervention in one area generally will not reap the desired results if other components of the system are ignored. With multiple performance factors substandard in so many developing country health care contexts, non-training interventions are important in any intervention package.
- “Scope creep” is endemic to the PI process. Practitioners often see much to be improved after conducting a PNA. A too-long list of performance gaps to be closed may result in an overwhelming and costly project that may never be finished—or even started. An important skill for PI practitioners is to be able to prioritize gaps and interventions and work on only the most important first, generating early successes to help motivate the project team. Likewise, the PNA itself may become unmanageable unless project staff is careful to focus on intended outcomes and avoid excess data collection.

Responsive Training and Learning

A majority of the performance needs assessments conducted by PRIME II revealed the need for an intervention to close performance gaps caused by lack of knowledge and skills. Recognizing that classroom-based training remains the most frequently used intervention, PRIME II continued work to improve that “classical” approach while developing other configurations that are more suitable to primary providers’ environments. Using evidence-based practices, PRIME II developed and implemented a variety of cost-effective, innovative and blended learning approaches, appropriate to local situations and designed to transfer knowledge and skills into improved job performance in low-resource settings. These approaches included self-directed and self-paced learning, combining traditional and peer-assisted learning, and interactive simulations delivered via DVD technology.

Lessons Learned

- PRIME II’s experience designing and implementing responsive training and learning approaches confirms that training interventions must be performance-focused and combined and coordinated with non-training interventions to ensure transfer of learning to the workplace and improved performance on the job. Combinations of training and non-training approaches are effective when they are based on performance behaviors, learning needs and systematic instructional design as well as contextual and cultural factors that can affect performance in the workplace.
- Identifying the essential content for provider learning is feasible and produces stronger performance results by keeping training focused on the priority performance that is desired.
- Innovation in learning in a large and decentralized project like PRIME II requires close collaboration between headquarters and the field.
- In innovative or new programs, careful monitoring is needed to allow modifications in response to preliminary or intermediate data that reveal project strengths and weaknesses.
- While the process is often difficult or slow, PRIME II found that fostering linkages among pre-service institutions, in-service programs and service delivery points yields results—particularly if a multi-year program is envisioned. These linkages reduce redundancies and lessen the burden of multiple vertical FP/RH programs on the FP/RH workforce.

Non-Training Interventions

Evidence continues to show that training alone—even very good training—is not enough to solve provider performance and service delivery problems, and that even when training is a priority intervention, it can be effectively supplemented with other interventions tailored to the situation. PRIME II integrated solutions beyond training to address the other factors affecting provider performance. These approaches included supportive supervision, provider motivation, setting clear performance expectations, integrating consumer perspectives and client feedback, and fostering consumer-provider partnerships.



Lessons Learned

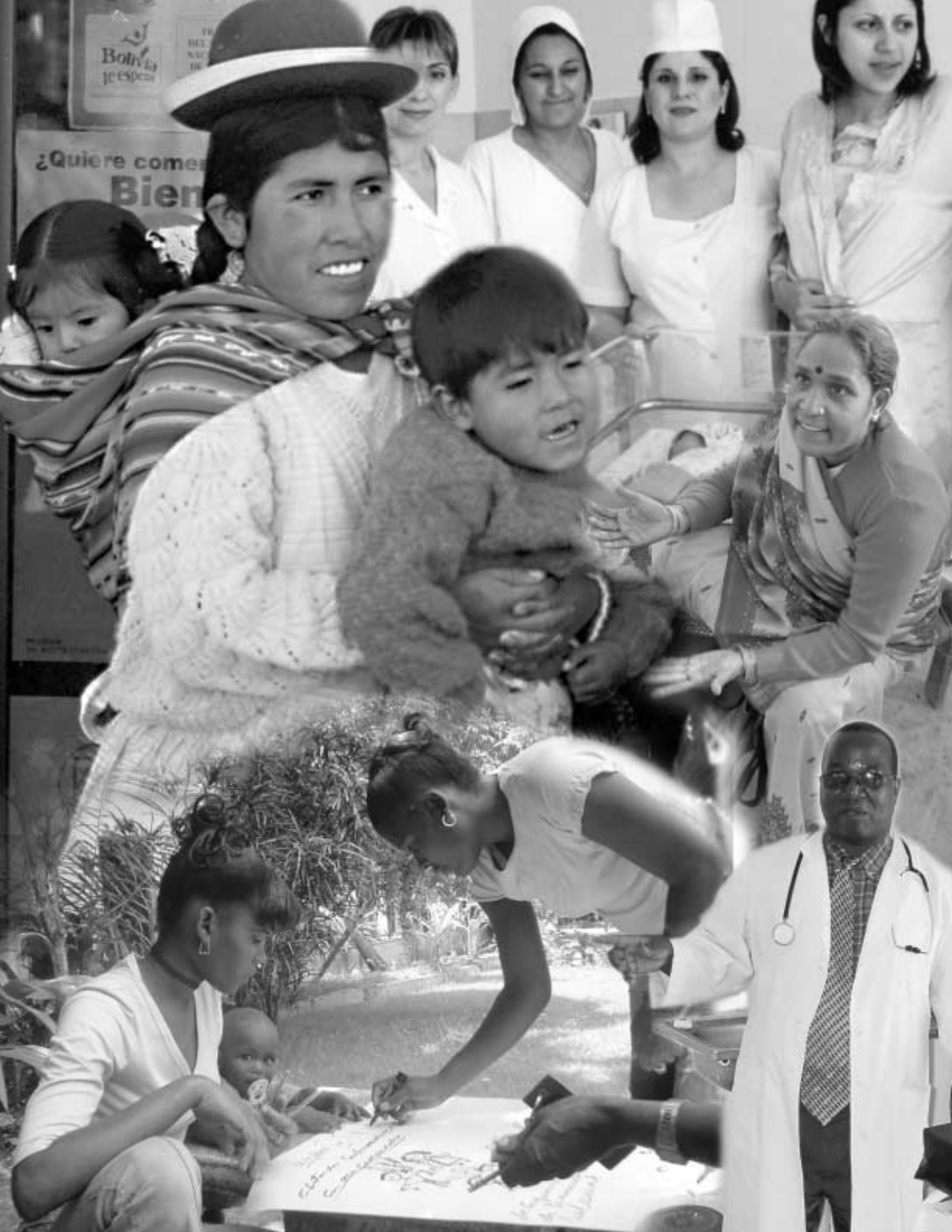
- Providing an analysis (i.e., a PNA) is easier than delivering solutions, especially when multiple performance factors are substandard and some solutions are outside a project's manageable interests (for example, contraception procurement or Behavior Change Communications). Partnering with organizations that can provide the needed solutions is one answer; however, working with partners who have different priorities can present new challenges.
- Program managers need increased awareness of non-training interventions and access to information and models they can use.
- Once non-training performance factors are identified, it is frequently challenging to decide the weight each factor should receive when designing interventions. Feasibility, timeframe and budget are typically influencing variables.
- PRIME II found it imperative to integrate consumer/client perspectives when defining desired performance of health workers and subsequently in project design; mechanisms to ensure consumer input should be incorporated during the initial phase of a project.
- PRIME II also found that clients and consumers can serve as an important source of feedback and motivation for providers.
- PRIME II projects reiterated the important lesson that safe motherhood models and interventions are most effective when they build on and strengthen community-service provider partnerships.

External Evaluation

An external evaluation of PRIME II was conducted in September 2003 by a team of experts assembled by USAID through the Population Technical Assistance Project (POPTECH). The team reviewed project documents including a self-assessment prepared by PRIME II staff, solicited feedback from USAID missions, and visited IntraHealth's offices in Chapel Hill and PRIME II programs in Armenia, Bangladesh, Ghana and Paraguay. Among other findings, the team concluded that PRIME II had achieved:

- Strong performance under the five-year cooperative agreement, aided by an excellent partnership that should "serve as a model for future programming"
- High receptivity by USAID missions, as evidenced by increasing annual Field Support funding that totaled more than half of PRIME II's overall budget
- An "exceptionally well organized monitoring and evaluation system" to track and accomplish the key indicators of the project's Performance Monitoring Plan
- An "impressive portfolio of field projects that have been strategically selected for their potential impact and scalability."

The evaluation team stressed the importance of preserving and continuing PRIME II's focus on the primary provider and the project's Performance Improvement and blended learning approaches.



2.0 Overview of Results

This section highlights key results and lessons learned organized by PRIME II's technical leadership areas and other important focus areas.

2.1 Performance Improvement

Background and Strategy

In the mid-1990s, USAID began to examine its significant investment in training health care providers in developing countries. The investigation made it clear that providers needed a more comprehensive approach than just training to perform at their best and improve service delivery quality and use. During PRIME (1994-1999), partner staff researched various models of supporting workers more holistically, leading to the formation of a provider Performance Improvement (PI) approach based on the human performance technology (HPT) model in wide use in developed countries. USAID funded three pilot projects during the final years of PRIME that demonstrated the suitability of PI for use in low-resource settings.

In addition to being a technical leadership area (co-led by IntraHealth and TRG), Performance Improvement quickly became the way of “doing business” within PRIME II—an overarching framework for carrying out projects from design and implementation to evaluation. Over the course of PRIME II, 35 projects in 20 countries implemented the full PI approach. In each case, the scope of work included building the capacity of in-country counterparts to use PI. In turn, using PI helped project stakeholders become more aware of the limitations of training as a stand-alone intervention, encouraged collaboration among stakeholders and cooperating agencies, and engaged health care leaders in FP/RH policy dialogue.

The PRIME II PI approach begins with a performance needs assessment (PNA) that involves project stakeholders in a simple set of steps that answer basic questions about the performance of providers and other health care workers:

1. What is desired performance?
2. What is actual performance?
3. Are there significant gaps between desired and actual performance?
4. What are the root causes of the gaps?
5. What interventions will address those root causes?

To determine the causes of gaps, the PI approach examines five key “performance factors” that create an enabling environment for providers:

- Clear job expectations
- Performance feedback
- Adequate physical environment and tools
- Motivation
- Knowledge and skills.

The PI global team's five-year strategy for PRIME II focused on building capacity to implement PI, demonstrating best practices in using the PI approach, and discovering effective ways to improve provider performance through non-training interventions.

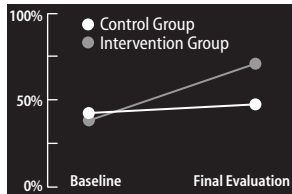
Results

Armenia: With funding from USAID/Armenia, PRIME II conducted a PNA in 2001 that led to national RH policy and standards development. The PI approach was then used to implement a package of interventions to strengthen the performance of nurses and midwives in maternal and infant health in the province of Lori (population 280,000). Reaching 60 rural health centers, ambulatories and their satellite health posts (approximately 70% of health facilities in the province), the interventions included training using a blended self-paced learning approach, upgrading working conditions, strengthening supervision and increasing community involve-



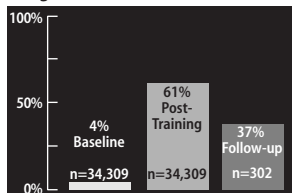
ment in services. A final evaluation comparing providers in intervention facilities with providers at control facilities showed mean performance scores¹ (based on observations) for prenatal care tasks successfully completed improving from 37% at baseline to 69% for providers benefiting from the intervention (n=86 baseline, n=60 final evaluation). Control group providers (n=127 baseline, n=34 final evaluation) also improved but to a much lesser degree: from 41.5% at baseline to 47%. Mean performance scores (based on observations) for postpartum care tasks successfully completed revealed a similar trend: providers at intervention facilities improved from 56% to 76% while control group providers increased their average score from 48% to 59%. The program showed that nurses and midwives working at the most primary level of care could effectively take on an expanded scope of work in maternal and infant health. The evaluation also indicated that client visits and client satisfaction increased at higher rates in the intervention area.

Armenia



Prenatal Care Tasks Successfully Completed by Nurse-Midwives

Bangladesh



Providers' Mean Scores on Performance Observation Checklist

Bangladesh: PRIME II introduced the PI approach to strengthen three Lead Training Organizations (LTOs) conducting in-service training for primary providers to deliver the government's Essential Services Package (ESP). The PI capacity building was part of PRIME II's assistance to the government's Health and Population Sector Program in developing and implementing a national in-service training strategy. Between May 2000 and July 2003, the program trained 45,035 health and family planning personnel in the ESP (83% of the target). An evaluation found all of the LTOs meeting the quality standards established in the national training standards, and the percentage of trainees with acceptable scores (84% or higher) on a performance observation checklist rose from 4% at baseline to 61% post-training (n=34,309) and 37% for a sample of 302 providers at six months follow-up.

Benin: The 2001 Demographic and Health Survey showed high unmet need for FP in Benin, where the average woman bears six children and only 7% of married women aged 15 to 49 use modern contraception. PRIME II applied PI in the private health sector to assess and prepare 140 pharmacy agents to improve the quality of FP counseling and increase provision of oral contraceptives in the two largest cities, Cotonou and Porto-Novo (combined population approximately 880,000). A year after training and non-training interventions, including clearer job definitions and development and use of job aids, an evaluation found prepared agents (n=58) performing significantly better than unprepared agents (n=21) in five areas of care (57% vs. 28% of all tasks carried out satisfactorily).

Ghana: With a goal of reducing maternal mortality and morbidity, Ghana Health Services (GHS) has been scaling-up RH services since the mid-1990s. As part of this effort, Regional Resource Teams (RRTs) in safe motherhood were established to conduct life-saving skills and postabortion care (LSS/PAC) training for midwives, and supervise and support the application of these new skills. After it became apparent that many RRT members were not performing to standard, PRIME II assisted GHS in conducting a PNA and implementing interventions including training, supportive supervision and ensuring adequate equipment and supplies. An evaluation revealed marked improvements in the performance of RRT members, including gains in performing their designated roles (87.5% vs. 36% at baseline, n=40, n=42) and providers receiving supervisory visits (67% vs. 40%, n=72, n=83) and being told their job expectations (97% vs. 31%, n=72, n=83).

Paraguay: PRIME II provided technical assistance to the Quality Project, which supported the Ministry of Health at 22 facilities in five regions to improve FP/RH services. The PI approach was used to select interventions that included training 45 doctors and 246 nurses in FP, informed consent, client-provider interaction, infection prevention and postabortion care; clarifying job expectations through review and analysis of RH protocols and norms; giving performance feedback to providers during on-the-job training; and using EngenderHealth's COPE tool to institute changes in clinic environments and structure of services. Providers (n=27 baseline, n=23 final evaluation) significantly improved their performance in five priority areas from 36% of tasks performed to standard at baseline to 80% at final evaluation. Achievements were especially dramatic in the areas of informed consent (40% to 94%) and client-provider interaction (60% to

98%). Acceptance of modern contraception among samples of FP clients (n=36 at baseline in 2001, n=232 in December 2003) increased from 42% to 75.5%.

Rwanda: Even when necessary drugs are available, prevention of mother-to-child transmission (PMTCT) of HIV in Rwanda is a major challenge, especially since less than a third of all deliveries are attended by skilled personnel. Using PI to assess performance factors, PRIME II assisted the MOH to establish PMTCT services at seven hospitals and health centers. More than 175 primary providers, laboratory technicians and supervisors were trained in the various components of PMTCT services including group and individual counseling during prenatal care, voluntary counseling and testing (VCT), provision of nevirapine to HIV-positive women and their infants, FP counseling and services, postpartum care, breastfeeding counseling and using computers for data collection. The interventions achieved high rates of voluntary counseling and testing for women: 9,311 (98%) of 9,501 women attending prenatal care were counseled between March 2002 and May 2004; 8,752 (94%) of women counseled accepted an HIV test, and 7,921 (90.5%) of the women tested waited or returned for test results. Campaigns to reach women's husbands or sexual partners through discreet letters of invitation to VCT services also showed promising gains; 22% of partners came for counseling, with 1,992 (99%) of 2,012 partners counseled accepting an HIV test.

Tanzania: PRIME II's work with the Reproductive and Child Health Section (RCHS) of the Ministry of Health offers a successful example of capacity building in PI. The project took shape after Tanzanian health care leaders were inspired by a short course on PI taught by PRIME II at the Regional Center for Quality of Health Care at Makerere University in Uganda. The RCHS adopted the PI approach to improve the quality of decentralized RCH services. PRIME II coordinated a PNA and began providing assistance to the RCHS in 2001. PRIME's work focused on enabling RCHS to apply PI at the central, zonal and district levels, and assisting interventions to expand postabortion care and FP services. At the two zonal training centers where PRIME II built PI capacity, performance scores reached the optimal level (100%) in five key performance dimensions, including improvements from 12% at baseline in capacity for RCH training and 44% at baseline in capacity to partner with districts.

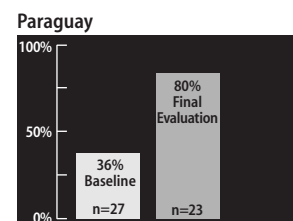
Non-Training Interventions

Applying the PI approach across PRIME II confirmed that training alone is not enough to support primary providers: 88% of the PNAs conducted by PRIME showed at least three of the five key performance factors to be substandard, and 22% found all five below acceptable levels. With core funding from USAID, PRIME II PI staff developed and tested non-training interventions to respond to the wide variety of provider needs. In addition to the projects highlighted below, PRIME II implemented a number of interventions related to supervision with significant technical assistance from EngenderHealth. These included peer support networks to augment traditional supervision from afar (Kenya), efforts to strengthen existing formal supervision systems (Armenia, Honduras, India) and a supportive supervision strategy for community-based health workers (Senegal).

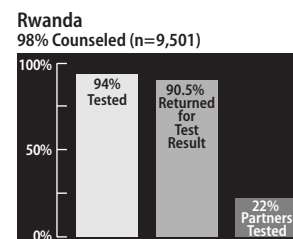
Benin: Health care providers often do not clearly understand what is expected of them in a way that is prioritized and personalized. From mid-2003 to mid-2004, in collaboration with the Ministry of Public Health/Department of Family Health and regional and district health teams, PRIME II, with leadership from Abt Associates, developed and tested a set of interventions designed to improve the clear performance expectations (CPE) of nurse-midwives. Nurse-midwives (n=23) in four districts received CPE interventions while nurse-midwives (n=26) in three others served as a control group. All providers received standard orientation and training in revised national family health protocols, but in the CPE group four priority services were identified: prenatal care, FP and HIV/AIDS/STIs counseling, normal delivery and newborn care. The CPE group developed individual action plans for the priority services, agreed with mentors on desired performance, and adapted the action plans based on facility-specific situation analyses conducted with tutors. Community leaders added local perspectives to the action plans, helped mobilize modest resources to address facility deficiencies, and supported health education sessions. Mentoring, job aids, peer support and supportive supervision were employed to support the CPE interventions.

"In our routine work we sometimes forget to talk with clients about sexually transmitted infections. The public postings remind us to include these messages when we are engaged with our patients."

—N. Kim, ob/gyn, Kyrgyzstan
PRIME Voices #29, April 2004



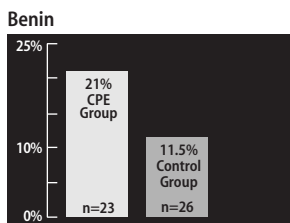
Priority FP/RH Tasks Performed to Standard by Providers



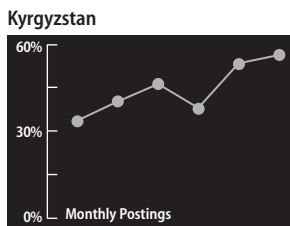
VCT at PMTCT Sites
March 2002-May 2004

“The supervisor helped me organize talks on family planning by providing me with supplies and information, education and communication materials, and by sensitizing community members to the importance of my work... He did not forget me. It makes me more motivated that he is interested and likes the work that I was trusted to do.”

—Community-based health worker,
Senegal
PRIME Voices #28, March 2004



Percent Improvement, Indicators Representing Priority Services



Clients Reporting Correct STI Prevention Counseling

Percent improvement on a composite set of indicators representing the priority services was significantly higher in the CPE group, 21% vs. 11.5%. The cost of the interventions was about 17% higher for the CPE group, which, when compared with the improvement in provider scores, suggests that CPE is more cost-effective. Focus group discussions provided information that will be useful for fine-tuning the CPE approach.

Kyrgyzstan: With financial incentives not possible, PRIME II tested a low-cost alternative method of motivating providers to counsel on sexually transmitted infections (STIs). For this pilot project in 28 family medicine centers and clinics in Bishkek, provider performance data were collected through exit interviews with FP clients and posted monthly in areas of the facilities where only the providers could see them. To maximize the impact of the postings, PRIME also conducted a short workshop for supervisors on supportive supervision. The percentage of clients reporting STI prevention counseling during FP visits rose steadily during the first three postings, from 33% to 46%, before dropping to 37.5% at the fourth posting. Performance increased to 53% for the fifth posting and to 56% for the sixth, gains PRIME II attributes to the constructive reaction of clinic supervisors to the drop in fourth posting results. More than 2,400 clients were interviewed for the study.

India: Over the course of PRIME II’s assistance to develop the capabilities of Indigenous Systems of Medicine practitioners (ISMPS) in family planning counseling and provision of non-clinical methods, follow-up revealed that while providers’ counseling skills remained strong, eligible clients were being counseled less than 25% of the time. A root cause analysis of the performance gap revealed that providers had little motivation to counsel. The ISMPs did not charge fees for counseling or diagnosis of illness, and had been instructed to give away free government FP methods if a client chose one. Thus, they made no profit from their FP services, as they did from selling medicines to treat illnesses. The main intervention chosen to close the gap was to introduce commercial FP methods into the ISMPs’ facilities alongside the free government supplies. Many clients chose the commercial methods, which they perceived to be of higher quality, and qualitative data from a follow-up analysis showed that sales of commercial contraceptives had indeed motivated ISMPs to offer FP counseling.

Paraguay: Clients are uniquely positioned to evaluate provider performance during their care, and client satisfaction is the most important determinant of their willingness to return for future services. Yet providers and their supervisors are often unaware of clients’ expectations and perceptions. Dissatisfied clients simply fail to come back. At hospitals and health centers in Paraguay, PRIME II compared two strategies for client feedback: group meetings with clients and providers (10 facilities) and feedback cards that clients could leave in an “opinion box” (6 facilities). Both approaches featured public display of client communication posters to summarize the good things clients said about services, their suggestions on ways to improve services, and the changes providers were making in response to the feedback. Observations of provider performance in components of prenatal care included in feedback showed significant improvement at the intervention facilities—from 21% (n=36) to 57% (n=34) for the group approach and from 24.5% (n=30) to 35% (n=28) for the feedback card approach—as compared with an improvement of 23% (n=31) to 23.5% (n=28) for providers at a control facility.

Performance Factors Special Study: To determine whether there is a correlation between individual performance and each of the five performance factors as perceived by providers—and which of these factors, if any, are more significantly associated with producing maximum performance gains—PRIME II conducted a study with FP/RH providers in Armenia, Bangladesh, Bolivia and Nigeria. Similar cadres of providers offering the same range of services—prenatal care, postpartum care, family planning and sexually transmitted infections—were selected for random sampling. Baseline results revealed that performance was consistently sub-standard in each country and service delivery area, and multiple performance factors were deficient or nonexistent in each study. Deficiencies differed between studies, but in each case significant relationships were found between observed performance and the presence or absence of the performance factors analyzed. The results of the multivariate analysis varied by country, and further studies are needed to determine any significant cross-cultural trends, but an overall trend showed the importance of provider motivation (first) and job expectations (second) in “predicting” provider performance. Following these two factors were feedback, environment and tools (both third), and knowledge and skills.

Lessons Learned

- Defining desired performance—and hence, desired project outcomes—is perhaps the most important step of a PNA, and often the most difficult. If desired performance is misstated or unimportant performance is emphasized, the remaining steps will only do a good job of generating a high level of the wrong performance. While getting agreement about generalities such as “good counseling” is easy, bringing a team of stakeholders with varying backgrounds and constituencies to operationally define these concepts is challenging.
- Obtaining and maintaining stakeholder agreement is also vital as it ensures that those in decision-making positions support a project for its duration. PRIME II found that closely involving stakeholders increases transparency, helps clients and stakeholders “own” the PI process, makes it easier to prioritize performance problems, decreases the risk that personal biases will unduly influence outcomes, and increases opportunities for learning—and project sustainability—on the part of local counterparts. Since PI relies heavily on stakeholders to move the process forward, it is important to be flexible and responsive to country and local needs.
- Interventions to measurably improve formal supervision systems may take more time and resources to show change than PRIME II’s limited project timelines and budgets allowed (for example, in Armenia and Honduras). And it may be that some formal supervision systems cannot be improved without sustained or significantly enhanced budgetary and organizational support.

2.2 Postabortion Care

Background and Strategy

Of the estimated 600,000 annual pregnancy-related deaths worldwide, about 13%—representing approximately 67,000 women—are related to complications of unsafe abortion². For many women, unsafe abortion causes long-term consequences such as chronic pain, pelvic inflammatory disease, tubal occlusion and secondary infertility. Hospital records from developing countries suggest that between 38–68% of women treated for postabortion complications are younger than 20—and these data represent only those young women who make it to a hospital for treatment. The World Health Organization (WHO) estimates that 10–50% of women who have an unsafe abortion need medical care; some women who experience spontaneous abortion also need treatment.

Evidence from USAID-funded pilot projects in several countries in the late 1990s—including PRIME-assisted projects in Ghana, Kenya and Uganda—showed that midwives in primary-level facilities could provide high-quality postabortion care (PAC) services using manual vacuum aspiration (MVA). Data also demonstrated that primary-level PAC services increased postabortion family planning (FP) counseling and method provision, thus contributing to a reduction in unwanted pregnancies and repeat abortions.

Despite this knowledge, most national service delivery networks in the developing world do not offer PAC services at the primary level. When offered, PAC services are more commonly found at the district hospital level or higher. In countries where comprehensive PAC services have been successfully established at primary-level facilities, the services are often available only within limited or “pilot” areas of the country.

Building on the positive momentum, results and lessons learned from PRIME, the PAC technical leadership area’s global team developed PRIME II’s multi-year strategy for PAC. The TLA was initially co-led by IntraHealth and Ipas, and subsequently by IntraHealth and Engender-Health after Ipas left the PRIME II partnership. With the goal of expanding and scaling-up primary-level PAC services, the strategy placed special emphases on:

- Increasing access to treatment
- Ensuring FP counseling and methods as part of PAC services
- Establishing linkages with STI/HIV counseling and treatment
- Linking primary and referral facilities.

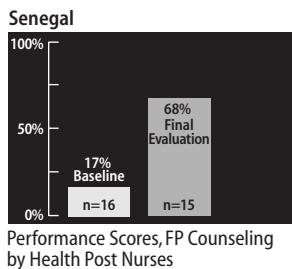
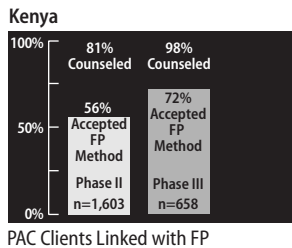


“The other sisters were against postabortion care services until they saw the way a client presented herself, bleeding and in pain. Following the procedure the patient was very happy and cured. Now the sisters have changed their minds.”

—Sister Mary Njuguna, private nurse-midwife and Catholic nun, Kenya
PRIME Voices #26, January 2004

“I can say that I saved a life. I treated a woman who was bleeding profusely. She was worried and her parents were worried. Performing MVA and rapidly stabilizing her with an IV gave confidence to the woman, and she thanked me a lot for having saved her life.”

—Madame Bà Fatou Diouf, health center nurse, Senegal
PRIME Voices #21, July 2003



PRIME II's efforts at the country level took into account issues such as decentralization, health sector reform, public/private partnerships, and partnering with key obstetrician/gynecologist and nurse-midwife leaders. Projects promoted the best use of complementary resources and approaches through global partnering with in-country stakeholders and other cooperating and donor agencies. As PRIME II built capacity in the Performance Improvement (PI) approach, the PAC TLA adopted PI as a framework for designing and implementing projects.

Results

Kenya: Complications from unsafe or incomplete abortion are a major cause of maternal mortality in Kenya and add a tremendous strain on the already overburdened public-sector health care system. A two-year core-funded pilot project that trained 75 providers in 44 facilities during PRIME demonstrated that private nurse-midwives in Kenya were capable of delivering quality PAC services and that this care would increase the accessibility and use of FP services. Since many of the nurse-midwives own their own facilities, they also represent the potential for a national, financially sustainable base of non-hospital PAC services. Building on the pilot with funding from USAID/Kenya, PRIME II implemented a scale-up of PAC services from 2000 to 2002 in 120 facilities in the three pilot project provinces: Nairobi, Central and Rift Valley. In July 2002, PRIME II began “phase three” of the PAC scale-up in Coast province, primarily in districts where the USAID bilateral Amkeni project was already working.

During the two-year scale-up in the three pilot provinces, 155 trained providers successfully treated 1,603 women with postabortion complications using MVA and counseled 1,298 (81%) of these women in FP, resulting in 898 (56%) leaving with or agreeing to return for a FP method. In Coast, PRIME II trained 101 private nurse-midwives and clinical officers. As of June 2004, 658 clients had received treatment for complications, with 638 (97%) managed at the providers' facilities with MVA; 625 (98%) of those clients were counseled in FP after the procedure and 459 (72%) accepted a FP method.

Senegal: For a pilot project in Sokone district (population 100,000), the MOH requested PRIME II's assistance to bring PAC services to the primary and community levels, beyond where MVA is available. JHPIEGO and EngenderHealth had helped to establish PAC with MVA at regional and district hospitals in Senegal (including the health center in Sokone, which serves as a district hospital) and the MOH wanted a model for expanding PAC to rural health posts and health huts where PAC begins with stabilization and referral. PRIME II applied the PI approach with key stakeholders from the central, regional, district and community levels to select interventions to close gaps between desired and actual provider performance. The package of interventions included training, organizational support and community partnerships.

The pilot led to significant improvements in mean performance scores (based on observations) for health post nurses (n=16 baseline, n=15 final evaluation): from 19% to 66% in infection prevention, 17% to 68% in family planning counseling, and 43% to 69% in digital curage. In addition, the project demonstrated that clients would use the improved services and could be tracked through the new referral system. Client statistics from 13 health posts (of 14 in the district) over the year-long project illustrate, among other findings, that providers at the health posts will treat postabortion clients for complications that they are comfortable treating and will utilize the referral system when necessary. All 66 PAC clients received by health posts benefited from FP counseling and 41 (62%) went home with FP methods. Health hut *matrones*, who were trained in referrals from the community level to the health posts, also began re-supplying FP users with assistance from PRIME II.

Kyrgyzstan: Prior to Kyrgyzstan's independence from the Soviet Union, abortion was the principal method of fertility control. Despite increased availability of contraceptives since 1991, the provision of family planning counseling and services to women following legal abortion has not been a priority. Using the PI approach, PRIME II identified and prioritized interventions to address barriers to family planning for postabortion women who want to delay, space or prevent a subsequent pregnancy. The project was conducted in the regions of Osh and Jalalabad, home to approximately 40% of the country's population of 4.8 million. PRIME II collected data on client, provider and facility level barriers to postabortion family planning (PAFP). The data

revealed that immediate FP services were often unavailable to postabortion women who wanted them, FP commodities were often out of stock at facilities, and misinformation about potential side effects of contraceptives was common. Of the 104 women interviewed at baseline, 89 (86%) wanted to use a FP method postabortion and identified the method they wanted to use. However, only 20 (19%) left the facility with their method of choice.

Interventions to address these gaps included developing a national protocol for PAFP services, training and clinical updates in PAFP counseling and service delivery, monitoring and reporting of contraceptive stocks in intervention facilities, and radio messages about contraceptives and health broadcast in local markets. The final evaluation showed great improvement: of 48 women who wanted to use a method, 41 (87%) received one before leaving the facility. None of the respondents listed the unavailability of their method of choice as a reason for non-receipt.

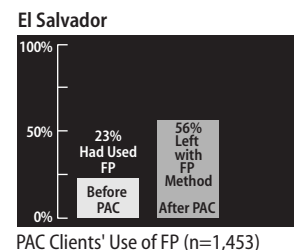
Latin America and the Caribbean: Unsafe abortion is a major cause of maternal mortality in the region, and PRIME II worked to include PAC services as an essential component of safe motherhood projects in El Salvador and Paraguay. Through the SALSA project, PRIME II collaborated with the Salvadoran Ministry of Public Health and Social Welfare to create teams of doctors, nurses and health educators to update and strengthen providers' PAC skills at six regional hospitals. Training included technical updates on MVA to reduce the use of expensive and often painful dilation and curettage procedures and instruction in family planning counseling. In Paraguay, PRIME II assisted USAID/Paraguay and the MOH to improve the quality and accessibility of RH care in five regions, including training 45 hospital-based doctors to provide PAC services.

While only 334 (23%) of 1,453 postabortion clients at the six hospitals in El Salvador had used FP before receiving PAC services, 814 (56%) left the facility with a FP method. For a sample of providers (n=27 baseline, n=23 final evaluation) participating in the Paraguay project, mean performance scores (based on observations) on tasks performed to standard improved from 25% at baseline to 67% at final evaluation in technical competence and from 18% to 72% in FP counseling.

PAC Sustainability Study: Before making further investments in scaling-up PAC among private providers in Kenya it is important to identify and document the key determinants of long-term sustainability of PAC services. Results from the May 2002 USAID/Kenya evaluation of phase two of the PRIME II PAC program found that as many as 20% of the providers who were trained in PAC did not offer the service post-training. In addition to supply-side issues, other sustainability issues related to the ability of clients to pay for the service. The evaluation found that provider attitudes contributed to whether or not a provider will offer PAC services. Further evidence from PRIME-trained nurse-midwives indicated that PAC services might not be profitable for them and that could discourage providers from offering the service. A PRIME II-assisted study led by Abt Associates and completed in April 2004 used a provider survey and case studies to identify factors contributing to or hindering the sustainability of PAC services.

Factors contributing to sustainability include provider attitudes, competition, business acumen, range of services offered, quality of services, and participation in peer support networks. The study recommends strengthening providers' business and management capacity, identifying an organization to represent providers' needs and help mobilize resources, redirecting PAC advocacy to be more broad-based, supporting provider peer clusters, linking providers to ready sources of capital, and fostering an appreciation for monitoring and evaluation among providers. The study concludes that PAC services can be sustainable if the provider's facility is viable, but that private providers need technical assistance in improving general business practices and stronger initiatives to enhance understanding and acceptance of PAC services in the community.

Francophone PAC Initiative: In collaboration with WHO and USAID, the Francophone PAC Secretariat, housed in IntraHealth's office in Senegal, organized the first regional conference on PAC. Held in Dakar in March 2002, the conference attracted 200 delegates from 15 West African countries and Haiti, and included representatives from ministries of health, regional health organizations and US-based cooperating agencies. Participants shared experiences, received technical updates, and developed regional and country PAC action plans. Results from the conference included the Senegal MOH asking PRIME II to develop a replicable model for expanding PAC



“Villagers appreciate that we are selling family planning commodities. And when someone is benefited, he conveys it to another person. This is the way the number of clients has increased.”

—Indigenous Systems of Medicine practitioner, India
PRIME Voices #17, March 2003

services to community-based facilities and the Benin MOH conducting a national PAC assessment. The secretariat's work continues under the leadership of the Center for Training and Research in Reproductive Health (*Le Centre de Formation et de Recherche en Santé de la Reproduction*).

Lessons Learned

- While some PAC issues are global, PAC projects must respond to specific regional and country issues and needs including cultural and religious contexts, settings where abortion is legal and elective, and the level of unmet need.
- Where the climate for PAC is extremely restrictive, bundling PAC services within a safe motherhood or quality RH initiative may be necessary.
- Due to their sensitive nature, PAC projects must be led by knowledgeable and savvy local partners, and evidence of project impact and value is particularly important to scale-up.
- The PRIME II PAC strategy and framework provide language that country-level partners have successfully used to deal with the problem of unsafe abortion and the need to increase FP.
- The Performance Improvement approach and principles are well suited to PAC expansion and scale-up because they help to focus stakeholder energy and commitment on documented performance gaps.
- A major challenge and goal for future activities is to ensure links with HIV/AIDS and other STI services that women need and want. Postabortion women are at risk of HIV/AIDS because they have had unprotected sex. With the epidemic on the rise in most developing countries, it is important that postabortion women are offered HIV/AIDS services including prevention education, management of sexually transmitted infections, and referral for voluntary counseling and testing.

2.3 Responsive Training and Learning

Background and Strategy

PRIME II's Responsive Training and Learning (RTL) technical leadership area focused on developing innovative ways to enhance training effectiveness and efficiency to improve the performance of primary FP/RH providers. To enable providers and health care organizations to reach their goals, the RTL global team led by IntraHealth and TRG designed and tested new tools and sought “cutting edge” learning solutions to close identified gaps in knowledge and skills.

The RTL TLA's strategic goals were to:

- Develop and field-test viable alternative learning approaches, interventions and support systems that would complement and reduce reliance on traditional, instructor-led and classroom-based training
- Develop, adapt and apply evidenced-based training and learning practices and communicate lessons learned to build capacity in the field to make evidence-based decisions for training programs
- Explore using technology-based learning solutions in low-resource settings and apply lessons learned to other contexts.

Results

PRIME II developed and tested new learning tools and approaches, working in close collaboration with numerous partners, and produced evidence-based documents that were subsequently disseminated throughout the international RH professional field. Highlights include:

Performance Learning Methodology (PLM): Training curricula are often laden with too much content, diluting job-related learning and the focus on the critical performance gaps. The PLM is an approach to help content developers analyze, assess, make choices about and improve the content of their programs. The PLM analytical decision-making methodology can be used to distill essential knowledge and skills and determine the most appropriate training methods to achieve desired performance. A key to this process is a filtering concept that employs tools to

help training and content developers “let go” of non-essential material. Course content is based on practical, realistic job performance expectations. Once the essential content is identified, the PLM enables training developers to select the best methods for training, placing at their fingertips an array of evidence-based principles that promote effective learning, retention and transfer of content.

In late 2003, PRIME II used the PLM to revise the postpartum care chapter of the 18-month pre-service curriculum for Community Midwives (CMWs) in Uttar Pradesh, India. To test the effectiveness and usability of the PLM, the revised chapter was implemented with 102 CMW students in Agra and Meerut (intervention) districts, and the original postpartum care chapter was implemented with 113 CMW students in Sitapur and Varanasi (control) districts during February-March 2004. All students took a knowledge test at the end of the postpartum care unit, and the average score from the intervention sites (77%) was significantly higher than the mean score from the control sites (53%). Students from the intervention sites also scored much better on a skills observation checklist. Most importantly, 74% of students followed-up (n=35) from the intervention sites were able to perform postpartum care overall to standard, while only 17% of students (n=30) from the control sites were able to do so.

Interactive Simulation-DVD: Innovative learning approaches delivered via technology, when applied judiciously, hold great promise as an alternative or supplement to traditional classroom-based training of primary providers in low-resource settings. For example, digital video disk (DVD) technology has the potential to deliver learner-centered interactive video simulations that provide consistent content and uniform learning experiences. The capacity of portable DVD players, their ease of use, and their declining cost give this technology high potential for decreasing time away from the workplace, reducing total training time and costs, and allowing the provider control over the pace of learning.

To determine the feasibility of using DVD technology, PRIME II developed two interactive video training simulations, with leadership from TRG, for in-service refresher training of experienced PAC providers in Kenya. PRIME II field-tested the interactive simulation-DVDs in 2003-2004 to investigate the usability, acceptability and durability of the DVD players (and program) in situations that are “typical” of their intended uses (e.g., as tools for independent learning in low-resource settings). The results of the field test were extremely encouraging. Observations and interviews confirmed that providers saw the learning approach and tools as easy-to-use, convenient and flexible. Providers reported that they thought the DVD method was especially effective because they were in control of when they engaged in the learning process, and they did not have to leave their facilities to update their skills. One provider put it this way: “The learning process is like hiring an instructor right at your desk.”

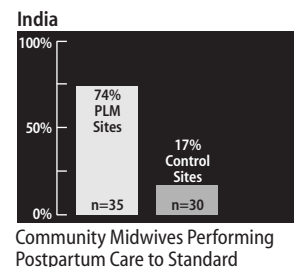
Transfer of Learning: A Guide for Strengthening the Performance of Health Care Workers:

This successful global partnering effort with JHPIEGO resulted in a dynamic matrix—published as a guide—that outlines specific steps for enhancing the transfer of learning. The primary purpose of the guide is to share strategies and techniques that can be used before, during and after training interventions to ensure support for the transfer of knowledge and skills to improved performance on the job. The information in the guide enables all of the stakeholders involved in a training intervention to play their respective roles in ensuring that transfer of learning occurs. Print (English, French and Spanish), interactive CD-ROM, and web-based versions have been published and disseminated.

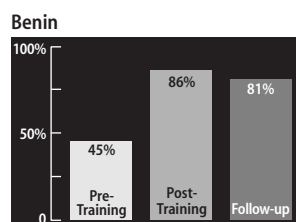
Training Works!: Based on the best and latest thinking of professional trainers working in FP/RH, *Training Works!* is the product of a rigorous process of identifying excellent practices in the various phases of training. Collaborating with JHPIEGO, FHI, the Population Leadership Program/Public Health Institute and USAID’s Office of Population and Reproductive Health, PRIME II contributed to the development of guidelines for the design, delivery, evaluation and management of group-based training. PRIME II and JHPIEGO also cooperated to design and implement two global workshops to broadly disseminate this publication, which conveys the current “state of the art” for the field.

“I’ve taken my family planning work into my own life. I had two children, both girls, and they each have only two children as well. This is the way nurse-midwives can make the greatest impact when counseling their clients and supervising village dais.”

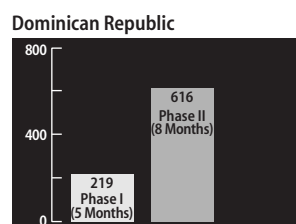
—Bina, Auxiliary Nurse-Midwife, India
PRIME Voices #9, February 2002



Ghana: PRIME II worked with Ghana Health Services (GHS) of the Ministry of Health to design and implement a self-paced learning (SPL) approach in postabortion care (PAC)/safe motherhood as an alternative to their traditional group-based classroom training for doctors, nurses and midwives. The GHS Health Research Unit, with support from Population Council/FRONTIERS II and PRIME II, conducted operations research to compare the two approaches in terms of outcome, impact and costs; drawing on technical expertise from Abt Associates, PRIME II led the cost-effectiveness analysis component of the study. While the financial costs of the SPL approach are about 14% higher than the traditional approach, analysis documented that gains in learning and service delivery are accomplished more cost-effectively through SPL. SPL learners (n=40) showed 25-49% higher knowledge and skills gains and 4.5-6% higher performance gains in simulated service delivery (with the largest increase in PAC) than participants in traditional training (n=40). When examining client outcomes and service delivery before and after training, the SPL group showed relatively high increases, ranging from 34.5% for new and continuing use of injectables to 314.5% for new and continuing use of condoms. The traditional training group showed an increase only for use of condoms (18%). Each percent gain in condom use by the SPL group was obtained on average for an expenditure of \$7, while each percent gain for the traditional group cost \$76.



Provider STI/HIV Knowledge Test Scores (n=27)



Provider Home Visits

Benin: In November 2002, revised family health protocols were nationally approved by the Ministry of Health. PRIME II assisted the MOH to implement a blend of traditional classroom training, tutoring and self-directed learning to enhance the dissemination of the protocols in the Borgou/Alibori, Atlantique/Littoral and Mono/Couffo regions. Scores for a sampling of providers (n=27) on STI/HIV knowledge tests rose from 45% pre-training to 86% post-training, and had fallen only slightly to 81% at a six-month follow-up in the Borgou/Alibori region. Similar improvements were documented in the other regions, and the providers also earned high performance scores (based on observations) on use of the protocols for STI/HIV/AIDS, safe motherhood, child health and infection prevention.

Dominican Republic: PRIME II used traditional classroom, self-directed and peer-assisted learning approaches along with supportive radio programming to train volunteer FP/RH (including STIs and HIV) health promoters working in isolated and marginalized slum communities (bateyes). Attention to performance factors other than knowledge and skills—clarifying job expectations, giving incentives, ensuring necessary supplies and providing feedback—increased promoter learning, and this then translated to performance. Promoter knowledge test scores increased from 50% to 82% (n=12) and home visits in the community rose from 219 during the first phase of the project (five months) to 616 during the second phase (eight months).

India: After a PNA to ensure that all performance factors were taken into account, three cadres of primary FP/RH providers—traditional birth attendants (TBAs), Indigenous Systems of Medicine practitioners (ISMPs) and Auxiliary Nurse-Midwives/Lady Health Visitors (ANMs/LHVs)—were trained and supported with assistance from PRIME II in Uttar Pradesh, India's most populous state. Areas of focus included clean delivery, FP counseling and services, and referrals for obstetric complications (TBAs); FP counseling, referrals and provision of non-clinical methods (ISMPs); and clinical FP services, identification of STIs, and infection prevention (ANMs/LHVs). All cadres consistently achieved high levels of performance to standard: 6,006 (86%) of 6,948 TBAs assessed; 9,851 (81%) of 12,162 ISMPs assessed; and 6,190 (92%) of 6,728 ANMs/LHVs assessed.

Lessons Learned

- The Performance Improvement approach often involves familiarizing planners, trainers and managers with evidence-based training practices and helping them monitor and evaluate pilot programs. Despite this, project planners and trainers tend to gravitate toward approaches and methods they are familiar with, and there has been a strong tendency to request classroom-based training. PRIME II found, however, that training professionals are receptive when alternative learning approaches are tailored to respond to the particular needs of learners and organizational resources.

- Technology can be applied effectively for learning in low-resource settings. Piloting and careful monitoring are necessary to ensure that the right technology is matched to the situation, especially when introducing a new technology.
- DVD technology holds much promise as a learning tool. From a user's perspective, it appears to be entirely acceptable (effectiveness remains a future challenge to be assessed). The price of one delivery method—the portable DVD player—continues to decline while durability goes up. Still, the development of interactive DVDs—or even DVDs that mainly model new skills or procedures—remains somewhat complicated.
- Blended learning approaches need the active involvement of key stakeholders at all levels to maintain commitment to implementation and ensure success. For optimal results, they require a strong learner support system including carefully selected, prepared and supported facilitators. Blended learning can be effective in developing clinical as well as cognitive skills, and can be designed to allow learners to apply new knowledge and skills as soon as they are learned, given the appropriate guidance from facilitators. Blended learning also allows flexibility in scheduling and can reduce the number of consecutive days away from the job for training.
- A challenge for PRIME II was to ensure the highest quality of training and learning activities conducted by field-level trainers. Despite quality assurance efforts, many trainers still tend to rely heavily on lecture or classroom methods.

2.4 Integrating Consumer Perspectives

Background and Strategy

In its quest to improve the performance of primary providers, the PRIME II Project found it valuable to integrate consumer perspectives on quality, timeliness and perceived value of FP/RH services. These community-based efforts targeted clients and potential clients, with the ultimate purpose of delivering quality services based on a better understanding of consumer needs.

Feedback and clear expectations are important performance factors affecting providers, and in both areas consumer input can offer vital insights. By integrating critical consumer input, providers can change ingrained practices and beliefs about how to treat clients, make decisions and structure work. In the ideal situation for integrating consumer perspectives (ICP), providers have an ongoing mechanism for listening to consumer feedback, incorporating this input into their performance, and fostering partnerships with their clients and potential clients (consumers). Building on lessons learned from successful models created by global partners Save the Children and EngenderHealth, PRIME II designed activities to put ICP concepts into practice in a variety of settings.

PRIME II's ICP strategy generated an approach that providers and managers can use to improve the quality of FP/RH services based on consumer input. The approach details which components of consumer input to gather through performance needs assessments. These findings translate into quality improvement action plans developed jointly between providers and consumers. The ICP approach incorporates *feedback* on FP/RH services from consumers, provides *tools* for gathering ongoing input, and weaves these findings into *norms or protocols* for service delivery.

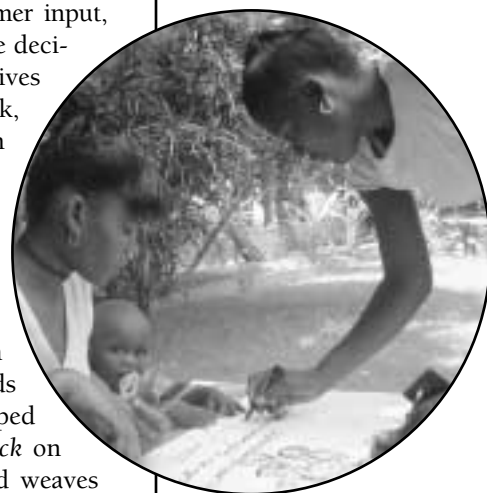
Consumer Feedback

With leadership from PATH, the ICP TLA team developed systematic ways for providers and managers to collect and evaluate consumer perspectives on the delivery of RH services. Consumer feedback addresses:

- Respect for client values and right to privacy
- Client-provider interaction
- Appropriate constellation of services offered
- Convenient location and hours and reasonable prices for services

“Involving people from the community is critical because they will always have the best idea of how to better their own quality of life... The increase in patient numbers and income is a result of all the community work we have done.”

—Dr. Jose Gregorio Aponte, clinic director, Dominican Republic
PRIME Voices #14, October 2002



“For women who want to plan their families and their husbands won’t let them, I tell them to come with their kids to my house in the afternoon and we take advantage to talk about family planning.”

—Lichita, health promoter, El Salvador
PRIME Voices #6, October 2002



- Physical comfort
- Providers’ technical competence
- Overall client satisfaction.

Consumer Input Tools

To gather consumer input at the community level, PRIME II assessed and adapted elements of Save the Children’s community assessment tools and EngenderHealth’s Community COPE tool. Adapted to PRIME II’s target of improving provider performance, these tools proved effective in coalescing potential clients and gathering their opinions and expectations for improved FP/RH services. PRIME also developed a tool to facilitate discussion and consensus among consumers and providers on recommended improvements. The resulting opinions and expectations serve as the foundation for jointly produced quality improvement action plans, which then shape the ongoing relationship between the consumers and providers.

Norms and Protocols

Once providers and managers have a solid understanding of consumer needs and expectations for quality services, and these expectations are accepted and built into quality improvement plans, they must also be incorporated into RH service delivery norms and protocols in order to ensure sustainability of the quality improvements.

Results

Dominican Republic: For the nongovernmental organization ADOPLAFAM, PRIME II applied the ICP approach at a clinic serving low-income neighborhoods on the outskirts of Santo Domingo. A series of participatory group activities collected consumer feedback about FP/RH service needs and perceived barriers to quality services. Ongoing dialogue between clinic staff and community spokespersons recognized consumer satisfaction as an essential component of the clinic’s strategy to ensure financial sustainability by providing accessible services that meet consumer expectations. Consumer feedback and information gathered using community-based tools were integrated into a quality improvement plan. Carried out with monitoring by the consumers, the plan resulted in many changes at the clinic including: greater constellation of services, longer and more convenient hours for FP/RH services, increased privacy and improved client-provider interaction. Over the course of the intervention, the perception among samples of clients (n=32 baseline, n=40 endline) that the clinic offers necessary services increased from 50% to 97.5% and the perception that clients can ask questions of their provider increased from 31% to 62.5%. The clinic recorded an increase in paying clients from 28% to 60% in one year, and client visits increased by more than 100% (from 956 clients, October-December 2001, to 1,925 clients, October-December 2002).

Rwanda: Building on Save the Children’s Partnership Defined Quality (PDQ) methodology, PRIME II’s ICP approach for Rwanda linked improvement with community mobilization. PRIME used ICP tools to strengthen the capacity of the MOH to build partnerships between health providers and the communities they serve, especially to support community-based mutual health organizations (*mutuelles*) and prevention of mother-to-child transmission of HIV services. At pilot sites in two districts, PRIME II and Save the Children staff worked with the MOH to explore community members’ definitions of quality services. This exercise revealed that community members and providers agreed on the majority of expectations related to quality services, including accessibility, technical competence, effective management, safety, cultural compatibility, enhanced client-provider interaction, and the availability of supplies including contraceptives. After consolidating their perspectives, community members and providers worked jointly to carry out solutions and improvements.

PRIME II helped establish 22 PDQ teams to increase *mutuelle* membership and advocate for health facility improvements such as more personnel, availability of supplies and improved patient flow. Qualitative evidence indicates that PDQ resulted in a shift in the mentality of both providers and clients to a partnership approach. As one district health officer remarked, “PDQ is the eyes of the health center in the community, and the eyes of the community in the health center.”

While the PDQ approach was not implemented in all of the health facilities serving PRIME-assisted *mutuelles*, PRIME's overall efforts to increase accessibility and use of services through *mutuelle* membership relied on enlisting community health staff (including social workers) and responding to consumer needs. According to PRIME II's evaluation, a *mutuelle* member is five times more likely to seek modern health care than a non-member (1.6 versus 0.27 visits per year). As a result of PRIME II's work since 2000 in five districts, the number of *mutuelles* has increased from 54 to 90, serving more than 325,000 members.

Zambia: PRIME II worked with the General Nursing Council (GNC) to promote a client-centered approach to nursing and midwifery and develop FP/RH practice norms and protocols that reflect consumer-oriented care. Using ICP tools with providers, clients and potential users of services, the GNC solicited and incorporated significant consumer input in the validation of existing FP/RH norms and protocols. PRIME and the GNC also implemented approaches to reach non-clients to determine why they are not accessing FP/RH services.

Lessons Learned

- Providers and project staff must remain adaptable when working with clients and potential clients, taking into account their time pressures from jobs and families. A significant amount of time with consumers may take place in the evenings and on weekends and in venues outside of the clinic such as schools, churches, stores and community centers.
- Service delivery leadership must facilitate and support providers' efforts in the community, making this a part of clear job expectations. Managers and providers must be willing to "go the extra mile," showing consumers they have been heard.
- Providers can be effective mobilizers of community input, but they may have to adopt new skills, become open to listening to their clients, and change their approaches to service delivery accordingly.

2.5 Family Planning and HIV/AIDS Integration

Background and Strategy

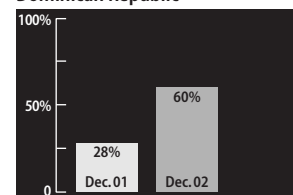
The HIV/AIDS pandemic has placed an enormous strain on health care systems. Developing countries face the challenge of offering HIV/AIDS prevention and care services with diminishing health care workforces, and with inadequate policy guidelines, management support and infrastructure. These strains are compounded in many countries by continued high unmet need for other FP/RH services.

Over the course of five years PRIME II linked primary-level FP/RH services and HIV/AIDS prevention in 36 projects in 18 countries. PRIME II's integration strategy was designed to build on existing family planning efforts and infrastructure, optimize the time and resources of primary providers, train and support non-traditional cadres in FP counseling and community-based HIV/AIDS outreach, and take advantage of opportunities to deliver HIV and FP messages when clients seek care. In 2003, PRIME II established a new technical leadership area (TLA), Family Planning and HIV/AIDS Integration (co-led by IntraHealth and PATH), dedicated to finding the most effective and efficient ways to offer FP and HIV/AIDS services. With a short timeframe to achieve results, the primary emphasis of the new TLA was to document experiences and develop replicable tools in integration of these services.

Results

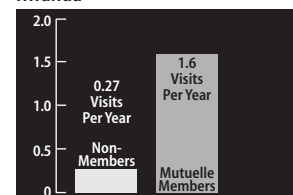
Rwanda and Ethiopia: Building on the project's field experience in implementing safe motherhood programs, PRIME II designed interventions to help providers deliver prevention of mother-to-child transmission (PMTCT) of HIV services in Rwanda and Ethiopia. As part of a national PMTCT effort in Rwanda, PRIME worked with the MOH to establish PMTCT services at seven hospitals and health centers (see page 13). In collaboration with the Ethiopian Ministry of Health and HIV/AIDS Prevention Control Office, UNICEF and other partners, PRIME II was the lead implementer in the start-up of the *Hareg* Project, a part of the United States Government's Presidential Initiative in Ethiopia. Start-up activities included site and needs assessments, procurement and distribution of supplies, training of providers and other staff,

Dominican Republic



Clients Paying for Services, NGO FP Clinic

Rwanda



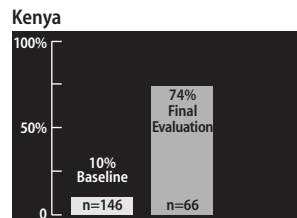
Mean Health Care Consultations

"Before, if we got sick and didn't have any financial resources we used to have to sell our livestock or our land. Now, once we pay our contributions to the mutuelle we receive a membership card that we show to the health center, and we are treated without any constraints."

Mutual health organization member, Rwanda
PRIME Voices #15, December 2002

“When clients inquired about various family planning methods in the past, we were usually unable to give them relevant information since we were more focused on HIV/AIDS prevention. Now, we can easily explain and promote dual protection.”

—Julie Generalao, Community Health Outreach Worker, the Philippines
PRIME Voices #25, December 2003



Distribution of Condoms alongside Preferred FP Method

and preparation of health management and information systems. *Hareg* was launched at 23 sites in early 2004. In addition to HIV prophylaxis for HIV-positive women and their infants, the sites provide prenatal, intrapartum and postpartum care, FP counseling and services, and counseling on infant feeding options. With significant technical assistance from Save the Children, *Hareg* developed a Community Action for Behavioral Change component through which community members, groups and organizations design and implement activities to prevent HIV, generate demand for services, and reduce stigma and gender discrimination related to HIV/AIDS.

With core funding, PRIME II developed and field-tested a methodology and tools to analyze the FP and PMTCT service systems in order to facilitate their integration. The field test was conducted at two PMTCT sites in Rwanda and two in Ethiopia. Conclusions and data to be shared with other PMTCT sites include an assessment of the most appropriate integration points of FP and PMTCT services, an evaluation of missed opportunities for integration, a list of key messages for women regarding FP and available choices, and a list of possible solutions to obstacles to integrated services. After reviewing findings from the field test, the Rwandan MOH resolved to develop and disseminate national integration guidelines, conduct intensive FP training for providers at PMTCT sites, and make changes to streamline record-keeping practices.

India: PRIME II promoted the integration of FP and HIV/STI services during training in clinic-based FP and supportive supervision in Uttar Pradesh. More than 10,500 auxiliary nurse-midwives and their supervisors, Lady Health Visitors, were trained to screen for STIs and counsel on HIV/AIDS prevention during FP visits. Job aids were provided and clear expectations set to ensure the nurse-midwives met performance expectations. Mean performance scores (based on observations) in FP counseling skills for auxiliary nurse-midwives (n=7,009 at baseline, n=5,632 at follow-up) rose from 30% to 85%.

Philippines: PRIME II worked to complement the PATH-led AIDS Surveillance and Education Project by improving access to FP/RH information, counseling and services for youth engaged in high-risk sexual behaviors. With input from youth consumers, PRIME designed a refresher training course for community health outreach workers and peer educators on FP and adolescent health. Behavioral monitoring surveys conducted in 2002 and 2003, which examined exposure to the intervention along with knowledge and belief variables among two sentinel groups, found that exposure to the intervention was significantly associated with increased condom use. Among young female sex workers, significantly more reported using a method to prevent pregnancy in the 2003 survey than at baseline in 2002 (73% vs. 62%, n=441, n=472), with condoms being the most frequently mentioned method.

Kenya: PRIME II and Family Health International conducted an initiative to investigate and address factors hindering FP service providers from promoting condoms and dual protection to clients. Formative research results were used to develop interventions to strengthen dual protection counseling and improve condom promotion and distribution. Interventions included facilitative supervision, orientation to guidelines and standards, establishment of a resource center, reorganized client flow and added privacy during counseling. Observations of client-provider interaction showed significant improvements in provider counseling on condom use, from 26% of clients counseled at baseline (n=146) to 80% at final evaluation (n=66) and dual method use, from 22% of clients counseled to 75%. Condom distribution also improved significantly at participating facilities, with 74% of clients receiving condoms alongside their preferred contraceptive method, compared with just 1% at baseline.

Lessons Learned

- Efforts with both traditional and non-traditional providers require targeted support to improve integrated HIV/AIDS and FP services: critical content, key messages, clear expectations, and appropriate services for each cadre of provider and health outreach worker must be identified.
- In all four sites where PRIME II tested its methodology to analyze opportunities to integrate FP and PMTCT services, an overall lack of commitment to FP was a fundamental barrier to integration of services.

- Reducing stigma and strengthening infection prevention are challenges in both clinical and community FP service delivery settings.
- Vertical planning and programming makes integration of FP/RH and HIV/AIDS services at the implementation level difficult and at times impractical. Multiple funding streams may be needed to support services at integrated sites, but lack of common priorities can undermine the efforts to co-fund interventions or limit the scope of activities undertaken.
- When funding for HIV/AIDS is allocated separately from other FP/RH efforts, it becomes a challenge to integrate these efforts at the project level, especially when well-funded global projects already exist to work only in HIV/AIDS.
- Rapidly evolving technical and clinical knowledge and guidelines on issues such as ARVs and PMTCT regimens make project design or scale-up a challenge for integrated services.

2.6 Policy and Protocols

Background and Strategy

PRIME II found policy and protocols development and revision to be a natural and critical intervention required as part of the PI process. In addition to assisting with drafting or revising new national policies and protocols, PRIME II worked to update and integrate existing protocols, further the use of policies and protocols, and develop job descriptions, job aids and other materials to support these efforts. In Armenia, Benin and Rwanda, PRIME II applied PI in efforts to translate new or revised policies and protocols into enhanced provider performance and accessibility of services.

Results

Rwanda: The MOH asked PRIME II to assist in drafting the first national RH policy since the country's civil war. To help identify national RH priorities PRIME organized a roundtable conference in 2000, which launched a collaborative process with key RH stakeholders. PRIME II 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 drafted new RH guidelines to ensure effective implementation of the national policy.

Armenia: PRIME II 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 in accordance with 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. Early on in its work in Armenia, PRIME II also assisted a MOH working group to draft a national RH policy. After the group prioritized RH needs and services, PRIME helped to define 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 served as a guide for additional policy work 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.

Paraguay: PRIME II designed and implemented the evaluation of the MOH'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 a 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 plan dissemination. PRIME helped the MOH design a new national plan for 2003-2007 through a highly participatory process that included stakeholder workshops in 17 geographic departments. Through TASC 2, IntraHealth will provide training in components of the plan and assist with its dissemination.



"I first heard of PMTCT during an educational talk at the health center. Now I know that I can live positively and do things to prevent my baby from becoming infected with HIV... I will follow-up like I should and deliver my baby here. I am reassured that the health center staff will support and care for me."

—Abyot, client, Ethiopia
PRIME Voices #30, May 2004

“Hemorrhage has been our *bête noire*... AMTSL is good for morale, good psychologically for the clients because they feel like they should be done once the baby is out and for the providers because they don't have to be afraid of hemorrhage anymore. It's also more economic, with less dirty materials and clothing. Plus the time gained lets providers take care of other patients.”

—Dr. Hamadoun Garba Cissé,
ob/gyn, Mali
PRIMEVoices #22, August 2003

Protocols:

In addition to work in Zambia (see page 23) and Benin (see page 20), PRIME II's efforts in protocols development or revision included:

- **Bangladesh:** PRIME II played a key role in developing and disseminating new national training protocols and supportive checklists for in-service training.
- **El Salvador:** As part of the SALSA project, PRIME II helped revise the national protocols for FP, cervical cancer and safe motherhood, and encouraged their use through a variety of efforts with the MOH.
- **Honduras:** With leadership from Abt Associates, a PRIME II-supported effort validated guidelines for licensing facilities and improving provider performance, especially through facilitated supervision.
- **Nicaragua:** PRIME II took a lead role on the national commission to review and revise the national emergency obstetric care protocols.
- **Paraguay:** PRIME II assisted in the revision of the IUD insertion protocols with the MOH.
- **Tanzania:** PRIME II worked with a consortium to update national FP and safe motherhood protocols.
- PRIME II assisted in adding new components to protocols in **Armenia, Benin, Mali and Tanzania**. Areas included STIs, HIV/AIDS, gender-based violence, female genital cutting, and active management of the third stage of labor.

Lessons Learned

- 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.
- Accompanied by effective training and learning interventions and job aids, national service delivery protocols can offer an effective framework for improving primary provider knowledge and skills.
- Protocols are more easily developed and approved when they emanate from national policy.
- Clearly stated policies and related protocols should form the basis for clear provider performance expectations.
- Gathering consumer feedback on their expectations for quality care can provide useful input to 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.

2.7 Preventing Postpartum Hemorrhage

Background and Strategy

Postpartum hemorrhage (PPH) is the single most significant cause of maternal death worldwide, accounting for half of all maternal deaths that occur after childbirth and 24% of overall maternal mortality, approximately 130,000 deaths each year; 99% of women who die from PPH are in developing countries and half of the women who suffer from PPH have no risk factors. 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. Active management of the third stage of labor (AMTSL) has been shown to significantly reduce PPH, and the WHO recommends AMTSL for all facility-based vaginal births. AMTSL has three main components: 1) administration of an uterotonic drug within one minute of birth to induce a strong contraction of the uterus (after ensuring there is not another baby in utero), 2) controlled cord traction of the umbilical cord 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 atony, which is associated with 90% of PPH.

In September 2002, USAID/Washington launched a special initiative to reduce postpartum hemorrhage in Benin, Mali, Ethiopia and Zambia. In collaboration with MOHs and professional associations, PRIME II joined this initiative, working at seven pilot sites in Benin, eight in Mali and 24 in Ethiopia to demonstrate that AMTSL could be successful in each country's service delivery system. The pilot site facilities ranged from community health centers to tertiary teaching hospitals. More than 300 providers—midwives, nurses and ob/gyns—were trained in AMTSL and related areas including birth preparedness and complication readiness counseling, infection prevention, and storage of oxytocics (the USAID-approved uterotonic for facility-based AMTSL). PRIME II also worked at the national level in the three countries to incorporate AMTSL into service standards and protocols, begin the process of revising pre-service training curricula to include AMTSL, emphasize the importance of endorsing skilled attendants to administer oxytocics, and ensure the supply of oxytocics.

Results

A baseline assessment showed that skilled attendants in Benin and Mali were not performing AMTSL at all. Many of the providers in Ethiopia had received previous training in AMTSL, but not to WHO standards. By the time of the final evaluation in 2004 in all three countries, 318 providers—including 40 trainers in 39 sites (teaching hospitals, reference hospitals and community health centers)—were offering AMTSL services in urban and rural areas. The percentage of providers performing AMTSL to WHO standards increased from 0% to 54% in Benin, 0% to 40% in Mali, and 48% to 73% in Ethiopia.

Vaginal births with AMTSL at the intervention facilities increased considerably: from 0% to 76% (4,687 out of 6,187 births) in Benin, 1% to 90% (5,235 out of 5,819 births) in Ethiopia, and 0% to 55% (6,151 out of 11,191) in Mali. Data from project facilities indicate that the proportion of PPH cases for vaginal deliveries decreased significantly following the intervention, from 6.2% of all vaginal deliveries to 2.5% in Benin, and from 1.08% to 0.06% in Mali. No complications from AMTSL were reported at any of the Mali and Benin facilities. In Ethiopia, few complications were reported, and there were no maternal deaths, with only one case of PPH serious enough to warrant a transfusion.

Beyond reinforcing the value of AMTSL in averting maternal mortality and morbidity, qualitative data reveal a high level of provider satisfaction with the practice. Providers find AMTSL safer, cleaner, faster and often less expensive than previous practices, for both the facility and the client. Providers indicate that they are being exposed to less blood (thus reducing risk of HIV infection), do not have as many bloody 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 to other clients, and for the mother to rest and hold her baby immediately after birth.

Due to these positive results, the Benin Department of Family Health and the Mali MOH indicated their interest in country-wide scale-up of AMTSL for all facility-based skilled attendants. Monitoring results were so promising that AMTSL was included in the national protocols in Benin (December 2002) and Mali (May 2004) prior to the final evaluation of the project. USAID/Benin is funding the expansion of AMTSL through the ACQUIRE project, and USAID/Mali has included PPH prevention as a high-impact service in its two bilateral projects.

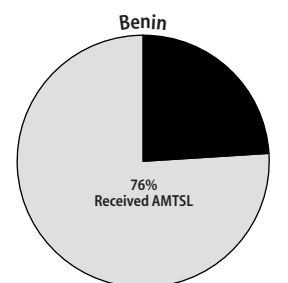
The Ethiopian Society of Obstetricians and Gynecologists (ESOG) and the Ethiopian Midwives Association have highlighted PPH prevention and AMTSL in their annual meetings. Results of the pilot project were presented and discussed at ESOG's May 2004 Congress, and the society formally recommended to the MOH that AMTSL be officially sanctioned to be performed by skilled attendants for all facility-based vaginal births. The AMTSL training guide, job aids and tools developed by PRIME II are now used by MOHs and professional associations in all three countries.

Lessons Learned

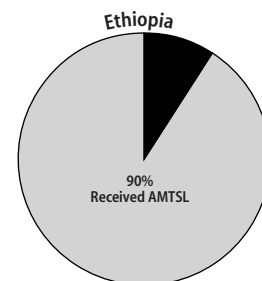
- Partnering with the MOH and the national-level group responsible for the scope and standards of practice for skilled attendants is essential for support of pilot efforts and

"I've seen a lot of women die in front of me of hemorrhage... I am very happy for this intervention."

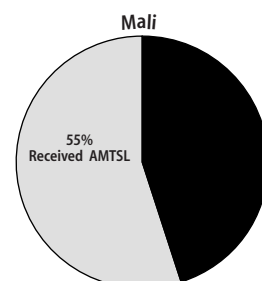
—Dr. Sylvain Coudoro, ob/gyn, Benin
PRIME Voices #22, August 2003



Vaginal Births, 7 Pilot Sites (n=6,187)



Vaginal Births, 24 Pilot Sites (n=5,819)



Vaginal Births, 8 Pilot Sites (n=11,191)

“If it is a birth I cannot attend alone, I look for help. When there is no emergency vehicle, I find the person on call to help me take the patient.”

—Felipa Arteta, traditional birth attendant, Nicaragua
PRIME Voices #19, May 2003



subsequent scale-up of AMTSL. Once evidence is available that AMTSL is feasible and acceptable, the MOH and regulatory groups are willing to authorize or sanction the practice, which subsequently translates into its incorporation in providers’ job descriptions and performance expectations. The MOH must play a key role in ensuring the procurement, cold chain and distribution of uterotonic drugs.

- The regular and consistent supply of oxytocics may be the most significant challenge to the scale-up of AMTSL, as it is essential to the service. Oxytocin has a limited shelf life and loses potency if not maintained under an adequate cold chain. This can present enormous barriers to AMTSL in resource poor countries, and it is essential that efforts to improve the procurement, distribution and management systems for oxytocin are concurrent with the preparation of providers to perform AMTSL.
- AMTSL is fairly easily learned and accepted by providers.

2.8 Safe Motherhood

Background and Strategy

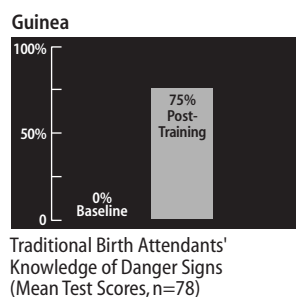
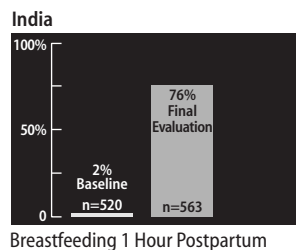
Every minute of every day, a woman somewhere in the world dies from complications of pregnancy or childbirth—more than 500,000 deaths per year. Almost all maternal deaths (99%) occur in the developing world, and maternal mortality shows the largest disparity among health statistics that compare developed and developing countries. Limited access to emergency obstetric services are the main cause of this problem, and high fertility and low rates of contraceptive use, poor nutritional status and lack of basic health services compound the problem. In developing countries, pregnancy-related complications are among the leading causes of death and disability for women aged 15 to 49, and in some countries a woman’s lifetime risk of dying from pregnancy-related causes is staggering. For every woman who dies, 30 to 50 more suffer injury, infection or disease.

Drawing on significant technical assistance from the American College of Nurse-Midwives (ACNM), PRIME II’s work to address safe motherhood in low-resource environments focused on improving primary provider performance, strengthening community responsiveness to obstetric and neonatal emergencies and ensuring that services at referral facilities were up to standard. USAID/Washington provided PRIME II with Special Initiative funding to support the USAID maternal health strategy and the Safe Motherhood Agenda’s ten key action items to improve safe motherhood, which include FP and management of complications from unsafe abortion³.

Results

India: In 11 villages and 29 hamlets of Utter Pradesh (combined population approximately 20,000), the PRIME II-assisted Community Partnerships for Safe Motherhood (CPSM) project significantly increased the number of pregnant women and families who take steps to prepare for births and possible complications, and who are better informed about FP options. The ACNM’s Home-Based Life-Saving Skills (HBLSS) modular materials used in CPSM workshops focused on hemorrhage and neonatal and maternal sepsis and also included prenatal care, safe delivery, postpartum care and family planning. Visual aids (“Take Action Cards”) facilitated the recall of HBLSS messages among trainers, home-based birth attendants and recent mothers, proving to be an essential tool for promoting the longer-term impact of CPSM, although limited personal and prompted recall of certain items (e.g., “do not put anything in the womb”) was of clinical concern. The project also worked to develop referral systems with emergency transportation and funds, and establish sustainable networks of community volunteers.

A final evaluation of the year-long project demonstrated that healthier practices had indeed increased. Women who had completed the HBLSS series were significantly more likely to put their newborn to the breast within one hour of birth (76% as opposed to 2% at baseline, n=563, n=520)—a break from centuries of local tradition. The women were also more likely to accept tetanus toxoid injections (86% vs. 37%, n=668, n=542) and accept a modern family planning method in the immediate postpartum period (61% vs. 13.5%, n=545, n=533). In addition, data showed that in 75% of deliveries (n=646), pregnant women and their families had saved money,



made transportation arrangements and were aware of the nearest referral site in the event of complications; only 15% of pregnant women and their families (n=600) had made such preparations at baseline. However, the evaluation also showed that very few women who experienced hemorrhage had initiated the process of referral. Findings indicated that family members continued to rely on less-expensive, community-based rural medical practitioners (*quacks*) in the event of life-threatening problems.

Guinea: Beginning in 1998, PRIME received USAID/Africa Bureau funding to reinforce Save the Children’s maternal health program with a community-based model to reduce maternal mortality. The model emphasizes improving responses to obstetric emergencies through stronger links among health facilities, traditional birth attendants (TBAs) and communities. PRIME II implemented the model in the northern district of Mandiana (population approximately 140,000), training TBAs in Community-Based Life-Saving Skills (CBLSS), an adaptation of HBLSS, and helping communities establish emergency obstetric response plans, including revolving transportation funds.

Under the guidance of eight service providers trained by PRIME II, 78 TBAs (39% of those working in Mandiana) participated in facility-based clinical training. An evaluation conducted three months after the intervention showed that TBAs had dramatically increased their knowledge of the danger signs of obstetric emergencies (mean test scores rose from 0% at baseline to 75% post-training, n=78). TBAs also demonstrated significant improvement in their ability to perform infection prevention procedures (mean observation scores increased from 33% to 84%), and reported eliminating such harmful traditional practices as giving newborns water or other liquids after birth. A follow-up evaluation 15 months later produced further affirmation of the project’s success, revealing that trained attendants were now assisting in 83% of births—a jump from 36% at baseline. All of the 73 villages participating in the project established emergency treatment and transportation funds. In 2001, with Save the Children and the Adventist Development and Relief Agency, PRIME II helped to build the capacity of the MOH to expand the model nationally.

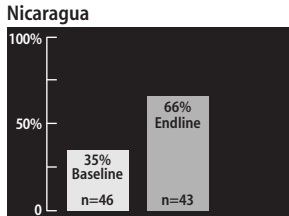
Nicaragua: Nicaragua has among the highest maternal mortality ratios in Latin America. Over a third of births are attended at home, frequently by a TBA. In the rural Jinotega region (population approximately 290,000), PRIME II collaborated with the NicaSalud consortium of NGOs to build and reinforce 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 CBLSS, while facility-based providers were trained in basic emergency skills. Community mobilization activities focused on setting up emergency obstetric and neonatal care committees, pooling emergency funds, and establishing transportation plans to ensure women and newborns reach referral facilities quickly in the event of an emergency.

The final evaluation demonstrated significant improvement in provider performance. As defined by mean performance scores (based on observations), care of immediate postpartum women by TBAs (n=46 baseline, n=43 endline) improved from 35% to 66%. Management of postpartum hemorrhage by physicians, nurses and auxiliary nurses (n=31 baseline, n=56 endline) improved from 68% to 82%. These positive results for providers were matched by community efforts. Of the 32 project communities, 78% reported the establishment of committees for emergency obstetric and neonatal care. Emergency transportation systems were established in 56% of communities and emergency funds set aside in a quarter. In an illustrative example, emergency funds in one community are administered by a committee, and a community member with a vehicle is on call to transport women to the nearest hospital in cases of an emergency at any hour. A census of pregnant women was prepared in 81% of the communities, and nearly half have implemented birth and complications readiness plans.

Benin: To reduce high rates of maternal and neonatal mortality, the Ministry of Health developed a national plan of action for emergency obstetric and neonatal care (EONC) in 1999. In collaboration with the MOH and the USAID bilateral PROSAF project, PRIME II conducted a performance needs assessment (PNA) in late 2000 in the area selected for pilot EONC inter-

“Before we elected our committee, the nurse-midwife would come, take a walk around the village and leave. We did not know who she vaccinated nor did we know how many women were pregnant. Now we catch her and get our work done.”

—Parvati, mother of three, India
PRIME Voices #4, August 2001



Care of Immediate Postpartum Women by TBAs (Quality Index Scores)

“I am grateful for this training, for without it I would have committed a terrible injustice against my niece. Instead, I will now work toward ending female genital cutting in my community.”

—Dr. D, physician, Mali
PRIME Voices #23, October 2003

ventions, Malanville/Karimama health zone in the northern region of the country. The PNA identified numerous obstacles to service delivery including under-trained, under-performing personnel, logistical problems and lack of community awareness. Interventions selected in response included reinforcing managerial capacity for EONC services in the health zone, improving provider performance at maternity centers, developing the capacity of community health workers and family members to recognize and respond to danger signs in pregnancy and delivery, and establishing community partnerships to respond to emergencies.

The pilot project trained 54 providers in EONC, 24 based at the zonal hospital and the rest in primary facilities. At the time of the PNA, 0% of health aides and only 33% of nurses and midwives had sufficient knowledge to offer EONC services, and no standards of care existed to support these providers. By the final evaluation in 2004, all of the nurse-midwives (n=7) at the zonal hospital were able to correctly identify at least 14 out of 16 complications outlined in case studies, and 89% of health aides sampled (n=9) were able to recognize danger signs in pregnancy, birth and postpartum care. Over 90% of community-based health agents (n=24) could describe complications requiring referral, and the evaluators observed active emergency savings funds and transportation plans in all 11 villages in the pilot zone, with 114 recorded cases of transported referrals between April 2002 and April 2004.

Lessons Learned

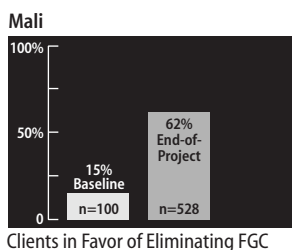
- Informed and involved communities can make a difference in improving health practices and outcomes, especially in areas where modern medical care and emergency services may be out of reach without pooled resources and advance planning for transportation.
- PRIME II’s Community Partnerships for Safe Motherhood feasibility study in India—and safe motherhood projects in Guinea, Nicaragua and Benin—demonstrated that when pregnant women and their caregivers understand the birth process and can recognize and manage signs of life-threatening complications when they arise, their knowledge and skills can help reduce risky behaviors and delays in seeking care.
- Community providers must work in partnership with the local health facilities, and the facility-based and community-based providers must feel that they are part of the same team. Effective strategies to ensure this include carrying out training for community providers at the health center and establishing clear expectations for partnership, referral and counter-referral.
- Efforts to strengthen community-provider partnerships often must include improvements to health care facilities and the range and quality of services offered.

2.9 Female Genital Cutting

Between 100 and 180 million women, most of them in Africa, have undergone the harmful traditional practice of female genital cutting (FGC). Although eliminating FGC can be seen as a human rights and gender violence issue, efforts to eradicate the practice must take into account complex social, cultural, religious and even economic issues that surround its perpetuation. Programs that target only circumcisers, without considering the motives and beliefs of families and communities that practice FGC, are usually ineffective. Accordingly, PRIME II’s assistance to FGC abandonment programs in Mali and Ethiopia supported community-level efforts to integrate FGC prevention into ongoing activities in culturally sensitive ways.

Results

Mali: In Mali, where 92% of women have experienced FGC, political will is growing to end the practice. USAID/Mali asked PRIME II to assist the MOH in developing and piloting a national training curriculum for primary providers to increase their capacity to identify, treat or refer FGC complications and educate and counsel clients and community members on the negative aspects of the practice. The curriculum is adaptable for in-service training, pre-service education, and regional trainers who can implement and evaluate the materials in the context of other FGC eradication interventions. Job aids and a 35-minute video on complications of FGC were produced as part of a FGC resource package, and the video was popularized and supported by government officials and members of parliament.



Doctors, nurses and midwives have limited time, however, to conduct outreach activities to change FGC behaviors and attitudes. To increase the impact of the training intervention with primary providers, PRIME II collaborated with local stakeholders to build a network of trained providers, NGO extension workers (*animateurs* and *relais*) and community and religious leaders to plan a community-based FGC abandonment strategy and identify appropriate messages. The community project was implemented in 97 villages of Bougouni district.

At 27 health centers in the three PRIME intervention zones, the percentage of providers (n=127) with an acceptable level of FGC knowledge increased from 0% at baseline to 55% at final evaluation. While counseling on FGC was virtually nonexistent before the pilot, an end-of-project review of health center registers showed that 414 female clients received private counseling about the practice. Nearly three quarters of providers passed the counseling skills performance test, up from 12% at baseline, and the improved counseling also paid off in a dramatic increase in educational sessions on reproductive health topics in general.

In addition, providers facilitated 473 education sessions on the negative health effects of FGC, and 958 men participated in waiting-room education. At the end of the year-long intervention, the percentage of clients surveyed (n=364) who said they were in favor of eliminating FGC rose from 24% to 60% in the intervention zone—a significant outcome—while holding steady at 31% in a control zone. The percentage of clients surveyed (n=367) who said they intended to have FGC performed on their daughters declined from 68% to 42% in the intervention zone while increasing from 64% to 74% in the control zone.

A separate evaluation of the community project showed equally encouraging results. During the five months of the intervention, trained NGO extension workers facilitated 4,140 group talks and conducted 476 private counseling sessions. The percentage of men and women who said they were in favor of abandoning FGC increased from 15% at baseline (n=100) to 62% (n=528), and the percentage who intended to have FGC performed on their daughters declined from 81% to 33%.

Ethiopia: FGC is widely practiced in Ethiopia, with surveys showing that as many as 80% of women have been circumcised. In three regions with very high prevalence of FGC—Oromia, Harari and Somali—PRIME II collaborated with the MOH and the National Committee on Traditional Practices in Ethiopia to educate communities about the harmful effects of FGC on reproductive health. Focusing especially on women and community leaders, the project worked to understand the motives of “FGC demanders,” respond to their concerns and provide them information on the negative impact of FGC. The project also sought to link FGC knowledge to health, gender, human rights and religious issues and build community mobilization teams at the national, regional and grassroots levels. After a rapid appraisal of the five intervention sites, the project was launched in December 2003 with the establishment of a national Anti-FGC Women Leaders’ Team.

A member of the Women Leaders’ Team drafted a law against FGC that was passed by the Ethiopian parliament in July 2004. A forum of 83 prominent Muslim and Christian religious leaders organized through the project also issued an edict against the practice. In the targeted communities, more than 2,250 people participated in FGC education activities. Anti-FGC rules and penalties were written by community representatives and approved by community members in three project sites, and eight well-known circumcisers who had practiced FGC for 15 to 31 years promised publicly to cease performing the practice.

Lessons Learned

- The pilot project in Mali demonstrated that primary providers can play a vital role in programs that promote the abandonment of FGC.
- The ongoing use of information, education and communication activities and social mobilization strategies remains essential to bring about and support changes in attitudes toward the practice.



- More religious leaders need to be targeted. In addition, integrating FGC abandonment into community campaigns by other organizations in such areas as HIV/AIDS, poverty reduction and environmental issues could be beneficial to anti-FGC efforts.
- Transferring project “ownership” and leadership through a cascading approach was vital to ensure broad community involvement in project activities in Ethiopia.
- More attention should be given to the linkages between FGC and HIV/AIDS transmission, especially since the issue was repeatedly raised at all project sites.

2.10 Adolescent Reproductive Health

Background and Strategy

Worldwide, the reproductive health of youth is threatened by a combination of factors including lack of awareness of reproductive health issues; high rates of risky sexual behaviors such as early sexual debut, multiple partners and unprotected sex; and limited access to preventive and curative health services. Adolescents are frequently at high risk of unwanted pregnancy, STI/HIV infection, and life-threatening complications of pregnancy, childbirth and unsafe abortion.

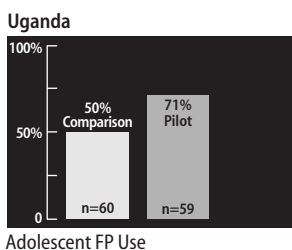
PRIME II successfully created adolescent-friendly health services within reproductive health clinical settings. The project’s efforts in adolescent FP/RH included interventions designed to improve client-provider interaction (CPI) skills, increase adolescents’ access to FP/RH services by considering adolescents’ specific needs, and utilize non-traditional providers who often have greater access to youth than formal cadres (see description of the Philippines project on page 24).

Results

Uganda: A pilot project in Jinja district attracted youth to primary-level health care facilities through the creation of a youth-friendly environment including structured educational and recreational activities designed to improve adolescents’ reproductive health knowledge and care-seeking behaviors. The project began under PRIME in September 1998 and finished under PRIME II in 2000. Adolescent views and preferences helped guide the creation of a training curriculum that emphasized an examination of provider attitudes vs. professional duties, appropriate counseling skills, and the information necessary to offer adolescents unrestricted FP/RH services. In the pilot facilities, the proportion of adolescents among clients seeking outpatient services more than doubled, from 24% before the intervention (2,370 out of 9,785) to 49% after (5,419 out of 11,038). This was significantly higher than the proportion at comparison facilities, where only 23% of outpatient clients were adolescents at the time of the final evaluation (788 out of 3,495). In addition, a sampling of sexually active adolescents in the intervention area reported significantly higher rates of FP method use than among adolescents in comparison areas (71% vs. 50%, n=59, n=60). This successful pilot project was scaled-up through the bilateral DISH II initiative.

Ghana: PRIME II helped the Ghana Registered Midwives Association strengthen private-sector midwives’ ability to counsel and interact with their adolescent clients through a self-directed learning (SDL) approach including skills updates in FP, STI/HIV prevention, and client-provider interaction (CPI) skills. Baseline and follow-up evaluations of a sample of learners (n=59) found that three times as many offered STI diagnosis and treatment to adolescents, more than two times as many offered emergency contraception, and almost two times as many provided condoms to adolescent clients. The modular SDL course and monthly meetings improved mean performance scores (based on observations) in various aspects of CPI related to adolescents from 54% at baseline to 77% at final evaluation for 52 providers.

El Salvador: PRIME II worked with MOH health promoters and hospital-based providers through the APSISA and SALSA projects to build peer education programs among teen leaders, encourage referrals of pregnant adolescents to regional hospitals, and foster adolescent-friendly services. Incorporating input from adolescent consumers, workshops were designed to improve providers’ knowledge, skills and sensitivity in handling adolescent needs and concerns. PRIME also helped establish clubs for pregnant adolescents and young mothers at hospitals and maternal health centers. Adolescents receive FP/RH and maternal health education through the weekly



club meetings while learning practical skills such as knitting. PRIME II's pre- and post-intervention random sampling of 114 postpartum adolescents at Sonsonate Hospital showed that the percentage of adolescents who planned to space their next birth jumped from 38% to 70% and knowledge of condoms increased from 27% to 66%. Qualitative data indicated that adolescent client satisfaction increased at the three pilot hospitals.

Lessons Learned

- Creation of a youth-friendly facility atmosphere can effectively foster an environment for learning about reproductive health issues. However, sustaining adolescents' interest in visiting health facilities through varying recreational and educational activities in these settings remains a challenge.
- Establishing a friendlier environment for youth frequently includes addressing provider biases and barriers to services.
- Properly trained and supported non-conventional providers can positively affect adolescents' health seeking behaviors.
- To succeed, it is essential that FP/RH messages for adolescents be targeted, tested and developmentally appropriate.

2.11 Gender

Background and Strategy

FP/RH providers who are responsive to gender-related inequities in health care can reduce barriers to service acceptance, access and use. The PRIME II Project responded to USAID's expectation to integrate a gender sensitive approach⁴ and/or partner communication in training and service delivery programs with a gender strategy designed to:

- Ensure that gender sensitivity and a recognition of gender issues and inequities, responses to gender-based violence, and male involvement in FP/RH were covered in pre-service/in-service curriculum development, continuing education, Performance Improvement and postabortion care initiatives
- Address gender issues in the elimination of female genital cutting, STI and HIV/AIDS prevention, safe motherhood and adolescent reproductive health
- Identify, develop, use and disseminate approaches, tools and better practices in integrating a gender perspective and responding to gender-based violence that are appropriate for primary providers and trainers in FP/RH settings.

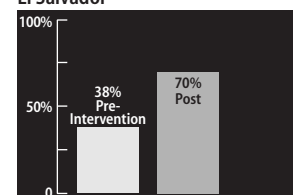
Results

Tools: PRIME II developed and published gender sensitivity assessment tools to evaluate the training and service delivery environment of FP/RH programs, tested an approach to gender analysis and project planning that is useful in assessing the demand for FP/RH service use, and piloted a successful model that expanded the role of RH providers in responding to violence against women (VAW).

Global: In Bangladesh, PRIME II facilitated a gender and RH orientation for 25 public-sector trainers and instructional developers in February 2002 through the Health Population and Sector Program. PRIME then field-tested the draft "Gender Sensitivity Assessment (GSA) Tool for RH Curricula" in Bangladesh and used it to revise curricula for increased gender sensitivity in Bangladesh, Ethiopia, India and Mali. This has resulted in gender-sensitive training of a range of FP/RH service providers in these four countries. PRIME II staff also facilitated a post-conference workshop on the GSA Tool at the USAID Interagency Gender Working Group's "International Conference on Men in Reproductive Health" in Washington, DC. The workshop focused on using the tool to improve men's participation in FP/RH services.

Rwanda: PRIME II conducted a performance needs assessment of 41 sites in August 2001 that found services were not gender sensitive. In response, PRIME facilitated an orientation to gender issues in July 2002 with MOH personnel from Kabgayi district and asked them to apply PRIME II's "Gender Sensitivity Assessment Tools for RH Service Providers and Managers" throughout

El Salvador



Adolescents Planning to Space Next Birth (n=114)

"Now I know how to handle adolescents... I used to shout at them when they came to me for services, telling them they are not old enough to be sexually active or practice family planning. Now I welcome them, give them a talk on STI, HIV/AIDS, and give them family planning services. It has opened my mind to love my patients."

—Midwife, Ghana

PRIME Voices #7, November 2001

2003. PRIME II also provided guidance related to gender issues in prevention of mother-to-child transmission (PMTCT) of HIV service delivery. In spring 2004, PRIME followed-up FP/RH providers and service sites in which these tools had been applied and found more gender-sensitive provider performance and increased local supervisory capacity to assess and improve the gender sensitivity of services. Improvements included:

- Integration of gender sensitivity indicators in supervisory checklists
- Introduction of the practice of “invitation letters” to female PMTCT clients’ partners. When clients gave explicit consent, letters were sent home with the clients to give to their partners; this resulted in a six-fold increase in partners coming for voluntary HIV counseling and testing at Kibuye Hospital
- A higher percentage of providers in the intervention district (Kabgayi) counseling clients and their partners on HIV prevention, risk and voluntary testing than providers in a control district (50% vs. 36%).

Supervisors interviewed at follow-up also noted that in Kabgayi sites, men more frequently substituted for their wives for child immunization sessions and FP re-supply than in the past, and more frequently accompanied female relatives for screening in cases of rape.

Armenia: PRIME II designed a successful demonstration project in 2002 using Performance Improvement principles, and assisted the MOH to put in place and evaluate the factors necessary to improve and expand the role of FP/RH providers in assisting women to overcome violence. Providers (n=10) trained in skills related to response to violence against women (VAW) scored 5.23 times higher than untrained providers (n=9) on skills tests. The project showed that with community support Armenian FP/RH providers can and will offer screening, client counseling and education, referral to psychosocial and other support mechanisms, and community outreach education to address VAW. PRIME II coordinated provider/NGO partnerships for community education and technical updates through periodic meetings drawing on existing VAW expertise in the community and by developing a directory of NGOs offering services to victims of violence. Clients responded favorably to the integration of VAW in FP/RH activities and acted on referrals made by the health facility. The project influenced national awareness of VAW as a public health issue, and contributed to health policy and strategies that recognize VAW as a factor in Armenian women’s and children’s health and well-being.

Ethiopia: PRIME II developed and integrated a new gender analysis approach in the baseline community assessment of the PRIME-assisted PMTCT project (see page 23). The gender analysis results revealed gender inequities that constituted barriers to PMTCT service use, including both service barriers and societal and structural inequities that contributed to the risk of HIV infection⁵. These results were disseminated during a gender integration workshop conducted by PRIME II in June 2004 for 13 regional MOH personnel. Long- and short-term action plans were developed to improve the gender sensitivity of PMTCT services, including a commitment to improve men’s responsibility in PMTCT and to address gender inequity in FP/RH services.

Lessons Learned

- Gender issues can and should be addressed in the design and evaluation of a variety of FP/RH projects through gender analysis, gender planning and gender sensitivity assessment with project stakeholders; these efforts can result in improved training and service delivery.
- Gender integration activities still require special advocacy and funding in USAID projects.
- Improving FP/RH provider response to violence against women is possible through Performance Improvement and community partnership approaches.



2.12 Maximizing Access and Quality

Background and Strategy

USAID's Maximizing Access and Quality (MAQ) program is a collaborative initiative to increase the accessibility and quality of FP and other reproductive health services through state-of-the-art methods that are practical and realistic. Implemented through USAID, collaborating agencies and host-country partners, MAQ provides technical assistance and financial support to countries in the development and revision of service delivery guidelines and funds regional conferences, workshops and MAQ Exchanges. With a focus on collecting, disseminating and applying best practices, the MAQ Exchanges serve as a forum to engage USAID, its missions and their host-country counterparts in a dialogue aimed at developing or improving FP/RH programs.

As a leader in the MAQ initiative, PRIME II focused its participation as follows:

- Hosting and co-chairing a nine-country regional effort to promote integration of HIV/AIDS prevention with FP/RH programs in Francophone Africa
- Assessing and revising the STI/HIV/AIDS content of Benin's FP/RH guidelines through a tool created in collaboration with Family Health International and JHPIEGO
- Contributing to the production and dissemination of key technical documents through the MAQ/WHO Implementation of Better Practices initiative and providing organizational and technical assistance to WHO's Implementing Best Practices conferences in Cairo, New Delhi and Entebbe
- Participation, as part of a collaboration with WHO and other international agencies, in the publication of medical eligibility criteria for contraceptive use
- Co-chairing the MAQ subcommittee on Community-Driven Quality (CDQ), which facilitated a collaborative effort to identify, test and disseminate tools that strengthen provider-client partnerships to define and improve quality of services; PRIME II's role included organizing and facilitating a January 2003 "CDQ Day" in Washington and producing the resulting CD-ROM of presentations, tools and other resources
- Providing leadership and facilitation for MAQ Exchanges in Nigeria, Mali and Ghana that covered a range of MAQ topics including client-provider interaction, informed choice counseling, supportive supervision and contraceptive technology updates
- With JHPIEGO, pre-testing the MAQ module on postabortion care during a MAQ Exchange in Haiti
- Linking the MAQ model with FLASOG, the major ob/gyn federation in Latin America and the Caribbean.

"The violence against women program has had a great influence on our health providers. They now understand that many complications occur as a result of violence, problems that cannot be treated or prevented without addressing the issue of violence upfront."

—Dr. Efrosya Nahapetyan, clinic director, Armenia
PRIME Voices #31, June 2004

“Now I have the self-respect
to just say ‘no’ to boys,
and I know I can use
condoms if I want to
have sex.”

—Sarah, teenager, Uganda
PRIME Voices #1, May 2001

Chapter Notes

1. PRIME II defines performance scores as a measure of provider performance based on desired performance standards, usually scored by observation of performance by trainers or supervisors (in actual service delivery situations or simulations).
2. WHO defines unsafe abortion as “any procedure for terminating an unwanted pregnancy [carried out] either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.”
3. Report on the Safe Motherhood Technical Consultation, *The Safe Motherhood Action Agenda: Priorities for the Next Decade*, 18-23 October 1997, Sri Lanka.
4. PRIME II used the Interagency Gender Working Group (IGWG) definition of gender sensitivity: “the ability to perceive existing gender differences, issues and inequalities, and to incorporate these into strategies and actions.” As a result of increased gender sensitivity, programmers, supervisors or providers were expected and assisted to integrate gender strategies, and to recognize gender exploitative strategies.
5. Factors included cultural norms of masculinity and femininity, gendered patterns of employment contributing to female poverty and dependence on husbands, unequal caretaking responsibilities, unequal decision-making power, sexual coercion, and lower literacy and educational levels for girls and women.



3.0 Management and Partnership

This section reviews lessons learned in managing this large global project, including lessons in partnering.

Projects managed by PRIME II ranged from \$100,000 interventions to large country programs of \$3 million per year. PRIME II's fairly decentralized implementation structure presented the challenge of ensuring that all projects were cohesive, followed global standards, and contributed to technical leadership, results and global performance indicators. The PRIME II leadership employed a variety of strategies to meet this challenge, including:

- Setting up and implementing global (virtual) technical teams to allow for cross-project communication and skill building
- Using the PRIME II Performance Monitoring Plan to keep all projects focused on key indicators and required results
- Developing and practicing a communications strategy involving a variety of well accepted products and formats for sharing lessons learned both within the project and with external audiences.

PRIME II had four regional offices, which enabled the project to build and maintain local presence and foster effective relationships with USAID missions as well as with public and private sector counterparts. The system offered missions and counterparts easier access to PRIME II expertise and quicker start-up of country projects. PRIME staff sought to design projects that met both global objectives and mission strategic objectives. This contributed to strong relationships with missions and high levels of Field Support funding. PRIME II was generally successful in introducing state-of-the-art approaches and technical leadership into Field Support projects while maintaining a balance between USAID/Washington and mission objectives. The primary challenges in this decentralized system were aligning technical leadership areas with field supported activities and synchronizing regional and headquarters technical assistance.

Implementation Challenges

Balancing short-term versus long-term goals and competing priorities posed the most significant implementation challenges for PRIME II. At times requests from USAID missions and host-country partners did not match the priorities of PRIME II and USAID/Washington. The main examples were missions that requested traditional training without a performance needs assessment to support that intervention choice, and missions wanting PRIME II to focus on technical areas that were not the priority of the Office of Population (e.g., HIV/AIDS). With the support of USAID/Washington and mission teams, however, PRIME was usually able to resolve these issues, often by conducting at least a modest performance needs assessment that revealed performance factors that needed to be addressed in addition to knowledge and skills. Following this exercise, missions generally recognized the benefit of addressing at least some of these factors in order to improve provider performance.

Pressure to show results within a fairly short timeframe was challenging for PRIME II, since it often takes two to three years to produce outcome results. PRIME II was able to identify outcome indicators at the start of projects that could show measurable change within one year in many cases. PRIME typically found that provider performance could be observed and significant change measured within a year. In addition, PRIME was sometimes able to collect service use data (from existing systems) and show improvements within a year.

Management systems were revised early in PRIME II to require project plans to identify evaluation indicators and which of the Performance Monitoring Plan indicators the project would report on. This set clear expectations from the outset that these indicators needed to be included in all projects.

A Model for Global Partnership

From the earliest stages of forming a partnership, drafting the proposal for PRIME II, and start-up operations, the PRIME II partner organizations shared a powerful vision of the partnership in action, and the resulting collaboration proved rewarding. Key elements of the PRIME II partnership model included:

Partner Leadership Group: Composed of two senior leaders from each partner organization, and drawing on TRG's expertise in facilitating partnerships, the Partner Leadership Group (PLG) provided a stable and consistent mechanism for the project's strategic direction and technical leadership. Substitution of representatives was discouraged, and the group generally met four times a year, rotating venues among partner offices. Leaders of the PLG were charged with setting the example of focusing on the common good and desired results of the project and seeking 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, provided 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. This model document has been widely shared and adopted by other partnerships.

Seconded Staff: The PRIME II partnership operated daily, in a very straightforward way, with seconded staff from the partner organizations based in IntraHealth's Chapel Hill headquarters. In addition, a number of partner staff members were based in PRIME field offices. Several seconded staff held key decision-making positions on the project such as unit director and regional director, and this secondment model helped the project tap partner expertise.

Partnership Collaboration in the Field: The partners sought to extend the same collaborative relationship established among the US offices to the partners' regional and country offices. In the beginning of the project the organizations came together in the field to plan how they would work together. This collaboration frequently proved valuable in identifying new opportunities, helping to start new country projects (for example, in Honduras, Rwanda and Armenia) and sharing experiences and resources (for example, in Kenya and Ghana). However, competition between the organizations at the field level was an issue at times.

Advantages of the Global Partnership

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

- The project maintained easy access to the partners' diversity, complementary strengths, technical expertise and management know-how.
- A sense of common purpose and shared commitment encouraged partners to define together the project's technical leadership areas and cutting-edge technical agendas in a collaborative and synergistic manner.
- PRIME II drew from all partner organizations to constitute its interdisciplinary global teams, developing strategies to move technical agendas forward. This 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 cooperating agency and donor contributions.
- Because the PRIME II partnership was effective, USAID was less taxed to engage in fostering collaboration, solving problems and negotiating among partners. The partnership itself helped to ensure that the technical competencies of the various agencies were considered and used to the best extent possible.



Lessons Learned

- Establishing and sustaining a trusting partnership requires leadership commitment and resources. The level of commitment from all PRIME II partner organizations, including USAID, was exceptional.
- Each partner organization expected their technical resources to be utilized as fully as possible. PRIME II's twin goals were to assign the most appropriate technical resources to the job at hand, and to share work so that each partner organization contributed to the project's success. Decisions on work distribution were guided by technical needs, not a predetermined portion of the work. A more formal review and process for work distribution may be a useful addition to the partnership model.
- The PLG structure helped to ensure that the project leadership and PLG members from each partner organization were informed about project developments, aware of each partner's capabilities, and ready to access these competencies to meet the project's needs.
- PRIME II had 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 were not PLG members. Consequently, the supporting institution relationship was not as well defined as the partnership model and proved more cumbersome to manage.
- While the PLG meetings fostered effective communications among partners, a more regular and formal feedback mechanism (perhaps an annual review) would have enabled partners to continuously monitor and improve partner relationships and performance.



1 2 3 4 5 6 7
8 9 10 11 12 13 14
15 16 17 18 19 20 21
22 23 24 25 26 27 28
29 30



4.0 Monitoring and Evaluation and Communications Strategies

The September 2003 external evaluation of PRIME II noted that the “project executed an outstanding monitoring and evaluation component [that] helped document outcomes.” PRIME II’s monitoring and evaluation (M&E) strategy relied on four elements: creating a culture of results, building strong M&E skills at headquarters and in the field, balancing rigor and practicality, and developing clear and creative communications mechanisms.

Creating a Culture of Results

The foundation of PRIME II’s M&E strategy was the Global Performance Monitoring Plan (PMP) based on the USAID Communications, Management and Training Division’s Results Framework. Ten indicators were selected as key to monitoring the effects of PRIME’s interventions. The PMP served as a road map for each PRIME II project, and the projects were required to include at least two indicators from the PMP. PMP Indicator #1 “providers performing to standard” was included as a rigorous numeric indicator in most project M&E plans.

PRIME II’s M&E staff reviewed all project documents and worked to ensure they included an M&E framework that focused on measurable activities and results through the use of indicators for process, outputs and outcomes. By applying and periodically revisiting these M&E plans, project staff and stakeholders remained focused on the objectives of the project. Because projects included an M&E plan from the start, project budgets generally allocated sufficient funds for the needed M&E activities.

PRIME II used the Performance Improvement (PI) approach in most projects, and it required staff, counterparts and stakeholders to strive to define desired provider performance and actual provider performance. Performance gaps and the root causes for these gaps were determined through the use of quantitative data. This information provided baseline data, measurable indicators and anticipated targets, and contributed to the creation of an organizational culture that valued high-quality project data. The use of the PI process itself leads to better project monitoring and evaluation.

Ensuring Strong M&E Skills

PRIME II employed expert M&E staff at the headquarters level (up to five full-time professionals) and also at the regional and country levels as project needs required. These staff interacted as a global (virtual) team and the M&E Unit worked to ensure a common vision among team members and to keep all M&E staff skills strong. In addition, the M&E staff worked very closely with project staff to ensure project staff shared a commitment to the M&E team’s vision and standards and to build basic M&E skills in project staff.

M&E staff helped project teams to focus on activities and indicators that could produce measurable results and to design the most cost-effective and rigorous methodologies to produce these results. Regular consultation ensured that M&E plans were adapted to changing project strategies and that project staff were conversant on the latest results from the project. Week-long M&E Global Team meetings were held every two years with the objective of ensuring that all M&E staff had the opportunity to improve skills and share lessons learned and experiences with colleagues.

Balancing Rigor and Practicality

PRIME II found that rigorous monitoring and evaluation techniques are valued and can be used by stakeholders, project staff, donors and project participants. One of the lessons was that indicators can be expanded beyond traditional output measures like numbers trained and knowledge test results to include outcome measures such as providers performing to standard, new and improved services available, and client use of and satisfaction with these services.

During PRIME II, an expanded definition of provider performance was adopted to enhance the results orientation of the project and respond to the project’s shift in focus from training to



Performance Improvement. “Performance” in the PRIME II model included both provider behaviors (skills) and accomplishments (such as service statistics). When possible, data were gathered not only from a provider performance perspective but from the client and service use perspectives (e.g., clinic records, client exit interviews and measures of client satisfaction). Collecting data on providers as well as on service use allowed a more complete picture of the overall results of the project and enabled PRIME II to answer the “so what?” question with added persuasiveness.

In addition to having robust indicators, PRIME II M&E plans were designed and implemented so that indicators traditionally reserved for final evaluations were collected and reported on a more regular basis, contributing to more frequent results reporting to partners and donors. Monitoring data also supported project management by informing project staff of the status and progress of interventions while there was still time to make changes and improve project outcomes. Costs were minimized by systematic sampling of facilities and providers. Whenever possible, existing data from surveys, needs assessments and final evaluations were used to inform baseline assessments. Additionally, comparison groups, where appropriate, added essential context to many of PRIME II’s project results.

Communications Strategy

PRIME II’s results and lessons learned would not have been as widely recognized without a strong communications strategy. A lesson learned from PRIME II is the importance of creatively sharing results with appropriate audiences, ranging from monitoring results to substantial final evaluations.

To deliver key messages and results to people who are often overwhelmed with information, the *PRIME Voices* and *PRIME Pages* formats were designed to be succinct and easy to read. Distributed to an email listserv with more than 350 subscribers, via the PRIME II website and in print, the monthly *Voices* told stories of PRIME projects from a personal perspective and were designed to answer the “so what?” question by showing the effect of a PRIME program on a particular primary provider or individual client, as related in their own words. This personal story was followed with a summary of the project and interim or final results. Results-oriented *Pages* were used as handouts to provide project progress reports, and to more widely disseminate the project’s annual Results Review reporting to USAID.

Formats were also developed to suit audiences interested in greater technical detail on the project’s approaches and results. These included 1) communications pieces in English, French and Spanish to clearly articulate each of the project’s technical leadership areas; 2) *PRIME Dispatches*, visually appealing 12-16 page summaries of projects and country programs; and 3) a series of data-intensive *PRIME Technical Reports* on baseline assessments, special studies and project evaluations. To maximize distribution, all PRIME II publications were downloadable from www.prime2.org, a dynamic database-driven website featuring the project’s work by region, country, technical leadership area and special initiative. The website also provided access to online interfaces for use of resources such as the *PI Stages, Steps and Tools* guide.



Lessons Learned

- It is important to build a unified team approach to M&E efforts at the headquarters, regional and country levels. This was addressed partially through the periodic M&E Global Team meetings as well as through technical assistance visits by the M&E Director and headquarters M&E staff to almost all projects in the field at the beginning and throughout the life of PRIME II.
- There is an inherent tension between investing in quality data and investing in project interventions. PRIME II addressed resistance to M&E investments by building the culture of results within the organization and demonstrating the value of quality data. Project staff quickly realized that having strong data improved their ability to secure partners, convince stakeholders to scale-up interventions and gain additional funding as needed.
- The short lifespan of those projects that started toward the end of PRIME II (in some cases 18 months or less) posed challenges for achieving results. Most of these projects continued to demonstrate, however, that selection of appropriate indicators and data collection techniques could generate good outcome data, even within a limited time period.
- At times, PRIME II faced competing priorities of stakeholders, including differing reporting and funding priorities of USAID at the mission level and in Washington. While it was at times a challenge to convince missions to spend funds on data collection for baseline and final evaluations, judicious use of core funds, inexpensive data collection approaches and negotiations generally resulted in satisfactory M&E plans.
- Another challenge was balancing stakeholders' perceived or desired needs for data with the actual minimal needs of projects. Stakeholders sometimes wanted to add to the basic needs, resulting in very lengthy data collection instruments and an excess of unused data that would never be used. In response, M&E staff and project teams increased efforts to minimize data collection. In addition, new data collection methodologies were developed for performance needs assessments to streamline the PI process, resulting in more focused baseline assessments.





5.0 Looking Ahead

Much has been accomplished under the PRIME II Project and this report is full of lessons learned. The broad, critical lessons can be summarized as:

- Support the work of primary providers, since they are clearly positioned to make a very significant difference in global family planning and reproductive health
- Scale-up the Performance Improvement approach to strengthen service delivery quality, access and use
- Expand recognition of the other performance factors beyond knowledge and skills (e.g., adequate work environment and tools, clear performance expectations, performance feedback and motivation) and share information and models for addressing these factors
- Scale-up the use of performance needs assessments before conducting training programs and the implementation of innovative learning approaches, matched to the needs of each situation (e.g., distance learning, peer-assisted learning, blended learning, and approaches delivered via information technology).

The need now is to incorporate these lessons more widely into future health and development efforts. This process of scaling-up and applying evidence-based best practices and lessons includes:

- Knowledge management and creative systems for sharing lessons and results in a user-friendly manner (e.g., a variety of succinct formats, electronic and non-electronic, formation of resource and support groups, communities of practice)
- Tools and concrete examples—rather than just general recommendations—to help managers take action (e.g., rather than just receiving advice to consider the need for performance feedback, managers and supervisors need a menu of options and ways to set up successful feedback systems)
- Availability of strong evidence to support the desired change or best practice, in order to convince partners and decision-makers of the benefits of trying something new or scaling-up an intervention (e.g., the value of strengthening supervisory systems, the benefits of going beyond traditional classroom training, the results possible with a new technical approach for preventing postpartum hemorrhage or integrating FP into HIV/AIDS services)
- Additional expertise and tools are needed to create and maintain strong partnerships (at the international, country and service delivery levels); such partnerships are required to address the wide range of service delivery and provider performance issues and to achieve scale-up of best practices
- New projects and development efforts that purposefully aim to scale-up best practices will be needed; scale-up must be an intentional effort—more knowledge about change management and the factors that promote and inhibit scale-up will be important to future projects.

Although we can reflect positively on the accomplishments of the PRIME II Project and conclude that we have learned much about how to improve family planning and reproductive health, the list above highlights the important work and significant challenges still ahead of us in order to ensure that these lessons are commonly practiced and that they lead to the impact that is possible.



List of PRIME II Projects by Region and Country

Note: In addition to projects highlighted in the PRIME II Final Report (as referenced below), descriptions and key results from all projects are available on the PRIME II website CD-ROM (Annex D).

ASIA**Bangladesh**

- Health and Population Sector Program (page 12)
- National Integrated Population and Health Program
- Performance Factors Study (page 14)

India

- Auxiliary Nurse-Midwives/Lady Health Visitors (page 20, page 24)
- Community Midwives (page 19)
- Indigenous Systems of Medicine Practitioners (page 14, page 20)
- Traditional Birth Attendants (page 20)
- Community Partnerships for Safe Motherhood (page 28)

Philippines

- Dual Protection Outreach for High-Risk Adolescents (page 24)

EAST AND SOUTHERN AFRICA**Ethiopia**

- Prevention of Mother-to-Child Transmission of HIV (page 23)
- Methodology to Facilitate FP/PMTCT Integration (page 24)
- Preventing Postpartum Hemorrhage (page 27)
- Encouraging Communities to Abandon Female Genital Cutting (page 31)

Kenya

- Scaling-up Postabortion Care Services (page 16)
- Postabortion Care Sustainability Study (page 17)
- Peer Support for Private Nurse-Midwives
- Linking Postabortion Care with other RH Services
- Strengthening Dual Protection Counseling (page 24)
- Mobilizing Providers to Abandon Female Genital Cutting

Tanzania

- Improving District-Level Reproductive and Child Health Care (page 13)

Uganda

- Creating Adolescent-Friendly Services (page 32)

Zambia

- Promoting Consumer-Oriented Care (page 23)

Regional

- East, Central and Southern African College of Nursing
- PI Short Courses at Regional Centre for Quality of Health Care

EUROPE AND EURASIA

Armenia

- Improving the Performance of Rural Facilities and Providers (page 11)
- Integrated Management of Sexually Transmitted Infections
- Strengthening Family Medicine Training
- Improving Provider Response to Violence against Women (page 34)
- Performance Factors Study (page 14)

Kyrgyzstan

- Increasing Quality and Use of Postabortion Family Planning (page 16)
- Motivating Providers to Counsel for STIs (page 14)

Uzbekistan

- Learning Package for Maternal and Child Health Providers

LATIN AMERICA AND THE CARIBBEAN

Bolivia

- Performance Factors Study (page 14)

Dominican Republic

- Promoting Community Health in *Bateyes* (page 20)
- Involving Consumers in Establishing Quality Services (page 22)
- Strengthening NGO FP/RH Services

El Salvador

- Ensuring a Healthier Future through SALSA (page 17, page 33)

Honduras

- Emphasizing Supportive Supervision in Health Sector Reform

Nicaragua

- Strengthening Response to Obstetric and Neonatal Emergencies (page 29)
- Connecting Pharmacists and Youth

Paraguay

- Expanding Access to Quality FP/RH Services (page 12, page 17, page 25)
- Improving Maternal and Newborn Health Care
- Client Feedback on Provider Performance (page 14)

MIDDLE EAST AND NORTH AFRICA

Yemen

- Connecting Midwives and Communities

WEST AND CENTRAL AFRICA

Benin

- Applying National Protocols (page 20)
- Establishing Clear Performance Expectations (page 13)
- Strengthening Emergency Obstetric and Neonatal Care (page 36)
- Preventing Postpartum Hemorrhage (page 27)
- Improving Pharmacy FP Services (page 12)

Ghana

- Strengthening Midwives' Counseling in Adolescent RH (page 32)
- Self-Paced Learning in Postabortion Care/Safe Motherhood (page 20)
- Improving the Performance of Regional Resource Teams (page 12)
- Supporting Community-Based Health Planning and Services
- Saving Newborn Lives Initiative

Guinea

- Community Response to Obstetric Emergencies (page 29)
- Improving the Performance of Immunization Workers

Mali

- Advocacy to Abandon Female Genital Cutting (page 30)
- Preventing Postpartum Hemorrhage (page 27)
- Supporting National In-Service Training

Nigeria

- Performance Needs Assessment for FP Program Recovery
- Performance Factors Study (page 14)

Rwanda

- Establishing Prevention of Mother-to-Child Transmission Services (page 13, page 23)
- Methodology to Facilitate FP/PMTCT Integration (page 24)
- Community-Managed Health Care (page 22)
- Building Community-Provider Partnerships (page 22)
- Improving Provider Performance
- Making Services Gender Sensitive (page 34)

Senegal

- Strengthening Supervision of Community-Based Providers
- A Community Model for Postabortion Care (page 16)

The PRIME II Performance Monitoring Plan (PMP)

The PRIME II PMP proved to be a useful management and evaluation tool for monitoring and assessing project progress at the global level. The PMP consisted of 10 key indicators and estimated baseline and target values for different periods during the life of the project. PRIME II exceeded all of its PMP targets as outlined in the Cooperative Agreement.

The indicators selected by the PRIME II partners and approved by USAID/Washington correspond to the project's Strategic Objective (SO), Intermediate results (IRs) and Sub-results (SRs). As such, the PMP served as both a roadmap for project activities and a comprehensive summative and reporting tool for showing the breadth of PRIME activities. Key PMP Indicator #1—Providers Performing to Standard—served as the most rigorous expression of the project's progress in improving access, quality and use of FP/RH services. Data for this indicator were generated through observations of actual provider performance at baseline and follow-up and allowed the project to quantitatively document its accomplishments.

As part of the new project proposal writing process implemented by PRIME II, each project plan required an M&E plan at the beginning of the project that included two to three key PMP indicators. In this way, PRIME was able to ensure that projects were implemented under all of the relevant indicator areas.

The other key indicators corresponded to particular areas of technical work including curricula development and evaluation capacity building, quality of training sites and centers, development and use of PI plans, strengthening of supportive supervision systems, linkages between differing levels of performance support systems, promotion of gender sensitivity including efforts to encourage the abandonment of female genital cutting, incorporation of client feedback into services, and the creation of global partnerships to accomplish project goals. Data for these indicators tended to be more qualitative and output-oriented than for Key Indicator #1.

Progress against the PMP targets was reported to USAID annually at the end of the fiscal year and included in the annual project workplans. Data collection for the PMP began approximately three months prior to the reporting date and was coordinated by the M&E Specialist in headquarters who served as the PMP Coordinator. Definitions and data collection techniques for the key indicators were spelled out in the PMP Guidelines at the beginning of the project and were modified over the life of PRIME II to maximize the utility of the data and ease of data collection and reporting from the field. The PMP data collection process involved the regional and country-level M&E staff conducting the necessary interviews, completing the required instruments and updating the regional PMP matrix for their respective regions. These matrices were then merged by the Headquarters Coordinator, reviewed by the M&E Director and other senior management and submitted to USAID/Washington. PMP Results were also reported annually to the Partner Leadership Group to ensure that the project was on track to meet its objectives, and were shared periodically with field staff.

Limitations

While the project originally conceived of a rigorous data collection and reporting system for all ten of the key indicators using quantitative, standardized instruments, this proved impractical given the wide variety of project activities and the large amount of financial resources this would have entailed. As a result, the PMP served appropriately as an overall monitoring and management tool to track the progress of the global project and provide illustrative projects and activities for a given indicator. Other sources of data collection such as performance needs assessments, final evaluations and special studies provided quantitative results on progress under these indicators.

In a large global project, it was difficult to define ahead of time exactly what specific projects and processes would entail. Flexible PMP systems need to be developed that allow for mid-stream corrections in the key indicator list or in the definition or specifics of a given indicator. For example, the PRIME II PMP as it is written tracks “multi-year PI plans” when, in fact, few of the PI plans developed proved to be multi-year due to the short project cycles of PRIME II. Anticipating the need to modify the PMP to better reflect the priorities of both the clients and funder of the project could have helped to alleviate anxiety about such discrepancies.

A final summary of the PMP results is accessible in the Monitoring and Evaluation section of the PRIME II website CD-ROM (Annex D).

Funding Overview: Core and Field Support

Total Obligations

I. Core/Technical Leadership

& Global Implementation 31,267,000

II. Field Support

Armenia 3,265,000

Bangladesh 3,975,434

Benin 1,800,000

Dominican Republic 365,000

El Salvador 2,955,000

Ethiopia 2,500,000

Ghana 4,618,000

India 3,703,000

Kenya 1,000,000

Mali 950,000

Nicaragua 75,000

Paraguay 2,714,000

Rwanda 8,516,807

Tanzania 2,825,000

Uganda 200,000

Uzbekistan 150,000

III. Total **\$70,879,241**



The PRIME II website describes the Project's approaches and activities to improve the performance of primary providers in family planning and reproductive health care in 25 countries around the world. All of the PRIME II publications are included in printable files, along with Project resources and two interactive tools: *Performance Improvement Stages, Steps and Tools* and *Transfer of Learning: A Guide for Strengthening the Performance of Health Care Workers*.

Instructions: Windows and Macintosh compatible. Insert the CD and open the directory 'www.prime2.org'. Double-click the file index.html. This will open the website home page in your web browser. From there you can browse or search the entire site's contents.



This publication and the PRIME II website were produced by IntraHealth International for the PRIME II Project and were made possible through support provided by the U.S. Agency for International Development under the terms of Grant Number HRN-A-00-99-00022-00. The views expressed in this publication and website are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

The PRIME II Partnership

IntraHealth International

Abt Associates

EngenderHealth

Program for Appropriate Technology in Health (PATH)

Training Resources Group, Inc. (TRG)

with supporting institutions:

The American College of Nurse-Midwives

Save the Children

IntraHealth International

6340 Quadrangle Dr., Suite 200

Chapel Hill, NC 27517

Tel: 919-313-9100

Fax: 919-313-9108

intrahealth@intrahealth.org

www.prime2.org



Paper made from 50% recycled fibers.