ADRA Madagascar Child Survival XIV

(Project # FAO A-00-98-00042-00)
September 30, 1998 – September 30, 2002

Toamasina Child Survival Project

MID-TERM EVALUATION REPORT

ADRA

Submitted to:

United States Agency for International Development
Washington, D.C.

By:

Adventist Development and Relief Agency International
Silver Spring, MD

30 September 2001

ADRA Madagascar
CHILD SURVIVAL XIV
(Project #FAO A-00-98-00042-00)

Toamasina Child Survival Project

MID-TERM EVALUATION REPORT

Toamasina II District, Toamasina Province
MADAGASCAR

Submitted to:
ADRA/Headquarters

Submitted by:
Mr. Heritiana Andrianaivo
Independent Evaluation Consultant
Management Sciences for Health
(MSH Madagascar)

Evaluation Team:
Heritiana Andrianaivo, Evaluation Consultant, MSH
Dr. Solomon Waco, Director of Evaluation, ADRA/HQ
Dr. Haja Razafindrafito, Project Director, ADRA TCSP
Colin Radford, Health Programs Coordinator, ADRA Madagascar

TABLE OF CONTENTS

ACRONYMS and GLOSSARY

AAA	*Auto-Apprentissage Assisté* / "AAA" or "3A", self-directed learning modules
ADRA	Adventist Development and Relief Agency
ADRA HQ	Adventist Development and Relief Agency Headquarters (USA)
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASBC	*Agent de Service à Base Communautaire* / Community-Based Distributors of Family Planning Services.
ASOS	*Action Santé Organisation Secours* / Health Action Organization for Assistance
AVA	*Andron'ny Vaksiny* / Immunization Day Campaign
BCG	*Bacille de Calmette et Guérin* / TB vaccination
BP	Breastfeeding Promotion
CDC	Center for Disease Control, Atlanta, GA
CDD	Control of Diarrheal Disease
CDMO	Chief District Medical Officer / *Fr: Medecin Inspector*
CARE	Cooperative Assistance and Relief Everywhere, Inc.
CASC	*Comité d'Action Sanitaire au niveau de la Commune* / commune-based health management committee
CISCO	*Circonscription Scolaire* / administrative district for schools
COGE	*Comité de Gestion* / management committee at the commune level
COSAN	*Comité de Santé au niveau fokontany* / Health compliance committee at the level of the *fokontany*
CR	Cost Recovery system / *Fr: Participation Financière des Usagers* (PFU)
CRS	Catholic Relief Services
CS	Child Survival
CSB	*Centre de Santé de Base* / Community Health Center/Clinic
CSB1	A community health center with no doctor, and only basic services
CSB2	A community health center with a doctor, and more extensive services
CtC	Child-to-Child (approach for school/community-based health promotion)
CVA	*Cellule Villageoise d'Animation* / a group of at least three volunteer community health animators
DDP	District Development Plan / *Fr: Plan de Développement du District, PDD*
DHS	Demography and Health Survey
DIP	Detailed Implementation Plan
DIRDS	*Direction Inter-Régionale du Développement Sanitaire* / Regional Health Administration Office
DIRESEB	*Direction Inter-Régionale de l'Enseignement Secondaire et de l'Éducation de Base* / Regional Education Administration Office
DPT	Diphtheria/Pertussis/Tetanus vaccine
EMAD	*Équipe de Management du District* / District Health Management Team
EOP	End of Project
EPI	Expanded Program of Immunization
FGS	Focus Group Study

Fokontany	Administrative unit presiding over several villages, but smaller than the level of the commune
FP	Family Planning
FRAM	*Fikambanan'ny Ray Aman-drenin'ny Mpianatra* / Association of Parents of School Children
FSP	Food Security Project, ADRA Moramanga
GAINT	*Groupe d'Action Inter-sectoriel en Nutrition de Toamasina* / Toamasina Region Inter-sectoral Nutrition Coordination Group
GM	Growth Monitoring
HIS (Fr: SIS)	Health Information System / *Fr: Système d'Information Sanitaire*
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health/Management Information System
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IRSTAT	*Institut Régional de la Statistique* / Regional Institute of Statistics Office
JSI	John Snow, Incorporated (Jereo Salama Isika, Madagascar)
KAPC	Knowledge, Attitudes, Practice and Coverage survey
km	Kilometer
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCDI	Medical Care Development International (INGO)
MoH	Ministry of Health / *Fr: Ministry de la Santé*
MIS	Management Information System
MOU	Memorandum of Understanding / *Fr: Protocol d'Accord*
MSH	Management Sciences for Health
MTE	Mid-Term Evaluation
NAC	*Nutrition à Assise Communautaire* / Community-based nutrition rehabilitation program, implemented by ASOS/UNICEF
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
SEECALINE	*Surveillance et Éducation des Écoles et des Communautés en matière d'Alimentation et de Nutrition Élargie* / food distribution project funded by the World Bank to improve nutrition inside schools and communities
SSD	*Service de Santé du District* / District Health System
STI	Sexually Transmitted Infection
TCSP	Toamasina Child Survival Project
TIPs	Trial of Improved Practices (approach to promotion of improved nutrition)
ToT	Training of Trainers
UNICEF	United Nations Children's Fund
UNFPA / FNUAP	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VISA 5/5	Local name for the TCSP's innovative, school-based vaccination promotion campaign.
WG	Women's Group

WRA	Women of Reproductive Age (15-49 years)
ZAP	*Zone d'Administration Pédagogique* / Regional Ministry of Education Administrative Zone

A. Executive Summary

A-1. Brief Program Description

ADRA Madagascar's Toamasina Child Survival Project (TCSP) is located in the remote rural Toamasina II district of Toamasina province along Madagascar's east coast. This region reaches approximately 50 kilometers (km) north and 40 km south of Toamasina town, and is known as the cyclone coast because of its vulnerability to devastating storms that destroy homes, crops and infrastructure every few years.

The TCSP is focused on capacity building for the district health system (referred to in this document as the "SSD"), and has the goal to reduce morbidity and mortality among women of reproductive age (WRA) and children less than five years old in the Toamasina II target area. The program objective is to strengthen the capacity of the district health system to provide and manage an integrated program of essential preventive, promotive, and curative health care services in Toamasina II district.

The project was designed as a collaborative project, with all TCSP activities implemented in partnership with the SSD. The potential for collaboration is maximized with the project office being located within the same administrative building as the Toamasina II SSD. The project was signed in Washington, DC in October 1998, although actual implementation was delayed until June 1999 while waiting on the official government signing of the Memorandum of Understanding (MOU). The project will continue until September 2002.

A-2. Main Accomplishments of the Program

- ***Capacity building for sustainability at all levels***: The project has developed a comprehensive, integrated and collaborative approach to strengthening IMCI health care services at the SSD, CSB (community health centers) and community levels.

- ***Diversity of trainings***: Many capacity-building trainings have been held for the SSD and CSB agents, including management training, as well as computer and language training for the SSD personnel. Staff upgrading opportunities has been well utilized by TCSP and SSD staff.

- ***Job Descriptions*** have been developed for all TCSP and SSD staff, dramatically improving efficiency of the SSD. Organograms have also helped improve working relations.

- ***Integrated Strategic Planning***: For the financial year 2000-2001, the SSD fully integrated the operational plan for the TCSP into their District Development Plan (DDP). More recently, the SSD has developed its own integrated DDP for 2001-2003, the first time they have done so completely on their own.

- ***Computerization of HIS:*** A computerized HIS data collection and analysis system has been developed for the SSD and is fully integrated with the MoH's HIS format. The TCSP has worked with the SSD to develop software in ACCESS database to facilitate the monthly data entry of the HIS data collected from the CSBs.
- ***Supervision strengthening:*** Integrated supervision visits have emerged as a key to success. Follow-up supervision visits are important motivators and provide opportunities for more open dialogue to address priority issues.
- The ***cost recovery system*** in the CSBs is being strengthened and improved to become more cost-effective.

IMCI accomplishments

- ***Improved vaccination coverage rates and measles control***: Toamasina II district vaccination coverage rates have increased significantly since this joint project began. There have only been two cases of measles reported between July 2000 and June 2001, all in non-immunized children.

- ***Improved Cold Chain:*** After training in the maintenance and repair of the cold chain, and in EPI techniques, the number of cases of measles in vaccinated children has dropped to zero, with no new cases in vaccinated children since May 2000.

- ***Successful VISA 5/5 program***: The vaccination rates in low-coverage areas have been boosted by an innovative school-based program to track vaccination dropouts.

Malaria Prevention Accomplishments

- ***Distribution of insecticide treated bed nets***: An initial 225 nets were distributed in four sites before nets ran out. New supplies should arrive in October 2001, with distribution of 10,000 nets planned for the next 12 months, targeted for the protection of pregnant women and children.

- ***Community Mobilization***: There has been strong community demand and widespread interest in buying nets once the awareness campaigns began.

Control of Diarrheal Disease Accomplishments

- ***Successful response to, and containment of cholera epidemic*** after cyclones

- ***Small equipment purchases for CSBs for use in CDD and cholera control***; e.g., stretchers and primus stoves for sterilization of equipment using pressure cookers.

- ***Training of CVAs and CSB agents*** in CDD and cholera control methods.

Nutrition accomplishments

- ADRA and SEECALINE collaborated to establish a **Toamasina Region Intersectoral Committee on Nutrition (GAINT),** with regular monthly meetings.

- **Community-based nutrition promotion** using **Trials of Improved Practices** (TIPs) approach.

- ***Kitchen garden promotion*** in 14 women's group sites, with **the distribution of seeds and shovels** for establishing community garden plots.

- ***Micronutrient promotion and distribution:*** Micronutrients are being promoted according to MoH protocols, with logistical assistance given as needed.

School and Community Health Accomplishments

- ***Child-to-Child Activities*** involving 271 teachers, 113 schools and 11,000 students, have promoted age appropriate health messages to be shared back in their homes and communities. Topics include nutrition, breastfeeding, immunization, STI/HIV/AIDS, CDD and malaria prevention.

- ***Community-based CVAs and Women's Groups*** are working effectively at health promotion and referral to the CSBs.

- ***Community-Based Health Committees*** (CASC and COSAN) have been revitalized and strengthened to promote sustainability of the project interventions.

Community-Based Family Planning Promotion/Service

- The TCSP has already established modern family planning services in nine CSB sites, with plans to have all 12 CSB2s functioning as FP sites by the end of the project.

- A total of 53 ASBCs (i.e. community-based distributors of FP services) have received training in Reproductive Health, including the Family Planning components.

STI/HIV/AIDS Prevention

- ***Complementary STI/HIV/AIDS project:*** ADRA is collaborating with JSI to implement a small HIV/AIDS capacity-building for the SSD, with a focus on church and community-based prevention interventions

- ADRA has taken the lead in coordinating the multi-sectoral ***Toamasina Regional AIDS Coordination Committee*** (known as ***CRCT*** in French), involving about 30 member agencies.

INNOVATIONS

- The initial program planning process for the TCSP was based on the positive reinforcement feedback of the **Appreciative Inquiry** model.

- A successful school-based **VISA 5/5** program has been developed for targeting vaccination promotion in low-coverage areas.

- The **TIPs** approach has gained widespread interest for improving nutrition among households in poor, remote village communities.

- The TCSP has developed and disseminated a regular **information bulletin** for SSD and CSB agents, with four issues published thus far.

- The TCSP has organized **exchange visits** for the two-way sharing of experience with other colleagues in health and development in Madagascar (JSI, MCDI, Linkages, FSP).

- A **Peace Corps Volunteer** has been incorporated into the project to focus attention on community-based health initiatives, including research into development of a community-funded health insurance scheme. A second Peace Corps Volunteer is scheduled to commence with the project in December 2001, and will focus on the coordination of **STI/HIV/AIDS prevention at the provincial level.**

A-3. Overall Progress in Achieving Objectives

The TCSP has made reasonably good progress in achieving the program objectives, with the most significant progress taking place during 2000 and 2001. Because of the many delays in its early stages, the project has had to plan and implement a heavy schedule of "catch-up" activities. Despite these challenges, the TCSP staff believes they will still be able to finish the project on time, and are working towards that goal. Extra staff has been hired to assist with the increased intensity of activities, and there is both dedication and a good team spirit as the project progresses.

Given the qualitative nature of many of the **Preferred Futures**[1] (developed by the SSD as the guiding priorities for the focus on capacity-building in this project), it is difficult to objectively evaluate and quantify the progress made in some components. Although the project has worked with the SSD to collect data on indicators that are part of the national HIS, unfortunately, the national HIS does not collect data regarding several important Mother and Child Health (MCH) indicators (such as those relating to breastfeeding or CDD interventions). This leaves some significant areas in need of further research, evaluation and documentation before the end of the project.

During the implementation process, the TCSP has moved to a more integrated community-based approach to providing sustainable health care services, working with the SSD to first strengthen the services being provided at the CSBs, and also establishing *new* community-based structures including Women's Groups and community-based distributors of family planning services (ASBCs). In response to the MoH policy, the TCSP has worked with the SSD to established a system of health coordination committees at the level of the commune and *fokontany*[2], CASC and COSAN respectively, described in more detail on pages 33 and 34. (See also diagram in appendix F-6).

The project has also focused on strengthening or revitalizing a number of *existing* community-based structures including training for the Health Management Committees set up by the MoH

[1] Refer to Appendix F-5 for a list of the preferred futures, and the estimated achievement of progress to date.
[2] *Fokontany:* Administrative unit presiding over several villages, but smaller than the level of a commune.

(COGES) specifically for the management of the cost recovery system at the CSBs. These committees can also collaborate with the groups of community health animators (CVAs[3]), who promote key health messages.

Recognizing the priority needs that remain to be addressed, or specific challenges that were blocking effective progress, the TCSP has developed and implemented a number of supplementary project components to enable the overall program objectives to be achieved within the original timeframe. These are outlined in section B -1.3.

A-4. Project Constraints and Problems

- ***Administrative constraints*** have led to challenges in implementation due to bureaucratic delays, absence of administrative personnel, differences in leadership styles, and changes in government priorities (e.g., cholera) or MoH policies (e.g., restrictions on formal training programs for CSB staff).

- ***Technical constraints*** have included the difficulty of finding qualified local staff; conceptualization and consultant problems at the time of the writing of the original DIP; the need to take time to build relationships with the key collaborating partners; and the challenges inherent in moving from a system of vertical program implementation to a system of more horizontal (multi-disciplinary) integration within the SSD.

- ***Community constraints*** stem from the underlying problem of poverty that cuts across all other issues of health and development.

- ***Financial constraints*** have included issues regarding per diems, and requests for equipment and rehabilitation of clinics, which are outside of the scope of this project.

- ***Logistical constraints*** range from initial SSD resistance to project regulatory policies; the challenges of insufficient project transport, and the difficulty in purchasing certain essential supplies, parts and equipment.

- ***Geographical constraints*** combined with a lack of basic infrastructure such as roads, bridges, electricity and communications systems make access into remote rural project areas a major challenge.
- ***Delays***: A combination of many of the factors outlined above, which were outside of the control of the project, have led to unavoidable delays in trainings and in the nutrition, malaria and HIV components.

- *Accessibility:* The project faces major transport challenges due to only one project vehicle and difficult geographical access. See Appendix F-1 for details.

[3] The *Cellules Villageois d'Animation* (an MoH term) work in collaboration with the commune authorities and under the direct supervision of the CSB agents. A CVA includes at least three persons (typically two women and one man).

- ***Administration styles***: The transformation from autocratic to more democratic and participatory management styles, as well as transformation from vertical to integrated system for provision of health care services takes time and needs full commitment from SSD administration.

- ***Understanding true partnership***: The disparity between resources available to ADRA's TCSP compared with the SSD led to tensions and jealousies in the first year of implementation, although now the project is better understood as a true collaborative partner rather than a competitor.

- ***Personality differences*** among SSD and community authorities have led to significant impacts on the success or failure of project integration at CSB and community levels.

- ***Personnel/human resource problems*** have affected the program, most noticeably in the challenge to find suitably qualified local staff[4] to work in the TCSP.

AREAS IN NEED OF FURTHER ATTENTION

- ***Utilization of computers*** by SSD personnel has not yet reached its full potential. Learning and integration have taken longer than anticipated.

- ***Potential supervision problems*** loom now that there are 12 new doctors working in the SSD, who are currently being supervised by paramedical SSD staff. ADRA is already working with the SSD to address this problem by incorporating these doctors into the integrated supervision teams.

- ***Staffing and Equipment***: The CSBs have expressed the need for both additional staff, and basic equipment in order to work more effectively; e.g. weighing scales, beds, obstetrical and surgical instruments, communication equipment, etc.

- The MoH ***cost recovery system*** needs a better way to deal with the "poorest of the poor", who in the most remote areas can account for up to 80% of the patient consultations.

- The ***Child-to-Child program*** needs better follow-up and evaluation of impact at the community and household levels.

- ***Stock Inventory Management:*** The senior SSD administration reported there were no medication stock shortages, but HIS and field analysis during the evaluation reveal

[4] In the context of this document, "local staff" refers to either those who are Betsimisaraka, the predominate "tribal" group in the Toamasina II region, or to those who have lived in Toamasina long enough to be familiar with its unique dialect and local customs.

that this is not the case. Attention needs to be focused on improving the tracking and management of ordering medical supplies on a monthly basis.

- Need for improved ***time management and workflow analysis,*** as well as organizational assessment at CSBs. For example, How can long waiting times for queues of mothers and babies be reduced on vaccination days? How can waiting time be better utilized? CVAs could be invited to do a targeted IEC promotion campaign at the CSBs on the vaccination days, capitalizing on the captive audience.

- ***Volunteer motivation:*** Although the community-based volunteer programs have been implemented very effectively, the evaluators feel it is important to review the whole concept of motivation of volunteers, looking at what can be done to maximize sustainability.

- ***Integrated supervisions:*** Increasing the number of regular integrated supervisions is needed at all CSBs. Before the commencement of the project, the most remote CSBs had not received a supervision visit in more than seven years.

- ***Interpersonal communications:*** The passage of time is underscoring the importance of building strong personal relations, for example, between: ADRA-SSD; SSD-CSBs; CSBs-community and the SSD-DIRDS etc.. The relation between SSD and the CSB agents has been singled out as in need of particular attention during the remainder of the project.

A-5. Adaptations Made

- ***Catch-Up Schedule:*** The project was delayed due to many constraints including the MoH moratorium on formal training of CSB personnel; however, the TCSP has adapted and implemented an intensive "catch-up" schedule, with plans in place to have everything accomplished by the end of the project.

- ***Mini-trainings***: In response to the formal training moratorium, the project has worked with the SSD to add on either one or two days of upgrading trainings each month, at the time the CSB agents come in to give their monthly activity report and to pick up their salaries and medical supplies.

- ***Enlarged management team:*** Blockages and delays with the former DMO led to a change of approach to integrate more planning and decision making in conjunction with the new doctors on the enlarged district management team (EMAD).

- ***Targeted Vaccination campaigns:*** Low vaccination rates have been targeted with the school-based VISA 5/5 program, leading to dramatic improvements in vaccination.

- Several ***short-term staff have been employed*** to address the priority needs at the most critical times, such as nutrition promotion and malaria prevention campaigns.

- ***Increased direct intervention at community level:*** The highest priority /weakest areas in the public health service system have prompted ADRA to develop direct interventions at community level, particularly the promotion of vaccinations, malaria prevention, and nutrition promotion.

A-6. Summary of Capacity-building Effects

The entire TCSP project is focused on capacity building, whether at the level of the SSD, with CSB agents or in the community.

At the ADRA/SSD level:

- ADRA and SSD personnel have been involved in numerous training and upgrading programs, both to strengthen their own capacity, and to enable them to share their experiences with others. Management has been an important focus, although transfer of competence has been slower than originally expected.

- A joint ADRA-JSI "Health Education for Life Project" (HELP) was designed as a supplementary project to build capacity in ADRA's staff, to provide excellent IEC resources to facilitate the field training programs, and to allow for exchange visits between staff of the two organizations.

- Capacity-building for SSD staff, with trainings in management, computers, interpersonal communications, HIS/MIS forms, and English language instruction, have led to greater utilization of computers, with more integration into the decisions and daily work of the SSD.

- The overall effect has been increased confidence of TCSP and SSD staff to implement and manage successful interventions within the Toamasina II district.

- The increase in vaccination rates is a good example of increased effectiveness under the collaborative approach.

- Another positive effect has been the move towards a more open, participatory approach to management by the staff of the SSD. This has come about by the SSD's desire to move in this direction, having seen and experienced for themselves the contrast between the autocratic and democratic management styles.

At the CSB level:

- Capacity-building for CSB agents, with focus on promotion of IMCI, CDD/cholera control, nutrition, breast-feeding and vaccination interventions and counseling have led to their request for greater involvement in the training and supervision of community-based health educators (such as the CVAs).

- Commencement of "on-the-job training" in integrated supervision for the twelve CSB2 doctors will enable them to take a more active role in supervision of the CSB1s located in their area.

- Improvements have been noted in refrigerator maintenance after a training course in the repair and maintenance of the cold chain related equipment, although spare parts are still hard to obtain from the MoH.

At the Community level:

- Community-based training of volunteers is helping to build capacity at the community and household levels. Training has focused on CVAs, commune health management committees (COGE, CASC, and COSAN), Women's Groups, and commune authorities.

- The CtC program has enabled capacity building for 271 teachers in the MoEd system, with training in approaches to share key health and development messages.

- Strengthened relations with local commune authorities have resulted in greater interest, accountability, and integration of health-related activities at the community level.

- Training for the COGE (cost recovery system management group) has resulted in capacity building for both CSB and COGE personnel.

A-7. Summary of Prospects for Sustainability

The fact that so little money has been budgeted for direct aid to the SSD (other than the supplementary trainings and support interventions) underscores the fact that the SSD is not financially dependent on the TCSP to implement its day-to-day programs and interventions. The TCSP has enabled the SSD to expand the scope and impact of their programs, and to accelerate the rate of progress towards achieving their program goals. The progress in achieving this capacity-building transfer has been slower than expected in a number of situations; however, with the change of senior administration at the SSD, and the welcome addition of 12 new doctors to work at the CSB2's, the future looks very promising for the remainder of the project.

Now that the new SSD administration is taking a more active, open, decentralized, and participatory approach to management, changes have begun taking place, and personnel are becoming more involved in the planning and decision-making. The system as a whole is accelerating into a new phase of growth, development and advancement. The SSD and ADRA teams have become more transparent, with the SSD more open in sharing their limitations and training needs. They have also demonstrated a clear desire to work closely with ADRA on addressing their priority needs in the future.

A-8. Priority MTE Recommendations

Lists of recommendations are included throughout this report, with a list of general recommendations in section E. Key priority recommendations are summarized as follows:

1) ***Multi-disciplinary training for SSD:*** Move to a more integrated, field-based approach to community-based IMCI approach, with multi-disciplinary training for SSD program officers, and regional supervision.

2) ***Focus on Quality-Assurance/Monitoring and Evaluation***: A Quality-Assurance/M&E Program Officer should be employed to work with the Management Advisor in order to strengthen the HMIS collection and reporting systems, as well as to improve and expand the management and integrated computer training components of the project.

3) ***Volunteer Motivation:*** Review of community-based volunteer program, with assessment of how to best sustain the motivation of volunteers.

4) ***Communication Problems:*** Develop plans with SSD to address the communication needs (e.g., equipment and interpersonal) at the level of the SSD, CSBs, community-based volunteers and the TCSP.

5) ***Evaluation of Child-to-Child program:*** The CtC program needs to be thoroughly evaluated as to impact at community and household level, with improvements and modifications made according to need.

6) ***Radio Broadcasts:*** The project needs to focus on maximizing the opportunities to use local FM radio stations to promote the key health and development messages to the listening audience in the project area.

7) ***Consolidation of Community Groups:*** The project has established a variety of new community-based groups, and committees; however, for sustainability purposes, it would be best to streamline and consolidate such groups or committees where possible.

8) ***Research and Documentation:*** There is a significant absence of research data and reports for the Toamasina east coast region. The TCSP should seek to work with local and international researchers to address this critical lack.

9) ***Traditional Birth Attendant Training:*** Where possible, TBAs should be included in training of community-volunteers, as they are a major potential influence on pregnant women and mothers with newborns.

10) ***Host Newsgroup***: In the absence of a centralized clearinghouse for health and development information on Madagascar, the TCSP should try to establish a bi- or tri-lingual Madagascar health exchange newsgroup list for improved sharing of health and development ideas and lessons learned.

B. Assessment Of Program Progress

The Toamasina Child Survival Project is now in its third year of implementation following a nine-month delay in project startup while awaiting official government approval. As proposed in the DIP (p. 46), this evaluation was conducted in mid-2001 to allow for a clearer indication of progress corresponding to the true "mid-term" of the commencement of project activities.

B-1. Evaluation of Technical Approach

Project Overview

Program Goal: To reduce the morbidity and mortality among WRA and children < 5 years of age in the Toamasina II district of Toamasina province, eastern Madagascar.

Program Objective: To strengthen the capacity of the District Health System to provide and manage an integrated program of essential preventive, promotive, and curative health care services in Toamasina II District.

Strategies:

- A modified "Appreciative Inquiry" approach to define the SSD's desired positive changes in management, health care delivery, and inter-personal communications; to build organizational capacity of the SSD and of ADRA, and to give direction to the project.
- Improved community-based health services and promotion of healthy, protective behaviors for mothers and children.
- Increased community participation in health care and development issues (involving CVAs, EMAD, and CtC approaches).
- Increased capacity of SSD to plan and manage health programs that deliver quality health care services in the community.
- Innovative team building and interpersonal communication approaches used in management training for SSD and CSB personnel.
- Improved, innovative approaches to integrated planning, implementation, monitoring and evaluation of all SSD activities.

In keeping with the modified appreciative inquiry approach mentioned in the first strategy, the TCSP was designed as a "needs-focused" project, addressing the following priorities identified by the SSD at the time of the writing of the Detailed Implementation Plan (DIP). The preferred futures of the Toamasina II SSD are:

1. The SSD is the reference standard by which other SSDs in the Toamasina region are compared, in terms of organization and coordination of activities.

2. The SSD pilots new and innovative approaches to preventative, promotive and curative health care.

3. The SSD program officers use the computer in creative ways to increase their effectiveness.

4. All SSD Program Officers have the capacity to design, plan, organize and evaluate how to effectively manage their health programs.

5. There is an SSD community health program including integrated health care of children, environmental health, malaria prevention, nutritional rehabilitation and nutritional education.

6. The SSD has a "professional conscience" in the interests of the community.

7. There is an SSD human resource development program for change, which enables team-building, enhanced interpersonal relationships between staff, and open communications.

8. In order to be most effective, the SSD's planning, management and data collection are integrated, coordinated and realistic.

General Program Strategy

Although the TCSP's main focus is on capacity building, the project has been modified to deal with constraints encountered. For example, there is no counterpart staff in SSD for malaria interventions, so ADRA implements approximately 15% of the direct interventions in the target communities, with 85% of the time spent on collaborative (capacity-building) interventions with the SSD partners. This change has been necessary to ensure the project could still proceed even when the SSD counterparts have been unable to do any activities, whether through MoH directives, or when MoH directives require them to drop everything to focus on a new crisis, leaving other interventions lagging. This change has enabled ADRA to continue to target the specific high-priority indicators (e.g., low vaccination coverage rates), so that the overall SSD program goals do not get off track.

Child Survival Intervention Mix

The TCSP began with the following planned program intervention mix. Interwoven into all of these components are the capacity-building interventions at the level of the SSD, the CSBs and the community:

1) Community-Based IMCI Interventions (30%):

a. Home-based Control of Diarrheal Disease (CDD)

b. Vaccination promotion
c. Appropriate treatment of fever/malaria
d. CVA training for basic health promotion

2) ***Nutrition Interventions (20%)***
   a. Trials of Improved Practices (TIPs) approach
   b. Breast-feeding promotion
   c. Micronutrient promotion

3) ***Malaria Prevention Interventions (25%)***
   a. Promotion of commercially available bed-nets
   b. Education regarding appropriate treatment of malaria
   c. Environmental health promotion

4) ***School and Community Health Education Interventions (25%)***
   a. Child-to-Child approach for promoting key health messages to school children
   b. Community-based health promotion interventions
   c. Training of CVAs and community health coordination committees

Overview of Project Site: Given the effect of the area's terrain and subsequent lack of infrastructure on project activities, a brief description is provided here. The 28 community health centers are scattered across a district that can be divided into three zones: north, central and south. The southern zone is located along National Route No. 2 and is the most accessible. The central west zone is situated along the Ivoloina River and extends to the western limits of the SSD. Geographically, the majority of CSBs are concentrated in this zone. Accessibility on the east extends to the coastal border, while the western region is the most remote zone. The northeastern zone can be reached all year round; however, the northwestern region has scattered villages along the Onibe river and is only accessible in the dry season.

The difficulty of accessibility is a major constraint impacting many of the CSBs and the implementation of health activities. Only nine out of 28 CSBs are accessible by car. To reach another 10 centers requires 3-5 hours walk after 1-3 hours travel by 4WD. The remaining clinics are only accessible after 8-18 hours of walking or by boat. On the longest trips, TCSP staff walks up to 18 hours through rivers, streams, forests and mud paths, covering 50-60 kilometers.[5]

B-2. Progress by Intervention Area

Community-based IMCI Interventions (30%)

The activities of the IMCI component of the TCSP consist of strengthening the capacity of the SSD to provide integrated, community-based, whole-person care of sick children. The MoH, through the Family Health Service, has been committed to logistically and financially supporting

[5] See Appendix F-1: "Accessibility Challenges for Reaching Toamasina II District CSBs."

the IMCI training and follow-up for the CSB agents using another source of money. Consequently, the TCSP is only accountable for the community-based IMCI components, not the full IMCI training, which is under the MoH's responsibility. The two components should exhibit a good complementarily once they are both in place and functional.

General IMCI Activities

- During the first half of the project, the IMCI Advisor has supported the following interventions: establishment and training activities of community-based CVAs; vaccination campaigns in conjunction with the national EPI program campaigns; malaria prevention activities such as the promotion of insecticide-impregnated mosquito nets.

- A total of 157 CVAs have received training in community-based IMCI, including the following topics: malaria, CDD, EPI, breast-feeding and nutrition, as well as STIs, HIV and AIDS.

- In April 2001, the IMCI Technical Advisor provided training to the 12 physicians newly appointed to work in the CSB2s of the Toamasina II district. The training focused on an orientation and overview of the introductory IMCI modules from the first of the "AAA" self-guided courses instituted by the MoH.

- Support for the MoH and SSD program of cholera prevention and control in early 2000, with establishment of reference treatment centers at CSB2s.

- Training in cold chain maintenance and repair for all the CSB agents, as well as EPI refresher training for SSD and CSB agents.

General IMCI Challenges

- The major challenge met during the implementation of this component has been the lack of accessibility of the CSBs and related field sites, as described above.

- Although the community-based IMCI training of volunteers has been completed, and they are ready to refer people to CSBs, the CSB agents have not yet completed their full training on what IMCI services and counseling to provide. The CSB agents have only received the first three AAA modules focused on IMCI, and they are not ready to implement changes to their services until all the IMCI training is completed.

General IMCI Recommendations

- A program of EPI supervision has been established, and it is evident from data collected for the SSD's monthly activity reports that the EPI program should continue to closely supervise the remote sites for absence of or inconsistent reports, and for those showing significant coverage problems.

- A similar supervision program has been established for the community-based IMCI interventions, and the same remark is indicated: Prioritize zones identified with significant IMCI-related health problems per HIS analyses.

Immunizations Intervention

Since the beginning of the project, improvement of vaccination rates has been a major priority for the TCSP, and one of the most notable achievements of the ADRA TCSP/SSD collaboration to date.

Immunization Strengths

- The TCSP project began with strengthening and improvement of the cold chain system. Training was held for the SSD with a focus on the repair and maintenance of refrigerators and related equipment within the cold chain.

- Increased accessibility to immunizations has been facilitated by the organization of special local or regional vaccination days; the utilization of mobile outreach teams to isolated and remote areas; and the development of a strong system of immunization promotion, with utilization of banners, posters, flags and Child-to-Child vaccination-promotion campaigns.

- Strong project support for the biannual Vitamin A distribution campaigns.

- Effective role of the CVAs and Women's Groups (WGs) in community mobilization, helping to reduce the "drop-out" rate by actively searching for non-immunized children.

- This IMCI intervention has shown a good degree of impact with coverage rates climbing 20-35% higher than the initial baseline vaccination coverage within the first project year, and another 20-35% increase again in the second year.

Vaccination coverage rate for the Toamasina II SSD

VACCINE	Baseline Survey Dec 1998	1999	2000	2001 (Jan-Sept only)*
BCG	38%	74 %	109%[6]	60%*
OPV 3	35%	56%	83 %	53%*
DPT 3	35%	57 %	83 %	53 %*
Measles	28%	54 %	83 %	53 %*

[6] Note: The target number of children to be vaccinated in some CSBs is different to the reality, resulting in coverage >100%. Once the 2002 census takes place, this reporting problem will hopefully be resolved. This happens because many children older than 12 months are still immunized if they show up at the CSB, although separate HIS records are not kept in the MoH system for these children. Also inaccuracies in the register of births and deaths at the commune level often conflict with the last census data, (sometimes up to 25% different) resulting in inaccurate population projections.

- Excellent, highly motivated response to the VISA 5/5 special vaccination campaigns in schools. See section B-1.3.

Immunization Weaknesses

- There is still a critical lack of reliable, functioning equipment to support the cold chain in a number of CSBs, with old, malfunctioning refrigerators or the absence of refrigerators in some of the more remote locations. In these isolated CSBs, bringing in fuel takes up to two days of walking. The SSD also lacks spare parts for the refrigerators in the CSBs, resulting from a supply problem in the UNICEF/MoH system.

- There are ongoing problems with the cold-chain system, some having to do with stock shortages and the need for improved management of inventories, including better anticipation of needs on campaign days, and improved time management.

- During 2001, UNICEF indicated that they would work with the MoH to provide (three-way electricity/gas/kerosene-powered) refrigerators, vaccination kits, vaccines and fuel for CSBs across the country. Consequently, instead of buying vaccination-related equipment with money budgeted for support of EPI activities, ADRA decided to cover the upgrading training for CSB agents regarding the new MoH policy of vaccination, cold-chain maintenance, management of vaccine stocks, and the supervision of vaccination-related field activities. There is still no indication when the UNICEF equipment will be provided. In the meantime, the system still struggles with the limited resources available.

Immunization Recommendations

- In the most remote clinics, the possibility of using solar panels needs to be investigated in order to ensure a more reliable and sustainable cold-chain system. ADRA should assist the SSD in exploring this option, and in developing a joint funding proposal if this seems feasible.

- The TCSP needs to continue working closely with the partners from the community in order to reinforce community mobilization, ensuring sustainable motivation of volunteers for the future.

Control of Diarrheal Disease Intervention (CDD)

The community-based CDD program was initially supposed to be a component of the community-based IMCI program that would be heavily supported by the TCSP. However, with the emergence of the cholera outbreaks, the activities of the SSD were requested by MoH directives to focus more on the cholera-control response, rather than solely on a community-based IMCI approach.

Because the cholera epidemic disrupted and diverted the SSD's resources of time, money and personnel for several months, the TCSP decided to integrate the control of cholera into the community-based interventions for the prevention and control of diarrheal diseases, rather than treating it as an independent problem.

CDD Strengths

- A very effective response was made to the cholera epidemics in 1999 and 2000. After the training and education campaigns took place, no new deaths were reported from cholera in the project district.

- The IMCI module had just been completed at the MoH, so the TCSP was able to incorporate this directly into the training program for the SSD staff and CSB medical officers.

- An IMCI training program for all CVAs was held, with a specific emphasis on control of cholera and other diarrheal illnesses.

- Community-based promotion of CDD/ORT programs has taken place via the volunteer women's groups and CVAs working in association with the CSBs. The training has targeted CVAs representing 25 CSB sites in 58 communities.

CDD Weaknesses

- The cholera campaign meant a delay in implementation of joint activities and interventions of the SSD with ADRA since all available SSD personnel and vehicles were "absorbed" at the height of the campaign.

- In July 2001, the IMCI Technical Advisor (a local doctor) resigned to take up a higher-paying position as a regional coordinator with a USAID-funded NGO in another part of the country. Trying to find a suitably qualified and appropriately experienced *local* doctor who knows the local customs and traditions, and who can speak the regional dialect has been extremely difficult.

CDD Recommendations / Lessons Learned

- Programs of direct intervention with government institutions need to "expect the unexpected" and build adequate "lag-time" into their implementation plans, as things will inevitably run into unexpected delays that can cause significant disruption to tight programming and training schedules.

- There is need for more research to track the adoption of cereal-based ORT for diarrheal control, and to understand what is currently being used as the traditional treatment of the basic childhood maladies.

- Need for better evaluation of impact of interventions at the community and household levels, with a more effective integrated supervision system.

- Investigate the selling of ORS packets as a potential source of revenue for volunteer health promoters in the future.

Malaria Prevention Intervention (25%)

Malaria Prevention Approach

The project's malaria intervention components were originally designed after collaboration with the other partners working against malaria along Toamasina Province's east coast. PSI was identified as the main partner, and the TCSP planned to promote (within the target district) the nets being distributed by PSI (and to a lesser extent by UNICEF) around the country. Unfortunately, a tax problem arose between the government and the suppliers, with the result that the bed-nets sat in import warehouses, creating a national shortage of mosquito nets for the past 18 months.

In light of this political stalemate, the TCSP decided to change their approach from that of promoter of PSI's nets, to distributor of any locally available nets. Unfortunately, local supplies were exhausted within one month, and local manufacturers could only supply 25 new nets per week. WHO, UNICEF and USAID Madagascar finally intervened to break the government stalemate. ADRA has since requested 10,000 nets from PSI and 1000 from ASOS to be distributed during the last quarter of 2001, with special incentives for pregnant women to buy the nets at greatly reduced prices.

Although the timeline for the malaria interventions has suffered major delays, the TCSP has begun implementing plans for a fast catch-up phase, with additional short-term staff to be employed to help with net distribution as needed. It is anticipated that large supplies of new nets will be available again in October 2001.

Malaria Prevention Strengths

- During the first month of promotion, mosquito nets have been promoted by 15 CVAs in five different sites with very positive response.

- Mosquito nets are promoted commercially in local roadside epiceries (small Malagasy shops/stalls), as well as in CSBs throughout the district.

- Community bed net-treatment days have been held in one site with six villages.

- Routine monitoring of malaria cases takes place within the regular monthly HIS data collection system. This will allow easy tracking of new malaria cases once all the new nets are distributed, allowing the project to monitor the impact in this area.

Malaria Prevention Weaknesses

- As described above, 18-month delay in supply of mosquito nets by PSI and UNICEF due to government red tape, causing a national shortage of nets.

- No sufficient local supplier of mosquito nets available, and high import taxes discourage entrepreneurs from importing supplies to meet the need.

- The beneficiaries prefer using pre-treated nets rather than local, untreated nets that must be treated with insecticide according to the instructions inside the bed-net package.[7]

Malaria Prevention Lessons Learned

- Program designs cannot rely on one major collaborating partner without taking into account the significant risk of problems or delays. Contingency plans need to be explored to enable blockages in one approach to not impede the progress of other implementing approaches.

- For interventions that are season and/or time dependent, it is better for the implementing NGO to take responsibility for direct intervention of activities. In this case, 18 months of project time was lost while the TCSP waited for the bed nets to become available in country. This could have been avoided if the project had an alternative or contingency approach, so that if no change took place within, say three months of when expected, the project could still make progress in other related areas.

- To support sustainability of the malaria interventions, the promotion of insecticide-treated bed nets can be an effective income-generating project for the CVAs and CSBs during the remainder of the project.

Malaria Prevention Recommendations

- The TCSP should explore the best alternative approaches for the CVAs to follow the new MoH guidelines that promote the prophylactic use of chloroquine by pregnant women to prevent malaria's effect on their pregnancy.

- The TCSP should work with PSI to maximize the use of the FM radio network in Toamasina to get out the message about the availability of bed-nets, and their importance in protecting against malaria.

- The TCSP should also explore research options with academic institutions both locally and abroad, in order to conduct more formative and operational research regarding the prevention, treatment, perceptions and beliefs regarding malaria, and the frequency of malaria-related morbidity and mortality in remote rural areas of Toamasina's east coast region.

---

[7] This preference appears due to two factors: 1) People are embarrassed for others to see the state of their bed-net during a community treatment campaign; and 2) people fear that the insecticide "tablets" supplied in bed-net kits could be used to intentionally poison someone.

Nutrition Intervention (20%)

The first TCSP Nutrition Advisor resigned due to ill health in early 2000, having accomplished very little in terms of major nutrition interventions prior to that point in time. It has only been since July 2000 that the newly appointed TCSP Nutrition Advisor and the SSD's Nutrition Program Officer have been implementing nutrition interventions at the CSB level and in the surrounding communities.

Nutrition Intervention Activities in General

- During the first half of the project, staff from 19 out of the 28 CSBs in Toamasina II received training, including a component on the six essential actions in nutrition. This training was included as part of their pre-service training on the six essential CSB contacts.[8] The CSB agents have since received supervision visits, but have not yet received training on how to conduct effective nutrition-related supervision in their area. Complementary training by the TCSP is anticipated during an upcoming monthly meeting of the CSB agents.

- A total of six women's groups were trained during the first nine months of project implementation. Women's Groups have been established at a total of 22 sites, (linked to the CSBs) with more than 202 WG members and CSB agents trained in community nutrition approaches.

- The Women's Groups have undertaken a number of tasks, ranging from weighing children, health care education and awareness-raising, to the promotion of vaccinations and the basic principles of good agricultural techniques as applied to growing kitchen-gardens.

- A supplementary intervention has been to introduce a four-day training session in agricultural and kitchen-gardening techniques for three women from each Women's Group. Vegetable seeds have been shared with the trainees during the trial period, and a communal digging hoe was provided for use within each Women's Group. Vegetable seeds distributed so far have included: tomatoes; green leafy vegetables (e.g. cabbages such as pe-tsai, tissam, and *ramirebaka*); green beans; peas, and carrots.

Nutrition Intervention Strengths

- The ADRA TCSP and SEECALINE took the lead roles in establishing a Toamasina region inter-sectoral coordination committee for nutrition (GAINT), with regular monthly meetings.

[8] 1) Antenatal care 2) Delivery 3) Post-natal care 4) Sick baby contact 5) Healthy baby contact 6) Family planning contact.

- The CSB agents are involved in the backstopping of activities for the Women's Groups. Supervisors report that Women's Groups are enthusiastic about the results of their activities. In general, there is a positive spirit of coordination between the CSBs and Women's Groups and their activities.

- There have been excellent levels of motivation among the women's groups, based solely on the participant's personal motivation. Refresher training with group follow-up visits is planned to allow for ongoing support. These meetings will allow women to exchange experiences and will introduce other topics besides health, such as income-generating activities.

- Anecdotal information suggests positive community response. During the MTE visit, the Commune Mayor in Sahambala publicly affirmed his appreciation for the introduction of ADRA in zones where the other NGO's have not been willing to work. He described a clear improvement in the quality of life of the population, notably in regards to hygiene and health care education, which has become evident since the Women's Groups have begun their work. Other commune authorities reported that in a neighboring village, Women's Groups are doing a good work by sensitizing the population to the important health issues. These women are reportedly very dynamic, make many home visits, and hold regular education meetings.

- The CSB agents have also begun to encourage the sale of the national "Child Health Book" notebooks to mothers of families, which can act as a small income-generating project for the agents, but more importantly, gets the key messages out into the households of the project area.

Nutrition Intervention Weaknesses

- The commune authorities said the only "problem" is that the number of Women's Groups does not cover all of the villages. They would like to have more women trained; however, the project has little money for further expansion beyond what was originally anticipated.

- In some of the first sites established, there was overlap with another NGO's activities (e.g., food distribution programs), which at times created a spirit of competition instead of harmony and complementarity between partners working in the region.

Nutrition Intervention Recommendations

- Long-term sustainability strategies for the Women's Groups need to be further evaluated and strengthened in order that motivation can be maintained at high levels in the future.

- In the remainder of the project, the TCSP can either establish new sites or strengthen the activities and practices in the existing ones. If additional supplementary funding can be found, it would seem appropriate to continue to expand, as long as it is within the limits of what can be reasonably supervised by the current nutrition-related staff.

- Greater utilization needs to be made of the radio broadcast networks in Toamasina. The TCSP should subcontract a creative multi-disciplinary person to work on social marketing and promotion of key health and development message via the existing radio network, and continue to work closely with JSI and PSI in developing and refining new materials.

- According to the TCSP baseline survey, more than 30% of mothers give strong (and generally very sweet) home-roasted coffee to their babies less than 6 months of age; this practice commonly continues throughout most of childhood. As far as the project is aware, no local data has been collected on what happens to mothers drinking *significant quantities of coffee while pregnant or breastfeeding. More research needs* to be conducted into the impact of this practice on the nutritional (including dental and mental) development of children and mothers in this region, including impacts on iron and calcium uptake.

a) *Trial of Improved Practices (TIPs)*

The TCSP has introduced the **Trial of Improved Practices (TIPs)** approach to encourage improvements in nutrition on a household level; a brief overview is included below.

This methodology selects sites in conjunction with the community authorities. New sites were prioritized according to the following criteria:

- Difficulty of access
- Lack of (nutrition-related) interventions by other NGOs in the area
- Distance from nearest CSB
- Elevated population density (i.e., a higher percentage of children aged 0-5 yrs)

The selection process begins with the local commune authorities asked to identify 10 women to be members of a new Women's Group, according to some well-defined criteria (e.g., candidate must be literate; one woman per village; willing/able to work as volunteer; a natural leader; sociable). The selected women then meet with the community authorities to confirm their willingness to work in this capacity as volunteers.

The next step consists of a four-day training on exclusive breastfeeding; age-appropriate supplementary foods for breastfeeding infants; techniques of negotiation to be used with mothers; ways to conduct an educational meeting; a direct field practice (at the local market) and the establishment of a structured plan of activities.

Once selected and trained, the volunteers are then introduced to members of the community in order to affirm their new status as health care partners in the commune. The next step is to supervise the activities of the Women' Groups. After training, each member in the Women's Group undertakes at least three home visits per household. The first visit is to observe, discuss, and learn about

the nutritional habits and status of the family, and to identify the potential nutritional problems in that home. A second visit is made to analyze and discuss the findings of the first visit, and to give advice regarding possible alternative changes to try introducing to the family in an effort to improve the eating habits and nutritional status of the family. A third visit is made two weeks later to follow up on the progress in the home as they have tried adopting the new eating habits, and to discuss and hopefully solve any other small nutrition-related problems identified.

Personnel from both the TCSP and the SSD have made follow up supervision visits after the Women's Group volunteers have done at least two visits to the households in their community, then a second supervision visit is made after the Women's Group volunteers have made their third household visits in the community.

TIPS Strengths

- Nutrition promotion takes place as an integrated activity via Women's Groups, CVA's and CSB agents.

- There has been high interest, unaided-promotion and adoption within the target and surrounding communities.

- There are now 22 active Women's Groups in six different communes within the project area. This means about 202 members trained in the concepts of the TIPs approach.

TIPS Weaknesses/Challenges

- Access to the more remote villages is very difficult for SSD and TCSP staff, yet many of the closer and most accessible villages have already been chosen by other organizations.

- There is lack of coordination between NGOs on certain activities, even though there is a regional coordination group for nutrition. Some of the larger NGO or UN programs "bulldoze" over others, leading the TCSP to advocate on behalf of small NGOs in order to negotiate alternative solutions.

- There needs to be a standardization of motivational incentives between NGOs and government partners regarding the community approach. For example, one NGO may pay salaries to all community-based workers, while others expect community-based workers to work as unpaid volunteers.

- Sometimes CVAs give different messages to the community depending on where they have received training. This leads to confusion in areas where agents from two different organizations are working alongside each other.

b) *Breastfeeding Promotion (BP)*

Breastfeeding is already relatively popular within the country; however, some local taboos advise mothers to only breastfeed using one breast, or to discard the colostrum. These beliefs have been countered with explanations and positive encouragements to change behavior accordingly. The main focus within the promotion efforts has been to:

- Reinforce the "breast-fed is best-fed" message.
- Emphasize the importance of the immediate commencement of breastfeeding after birth, and of giving colostrum (often considered locally as "bad" milk, and therefore discarded).
- Promote the importance of exclusive breastfeeding.
- Promote the introduction of nutritious, age-appropriate supplementary foods.

BP Strengths

- Strong liaison and trainings with LINKAGES Madagascar project
- Strong support for BF trainings among women's groups
- Utilization of JSI's counseling cards for promotion of BF and improved weaning practices
- Mothers are quick to adopt the recommended changes in practice

BP Weaknesses

- The government HIS does not collect any data related to the traditional indicators regarding breastfeeding, such as initiation, persistence, and exclusivity of breastfeeding, as well as the introduction of appropriate supplementary foods.
- Use of colostrum is inconsistent across the project area, and needs more research to better understand the diversity of local taboos (*fady*) and beliefs. In general, there is a need for more research data and reports specific to the Toamasina region.
- Many women are not aware of the importance of high nutrient-density weaning foods.

BP Recommendations

- Training of TBAs to help promote key BP messages is planned for a limited number of sites; however, further expansion is needed.
- Mass media campaigns are needed to broadcast key nutritional messages on radio.

- The TCSP needs to research and document incidence of exclusive breastfeeding, initiation and persistence of breastfeeding and introduction of appropriate weaning foods.

- ADRA TCSP needs to publish/disseminate data from Focus Group Studies on local breastfeeding practices and taboos.

c) ***Growth Monitoring (GM)***

The TCSP has been challenged by the difficulty of finding and purchasing high-quality scales in Madagascar for use in the clinics and communities within the project area. At present, very little growth monitoring is taking place in the project areas, except where the CSBs already have weighing scales available

GM Strengths

- The MoH has established a new system to equip and update all CSBs across the country, and will take responsibility for providing all necessary medical and clinical equipment needs, including baby-weighing scales for all CSBs.

GM Weaknesses

- Ongoing absence of project weighing scales for the following reasons: difficulty in locating suitable suppliers with high quality and reasonable price; problems with import taxes on what is supposed to be a duty-free item according to project regulations; the UNICEF policy to not sell scales directly to NGOs within country; low ADRA budget relative to actual cost and freight of Salter weighing scales found, and government changes of policy regarding supply of CSB equipment.

GM Recommendations

- Even though the MoH will eventually supply the CSBs with weighing scales, the TCSP should still purchase Salter baby weighing scales (even if it means going over-budget to do so) as the scales can still be used in the community-level growth monitoring program once the government supplies are received at the CSB level.

- Since Salter baby weighing scales are such an essential tool common to many CS projects around the world, in the future, it would seem more practical and cost-effective if ADRA (and/or USAID) could purchase large quantities of the scales to be resold to their recipient projects, therefore taking advantage of economies of scale (no pun intended!), and avoiding the large amounts of time (and ultimately money) lost trying to locate and procure high-quality scales at a reasonable price.

d) ***Micronutrient Distribution***

The nutrition training provided for the community-based volunteer health promoters has also included key messages about the essential micronutrients of special importance to women and children.

i) ***Vitamin A Promotion***

Vitamin A Strengths

- Successful biannual Vitamin A distribution programs have been supported by the TCSP. Coverage on those days is estimated at 80% or higher.

- Promotion of kitchen gardens rich in Vitamin A foods helps supplement the Vitamin A distribution programs.

- In a new initiative to promote more nutritional diversity and to increase the consumption of Vitamin A in the diet, the TCSP is also promoting the growing of papaya trees within the Women's Group sites. More than 200 papaya trees have been donated from this supplementary project, with trees being distributed amongst the poorest of the communities throughout the target area.

Vitamin A Weaknesses

- There is an absence of research data on Vitamin A deficiency levels in the Toamasina coastal region.

- There is a lack of local research knowledge about what plants contain the most Vitamin A.

Vitamin A Recommendations

- Research is needed to determine Vitamin A deficiency levels in Toamasina; i.e., rates of night-blindness.

- Mobile outreach Vitamin A distribution campaigns should be promoted in remote rural areas, with support from print and radio campaigns.

- Future CS projects need greater integration with a food security programs to address the poverty and dietary deficiency needs of the target population.

ii) *Iodine Promotion*

Iodine Promotion Strengths

- The Malagasy government has implemented a national policy for adding supplementary iodine to all salt produced in Madagascar.
- Promotion of iodized salt is part of the TCSP's community-based integrated nutrition approach, working through Women's Groups, CVAs and Village Health Committees.
- Iodine testing kits are available at the CSBs for testing local salt supplies.

Iodine Promotion Weaknesses

- Many of the poorest people buy only the cheapest forms of rock salt available, most of which is still not iodized in Madagascar.
- Soils in high-rainfall areas are likely to be leached, and resulting vegetables grown in those soils will also be low in iodine. Research is needed to confirm the reality.
- Anecdotal evidence suggests a relatively high incidence of goiter amongst remote rural populations.
- There is a need for greater awareness-raising via posters and radio messages.

Iodine Promotion Recommendations

- Develop awareness-raising message for print and radio regarding iodine deficiency for the Betsimisaraka context and dialect.
- Initiate research to determine prevalence of iodine deficiency in the Toamasina region.

iii) *Iron Distribution*

Iron Distribution Strengths

- Iron promotion is integrated in nutrition and antenatal care (ANC) activities at the CSB level.
- Iron promotion is integrated at the community level through the TIPs activities involving the WGs and CVAs.
- Iron pills are available at CSBs and are routinely given during ANC visits.

Iron Distribution Weaknesses

- There is still a relatively low rate of CSB ANC visits, (anecdotally estimated at about 40% of pregnant women) thus perhaps missing a significant number of pregnant women unless mobile outreach campaigns are used.

- With high levels of poverty, most mothers cannot afford the cost of 180 iron pills to be used in conjunction with her pregnancy.

- The side effects of the iron pills discourage many women from continuing with the full course of treatment.

- Anemia continues to be a major problem in the project area, and deserves greater attention in this and future projects.

Iron Distribution Recommendations

- Need to involve TBAs in the promotion of ANC and to integrate key nutrition messages.

- Research availability of iron-cooking pots to promote as an alternative to aluminum pots.

- Research extent of anemia among rural populations of women and children, as well as previously mentioned topics concerning caffeine consumption and iron uptake.

School and Community Health Education Interventions (25%)

Child-to-Child Activities

The TCSP Child-to-Child approach began with a planning workshop in collaboration with the administrative school district for Toamasina II (CISCO) and the Regional Education Administration Office of Toamasina (DIRESEB). This was followed by a Training of Trainers for the regional education administrative zone directors (i.e., ZAP) and the teacher-training assistants for Toamasina II, in collaboration with the Unité d'Etude et de Recherches Pedagogique (UERP) of Antananarivo. Next, a training for teaching instructors for the upper primary school classes (4^{th}- 6^{th} grades) was held. A teaching "Guide to the Child-to-Child Approach" was developed during this process.

To monitor the CtC activities of the participating teachers, a workshop focused on follow-up and supervision forms was held with special training in supervision for all ZAP directors. Topics covered in the CtC component to-date have included:

a) Vaccination promotion
b) Control of Diarrheal Disease, including cholera
c) STI/HIV/AIDS prevention
d) Nutrition and breastfeeding promotion

The CtC program has also provided the opportunity for the promotion of the successful **VISA 5/5** program approach, described in B-1.3.

CtC Program Strengths

- A total of 113 schools in Toamasina II have been involved with 271 teachers participating in the "Training of Teachers" phase of the program. Eight secondary and 105 primary schools now participate in the CtC program, with an estimated 11,000 school children directly involved. An integrated supervision system has been set up in collaboration with CISCO.

- At the schools visited during the MTE, the teachers trained in the Child-to-Child approach appear to have transmitted their knowledge to their pupils. Most of the pupils of the class knew the meaning of an image on exclusive breastfeeding; almost all students responded to the meaning of the flag system used for the lead-up to the vaccination days; some pupils reported that they had spoken with their parents or in their community about the principles of good hygiene, health care actions and vaccinations. Some knew about the hygiene principles relating to potable water, with most reporting using only well water for drinking.

- Teachers also report an improvement in neatness and in the health of students. Anecdotal reports from several teachers indicate there has been less absenteeism as a result of sickness observed during the previous few months. (Independent verification needed.)

- Schools participating in the Child-to-Child approach have shown an increased awareness of hygiene and sanitation issues, most notably by the clearing of excess plant growth at the school grounds, tidying the grounds and classroom environment, and planting of trees to form a fence around the school boundary.

- The working relationship between the ADRA TCSP and the CISCO is very positive, even though there is no formal Memorandum of Understanding between the two entities.

CtC Program Weaknesses

- Instructors recognize the usefulness of the CtC training approach to increase their knowledge and to help them transmit key messages; however, they report that the technical forms are too condensed and difficult for the trainees to fill in.

- The teachers also report facing reticence on the part of some of the parents. Their awareness campaign has become very arduous since "the value of the things they are teaching has been given a secondary priority in the life of the poorest people."

According to the teachers, more than 90 % of parents respect the teacher's authority and their teachings concerning health care. The remaining 10 % do not do so because of their low level of education and extremely poor socio-economic status.

- There is need for a revision and improvement of the supervision system for the CtC program. Without any follow up monitoring and upgrading training, the knowledge acquired by teachers and students during the initial CtC training is at risk of losing its effectiveness. The most suitable authority for performing the follow up supervision is the CISCO director; however, his workload and other responsibilities have prevented this from becoming a reality. ADRA also needs to review the indicators of success in the CtC program, and focus more on an evaluation of what has already been done, refining and improving it before considering plans for further expansion of the same approach.
- While the SSD is responsible for the health services in the Toamasina II district, the SSD staff has not really been involved in the CtC activities. The former deputy director of technical services participated in the initial CtC training.

CtC Recommendations

- ADRA needs to revise its plans for making the supervision more effective for the Child-to-Child interventions, and for evaluating the true impact of these activities at the community and household levels.

- In order to reinforce the key messages of the CtC campaign, several teachers interviewed at Foulpointe have suggested that ADRA raise awareness amongst the poorer parents by using a mass-media campaign focused on health subjects that support the actions and interventions of the CtC approach.

- The teachers also expressed their desire that the FRAM members (i.e., the Association of Parents of School Students) also receive training in the Child-to-Child approach. Given the positive impact that collaboration with the FRAMs has had on ADRA Moramanga's project, this recommendation merits further consideration.

- Teachers need to be provided with pre-formatted technical sheets and class outlines to facilitate the implementation of the CtC activity, with more information and explanations to help clarify what information is to be collected, and how best to transfer the health care knowledge to others. An operational review to update the forms to contain more relevant information and practical examples has been requested.

- Other NGOs with CtC programs in Madagascar have raised similar questions about impact and sustainability. CARE, CRS and ADRA have discussed the need to analyze the CtC approach in more detail within the Malagasy context and determine how best to maximize the impact of this program.

- When starting a large-scale approach such as this, it is important to start small and then expand as the success is proven. By focusing initial efforts on a limited number

of schools in terms of training, implementation and evaluation of the activity, more attention can be given to reviewing and revising the methodology before it is up-scaled across the entire area.

- ADRA needs to investigate the possibility of moving the CtC program outside of the regular classroom curriculum, and making it an "after-school" club, possibly run with assistance by the FRAM or other motivated school, community or religious leaders.

Training of Community-level Health Committees

To strengthen the focus on training for sustainability, the TCSP is working with two types of health coordination committees that have been established in the rural communities of Toamasina II. The first type of committee is known as **CASC** (*Comité d'Action Sanitaire au niveau des communes*), which is a structure set up in each commune according to government policy.

The role of the CASC is primarily one of overall coordination of the health activities in each commune. The CASC receives directives from the government, (such as a Ministry of Health request for all communes to take measures to protect their community against a cholera epidemic), and are expected to pass on the key messages to all in their commune. The CASC members include important commune authorities such as the mayors and the commune counselors, and the decisions made at the CASC level are to be carried out across the commune.

The next level of formal committee is known as the **COSAN** (*Comité d'Action Sanitaire au niveau de fokontany*). The jurisdiction of the COSAN is limited to just the *fokontany*, (an administrative district covering several villages, but not as large as a commune). Consequently, the COSAN functions more in the role of a "policeman" to inform and check on the villages under its control. This committee reports and responds directly to the requests and recommendations of the CASC concerning actions to be taken in their *fokontany*. So, for example, in the case of a cholera epidemic, it would be the CASC that first sends out the directive to all local authorities asking them to clean up the environment around their house, and telling people to use latrines. It would then be the COSAN members that would go from house to house to inform, to check up, and to encourage village members to see that the SASC directives and requests are being followed properly. The COSAN does not usually stand up in front of their community to give general health promotion lectures or to make home counseling visits to share preventative education, (although in certain emergency circumstances this may be required). Usually their role is one of informing when there are specific health problems, and then checking to see that people follow up as requested by the government and local commune authorities.

By virtue of their role as community health educators, all CVAs are automatically included as members of the local COSAN groups.

Activities

So far, the TCSP has conducted the following training programs at the level of the community authorities:

Training for 15 CASC groups from 15 communes. A three-day training has focused on IEC methods for behavior change, followed by a five day training to cover the Participatory Rural Appraisal (PRA) methods, to assist in the community-development work of these structures.

The CASC groups, in turn, have been responsible for then training the COSAN groups under their charge.

Recommendations
Like in Ampasimbe Onibe, the TCSP should encourage the local CASC's to prioritize the construction of simple guest quarters near to each CSB that could be used by caretakers staying to look after patients at the CSB, or that could also be used by women waiting to deliver at the CSB.

B-3. Achievement of Preferred Futures

The SSD's preferred futures were developed by the SSD/ADRA teams at the time of the initial DIP workshop as part of the Appreciative Inquiry approach. They were chosen by the teams to reflect the most important programmatic issues faced at that time. During the MTE, the TCSP and SSD personnel were asked to rate the achievement to-date of the Preferred Futures developed at the commencement of the project. The results of these staff perceptions are summarized in Appendix F-5.

With a new team of doctors in the CSB2s, it would be worthwhile for ADRA to repeat the Appreciative Inquiry approach with the enlarged EMAD in order to identify any other issues important for shaping the remainder of the project.

Progress towards Benchmarks or Intermediate Objectives

Since specific comments have been made under each intervention, this section relates mainly to the SSD capacity-building efforts. Initially the project started out with a goal of about 90% capacity-building for the SSD, with few direct interventions by ADRA. However, as the project has tried to adapt to challenging circumstances and needs, the project components now include about 70% capacity-building for the SSD, with 30% direct community-based interventions led by ADRA. The TCSP's direct interventions are mainly in the area of the malaria prevention activities (since the SSD still does not have a Program Officer for malaria) and in the community mobilization activities.

There is a great degree of integration and collaboration with the SSD in dealing with the community-based volunteer groups, mainly because ADRA's focus is on sustainability, empowering the SSD to continue with these activities and interventions under their own control once the project is finished. The main reason ADRA took the lead in getting the direct interventions started was because there was either a lack of personnel or training, or little initiative or motivation to start such interventions in the target area prior to this. Alternatively, where there were special needs, such as critically low immunization rates, then direct interventions (such as the **VISA 5/5** program) have been implemented to address those priorities.

(N.B.: Sections B-1.2.iii-vi refers only to details **not** previously covered under each specific intervention.)

Effectiveness of the Interventions

In general, the one consistent comment about the TCSP has been that while interventions may appear to be successful, nevertheless, the project needs to develop a more effective monitoring and evaluation system with which to document the changes and impact of the activities conducted thus far.

With the project delayed at start up for reasons outside ADRA's control, the TCSP has since been operating at increased speed for many interventions. It is now the time in the life of the project to evaluate the methods used to date, and to determine how these can best be refined and re-tooled in order to leave the SSD with effective and sustainable programs that can continue long after the end of the TCSP.

Changes to DIP and Rationale

Changes in Training and Capacity-Building Approaches

The most significant change in technical approach was in regard to the capacity-building interventions for the SSD. In early 1999, a suspected cholera death was reported in the northwest of Madagascar, reportedly caused because the chief medical officer was away at the time the patient arrived at the clinic. Consequently, the MoH sent out a mandate that in effect stopped all formal training programs for government CSB personnel by prohibiting any chief medical officer from leaving their post of duty other than by government command. For 12 months, the international NGO community has been waiting and hoping that there would be a change of policy, but in the absence of such change, adaptations have been made in the program design.

The original DIP was designed to bring in all the CSB agents for up to one week a month for upgrading training at the district administrative offices in Tamatave. Because of the change in government policy, the emphasis has changed to field-based upgrading training and supervision visits. This has slowed down the program implementation significantly because of the major challenge of having to do one-on-one training, and having to physically get out to remote CSBs. Programmatically, it is much less time and cost effective to visit 30 people in remote field sites, as opposed to bringing everyone in for a combined training.

In order to reach a workable compromise, the TCSP has negotiated with the DIRDS and SSD to add an extra day (or two) of training to the time when the CSB staff come to Tamatave each month to pick up their salaries, medical supplies, and to give their monthly activity reports. This has become the standard approach during the past project year. In addition, following discussions between the NGO community and the MoH, a series of "guided self-learning modules" (known in French as "AAA") were developed at the national level.

Changes in Personnel

The original DIP emphasis was on numerous upgrading trainings for the CSB agents, all of whom are nurses or paramedical staff. Apart from the former District Medical Officer and her assistant, there were no doctors in the district at the start of the project (except for two doctors in the private medical system). After a government recruitment drive to put more doctors into remote areas, there are now 12 doctors employed within the district's 28 CSBs. This change means that there are now medical doctors (with higher qualifications) being supervised by paramedical staff, a situation that is causing conflict as the field-based physicians either refuse or feel embarrassed to be supervised by the less-qualified paramedical staff. In response to this change, the project has suggested integrating these 12 doctors into the enlarged EMAD (district management team) and there are plans to involve these CSB2 doctors in the integrated supervision visits being made to the CSB1 clinics from month to month. Consequently, their role will become more supportive of those who are not doctors, yet are working alone at the remaining CSB1s across the district.

There have been also changes in the key administrative personnel in the SSD over the past year. This has meant significant changes in administrative styles and approaches, moving from a more autocratic top-down approach, to a more democratic and participatory approach under the new staff. With the new change of leadership, there is already a different level of accountability and transparency, with a willingness to work as partners in problem solving and planning for a more effective district health team.

Changes in Appreciative Inquiry Approach

The project planning and DIP phases began with a strong emphasis on the innovative Appreciative Inquiry approach to program planning, in which the focus is not on the "negatives" and "problems" within an organization, but on the "positives" and "strengths" of what the organization does best. The model is excellent in theory; however, making it sustainable in practice has proved challenging within the project environment. The number, extent and complexity of problems faced on a daily basis forced staff to confront crises as they arose, defaulting to the more familiar "problem-solving approach" which is the most time-efficient way of dealing with the problems. Often the staff could not just "ignore" the immediate problems until a more positive and proven approach could be applied. A crisis demands immediate response, as in the case of a cholera epidemic or cyclone.

Up until now, the project has tried to help the SSD deal with the most cost and time effective responses to the crises as they have arisen, which has often meant that the appreciative inquiry approach has been relegated to the back burner. However, now that the project is in the final phase of implementation, it is a more appropriate time to ask the SSD and TCSP staff to plan for integration of the Appreciative Inquiry and Quality Assurance approaches, with a focus on what has been done best, and reflection on why these approaches have been more effective than other interventions.

Changes in STI/HIV/AIDS Prevention Approach

The STI/HIV/AIDS intervention has faced numerous delays while waiting for government and donor politics, strategies and approaches to be defined. ADRA had hoped to use the smaller amount of funds already designated for the TCSP's STI/HIVAIDS component to leverage more funding to begin a supplementary STI/HIV/AIDS prevention project in the year 2000. The initial plans were put on hold as first the government, and then the donor community asked ADRA to wait while they defined their national AIDS strategic plans for Madagascar. During these delays, several promising funding opportunities came and went.

In response to the changing needs, a multi-sectoral coordination and capacity-building project was then developed with plans to commence in the final quarter of 2000; however, the DIRDS authorities then recommended waiting until the new Autonomous Province was established before launching the project. In fact, the DIRDS was not even sure they would exist in the same form once the new Autonomous Province was established, so the project was delayed again until early 2001. However, the commencement of the Autonomous Province, originally scheduled for early in 2001, was then postponed several more times, and did not become reality until June 2001, finally clearing the way for the multi-sectoral coordination project to commence. By then the donor funding windows had closed, leaving ADRA to begin seeking new funding sources once again.

In retrospect, it would have been better if ADRA had begun with its own smaller AIDS project targeting the Toamasina II SSD. Given the continued slow progress now that the Autonomous Province is in place, ADRA has decided to commence with the internal AIDS project focused on Toamasina II, and will seek additional funding under a separate proposal for the multi-sectoral regional AIDS coordination project.

Analysis of TCSP Program Constraints

ADMINISTRATIVE CONSTRAINTS

Bureaucratic delays: The main problem in project start-up was the delay in waiting for the MOU to be accepted and signed within the different levels of the MoH. The formal agreement was finally signed at the MoH and then countersigned by the SSD late in June 1999. This long delay meant that project activities only commenced officially in the final quarter of the first project year. Understandably, the SSD staff were reluctant to get involved until the MOU was signed. ***Project Action:*** TCSP personnel worked informally to build relations, hold meetings with the SSD, provide limited technical assistance and/or implement preliminary activities until the formal agreement was made.

Building trust in relationships takes time: During the time ADRA was waiting for the MOU to be signed by the MoH, relations with the SSD were somewhat "cool" as the SSD did not fully understand what the project was there for nor what they would do. TCSP personnel were initially perceived as being in "competition" rather than in "collaboration." ***Project Action:*** Once the MOU was signed, the SSD and ADRA began to formally work together, allowing more discussions and greater understanding of the project. The relationships have strengthened to the

point where there is now a high level of respect and trust between the SSD and ADRA. It is evident that the SSD feels very open and comfortable sharing and planning together with ADRA, knowing that this is truly a collaborative partnership that is seeking their best interests.

Absence of administrative leadership: During much of the first two project years, the SSD Chief Medical Officer was away from her office in Toamasina every second month to complete MPH studies in Antananarivo. During this time, the administrative decision-making was affected at the SSD level, especially for important decisions such as staff mobilization, training, future directions, or areas of change within the SSD. ***Project Action:*** Strong working relations were built with both the Chief Medical Officer and her deputy, with full and open communications between them and TCSP personnel in order to maintain support, keep everyone informed of changes and progress, and to facilitate decision-making processes.

Administrative leaderships styles: The SSD has had a very strong autocratic leadership style in recent years, with very few important management decisions made by program officers; i.e., when the CMO was in the office, things moved, but when she was gone, many decision were put on hold. Tensions were evident amongst the SSD staff early in the project as staff wanted to bring about a change of management styles and more open communication, but this change of approach in administration style was threatening to the CMO. ***Project Action:*** Fortunately, this problem has since been resolved because the senior administrators for the Toamasina II SSD have been changed. There is now a much more open, transparent, and participatory approach to management within the SSD, leading to more efficient SSD staff.

Governmental constraints: As explained earlier, in February 2000 the MoH issued a formal declaration forbidding formal trainings of CSB agents across the country. Consequently, the majority of formal training activities scheduled for fiscal year 1999-2000 were cancelled or postponed. Many of the newly appointed CSB physicians reported feeling very stressed during this time because of their role as newly appointed CSB2 Medical Officers, yet not being oriented to their new roles in different locations. Meeting for just one-day a month was not sufficient to provide these health personnel the orientation and capacity strengthening they felt they needed at this time. ***Project Action:*** The TCSP scheduled a training course specifically for the new CSB2 Medical Officers, during which a more general orientation was given to enable them to function more effectively in their new work environment.

External factors: Although the project activities have been incorporated into the SSD annual work plan, the implementation of activities could not always take place as planned. Because of unforeseeable crises, the priorities sent out in directives from the MoH would cause a change of schedules; project activities were often delayed or even cancelled. This was not caused by any unwillingness on the part of the district health team, but reflected the changing priorities of the MoH. ***Project Action:*** The project has tried to be as flexible and adaptable as possible, and has had to make major schedule changes on numerous occasions. Where important intervention activities have been repeatedly postponed, delayed, or on occasion, cancelled, ADRA has taken the initiative to implement revised activities (sometimes more independently) so that things can still move ahead, and the priority targets and achievements can be met.

TECHNICAL CONSTRAINTS

DIP conceptualization problems: The first DIP workshop was in February 1999; however, inter-personal problems between the two external consultants resulted in a document that needed considerable work, resulting in a second review of the DIP in June 1999. This process identified the need for more planning and preparation time to clarify the program focus, and for management training with the SSD in order to have the project begin on a more solid foundation. Also, the Chief Medical Officer was unable to attend many of the most critical DIP planning meetings in February, and in her absence, many of the SSD personnel present seemed reticent to think and plan for themselves. ***Project Action:*** The second revision of the DIP further delayed the full implementation of the project, but enabled it to be a stronger program, targeted at the priority needs identified at that time.

Few qualified local staff: The project experienced considerable difficulty finding suitably-qualified Betsimisaraka staff for the project. In fact, more than half of the technical staff were not found and recruited until July 1999. To make the partnership-building and community-based approaches more efficient, the project wanted to recruit only local staff from the Toamasina area. This has been an ongoing challenge, as there are so few local personnel with the professional qualifications needed for working as advisors and mentors. ***Project Action:*** The project has eventually employed a mixture of both local staff and personnel originally from the High Plateau, preferring those who have previously lived and worked extensively in the region, and have a working knowledge of the local dialect, culture, beliefs and practices.

HIS Constraints: A major constraint regarding the collection of data for the HIS is the accuracy of the demographics data available. Until last year, the official population of Toamasina II district was reported to be approximately 168,000 people, based on the last population census (conducted in 1993), and assuming a population growth rate of 2.9% per annum. Last year, a new figure was reported with an estimated 185,000 people, based on the same 2.9% p.a. increase, but using the population figures for 1998. As this number was calculated for local election purposes, the tendency to inflate numbers was high, so the project has continued to use the original estimates based on the 1993 official census. In this current election year, the commune authorities have produced another set of *new* population figures for the district, reporting an estimated population of approximately 214,000 people based on a commune census made in April 2001. As the national census is not due until next year, there is much confusion over how accurate these latest figures are, and whether it or a reliable estimate to use for setting health-related achievement goals. Given that there is a 27% difference between the lowest and highest population estimates, this can have a significant impact on the estimated and actual coverage rates calculated for health interventions such as vaccination or contraceptive prevalence rates. ***Project Action:*** The TCSP has compared the situation in other USAID partner projects, and it seems this problem is widespread around the country. Most suggest there is little that can be done to completely rectify the situation until the next census, hopefully in 2002 or 2003. Meanwhile, the TCSP has revised and approximated the data according to the best baseline and census data available, although considerable work still remains to make sense of HIS data in a number of CSBs where the reported population fluctuates significantly from year to year.

Vertical vs. Horizontal Integration: Within the SSD, some of the areas of project intervention (e.g., malaria prevention) do not have any person in charge with whom ADRA can work as a

counterpart. Additionally, although officially the government health care services are meant to be moving towards a more integrated approach, in reality, this will take time. At present the SSD is still largely following a structured system of vertical programs (EPI, CDD, FP, IMCI, etc), with a more bureaucratic (top-down) decision making system in place. ***Project Action:*** Because the SSD staff lack opportunities to demonstrate their creativity and initiative in all aspects of planning, management and organization, this is something on which the TCSP will focus during the practical, competency-based trainings in the remainder of the project.

COMMUNITY CONSTRAINTS

Poverty: As indicated elsewhere in this document, the message is clear and consistent that poverty is one of the most devastating constraints impacting the progress of the project at the community level. With more than 70% of Madagascar's population estimated to live below the poverty line of US$1 per person per day, even if the health services are available with motivated, well-trained staff, it is meaningless if people are still too poor to access the available services. ***Project Action:*** The project is planning to introduce a pilot program to determine the most workable model for a community-based health insurance program. A separate project proposal is also being developed for the region, to target more of these poverty issues. Future projects need to also look at incorporating food and income-generating components.

FINANCIAL CONSTRAINTS

Per Diems: As the project interventions are mainly focused on training, the per diem issues were a common theme raised among the trainers (from the SSD or other departments or organizations) and the trainees (SSD staff, CSB agents). The concept of per diem is largely misunderstood because attending trainings, or working with past (International Organization's) projects has commonly been associated with receiving large amounts of money, whereas this project is rather tight in terms of money available for training per diems. ***Project Action:*** Considerable time and effort has been expended on discussing this issue with the SSD and CSB personnel, so that they understand this project is different to the large-budget trainings of other organizations. A recent meeting with SSD and project personnel has established a new standard, which seems acceptable to all.

CSB Rehabilitation: In keeping with USAID policies, it is not possible for this project to construct or rehabilitate any clinics, even though this is a major problem faced by the SSD, as some buildings are literally falling down wooden shacks with rusted out roofs. (See Appendix F-1 for photos). ***Project Action:*** The TCSP plans to help the SSD locate other funding sources for the construction of new clinics, and the renovation of many of the older ones, as well as help to locate small essential equipment.

LOGISTICAL CONSTRAINTS

Resistance to new logistical policies: The SSD partners were initially quite reluctant to respect the introduction of (what was considered) the "heavy" new logistics requirements such as formal requests, paperwork, procedures and operating protocols. ***Project Action:*** Communication about the reasons behind such requests, and discussions about what type of requests were "acceptable" (e.g. competency-based trainings) and which were "unacceptable" (e.g. consumable supplies,

building construction, etc) in terms of the project, have helped increase the understanding of the need for such protocols. In the two years since then, the system now seems to be working more efficiently as the SSD has learned how to plan and schedule its own needs ahead of time, rather than just acting in response to the latest crisis when it occurs.

Transport challenges: When all the project activities are taking place concurrently, the available logistics are inadequate, especially in terms of transport, as there is only one 4WD pickup. Even though motorcycles are available, in some cases they are more hazardous than useful, as the red-clay mountain roads are so rocky and slick after rains. ***Project Action:*** As the project activities are integrated with the SSD activities, in some cases the SSD vehicle is also used on these joint activities. Also, the team tries to coordinate activities taking place in the same geographic area. On some occasions, renting another vehicle is the only alternative that remains, although costs for casual hire like that are very expensive.

Medical equipment: The project has budgeted to provide the health centers with some small, basic medical equipment, and some has already been donated or purchased and given to the CSBs. However, the prices have been considerably higher than expected (or the quality so much lower) for some items such as the Salter-type baby-weighing scales, and quality surgical or obstetric medical instruments.
Project Action: Consequently, the project has decided to search through international suppliers and direct warehouses for UNICEF, although freight costs will be higher, and the whole procedures will take much longer time complete.

GEOGRAPHICAL CONSTRAINTS

***Reaching the unreached*:** The project has chosen to strive to reach more effectively the accessible sites, and continues to seek solutions for improving access and services in the most inaccessible sites. The physical movement of the slash and burn "tavy" farmers in the inaccessible zones makes it difficult to plan for health care services in a permanent CSB building. It has also been noted that mobile outreach projects impacting on the health of the community are needed in these zones.
***Project Action*:** To avoid any potential conflicts between the activities of different NGOs in the most accessible zones, and to make the most effective and efficient use of time for supervision visits, the ADRA CS Project has focused largely on the zones of average accessibility which have not been involved in any other projects.

Follow-up and Next Steps

The evaluation team recommends a follow-on Child Survival Project be developed for submission to USAID as a cost extension in December 2001. On a number of different occasions over the past year, the USAID Madagascar Mission has expressed their encouragement and support for submitting a cost extension follow-on proposal.

It is anticipated that the follow-on document will also facilitate a greater integration between ADRA's Title II monetization project in the Moramanga region of Toamasina Province, and the more traditional CS project interventions. The extreme poverty affecting the Toamasina II target

region is a major reason for developing a more integrated project for the future. This would allow a greater emphasis on the development of basic infrastructure such as access roads, CSB and equipment upgrading or rehabilitation, improved agriculture techniques and the supply of water and sanitation systems to the schools, clinics and larger communities within the target area.

B-4. Supplementary Project Components and Successes

VISA 5/5 Program

This component has been a very successful school/ community-based immunization promotion campaign conceived since the DIP. Within the space of just a few short months, the immunization rates in several low-coverage areas have improved dramatically, with excellent success in those areas where the program has been implemented in conjunction with immunization promotion by the CVAs and CSBs. The VISA 5/5 project is based on the principles of:

***V**accination*	Children first learn about the importance of vaccinating the target population.
***I**dentification*	Children are encouraged to seek other younger children not fully immunized
***S**ensitization*	(awareness raising) among the caretakers of the at-risk population
***A**ccompany*	The mother brings her child to the health center for vaccinations and reminds her of the next vaccination date for her children.
5/5	*Five out of five contacts* for the main childhood immunizations (i.e. all six vaccines) must be completed before the vaccination diploma is given to the parents of the immunized child. For each child under one completely immunized in this program, the referring school child is given a small reward pack consisting of a ruler, pencil, pen, eraser and sharpener. For those school children motivated enough to bring five or more children to the CSB for vaccinations, the child also receives a special VISA 5/5 certificate at the end of the promotion campaign.

VISA 5/5 Strengths

- The VISA 5/5 program is now active in 18 targeted priority schools.
- Normally NGOs try to motivate clinic health staff and volunteer health promoters to go out and find non-immunized children. With VISA 5/5, the health worker stays at the clinic, while school children (eager and motivated to gain a small reward) become "case-finders" to help raise the immunization rates in low-coverage areas.
- An added benefit is that the child's "reward" is directly applicable to their schoolwork, hopefully having a synergistic effect.

VISA 5/5 Weaknesses

- The program has only been used in a relatively small target area thus far, and needs to be quickly up-scaled into all the priority lowest-coverage areas that remain.

- The sustainability of this intervention depends on the ongoing provision of "rewards" which are presently paid for by the TCSP.

VISA 5/5 Recommendations

- More detailed evaluation is needed to evaluate the effectiveness of the approach in the targeted areas where it has already been used.

- The TCSP needs to investigate other alternative sources of local and/or international corporate sponsorship to keep the program sustainable.

ADRA/JSI "Health Education for Life Project" (HELP)

This project was made possible by private funds that were donated to ADRA International and earmarked for interventions targeting women and children in Madagascar. A total of US$35,000 of ADRA's money was matched by $35,000 of JSI's money in this joint HELP project. The project has been designed to:

- Add a Family Planning component to the TCSP program, with the establishment of at least nine new FP sites at the CSB level, and the training of a network of ASBCs to work as volunteer community-based promoters and distributors of FP services.

- Add nutrition and more traditional Child Survival components to the Moramanga Food Security project.
- Strengthen the Family Planning component of ADRA's Food Security project in Moramanga

- Provide a full complement of the JSI IEC resource materials for use in ADRA's CS and FS programs.

- Provide technical assistance from the JSI programs to strengthen the ADRA programs in their startup phase.

- Increase the STI/HIV/AIDS prevention interventions in the Toamasina II district.

This supplementary project activity has been given widespread support at the community and SSD levels, as there appears to be considerable unmet demand for FP services.[9] As of June 2001, there were 915 regular FP users reported in the monthly activity reports from the CSBs of Toamasina II. District. A large part of the problem in the past has been related to access, as there have only been four CSBs within the target area that provided family planning services, with only limited promotion taking place. All of these four previous sites were part of the

[9] In ADRA Moramanga's baseline survey, 80% of household respondents said they do not want any more children in the next three years, however only 8% are using any form of modern contraceptive methods.

Bamako initiative, and therefore had the benefit of regular equipment and supplies being available through UNICEF according to the CSB's request.

ADRA "Tamatave Assistance to Primary Schools" (TAPS)

- A small US$16,000 project is being implemented in conjunction with funding from ADRA Australia, and involves the provision of a basic water pump at 20 primary schools in the Toamasina II district. Gravity-fed water supply systems will also be supplied in an additional five communities.

- The project was initiated to address the absence of water sources at schools within the region, and in response to the cholera outbreaks after the cyclones of 2000.

- It is anticipated that a larger **WA**ter/ **S**anitation / **H**ygiene (**WASH**) project will be funded in the future to further address the priority problem of water access in Toamasina II.

C. Evaluation Of Cross-Cutting Approaches

C-1. Cost Recovery System Strengthening

The responsibility for strengthening of the cost recovery system has been largely under the guidance of the TCSP Management Advisor, with technical support from the Project Director and the DIRDS.

Strengths

- The cost recovery system is now operational in all 28 functional CSBs in Toamasina II district.

- Training of the COGEs on how to manage the cost recovery system more effectively, has been implemented in conjunction with DIRDS.

Weaknesses

- The new government cost recovery system is still not accepted by, nor providing coverage for, many of the poorest villagers. Consequently, physicians end up prescribing less than the best medicine, or patients only buy less than the optimal treatment dosage. In one locality, the physician reported that if he did not prescribe the cheaper or "less than best" medicines, more than 75 % of his patients would not be able to pay.

- To solve the problem, some communes have decided to pay for the poorest people in their community (as long as they are on the commune list of most impoverished). Other communes have refused any and all financial involvement with their CSB management committee, even though this is a requirement stipulated by the MoH.

On average, about 20% of the target population are too poor to pay for their medical care. In the more remote areas, this percentage rises to around 80%[10].

Recommendations

- The limited ability of the poorest people to pay for their health care services, particularly in the most remote rural populations, requires further study during the remainder of the project.

- The TCSP needs to investigate options for implementing a community health insurance fund or community credit program for health care services in the future. The TCSP is beginning a pilot project in Ampasimadinika village (with the assistance of a Peace Corps Volunteer) to see if an effective rural village credit scheme can be developed that will be suitable for use in this part of Madagascar, where disposable incomes are so low. The pilot project is scheduled to commence in October 2001, and should be expanded if proven successful.

C-2. Community Mobilization Activities

Most of the interventions in the TCSP have been designed as cross-cutting approaches given the integrated nature of the project. The **IMCI**, **nutrition**, and **malaria** interventions, as well as the community-based health promotion activities such as the **Child-to-Child** program, are all considered cross-cutting approaches. Since each of these has already been discussed in detail in Section B-1.2, this section will only review the remaining cross-cutting components.

Activity #1: CVA Training

The *Cellule Villageois d'Animation* (CVA) is defined as a group of three volunteer community health animators (typically two women and one man) working in collaboration with the commune authorities and under the direct supervision of the CSB agents for the promotion of key health messages on a household and community level.

CVA Program Strengths

- A total of 47 CVA groups have been established to date, with 141 CVA personnel having received training.

- CVA trainings have focused on how to make effective home visits and to conduct role plays. Topics taught to-date include understanding of basic communication techniques, nutrition, CDD, malaria, acute respiratory infections, malnutrition, vaccinations and STI /HIV/AIDS.

- CVAs sensitize the villagers regarding common health problems and contribute to the increased utilization of services at the CSBs. CVAs also search for and locate people who have not shown up at the time of vaccination campaigns.

[10] See appendix F-4 for a graph indicating estimated ability to pay for services at CSBs.

- A sample of community representatives interviewed by the evaluation team said they approve of the health care actions undertaken by the CVAs. They have noticed a significant improvement in the general hygiene levels of their villages and housing areas. The also said the CVAs have raised awareness among their communities, sensitizing them regarding health-related topics.

CVA Program Weaknesses

- In some places, the level of education of CVAs has limited the expansion of activities. The early selection criteria did not specify a minimum level of education, only stipulating that agents should be literate. Not surprisingly, the monthly reports sent by some CVA agents reflects gaps consistent with their level of education. This problem has since been corrected.

- Apart from ADRA, several other organizations in the region work with community mobilizers; e.g., CRS, CARE, UNICEF, ASOS, and SEECALINE. These organizations have chosen interventions in the more easily accessible zones and have their own working styles. There has sometimes been confusion at the community level regarding the different roles and responsibilities of each organization; e.g., when one organization begins working inside the zone of intervention of another within the same target population.

- In some of the early sites, organizations "competed" for villagers to get involved with their programs through donations of food, clothes or money as motivational incentives. This has the effect of destroying the volunteer spirit amongst those who are currently working purely on a volunteer basis for ADRA.

- The high rate of staff absenteeism is still a problem at some CSBs, making coordination between CVAs and CSBs a challenge. In the absence of the primary service provider, the CSB is basically closed down until the health care worker returns.

CVA Program Recommendations

- New means of motivation should be found for CVAs in their work, such as: 1) agriculture training, a successful initiative already tried with WGs; 2) provision of work-related equipment such as a raincoat, rain boots, carry-all, bicycle, etc.; 3) ensuring regular supervision visits; 4) integrating CVAs into other community health activities; 5) giving diplomas or personal photos; 6) recognizing the value of their work during village festivals or ceremonies; and/or 7) organizing forms of micro-credit to enhance their income;

- Upgrading and refresher trainings will be important to avoid the problem of loss of quality of messages taught by the CVAs. The impact of CVA IEC campaigns on the number of CSB visits needs to be a topic of further study.

- Situations such as immunization days, when many villagers come to the CSBs for consultations, are an ideal time for the CVAs to give patient education and IEC demonstrations to this captive audience of women and children.

- The TCSP needs to review the community mobilization approach with a view to consolidating the different types of volunteer groups into one group of multi-disciplinary community-health educators/animators.

- The TCSP will need to look closely at the effectiveness of the community-based structures, and determine the most cost effective approach for maximizing sustainability. Already the supervision of activities of CVAs is not as regular as planned, largely due to a lack of resources and personnel at the SSD level. In general, CSB agents should be more involved in the training and supervision of CVA activities.

Activity #2: IEC Activities

IEC Program Strengths

- Rather than "reinvent the wheel", the TCSP has incorporated the IEC resources developed by JSI into program outreach. Resources used have included: counseling cards; a variety of informative "gazette" magazines; vaccination day flags; promotional banners for the AVA vaccination day, the local vaccination days, and the regional nutrition days (e.g., NAC day, National Iodine Deficiency Disorder day, etc.); cholera prevention/control posters and leaflets; spot messages and broadcasts for use on local radio stations (Voanio, Lakana Tsara Voy, Ravinala Foulpointe) with topics including: Nutrition, CDD, Vaccination and Micronutrient deficiency.

- The use of "one-on-one" counseling is an important component of the community-based interventions. It is the most efficient mode of communication for behavior change, especially given the isolation and poverty of the target population.

- Numerous songs and role-plays have been developed by the community animators and school pupils to help spread the key prevention messages for improving health.

- Partnerships with animators or ASBCs trained in other projects (such as SEECALINE, UNICEF, UNFPA, etc.) have enabled the project to participate in other behavior change communication activities.

IEC Program Weaknesses

- Many IEC resources still need to be adapted or "re-worked" specifically for the Betsimisaraka dialect and cultural context.

IEC Program Recommendations

- Now that the TCSP and SSD have developed a good working relationship with radio station *Voanio*, many of the IEC radio resources should be specifically adapted for the local context using the Betsimisaraka dialect.

- The IEC components need a better system of supervision, monitoring and evaluation of impact (such as regular LQAS or KPC investigations by theme and by sector).

- During the remaining phase of the project, the TCSP should endeavor to strengthen and streamline the roles of the CASC and COSAN committees, enabling them to be more effective and active in promoting and supporting community health interventions.

- Develop or adapt the most useful IEC resources specific to the Betsimisaraka dialect and cultural context.

a) ***To what extent has the community responded to the Community Mobilization activities?***

As indicated elsewhere, the community response over the past year has been overwhelmingly positive in support for the community mobilization activities. Around the world, ADRA excels at implementing integrated community-based development programs. As the program mix has been changed in this project to a more direct involvement with a community-based approach, the results have been significant in all of the priority interventions.

b) ***How have these activities been used to refine program implementation plans?***

The training and supervision of the community-based groups has enabled the project to learn more specifically about the cultural context, beliefs and taboos that influence mothers to either reject or adopt behavior changes at the household level.

The experience of the Women's Groups in using the TIPs approach in the field will also form the basis for modifying the future of the nutrition intervention in this project. The most frequently adopted methods and approaches under the TIPs program could become the key messages and approaches selected for promotion in the next project, without having to use the more time, labor and cost-intensive TIPs approach.

Feedback during the training of the CASCs and COGEs has also helped to better understand the needs remaining to be addressed in implementing the cost recovery system, and in streamlining management procedures.

c) ***What kind of barriers exist to prevent members of the community from benefiting from the program, and how have these been addressed?***

Personnel: One of the biggest barriers noted thus far can be the personality of the community leaders and the CSB personnel. Where there is a positive, outgoing, likeable personality in leadership, strong, productive relationships are quickly built, and effective interventions are the result in those communities. On the other hand, where there are health agents or commune authorities that are non-communicative, fiercely independent, corrupt, or disagreeable, then relationships

are difficult to build and there is little motivation for progress, leaving the surrounding communities to suffer. ***Recommendation:*** The TCSP should strengthen the SSD-CSB-Commune communication links, and give training to the CSB personnel regarding the critical importance of their role in building interpersonal relationships with the SSD and commune authorities.

Poverty and Poor Accessibility: As stated earlier, poverty is a major factor underlying almost all aspects of the health and development components in this project, from the household to the SSD-level. In addition, the challenging geographic environment in this project makes physical access to the most remote areas a nightmare. A woman needing a C-section or someone with major trauma or cerebral malaria, is more likely to die before reaching a larger health clinic. ***Recommendation:*** Any future projects should look carefully at the priority infrastructure and medical equipment needs so that some of the most pressing needs can be addressed as quickly as possible. Establishment of a village health insurance scheme should also be a priority for assistance at the household level, particularly with emergency transport. CASCs should continue to be empowered and encouraged to construct maternity waiting homes at their local CSB.

d) ***What impact do factors such as security, politics, roads, mass media, theatres group issues, etc., have on program implementation?***

Roads: Previous sections underscore the impact of poor or nonexistent roads and the lack of basic trails suitable for bikes or motorcycles. Even the roads that exist are challenging, especially in the wet seasons, when it can take up to 90 minutes to drive just 9 km on mountain routes.

Security: Fortunately, the security in this target district seems reasonable. The absence of political activities in the first few years has also meant relative stability for the project and for the communities where the project is working. With 2001 a national election year, the lead-up to the election on December 16, 2001 has the potential for conflict around the country. The project plans to stop field activities during the three weeks of election campaigning, in order to avoid having community-based events commandeered by political figures trying to gain political points from being associated with program interventions doing good for the benefit of the communities.

Mass Media: In mid-2001, during field trips to some of the most remote rural areas, the TCSP personnel learned that even in the most isolated communities, villagers' radios can pick up the local Tamatave FM radio station. This was a pleasant surprise, as previously it was thought that only short-wave radio would be able to gain access to those areas. Knowing that many of the poor people living in remote mountainous areas regularly listen to the Tamatave FM radio stations each morning and night is an important reason to include the mass-media communications as a major target. Consequently, the remainder of the project will focus a significant portion of the IEC promotion onto greater utilization of this effective means of mass communication. Not only is this a more cost-

effective approach to health promotion, but it is also a more efficient use of time and personnel.

Theatre: Theatre is all but gone in this region, although videos are still an effective replacement for this entertainment medium. Although many people do not own TVs, they are still willing to pay to watch a movie at one of the local video clubs. This is a means of communication that can be used to target a rather specific socio-economic segment of the population not reached by other means.

Group Issues and Health Credit: Community bonds, accountability and group issues are important considerations when setting up a community-health credit scheme or a small-income generation scheme. In the exchange visit to Toliary to visit MCDI's sister Child Survival project, it was noted that the village credit scheme had worked effectively for three years without any defaults on payment, largely because people in that region were considered relatively "rich" compared to other areas of Madagascar. If they had three weeks to pay back a health care loan, this would not present a problem, as they had many livestock they could sell to raise money. Unfortunately, this is not the case in Toamasina II. People are generally poor with low levels of disposable income and without numerous livestock that can be sold off in the event of an emergency. As mentioned earlier, the TCSP has plans to commence a pilot community health insurance scheme in October 2001.

In the project area, the concept of forming Women's Groups and CVA groups has proven very effective, with strong, loyal bonds developing between those in each group. Clearly, solidarity is an important characteristic of the Betsimisaraka people.

C-3. Communication for Behavior Change

One-on-One Counseling and Small Group Education The program has focused a great deal of attention on direct one-on-one counseling at a community level to achieve its goals in behavior change thus far.

The CVA agents have received training on how to make home visits, helping to educate mothers in simple ways to improve the health and well being of their families, and directing family members to health care services available at the local CSB.

The Women's Groups work with mothers on a household-to-household basis, helping the mother develop a better approach to improving her family's nutrition, working through nutrition problems, and finding alternative solutions that are not only practical, but also acceptable to all the family members. These volunteer workers visit women even in the most remote villages, and are reportedly having a positive impact on influencing positive health-seeking practices. While this TIPs approach has been very effective to date, it will need additional long-term evaluation of impact to validate the changes that are reportedly being made.

CSB health workers interviewed during the evaluation reported higher levels of patient referrals once the CVAs and women's groups began working in their communities. Both strategies use counseling cards developed by JSI.

CSB Agents The project has also targeted the CSB agents for health care training in order to encourage them to spend more time counseling with their patients, promoting simple, positive, health-seeking behaviors that will improve the quality of life of families in the target area.

Demonstration plots The promotion of kitchen gardens via Women's Groups is a concept that has spread quickly into the surrounding communities. Success breeds success, and it would be advisable for each CSB to establish a demonstration plot in the coming year, identifying the nutrient-dense foods most helpful for malnourished families. The promotion and distribution of papaya trees is another intervention designed specifically to encourage people to eat more of the vitamin-rich fruits and vegetables available at relatively low cost to families.

Regional or Community-wide promotions The TCSP has demonstrated significant success with vaccination campaigns. Elsewhere in this document, the successes of the local vaccination days, the regional vaccination days, and the VISA 5/5 vaccination campaigns are outlined in detail. The increase in vaccination coverage rates is a clear testament to the impact of these campaigns.

Recommendations

- The main recommendation to improve the behavior change interventions would be to focus more attention onto development of mass-media resources that can be broadcast over the local FM radio stations, in order to capitalize on the large rural listening audience. These messages should be in the local dialect.

- Radio broadcasts could utilize promotional messages spoken by the trained CVAs and Women's Group members from the project area, thereby honoring and reinforcing their roles in the local communities where they work.

Technically Up-to-date

Almost all of the IEC resource materials used to-date are JSI materials that have been thoroughly field-tested around the country before being put into national use. In fact, many of the original JSI IEC resources were first field-tested within the former ADRA Tamatave MCH project. Nevertheless, there are still some of the national materials that could benefit from being put into more of a Betsimisaraka context in terms of pictures and the language or dialect used.

It appears that all of the key Child Survival messages are included, although initially the TCSP did not have any family planning component in it (at the insistence of one of the contracted proposal writers at the time the project was first conceived). This has since been rectified by the addition of a family planning component to the TCSP under the ADRA-JSI "Health Education for Life Project" (HELP) described elsewhere in this document.

The only other major message that appears to be missing is the promotion of the link between the environment and health. Environmental health was one of the components mentioned in the

indicators of the preferred futures developed by the SSD/ADRA team; however, this has not been addressed in this project to date, and needs to be an important focus of attention in the remainder of the project, particularly as it relates to the malaria component.

Measurement of Behavior Change Activities
The last twelve months have been an intense time of project activities, many of them "fast-tracked" in an attempt to make up for time lost at the beginning of the project. During this final phase of the program, greater attention needs to be given to measuring the longer-term impact of community-based campaigns targeting behavior change.

In addition to collecting the national HIS data, the only other documented data collected by the project includes: 1) Women's Group member nutrition activity reports; 2) The number of children referred for vaccination under the VISA 5/5 program; 3) the number of new kitchen garden demonstration plots developed; and 4) the number of primary schools with a water pump for improved personal hygiene amongst school children.

The data collection tools have been mainly project records, HIS records, and focus group studies. The TCSP staff is also investigating the use of Lot Quality Assessment Sampling (LQAS) methods for more effective monitoring of progress in the remainder of the project.

Use of Behavior Change Data
The data has been used mainly by the SSD and the TCSP for the monitoring project progress and for planning interventions in the most critical areas of need. Some of the data has also been used by other NGOs such as PSI and CARE, who were planning new programs within the Toamasina region. In the remainder of the project, the TCSP needs to focus more on the sharing of the summary data back down to the community levels, making this two-way exchange a higher priority.

C-4. Capacity Building Approach

ADRA Madagascar's Toamasina Child Survival Project has already accomplished much to elevate the status of ADRA within the health sector of the country. The project is reasonably well known, and is respected for the accomplishments that have been achieved under challenging circumstances. ADRA is known in the country for having solid programs with strong, integrated community-based approaches, and good links between the public sector and the community beneficiaries.

In general terms, the Toamasina Child Survival Project is progressing as well as can be expected despite the many challenging constraints the project has faced. At the time the project began, it was not anticipated that within the first year the MoH would effectively put a stop to all formal training programs involving government health employees. After many months of waiting for a lifting of this prohibition, efforts have been directed at finding alternative ways of dealing with this blockage. Following discussions between the NGO community and the Ministry of Health, the AAA "self-guided learning" system was developed (by the MoH), and the first few modules have now been distributed to the CSB agents in the project area.

Strengthening ADRA

The TCSP now has a total of four technical advisors, two field assistants, three admin-istrators, and six support staff.
The DIP contained plans for ADRA staff capacity building, with at least two upgrading trainings budgeted per advisor, per project year (at up to $500 per session). This line item has been 40 % spent to date, with many trainings already attended by the staff (see Training and Capacity-Building Accomplishments, Appendix F-2). Fortunately, the costs for upgrading training have been kept low because most trainings attended by project and SSD staff have been conducted by other USAID partner organizations. Space was reserved for TCSP staff at no extra cost, with only a minimal amount spent on food, accommodation and transport expenses for participants.

Apart from the TCSP Management Advisor who has not yet attended any upgrading trainings, the IMCI Advisor and the Community-Health Advisor also need to seek additional trainings in order to keep the ADRA's capacity building on the cutting edge.

At the time of staff evaluations, the TCSP endeavors to assess individual staff training needs and progress. A standardized personnel assessment form (based on the "Performance Now" software developed in the USA) is used help provide a more uniform, and hopefully less-biased assessment of individual progress, and to document the changes in capacity, skills and behaviors that take place over time. Unfortunately, this document is still in English, which limits its usefulness in the French working environment. So far, the key project administrators (all capable English speakers) have used the document to assess the staff, and then a consensus report (in French) is derived after comparing the evaluations made by each administrator.

At the mid-point in the project, ADRA Madagascar has already been able to demonstrate an improvement in its capacity as an organization, as evidenced by the improvement in quality of trainings conducted by the project personnel, the degree of cooperation between the primary partners, and the improvements noted in the personnel performance evaluations. In addition, the Health Programs Coordinator reports a change in the type of technical support needed by the project personnel. Since each advisor has been given the responsibility of setting their own budgets for the interventions within their field and knowing that they will be held accountable to this, there has been an increased maturity in terms of the planning, monitoring and evaluation of project activities.

Strengthening the SSD

For a detailed summary of the capacity building interventions implemented in this project to date, please refer to the "Training and Capacity-Building Accomplishments Table" found in Appendix F-2.

It is evident that the strongest partnerships within the SSD are with the Nutrition, FP and EPI components. These partners are consistently more motivated to work, study and train together, and have a better grasp of what the project is about, in addition to viewing ADRA as a development partner.

External to ADRA, the SSD also benefited from the professional training for the former Chief District Medical Officer, part of the MoH's plans to upgrade the quality of key personnel. The CDMO was completing an MPH degree with blocks of three months of study in Tana followed by three months of work over a period of two years. The study program was scheduled for completion by mid-2001; however, in July 2001 the CMDO was moved to another district, with the Deputy DMO promoted to become the new CDMO.

The first major change in personnel since the writing of the DIP was the replacement of the Deputy DMO (*Adjoint Technique* in French) due to the promotion noted above. The Deputy DMO (now CMDO) and former CMDO often differed in terms of approach, philosophy, personality, and decision-making. This created an organization with "two heads," each going in opposite directions at times, and trying to "win" the approval of ADRA in order to "convince" their counterpart that their approach was correct. Consequently, since the changes in personnel, there is much more stability at the SSD administration level, with the two senior people better matched in terms of personality and approach.

Capacity-Building for other Community-Partners

***Women's Groups*:** By training women selected and respected by the community, it is possible to increase the prospects for sustainability within the project. The nutrition-related training received by these women has become a very successful part of the program with the demand for expanded services far exceeding the project's ability to keep up with trainings and follow-up. The women have expressed their appreciation for the trainings, and enjoy their new status in the community based on their trainings and volunteer roles as counselors to other mothers in the community. Although the program has been very successful thus far, the volunteer nature of the project is placed in jeopardy when other NGOs come in with paid nutrition education promoters. This issue is currently being referred to the provincial nutrition sectoral coordination meeting (GAINT) in order to help ensure that all NGOs and communities are satisfied with the outcome, and are willing to abide by the chosen guidelines.

Working with Women's Groups has developed as a direct outgrowth from the TIPs component, and has become the most effective means of getting the key nutrition messages through to the mothers in the community. The interest has become so great that community leaders are seeking out ADRA staff to ask if similar groups can be formed in their own village communities. Future limitations to expansion are time, transport and personnel.

***Child-to-Child Approach*:** As indicated earlier, this component has already trained 271 schoolteachers, representing 11,000 children from 113 schools out of the 174 public primary schools in the project target area. By integrating the key health messages into the curriculum and action plans of these teachers, it is possible to build a long-term sustainability into the sharing of these key messages with the women and children most at risk. It would be helpful if additional resources could be developed to support the teachers, as the distribution network is well established, and there is good potential for effective follow-up and management.

Health Center Management Committees: The COGEs have been established in conjunction with the management of the government's cost recovery program. The members are selected by the community and are responsible for all the financial management and control of the CSB and associated pharmacy. ADRA has been collaborating with the DIRDS to train these committees in the principles of effective financial management and in the essentials of the cost recovery system. It is anticipated that this knowledge and the skills developed will remain with the community long after the immediate project has been completed.

STI/HIV/AIDS Prevention Component: The TCSP also includes an STI/HIV/AIDS prevention component as part of the ADRA match. It is anticipated that activities will begin in the third quarter of 2001. One of the main components will be capacity building for the SSD and community-based organizations working in the private sector for the prevention of STI/HIV/AIDS. The TCSP is already collaborating with "The AIDS Alliance" (an international NGO based in the UK) for the strengthening of capacity of the community-based organizations working in AIDS prevention in Tamatave.

Changes in Organizational Capacities

At the beginning of the project, a simple assessment of the organizational capacity of the SSD was conducted at the level of the CSB agents. A more detailed inventory was made in 2000, and then another less detailed assessment was repeated in August 2001, helping to identify the ongoing actual and perceived needs. For the SSD, the TCSP's primary local partner, there has been:

- An increase in the SSD's capacity for working with HIS data, as evidenced by computerized entry of district level HIS data on a monthly basis. For the SSD, this next year will enable the HIS Officer to gain more confidence in the manipulation and analysis of this data, and to monitor important trends.

- An increased capacity for program planning, evidenced by the SSD being one of the few districts in the province to have held a strategic planning workshop, with a computerized GANTT chart and action plan for the calendar year 2001 as outputs.

- An improved level of openness among staff when discussing work-related problems, evidenced by increased willingness to discuss problems directly with ADRA staff, and to seek solutions collaboratively.

- Under their new leadership, the SSD has adopted a more multi-disciplinary and participatory approach to program implementation and field supervision, which is an improvement to the former vertical program approach.

Primary Challenges

Transparency: There is a need for more openness and transparency in matters of management and communication, including the tasks of high-level administration and budgetary/finance

matters. ADRA can only help develop a better management system if working in collaborative partnership with the SSD to solve the problems that arise. In addition, assistance with the budgeting and planning functions will be needed to help avoid some of the problems which are still being observed, as the control over finances and information relating to budgets has been kept a rather closely guarded secret by the former CDMO. Maximizing transparency within the TCSP will also likely lead to increased transparency within the SSD, especially given the new, positive administrative leadership.

Alternative Funding Sources: ADRA needs to focus specifically on helping build the capacity of the SSD to access alternative funds and donors to meet their program needs not covered by their current budget. It is very difficult for the SSD to prioritize the broader management, planning and programmatic issues that ADRA is trying to address, when the SSD is still struggling with the daily problems of insufficient materials, resources, and finances – none of which can be budgeted for in a CS training project. To address this problem, ADRA needs to help the SSD find alternative funding sources, or to plan ways of reducing these "unforeseen" problems in the future.

Specifically, ADRA needs to plan trainings on project proposal writing for senior admin-istration staff, enabling them to more effectively access other funding sources to address the SSD's priority needs.

***Formal Training Policy*:** Without government approval to hold formal training programs it will be more difficult, time-consuming, and expensive for ADRA to continue its planned CSB agent trainings. More time will continue to be needed in the field doing one-on-one trainings and field supervision.

Strengthening the Health Facilities

Appropriateness and Effectiveness of Health Facility Strengthening

Training of CSB Personnel: As indicated, the government moratorium on formal training programs has limited the amount of training that could be conducted. The main change has been to negotiate with the CDMO and the DIRDS to enable the CSB agents to add a one day informal professional upgrading either side of their monthly visits to Tamatave for picking up salaries, and for giving their monthly activity reports to the CDMO and the HIS Program Officer.

It appears that under this new approach, the technical capacity building for the CSB agents has been thorough, positive, appreciated, and beneficial. A review of the schedule for upgrading trainings implemented by the project for the health facility staff seems adequate and well planned. The pre- and post-test results indicate a change in knowledge. More direct supervision is needed in the field to confirm that changes in skills and behaviors are taking place on-the-job and are being translated into practical reality. To encourage this approach, the TCSP needs to link the integrated supervision visits with the changes being promoted in the upgrading trainings from month to month.

One of the challenges will be to ensure that the CSB agents are not too overloaded with tasks, decreasing motivation and time for follow-up. To avoid this, ADRA is trying to train and empower the CVAs and the Women's Groups to take a more active role in promotion of community-based health care services, with appropriate referral to the CSBs for health care services, freeing the CSB agents to focus on clinical care, while taking a greater supervisory role in coordinating the work of the community mobilizers.

Communications System: An ongoing problem is the lack of adequate communication with the most remote CSBs. The challenge for the TCSP is that there is insufficient budget to purchase any communication system, so the project must either look for alternative funding or wait until the next follow-on project. Budgeting for communication radios would help on a day-to-day basis, as well as provide an effective means of communication during times of natural disaster, such as when cyclones or other regional or national emergencies occur. The radios could also enable the commune authorities, the education system and the agriculture system personnel to communicate with their respective administration offices in Toamasina, a multi-disciplinary advantage for all.

CSB Equipment: Unfortunately, many of the CSBs still lack basic medical equipment. Because this is a training project, the CS project had only budgeted approximately $125 per clinic for medical equipment. However, the reality is that there is a major demand for even the most basic health care equipment, and in a number of places, the CSBs themselves need repair and/or rehabilitation (see appendix F-1). ADRA is exploring alternative sources of donated medical equipment to help address this need.

Health Facility Assessments Tools

ADRA has used a number of different assessment tools for the health facility assessment. In addition to using the SSD's inventory reports and direct observations made while in the field, an initial facility assessment was made at the time of the DIP in 1999. This correlates with the findings from the SSD inventory of 2000. A comparison can now be made to the assessment at the time of the 2001 MTE. To confirm the ongoing accuracy of the written facility assessments and the monthly CSB activity reports, the data and changes need to be confirmed at the time of the regular integrated field supervision visits.

Use Of Assessment Results

ADRA purchased some basic medical equipment to assist in the upgrading of those CSBs selected to be cholera treatment centers, as this fell under the CDD training that the project was already planning to do from the beginning.

Private donations for the TAPS project have permitted repairs to be made to the water systems in several CSBs, with plans in place to develop a larger water/sanitation project for the future. This will look at improving the water supply systems at some of the more remote CSBs and communities in the project area.

In terms of other CSB equipment and supply needs, requests have been made to UNICEF via the SSD and DIRDS, in order to expedite the procurement of necessary equipment and supplies; however, the system seems to be slower than originally anticipated. The CSBs have indicated they are still waiting on spare parts and basic equipment.

Addressing Gaps Between Performance Standards and Actual Performance

Much attention is still needed to reduce the gaps, particularly in terms of transfer of competence. Now that the SSD program officers have a basic foundation in computers and management training, it is hoped that with continued ongoing training and mentoring, it will be possible to achieve the goals originally established at the beginning of the project. In the remainder of the project, the TCSP also plans to bring in more specialized trainers under subcontract, in order to facilitate the accelerated transfer of competence, and to enable the progressive "handing over" of program responsibilities currently still being undertaken by TCSP personnel.

C-5. Sustainability Strategy

Progress to Date in Meeting the DIP Sustainability Objectives

A progressive and measurable transfer of competence to the SSD personnel has begun by the ADRA staff. This consists in giving the SSD greater responsibility and having them more involved in the implementation of the District Development Plan, especially in regard to scheduling, release of funds, as well as in the administration of these interventions. However, as indicated above, it is evident that this process will need more time and perseverance on the part of the program officers in order for them to eventually take full responsibility for all the interventions. The procedure also requires a deeper level of commitment to handing over responsibility on the part of the TCSP Advisors, who are the direct supervisors of many of these activities. The TCSP's role is to build capacity by training for increased competency and confidence, something that now requires more mentoring and working alongside, rather than actually "doing" the interventions.

The reported achievement of preferred futures (appendix F-5) indicates both the SSD and TCSP staff believe there is still a significant way to go in terms of achieving the sustainability objectives; however, they have also indicated their desire to continue moving towards the full achievement of those goals. During the MTE, the SSD staff were asked to prioritize the preferred futures, to help the TCSP in focusing attention on where it is needed most.

The move towards strengthening the integrated, community-based approach is a major factor that will help enhance the move towards greater sustainability in this project. The fact that there is no significant infusion of funds into the SSD's operating system means that it should be easier for the SSD's programs to achieve sustainability once the project is completed. As the improvements in the cost-recovery system continue to advance, greater financial sustainability can also be achieved by the CSBs in the future.

Finally, once the remaining problems in the cost-recovery system can be ironed out, this will do much to help the SSD continue with a more sustainable funding base for the future. The project

is currently investigating several possibilities to help address the 'coverage gaps" for those too poor to pay for the health care services provided under the current cost recovery system.

Exit Strategy Groundwork

The whole program approach is geared towards sustainability, so that even if the project were forced to leave immediately, the SSD could still continue without major interruption to plans although on a somewhat reduced scale of activity.

As indicated earlier, the SSD personnel have also begun the move towards taking greater responsibility within their programs. Nevertheless, there is still a need for mentoring and advisory support from the technicians of ADRA, especially given that the TCSP has six physician advisors on staff, while the SSD has only one physician to support their program administration and implementation.

Given that the project is currently planning on applying for a Cost Extension, it is anticipated that the complete "phase out" and "handover" plans will not be needed until the end of the follow-on project. In the event that the cost extension is not funded, the TCSP plans to begin winding down project activities in the final six months of this current project, and will assist project staff in locating alternative employment, wherever possible.

Building Financial Sustainability

- The TCSP is working closely with the district and commune authorities to ensure the success of the government's cost recovery system. The system is working with varying degrees of success, depending on the remoteness and degree of poverty of the communities surrounding the CSBs. It is now approximately three years after the introduction of the cost-recovery system, and about 80% of the CSBs are operating acceptably within the system. However, as indicated elsewhere, some remote clinics reports that up to 80% of the patients served by the clinic cannot pay, and this problem needs close attention between now and the end of the project. The rural areas of Tamatave II are extremely poor, and the level of disposable income available to pay for medical care and treatment is very, very low, suggesting that alternative arrangements need to be introduced in some of these areas, with new recommendations to go back to the MoH.

- The SSD's District Development Plan is comprised of activities financially supported by the Ministry of Health and by other funding agencies (UNICEF, SEECALINE, USAID/JSI, etc.) or by the TCSP itself. Consequently, if ever there was a problem with the TCSP funding, the SSD would still be able to continue, as the MoH continues to be the primary source of funding for the SSD.

The main direct beneficiaries of the project assistance is primarily the SSD staff. After the departure of ADRA, the CDMO says the SSD would use less funds in their DDP, and would also look for alternative sources of funding. At the community level, little has been said to date about this issue.

D. Program Management

Strengths

1. ADRA has a good team of advisors, capable, and willing to meet the challenges, despite the hardships sometimes involved.

2. The project is led by a strong and experienced manager with a wealth of professional contacts from across Madagascar, a legacy of his previous work. The TCSP Project Director has had numerous opportunities for overseas training and capacity building.

3. There is good rapport between the senior management with the SSD and ADRA.

4. In the strengthening of capacities, a district development plan has been created by the SSD, and is being implemented in collaboration with ADRA.
5. The SSD and TCSP teams gained considerable richness of experience from the exchange visits made to other USAID partner projects in Madagascar.

6. The project has benefited from strong financial administration, with prompt accounting, and good internal controls.

7. An accelerated "catch-up" schedule of activities has been planned to enable the project to finish on time.

Weaknesses/Challenges

1. At times the TCSP regulations concerning the use of the project resource materials were considered "too strict" by some of the program officers of the SSD, as it did not facilitate management of unforeseen emergencies. For example, photocopying of the SSD's request forms created some problems while they waited for the release of the MoH budget funds so that they could arrange for their own photocopying. However, in order to improve good planning, logistics and resource management, the TCSP regulations required that the photocopier only be used if requisitions are received 24 hours in advance for large numbers of copies, with the paper for larger orders needing to be supplied by the SSD. In this case, discussion was needed to reach a middle ground, recognizing that unforeseen emergencies do arise, and that due consideration would need to be given to accommodate the needs and requests.

2. At a recent program review meeting, the TCSP and SSD staff requested more details concerning the amount of budget remaining to be used until the end of the project. The SSD staff were hesitant to formulate budgetary plans because of the unknown limit on their budget line items, as in the past, this information was only known by the Chief Medical Officer for the district. Fortunately, this now appears to be changing, with increased transparency within both the SSD and the TCSP, and plans to decentralize management of funds even further.

Recommendations

1. Regular monthly meetings of the TCSP and EMAD members have been difficult to coordinate given the diversity of schedules and personnel to coordinate; however, this needs to be a priority during the remainder of the project. It not only facilitates improved communications between all concerned, but also enables better coordination of schedules.

2. Discussion sessions are needed to clearly define the TCSP and SSD regulations, reaching a final consensus as to how best to apply these regulations from day to day. During these meetings, more information on the rate of the per diems, accommodations, and related regulations would help to clear up misunderstanding regarding collaborative work and field conditions.

3. The project needs to plan some form of regular social events (such as a Sunday picnic at the beach or at a park) in order to help build informal relationships between the SSD, CSB and TCSP staff.

D-1. Program Planning

Planning Involvement

The program planning and implementation for this project has generally followed a very participatory process. At the DIP planning stage, all levels of government and key stakeholders were invited to be part of the development process to provide input and to gain "ownership" as co-partners in this project.

Program Delays

The work plan in the original DIP has been delayed on several accounts. The most significant delays have been in the following areas:

- ***Government Delays:*** The program was initially delayed 9 months from the time of expected startup because the official MOU was not signed until June 1999. Official interventions could not be started by the project until this document was signed.

- ***Staffing Delays:*** Once the MOU was signed, the project was still without a nutrition advisor for several months because of the difficulty of finding a local female doctor with strong nutrition experience. Eventually a doctor was hired and put into several training programs; however, not long after, she had to have emergency surgery. After a month of recuperation, she resigned for medical/health reasons. A replacement nutrition advisor was not found until June 2000. Since then, the new advisor has been working overtime trying to "catch-up" on lost project time.

- ***Malaria Intervention Delays:*** These have been thoroughly detailed under the malaria intervention section in relationship to the local procurement of bednets.

- ***Training Delays:*** The causes of the significant training delays are detailed earlier in this document. These delays have also affected the project budget, as spending on training and capacity-building (which are the major components of the TCSP budget) has not been able to progress as planned during the past two years, leaving the training line-item with just 60% of anticipated spending completed, even though the project is now close to 75% completed. To address this unanticipated problem, the project has employed additional staff and planned additional activities, with an increased intensity of activity so that the project can still be completed by the end of project date.

Understanding of Program Objectives by Partners
The program objectives appear to be understood quite clearly by the TCSP staff, although the level of understanding with the SSD partners is less, and it has taken much longer to reach even this level of understanding. During the first year of program implementation, it was evident the SSD counterparts did not clearly understand the nature of the project, with the result being that the project was considered a "pot of gold" that would rarely share its resources with them. With time, the TCSP has eventually become understood as a "capacity-building project" with line items only to be used for training programs. Consequently, there are no longer the long discussions and debates over whether money could be made available to build or repair clinics, on vehicles, petrol, refrigerators, or any of the many other daily (and typically consumable) needs of the SSD. To help improve this situation for the SSD, ADRA also needs to begin helping the SSD to find other funding sources that will enable them to finance some of these numerous legitimate needs.

In terms of the community's understanding of the TCSP's program objectives, it is not as clear. Initially, the TCSP actively tried to avoid the use of ADRA's name during community-interventions, as they want the message in the community to be that this is the SSD's health and development programs, with some technical support coming from ADRA.

Sharing of Program Objectives
All ADRA Technical Advisors and SSD Program Officers have a copy of ADRA's program goal, objectives, strategies, and the Preferred Futures developed together at the time of the DIP. They also have a copy of the training budget remaining to be used in the TCSP.

Utilization of Monitoring Data
The Management Advisor has established a system of reporting for collection of the HIS information from the project and from across the target district. This information is collected on a monthly basis, and is used for tracking progress of the basic health indicators. Targeted interventions have been developed in response to HIS reports, so that locales with the most significant health care problems can have the most effective campaigns targeted towards them. However, this is an area which needs much more focused attention in the remainder of the project, so that the SSD feel comfortable using the HIS data and research reports to directly help them in strategic planning and decision-making.

D-2. Staff Training

Training Effectiveness
The problem has been to find suitable in-country training programs for the TCSP staff. Although a number of advisors attended a "ToT" program held by another NGO, the content was reportedly quite basic; staff indicated that they would have preferred something more advanced. After TCSP or SSD staff have attended a training program, they are required to prepare a written report outlining the topics in the training, and to evaluate their impression of the effectiveness of the workshop, and its relevance to their work. Regarding follow-up assessments, field discussions indicate ADRA still needs to focus more attention onto the review of long-term impact of the various training programs conducted by the project staff.

Assessment of Trainee Performance/Skills
Currently, the project advisors conduct both pre-test and post-test assessments of trainee knowledge at the time of training; however, this needs to be followed up with more field-based assessment of long-term impacts resulting from the training.

Staff training resources
The TCSP has budgeted US$500 per advisor per year for professional upgrading training. Although there have been a number of training opportunities provided by USAID within the US or Africa region over the past few years, the staff have not been able to attend these meetings either because of a lack of English language skills, or for a lack of budget for international transport within the CS project. To avoid this problem in the future, ADRA's CS projects need to budget more money for transport to allow staff to attend international conferences, trainings, and capacity-building workshops or study tours. ADRA is also looking into the possibility of finding internet-based (French language) distance learning programs at a Masters level, that would enable the project advisors to commence ongoing upgrading studies that can be continued in their own time and at their own pace.

D-3. Supervision of Program Staff

Effectiveness of Staff Direction/Support
The TCSP appears to have a good, functioning system of administrative support and direction. The TCSP administrators operate using a more democratic "open-door" policy, which provides the freedom for staff to discuss and resolve issues as they arise. The SSD staff has observed the difference of approach in the project, indicating their preference for a more open and transparent system of management and decision-making within their own SSD administration, something also desired by the new SSD administrators.

Within the TCSP, the Project Director takes an active role in direct supervision of the project employees. If problems arise, whether in the office or in the field, the Project Director has been quick to act upon it. Staff knows they can call on the guidance and support of their administrators whenever needed. If the problem cannot be resolved on an individual basis, the whole team is brought together to discuss and resolve the issues.

Personnel
According to the reports from the field staff, the number of ADRA personnel needs to be increased, preferably so that each advisor has an assistant to work with him/her. According to the project management; however, it is preferable to first look at the overall staffing needs, and to employ maybe one or two multi-disciplinary staff to help assist in meeting the workload needs of all staff, rather than just employing a new assistant for each advisor. The project plans to employ an additional person to work as an assistant for the malaria component, preferably choosing someone with a good IMCI and/or community health background. Later this year, the project will also employ personnel (with supplementary funding) to work on STI/HIV/AIDS prevention.

TCSP staff report they often work additional hours each week, especially when they need to travel to the field on Sunday afternoons to be in place for weeklong trainings that commence first thing Monday morning. Consequently the driver is also working long hours, so the project periodically employs a temporary replacement to enable the driver to take compensatory time off. The project personnel would like to increase the number of supervisory visits in the field, but are limited to just the one project vehicle, which minimizes the opportunity to expand the number of visits each month.

D-4. Human Resources and Staff Management

Personnel Management
The TCSP staff is under the direct supervision and management of the Project Director, and the Finance/Administration and Logistics Officer. In the past, any grievances, issues or problems have been raised with either the direct supervisors, or with the expatriate Health Programs Coordinator, who is the advisor and technical resource backstop for this project.

The TCSP personnel are routinely evaluated every six months. This consists of a personal evaluation form that is filled out by the staff member, and is compared (during an interview) to the results of the same form filled out by the staff member's immediate supervisor. Reports indicate reasonable consistency between the two evaluation documents, and both staff and administration have expressed satisfaction with this system. In general, apart from several issues raised during the first year concerning per diems, and one guard that was fired for an alcohol abuse problem, there have been no major personnel management issues that have developed. In general, there is a good and very positive team spirit among the staff.

Personnel Policies
Each member of the TCSP has been given a copy of the Internal Policy booklet, which outlines all the rules, regulations and rights of the employees of ADRA. This document has been revised, amended and updated by the administration committee whenever the need has arisen. Job descriptions have been developed for all positions at the time employees were sought, and are reviewed every six months at the time of the employee evaluation. ADRA's TCSP has also assisted in the development of job descriptions for all of the key SSD personnel, which has made a major impact on the effectiveness of work and delineation of roles and responsibilities within the district health system.

Personnel Relationships
As indicated earlier, there is a strong sense of team spirit among the TCSP personnel. This sense of team spirit has also become more evident among the SSD, and as the collaborative relationship has grown, the relationships and respect have deepened. Morale is high despite the challenges of working in hot, humid, remote and difficult field terrain. After two years of "building bridges", ADRA's TCSP staff is generally accepted as friends, colleagues and confidantes that can be trusted. When the SSD has problems, they feel comfortable enough to come to the TCSP technical personnel to seek advice on problem solving. The synergism has become evident, as now various staff from the SSD are stronger and more confident managers in their own right. The Nutrition/FP Program Officer in the SSD is a good example of someone who has taken her new and expanded role seriously, and has taken on much of the work that previously only ADRA had been implementing, such as leading training workshops for field and community-personnel.

Staff Turnover
The TCSP has had an average rate of turnover of staff. As indicated earlier, during the first year of the project, the nutrition advisor resigned due to medical and health reasons, and a new replacement advisor was not located until June 2000. Apart from that, the project fired one guard for alcohol abuse. In September 2001, the IMCI Technical Advisor for the TCSP resigned to take up a higher-paying position with another USAID partner in another part of the country. Fortunately, the TCSP had employed an assistant to work specifically on malaria prevention, and this doctor is now being mentored for the expanded role as IMCI advisor. Because the staff enjoy working with the TCSP in Tamatave and seem content to live in this location (considered a popular tourist destination in Madagascar), staff turnover has been relatively low. The project is always on the lookout for the most suitably qualified local personnel to bring into this or future programs.

Staff Transition at EOP
At this point, the TCSP plans to apply for a cost extension, so that existing project staff will have opportunity to continue working within the expanded project. If any existing project staff choose to leave at the end of this current project in September 2002, every effort will be made to locate employment opportunities within the network of other health and development NGO partners working in Madagascar.

D-5. Financial Management

The TCSP has a clear system of financial documentation that is in accordance with Generally Accepted Accounting Practices (GAAP) standards required by USAID projects. The AAA accounting software[11] used by the project is designed to avoid user-manipulation of either data or reports, and is used by ADRA in all their projects around the world. It allows for working in multiple currencies, and gives helpful summary reports comparing budget used to date with total budget, and expected budget use to-date.

[11] Not to be confused with the AAA self-learning modules for health workers mentioned elsewhere.

ADRA Madagascar has a policy of maintaining separate bank accounts for all projects, and even the supplementary projects have separate bank accounts and financial tracking on a monthly, quarterly, and annual basis. Monthly, quarterly and annual financial reports are sent to ADRA HQ for review, and annual reports are sent to the local USAID mission. All ADRA projects are also subject to annual auditing of accounts. The last financial audit was held April 2000 by a team of international auditors from PriceWaterhouseCooper. Apart from several clerical errors and identifying the need to modify some internal procedural regulations, no findings of major significance were made during this audit of the CS project accounting system and records.

As indicated earlier, greater assistance is needed by the SSD in planning for financial sustainability. The Health Advisor has recommended that the TCSP provide a Project Planning and Proposal Writing workshop to strengthen the capacity of the SSD to develop strong proposals for funding by alternative donor sources.

D-6. Logistics

Impact of Logistics
In general, the provision of supplies and logistical support has been able to keep pace with the project's needs. Because the training program has been scaled back compared to what was envisaged at the time of the original DIP, no overly excessive demands have been placed on the logistics system. One of the ongoing challenges, however, has been to obtain spare parts (at reasonable cost) for the project transport vehicle. Another difficulty has been the challenge of locating high-quality (Salter) baby weighing scales at reasonable cost, and to get these into the country without paying exorbitant amounts in freight and import taxes.

The TCSP could also have benefited greatly from a second vehicle; however only one was originally budgeted for the project. The logistical challenges of getting project staff out to the remote field sites were underestimated.

Logistical challenges remaining
Clearly, the transport and communication challenges are major obstacles to be considered in the remainder of this and any follow-on projects. Now that a satellite communications network has been installed over Madagascar, future projects may be able to benefit from including some type of satellite/GSM mobile phone in the budget. This would facilitate communication links with the project personnel while in the field, between health care personnel at remote posts, and with their administrators in Tamatave, although several of the satellite companies contacted indicate this may still be a few years away.

The problem of access to mosquito bed nets has also been covered in detail in the malaria section.

D-7. Information Management

Health Information System

Systematic collection and feedback of HIS information
The TCSP has a systematic and routine data collection system for the HIS data gathered by the district health office. The project began by first improving the collection of data for the national HIS at the level of the CSBs and the SSD, followed by the development of data collection software for data entry and program analysis for reports. The HIS data is now collected on a monthly basis, after which it is entered onto the SSD computers enabling automatic printout of cumulative reports, from which graphics can be derived.

The monthly reports go up to the SSD, DIRDS and ADRA administration, and in theory, consolidated analytical reports go back to the SSD, DIRDS, ADRA and CSB personnel on a quarterly basis so that planning and decision-making can target specific areas of need identified. In reality, although the monthly reports have been on time, the data moves "up" faster than "down" the hierarchy, and even the quarterly analytical reports have been considerably delayed. So far, accurate and complete data is available for the year 2000, and 2001 up-to-date, however data collected prior to 1999 seems unreliable at best.

Monitoring progress
The TCSP collects all the information reported in the national HIS, and has trained the SSD HIS Program Officer to input the data and make basic graphics and reports on a monthly basis. However, the information collected in the HIS has a number of significant gaps, and the TCSP needs to carefully review the HIS in order to track more carefully the most critical indicators of progress. For example, the HIS does not collect data on causes or frequency of mortality. Neither does it collect information on the initiation, exclusivity, or persistence of breastfeeding. If the project could assess these indicators in some form of regular sampling process, it could provide a form of feedback regarding the degree of progress made in terms of behavior change at the community level.

The need for a more clearly defined monitoring and evaluation plan, with progressive regular sampling of data is a priority in the remainder of this project. Future projects should also include a full-time monitoring and evaluation officer to follow up on these the collection and reporting of this important information.

Effectiveness of the HIS
The transfer of competency is taking longer than expected, due to a variety of factors, including the difficulties inherent in revising and improving the data collection system; inaccuracies in population estimates; lack of familiarity with computers among Program Officers, and limitations of personnel.

The data entry and retrieval system has been written for the ACCESS database software, which unfortunately, is limited in terms of the type of graphics it can generate automatically. For now, the HIS staff generate graphs in spreadsheets after manual entry of data from the cumulative

monthly and annual reports that are generated. It is anticipated that more of this system can be automated before the end of the project.

HMIS Recommendations

***Comparative analysis of data*:** The TCSP needs to develop and share more comparative analyses of data to all program levels. Although the present system generates monthly and cumulative reports, critical analysis of this data is needed to identify trends or priority problems that can lead to direct planning and decision-making. Analyses like this can help the CSB agents to better understand the importance of accuracy in their reports, and would underscore the need for planning targeted actions and interventions according to the priorities identified in the reports.

***Graphical feedback to community level*:** Development of simple, automated graphic reports are needed for feedback to the community level, enabling them to take a more active role in monitoring their health care services and in making more informed plans and decision-making for the future.

***Computers/Training*:** SSD personnel have requested more computers and additional training programs to enable them to use the computers more effectively. Several key SSD staff should be training in advanced computer application skills.

Operational research: and the practical integration of data and reports for decision-making at SSD, CSB, and community levels should be a topic of training for the ADRA and SSD Program Officers. Training should be practical, and involve utilization of data, as well as an introduction to the basic concepts of statistics (tendencies, variables, etc.).

***Extra management/M&E staff*:** The TCSP should consider either hiring another full-time staff member to assist with the management and computer training components, or consultants could be brought in for short-term assignments to focus on specific aspects of technical assistance in management required by the SSD.

In addition, the TCSP management advisor should also manage the information collected regarding the community health activities, freeing up the TCSP community health advisor to focus more on his technical support, rather than doing data entry and analysis

***Integrated and regular data sampling*:** The HMIS currently collects HIS and management data such as updated stock inventories. However, a more integrated approach is needed that also collects qualitative and quantitative survey data from the community for the purpose of crosschecking and validating the routine monthly HMIS data. It is also desirable to integrate cross-references with other sources of data existing nationally or regionally in order to improve cross-analysis, e.g. DHS, IRSTAT, national census data, etc.

***Information Dissemination*:** Currently, a quarterly review of the SSD is published as an Information Bulletin, however, the SSD personnel should be give the responsibility of developing this report each quarter, with the initial support from the TCSP. In addition, the

TCSP could help the SSD to develop a website for the SSD, on which there could be regularly updated statistical reports and analysis.

Increased use of computers in everyday work applications: The management advisor for the project needs to use novel approaches and integrate practical applications of computer technology into the daily work of the SSD staff, providing on-the-job training for people needing specific computer tasks.

***Handover of responsibilities*:** To encourage the move towards sustainability, the SSD should begin maintaining the HMIS on their own (both the data entry program and the analytical applications), and an SSD resource person should be identified as the main one who is capable of carrying on these tasks, and training others within the SSD.

New Approaches for CVA Data: The data collected for the community health interventions is largely qualitative, leaving it difficult to analyze objectively. It is recommended the TCSP should investigate the adaptation of the CVA monitoring and evaluation system conceived by Voahary Salama at the Mangoro project.

Purpose of Assessments Made by TCSP

Baseline Survey: A baseline survey was conducted before the commencement of the project to identify priorities for project focus, and to establish the starting point for measurement of achievement of objectives. Results have been used by the TCSP and SSD, but should be published for distribution to other interested organizations.

Focus Group Studies (FGS): A number of qualitative focus group studies have been conducted as a formative research tool to enable the project to better understand priority problems, and to enable IEC campaigns to target specific beliefs and practices prevalent in the project area. The FGSs have focused on a better understanding of breastfeeding, malaria, diarrheal disease and HIV/AIDS. The results have been used by ADRA and the SSD, as well as other NGOs to develop targeted campaigns at specific priority issues.

Health Facility Assessments: Two such assessments have been made to better understand the priority needs at the level of the SSD, and to understand the training needs identified by the CSB agents. Results have been shared between the TCSP and SSD.

Personnel Evaluations: These joint assessments are made for the TCSP staff every six months, for the purpose of evaluating progress, and work satisfaction. These evaluations form the basis for an annual incremental increase in salary that is separate from the cost-of-living increase. Results are kept by ADRA in the employee files, and form the basis for modification of job descriptions.

Human Resource Assessment: Studies have been made of the ADRA and SSD personnel's perceptions, with questionnaires designed to give staff the opportunity to provide anonymous feedback regarding their work environment, administrative leadership styles, job satisfaction, and perceived training needs. The results have been used by ADRA to develop specific training programs to address priorities.

Integrated Supervision Assessments: Each integrated supervision team member fills out an "integrated supervision grid" that is based on the national MoH template. Results are kept by the SSD and ADRA, with cumulative reports sent to the DIRDS.

D-8. Technical and Administrative Support

External Technical Assistance

John Snow Inc.
The project has had the benefit of technical assistance from the JSI project under the ADRA - JSI "Health Education for Life Project" (HELP).

This assistance has come in the form of field and exchange visits between projects; sharing of project personnel to assist as trainers at workshops; program planning and management support for family planning interventions; ToT workshops for TCSP staff; and the provision of IEC resources, as described elsewhere in this document.

LINKAGES
The LINKAGES project has provided openings in trainings, technical resources, and exchange opportunities for the TCSP project nutrition advisor and assistant.

Medical Care Development International (MCDI)
The MCDI CSP is very similar to the ADRA Toamasina Child Survival Project, and for this reason, the two projects have been able to benefit from a mutual sharing and exchange of ideas, approaches, and lessons learned. The MCDI CS project director came twice to visit the TCSP and to exchange ideas, plans and lessons learned. Each visit was for about one week; the first at the time of the writing of the DIP, and the second, at the time of this MTE.

PACT
Trainers in the community-development approach have been invited to work with ADRA personnel to implement training workshops for the CASC groups, with a focus on learning the methods of Participatory Rural Appraisal (PRA).

PSI
Trainers have collaborated with ADRA to implement joint workshops on STI/HIV/AIDS prevention, as well as collaboration on the focus group studies leading up to the development of the malaria prevention and control project.

Ministries of Agriculture, Education and Health
Representatives from the different Ministries have also assisted ADRA during various training workshops to build capacity among the SSD, CSB or community-based personnel.

ADRA Madagascar
Personnel from the ADRA Madagascar Antananarivo administration team have come to visit the project for routine monitoring and management visits as needed.

USAID Madagascar
Several informal visits have been made to the project site over the past few years. The visits have provided opportunity for valuable discussions, and also give stimulus for introducing new ideas and approaches.

Future Technical Assistance Needs

- As indicated elsewhere, there is need for a thorough review of the current monitoring and evaluation system, with assistance to develop a streamlined ongoing sampling analysis for verification of project progress and impact.

- There is ongoing need for assistance with the management training and practical computer skills workshops components.

- Technical assistance is needed in regard to cost recovery systems, and the development of a community credit/health insurance scheme.

ADRA HQ/Regional Support

ADRA International has provided technical support during the times of most critical program need. The project has received visits by the director of health programs on two occasions (during the writing and re-writing of the DIP); by the director of finance for health programs (for a mid-term monitoring and evaluation visit), and by the director of evaluation (at the time of the baseline survey, and the MTE). The director of the ADRA regional office, the senior auditor, and the ADRA International director of compliance also came to Madagascar at the time of the initial DIP, or at the time of the country office audit and review in mid 2000.

ADRA HQ has decided on a new supervision approach, in which conference calls will be held on a regular (probably quarterly) basis, to keep the field and HQ up-to-date.
This should help to reduce the need and expense for travel to those countries where the projects are progressing acceptably and only routine monitoring is required.

The most consistent and reliable support has come via email communications, which provide immediate response to questions, information regarding trainings or resources relevant to the projects, and contact information for other technical resources, according to the project's needs. The HQ office has also purchased technical reference materials on behalf of the project, and has mailed out useful resources, or small equipment as requested. ADRA International located a donation of a used notebook computer that was given to the project to help address the need for more computers. Because the project has a good team of administrative personnel, including an expatriate advisor, the HQ support has not required as much direct intervention for the day-to-day management and administration issues.

E. Other Issues Identified By The Team

- As with many other ADRA programs around the world, there is a need for ADRA to document and share more of its work – the successes, failures, and lessons leaned, so that others can benefit from ADRA's experience.

- Special sensitivity is needed to the cultural differences between the local people and the SSD, CSB or ADRA personnel from outside the local region. Training may need to focus on understanding and improving interpersonal attitudes and communications, with more social and team-building activities.

- To better reflect the changing role of the Health Programs Coordinator, after September 2001, the percentage of time allocated to the CS project will drop from 60% back to 40%, with the resulting 20% being picked up by the ADRA Madagascar administration office in Tana. This will enable more funds to be freed up in the TCSP personnel line item, allowing the project to hire or contract additional staff during the remainder of the project. It will also enable the Health Programs Coordinator to devote more time to the development of new project proposals and other administrative work.

- Encouragement, support and positive feedback are an important need in the project. When working with professionals under challenging circumstances, it is easy to overlook encouraging the efforts of others, especially when everyone is equally overloaded and stressed. The Health Programs Coordinator has suggested the implementation of an "Employee of the Month" competition, to reward, honor and recognize the efforts of those who go "above and beyond" what is required of them. The criteria for selection should be defined by the staff themselves, with a view to encourage and reward the most positive attitudes to service, learning, sharing and integration etc. A similar program amongst the CSB staff, and the community-based volunteers can do much to improve morale and lift quality of care and work standards.

F. Conclusions And Recommendations

F-1. Conclusions

The TCSP has accomplished much under difficult and challenging circumstances. The project was designed as a "needs-driven" project, developed as part of a participatory process in collaboration with the key partners and stakeholders, and addressing the primary capacity-building needs of the Toamasina II district health system.

The preferred futures identified by the SSD help define the framework within which this project operates, although at times along the way, it has been easy for the project and SSD staff to lose sight of the overall goal and objectives. It is important for the administration to keep painting the

vision of what is to be accomplished, and encouraging staff for the accomplishments they make along the way.

The TCSP has grown to become a trusted and loyal partner for the SSD, and there is a good, strong working relationship between the two organizations. To address the ongoing shortage of funds to accomplish its desired purposes, the ADRA TCSP needs to work with the SSD to enable them to develop simple but strong proposals for attracting alternative sources of funding.

The project still faces major challenges with poor accessibility into the remote rural areas. An important approach to overcoming this obstacle is to maximize the utilization of local FM radio stations in Tamatave for broadcast of targeted IEC programs in the future.

The SSD and TCSP have had considerable success with their community mobilization activities, which are addressing areas of real interest and need to the local communities. Consequently, the demand for such services has outpaced the budget for continued expansion of this component. Alternative sources of funding would enable this component to take on an expanded life of its own.

The project has developed or introduced several innovative supplementary approaches that have been quite successful in this project, including the VISA 5/5 program for promotion of vaccination among children, the supplementary kitchen garden component, the malaria bed-net distribution project, the "Toamasina Assistance to Primary Schools" (TAPS) water project, and the ADRA-JSI "Health Education for Life Project" (HELP).

Finally, the long delays in several major components of the project are now on an accelerated "fast-track" to make up for lost time. It is anticipated that the project will be able to complete its scheduled activities on time.

F-2. Recommendations[12]

1. **M&E / Quality Assurance Officer:** The TCSP should employ a full-time Quality Assurance Officer to focus on issues of quality assurance, monitoring and evaluation, and improvement of management services. This person needs a solid experience in statistics, as well as M&E issues.

2. **M&E Review:** A thorough review of the monitoring and evaluation system is advised, with development of a scheduled plan for periodic sampling and assessment of beneficiaries and stakeholders.

3. **FM-radio broadcasts**: Greater use of radio-based IEC for a targeted awareness campaign focused on the remote rural population.

[12] Please refer to each of the previous analytical sections in this document for more detailed recommendations by sector. This section includes only those general recommendations not covered earlier, or includes the most important components addressed to a lesser extent in the earlier parts of this evaluation report.

4. **Continued practical nutrition promotion**: The TCSP should continue to support the home gardening promotion and training among poor rural populations, including the distribution of papaya plants and seeds for other nutrient dense vegetables under supplementary funding.

5. **Malaria and environmental health:** Increased emphasis on environmental health issues under the ADRA/PSI project, particularly in conjunction with the malaria prevention project. Explore the possibilities for exchange visits to ADRA's Food Security Project in Moramanga, and some of the other environmental health projects being implemented in Madagascar by other USAID partners such as ECHO or the US Peace Corps Volunteers.

6. **Environmental Conservation through Family Planning:** Under the supplementary Family Planning component of the HELP interventions, the TCSP can collaborate with the Madagascar Fauna Group and as requested by them, provide FP services in the areas bordering the protected Ivoloina Biological Park and Betampona Nature Reserve, both within Toamasina II district, and under population pressures, with people cutting forest for firewood or charcoal.

7. ***Sustainability of SSD Interventions:*** *There is need to review the system of* community-based volunteers, with a view to seeing how the different groups of CVAs, Women's Groups and ASBCs could be consolidated into just one or two groups (having received multi-disciplinary training), making for easier and more sustainable supervision by the SSD in the future.

8. **Review of Integrated Supervision System**: The external evaluator has indicated the SSD integrated supervisions should respect the ADRA administrative and logistical paperwork deadlines and regulations (e.g., work requests, per diems and travel requests, etc.) and also the need for a truly integrated approach to supervision (i.e., multi-disciplinary members on the supervision team). The supervision team should also include at least one physician.

9. A **strategy of 'cascade' supervision**[13] is needed to overcome the difficulty of remote accessibility within the target district, with the medical doctors at the CSB2s taking responsibility for organizing the supervision of CSB1s in their area.

10. The TCSP needs to increase support for the most remote CSBs through regular **supervision visits**, and should allow sufficient time (if needed) during their visits, for the supervision team to advocate on behalf of the CSBs at the level of the local authorities.

Equipment

11. The SSD has requested that the TCSP search for funds to provide a computer for each program office in the SSD, enabling the SSD staff to better plan and manage their

[13] One layer (at the SSD level) is supervised, then they supervise the next layer (at the CSB level), who in *turn supervise the next cascade (at the community) level.*

programs. Additional training in the practical use of computers within the work environment is also needed.

12. The SSD has asked for increased support for CSBs by helping to locate sources for essential equipment and repairs to enable the CSBs to be more functional.

Communications and Team Building

13. In order to promote open communications with two-way dialogue, the TCSP should take the lead in coordinating the periodic meetings of the EMAD and the enlarged EMAD with the ADRA staff, also enabling the CSB agents to voice their opinions regarding problems at their CSBs and with their collaboration with local authorities.

14. The TCSP should explore options for the purchase of UHF radios to improve the communication between CSBs and the SSD, particularly in the most remote locations (e.g., Fito, Antenina I). The radios could be installed as a means of improving the communications systems for not only the health care services, but also for education, agriculture and the commune authorities.

15. The TCSP should print the SSD organogram and goals and objectives, leaving them in prominent locations for the SSD, CSB and ADRA personnel to reflect on from week to week, helping to keep everyone focused on where the project is headed in terms of transfer of competence and sustainability.

Decentralization of HMIS data sharing

16. The TCSP should continue with even stronger support to the SSD for the sustainable production of a quarterly information bulletin about the SSD, targeted at the SSD and CSB staff. This bulletin can contain articles on training, information on new health technologies, new policies and practical care instructions, information on the current trends in morbidity or mortality within the district, as well as providing feedback and summary information with corresponding analysis. The SSD should form an editorial committee to regularly collect articles and to ensure the continued progress of this useful publication.

17. The TCSP should develop graph templates using "Excel" spreadsheets so that basic summary data can be entered to automatically produce graphical presentations of trends and analyses. Reports should then go out on a monthly basis, both down the level of the community and CSBs as well as up to the DIRDS and MoH levels.

Staffing/Personnel issues

18. The SSD and ADRA need to review the organization of their personnel at the level of the CSBs. All CSB chiefs should be aware of the rule requiring at least two people to be physically present at the CSB at any time, and especially during important events such as the immunization campaign days or for other major health interventions.

19. The TCSP should help the SSD to develop an updated, computerized organogram to clearly identify the current staff, reporting relationships and decision-making lines of authority.

Traditional Birth Attendant Training

20. The TCSP should try to integrate basic training for TBAs regarding the promotion of the key prevention messages for mothers and children regarding nutrition, breastfeeding and family planning. The follow-on project should also train the TBA in regards to complications of high-risk pregnancies.

Formative and Operational Research

21. Finally, the TCSP should explore the possibility of developing links with academic and research institutions both in Madagascar and abroad, in order to address the absence of research reports on priority health issues in the Toamasina region.

Priority topics for research in the Toamasina region include the following:

- ***Access to Health Care***: The % of rural Toamasina II district that access the current health care system, where they go for traditional health care services, and costs involved.

- ***Malaria***: KAPS; prevention and local treatment options; extent of malaria-related morbidity and mortality in the coastal vs. mountainous regions; biting patterns of local mosquitoes; effectiveness of nets in prevention, etc.

- ***Health Care Planning***: How best to strengthen the formal and informal health care and medical supply system in the rural remote regions.

- ***HIS***: Primary causes and frequency of (unreported) morbidity and mortality (especially among women and children) in remote rural areas.
- ***Demographics***: Resolve the incongruence between the official estimates and actual population figures in rural areas; migratory trends.

- ***Natural/Traditional Therapies***: Local treatments for illness and disease.

- ***Pharmacology***: Drug resistance, inappropriate prescribing, and self-medication.

- ***STI/HIV/AIDS***: Awareness, beliefs and practices among rural populations; local treatments for STIs.

- ***Health Care Financing***: Medical emergencies, health care impacts, and ability to pay for health care services among remote rural populations.

- ***Alcohol Abuse***: Impact of alcohol abuse on rural populations; frequency of alcohol-related morbidity and mortality, particularly as it relates to sexual/domestic violence.

- ***Dental Hygiene***: Impact of nutritional status, diet, socio-economic status, coffee and sugar consumption as factors contributing to high incidence of dental caries among poor populations. Local alternatives to reducing the high incidence.

- ***Nutrition***: Impact of supplemental iron, zinc, Vitamin A and anti-helminthes on the health and nutritional status of children. Research extent of micronutrient deficiencies in rural coastal populations of women and children.

- ***Parasitology***: Research into perceived causes, impact and local treatments for parasites, including worms, cysticercosis, bilharzias, tungiasis, etc.

APPENDIX A

BASELINE (DIP) INFORMATION

A1) Field Program Summary

1. Program Effort and USAID Funding by Intervention

Intervention	Percent of Total Effort	USAID Funds in US$
Community-based IMCI	30%	300,000
Nutrition	20%	200,000
Malaria Control	25%	250,000
School & Community Health Education	25%	250,000
TOTAL	100%	$999,968

2. Toamasina II Population: Children and Women

Population Age Groups	Estimated Number in Age Groups
Infants (0-11 months) (20% of U5s)	6,348
Children (12-23 months) (30% of U5s)	9,522
Children (24-59 months) (50% of U5s)	15,870
TOTAL Children (0-59 months) 18.7%	31,740
Women (15-49 years) 22.9%	38,868
TOTAL Beneficiary Population	**70,608**

A2) Program Goals, Objectives and Indicators

Program Goal: To reduce the morbidity and mortality among WCBA and children less than five years in the Toamasina II district of Toamasina Province, Madagascar.

Program Objective: To strengthen the capacity of the District Health System (SSD) to provide and manage an integrated program of essential preventive, promotive, and curative health care services in Toamasina II District.

Strategies:

- A modified "Appreciative Inquiry" approach to define the SSDs desired positive changes in management, health care delivery, and inter-personal communications; to build organizational capacity of the SSD and of ADRA, and to give direction to the project.
- Improved community-based health services and promotion of healthy, protective behaviors for mothers and children.
- Increased community participation in health care and development issues (involving CVAs, EMAD, and CTC approaches).
- Increased capacity of SSD to plan and manage health programs which deliver quality health care services in the community.
- Innovative team-building and inter-personal communication approaches used in management training for SSD and CSB personnel.
- Improved, innovative approaches to integrated planning, implementation, monitoring and evaluation of all SSD activities

PREFERRED FUTURES AND INDICATORS

(Listed according to the CAPACTY AREAS addressed)

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
LEADERSHIP / NETWORKING / TECHNICAL				
PREFERRED FUTURE # 1: The SSD is the reference standard by which other SSDs in the Toamasina region are compared, in terms of organization and coordination of activities.	1.1) The SSD has a long-range plan that is directional, flexible, and regularly reviewed for specific annual planning. 1.2) The results of the SSD's programs and approaches are monitored, reported, shared and celebrated.	1.1) SSD Strategic planning meetings, with annual reviews. 1.2) Reports, meetings and exchange visits to monitor, share, and celebrate the changes in the SSD. 1.2a) Development of capacity-assessment tool for SSD and CSBs.	1.1) Strategic Master plan for SSD in place with bi-annual reviews. 1.2) Written reports and lesson's learned are shared within the SSD and with others. 1.2a) An effective capacity assessment tool which is simple and practical.	1.1) Annual, six-monthly and quarterly work-plans and reports. 1.2) Quarterly & annual reports. 1.2.1) Meeting reports 1.2.2) Site visit reports 1.2.3) Stories illustrating SSD innovation and growth; interviews.
INNOVATION / RESEARCH / TECHNICAL				
PREFERRED FUTURE # 2: **The SSD pilots new and innovative approaches to preventive, promotive and curative health care.**	2.1) # of new and different types of innovative approaches sought, researched, and adapted for use by the SSD, which address promotive, preventive and curative health care, and cost recovery.	2.1) Innovative approaches sought, modified, and/or piloted by SSD and CSB agents. 2.1.1) Development of SSD Master plan for preventive, promotive and curative health care programs.	2.1) Innovative new approaches implemented in SSD and CSB workplace. 2.1.1) Combination of preventive, promotive and curative activities and interventions at SSD and CSBs.	2.1)Documented trials/reports of innovative approaches. 2.1.1) Action plans ; quarterly and annual reports.

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
CREATIVITY / TECHNICAL				
PREFERRED FUTURE # 3: **The SSD Program Officers use the computer in creative ways to increase their effectiveness.**	3.1) # of persons trained and competent in development of computerized reports, documents and action plans.	3.1) Computer training for SSD program officers covering practical, everyday work applications of computers.	3.1) # SSD program officers trained and competent with computers, able to produce computerized reports, work documents and action plans.	3.1) SSD training records, and computerized work documents, reports, action plans etc.
	3.2) # of appropriate actions taken by the SSD, CSBs and communities in response to the HIS / MIS database outputs.	3.2) Practical training in computerized HIS/MIS data entry, analysis, and reporting.	3.2) More effective HIS/MIS reporting and feedback enable appropriate actions/response by SSD, CSBs and communities	3.2) Meeting reports 3.2.1) Changes in action plan
	3.3) # of SSD staff using the computer tools for creating simple, easy-to-understand reports for feedback to the team and the community.	3.3) Training in development of simple, appropriate reports, graphical communications, and health promotion tools for low-literacy contexts.	3.3) Simple, effective graphics, reports and health promotion tools designed for use in low-literacy environments.	3.3) Low-literacy materials. 3.3.1) Charts / reports used in the CSBs + exit interviews. 3.3.2) Feedback from the community. 3.3.3) Actual use of information collected.

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
STRENGTHENING OF MANAGEMENT SYSTEMS / TECHNICAL				
PREFERRED FUTURE # 4: **All the Program Officers have the capacity to design, plan, organize and evaluate to effectively manage their health programs.**	4.1) # of Program Officers trained in Management. 4.2) # of Program Officers with an annual or six-monthly action plan which is reviewed monthly. 4.3) Program Officers visit the CSBs regularly and know the staff and their beneficiaries.	4.1) Practical management training for SSD Program Officers and CSB agents. 4.1.1) Analysis of current MIS tools, trainings and practices, with regular reviews of past performance. 4.2) Practical, competency-based program management training which addresses development of annual action plans. 4.2.1) SSD meetings for critical review of annual, quarterly, and monthly action plans. 4.3) Develop regular supervision schedule for CSBs and CVAs.	4.1) SSD Program Officers and CSB agents trained in practical program management. 4.1.1) SSD, CSB and CVA personnel understand MIS tools, review them, and use them appropriately. 4.2) SSD Program Officers develop their own annual action plans. 4.2.1) Monthly meetings for review of action plans, with analysis of timeliness and effectiveness. 4.3) CSBs and CVAs visited regularly by SSD Program Officers.	4.1) Training records for SSD and CSB trainings. 4.1.1) Interviews with SSD, CSB, CVA personnel. 4.1.2) Meeting reports 4.1.3) Timeliness of reports 4.2) Actual action plan 4.2.1) Meeting reports. 4.3) Supervision schedule 4.3.1) Interviews with CSB personnel.
COMMUNITY / PARTNERSHIPS / TECHNICAL				
	5.1) The SSD has an integrated community-based IMCI program in place. 5.2) Cost recovery system	5.1) Community-based IMCI training and refresher training for CSB agents and CVAs. 5.2) Cost recovery training for Community	5.1) CSB agents and CVAs trained and competent in community-based IMCI approaches. 5.2) Community	5.1) CSB and CVA training records; IMCI curriculum for CSB agents and CVAs. 5.2) Training records,

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
	strengthened and refined by SSD/ADRA.	Management Committees.	Management Committees trained, and implement effective cost recovery strategies.	and training curriculum.
PREFERRED FUTURE #5: **There is an SSD community health program including integrated health care of children, environmental health, malaria prevention, nutritional rehabilitation and nutritional education.**		5.2.1) Development of an integrated cost recovery supervision plan.	5.2.1) Integrated supervision of cost recovery programs at CSBs.	5.2.1) Integrated supervision schedule for cost recovery.
	5.4) # of CVAs selected, trained and operating actively in the villages.	5.4) Selection, training and regular supervision of CVAs.	5.4) Active involvement of CVAs in the health care needs of their community.	5.4) CVA reports. 5.4.1) Community reports.
	5.5) # of Environmental Health Committees set up and working in the community.	5.5) Selection, training and supervision of Environmental Health Committees.	5.5) Environmental Health Committees established and active in target communities.	5.5) Meeting reports 5.5) Anecdotal community reports.
	5.6) Visible changes are evident in the communities, which are a result of the work of the SSD.	5.6) Community-level evaluation of SSD's program approaches.	5.6) Documented community perceptions of changes resulting from the SSD's work in their community.	5.6) Focus Group Studies 5.6.1) Exit Interviews at CSBs. 5.6.2) CSB and CVA reports
	5.7) Programs are relevant to the needs of the people, are effective, and reach the target population.	5.7) Establish meetings or workshops for SSD critical Program self-evaluation. 5.8) Develop an	5.7) Critically-constructive self-evaluation of current SSD programs and their effectiveness.	5.7) Self-evaluation reports 5.7.1) Capacity assessment reports.

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
	5.8) Local resources are valued, mobilized, and utilized to the optimum. 5.9) The SSD has in place an effective monitoring, evaluation, and data collection system in place for the health indicators they are accountable for.	organizational assessment of local, community-level utilization of resources. 5.9) Assist SSD in collating, monitoring and evaluating the key indicators required of them by the MOH (and USAID).	5.8) Community-level accountability for effective utilization of local resources 5.9) SSD has practical, accurate HIS/MIS in place for monitoring all key MOH and USAID health indicators.	5.8) Organizational resource assessment tool. 5.8.1) CVA meeting reports 5.9) HIS/MIS reports
ORGANIZATIONAL PERFORMANCE / COMMUNITY / TECHNICAL				
PREFERRED FUTURE # 6: **The SSD has a "Professional Conscience" in the interests of the community. **** ** "Professional Conscience" as defined by the group participants is defined in Section C.	6.1) The CSB agents meet regularly with the Community Health Management Committees to address community health concerns. 6.2) Appreciation of the quality of service by the community and/or by the management committee. 6.3) Quality feedback is promoted and used in monitoring, sharing, & strengthening the capacity and performance of the SSD/ADRA and the Community.	6.1) Establish and help maintain CSB schedule for regular meetings with the Community Health Management Committees. 6.2) Community-level assessment of the quality of health care services in their community. 6.3) Development of an effective, measurable performance evaluation tool for the SSD. 6.3.1) Quarterly community-level feedback via PRA approaches in	6.1) Regular meetings of Community Health Management Committees attended by CSB agents. 6.2) Improved quality of health care services being provided at the community level. 6.3) Effective regular feedback from community to the SSD/ADRA which is incorporated into ongoing refinement of program. 6.3.1) SSD programs are in tune with community needs, and	6.1) CVA meeting reports 6.1.1) CSB activity reports 6.2) Focus Group Studies 6.2.1) Exit interviews at CSBs. 6.3) Focus Group Studies & Exit interviews at CSBs. 6.3.1) CVA and CSB reports

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
		target communities.	respond accordingly.	6.3.2) Informal discussions 6.3.2) Key informant interviews. 6.3.3) Exit interviews 6.3.4) Focus group studies.
	6.4) There is mutual concern and openness to help one another so that people know what is happening to each other and their families a) in the SSD b) in the CSBs, and c) in the communities.	6.4) Develop means of raising awareness among staff of inter-personal needs and considerations, and train in effective communication and counseling skills for program managers.	6.4) Increased openness and concern for peers within the SSD, CSBs and communities.	6.4) Supervision reports 6.6.1) Self Evaluation reports. 6.6.2) Anecdotal reports
HUMAN RESOURCE DEVELOPMENT / TECHNICAL / COMMUNICATION / TEAMWORK				
PREFERRED FUTURE # 7: **There is an SSD Human Resource Development program for change, which enables team-building, enhanced inter-personal relationships between staff, and open communic-ations.**	7.1) # of regular meetings with SSD and/or CSB staff with two-way communication and exchange of information, and having detailed meeting minutes kept. 7.2) Assessment of the "Quality" issues in personnel development, in terms of team spirit, receptivity, listening capacity, openness to correction etc.	7.1) Management trainings for SSD and CSBs, including effective communication methods, and principles for running effective business meetings. 7.2) Development of a measurable quality-assessment tool for evaluation of inter-personal development skills, work ethics and motivation.	7.1) Open, effective, two-way communication without barriers at all levels of the SSD, with recorded meeting minutes kept. 7.2) SSD personnel able to self-evaluate in terms of development of inter-personal communication skills, work ethic, and motivation. 7.2.1) Regular meetings of the SSD	7.1) Self-Evaluation reports 7.1.1) Meeting minutes and supervision reports. 7.2) Completed assessment tool. 7.2.a) Evaluation reports 7.2.b) Individual staff personal development plans. 7.2.1) Meeting reports

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
	7.3) Team-building is actively promoted at all levels of the SSD. 7.4) SSD and CSB personnel have opportunity to be trained, and to learn "on the job."	7.2.1) Management training which addresses constructive criticism, story-sharing as an assessment tool, and organizational self assessment. 7.3) Introduce team-building activities, training, and approaches to the SSD. 7.4) Health Advisors assist with Integrated supervision and mentoring of SSD & CSB staff.	with open sharing of experiences/ stories, and provide opportunity for constructive criticism. 7.3) A more effective, cohesive, integrated and bonded SSD team. 7.4) Competent SSD and CSB agents with clear, practical knowledge.	7.2.2) Staff discussions 7.2.3) Evaluation reports 7.3) Activity schedule 7.3.1) Training curriculum 7.3.2) Training reports 7.4) Training, evaluation, and supervision reports.
ORGANIZATIONAL STRENGTHENING / TECHNICAL				
PREFERRED FUTURE # 8: **In order to be the most effective, the SSD's planning, management and data collection are integrated, coordinated, and realistic.**	8.1) Reporting rate (reliability) 8.2) Evaluation of progress and impact (using Focus Group Studies) in the field.	8.1) Incorporate into trainings for all levels of health care system, the importance of integrated, coordinated and realistic planning, management, and data collection, and the importance of their roles in these processes. 8.2) Schedule regular community-level evaluations of the progress and impact, after training the SSD	8.2) Increased understanding of the importance of integrated, coordinated, realistic, and accurate planning, management and data collection within the SSD. 8.2) Regular community-level feedback regarding program progress and impact. 8.2.1) SSD Trained in	8.2) Congruence between activity reports and supervision findings. 8.2.1) Evaluation reports 8.2.2) Org. Self-assessment reports. 8.2.3) Quality Assurance checklists. 8.2) Quarterly Focus Group Studies, focused on relevant topic being implemented, using the original KPC baseline

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
		in use of Focus Group Studies.	PRA data-collection techniques.	survey questions as a guide.
	8.3) Does the SSD practice good budgeting, up-to-date bookkeeping, complete/timely reporting, and regular audits?	8.3) Practical management training which addresses effective budgeting, book-keeping, accounting, reporting, auditing etc.	8.3) SSD personnel at all levels practice good budgeting, up-to-date book-keeping, complete/timely reporting, and have regular audits.	8.3) Supervision reports 8.3.1) Timeliness of reports 8.3.2) Accuracy of accounting records; Quarterly budget analysis
	8.4) Is the cost recovery system showing a move towards being fully sustainable?	8.4) Ongoing monitoring, analysis and review of Cost Recovery system.	8.4) The SSD Cost Recovery system is moving towards being fully sustainable.	8.4) Monthly income/expense reports for CSBs.
	8.5) All SSD and related staff know why they do what they are doing.	8.5) Development of job descriptions for all SSD personnel during management training	8.5) All SSD personnel have clear, upgraded job descriptions, and know why they do the work they are doing.	8.5.1) Meeting reports 8.5) Job descriptions on file. 8.5.0) Regular upgrading of job descriptions.
		8.5.1) Specific trainings in areas of self-indicated need, in addition to multi-disciplinary training.	8.5.1) SSD staff clearly understand all aspects of the work they are required to do, having been trained in multi-disciplinary skills and competencies.	8.5.1) Supervision reports 8.5.2) Self-evaluation reports 8.5.3) Training record 8.5.4) Training curriculum
			8.6) SSD and CSB	

Preferred Futures	Measurable Indicators	Major Inputs	Outputs	Means of Verification
	8.6) The SSD has an efficient, effective reporting system in place.	8.6) HIS/MIS trainings for SSD	personnel trained in HIS/MIS	8.6) Training Reports 8.6.1) Reg. Monthly Reports

A3) PROGRAM LOCATION

Location: The CS program is located in the Health District (SSD) of Toamasina II, Toamasina Region, Madagascar. The area lies on Madagascar's eastern coast, reaching approximately 50 kilometers north and 40 km south of Toamasina (also known as Tamatave) town, the main port of Madagascar and the capital of the Toamasina Region. This area is part of the "cyclone coast", vulnerable to devastating storms every few years that destroy homes and crops. The last major cyclone was in 1996. Several bridges and health centers were still in disrepair as of early 1999. There are 25 functioning public health facilities and five private health facilities belonging to private businesses or religious groups within the project area.

Toamasina II is the rural district located outside the city of Toamasina (also known as Toamasina I). Toamasina II district is characterized by numerous small villages and hamlets concentrated along rivers and roads or connected by steep trails that are generally only passable on foot. Dwellings are generally constructed of bamboo with thatched roofs. Any existing roads, other than the north-south coastal highway, are poorly maintained. Many towns on secondary roads do not have bush-taxi service. Existing toilet facilities are limited to pit latrines, available at schools, sometimes at CSBs, but only rarely at private homes. Water supply in large towns is sometimes available from borehole wells or from public water faucets. In rural areas, water is usually obtained from shallow wells, springs, rivers, and a few boreholes. Most households use charcoal and wood for cooking and lighting purposes.

The economy is overwhelmingly agricultural, divided between subsistence farming of staples such as rice and cash crops, coffee, cloves, pepper, bananas, and is based largely on "slash and burn" agriculture. The area is primarily dependent on rice cultivation and most homes experience a "time of food shortage" lasting up to six months of the year. Over 62% of the mothers reported they did not have enough food to support their family (typically with five or six children) for the whole year.

Target Population: Betsimisaraka women and children (under five years of age).
The majority of the Toamasina II population are from the Betsimisaraka ethnic group, with a few ethnic Chinese and Indo-Pakistanis. The Betsimisaraka culture is influenced by African cultures and languages and has many taboos and cultural practices that can affect child survival. For example, Tuesdays and Thursdays are considered *Taboo Days*, the only days where workers do not go to the rice fields to work. These are the only days when mothers will bring their children to the health center (Centre de Santé Base, CSB) for preventive care. Fortunately, there is no limitation on when a child can be brought for curative care.

Only 25% of the population are Christian, either Catholic or Protestant, with a small Muslim minority. The majority of the rural population believe in spiritism (being possessed by spirits which give people supernatural healing powers) or animism (in which animal sacrifices are given to appease the spirits all around in nature). Although the Betsimisaraka speak Malagasy, (the national language), their dialect has attributed different meanings to words than meanings for those words when used in the highlands of central Madagascar. Some innocuous words or expressions in the central highlands have completely different, or even vulgar meanings in the coastal lowlands.

There are no significant minority or disadvantaged groups within the Betsimisaraka ethnic group. High-risk groups include those living a long distance from health centers; several are more than a day's walk, and those living a long distance from the nearest referral hospital (in Toamasina I). It will be many years before a good transportation infrastructure is available. While a high proportion of women stated they had been to school (51% had been to primary school), 63% of women stated they either could not read a letter, or could read it only with difficulty.

Madagascar has the highest rates of stunting and childhood malnutrition in all of Africa, placing slightly under half of all children at risk of death. An estimated 48% of children under 3 years of age are stunted, 22% with severe stunting (DHS 1997, p148). Likewise, an estimated 40% of children under 3 years of age are moderately underweight, and 13% are severely underweight. The children with the poorest health indicators are those aged 12-36 months. Limited availability and quality of health care services at the CSBs in the project area means that many women and children at highest risk for increased morbidity and mortality do not have access to the most-needed services. Much of the time and resources in this project will be devoted to helping the SSD to plan, restore, upgrade, expand and improve the quality, availability and range of maternal and child health care services.

The Infant Mortality Rate (IMR) for the Toamasina province is 104 per 1,000 live births, compared to 97 per 1,000 nationally. The under-5 mortality rate (U5MR) is 174 per 1,000 live births, compared with national rate of 159 per 1,000 (DHS, 1997). UNICEF reports the top three causes of under 5 mortality are 1) Malaria, 2) Diarrheal disease, and 3) Malnutrition, while the SSD reports additional child deaths attributable to the vaccine- preventable diseases, measles, pertussis and tetanus.

The estimated maternal mortality rate (MMR) ranges between 488 (DHS 1997) and 570 (MINSAN 1997) per 100,000 live births. Maternal deaths are primarily associated with abortion, sepsis, and hemorrhage, (UNICEF 1994) as well as hypertensive disorders of pregnancy and obstructed labor, exacerbated by poor maternal nutrition and lack of access to quality obstetric care.

Existing health infrastructure

In the Toamasina II health district, there are 31 public health clinics (called "Centre de Santé Base, or C.S.B.s) of which six are not yet functional. These clinics are supposed to provide delivery of the basic Primary Health Care services at the community level.

All the "level one" CSBs are staffed with a nurse, midwife or "Aide Sanitaire", many of whom had an initial 9 months training and were appointed by political authorities as far back as the early 1980's. In addition, there are three private dispensaries, attached to companies, and two clinics affiliated with religious groups, (including the Adventist one in Ambatoharana). Apart from the traditional healers, the only other private health care providers are located in the town of Toamasina.

There is no hospital in the district. The regional Hospital in Toamasina is the main referral center for the central parts of Toamasina II, Fenerive Est to the north, and Brickaville to the south.

The Toamasina II SSD has a total of 25 staff, the positions of which are outlined in Annex # 9 of the DIP. In the entire rural district there are only two doctors, both of whom work at the SSD office in Toamasina. Thirty-five people work in the CSBs. This includes one physician, four midwives, 12 nurses, and 18 "aide sanitaires." The MOH has requested some of the more important clinics need to be upgraded to become CSB-2's in the future. These clinics will be upgraded and the MOH is currently recruiting (newly graduated) doctors willing to serve in these more remote rural areas.

Cold chain equipment has been improved since the proposal was written, with installation of kerosene refrigerators by UNICEF. Five CSBs still do not have functioning refrigerators. There is not a systematic program of monitoring of the cold chain. There is no plan for preventive maintenance of the refrigerators. Thermoses have been supplied by ADRA since the project's beginning, with funds donated from Australia. Sterilizing equipment is either not available or in poor repair. The supply of syringes is poor, with reports of disposable needles and syringes being reused multiple times.

There are abundant numbers of traditional healers and traditional birth attendants (TBAs) throughout the area. While no formal relationship between the health system and the traditional healers, SSD personnel recognize that these people are the most sought after advisors for many aspects of health care. There is considerable resistance from the national midwives association to working with TBAs. They have stated that midwives have undergone many years of training and they do not want to "give up clients" to TBA's. (There are only 4 trained midwives in Toamasina II to cover an estimated 6,100 births per year.)

Although it is not MOH policy to train TBAs, the SSD have indicated they would like to see the traditional health care providers included in their future training plan, as they recognize that these health care providers are the first point of contact for most villagers when they have need of medical or health-related assistance. The plan is to hold more discussions with the MOH and DIRDS to see if it would be possible to do some (pilot) training for these traditional health care providers in basic preventive IEC approaches, with clear guidelines for when to refer. The project will also explore the possibility of including the TBAs in a Vitamin A outreach strategy, as the current MOH Vitamin A policy calls for postpartum women to receive one high dose capsule within 8 weeks of delivery. This policy will be actively promoted in the CSBs and in the communities via the Comité Villageois d'Animation (or CVAs).

Health Sector Reform is based on the decentralized WHO model of the health district as the major decision-making and implementing unit within the Ministry of Health. Toamasina II is one of 18 SSDs in the DIRDS of Toamasina. The GOM is following WHO-recommended approaches to strengthen the SSDs, but the disparity between resources and capacities is still large, leaving the SSDs to function at less than optimal levels. The priority of the Ministry of Health is to focus resources for strengthening of these newly instituted Health Districts. Policy changes still occur, however, at the central level and are quickly imposed on the district health

systems. One example is the introduction of the IMCI approach to child health care services, when it became national policy in 1998. The new approach was imposed on a system organized along a vertical intervention (or disease) management structure. The current SSD management is not integrated and will require reconfiguration to coincide with this new emphasis. Fortunately, SSD managers recognize this necessity.

A4) PROGRAM DESIGN

The first new and innovative approach of the program is the team Appreciative Inquiry strategic planning done jointly by the SSD and ADRA. As the process of mutual learning, discovery and visioning continues, it is expected that the SSD/ADRA team will implement at least one new and different health care approach each year of the project. The major innovative emphasis will be on prevention and health promotion. These new approaches will be the best demonstration of increasing capacity and sustainability.

The strategies and indicators are different from those found in a traditional CS project. They are more likely to be found in a business plan for an innovative organizational development team in a cutting-edge company preparing to enter the new millenium. Derived from their dreams and visions for the future, this plan is what the SSD wants to become by the end of the project. This is exciting new ground. It has been facilitated by introduction of the innovative new approach to management known as "Appreciative Inquiry" (AI).

Program Relationship to Health Facilities:
The TCSP will work most closely with the SSD and CSB agents. In the past the CSB agents have had little opportunity for upgrading training. Initial HFA analysis indicates there are two categories of CSB agents: a) Those who are well experienced, and have worked in the same facility for some 15-20 years or more, and b) those who are relatively new in the field, and have worked only 1-3 years in their CSB. (Refer to graphs in Annex # 10 for details).

The HFA report indicated that a number of CSB agents have not been visited by an SSD supervisor in the last three years. Some even reported they could not remember being visited within the last seven years. Admittedly, these clinics are very remote, and it takes up to three days (depending on the weather) just to walk in to their site from the nearest access roads! However, it will be a priority in this project in the second project year to ensure that all clinics receive supervisory visits, and the opportunity to receive on-the-job training. The HFA has highlighted the need for practical training for those who are new to the field of health care delivery, as well as upgrading training specific to the needs of those who have worked longer in the field, but may not be aware of new approaches or policies. A major priority will be to ensure that these CSB agents receive appropriate training which is simple, practical, competency-based and will enhance their efficiency and effectiveness in the field. Realizing the need to balance the desire on the one hand to train these agents as quickly as possible, and the reality that every day in training means more days the rural communities they work in are without a qualified health care provider, a middle ground has now been reached. The CSB agents come in once a month to Toamasina town to present monthly activity reports, and collect their salary. The TCSP is conducting regular monthly two to three day trainings and upgrading workshops for the CSB agents.

Discussions with the DIRDS have reinforced the need for an emphasis on the CSB agents for technical training, as the DIRDS feels the SSD program officers have received considerable technical training over the years, but have not always been able to pass this on in clear and practical ways to the CSB agents. It is anticipated that over the next few years of trainings this

change of focus will demonstrate a significant improvement in what is happening at the CSB level.

With regard to the SSD, it has become very clear from discussions surrounding the Appreciative Inquiry approach that key program officers in the SSD want to bring about change for the better. A number of factors seem to be motivating this. First, the current health care system under the Ministry of Health is based on numerous vertical programs, as described earlier in this document. The SSD Program Officers recognize the need for moving toward multi-disciplinary training. Currently, there is considerable overlap of supervision. Program officers from EPI will go out to the field one or two days with an SSD vehicle. They may be followed within two weeks, by supervisors from CDD, malaria, nutrition, or another similar vertical program.

Discussions have highlighted many topics which need to be covered in basic manage-ment training, including scheduling, M&E, stock-taking inventories, and personnel management issues. The SSD staff have also recognized the need to improve their efficiency in the field. They have requested to have all key program officers trained in a core of multi-disciplinary topics. Each officer wants to feel confident and competent to advise, train, evaluate and support CSB agents in the field, regardless of what is their primary intervention responsibility.

A series of monthly meetings is planned at the SSD training room (adjacent to the ADRA office) to address these expressed needs. ADRA will continue weekly and staff meetings with SSD Program Officers. This is already proving to be a very significant part of the project, as much of the impetus for change is arising in these meetings. As a result of the Appreciative Inquiry approach, the SSD Program Officers have identified a significant need for "team-building" trainings, and for help in breaking down communication barriers. The Chief Medical Inspector and ADRA have agreed to weekly trainings for the SSD staff. The primary focus of these meetings will be management training. They will also cover other major issues in inter-personal relationships, and modern team-building approaches. The DIRDS will give support with trainers and/or other technical assistance where relevant.

Rationale for Choice of Interventions: As indicated previously, interventions and strategies chosen for the remainder of this project reflect the highest priorities of the SSD in terms of preferred futures, and what they consider as the greatest needs for their district. It is significant that these are largely in line with the project proposal and with what the HPN office of USAID Madagascar is focusing on as mission priorities for the next few years of their strategic plan. Consequently, it is appropriate that the program move in this direction. The main point of difference with the traditional CS approach, is that most of the traditional CS (health) indicators will not be directly applicable. ADRA will be directly responsible for training and mentoring of SSD and CSB agents in an integrated approach to child-care needs at the community level. The SSD, CSBs, and CVAs will be the implementers of those interventions which relate to more traditional health indicators. Some key child survival indicators will still be measured, but most indicators relate to management, personnel, and technical trainings.

As indicated earlier, the malaria interventions are an area included in the SSD's list of dreams which ADRA feels is a high priority, given the degree of morbidity and mortality in the district resulting from malaria. There are relatively few cases of measles recorded in the project area,

which indicates vaccination is having an effect. It is anticipated that with adequate sensitization of the community and health care providers in regard to malaria prevention, it will be possible to also achieve significant gains.

Given that the Toamasina II project area has had little involvement with outside health and development agencies to date, little is known about what works and what does not in this region of the country. After discussion about relative advantages of the HEARTH model or the Trial of Improved Practices (TIPS) approach to nutritional education and rehabilitation in the target communities, it was decided to go with the TIPS approach.

The TIPS model has been used by LINKAGES in other regions of Madagascar. Significant lessons have been learned that can be drawn from their experience. Additionally, to use the HEARTH model successfully, there needs to be a constant and adequate food supply in the intervention area. This is something that the baseline survey indicated is not found in the target area. Though this will be a new approach for the project staff, it is anticipated there is enough expertise available within country, or through readily accessible sources to enable ADRA to use this approach in selected communities.

A5) PARTNERSHIPS

An important part of this project is building partnerships at Ministry, regional, district and community levels. Since the project began, numerous meetings and consultations have been held with key partners at each of these levels. Initial meetings were geared towards informing these organizations about ADRA, the purpose of the project, and exploring approaches to collaboration. More recent discussions have explored where the TCSP can participate in trainings or collaborate on development and use of IEC materials. Key government departments and non-governmental organizations, related to the health sector, education and infrastructure, were contacted in Antananarivo and Toamasina. These have included JSI, LINKAGES, USAID, MOH, MoEd, SEECALINE, UNICEF, PACT, PSI/CMS and GAIN. Details of these relationships are outlined below.

Ministry of Health (MOH):
The Ministry of Health is the main ADRA CS project counterpart. When the TCSP proposal was initially developed, ADRA HQ and country staff met with Mme. Henriette Rahantalalao, the Minister of Health and her team during project design. At the time of the DIP workshop, the Secretary-General of Health as well as the DIRDS and SSD reaffirmed the Government's commitment to supporting the project. Senior personnel and departments within MINSAN were contacted and informed of Toamasina II Child Survival Project activities. Included were the MINSAN Secretary General, the Director of the Preventive Medicine Division, the District Health Development Division (SDD), and the EPI Division.

The Health Minister signed the MOU on June 07th 1999, and the Toamasina II SSD Chief Medical Officer counter-signed it on June 23rd 1999, thereby enabling the project to officially commence formal collaborative activities with the SSD. The CS project personnel hope to build stronger working relations at the Ministry level in the following years, although the distance and cost factors often make it difficult to get in to Antananarivo to attend many central government-level meetings throughout the month.

Ministry of Education (MoEd):
The "Child to Child" approach is one of the major components of the community-based health education of ADRA's CS project. The MoEd, through the Toamasina II CISCO (Education Department at the District level) and the research and studies unit (Unité d'Etudes et de Recherches Pédagogiques, UERP), is ADRA's main government partner in setting up the CTC approach within the primary schools and secondary schools in the Toamasina II District. The UERP technical staff are experienced in the CTC approach from their previous work with BASICS in the Madagascar highlands. CISCO has set up a training schedule for the school teachers, which is currently being implemented under the direction of ADRA's Community Health Education advisor between October 1999 and January 2000.

JOHN SNOW INCORPORATED (JSI):
Another USAID-funded partner, JSI (Jereo Salama Isika) is currently one of the largest health projects in Madagascar. The current JSI project is the combination of the APPROPOP family planning project and the BASICS Child Survival project, both previously funded by USAID. It is a significant benefit that Dr. Haja, the current TCSP Project Director previously worked with

APPROPOP, as he brings with him a rich background of working relationships with many of the key ex-APPROPOP personnel, most of whom are now working with major health care projects across the country.

The current JSI program is focused on IMCI, and reproductive health, which includes family planning, safe motherhood, STI/HIV/AIDS, and IEC components. Although their project is targeted to the Antananarivo and Fianarantsoa regions, the members of the technical staff have shown a willingness and availability to lend support to health programs in other regions of Madagascar, particularly those also funded by USAID. JSI has already included ADRA CS staff in several workshops and trainings, mostly IMCI and IEC oriented. These have been particularly helpful for the CS Health Advisors. In addition, the IEC materials now being used by the ADRA CS project are those designed and pre-tested by the previous BASICS project, which they continue to promote in the current JSI project. As new IEC materials are developed and field-tested by JSI, the TCSP plans to field-test and adapt those materials for use within the Toamasina II district. Those materials most useful will be the Nutrition, IMCI and STI/HIV/AIDS, and any future malaria prevention materials.

LINKAGES:

The LINKAGES project is also a two year USAID funded project focused on nutrition and breastfeeding. Allied closely with the JSI project, LINKAGES is in charge of the advocacy and promotion part of the USAID nutrition intervention, and has a strong emphasis on promotion of breastfeeding. The ADRA CS project has begun working more closely with the LINKAGES technical staff, and will benefit from nutrition trainings, innovative approaches, and their excellent nutrition resource materials. There is also a possibility of working together when the TCSP begins the Trial of Improved Practices (TIPS) approach to nutritional rehabilitation and education in Toamasina II. This approach has been successfully used by LINKAGES in other parts of the world.

UNICEF:

In order to ensure timely provision of vaccines to the health centers, through the Ministry of Health, ADRA has developed a good working relationship with UNICEF. The TCSP Project Director had a number of discussions and has made requests to obtain much-needed cold chain equipment and supplies for the Toamasina II SSD. UNICEF has since indicated they will commit to providing all the CSBs, including those in Toamasina II District, with cold chain equipment and supplies by the end of the year 2000.

UNICEF also expects to set up a treated mosquito bed-net program in some Health Districts in Madagascar. For now, Toamasina II District is not, unfortunately, among those Districts. However, the ADRA CS staff have already met with the UNICEF person working on this project, and briefed him on the ADRA CS plans for malaria intervention in this district. It is anticipated that UNICEF will become a future partner in malaria prevention within the Toamasina II district.

Population Service International/Commercial Market Strategies (PSI/CMS):

The social marketing of contraceptive methods in Madagascar is managed by PSI/CMS, another large USAID funded project working throughout the country. According to the initial meetings ADRA staff has had with PSI/CMS, an impregnated mosquito net program is wanted, but is still currently waiting for funds. The ADRA CS project plans to collaborate with PSI/CSM in terms of malaria prevention. The TCSP will actively promote bed-net impregnation and use in the communities across the SSD, while it is anticipated that PSI will be responsible for providing the nets in the area.

PACT:

Strengthening organizational capacity is one of the main objectives of the PACT project. Funded by USAID, PACT is working closely with LINKAGES and JSI, focusing their effort on reinforcing organizational capacity of the USAID partners in Madagascar. It is anticipated that the TCSP will be able to send staff to some of the PACT trainings in the next year, in order to help strengthen the capacity of the local project staff. Initial discussions indicate the work which PACT is doing in the Antsirabe and Fianarantsoa regions with the various JSI SSDs could also be relevant to this project's needs, although PACT is still in the process of developing their training calendar with JSI for the year 2000. As this project will take personnel on a training/study tour to Antsirabe in the new year, it is anticipated that mutually agreeable schedules will also be worked out early in the new year. PACT's "LOVA" program is also doing much work with NGO and village association capacity building, with programs tailored more specifically towards individual partner needs. In as much as PACT will be providing support to the "hot spot" NGOs, it is anticipated that the new year will provide opportunity to collaborate on trainings specific to meeting the TCSP needs in Toamasina as well.

Catholic Relief Services (CRS):

The CRS Food Aid for Child Survival project has many years of experience in using a community approach in nutrition. The CRS staff in Toamasina have willingly shared their experience with ADRA and other organizations within the nutrition coordination committee in Toamasina. CRS Toamasina also has some nutrition sites in Toamasina II District. As the TIPS approach is implemented in this project, there will be ongoing dialogue with the CRS personnel, and continued opportunities for exchange of information and reports. As the TCSP Project Director was previously working with CRS immediately prior to commencing work with ADRA, he also has a broad range of working relationships with CRS staff, especially at the central office level. CRS and ADRA have also been willing to help each other by sharing common transport if both organizations have personnel going to the same meetings at some distance from Toamasina, thereby reducing the need to only one vehicle instead of two.

Medical Care Development International (MCDI):

MCDI is implementing a USAID-funded Child Survival project in the Health District of Betioky, in the deep southwest of Madagascar. This MCDI project is quite similar to ADRA's district capacity strengthening project, and given that MCDI's CS project is more than a year further ahead in terms of CS experience in Madagascar, ADRA staff expects to visit the MCDI project early in 2000 in order to benefit from their lessons learned. The MCDI project director began the cross-exchange of experience and ideas after accepting the invitation to attend and participate in

the ADRA CS DIP workshop organized in Toamasina in February 1999. We have maintained regular email, phone and personal communications with the Project Director since then. ADRA is currently considering submission of a collaborative polio proposal for the two organizations.

SEECALINE:
The World Bank Food Security and Nutrition project (SEECALINE) has been operating in Madagascar for several years, and SEECALINE is currently implementing a program in Toamasina Region. The program consists of a community approach involving growth monitoring and promotion, food distribution, vitamin A supplementation to women and children, and education on both hygiene and nutrition. SEECALINE also developed a nutrition/breast feeding and weaning manual for project agents in other regions. The manual includes seasonal recipes for nutritious weaning foods according to foods locally available at that time, as well as songs, stories, etc. which may be useful in this project.

The ADRA CS project has already been working closely with SEECALINE within the Nutrition Coordination Committee in Toamasina region, and has helped in identifying intervention sites and coordinating activities with other organizations. It is anticipated that there will be ongoing opportunities for exchange and collaboration in the future, once the TCSP begins implementing the TIPS model in some of the poorer communities, as SEECALINE already has extensive community-based nutrition experience that will be beneficial to this project.

Nutrition Coordination Committee:
As two of the largest NGOs in the Toamasina Region, ADRA and SEECALINE have taken the initiative to set up a monthly regional "Nutrition Coordination Committee" in the region of Toamasina, with an inaugural meeting in June 1999. The purpose of this committee is to help coordinate all the nutrition activities throughout the region with a master plan, and to provide a forum for sharing experience and technical materials between organizations. This working group has grown to the point where it now involves about a dozen or more NGOs and public departments working in nutrition or related community activities in Toamasina region.

USAID partners regular meetings:
The HPN office of the USAID Madagascar mission regularly organizes meetings for all the USAID partners. The purpose of these meetings is to allow different organizations to network with each other, to coordinate activities, and to share relevant health-related information and experience. Different issues (not limited to just health) are addressed during the partners meetings. USAID backstopping personnel and visiting consultants also participate in these meetings to learn more about projects, or share their expertise in areas of specific interest. ADRA Madagascar is building strong working relationships with the other USAID partners through their participation in these important monthly meetings. The TCSP would also like to eventually see a health-related information resource library and "clearing-house" established in Tana to share information, research and reports with others working in health within the country, and is encouraging the USAID mission in that direction.

Nutrition Action Group (GAIN):
ADRA Madagascar is actively participating in the regular GAIN meetings. This action group allows ADRA to build working relationship and to get new information on the latest nutrition activities and approaches. GAIN is currently trying to coordinate and standardize national

nutrition materials and IEC messages with the help of the MOH. By regularly distributing materials, GAIN is trying to update all the organizations currently working in nutrition.

A6) HEALTH INFORMATION SYSTEM

As presented in this revised DIP, a more innovative approach to monitoring and evalu-ation of the project is being used. As indicated earlier, the focus of the project is now consistent with current expressed needs of the District Health office in Toamasina II. In accordance with this intention, typical CS health project indicators will not be measured, apart from some of the key vaccination and breastfeeding-related indicators that reflect SSD capacity to implement interventions in these areas. Another reason for including these indicators, is that they are of special interest to the USAID mission. In keeping with the change to an Appreciative Inquiry approach as the foundation in this revised project, most of indicators are now management and/or personnel training-related indicators. ADRA has assisted the SSD in developing indicators that reflect the ways they want to measure success of their program in the future.

Data Management System: The program Health Information System (HIS) is currently being developed to fully integrate with the SSD. It will enhance the capacity of the SSD to adapt to the new HIS being developed and implemented by the Ministry of Health. Initial discussions with the MOH and the TCSP Management Advisor have indicated that, if ADRA develops a good computerized HIS database, based on the new HIS forms, the MOH will allow this to be used until the MOH has their own database tested and ready. There are currently no other districts in the province with computerization of the new HIS forms. The TCSP Management Advisor has since developed a prototype that is currently being tested with data from the Toamasina II SSD. Monthly HIS reports from CSBs will be recorded on this new database at the SSD. This information will be analyzed, and fed back to the CSBs and communities where it came from, in addition to forwarding copies to the DIRDS and MOH. The SSD have already been given a computer for their HIS needs. Ongoing technical assistance and training will ensure that, by the end of the project, SSD personnel will be implementing a practical, sustainable HIS, using methods which can be readily replicated in other districts, when they have computers available. The DIRDS wants to see things move in this direction, so is giving good support in this domain.

Surveys: A 30 cluster, modified KPC baseline survey was completed in January, 1999. Additional questions were included on food security and cost recovery, and a number of basic anthropometric measurements were recorded. In October 1999, additional qualitative studies were conducted to help ascertain reasons behind some of the behaviors reported in the KPC.

The TCSP staff will hold more meetings with JSI in the new year, to discuss how ADRA and the SSD counterpart staff can best complete Health Facilities Assessments in our district. JSI has gained experience with HFA in Madagascar in the BASICS project, and work they have implemented in the Fianarantsoa II and Antisirabe II districts of central Madagascar. The survey questionnaire is already available in French and has been translated into Malagasy. The Seventh-day Adventist Medical System (SMA) will also be invited to include their health centers in the survey.

As the first stage in a series of ongoing surveys at the community level, a Participatory Rural Appraisal (PRA) survey began in the October 1999 with focus on issues affecting maternal health and child survival. Initially community-based Focus Group studies, a brief needs assessment survey of CSB agents, and informal interviews have been used to help round out the

overall picture of health needs in the project area. More detailed formal interviews, interviews with key informants, and exit interviews will be held as the Health Advisors visit all CSB sites in the next year.

In the middle of the third project year, a Mid-term Evaluation, will be conducted using primarily qualitative data and information from the HIS and key informants. Special attention will be applied to developments in the EPI and malaria initiatives, community level IMCI training, developments in the TIPS approach, and recommendations from the Health Facilities Assessment Survey. Participants from other NGOs, USAID, and the Ministry of Health and Education will also be invited.

The SSD staff need to become more than just computer literate. They will acquire skills that will enable them to translate dry data into effective health educational and community mobilizing tools. Through creative use of graphic representations of community health status, by SSD program officers, these essential messages will become clear even to illiterate community members.

Currently, data collection in each of the vertical specialty programs of the SSD is paper based. The MINSAN has mandated that there must be 100% reporting from all CSB agents or they lose their jobs. Unfortunately, this may impact on the reliability of the figures collected.

To strengthen SSD HIS capacity, the project has located a computer in the SSD office, trained SSD employees in the HIS, and has provided a staff member dedicated, at least 1/2 time to working with SSD staff on the HIS. This individual will assist the SSD in compilation of data for feedback to SSD management staff, ADRA personnel, program partners and reports to USAID. The program will develop feedback mechanisms into the community, primarily through monthly CSB agent meetings, teachers in the Child-to-Child program, and through communications to community leaders. CSB agents will be trained and encouraged to create and post graphs as appropriate.

UNICEF CSB sites (3), where the Bamako initiative is in place, have monitoring visits every 6 months. This provides more accurate detail than other monitoring, as program receipts should reflect service delivery. Since the MINSAN has instituted cost recovery as a National Policy, in principle, every CSB site will be required to periodically monitor program services and funds generated. CSB agents in Toamasina II were trained in cost recovery in February, 1999. Cost recovery is included in the new HIS that is being piloted in the Toamasina district. A copy of the new HIS form is included in Annex 8.

Cost recovery activities have already begun in November 1999, with commencement of a baseline assessment of current SSD and CSB activities. Monitoring of funds received and allocated is being done monthly.

Monitoring activities include monthly CSB reports, visits to CSBs, interviews with CSB agent during monthly meetings, and interviews of community members and beneficiaries. Child-to-Child activities will be monitored directly by the Community Health Education Advisor in

conjunction with CISCO, and through reports of the number of schools trained, teacher's reports and interviews of teachers, parents and community leaders.

Monitoring of the nutrition interventions will be by quarterly reviews of progress, with interviews, Focus Group Studies, and other qualitative PRA methodologies being used to determine the community perceptions and practices in regard to the nutritional messages learned, and the behavior changes sought. In addition, in communities where the TIPS program is being implemented, there will be monthly qualitative investigations to determine the attitudes, behaviors and practices of the mothers involved in the trials. This monitoring and evaluation will be the responsibility of the Nutrition Health Advisor, with the information and reports to go back to the CSBs, CVAs and community health committees.

In the same way, qualitative methods of evaluation and information gathering will be used to monitor progress and developmental changes taking place in the communities, with regard to promotion of the insecticide-impregnated mosquito bed-net program. Annual bed net sales, insecticide treatments, and/or exit interviews will help to determine the progress in the district in regard to the awareness and behavior changes in these malaria prevention efforts.

The TSCP plans to introduce key principles from the John's Hopkins University School of Public Health's "Quality Assurance Project" (QAP) in management and technical trainings conducted by the project. Practical guidelines, training curricula and manuals will be developed for CSB agents and CVAs, with standard operating protocols and checklists provided to help improve quality. CSB agents are already excited, as they previously only received a training every 2-3 years. Now, with TCSP involvement, they are receiving trainings every month for one to three days. Questionnaires and interviews with the CSB agents will provide feedback on changes occurring in their CSBs and communities.

APPENDIX B

EVALUATION TEAM MEMBERS AND THEIR TITLES

Primary Members:

- **Heritiana ANDRIANAIVO,** Consultant, Director of HIS, Research and Evaluation, Management Sciences for Health, Madagascar.
- **Solomon WAKO,** PhD, Director of Evaluation, ADRA International, Silver Spring, MD, USA.
- **Colin RADFORD**, MPH, Health Programs Coordinator, ADRA Madagascar
- **Haja RAZAFINDRAFITO**, MD/MPH, Director of the Child Survival Project, ADRA CS

Supplementary Members:

- **Becky de GRAAFF**, Assistant Director for Child Survival Health programs, ADRA International, Silver Spring, MD, USA
- **Josea Ratsirarson,** MD, Project Director, Betioky Child Survival Project, Medical Care Development International (MCDI) Toliary.

APPENDIX C

ASSESSMENT METHODOLOGY

Given the capacity-building approach that is the backbone of this project, ADRA's TCSP requested approval from USAID to conduct a ***participatory self-evaluation***, rather than a full external evaluation, thereby enabling ADRA's key project staff to participate in all aspects of the evaluation.

The main evaluation team was comprised of the Director of Evaluation for ADRA HQ, the Project Director for ADRA Madagascar's Toamasina Child Survival Project, the ADRA Madagascar Health Programs Coordinator and an external evaluation consultant from Management Sciences for Health (MSH)/Madagascar. During the evaluations, additional technical support and recommendations were shared by the Assistant Director for Child Survival Health programs at ADRA International, and the Project Director for the MCDI Child Survival Project, Betioky, Toliary, both of whom came for a week of meetings during the evaluation process.

The evaluation team began with a ***literature review*** of the project documents in order to identify the key program issues. Because this is his primary area of expertise, the evaluation consultant conducted the review of the HMIS developed by the project. A review was also made of the project statistical data available for the SSD to date.

The next step was to conduct ***staff and key implementing partner interviews***. To maximize freedom of expression, project staff and SSD personnel interviews were conducted by the external consultant.

After reviewing the USAID guidelines and the Scope of Work for the evaluation, an evaluation schedule and ***Framework of Analysis*** was developed in collaboration with the ADRA HQ Director of Evaluation, and is included in Appendix C.

To complement the findings of the evaluation team, several ***rapid data collection*** tools were used, including field visits to make direct observations, and key informant interviews with CSB agents, community members who use the health care services, and local implementing staff. The selection of sites for field visits was made randomly by the external consultant, with visits to the north, center and south of the project region. A complete list of CSB and field sites within the project area, as well as distances to the project sites is presented in Appendix F-2.

Finally, the key stakeholders among the implementing partners were invited to a ***dissemination workshop***, where preliminary evaluation findings were shared, followed by a ***brainstorming session to develop recommendations*** for the remainder of the project.

In May 2001, the ADRA HQ Child Survival Technical Support person came to Madagascar to review the MTE process and findings, and at the end of her visit, a ***debriefing meeting was held***

with USAID Madagascar, with preliminary evaluation findings presented along with the priority recommendations for the future.

APPENDIX D

List of persons interviewed and contacted

LIST OF PEOPLE INTERVIEWED BY MTE TEAM

No.	Name	Function	Organisation/Place
1	RAZAFIMAHEFA Rivohery	HIS Advisor	ADRA CS
2	MISY Florentine	In charge of vaccination	SSD Toamasina II
3	Dr RANJALAHY Gabriel	Adjoint Technique	SSD Toamasina II
4	Dr RANDRIANIRINA Fidèle Joseph	Community Health Advisor	ADRA CS
5	Mme RAZAFIMANDIMBIARISOA Marguerite Marie	Program Officer for Cost Recov-ery and Stock	SSD Toamasina II
6	Mme RAZANABAVY Alphonsine	Program Officer, Reproductive Health, Family Planning, and Nutrition	SSD Toamasina II
7	Dr PAMAKA Camille	PCIME Advisor	ADRA CS
8	Dr RASOLOMAHEFA Dieu-Donné	Director	DIRDS Toamasina
9	Dr RAZAFIMAHEFA Sébastienne	Medical Inspector	SSD Toamasina II
10	Dr Hanta RAZAFINDRAFITO	Nutrition Advisor	ADRA CS
11	Mme BOTO Françoise Lydia	Responsable IEC et Nutrition	SSD Toamasina II
12	Mme IANONJARA Micheline	Responsable SISG	SSD Toamasina II
13	Mme HAJASOA	Infirmière Diplômée d'Etat	CSB II Ampasimadinika
14	Mr.	COGE President	CSB II Ampasimadinika
15		Trésorier du COGE	CSB II Ampasimadinika
16		CVA	CSB II Ampasimadinika
17	LABITY	Mayor	Commune Rurale de Sahambala
18	Dr RABEARISON Donis	Chief CSB	CSB II Sahambala

19	Dr BAOZOMA Florentine	Chief CSB	CSB II Ampasimbe Onibe
20	Mme RATOANDROMANANA Noëline	Midwife	CSB II Ampasimbe Onibe
21	Dr FLORENT	Chief CSB	CSB II Ambodiriana
22	Mme JARINA Roseline	Nurse DE	CSB II Ambodiriana
23	Dr RASELANIVO Alice	Chief CSB	CSB II Foulepointe
24	Mme MARIE Angèle	Midwife	CSB II Foulepointe
25	Mme EUPHRASIE	Midwife	CSB II Foulepointe
26	Mme.	Dispensatrice	CSB II Foulepointe
27	Mme DENISE	Director	EPP Foulepointe
28	MPANANANDRO Privat	Teacher	EPP Foulepointe
29	RATSIMBARISOA Jeannine	Teacher	EPP Foulepointe
30	Dr RAZAFINDRAFITO Hajarijaona	Project Director	ADRA CS

List of meeting participants for the Mid-Term Evaluation review of the ADRA Toamasina Child Survival Project on 27/04/01

No.	Name	Function	Organization
1	ANDRIANAIVO Heritiana	Consultant Evaluator; Director of HIS and Research	Management Sciences For Health Madagascar
2	RAZAFIMAHEFA Rivohery	HIS/MIS/ Manage-ment Advisor	ADRA CS
3	MISY Florentine	Vaccination Program Officer	SSD Toamasina II
4	KOTOMANGA Albert	Logistics Officer	SSD Toamasina II
5	RADFORD Colin	Health Programs Coordinator	ADRA
6	Dr RANJALAHY Gabriel	Adjoint Technique	SSD Toamasina II
7	Dr RANDRIANIRINA Fidèle Joseph	Advisor in Community Health	ADRA CS

8	RAZAFIMANDIMBIARISOA Marguerite Marie	Program Officer for Cost Recovery and Stock	SSD Toamasina II
9	Mme RAZANABAVY Alphonsine	Program Officer for Reproductive Health / Family Planning /Nutrition	SSD Toamasina II
10	Mme RABARSON Stella	Administration	SSD Toamasina II
11	Dr PAMAKA Camille	ICMI Advisor	ADRA CS
12	Mme RANOROVOLOLONA Jeannette	Administration	SSD Toamasina II
13	TSALALAHY René Pierre	Cold Chain, maintenance & repair.	SSD Toamasina II
14	RANDRIANASOLO	Program Officer, Leprosy	SSD Toamasina II
15	Dr. RANDRIANARY Jean	Program Officer, IMCI	SSD Toamasina II
16	Dr WAKO Solomon	Evaluation Director	ADRA International
17	Dr ANDRIAMAHEFASOA	Technical Director	DIRDS Toamasina
18	Dr RAZAFINDRAFITO Hajarijaona	Project Director	ADRA CS

APPENDIX E

DISKETTE WITH MS WORD COPY OF MTE REPORT

Note: The diskette will be sent to accompany this document, with the report in MS Word for Office 2000 format.

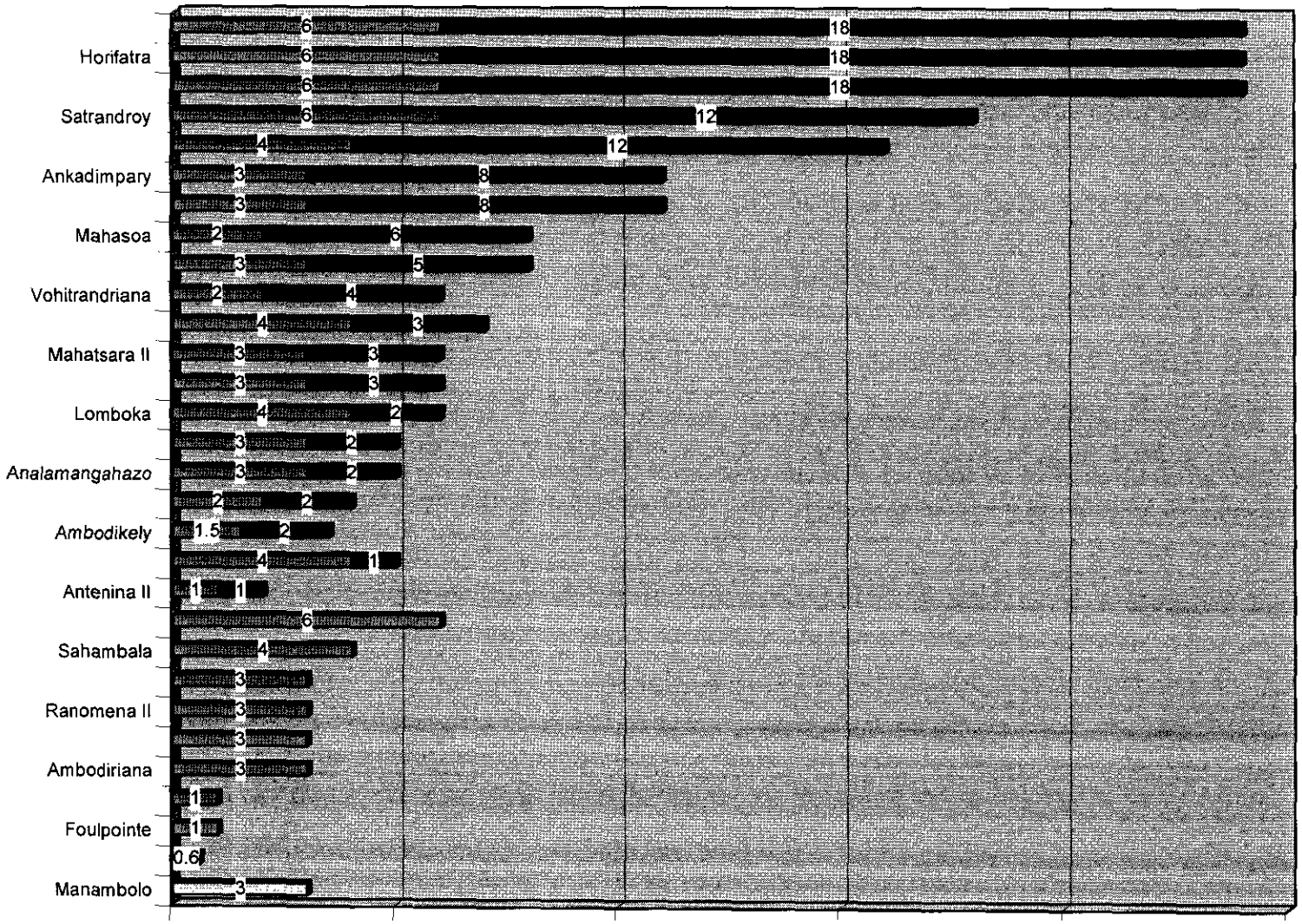
APPENDIX F SPECIAL REPORTS / ANALYSES

APPENDIX F-1

GEOGRAPHICAL ACCESS TO CSBs WITHIN TOAMASINA II DISTRICT

Many of the Toamasina II district clinics are located in very remote areas, such as this village near Sahambala. These isolated medical clinics are very basic, and in need of both equipment as well as maintenance and repair, such as this clinics at Satandroy.

APPENDIX F-1
ACCESSABILITY CHALLENGES FOR REACHING TOAMASINA II DISTRICT CSBs



APPENDIX F-2

TRAINING AND CAPACITY-BUILDING ACCOMPLISHMENTS OF THE TCSP

APPENDIX F- 3

SELF-EVALUATION SUMMARY REPORT

TOAMASINA II SSD TEAM

Organization: SSD Toamasina II **Date**: June 07, 2001

Cadre: EMAD (District Management Team)

Number of members who completed the evaluation: 21 **Male**: 13 **Female**: 08

Facilitator: Haja RAZAFINDRAFITO

Problems in team functioning:

Positive critiquing (73)*

When team members are criticized, they feel that they have lost respect.
Too little time is spent on reviewing what the team does, how it works, and how to improve it.
Team members are reluctant to give criticism

Effective meetings (70)*

The team do not achieve much progress in team meetings.
We seem get stuck when a problem is being discussed in team meetings.
Team members do not complete their assignments between meetings.

Team achievement (65)*

Team members seem more concerned with keeping up appearances than achieving results.
Achievements are too small to justify the time we have spent in team problem-solving. Time is wasted in unproductive activities.

Team creativity (61)*

Only a few members suggest new ideas.
Team members are reluctant to suggest new ideas.

Positive climate (40)

People in the team do not say what they really feel.
Team members do not really trust one another.

Effective leadership (38)

The leader is not willing to have his or her ideas challenged. She makes decisions without talking them over with the team member first.

What members dislike within the EMAD now:

Assiduity and willingness are hindered by the chief's order and the other's laziness.
The others simply do not care and do what they want to do and don't care about the discipline.
Some people are working secretively. There is somehow a spirit of mistrust and betrayal.

Lateness in making decisions.
Debate turning in a sense where it shouldn't
Sometimes the boss simplifies things when facing a difficult problem
Only those who speak always speak.
The work done and the work conditions are not taken into account, there is no acknowledgement.
Many still look on and do not participate
There are some basic rules that are not respected (eg: non-respect of time)
Criticism that does not bring any new organisation and any good thing to the work relationship.
Whispering and licking chief's boots. Colleagues putting in trouble others.
Some responsible are not willing to use new technology. Some are not attending any EMAD meeting at all.
Colleagues doing a messy job
Colleagues not serious
Do not know how to forgive the others' mistake, making a misuse of power
Boasting, wasting time for nothing
Some people are never blamed nor given responsibility
The program established and the times are not respected and must rush at last
Dictatorship, jealousy, hypocrisy, betrayal, gossip, lie, and selfishness.
Criticism outside the EMAD circle.
Non-respect between colleagues
Passing one's own responsibility to other colleagues
Working and not considering anyone

Where in problem solving cycle team has difficulty:

Identifying and prioritizing opportunities for improvement	(15)*
Starting work on new problem	(14)*
Implementing a solution	(13)*
Analyzing a problem	(11)
Identifying who will work on the problem	(11)

Who was present for the evaluation:

Team leader	Present	Assigned	
Secretary	3	Nominated by the members	
Recorder	1	Volunteer	
Members	17	Volunteer	6
		Nominated by the members	1
		Assigned	10

Where coaching could improve:

Helping the team reach decisions
Helping the team resolve conflict without taking sides
Helps keep the team on track
Giving guidance and on-the-spot training

Factors hindering team:

Team does not know the problem-solving tools well enough	(29)*
Members do not come to meetings	(26)*

Members do not take responsibility for actions	(26)*
Lack of time	(21)

Recommendations:
Real open coaching is an important guarantee for improving the way of working within the EMAD. Everyone should accept criticisms and feedback. These criticisms should be constructive and not destructive. The existence of the EMAD is an opportunity for colleagues to find out together the way to develop the SSD. Every member should make effort to respect the basic rules. The decisions taken by the EMAD should be respected by achieving the task assigned to every one timely.

Because we do work together, from the top to the bottom, the chief should be open to discussion.

Those who have new and interesting ideas should be encouraged to share them with their colleagues, and a time should be set to have a look at what has been done and how to improve it.

Collaboration will be nurtured by good and clean social relationship, so hypocrisy should be let down and trust from one to another should reign. Any difference of ideas should be discussed and solved always within the EMAD.

In regard to problem resolution, EMAD's members should be given training to be able to use different problem resolution tools.

Remark: If the relationship and the management within EMAD is effective, the number of problems about the way of working will be close to zero.

APPENDIX F- 4

ACHIEVEMENT OF PREFERRED FUTURES

PF-1 The SSD is the reference standard by which other SSDs in the Toamasina region are compared, in terms of organization and coordination of activities.

The DIRDS has indicated that on the whole, the SSD of Toamasina II has reached an acceptable level within the province in terms of results and overall program balance. The contribution of the new Deputy District Medical Officer responsible for management and support of technical services since April 2000 has brought a noticeable improvement in the effectiveness of the SSD's activities. This has been particularly noticeable in regard to the improved scheduling (under the District Development Plan); the variety of different trainings for the CSB Management Committees; the actual integrated management of the CSBs (as evidenced by a comparison between the 1999 and the 2000 Audits); the management of the logistics and resources, and also the level of integration with the team from ADRA's CS project.

Unfortunately, however, the Toamasina II SSD still experiences problems of personnel management and has experienced delays in recouping costs for some of the clinics within the cost recovery system.[14] The SSD also encounters problems in the management of emergencies with regard to some procedures, while staff have also expressed the lack of equipment in the CSBs, challenging inter-personnel communication difficulties, and physical communication difficulties between the SSD and the personnel living in remote locations.

The DIRDS defines the priority for all the SSDs within the region of Toamasina as follows: reinforcement of capacity for the district health team; improvement of the SSD planning schedules; increased interventions targeting STI/HIV/AIDS; research by the SSD of Toamasina II to investigate the nutritional status of the population, the reasons for decreased use of the CSBs and other sanitation problems of the SSD; to establish some CSB2's capable of performing Caesarean sections; to conduct some trainings for traditional midwives; and to improve the nutritional surveillance of children.

Finally, the DIRDS anticipates the changeover to the "Autonomous Province" system of decentralized government services will likely make the districts of Toamasina I and II even "more autonomous."

PF-2 The SSD pilots new and innovative approaches to preventive, promotive and curative health care.

The TCSP has implemented a number of innovative approaches:

- ***The VISA 5/5 project*** to involve the school children in the location and promotion of vaccination to non-immunized children.

[14] Recent survey data indicates that in the most remote CSBs within Toamasina II, approximately 75-85% of patients are so poor they cannot pay for their health care services. If this is the case, the Cost Recovery System may need to be revised in those particular areas, to determine what is the most appropriate way to deal with this problem.

- ***The Child to Child program***
- ***The TAPS Water project***

The results from the VISA 5/5 approach so far indicate it can help give an indirect measure of the number of children who visit the CSB, however to give a better measure of the full impact of this intervention would require a survey at the end of the project.

PF-3 The SSD Program Officers use the computer in creative ways to increase their effectiveness.
The TCSP has set up a computer room with three computers in the SSD office. Currently, all the administrative and official documents are developed on these computers. The SSD officials schedule their time in the computer room in order to type their letter and documents. Some local trainings have been provided to the Program Officers, teaching them about the utilization of the computers, and these trainings have been augmented by continuous on the job trainings.

PF- 4 All the Program Officers have the capacity to design, plan, organize and evaluate to effectively manage their health programs.
The TCSP has organized trainings in management and in integrated supervision to the members of the EMAD team at the SSD. All the Program Officers have been involved in the development of the District Development Plan (PDD) and in follow-up of these activities.

PF- 5 There is an SSD community health program including integrated health care of children, environmental health, malaria prevention, nutritional rehabilitation and nutritional education.
The TCSP has been working alongside the SSD on the activities of community-based nutrition promotion, by first establishing local women groups, then training and motivating them to work in their respective villages. The community leaders reported in their interviews that they have appreciated the nutrition activities of the women's groups, and indicated they have also noticed some improvements in the family food consumption habits and the general level of sanitation awareness and improvement in their communities.

Another approach used by the Project consists of promotion of mosquito nets. This coastal region is endemic with malaria, so the fight against the mosquito vector constitutes one of the proven ways to limit the spread of this illness. However, since commencing to promote the selling of these mosquito nets, it has not been possible to keep up with the demand. The result of this intervention activity can already be measured by the increased demand for nets once the IEC promotion began.

PF-6 The SSD has a "Professional Conscience" in the interests of the community.
This is a rather "gray" area to measure quantitatively. Discussions with the SSD at the time the preferred futures were developed indicated part of the reasoning behind this goal was the need to address many of the "quality" issues that were lacking in the programs of the SSD, and which needed to be improved, many of which stem from the most basic and ethical desire of wanting to do what is right by the community.

Monthly reports were often either a) inaccurate, b) improperly filled out, c) were misunderstood, d) were missing certain sections altogether and e) rarely returned any information to the level at which it was collected. To address this, ADRA has focused on training the SSD and CSB staff to understand the forms and data needs in the HIS and MIS monthly reports, and to better understand the importance and significance of the data collected. Since that training, there has been an improvement in the quality of reports received, with fewer invalid reports being received each month. There is still a greater need, however, to ensure reports and information are fed back down to the CSB and community levels.

The TCSP staff have also reported seeing a change in the motivation and drive of the SSD Program Officers, citing the changes in field supervision approaches, and their desire to take full participation and ownership of the most recent District Development Plan, which already reflects more of the community interests identified by the SSD Program Officers and ADRA personnel. Likewise, the TCSP Technical Advisors are more aware of needing to work in the interests of the community and the community's health, and have begun focusing a greater percentage of their direct interventions to train and supervise the community-based groups and to focus on addressing the priority healthcare needs at this level.

PF-7 There is an SSD Human Resource Development program for change, which enables team-building, enhanced inter-personal relationships between staff, and open communications.

To address this priority, the SSD has adopted a plan of monthly meetings for all CSB directors and including the enlarged EMAD team. Because it is the only time all the field health staff are together at the one place and time each month, the TCSP has taken this opportunity to also provide specific "condensed" trainings for one or two days either side of these scheduled monthly meetings. These monthly meetings have also permitted some exchange of experiences between the CSB providers and enable better communication of information from the SSD towards the more isolated health care providers.

The TCSP had the opportunity in 2000 to join ADRA Madagascar's other project teams for a team-building retreat one weekend. The positive impact of this weekend was talked about for many months after, and it would be beneficial for future projects to plan and budget for programs such as that to help strengthen team spirit between the working partners. In retrospect, the TCSP feels it would have been more beneficial to have had such retreats earlier in the first year of the project, as it could have had the effect of helping staff to get to know each other better, and to build trust and confidence earlier on in the project

Another significant change has been noticed by the TCSP staff in the working relationships and increased openness of communication during this past six months since there have been a number of senior administrative staff changes. Fortunately, the change of staff has been very positive, as the approach and administrative style of the new personnel is closer to that of the TCSP, and is more along the lines of what the SSD have been asking for since the commencement of the project.

There is also a noticeable increase in transparency among staff, between SSD personnel and their administrative staff, as well as between ADRA and SSD staff in general. As trust levels and

confidence have developed, it has been natural to see an increased willingness to be vulnerable, in a two-way-direction, which has also been a positive indication of success in achieving this objective.

PF-8 In order to be the most effective, the SSD's planning, management and data collection are integrated, coordinated, and realistic.

The Management Advisor for the TCSP has developed an effective and integrated HIS/MIS database for the SSD. The Monthly Activity Reports (RMA) of the CSBs are currently formatted for entry into this database. This software also facilitates the data entry and analysis, with the summary information able to be contained on a simple electronic spreadsheet.

Analysis of data is helping ADRA and the SSD Program Officers to better plan and to make informed decisions regarding the realization of their tasks and goals. More sharing of the information and analysis needs to take place to enlighten the CSB agents regarding the situation of their CSB compared to their other neighboring CSBs, or compared to the rest of the SSD in general.

APPENDIX F- 5

Summary of Perceived Achievement of Preferred Futures

PREFERRED FUTURES	MEASURABLE INDICATORS	Estimated % of goal achieved to date as reported by TCSP staff	Estimated % of goal achieved to date as reported by SSD staff
1) The SSD is the reference standard by which other SSDs in the Toamasina region are compared, in terms of organiz-ation and coordination of activities.	1.3) The SSD has a long-range plan that is directional, flexible, and regularly reviewed for specific annual planning.	70%	44%*
	1.4) The results of the SSD's programs and approaches are monitored, reported, shared and celebrated.	40%	45%**
2) The SSD pilots new and innovative approaches to preventative, promotive and curative health care.	2.1) Four new and different types of innovative approaches sought, researched, and adapted for use by the SSD, which address promotive, preventive and curative health care, and cost recovery.	45%	39%***
3) The SSD program officers use the computer in creative ways, to increase their effectiveness.	3.1) 90 % of program officers trained and competent in development of computerized reports, documents and action plans.	35%	10%***
	3.2) Actions taken by the SSD, CSBs and communities in response to the HIS / MIS database outputs.	60%	38%*
	3.3) 90% of SSD staff using the computer tools for creating simple, easy-to-understand reports for feedback to the team and the community.	30%	8%***
4) All SSD Program Officers have the capacity to design, plan, organize and evaluate to effectively manage their health programs.	4.1) 90% of Program Officers trained in Management.	85%	66%****
	4.2) 90% of Program Officers carry out an annual or six-monthly action plan.	45%	34%**
	4.3) Program Officers visit the CSBs regularly and know the staff and their beneficiaries.	40%	42%**

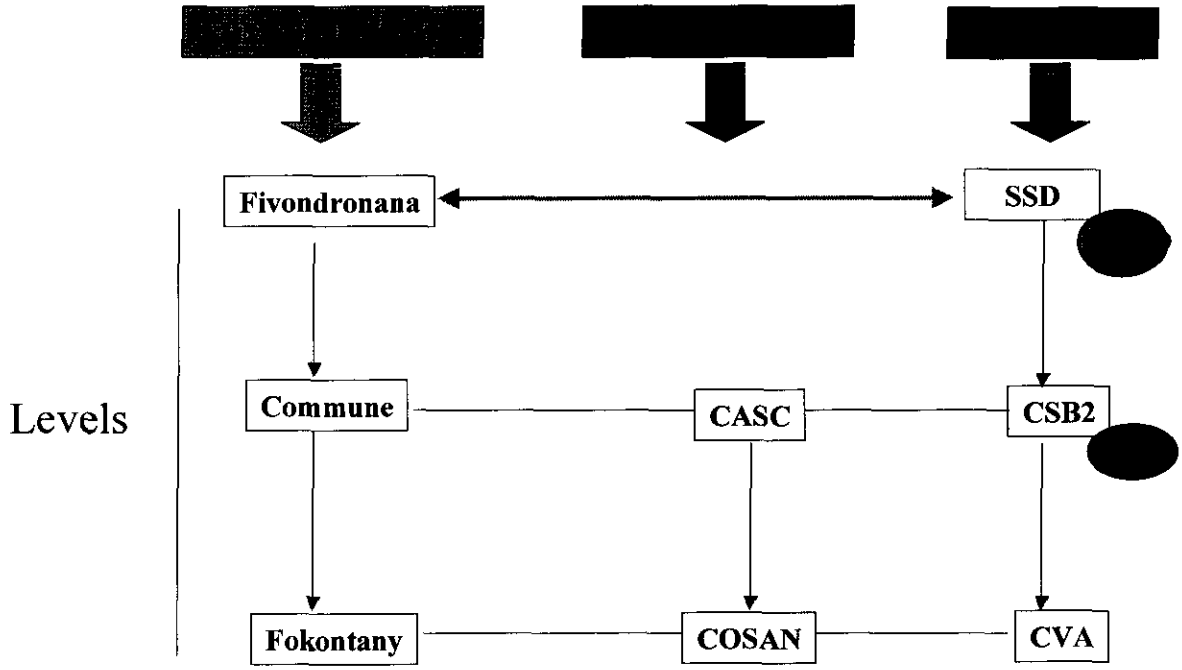
5) There is an SSD community health program including integrated health care of children, environmental health, malaria prevention, nutritional rehabilitation and nutritional education.	5.1) The SSD has an integrated community-based IMCI program in place.	65%	59%*
	5.2) Cost recovery system strengthened and refined by SSD/ADRA.	70%	72%
	5.3) 80% of CVAs selected, trained and operating actively in the villages.	75%	46%
	5.4) 70% of Environmental Health Committees set up and working in the community.	1%	18%*
	5.5) Changes are evident in the communities, which are a result of the work of the SSD.	40%	27%*
	5.6) Programs are relevant to the needs of the people, are effective, and reach the target population.	55%	47%***
	5.7) Local resources are valued, mobilized, and utilized to the optimum.	35%	34%
	5.8) The SSD has in place an effective monitoring, evaluation, and data collection system in place for the health indicators they are accountable for.	41%	40%**
	5.9) The SSD has identified and adopted a set of impact indicators related to major components of the program.	45%	--
6) The SSD has a "professional conscience" in the interests of the community.	*6.1) CSB agents meet at least* quarterly with Community Health Management Committees to address community health concerns.	50%	24%**
	6.2) Appreciation of the quality of service by the community and/or by the management committee.	20%	20%
	6.3) Quality feedback is promoted and used in monitoring, sharing, & strengthening the capacity and performance of the SSD/ADRA and the Community.	25%	46%*
	6.4) There is mutual concern and openness to help one another so that people know what is happening to each other and their families a) in the SSD b) in the CSBs, and c) in the communities.	30%	33%
	7.1) Monthly meetings with SSD		

7) There is an SSD human resource development program for change, which enables team-building, enhanced inter-personal relationships between staff, and open communications.	and/or CSB staff with two-way communication and exchange of information, and having detailed meeting minutes kept.	80%	52%*
	7.2) Assessment of the "Quality" issues in personnel development, in terms of team spirit, receptivity, listening capacity, openness to correction etc.	45%	17%**
	7.3) Team-building is actively promoted at all levels of the SSD.	65%	17%*
	7.4) SSD and CSB personnel have opportunity to be trained, and to learn "on the job."	65%	43%**
8) In order to be most effective, the SSD's planning, management and data collection are integrated, coordinated and realistic.	8.1) CSB and SSD reports demonstrate integrated, coordinated, and realistic planning, management, and data collection.	65%	25%**
	8.2) Evaluation of progress and effectiveness of the program are done regularly at the community level.	40%	9%*
	8.3) The SSD practice good budgeting, up-to-date bookkeeping, complete/timely reporting, and regular audits?	30%	70%
	8.4) The cost recovery system shows progress towards being fully sustainable?	55%	51%
	8.5) All SSD and related staff know why they do what they are doing.	40%	59%*
	8.6) The SSD has an efficient, effective reporting system in place.	70%	30%

* Denotes the **priority weighting** placed by the SSD staff on the importance of each Preferred Future. Scale: * = **Important priority** up to **** = ***Most* important priority.**

APPENDIX F- 6

Diagram of community-level structures in TCSP



The above is a representation of the community-level structures currently operating within the TCSP.