MADAGASCAR

TOLIARA PROVINCE CHILD SURVIVAL PROJECT
MID-TERM EVALUATION

Contract # FAO- A-00-98-00027-00

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Acronyms

ARI	Acute Respiratory Infection
ASB	Health agent – Agent de Santé de Base
BCC	Behavior Change Communication
BF	Breastfeeding
BFP	Breastfeeding Promotion
BFHI	Baby Friendly Hospital Initiative
CBD	Community Based Distributor
CF	Complementary Feeding
CHV	Community Health Volunteer
CSB	Health Centre – Centre de Santé de Base
CSTS	Child Survival Technical Support
CTC	Child-to-community approach
DAR	Rural Mobilization Department
DCM	Diarrhea Case Management
DHS	Demographic Health Survey
DIP	Detailed Implementation Plan
DPS	Provincial Health Authorities - Direction Provincale de la Santé
EAN	Essential Actions for Nutrition
EBF	Exclusive Beast Feeding
EMAD	District Management Team
EPI	Expanded Program of Immunization
FA	Field Agent
FP	Family Planning
HFA	Health Facility Assessment
HIAKA	Hetsika Iadiana Amin'ny Kitrotro mahazo ny Ankizy
HIS	Health Information System
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
ITNs	Insecticide-Treated mosquito Nets
JSI	John Snow Institute
KPC	Knowledge, Practice and Coverage
LQAS	Lot Quality Assurance Sampling
LOE	Level of Effort
MCM	Malaria Case Management
MCDI	Medical Care Development International
MIS	Management Health System
MoH	Ministry of Health
MTE	Mid-term Evaluation
NGO	Non Governmental Organization
PCM	Pneumonia Case Management
PSI	Population Service International
SSD	Health District
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendants
TH	Traditional Healer
TOT	Training of Trainers
TPCSP	Toliara Province Child Survival Project
TT2	Tetanus Toxoid 2
USAID	United States Agency for International Development
UNFPA	United Nations Fund for Population Assistance
UNICEF	United Nations Children Fund
VEMIMA	Vehivavy Miara-Mandroso
VISA	Visitor Identifier Sensibiliser Accompanier
WHO	World Health Organization
WRA	Women of Reproductive Age

A. Summary

Medical Care Development International's (MCDI) Toliara Province Child Survival Project ("the project") is a cost extension grant program funded at US$1,229,843 for the period October 2002-September 2006. The project was designed to reduce morbidity and mortality among children under five, and to improve the health status of women through the continuation of limited maternal and child health activities in the Betioky Sud District of Southwest Madagascar and the initiation of activities in the neighboring Toliara II District. The results-based objectives measure mothers' improved health knowledge, coverage and practices in six key intervention areas:

Project Area:	Percent of effort:
Pneumonia case management	15
Malaria	15
Control of diarrheal disease	15
Expanded program of immunization (EPI)	20
Breastfeeding and nutrition	15
Birth spacing and reproductive health	20
Total:	**100**

Improved health in these areas is achieved through strengthening the management capacity of district health authorities and NGOs, training and supervision of health workers and behavior change communication campaigns that transmit health messages via health volunteers, radio and community health festivals. The project interventions have achieved or exceeded results indicators in most areas and new targets have been set. Objectives in the areas of pneumonia and diarrhea case management and knowledge of danger signs, breastfeeding, infant immunization and birth-spacing have been exceeded. Interventions in the areas of malaria and HIV/AIDS have not yet demonstrated comparable levels of achievement due primarily to the fact that some activities are not scheduled to take place until the second half of the project, and the MOH protocol for malaria case management has not yet been released.

MCDI has recruited and trained a competent and committed technical and administrative field team. Eleven trainers and 60 facility-based health workers have been trained in Integrated Management of Childhood Illnesses (IMCI) and are applying IMCI protocols. In addition, 420 Community Health Volunteers have been trained in Community IMCI and are helping households prevent and manage diarrhea, malaria and pneumonia. Nearly 90% of all IMCI activities planned for the project have been carried out. MCDI's team carried out baseline and mid-term quantitative and qualitative assessments necessary to refine the project's strategy. MCDI staff built robust and collaborative relationships with communities and with regional and district authorities. Tools and methods created by MCDI for IMCI training and supervision have now been adopted by the MOH for national programs.

Project achievements can be attributed to MCDI's innovative and cross-cutting approaches to community mobilization and behavior change communications such as community health festivals, "VISA" mothers and the child-to-community approach which are highlighted in this mid-term evaluation. Health messages were communicated through local radio, schools, mothers, Traditional Birth Attendants and committed and well-trained community health workers.

Two major constraints delayed or deferred activities in fiscal years 2004 and 2005: (1) the lack of current, national policies and protocols for malaria treatment and distribution of insecticide-treated nets, and (2) an MOH district health calendar packed with last-minute pilot projects, random program evaluations, VIP visits, Health Day celebrations and similar events that disrupt health

district planning, increase workload and draw resources from on-going activities. Other constraints include a major population influx toward sapphire mines in the project zone, the cyclone Gafilo, long distances between health centers, the poor quality of roads and project vehicle breakdowns.

High MOH staff turnover and a lack of coordination between programs are constraints to sustainability. However, the project has created strong links between health system levels that will increase the likelihood of activities continuing when funding ceases. The motivation of community-based volunteers has thus far been maintained and the innovative and cost-effective VISA mother approach is promising for the continuity of BCC activities. Refresher training and supervision should be adequate to maintain current levels of service quality. MCDI should advocate at the regional and national level for a better distribution of health human resources and a stronger supervisory system for MOH staff.

Recommendations from this mid-term evaluation include:

- Use formative supervision instead of training to improve health staff performance and avoid absences of staff from the health centers, with a focus on low- performing health staff
- Increase efforts to improve malaria case management and prevention
- Emphasize messages on the importance of care-seeking behavior when danger signs are present
- Disseminate HIV-AIDS prevention messages in the context of birth-spacing
- Focus on key priority geographical areas identified at the time of the KPC follow-up in 2004
- Improve the quality of care through the definition of quality standards and facility-specific strengthening of supervision in collaboration with the regional and district health authorities
- Scale up the VISA mother approach to community mobilization
- Scale up the *mutuelle* community credit scheme to improve access to care and financial sustainability of MOH health facilities
- Capitalize on guides, handbooks and communication supports used during the project
- Submit an Expanded Impact proposal for a group of districts in the Toliara province to (1) scale up birth-spacing, immunization, breastfeeding promotion and IMCI (2) pilot interventions currently under discussion at the MOH such as micronutrient supplementation and community-based treatment of ARI (3) support the regional health authorities in improving the quality of care.

MCDI's response to these recommendations was to (1) gather project stakeholders for a participatory workshop in which a revised action plan for 2005-2006 was drafted (see page 43) and (2) secure the endorsement of the MOH and USAID for an Expanded Impact application.

Those who helped to carry out this Mid-term Evaluation included the MOH (central, regional, district and ASB), USAID, local partner NGOs (VEMIMA, Mampifoha), local authority representatives, community members, VCS, AVBC and MCDI staff.

B. Assessment of the progress made toward achievement of program objectives

1. Technical Approach

a. Brief overview of the project

Medical Care Development International's Toliara Province Child Survival Project (TPCSP) is improving maternal and child health in six intervention areas: Pneumonia Case Management, malaria, control of diarrheal diseases, immunization, breastfeeding/nutrition, and birth-spacing/reproductive health. The results-based objectives in each of these areas are presented in the tables in the pages that follow. The project is being carried out within the Ministry of Health's (MOH) Integrated Management of Childhood Illnesses (IMCI) framework both at the facility and community levels and has fulfilled the three components of the IMCI strategy: (1) improving case management skills of health workers (2) improving the health system for managing childhood illness and (3) improving family and community practices.

The project areas are the Toliara II and Betioky Sud health districts, which are two of the most populated districts in Toliara, the poorest Province of Madagascar, as reflected by health indicators. Of the country's six provinces, Toliara has the highest under-five mortality rate (140 per 1000), the highest fertility (6.3) and the lowest immunization rates (DHS 2003-2004). The project is progressively phasing out its past support to the Betioky Sud district and implementing new activities in the district of Toliara II. The estimated beneficiaries are 63,791 children under five years of age and 81,510 women of reproductive age.

The project is founded on a comprehensive strategy designed to improve access to quality health services, increase demand for health services and enhance synergy between actors through the following illustrative activities:

At the mother level: Mothers' health education via Behavior Change Communication (BCC) with community-based volunteers, Traditional Birth Attendants (TBA) and health staff
At the community level: recruitment and training of community-based volunteers and VISA mothers; community mobilization through radio programs; advocacy by local authorities; organization of community health festivals; a school-based prevention education approach called "child-to-community"; social marketing of insecticide-treated nets and essential drugs through a network of community-based distributors; and finally, improved access to care through a community credit insurance scheme or "*mutuelle*".
At the health facility level: Improvement of health staff skills in IMCI and quality of care, strengthening of the Health Information System (HIS), and enhancing links and collaboration between clinic-based health staff and community-based volunteers to build a more effective and accessible health system for patients.
At the regional and district level: implementation of both clinic-based and community-based IMCI; building an appropriate Health Information System (HIS); organizing joint training sessions for health staff; elaborating joint training materials and approaches; facilitating supervision and monitoring activities of the district health team; planning of activities at the district level (feedback, counseling, mentoring); and identifying new resources through networking with other organizations.

The TPCSP's primary partners are the Ministry of Health (MOH) at the regional, district and commune levels, SantéNet, Population Services International, the Ministry of Communication, the Ministry of Education, the Nurse and Midwife Training School, the School of Medicine, UNICEF, UNFPA, local NGOs and community members. In project areas of Betioky Sud, MCDI has BCC mentoring agreements with the Vemina NGO and the Rural Mobilization Department (DAR).

The project began in October 2002 and is scheduled to end in September 2006.

b. Progress report by intervention area

Pneumonia

According to the 2003-2004 Demographic Health Survey (DHS), Acute Respiratory Infection (ARI) has a serious impact on child health, with a prevalence rate of 9% in children under the age of five in Madagascar and 16% in Toliara Province**.** ARI is the second largest cause of infant mortality in the district after malaria, and health consultations for ARI represent 16% of all health consultations in the Toliara II district.

The mid-term KPC[1] found a twenty percent increase in mothers' ability to recognize pneumonia danger signs and an eight percent increase in care-seeking behavior among mothers of children with pneumonia symptoms. The project also achieved its mid-term goal with respect to the number of clinical staff correctly using IMCI treatment protocols. However, the KPC revealed inequality in mothers' knowledge between geographical zones and between indicators (Indicators were weakest in the coastal zone). The last two years of the project should focus on other geographic areas to improve awareness of both pneumonia symptoms and of the availability of pneumonia-related health services. Although some mothers acknowledged that health staff can be effective in curing pneumonia, others admitted that they preferred to consult traditional healers for pneumonia because drugs are not always available at the health facility.

Objective: Pneumonia Case Mgmt (LOE 15%)	**Baseline 2001 (N=180)**	**2004 Planned[2]**	**2004 Achieved**	**2006 DIP**	**2006 Revised**
1. Increase from 11% to 45% the percent of mothers of children aged 0-23 months with fast/difficult breathing during the last two weeks who sought treatment from a health facility by the end of the day	11%	30%	19%	45%	30%
2. Increase from 25% to 65% the percent of mothers of children aged 0-23 months who can identify at least two danger signs of pneumonia that indicate the need to seek medical attention	25%	45%	45%	65%	65%
3. Increase from 0% to 60% the percent of clinical staff that will correctly use IMCI treatment protocols.	0%	30%	27%	60%	60%

Pneumonia case management was improved in health facilities and at the community level in the health districts of Toliara II and Betioky Sud. The project staff have adopted community IMCI (C-IMCI) protocols and developed specific and appropriate supervision tools for C-IMCI.

The following table shows that most of the pneumonia-related activities described in the Detailed Implementation Plan (DIP) have been completed, including many of those planned for 2006. The exception remains health promotion in schools that was delegated to the international NGO Aide et Action. Aide et Action covers all the schools in the district of Toliara II, and is applying the child-to-community approach to health education.

[1] Fanoneza R.L., *Evaluation à mi-parcours: Rapport de l'enquête de suivi CAP*, MCDI, Nov. 2004, Madagascar.

[2] Targets planned for 2004 were based on a linear projection of the 2001 baseline survey

Planned activities for 2002-2006 (from DIP)	Achievements January 2003 to May 2005
Recruit 6 Field Agents and train as trainers and supervisors of Community Health Volunteers (CHVs) and in the management of ARI/pneumonia	Completed
ARI/pneumonia curriculum for CHVs developed	Completed
Trainees identified	11 trainers in IMCI identified and trained
420 CHVs in place and trained in ARI	445 CHVs operational and trained in ARI following C-IMCI protocols
Train 60 health agents (ASBs) in TOT and in supervision of CHVs in relation to management of ARI/pneumonia according to IMCI protocols	Completed
Provide ARI/pneumonia refresher training on quarterly basis for 80% of CHVs	Completed
Adapt and distribute Supervision tools for C-IMCI at all levels (CHVs, ASBs etc.)	Completed
Supervise 80% of CHVs on quarterly basis	Completed
Adapt education messages on ARI/pneumonia	Completed
Adapt and distribute BCC tools for ARI/pneumonia to all levels (CHVs, ASBs, CIS, Schools, NGOs, DAR)	Completed
Hold annual health festivals in each health sector	Community health festivals organized in 28 (out of 33) health sectors of Toliara II and in 1 health sector of Betioky Sud.
Implement the child-to-community (CTC) approach in 50 schools	Activities delegated to Aide et Action
Train 50 elementary school teachers in the child-to-community approach and in the management of ARI	
CTC program implemented and supervised on a quarterly basis in 80% of schools	
Refresher training for 6 trainers (DPS, MCDI, SSD) in C-IMCI	11 trainers in IMCI identified and trained
Train 60 ASBs in C-IMCI protocols	Completed
Adapt C-IMCI training modules for ASBs adapted and distribute	Completed
Distribute C-IMCI flowchart and consultation forms to all health centers (CSB)	Completed
Procure antibiotics for the CSB every quarter	More than 80% of CSBs have a sufficient stock of oral antibiotics and 63% have an adequate stock of injectable antibiotics[3]
Adapt C-IMCI supervision tools for CSB	Completed
Train members of EMAD in IMCI supervision tool, planning and supervision	11 members of EMAD trained in IMCI supervision tool, planning and supervision
Supervise regularly 80% of the CSB in	100% of CSBs have been regularly supervised

[3] Source: IMCI survey, 2004.

Planned activities for 2002-2006 (from DIP)	Achievements January 2003 to May 2005
accordance with supervision guidelines	in accordance with supervision guidelines during the last 12 months
Evaluate the quality of ARI/pneumonia case management through an annual health facility assessment	An evaluation survey on the quality of IMCI services was carried out in October 2004
Equip at least 60% of the CSBs with IMCI kits, which contain: a stopwatch, an ORT kit, an infant scale, a thermometer, and a case management card)	100% of CSBs equipped with IMCI kits

Follow-up and next steps
A workshop organized during the MTE produced the following recommendations for improving pneumonia management:

At community level:
- Develop new messages and communication tools on pneumonia danger signs and the importance of care-seeking
- Improve supervision of health staff in the promotion of care-seeking behavior
- Encourage Community Health Volunteers to organize additional pneumonia BCC activities with mothers
- Organize an annual health festival on care-seeking behavior and the referral system

At the facility level:
- Improve the quality of care and reduce stock-outs to attract more patients
- Strengthen the supervision of health agents (ASBs) on pneumonia issues
- Train new health staff in IMCI protocols

Future directions:
a) As suggested by the USAID Child Survival coordinator in Madagascar during the MTE, extend MCDI's experience in pneumonia case management to other parts of the country
b) MCDI has been encouraged by health authorities and by USAID Madagascar to apply its pneumonia experience toward implementing community-based distributions of zinc and cotrimoxizole.

New objectives for 2006
During a participatory workshop at the end of the MTE process, objectives were revised in light of the achievements and prospects for the future. (See the pneumonia objective table on page 7 for new 2006 targets.)

Malaria

With a prevalence of 33% for Toliara Province (2003-2004 DHS), malaria is the principal cause of death in children under five in the Toliara II district. Malaria is also a primary cause of morbidity in pregnant women. The results of the 2004 KPC estimate malaria prevalence in Toliara II at 65%, up from the 61% estimate in the 2002 baseline survey.

The project has adopted the Roll Back Malaria strategy of efficient management of cases at the facility level, effective home-based case management and ITN promotion. The main focus between

2002 and 2004 was on the training and supervision of ASBs in intermittent preventive treatment and malaria case management for pregnant women, as well as on home-based prevention and case management. ITN promotion messages were broadcast through mass media and Community Health Volunteers (CHVs). Distribution of chloroquine and ITNs began in March of 2005. Capacity building activities were combined with BCC in the training of 11 radio announcers on malaria, and on the development and diffusion of BCC messages.

The mid-term KPC and Health Facility Assessment (HFA) did not show acceptable improvements in malaria indicators, though all indicators increased slightly. The percentage of children aged 0-23 months who slept under an ITN increased only slightly from 3% to 7%. The percentage of mothers who correctly treated fever at home also fell short of 2004 targets. However, care seeking doubled, with 66% of mothers seeking treatment at a health center for a child with malaria, up from 33% at baseline. Reduction of malaria drug stock-outs exceeded its target, from 0% in 2002 to 50% in 2004.

The malaria component has experienced delays due to the absence of a national policy and coherent MOH planning for malaria activities. It is expected that the government will soon release new clinical treatment protocols and official policies for ITN distribution. Despite the lack of policy, MCDI's launch of socially-marketed nets (with PSI) and community-based distribution of chloroquine in March 2005 was successful and generally accepted by the community. ITN sales data show that more than 6500 ITNs were sold between March and May of 2005. This translates roughly to an ITN coverage rate of 30% of households. One cultural barrier remains a challenge: as it is locally recognized that an overdose of chloroquine can be effective for abortion, some mothers are reluctant to use chloroquine during pregnancy.

Another problem is the lack of coordination between actors. Under the Global Fund Program, the NGO SALFA was given permission to sell ITNs in the Toliara Region including the Toliara II and Betioky Sud districts. However, this new project did not take into account existing resources and networks of community-based distributors. In addition, SALFA's ITN prices are lower than the price agreed upon at the national level. The lack of coordination may have negatively effected the motivation and commitment of Community Health Volunteers.

Based on the following results, 2006 objectives were revised.

Objective: Malaria (LOE 15%)	**Baseline 2002**	**2004 Planned**	**2004 Achieved**	**2006 DIP**	**2006 Revised**
1. Increase from 3% to 20% the percent of children aged 0-23 months who slept under an insecticide-treated bed net the previous night	3%	15%	7%	20%	15%
2. Increase from 13% to 50% the percent of mothers of children aged 0-23 months with a febrile episode ending during the last two weeks who gave correct treatment at home	13%	35%	25%	50%	40%
3. Increase from 31% to 80% the percent of mothers who took anti-malarial medicines to prevent malaria during pregnancy	31%	80%	21%	80%	40%
4. Increase from 0% to 75% the percent of Community-Based Distributors (CBDs) with no stock-out of anti-malarial medicines during the preceding six months.	0%	40%	50%	75%	85%

Planned activities for 2002-2006 (from DIP)	Achievements January 2003 to May 2005
Train 184 CBDs in community-based sales of ITNs, re-impregnation, and social marketing of ITNs	All community-based distribution activities had been planned for year three.
Regularly supply 184 CBDs with ITNs and re-impregnation kits through PSI	
Regularly supply 50% of CSBs with ITNs in accordance with the PFU channel	
Form social groups in 25% of the health sector to facilitate ITN acquisition by the rural populations	
Equip CHVs, CBDs, NGOs, and CSBs with BCC with ITNs and tools to promote malaria prevention	Completed
Prepare and broadcast malaria radio programs	A bi-weekly radio program is being broadcast on ALT, and community listening/discussion groups are being created
Train eight radio communication agents in the development of educational programs on malaria control	11 radio animators and 6 Field Agents trained in the development of educational programs on malaria control.
Broadcast 60 spots and 60 radio programs on malaria control and ITNs	Completed
Train 420 CHVs, 184 CBDs, 4 NGOs, DAR and Field Agents (FA) in malaria prevention and home-based case management	445 CHVs, 72 CBDs, 2 members of local NGOs, 2 members of DAR and 6 Field Agents trained in malaria prevention and home-based case management according to IMCI protocols
Train 60 ASBs, 6 FAs, the DAR and 4 NGOs as trainers and supervisors in malaria prevention and home-based case management	21 ASBs, 2 members of local NGOs, 2 members of DAR and 6 Field Agents trained in TOT
Adapt, develop and distribute malaria supervision tools for CHVs, CBDs and ASBs	Developed by WHO
Supervise quarterly 80% of CHVs and CBDs	Completed
Provide malaria refresher trainings for 80% of CHVs and CBDs	100% of CHVs refreshed in malaria prevention and case management
Implement the child-to-community approach in 50 schools	Delegated to Aide et Action
Train 50 teachers in the child-to-community approach to support and promote malaria control	
Implement CTC programs in 80% of schools	
Adapt messages on malaria control and ITN promotion	Completed
Adapt, develop and distribute BCC tools for malaria control and ITN promotion at all levels (CHVs, ASBs, CIS, Schools, NGOs, DAR)	Completed
Organize contests for social mobilization to promote ITN use every six months in all health sectors	Postponed
Provide refresher training for 60 ASBs every six months in malaria case management and prevention in pregnant women	21 ASBs retrained every six months on case management and prevention of malaria in pregnant women

Planned activities for 2002-2006 (from DIP)	Achievements January 2003 to May 2005
Adapt training module on malaria case management for pregnant women	Not available as the new national policy has not yet been released
Procure anti-malarial drugs for the CSBs every quarter	Chloroquine available in 95% of CSBs, SP available in 81% of CSBs and injectable quinine in 59% of CSBs[4]
Provide cost-recovery refresher training for 60 ASBs	Completed by SSD
Adapt CBD module on chloroquine	Completed
Train 184 CBDs in use of malaria treatment algorithm	132 CBDs trained in use of malaria treatment algorithm
Supervise 80% of CBDs quarterly	Not completed as planned
Develop management tools for CBDs	Completed
Procure chloroquine for CBDs every quarter	Completed
Train 60 ASBs in MCM in accordance with the C-IMCI	60 ASBs trained in clinical IMCI. Refreshers will be organized upon introduction of new training modules by MOH.
Adapt and distribute malaria training modules for ASBs	Not available

Lessons learned:

- C-IMCI improved ITN use: More than 6500 ITNs were sold between March and May of 2005. Currently the supply of ITNs is not keeping up with the demand.
- ITNs are culturally acceptable to households and are in high demand at the current price
- Palustop (Chloroquine that is prepackaged and pre-measured by PSI) is much appreciated by the recipient population. ("Palustop quickly and effectively cures malaria cases")
- There is demand among the population for Palustop to treat adults[5].

Follow-up and next steps

At the community level:

- Messages should focus on ITNs, home case management, malaria prophylaxis for pregnant woman and recognition of danger signs for severe malaria
- Reinforce home-based case management of malaria through information delivered by CHVs
- Expand the network of Community-Based Distributors
- Promote malaria prevention for pregnant women through CHVs, TBAs, Community-Based Distributors

At facility level:

- Ensure continuous availability of drugs through improved management of the supply system by ASBs
- Strengthen the quality of care in health centers (CSBs) through IMCI refresher training on the malaria treatment algorithm

At project level:

[4] Source: IMCI survey, 2004

[5] Palustop is only produced for children under 5 years old.

- Ensure stocks of ITNs and chloroquine in Toliara through continued collaboration with PSI
- Focus on the zones and indicators that the 2004 KPC demonstrated to be problematic

At regional and national levels:

- Organize coordination meetings with health authorities, SALFA and all other actors to harmonize ITN prices and the distribution approach

Control of Diarrheal Disease

Diarrheal disease constitutes the third leading cause of morbidity among children under five and the first cause of infant mortality in the Toliara Province. The 9% prevalence rate (DHS 2003-04) is linked to lack of hygiene and lack of exclusive breastfeeding. At baseline, the majority of mothers (64%) said they reduced or discontinued breastfeeding during their child's diarrheal episode. Treatment was sought rarely or more than 48 hours after the episode's onset. Mothers preferred to seek treatment first from TBAs and traditional healers.

The intervention focused on the community level training of CHVs, Field Agents and local NGOs in the prevention of diarrheal disease, including hygiene and home-based case management. Prevention activities carried out at the community level by CHVs and NGOs were combined with the broadcasting of radio programs. Facility-based diarrhea case management was included in IMCI training.

The mid-term evaluation highlights positive progress in the acceptance of breastfeeding and use of ORT at home. Mothers' administration of food, fluids and breast milk during diarrheal illness surpassed planned targets. However, the care-seeking indicator improved only slightly. More work is needed to convince families to visit health centers at the onset of diarrhea.

Objective: Diarrhea (LOE 15%)	**Baseline 2002**	**2004 Planned**	**2004 Achieved**	**2006 DIP**	**2006 Revised**
1. Increase from 34% to 65% the percent of children aged 0-23 months who have had diarrhea in the past two weeks and who have been given more than the usual amount of fluids during a diarrheal episode	34%	50%	58%	65%	75%
2. Increase from 24% to 55% the percent of children aged 0-23 months who had diarrhea in the past two weeks and who were given the same or more than the usual amount of foods during a diarrheal episode	24%	40%	64%	55%	80%
3. Increase from 36% to 65% the percent of children aged 0-23 months who had diarrhea in the past two weeks and who were given the same or more than the usual amount of breast milk during a diarrheal episode.	36%	50%	60%	65%	75%

4. Increase from 52% to 80% the percent of children aged 0-23 months who had diarrhea in the past two weeks and whose mothers sought advice or treatment for the illness within 24 hours of the first sign of danger	52%	65%	55%	80%	65%
5. Increase from 33% to 65% the percent of mothers of children aged 0-23 months who can cite at least two danger signs for diarrhea as reasons to seek advice or treatment at a health facility	33%	50%	45%	65%	55%

Planned activities 2002-2006	Achievements January 2003 to May 2005
Adapt training module in prevention and home-based care of diarrhea	Completed
Train 420 CHVs, 6 Field Agents, 4 NGOs and the DAR in diarrheal disease prevention, including hygiene and home-based management	445 CHVs, 2 local NGOs, 2 members of DAR and 6 Field Agents trained in diarrheal disease prevention, including hygiene and home-based management of diarrhea within the C-IMCI strategy
Train 184 CBDs in ORS preparation, community-based sale of ORS, dehydration diagnosis and oral rehydration	Completed
Provide refresher trainings for 420 CHVs and 184 CBDs in home-based case management and prevention of diarrhea	402 CHVs retrained in home-based case management and prevention of diarrhea.
Adapt and distribute BCC materials and messages on diarrheal control and prevention at all levels (CHVs, CBDs, ASBs, NGOs)	Completed
Train and supervise quarterly 80% of primary schools in child-to-community approach	Activities delegated to Aide et Action
Implement child-to-community approach for diarrheal control in 50 schools	
Develop CTC supervision tool	
Establish 28 support groups to fight diarrhea and promote breastfeeding and vaccination.	5 support groups established to fight diarrhea and promote breastfeeding and vaccination. Among them, 2 support groups were created by the NGO Mampifoha
Establish in 80% of villages a local committee on cholera to prevent cholera epidemics	Cancelled
Institute CIS and community collaboration in diarrhea prevention activities including hygiene, water and sanitation, building and utilization of latrines	Cancelled
Train 4 NGOs in the mentoring approach, and the planning of child survival interventions	2 NGOs trained in the mentoring approach and the planning of child survival interventions (Vemima et Mampifoha)
Prepare and broadcast 60 spots and 60 radio programs on	Completed

Planned activities 2002-2006	Achievements January 2003 to May 2005
diarrhea	
Adapt BCC materials and messages on diarrheal control, prevention and treatment-seeking and make available for use at all levels (CHVs, CBDs, ASBs, NGOs)	In progress

Follow-up and next steps
Recommendations for the future have been described by all key stakeholders as follows:

At the community level:

- Focus on promotion of care-seeking behavior.
- Maintain effort on BF promotion and Oral Rehydration Therapy
- Develop appropriate BCC tools on "Hevo" (swollen head or the newborn's fontanel)
- Encourage community mobilization through the development of the "champion commune" approach (promoted by USAID) and VISA mothers
- Make sure that CHVs emphasize care-seeking when danger signs appear

At the facility level:

- Refresher training for ASBs on IMCI protocols regarding diarrhea

Future directions/Lessons learned:
The success of MCDI in diarrhea management could be easily replicated in districts throughout the Toliara Province. C/HH-IMCI training modules are ready for immediate distribution to other health districts. During a presentation of the MTE findings, USAID managers in Madagascar encouraged MCDI to submit an Expanded Impact child survival proposal.

MCDI is convinced that its successful community-based approaches could be very helpful in other areas such as zinc supplementation.

Immunization

According to the DHS 2003-2004, the proportion of fully-vaccinated children aged 12-23 months in Madagascar is 53%. The Toliara Province has the lowest rate (28%) of the five provinces. In the project area, the immunization rate of children aged 0-11 months for each type of vaccination in the project area is far from the MOH target of 80% and remains among the lowest in Toliara Province.

Percentage of vaccinated children aged 12-23 months

Vaccine	**TCS Project Area**		**Toliara Province**
	MOH 2002	**MCDI KPC 2002**	**MOH 2002**
BCG	62%	54%	79%
DTP3	38%	42%	53%
OPV3	38%	40%	53%
measles	36%	34%	59%
fully vaccinated		30%	28%

Vaccination of pregnant women takes place during prenatal consultations. During the KPC 2002, tetanus toxoid coverage (2 times or more) was 34%. MOH MIS data reports 39% coverage for

2002. Despite the service of tetanus vaccine during prenatal visits in private and public health centers, coverage is low and the majority of pregnant women are not vaccinated against tetanus.

The project has fully applied MOH immunization policies including infection prevention, immunization or verification of women during prenatal consultations and adoption of IMCI approaches. The project provided support at various levels of the health system:

- At the district level: The EMAD (district management team) was trained in supervision and improved cold chain management
- At the health facility level: most CSB were supplied with refrigerators and kerosene; ASBs were trained in EPI policies within the context of C-IMCI
- At the community level: CHVs were trained in EPI promotion and provided with BCC tools. These activities were complemented with radio programs and the VISA mother approach

Immunization efforts have been successful, having fully immunized 52% of children aged 12-23 months, as compared with 30% at baseline. However, the project did not achieve targets for tetanus toxoid (TT) for pregnant women. *ASBs explained during the mid-term evaluation that this is likely due to underreporting. TT data are based on health card records and mothers sometimes lose their health cards. ASBs also said that that women in the region fear vaccination during pregnancy.* There are discrepancies in vaccination rates between zones. For example, coastal regions have lower rates, perhaps due to mothers who work off shore and are inaccessible during the day.

The biggest difficulties faced by the project are still related to cold chain management and specifically to maintaining a regular supply of kerosene and spare parts for refrigerators in health facilities. These problems are caused by long distances between health centers and the lack of appropriate supply systems at the district level. However, resource planning has improved during the last two years.

Objective: Immunization (LOE 20%)	**Baseline 2002**	**2004 Planned**	**2004 Achieved**	**2006 DIP**	**2006 Revised**
1. Increase from 30% to 60% the percent of children aged 12-23 months who are fully immunized through the vaccination card	30%	45%	52%	60%	70%
2. Increase from 34% to 65% the percent of mothers who received at least two tetanus toxoid (TT) injections before the birth of their last child	34%	50%	20%	65%	40%
3. Reduce from 21 % to 10% or less the percent of children aged 12-23 months who default between DPT and DPT3 doses	21%	16%	NA	10%	10%

Planned activities 2002-2006	Achievements January 2003 to May 2005
Provider refresher training for 6 trainers (DPS, MCDI, SSD) in EPI related activities	11 trained in EPI related activities
Train 60 ASBs in new EPI strategies that include vaccination in the context of C-IMCI, utilization of multiple dose vaccine vials, and Vit. A supplementation	Completed
Refresh 60 ASBs in rationale of the EPI national policy	Completed
Provide security stock of spare parts (wicks & chimney	Not achieved

Planned activities 2002-2006	Achievements January 2003 to May 2005
for the refrigerators available in the SSD warehouses)	
Re-supply regularly kerosene for refrigerators established with EMAD	Completed for 100% of CSBs
Train SSD EPI manager, and 60 ASBs in cold chain maintenance	Completed
Equip at least 80% of CSBs with functional refrigerators	20 out of 33 CSBs equipped with functional refrigerators 1 CSB equipped but not functional
Assure functionality and maintenance of SSD warehouse refrigerators	Completed
Train 420 CHVs in the promotion of EPI, BCC circuits, and the VISA approach,	433 CHVs trained in the promotion of EPI, BCC and the VISA approach
Ensure that 60% of the CHVs are applying the VISA approach to vaccination	65% of the CHVs are applying the VISA approach for EPI
Develop EPI training module for CHVs	Completed
Adapt and distribute messages & BCC tools on vaccination at all levels of the health system.	Completed
Diffuse radio messages to promote EPI	Completed with ALT radio
Develop an information system to track drop-outs of children to be immunized	Completed
Train 420 CHVs to track drop-outs in the community and supervise 80% of CHVs quarterly on EPI related activities, including cold chain maintenance	Completed
Assess health facilities annually to evaluate service quality and the need for EPI training for ASBs	Completed
Develop supervision tool for the CSBs	Completed
Refresh 60 ASBs in management of vaccines	Completed
Supply vaccines to 28 CSBs every quarter	19 out of 33 CSBs have an adequate stock of vaccines

Follow-up and next steps

The focus for the next two years should be at the community and facility levels:

- Improve TT vaccination
- Strengthen the cold chain and availability of immunization services at the health facility as well as the community level
- Introduce new BCC materials on vaccination and pregnancy to help pregnant women understand the importance of TT and to ease fears about the effects of vaccination on the child
- Develop a tool that helps to reinforce the registration system for women's vaccines, for example: vaccination cards for TT and diplomas for ATT5 that could be used as an incentive for women and a second source of information for immunization rates
- Strengthen outreach activities and routine vaccination

Future Directions:

a) With the support and commitment of the regional health authorities, the EPI intervention could be expanded to other districts, applying lessons learned from the current project
b) MCDI should evaluate the feasibility of supporting UNICEF's Reach Every District program

Breastfeeding and nutrition

Because of the precarious socio-economic situation in southern Madagascar, Toliara Province is a problem area for malnutrition and famine. The MOH MIS data found in 2002 that 4.4% of children under five who went for health consultations were underweight. Only 2% had received exclusive breastfeeding for six months. Despite the high proportion of mothers who gave colostrum to their last child (72%), breastfeeding initiation remains later than the first hour after birth for most mothers (76%).

Objectives planned for 2004 have been surpassed. EMAD managers acknowledged during the MTE that the population's acceptance of exclusive breastfeeding has been surprisingly high. The success is explained by the completion of most activities (90%) that had been planned for 2006, the lessons learned during the first phase of the project in Betioky Sud, the "essential nutritional actions" campaign, the absence of socio-cultural barriers regarding breastfeeding and the visible and rapid impact of breastfeeding on the health status of children which encourages families to adopt the key behaviors. During the MTE survey, mothers explained that they had been convinced by community health festivals and the "big baby" contest. They could see for themselves the positive health impacts of breastfeeding on babies.

Objective: Breastfeeding (15%)	**Baseline 2002**	**2004 Planned**	**2004 Achieved**	**2006 DIP**	**2006 Revised**
1. Increase from 2% to 35% the percent of children aged 0-5 months who are exclusively breastfed	2%	20%	34%	35%	50%
2. Increase from 24% to 55% the percent of mothers who initiate breastfeeding within one hour after giving birth	24%	40%	42%	55%	55%
3. Increase from 19% to 50% the percent of children aged 12-23 months who receive 5 or more feeds per day (meals and snacks) in addition to breastfeeding	19%	35%	36%	50%	50%

Planned activities 2002-2006	Achievements January 2003 to May 2005
Provide a refresher training for a team of 6 trainers (DPS, MCDI, SSD) in the "Essential Nutritional Actions" (ENA) package and utilization of the modules	11 trainers trained in TOT and the ENA package
Train 60 ASBs in the ENA package	Completed
Implement baby friendly hospital initiative (BFHI) approach in the 28 CSBs	7 ASBs, 1 CSB of Toliara, 2 CHD of Betioky Sud and 3 CSBs of Betioky Sud trained in BFHI approach.
Refresh 60 ASBs in ENA package including feeding during illness	Completed
Establish channels to re-supply the CSB facilities with	Completed

Planned activities 2002-2006	Achievements January 2003 to May 2005
Vitamin A with the EMAD and with the PFU arrangement	
Procure & re-supply Vitamin A for the 28 CSBs on a quarterly basis	68% of CSBs have not experienced a shortage in Vitamin A during the last 6 months.
Train 420 CHVs in promotion of breastfeeding	445 CHVs trained
60% of CHVs apply the VISA approach for breastfeeding	92% CHVs apply the VISA approach for breastfeeding
Develop training modules on breastfeeding and ENA for CHVs	Completed
Adapt and distribute messages & BCC materials on breastfeeding at all levels	Completed
Diffuse radio spots to promote breastfeeding	Completed with ALT radio
Supervise 80% of the CHVs quarterly on breastfeeding related activities	90% CHVs are quarterly supervised on breastfeeding-related activities
Assess health facilities annually to evaluate the quality of service delivery (counseling in ENA and breastfeeding by the ASBs)	Completed
Develop a supervision tool for the CSBs on breastfeeding, including a supervision project for the available BFHIs	In progress
Develop supervision tools, including qualitative analysis of the EBF	Completed
Train and equip 420 CSVs with Salter scales for surveillance and growth monitoring	Cancelled
Ensure that 28 CSBs practice surveillance for growth monitoring of sick and healthy children	Completed

Follow-up and next steps

BCC activities have had significant impact on the acceptance of breastfeeding and should be continued. The development of the VISA mother approach is strongly advised for further effective breastfeeding promotion. The success of the project in breastfeeding was acknowledged by USAID and the MOH. Extending the current project to additional geographical areas could multiply the positive effects.

Birth-spacing and reproductive health

The Malagasy society is pronatalist and views children as gifts from God. This explains in part the low use of modern contraceptive methods among WRA (1.1% according to MOH MIS data and 12% according to KPC 2002) despite the high proportion of mothers (65%) who know at least one place to obtain birth spacing advice and services. The majority of mothers (94%) cannot cite the benefits of birth spacing. In Madagascar, two-thirds of women (66%) gave birth at home (DHS 1997), but in the province of Toliara, this proportion is even higher (90% according to MOH MIS data). According to the KPC 2002, only 30% of mothers reported giving birth to their last child at a health center and slightly more than half (58%) of mothers were assisted by a health professional during delivery.

The project surpassed birth spacing objectives for 2004, with contraceptive prevalence reaching 22%, compared with DHS (2003-04) data of 18% for Madagascar and 12% for Toliara Province. This success is explained by birth spacing promotion by VISA mothers and by the socially-marketed "Pill Plan" made available by community-based distributors. Stock-outs among distributors have been reduced. Women's lack of HIV-AIDS knowledge is not surprising considering the limited effort allocated to this activity during the first two years of the project.

The major challenge for the project is access to birth spacing services for women in the coastal zone. Few coastal women were available to come to community meetings. This aside, the relatively high use of modern contraceptive methods has been encouraging.

Objective: Birth spacing (20%)	**Baseline 2002**	**2004 Planned**	**2004 Achieved**	**2006 DIP**	**2006 Revised**
1. Increase from 9% to 25% the percent of mothers who are not pregnant, do not want another child in the next two years or are not sure, and are using a modern method of contraception	9%	20%	22%	25%	30%
2. Increase from 21 % to 60% the percent of women who can cite at least two ways of reducing the risk of HIV infection	21%	45%	22%	60%	40%
3. Increase from 0% to 75% the percent of CBDs that have had no stock-outs of condoms during the past six months	0%	18%	36%	75%	70%
4. Increase from 1% to 40% the percent of mothers who can cite exclusive breastfeeding as a method of child spacing	1%	20%	4%	40%	30%

Planned activities 2002-2006	Achievements January 2003 to May 2005
Provide child spacing (FP) supplies and equipment to 28 CSBs	33 CSBs of Toliara II and 21 CSB of Betioky Sud equipped and supplied to provide FP services
Train 420 CHVs in the promotion of FP, BCC techniques, VISA approach	439 CHVs trained in FP
60% of CHVs apply the VISA approach with FP	65% CHVs apply the approach VISA with FP
Develop training module on FP for CHVs	Completed
Adapt and distribute messages & BCC materials on FP at all levels of the system	Completed
Use mass media to promote FP	Completed
Develop a recording system to track drop-outs from the FP program	Not Completed

Train 420 CHVs to track those who drop out of the program at the community level	Not completed
Supervise quarterly 80% of the CHVs in FP activities	Not completed
Refresh 60 ASBs on PFU, supply and drug management	Not completed
Re-supply quarterly 28 CSBs with contraceptives in accordance with the established PFU system	More than 65% of CSBs have not experienced a shortage in contraceptives during the last 6 months
Assure appropriate stock of contraceptives in district pharmacies	Phagedis in Toliara and Betioky have not experienced contraceptive stock-outs
Refresh a team of 6 trainers (OPS, MCDI, SSD) on birth-spacing	Completed
Train and refresh 60 ASBs in 4 family planning methods according to the national policy for FP	50 ASBs in Toliara II and 13 ASBs in Betioky Sud trained and refreshed in 4 family planning methods according to the national policy for FP
Ensure that 28 CSBs are providing birth-spacing services	Completed
Assess Health Facilities annually to evaluate the quality of FP services being provided by the ASBs	Completed
Develop supervision tools for the CSBs on FP	Completed
Use mass media to promote FP	Completed

Follow-up and next steps

The recommendations for the project are: (1) a wider distribution of modern contraceptives through the network of community-based distributors; (2) promotion of the child-spacing benefits of breastfeeding; (3) education of the population on HIV-AIDS prevention; and (4) follow-up activities in the priority zones in order to ensure that women from the coastal zone get access to information and contraceptives. The birth spacing intervention could also be expanded to other districts.

2. Cross-cutting approaches

a. Community mobilization

Community mobilization activities have been implemented through a large network of 445 CHVs in Toliara II and by 420 CHVs and school teachers in Betioky Sud. These activities involved a wide range of actors such as local authorities, ASBs, community members, mothers and TBAs. During the MTE, many of these actors expressed their recognition of the effectiveness of the project's community mobilization approaches:

The VISA approach or "Reny Limy''

MCDI has adopted a simple and effective BCC approach known as VISA or "Reny Limy" (Malagasy for "five mothers"). The VISA approach helps to perpetuate and reinforce the impact of CHVs, reducing the problem of high volunteer turnover. The approach can be summarized as follows: Each CHV is required to choose five mothers in the community with whom they will work closely and encourage to adopt key healthy behaviors for themselves and their children. The five mothers may include members of the CHV's own family. The mothers who adopt good behaviors and who are convinced of the benefits of the messages are invited by the CHVs to share with other

women their new knowledge and the benefits they gained from this knowledge. Communication is interpersonal or in the form of public testimony during a BCC session held by the CHVs. These mothers are then invited to become CHVs. If they accept, each of them will be asked to recruit five other mothers to the program.

VISA stands for:

Visit pregnant women who have a child under two years old.
Identify behavior and practice that may endanger health
Sensitize the mothers on key positive behaviors
Accompany these mothers in behavior change

To launch the VISA approach in Toliara II, MCDI trained six project field agents in 2004 who in turn trained 445 CHVs. Among the trained CHVs, more than 70% (281) currently have VISA mothers with an average of two mothers per CHV. In Betioky Sud, the VISA approach began in 1999. The CHV turnover rate is approximately 10% in two years. More than 570 new CHVs have been recruited by the VISA approach and are currently participating, bringing to 949 the total number of CHVs. Many of the 2,788 mothers that participated in the VISA approach (and may or may not currently be CHVs) continue to support the CHVs in promoting BCC through testimonies. A total of 10,450 mothers were reached through the VISA approach.

Lessons learned:

- Breastfeeding promotion is the most effective entry point to launching the VISA approach
- The VISA approach accelerates adoption of key behaviors among mothers
- Some CHVs limit themselves to the recruitment of VISA mothers and neglect other BCC activities
- Most VISA mothers aspire to become CHVs to receive training and BCC kits
- The criteria for graduating from VISA mother to CHV are not well-defined and merit reflection
- The VISA approach has effectively contributed to improving mothers' health knowledge and practice

Community Health Volunteers

Community mobilization activities are made possible by a wide network of trained CHVs. There are currently 445 CHVs in Toliara II and 420 in Betioky Sud that have been selected by the communities via a participatory process involving local authorities (mayors), neighborhood chiefs, traditional authorities and ASBs. When recruited, CHVs are trained by project teams and supplied with communication kits containing BCC tools. CHVs are not remunerated for their job.

In community mobilization, CHVs play the role of facilitators to encourage local authorities and communities to initiate positive actions for the health of mothers and children. As a result, local authorities and communities have become more concerned about health issues and more aware of their capacities for improving health. The example of Ankilimovony's deficient cold chain illustrates the commitment of authorities and populations. To resolve the problem, the mayor and the community decided to purchase vaccines stored in the neighboring CSB of Beheloka prior to each and every immunization campaign. Specific community members are responsible for ensuring that the vaccines will be delivered on time.

Another example of good practice is the one concerning collective social agreements ("Dina") between members of the community. Now promoted by the CHVs, nearly every commune has established a collective social agreement defining key positive health behaviors to be adopted by

community members. Moreover, the CHVs encourage communities to participate in radio listening and discussion groups supported by the Andree Less Foundation Radio Project. The population has created groups of 8-12 households. Each group is provided with a free radio and commit to listening to educational radio programming and to discussing and quizzing each other to test their knowledge.

The impact of CHVs on the project can be described as follows:

- Improved awareness and involvement from communities in the mobilization of local resources to improve their own health
- Improved availability and quality of health services through involvement of communities in problem solving
- Increased diffusion of health information between CSBs, local authorities and the community, facilitating collective decision-making and leading to a favorable behavior-change environment

The mid-term evaluation assessed the level of motivation of CHVs. Through focus group discussions, the MTE identified key reasons that could motivate CHVs to continue their work in the community. Some CHVs are proud to say that they have learned about health and that their social position and role in the community is valued ("I am seen as the friend of the doctor"). The CHVs are aware of changes happening in their community and are enthusiastic about discussing these changes with others. Their work as a CHV has changed their own behavior and many CHVs have firsthand experience in prevention and treatment measures promoted by the project. Some CHVs stated that their home and personal hygiene have improved thanks to the project.

Lessons learned:

- A pilot test was conducted in the Belalanda commune of Toliara II. CHVs were exclusively recruited amongst village chiefs (chefs de fokontany). The conclusion was that problems can arise when assigning CHV work to people with political power. The village chiefs are too busy with other activities to carry out proper health promotion work. Indeed, results achieved in Belalanda are weaker than in the other CSBs where CHVs are not village chiefs. Poor outputs can be explained by: (1) the chiefs have a top-down, authoritarian approach that does not fit with the objectives of the project and the expectations of the population and (2) people perceive the chiefs as local authorities. The high social status of the chiefs does not allow transparent discussions between the population and the chiefs.
- The village chiefs acknowledged that they had difficulties assimilating new concepts and knowledge in a short period of time due to their old age. They also admitted their inability to walk long distances to visit families located in remote areas. Experience in other communes has shown that recruiting a limited number of chiefs as CHVs can be helpful for the project.
- The VISA approach is a successful way of recruiting and managing volunteers and mitigating volunteer burnout. CHVs are encouraged to recruit mothers before they decide to quit the project. Through the VISA approach, CHVs who decide to leave their post are congratulated by local authorities and project managers for their work and support. Knowledge and practice acquired by CHVs during the course of the project remain assets for each volunteer and their family. They are also encouraged to continue education activities with their relatives in an informal way.

Community health festivals

Community health festivals encourage the population, local authorities and community leaders to recognize and celebrate their own health successes and to mobilize the community in diffusion of

health education messages. Organized each year, community health festivals create official and widespread recognition of collective social agreements to adopt positive health behaviors. They promote key health messages through skits, songs, radio spots, posters and other media. Organization is the responsibility of the commune. The support provided by the project is limited to technical support and a small financial contribution (25% of the total festival cost).

In 2004, seventeen festivals were carried out in more than half of the health sectors of Toliara II. For Betioky Sud, one festival was held in the health sector of Beavoha within the framework of the child-to-community approach and in collaboration with the NGO Vohary Salama, the Betioky Sud Education Department (CISCO) and the Management of the Basic Studies Office (Ministry of National Education). For each festival, CSBs and MCDI organized contests on positive behaviors (eg: well-fed babies, fully-vaccinated children). Tools for mass animation like skits, songs and village drama developed during these festivals were recorded to be used as project audio-visual communication materials. The festivals benefited from broad media coverage and the presence of prominent personalities such as senators, deputies and *President de Faritany* (the Governor).

As a whole, community health festivals reached more than 25,000 members of the community in two districts with an average audience of 1,400 per festival.

Community Health Festivals have had a positive and effective impact on immunization, birth spacing and breastfeeding. The main lessons learned regarding community health festivals are:

- The impact of Community Health Festivals on the project is important in terms of (1) improving the knowledge of local health initiatives among district and regional authorities; (2) enhancing enthusiasm and motivation of community members; (3) promoting key positive health messages; (4) strengthening relationships and collaboration between the community and key actors and (5) encouraging community involvement in local health initiatives.
- Local authorities like community health festivals because they are an ideal occasion to communicate with the members of the community not only about health, but also to spread the other public messages related to their responsibilities. The festivals give the authorities a visible role in community development.
- Good collaboration with the authorities as well as active participation of the CHVs and the CSBs are determining factors in the success of the festivals. This includes consensual participation and integration of the beneficiary population and local actors such as the CHVs, the Chairs of Fokontany and the Mayors.
- The CHVs are very enthusiastic about the festivals. The festivals help institutionalize CHVs within the community and improve their recognition by authorities.
- At all levels, the festivals are an effective means of BCC and community mobilization, advocating the transfer of knowledge for better health.
- The showcasing of positive deviance (well-fed babies, for example) at festivals facilitates the participation of authorities and diffusion of health messages, as well as demonstrating the positive impact of individual health actions.
- The festival is a means of reinforcing the organizational capacity of the field agents and ASBs. “We learned much during the preparation of the festival”, said the head of the CSB Beroroha Marofoty.
- The festival is a good means of appreciating social cohesion, enthusiasm and solidarity within the community.

Child- to-community approach

Based on the child-to-child approach, the child-to-community (CTC) approach offers primary school students the opportunity to serve as community health messengers. Through this approach, students improve their knowledge and carry out concrete activities to improve the environment of their school, family and community. The child-to-community program has several specific objectives: (1) to vaccinate 80% of children under 12 months; (2) to ensure that 65% of children under 3 have an updated health card; (3) to organize two education sessions on malaria; (4) to ensure that latrines are regularly used by students; and (5) to ensure that 80% of students practice good personal water and sanitation behaviors. Schools that achieve these objectives are recognized with the Champion School distinction at the end of the year.

In collaboration with Vohary Salama, the Betioky Sud Education Department (CISCO) and the Management of the Basic Studies Office (Ministry of National Education), MCDI tested the CTC approach in fiscal year 2004 in the communes of Beavoha and Bezaha which include 31 schools spread out into 33 Fokontany. Since 2004, MCDI has trained 31 teachers from 31 schools on CTC. MCDI then organized with the CISCO of Betioky Sud a quarterly follow-up of the schools to evaluate their progress in implementing the approach. At the end of the school year, MCDI held a workshop to share experiences between teachers and members of the community and a festival to celebrate successes. Eighteen schools out of 31 obtained a Champion School award.

The results of CTC program in 2004 are concrete. The project measured a noticeable change in immunization coverage at the commune level thanks to the contribution of pupils in the diffusion of key health messages. DTC3 coverage increased in Beavoha from 25% to 68% in 2004. Latrines have been dug and are being used. Regarding CISCO, the Pedagogic Action Zone Head Officers are more and more motivated to provide regular supervision and follow-up for teachers.

The child-to-community approach has had additional impacts on the community:

- Students are absent less frequently for health reasons
- Communities and pupils have become more aware of health and environment issues
- Communities initiated other actions to improve health and environment

The child-to-community approach has nevertheless faced barriers: an inadequate commitment by educational and local authorities; a high turnover rate of school teachers; and a large number of students in schools resulting in a lack of availability of school kits.

A similar approach was planned for the Toliara II district. However, Aide et Action, an international NGO specializing in education, has plans to apply this approach in all schools in the district. MCDI contacted Aide et Action during the MTE and they have agreed to receive technical support from MCDI on the content of health messages.

Advocacy

Advocacy plays a key role in community mobilization. Each contact between a project member and local authorities is used as an opportunity to inform key actors on local health problems and solutions. MCDI has developed a rapid assessment tool used by field agents, who can assess the health situations, identify barriers and obstacles and inform authorities. This approach has resulted in good collaboration between local authorities, CHVs, ASBs, CBDs and field agents. Stakeholders are better aware of the health problems and interventions in their community.

Mutuelle

MCDI piloted a community insurance scheme or *mutuelle* in the Ankazomanga-Ouest health sector of the Betioky Sud district significantly increased demand for services provided at health centers. The mutuelle is managed by community members, who have set up eight village offices and one

central office close to the health center. Each office has a governing committee, a consultative committee and a financial control committee. The mutelle has built the capacity of members of civil society to organize themselves and to manage funds for the benefit of the community. (see 'Results Highlight', page 40)

b. Communication for Behavior Change

b.1. The targets of BCC activities:

The following table summarizes targets and objectives of BCC activities

Target	Behavior Change	Main approaches
ASBs	Relationships with patients, informing and counseling	Training
EMAD	Communication during supervision	Training, mentoring
NGOs, CHVs et CBDs	Relationships with community members	Training, mentoring
Mothers, community, family	Key behaviors promoted by the project	VISA, Mass media

b.2. The key messages of the project

The project has developed specific priority health messages for mothers, communities and families, based on the 16 key messages of the C-IMCI approach. These messages are consistent with MOH policy and reflect the findings of qualitative research conducted by the team.

b.3. The various BCC approaches

b.3.1. ***The VISA mother approach*** (see the description under cross-cutting approaches)

b.3.2. ***Mass Media***

Mass media have been used to increase the impact of messages:

(a) **Radio programmes:** This activity has been initiated in collaboration with the Andrew Lees Trust Foundation. It has produced radio programs including 60 spots developed with full participation of community members. It has also created 80 listening/discussion groups that have been provided with free radios. ALT radio follows up and monitors progress. This activity has helped reinforce key messages promoted by CHVs, CBDs and VISA mothers.

(b) **Traditional mass media:** the traditional mass media used by the project are *kabary* (traditional oration) and events like *ringa* (wrestling). Each opportunity is used to promote good model behaviors in health.

b.3.3. ***Community based distribution (see below)***

b.3.4. ***Training***

This concerns all technical aspects of the key messages and the communications training.

b.4. How BCC activities are monitored

MCDI measures the impact of BCC activities with KPC surveys using the Lot Quality Assurance Sampling (LQAS) tool. The team has become competent in using monitoring and surveys. Quantitative studies are combined with qualitative surveys based on observation, interviews and focus groups. Findings are shared with all key stakeholders in order to apply the lessons learned to future activities.

b.4.1. *BCC activity follow-up tools*

MCDI has developed tools for the follow-up of community BCC-related activities. These tools aim to reinforce the capacities of the CHVs, to reinforce collaboration between local authorities, ASBs and the CHVs and to carry out a rapid evaluation of progress made in adoption of key behaviors.

After each field follow-up, a feedback meeting is organized at the local level with commune authorities and at the district level with EMAD and ASBs. The major gap of these follow-up tools is the lack of information about the level of collaboration between CHVs and other partners (NGOs, TBA). However, focus groups with CHVs conducted during the MTE show relationships between CHVs and ASBs are very good. Joint health promotion activities are even organized at facility or community levels.
The follow-up of CHVs is carried out in two stages: the grouped follow-up and the individual follow-up in the field. The CHV follow-up activities are summarized here:

Summary of CHV follow-up

Follow-up type	Toliara II	Betioky Sud	Comments
Group follow-up	Among 440 active CHVs, 402 **(91%)** participated in at least two group follow-up sessions	355 on the 453 active CHVs **(78%)** participated in at least two group follow-up sessions	Group follow-up was conducted during training and other gatherings of CHVs. The focus was certain health topics and the VISA approach. The follow-up teams are composed of Field Agents, EMAD members, the MCDI Community Activities Manager and members of Vemima
Individual follow-up	165/440 **(38%)** CHVs spread out among 130/250 **(52%)** Fokontany participated	174 **(38%)** CHVs spread out among 26 Fokontany participated	ASBs often service on individual follow-up teams.

Lessons learned from the CHV follow-up activities are as follows:

- The time lapse between CHV follow-ups should not exceed three months.
- Field follow-up visits are an opportunity to reinforce messages and raise the credibility of CHV within the community.
- The follow-up tool for BCC activities is useful for decision-making for future orientations. This tool could easily be used by ASBs at the health center level.

b.5. Community-Based Service Providers

b.5.1. *Training of TBA in safe motherhood and child health*

Although the project does not have a formal newborn care component, MCDI has collaborated with TBA, who influence mothers' behavior and babies' health. In 2003 and 2004, MCDI trained 110 TBA (53 in Toliara II and 57 in Betioky Sud) in safe motherhood and child health management.

Currently, all the health sectors within the project areas are covered by trained TBAs. (See Attachment 5 for a summary of TBA training activities during 2004)

The training included theoretical courses and practical training courses at the CSB using MOH modules on safe motherhood and management of child health guides for traditional midwives. At the end of the training, each TBA was equipped with a safe motherhood kit including a sheet, one pack of five blades, a bottle of alcohol, one thread, one nailbrush and one piece of soap as an in-kind contribution from the MOH. MCDI supported the replication of the modules and report cards for TBAs.

The major constraints for TBA training are:

- Very low level of literacy of TBAs
- An insufficient number of women in the delivery process during the practice sessions

The solution proposed is regular follow-up and refresher training for TBAs, along with active and significant participation of ASBs.
In Betioky Sud, concrete results were observed after the training of TBAs. The 85 trained TBA have performed 151 normal deliveries since their installation, with a range of one to six deliveries per TBA. The majority of TBAs knew the seven danger signs to be checked for in pregnant women. So far, no problems have been reported by the community or the ASBs.

b.5.2 ***Community-based distributors***
Community-based distribution is complementary to the BCC strategy. It also improves the availability of health products at the community level. In 2004, following requests from the mayors during community health festivals, MCDI selected 20 community-based distributors (CBDs) in seven health sectors in the district of Toliara II. The 20 CBDs and three MCDI field agents were trained, and an additional 164 CBDs were trained in 2005. The CBDs are trained in social marketing, sales, management and communication and their duties are to inform and counsel mothers on key health messages, refer patients to CSBs and supply patients with basic health products. They sell oral contraceptives, male condoms, ITNs, ORS and chloroquine. MCDI orders products from PSI and makes them available for CBDs in Toliara. Distribution activities began in March 2005, following a delay due to uncertainty about national policy and protocols for ITNs and malaria treatment.

At mid-term, MCDI and the CBD team leaders in Betioky made field visits to count the number of active CBDs and to identify potential new CBDs. Approximately 18 CBDs among the 81 (21%) originally in place had remained operational and continued to be supplied by health centers. The fact that more 20% of CBDs were still active is impressive given that project support for activities in Betioky Sud had been drastically reduced. Five new CBDs per medical sector were identified and trained. MCDI contacted PSI to secure a more reliable supply of health products.

CBD activities in the project zone suffer from a lack of partner coordination. The NGO SALFA recently began Global Fund-financed CBD activities in Toliara II without coordinating with regional and district health authorities and other NGOs. SALFA will distribute ITNs at a lower price than the one agreed at the national level. They will set up a new network of CBDs that will not be connected to the district health system. This will undermine the existing network of CBDs. Discussions with SALFA during the MTE indicate they are unwilling to coordinate their activities with other stakeholders.

Other constraints are related to the lack of conviction of ASBs on birth spacing promotion and the existence of interpersonal conflicts between CBDs and ASBs which considerably disturb

community based distribution operations. One ASB in Betioky Sud refused to provide contraceptive pills to a CBD and as a result, 150 women in Vohipotsy Nord, Betioky Sud were without pills for months.

The lessons learned:

- In selection of CBDs, priority must be given to the most efficient CHVs and should involve field agents, health agents, MCDI and the SSD BCC Manager.
- Community-based distribution is attractive to CHVs as it is an opportunity for remuneration. Selection based on performance should be maintained and encouraged.
- The re-energizing of CBDs also requires a re-energizing of health agents through refresher training.
- Coordination issues need to be discussed at the national and regional level.

c. Capacity Building Approach

i. Strengthening the PVO Organization

MCDI has an extensive experience in the management of child survival projects and is currently implementing projects in South Africa, Mozambique and Benin. In Madagascar, the current grant follows a first phase of a four year project in the Betioky Sud district. The present MCDI management team in Madagascar is the same team that initiated activities in Betioky Sud six years ago. This team has benefited from experience and from a relatively low staff turnover. The team has built its capacities through the project and through training organized by CSTS. ADRA's child survival project in Tamatave asked MCDI to provide them with technical support and training, survey and evaluation techniques, and BCC and community mobilization.

The team in Madagascar receives technical support from MCDI headquarters as well as new tools and documents published by USAID, CSTS or other international organizations. MCDI developed and disseminates a quarterly child survival newsletter to share lessons learned between its projects in four countries.

ii. Strengthening Local Partner Organizations

As mentioned in the DIP, reinforcing local NGO capacity is a key sustainability strategy. Working under a mentoring approach with MCDI during the last two years, the NGO **Vemima** of Betioky Sud has become operational, autonomous and competent in implementing child survival interventions. Since the beginning of this cost extension project, Vemima has managed the planning, implementation and follow-up of CHVs in collaboration with the district and the Rural Mobilization Department (DAR). During the fiscal year 2004, MCDI provided refresher training for 17 Vemima members in basic communication techniques, EAN, EPI, FP, home based case management of childhood illnesses, STI/AIDS prevention, follow-up of community-based activities and health information systems.

MCDI held a child survival workshop for members of the NGO **Mampifoha** in Toliara II. Six members of Mampifoha also received training on PCM and EAN. MCDI will provide further capacity-building support in 2005 and 2006 for Mampifoha. The NGO **Zatovo** is another partner of the project. Their members were trained in community-based distribution and supplied with health products. They cover four communes in Toliara II.

The MTE identified new areas of development for local NGOs. The six field agents employed by MCDI play an effective role in supporting and supervising CHVs and ensuring collaborative links between ASBs and CHVs. Their contract will terminate at the end of the project in 2006. In

response to MTE findings about the importance of the field agents for the continuation of community activities, the six field agents created a local NGO called **Miainga**. The participants at the MTE workshop highlighted the necessity of building the capacities and sustainability of Miainga.

The CHVs from the same area have organized themselves into local NGOs. At an early stage in this movement, MCDI could encourage and build the capacities of these NGOs to help institutionalize the work of CHVs in the community.

The MTE recognizes the effectiveness of these partner NGOs and their contribution to the success of the project. These NGOs will play a key role in the continuation of community-based activities and in an Expanded Impact program. Capacity building activities need to be maintained to ensure that these NGOs will improve their organizational and institutional capacities.

iii. Health Facility Strengthening

Technical support for integrated health center supervision

A draft of an integrated supervision tool for health centers was developed during a three-day workshop with the EMAD members and DPS Officers. This tool focuses on IMCI quality of care and the availability of critical resources at the health center (CBS) level. Once the tool was validated by the DPS/MOH, EMAD and MCDI organized a supervision of health centers in Toliara II. Four supervising teams spread out in four different axes. Each team was composed of a district program officer, an administrative clerk, a service provider and a technical advisor from MCDI. All health centers received a supervision visit and the supervision capacity of EMAD was strengthened in the process.

Technical support for development of health district development plans 2004-2006
Within the framework of support for health district development plans, financed by the CRESAN/World Bank Health Project and implemented by the John Snow Institute (JSI), MCDI provided technical assistance to Toliara II and Betioky Sud districts for their triennial plans. The planning process was facilitated by JSI. Dr. Rija Lalanirina, the MCDI HIS Manager, was responsible for supporting the Betioky Sud district, and Dr. Oliva Andriamahefa, MCDI Health Educator, the district of Toliara II. These two MCDI staff participated in all the phases of planning, from data collection to budgeting, offering useful advice and leadership. During this exercise, all TPCSP-related activities were integrated into district plans.

Technical support for the realization of monthly reviews in the two districts
Monthly district reviews serve to reinforce EMAD and health center capacities in management and monitoring and evaluation. The reviews happen during a monthly meeting with all health center heads. MCDI provides a well experienced facilitator who participates in the design of the session plan, supplies technical resources and logistics, conducts the session and assists in logistical and financial support of the review.

Training of EMAD trainers in Community IMCI
A six-day training of trainers in Community IMCI was held in Toliara II in December 2003 with the collaboration of the IMCI regional officer.

Supporting vaccination catch up activities in the two districts
MCDI provided logistical and planning support to WHO-supported EPI re-launch activities. As

recommended by the Betioky final evaluation report in 2002[6], support was provided to increase immunization coverage in most problematic and populated communes. From October to December of 2003, MCDI provided support to health centers not supported by WHO, resulting in increased immunization coverage in these two districts in 2004. Eighty-five percent of health centers completed planned activities.

iv. Strengthening health worker performance

The priority of the project in terms of performance is the quality of care delivered by health staff. A comprehensive view of quality of care encompasses relationships with patients as well as adherence to clinical protocols and availability of drugs and equipment.

Various support activities have been implemented to improve performance:

- Training in IMCI and other project-related interventions
- Regular supervision of health staff by EMAD and MCDI, direct observation and a questionnaire on the knowledge and practice of health workers. The supervision tool developed by MCDI focuses on quality of care. It has demonstrated its effectiveness as ASBs increasingly follow IMCI protocols and principles.
- A Health Facility Assessment that evaluates several aspects of quality

During the November 2004 Health Facility Assessment (HFA), quality indicators were measured through direct observation of health care providers, exit interviews with mothers and analysis of reports. HFA findings describe a clear improvement in ASB ability to provide quality of care. ASBs follow the IMCI algorithm to treat sick children, though their diagnosis is often incorrect. The HFA also found that the ASBs focus on messages related to drug administration and often fail to deliver key messages about danger signs and home-based treatment.

Lessons learned and recommendations:

- Understanding and practice of quality of care varies from one individual to another. For example, doctors have fewer difficulties introducing issues of quality in their practice.
- Standards of quality are necessary to set objectives for health staff. Standards of quality are best defined using national and international standards and by building consensus among health staff.
- Ethical issues need to be introduced and debated
- It is useful to explore innovative solutions to maximize the availability of staff in health facilities. Health staff members pick up their salary every month in Toliara. A quarter of their working time is dedicated to this activity resulting in the non-availability of services at the health facility. The Ministry of Education model could be applied to improve the distribution of salaries to health personnel.
- Coordination meetings should be organized between EMAD and the Quality Assurance Coordinator of MCDI on quality issues
- EMAD members should be trained in each IMCI component
- Performance should be promoted through the introduction of incentive schemes. Performance-based contests with financial bonuses or sponsorship for training may be effective ways of motivating health staff.
- HFA and supervision tools can be disseminated at the regional level to improve the quality of care in CSB.

[6] MCDI, *Betioky Child Survival Project: Final Evaluation Report*, 2002

v. Training

Training in IMCI
Training curricula follow MOH policies and guidelines. Each training session is composed of a theory and practical exercises. MCDI, in collaboration with regional health authorities, developed a training module that facilitates the learning of IMCI clinical protocols and methods. This prototype module addresses the successive steps of evaluation, classification, and treatment at each sign of illness that a child presents (a horizontal approach). This approach is different from the methodology that was developed for the national module which advocates evaluating all signs and/or symptoms that the child presents, classifying the infant's condition accordingly, and then treating him/her (a vertical approach). This innovative approach developed by MCDI at the Toliara DRS allows for a more timely acquisition of both the concept and the application of the integrated case management strategy of IMCI.

All newly trained staff receive follow-up within one month of the training session. Supervision ensures that ASBs apply what they have learned during the training modules. An action plan is designed with the ASBs to establish how changes and improvement will be introduced in routine activities. In the C-IMCI training for CHVs, CBDs and TBAs, the training focuses on practical exercises.

Toliara II

- **Clinical IMCI Training of trainers**: In December 2003, MCDI and the Linkages Project widened the pool of IMCI trainers in the Toliara province by training 11 trainers in clinical IMCI. The group was composed of four EMAD members of Toliara II and seven trainers from the Training Institute for Health-Care Providers in Toliara. The training was facilitated by trainers from the provincial health department (DPS) central MOH, MCDI and Linkages.

- **Training of Toliara II basic health agents (ASB) in IMCI**
  In 2004, MCDI organized two 6-day training sessions in IMCI for 31 ASBs of Toliara II. The objectives of the training were (1) to reinforce ASB competencies in management of childhood illnesses according to IMCI protocols, (2) to reinforce ASB capacity in service reorganization so as to allow effective IMCI implementation and (3) to reinforce the implementation of C-IMCI in each health sector. In accordance with the national training curriculum, these clinical IMCI trainings were made up of six half days of theory and five half-days of hospital practical sessions. All Toliara II and Betioky Sud health centers now have at least one ASB trained in IMCI. This activity brings the number of ASBs trained in IMCI to 55. The evaluation of the training showed clear acquisition of knowledge.

- **Follow-up of ASB on IMCI**: In accordance with the national policy on IMCI training, MCDI carried out, in collaboration with the EMAD, post-training follow-up of all CSBs in Toliara II. The objective of the follow-up visits was to reinforce knowledge and competencies acquired by ASBs during the training and to ensure a successful launch of IMCI activities. IMCI equipment for CSBs was provided during the follow-up visits. On a quarterly basis, the EMAD and MCDI carried out supervision of CSBs using an innovative and appropriate supervision tool focusing on quality of care. This tool was developed by the DPS and MCDI.

Betioky Sud

- **ASB follow-up on IMCI**: MCDI focused its efforts on the follow-up and reinforcement of the Betioky Sud's care providers. This activity was carried out jointly with the IMCI Provincial Team and EMAD. The team conducted a group follow-up every quarter during monthly reviews including three days of practical training courses at the district hospital in Betioky Sud. Each ASB was observed during the consultation of a sick child. Afterwards, a discussion was organized with all ASBs on positive points and issues that needed detailed attention.

- **Refresher training of ASBs in IMCI**: After each grouped follow-up, ASBs participated in a 2-3 day refresher session based on the weaknesses identified during the practical evaluation. Twenty-four health agents from 19 CSB in Betioky Sud benefited from this kind of follow-up. In addition, group follow-up made it possible to test and adapt MOH IMCI follow-up tools.

Implementation of Essential Nutritional Actions (ENA) at the CSB level

ENAs include breastfeeding, complementary feeding, sick child feeding practices, healthy foods for pregnant and breastfeeding women, and micronutrient supplementation (Vitamin A, iron and iodine). Following ASB initial training in fiscal year 2003, MCDI, in collaboration with the health district and the Linkages Project led an April 2004 refresher training for 26 ASBs and five EMAD members of Betioky Sud. The seven components of ENA were reviewed during this three-day refresher focused on evaluation of feeding practices, counseling, complementary feeding and micronutrients.

Two main lessons regarding the implementation of ENA at the CSB level have been identified: (i) the BFP principles are easily accepted and acquired by health agents whereas (ii) the evaluation of feeding practices for a sick child is not current practice among health agents and should be supported during follow-up and integrated supervision.

Strengthening birth spacing services at the CSB level

- **ASB refresher in family planning** was provided to 32 previously trained ASBs in Toliara II to reinforce FP promotion and services at the CSB level. The five-day training course used FP training modules developed at the national level and emphasized FP health information systems and community-based distribution activities. The MCDI HIS Manager led an additional session on local use of data as a decision-making tool in regards to PF. Currently, all CSBs of Toliara II and Betioky Sud offer FP services.

- **Improvement of the contraceptive supply system**: In addition to the health agents' training, MCDI provided support to health districts to improve contraceptive supply planning. This activity was carried out during the district monthly reviews. The principal problems at all levels were analyzed using a problem-solving methodology, and realistic solutions were sought through participatory brainstorming. All levels (DPS, EMAD, and ASBs) took part in this exercise as well as in implementing the recommendations. This activity contributed to contraceptive supply improvements at the health center level: at the end of fiscal year 2004, 63% of the health centers had no contraceptive stock-outs, compared to 32% at the beginning of the project.

Constraints:

- Training of 25 ASBs in Toliara II originally planned for the fiscal year 2004 did not take place because of overlapping MOH activities and priorities. Rescheduled four times due to unexpected district activities, the training is now planned for 2005.
- Certain ASBs (for example Ambatofotsy and Maroarivo in Betioky Sud) were ideologically opposed to FP and refused to provide FP services. They managed to occasionally block the contraceptive supply system and FP management tools.

Refresher training in EPI
MCDI supported Betioky Sud and Toliara II with refresher training for 60 ASBs in EPI. This activity, based on the MOH National Immunization Policy, was organized in collaboration with EMAD during each monthly review, and knowledge was reinforced with each CSB through integrated supervision.

Orientation of ASB in TBA modules
MCDI, in collaboration with EMAD, oriented ASBs in the two health districts on the MOH safe motherhood and child health training modules for TBAs. On the whole, 28 ASBs from Toliara II and 21 from Betioky Sud participated in the orientation. The modules include guidance for traditional midwives on safe motherhood, identifying danger signs and home-based management of childhood diseases.

For better monitoring of TBA activities, each traditional midwife is required to send a monthly report to the health center. For non-literate midwives, a new system was established using tokens. The CHVs of the Fokontany where TBAs live were encouraged to help draft and submit the report. Follow-up and supervision of TBAs were under the direct responsibility of the health center heads and/or midwives.

Training of ASBs in malaria case management
In November 2004, in collaboration with DPS and EMAD, MCDI trained 19 health agents and seven EMAD members of Betioky Sud in malaria case management, epidemiological surveillance and malaria prevention at the CSB level, including IPT for pregnant women. This training was held to fill malaria service quality gaps that were noted during the supervisory visits. Betioky Sud EMAD noted that ASBs were using injectable quinine as a first response, whereas this drug is recommended as a third-line treatment in the national protocols. The five-day training used national training modules on current case management protocols.

BCC and community mobilization
The BCC approach adopted by the project aims to strengthen community capacity to promote positive changes leading to the improvement of maternal and child health. During fiscal year 2004, the local authorities' support for Community Health Volunteers increased. In the majority of the medical sectors, the CHVs were also increasingly supported by the district Program Officers (e.g. CHVs' involvement during the measles immunization campaign). Follow-up was structured and more systematic due to adjustments to follow-up tools.

Efforts focused on (1) increasing CHV geographic coverage; (2) completing training of CHVs; (3) celebrating successes regarding behavior change following community health festivals; (4) integrating local NGOs; and (5) testing the child-to-community approach. At the end of fiscal year 2004, the total number of operational CHVs trained in the districts of Betioky Sud and Toliara II were 453 and 440 respectively. The number of new CHVs established during the fiscal year was 77 for Betioky Sud and 116 for Toliara II.

Training of the Field Agents and Community Health Volunteers

Each training team was made up of at least one Field Agent, one member of EMAD and/or a community animation agent from DAR. The table in Attachment 5 summarizes the trainings MCDI completed during fiscal year 2004 for field agents and CHVs.

Lessons learned about CHV capacity strengthening related activities:

- The quarterly rhythm of refresher training is suitable and feasible
- Each contact with CHVs must be taken as an opportunity for formative supervision to reinforce capacities. A package of activities to be carried out during each contact with CHVs should be established.

d. Sustainability Strategy

The sustainability strategy implemented by MCDI relies on the development of local training resources (curricula, training materials), community-supported inputs (CHVs, TBAs, VISA mothers, community health festivals), government resources (EMAD, public health services) and the community insurance scheme or *mutuelle*.

This phase of the project in Betioky Sud was a good test of the sustainability of MCDI's approach, as the support Betioky Sud received in 2004 was limited to monthly reviews and planning. Despite phased-out support, the network of CHVs in Betioky Sud is still very active and well organized by Vemima. Interviews and focus groups during the MTE discussed the likelihood of activities continuing when the funding ends. Informants agreed that CHVs will sustain their actions, encouraged by their success and the value of their social role. Community-based distribution has also been seen as a sustainable activity as sellers can recover their expenses. The mutuelle in Ankazomanga-Ouest sector of Betioky Sud increased paying clients' usage of the local health center and pharmacy, thus strengthening the financial sustainability of MOH health services.

The biggest problem remains the high turnover rate of MOH staff. Many health professionals trained by the project are not sure whether to work in the district in the future.

Lessons learned:

- Local NGOs play a key role in ensuring sustainability: Miaingia, Zatovo and Mampifoha should be given more responsibilities in the direct management of activities
- A lack of coordination between actors can put project sustainability at risk (e.g. SALFA)
- The VISA mother approach is an efficient way of ensuring continuity of activities such as community-based distribution and health promotion.
- EMAD's capacity to supervise and manage activities remains limited in terms of resources and competencies. More efforts should be expended to strengthen the capacities of EMAD members
- The attitudes of health center staff are variable. Some staff are not friendly with clients and thus mothers are reluctant to use these services
- Drug and equipment supply for health centers is still very irregular
- Mutuelles contribute to the sustainability of health centers by increasing the number of paying clients

C. Program Management

1. Planning

Project planning and implementation is based on the DIP. The TPCSP was successful in implementing most of the activities that had been planned for 2003-2006. In fact, the project surpassed the expected schedule as the majority of activities have been completed in 2.5 years instead of four years.

Some activities have been postponed:

- Community-based distribution of chloroquine and ITNs experienced delays due to uncertainties about national policy
- Other malaria-related activities were also delayed in anticipation of national directives
- HIV-AIDS prevention interventions were postponed to 2005-2006

One activity has been delegated to another organization:

- Child-to-community interventions in schools will be implemented by Aide et Action

The completion of the majority of activities prompted project stakeholders to draw up a revised action plan for 2005-2006. Objectives and activities were adjusted in light of available resources, results achieved, and new needs identified during the MTE. The first draft of the action plan was elaborated on in a participatory workshop, with activities planned within the quarterly and annual work plans elaborated by EMAD and submitted to MCDI for discussion. This planning process has been appreciated by all actors and gives EMAD the responsibility of deciding the project's future.

Recommendations:

- Follow through with this planning process
- Review the draft action plan for 2005-2006 in light of the remaining financial resources and the EMAD orientations

2. Staff Training

Capacity reinforcement of field staff

- The Project Manager attended the Mini University DIP Workshop held at Johns Hopkins University in June 2004. The workshop helped update the Project Manager's knowledge on technical and planning aspects of child survival interventions and allowed him to become familiar with the network of child survival partners, experts and actors. He also received updates on funding agency procedures, mechanisms and requirements.

- In Madagascar, MCDI's Quality of Care Advisor and Health Educator both attended a training in health system and health program management led by the National Institute for Public and Community Health in collaboration with the Ministry of Health and Family Planning. This training provided insights for activity planning, a vision of the health sector development in Madagascar and useful contacts. Moreover, MCDI's Health Educator attended a training in FP health management information systems offered by UNFPA.

- The MCDI's health information system manager and the President of Vemima attended a training on health, environmental project design and M&E organized by ADRA Tamatave and Voahary Salama.

- The field agents attended training in radio program development as described above.

3. Supervision of Program Staff

In September 2003, after six months of work, an internal assessment of Field Agent performance was conducted by MCDI to identify areas for improvement. The areas assessed included not only technical aspects of their knowledge but also MCDI's work environment, teamwork, leadership, work ethics and partnership. Three assessment tools were used: an individual interview questionnaire, a group discussion guide and an observation guide for Field Agents for use in conducting advocacy sessions with community officials. Qualitative data were assessed on a five-step scale (very poor, poor, fair, good and excellent).

The performance assessment covered the following areas:

- Technical knowledge: field workers acquired the technical knowledge necessary for their assigned tasks. On a 100-point scale, they obtained an average of 87, and five of the six Field Agents scored higher than 90 points.

- Facilitation skills: Four Field Agents were rated as "excellent" and two as "good" facilitators.

- Teamwork: team spirit and sense of leadership were well developed among Field Agents as they were all rated "good" for these categories.

- Knowledge of MCDI's work environment should be developed among field workers. Field workers could benefit from additional knowledge on financial process, donors, the organizational flowchart and the project cycle.

- Knowledge of organizational ethics remains to be developed.

To conclude, Field Agent technical capacities in child survival are strong. New capacities to be developed and the activities by which this will happen will be discussed at monthly staff meetings. Tasks and the distribution of responsibilities are clear, and the MCDI team has the full capacity to manage the project.

4. Human Resources and Staff Management

Human resource management is an asset of the project. Policies are clearly defined by the MCDI Madagascar policy manual and financial management manual. Staff have clear job descriptions and create annual and quarterly work plans in coordination with the project director. Much has been done to build the capacities of the TPCSP staff and partner staff in terms of training and resource input. The cohesion and communication between project staff is exceptional and can be explained by the high commitment and motivation of staff and the open leadership offered by the project director. The MTE has been an opportunity to assess progress and performance of TPCSP staff. Evaluators asked project partners how they perceived the support provided by MCDI and received positive feedback from provincial officials and EMAD.

All human resources necessary for the execution of the project are in place in accordance with the human resources plan scheduled by the DIP. Monthly meetings and regular coaching have been good tools to maintain high cohesion within the team and high commitment of staff.

5. Financial Management

The field office regularly prepares a quarterly budget according to the quarterly work plans developed jointly by MCDI, DAR and the health district. The budget is submitted to the home office at the end of the quarter for approval and transfer of funds. The field office has not experienced a shortage of funds. A monthly financial report of expenditures is sent to the home office. The home office financial audit is quarterly-based. The field office regularly receives counseling and practical guidance from the MCDI HQ Administrators on project finance.

6. Logistics

Logistical issues are managed by the project administrator. The TPCSP experienced difficulties with the lack of reliability of cars. However, the main problems were caused by a delay in ITN delivery from Population Services International (PSI). A discussion with the PSI supply officer during the MTE helped to clarify the problem and ensure that delays would be avoided in the future.

7. Information Management

MCDI's field office holds quarterly three-day staff meetings attended by all personnel. The purpose of these meetings is to assess project status, update and share new guidelines, discuss and resolve general and individual difficulties and constraints, and develop team spirit among staff. It is an opportunity for the whole staff to speak freely about project implementation and improvements to be made. The proceedings of the meeting are distributed to all staff members and posted at MCDI's office. Recommendations adopted during staff meetings are included in the internal regulations of the field office.
In addition, a monthly meeting of the technical staff is held to review activity implementation, the technical aspects of interventions and planning issues. The field office works on a yearly and quarterly activity plan. Planning activities involve the participation EMAD and DAR, with whom MCDI holds a feedback meeting every two weeks to review project results, constraints, changes to the action plan and new MOH guidelines.

MCDI took part in each regional review organized by DPS and attended by all DHO chiefs of Toliara. The purpose of these regional reviews was to update the EMAD about MOH guidelines, to seek possible solutions to improve the implementation of MOH programs, to plan activities for the following quarter and to share experiences with each CSB head. MCDI took advantage of these meetings to share lessons learned and to inform regional and central health authorities about progress achieved by the project. In February 2003, MCDI invited the Betioky Sud's CHVs to this meeting for presentations on the project's Community-IMCI approach and to share certain communication methods for behavior change, such as plays, songs and BCC tools. Results from the final assessment of the previous project and the DIP of the new project were presented during the regional review in July 2003. At the district level, MCDI attends monthly review meetings to discuss the views of CSB heads and the community on activities in the project framework.

In July 2003, MCDI was asked by the MOH to give a presentation on the pilot *mutuelle* of Ankazomanga-Ouest at the central level. Central MOH officials (directors and service chiefs) attended the presentation, along with donors, including the World Bank, the European Union and the French, Swiss and German Cooperation. The presentation received positive reactions from

technical staff and high-ranking officers of the MOH on the importance of this initiative in the context of the imminent resumption of the drug cost-recovery system. The MOH's officials and donors expressed a great interest in working with MCDI to explore further the possibility of replicating the mutuelle initiative at a regional or national scale. In April 2005, MCDI made another presentation on the quality of care.

8. Technical and Administrative Support

The home office support team, composed of the CS Coordinator and other technical staff, provided on-going technical backstopping and regular technical updates to the project. Most of the technical information is based on materials obtained from CORE group, CSTS, BASICS, UNICEF, or WHO. MCDI received technical assistance from Linkages to implement the Nutrition Minimum Package (NMP, MinPak) in health centers and community centers. Dr. Rivo, a specialist, conducted the training of ASBs, the training-of-trainers for CHVs, and the wave of training for the CHVs. Dr. Rivo also helped to re-launch the Baby-Friendly Hospital Initiative in Betioky Sud and establish monitoring and development tools for midwives in district hospitals. He trained EMAD members in the Baby-Friendly Hospital Initiative and in formative supervision. Training tools for the ASBs were provided by Linkages.

With Linkages' support, MCDI received technical assistance from a group of national independent consultants for the implementation of a radio program in Betioky Sud on nutrition, immunization, FP, STI/AIDS and childhood illnesses. The responsibilities of the consultants included: developing radio broadcaster capacities in health education, establishing community listening groups, and developing work plans and monitoring tools for broadcasters. These activities were financed by the Multisectoral Project for AIDS Prevention.

MOH's Family Health Directorate assisted MCDI's Quality Healthcare Advisors in the use of the new training curriculum for clinical IMCI. WHO's five-day IMCI curriculum was adopted as the main training tool for health personnel. MCDI's Quality Health Care Advisors were trained to use the new tool with which they later co-facilitated the training of Betioky Sud's health workers (in August 2003) directed by the FHD/PHO team.

Dr. Christopher Schwabe, a health economist, provided on-going technical assistance to the pilot community credit group (*mutuelle)* in Ankazomanga-Ouest to conduct an assessment and replicability study. Dr. Schwabe developed the assessment protocol and refined the computer program for the mututelle's calculation model. This model indicates the contribution levels and lending thresholds.

Further technical assistance programmed for the remainder of the project:

- Evaluation of the organizational capacity of MCDI Madagascar and NGO partners; this activity was planned in the DIP but requires technical assistance for implementation
- Documentation of project successes and innovative approaches, mainly the VISA approach, the mutuelle, and BCC approaches.
- Capacity-building of the district program officers in quality assurance

D. Other Issues Identified by the Team

During the MTE, new ideas emerged on the future of the project. Guidelines, BCC materials and training handbooks have been produced and tested by the project. These could benefit a wider public at national and international levels. As discussed with the CS Coordinator of USAID Madagascar, some efforts should be made to publicize and disseminate these materials in printed or electronic copies on various websites or resource centers. For the same purpose, it has been suggested that the project director make visits to technical or policy committees at the national level so that the lessons learned from the project might influence national policies.

E. Conclusions and Recommendations

The project has experienced successes in promoting breastfeeding, FP, infant immunization, BCC and community mobilization and in fighting diarrheal disease. IMCI and C-IMCI have proven to be effective methods of prevention and case management at the health facility and community levels. Training methods and supervision tools created specifically for this purpose deserve attention and recognition. The regional and district health authorities have expressed appreciation for support and input provided by MCDI.

The success of the project is based on innovative and appropriate community mobilization methods such as the VISA mother approach, community health festivals and promotion of health messages by a network of committed health volunteers.

Recommendations for the last year and half of the project:

- Formative supervision instead of training should be used to improve health staff performance and avoid absences from the health centers, with a focus on low-performing staff
- Increase efforts to improve malaria case management and prevention
- Initiate HIV/AIDS prevention measures
- Improve the quality of care through the definition of quality standards and facility-specific strengthening of supervision in collaboration with the regional and district health authorities
- Maintain community mobilization activities and scale-up the VISA mother approach
- Scale up the *mutuelle* community insurance scheme to improve access to care and financial sustainability of MOH health facilities
- Advocate with regional health authorities for a sustainable recruitment, human resource management and supervisory system for MOH health agents. The system should be put in place before the end of the project to guarantee the continuity of activities.
- Capitalize on guides, handbooks and communication supports created and used during the project and promote lessons learned at regional and national levels
- MCDI should submit an Expanded Impact child survival proposal for all districts of the Toliara province to (1) scale up birth-spacing, immunization, breastfeeding promotion and IMCI; (2) pilot interventions currently under discussion at the MOH such as the introduction of zinc, SRO hypoosmolaire and antibiotics for community-based treatment of ARI and diarrhea; and (3) support the regional health authorities in improving the quality of care.

F. Results Highlight

Community insurance scheme (*mutuelle*) of Ankazomanga-Ouest

A community insurance scheme or *mutuelle* was piloted by MCDI in the health district of Toliara province in Southwest Madagascar. The objective was to improve villagers' access to heath care by making services more affordable. The mutuelle was launched in response to requests from the local community and in accordance with MOH policy on the financial participation of health center users that was introduced in 1999.

The *mutuelle* serves a community of 3,377 people who make their living by farming and raising animals. Sixty percent of women are illiterate. Cattle play an important cultural role in savings and household resource mobilization; extra cash is used to buy cows; and to get cash, a cow must be sold. This results in liquidity problems for daily expenses and health care costs.

The community and local Ministry of Health officials played a major role in setting up the *mutuelle* and establishing the rules for its operation and management. The *mutuelle* is now owned and operated by Ankazomanga-Ouest's civil society with less and less assistance from MCDI and MOH technical staff. The *mutuelle* is a credit system for health expenses incurred at the local health facility. The credit pool is funded by individual monthly contributions of 2,500 Fmg (about US $0.40). Families who make contributions receive a membership card which they can use to visit the health center at any time. The *mutuelle* then covers the cost of their visit, paying the money directly to the health center. Members have 21 days to reimburse sums disbursed to cover their personal or family health care costs. Credit is extended for members who have money problems. Control and internal management are delegated to community members who have established a system of eight village offices plus a central office located near the health center.

The *mutuelle* began in 1999, and the results for the first five years have been encouraging. More than half the population (61%) belongs to the *mutuelle* and enjoy its benefits. Household surveys show that the system has generated a feeling of financial security among its members and that members are more likely now than before the *mutuelle* to visit a health center in the event of illness. Use of health centers increased by 92% and prescriptions paid at health centers have increased by 77%. Members increasingly resort to credit (rate of credit use: 1% to 18%) with an acceptable reimbursement rate of 90%. The *mutuelle* is functional thanks to a competent local management committee.

G. Action Plan 2005-2006

Activities	Responsible	Length/Frequency	Time period
A. Improving Quality Health Care			
1. Provider training			
1.1. Provide refresher training for 60 ASBs (Toliara II and Betioky Sud) in malaria case management, especially for pregnant women.	DRS, SSD, MCDI	5 days	January 2006
1.2. Train the second group of providers at SSD of Toliara II in AEN	DRS, SSD, MCDI	5 days	October 2005
1.2. Provide refresher training for 60 ASBs in AEN and TBC	DRS, SSD, MCDI	5 days	March 2006
1.3. Train 10 remaining ASBs in Toliara II and new Betioky Sud personnel in PF (4 methods)	DRS, SSD, MCDI	6 days	
1.4. Provide refresher training for 60 ASBs in PF 4 methods	DRS, SSD, MCDI	6 days	July 2006
1.5. Provide refresher training for 60 ASBs in PCIME including advice on “when to visit the health center immediately "	DRS, SSD, MCDI	6 days	May 2006
1.6. Provide refresher training for ASBs in use of maternal and child health cards and bill books	SSD, MCDI	At quarterly reviews	2005
2. Health system strengthening			
2.1. Train EMADs and commune doctors in management (Ethics approach)	MINSAN PF / DRS		March 2006
2.2. Support the drug procurement and management system to assure supplies of Vitamin A, vaccines, fridge fuel.	DRS, SSD, MCDI, SantéNet	Throughout the year	2005 - 2006
2.3. Request refrigeration equipment for 12 CSBs from CRESAN/UNICEF	DRS, SSD, MCDI	During annual planning	January 2006
2.4. Support the SSD with accessories and spare parts for refrigerators	Resp. PEV SSD, MCDI	Throughout the year	2005 - 2006
2.5. Provide management tools to assure functioning refrigerators	Resp. PEV SSD, MCDI	Throughout the year	2005 - 2006
2.6. Support the SSD in the organization of periodic reviews (quarterly) of activities and services	SSD, MCDI, SantéNet	Quarterly	2005 - 2006
2.7. Organize a workshop to reach a consensus on consensual quality standards for PSE interventions	EMAD, SSD, MCDI, SantéNet	5 days	November 2005
2.8. Implement organizational standards according to the MOH	DRS, EMAD, CSB, SantéNet		First trimester 2006
3. Reinforcement of community-based services			

3.1. Identify and train the remaining Community-Based Distributors (CBDs)	Local authorities, MCDI Field Agents, CSB heads, NGOs, Relais, SantéNet		October 2005
3.2. Supply the DBC with drugs and social marketing products	DRS, SSD, MCDI, SantéNet	Throughout the year	2005 - 2006
3.3. Improve management and follow-up tools for the DBC	MCDI, SSD		September 2005
3.4. Train the TBAs in malaria prevention and case management, including IPT, and in family planning and promotion of antenatal clinic visits	DRS, SSD, MCDI	5 days	September 2005
B. BCC and Community Mobilization			
1. Capacity building of the Community Health Volunteers (CHVs) in behavior change communication (BCC)			
1.1. Train CHVs in HIV/AIDS prevention	SSD, MCDI	3 days	September 2005
1.2. Train VISA mothers in PSE interventions	SSD, MCDI	5 days	February 2006
1.3. Train Community Health Volunteers to collect epidemiological data	DRS, SSD, MCDI	2 days	December 2005
1.4. Provide refresher training for CHVs in IMCI and disease prevention	MCDI, SSD	3 days	July 2005
1.5. Hold a workshop to update training modules for CHWs (especially FP) and adjust length of trainings	DRS, SSD, MCDI, SantéNet	2 days (Lors Revue)	December 2005
1.6. Apply the «Kaominina Mendrika» approach in 8 health sectors in collaboration with SantéNet	DRS, SSD, MCDI, SantéNet		Starting July 2005
1.7. Develop health messages and BCC tools on recognizing warning signs including ”hevo” (swollen head or the newborn’s fontanel) and home-based care for childhood diseases	DRS, SSD, MCDI		September 2005
1.8. Develop health messages and BCC tools on tetanus vaccination for pregnant women	SSD, MCDI, DRS		September 2005
1.9. Make BBC tools available on maternal and childhood disease control and prevention at all levels (CHWs CBDs, AS, NGOs, MOH coordinators)	SSD, DRS, MCDI, Task force IEC	Throughout the year	Starting October 2005
1.10. Develop a radio program each month on the six key intervention areas of the project and broadcast them regularly on two local radio stations, involving the local listening groups	SSD, MCDI, ALT Radio	Monthly	2005 - 2006
1.11. Extend local listening groups throughout the community	MCDI, ALT Radio	Monthly	2005 - 2006
1.12. Create five new mother support groups in three health sectors with the Mampifoha NGO	MCDI, SSD, ONG Mampifoha		September 2006
1.13 Install new IEC Task Force at regional and district levels	DRS, Intervenient (health), DPC, SSD		By end of December 2005
2. Celebrate accomplishments			
2.1. Organize health festivals in at least 50% of health sectors, targeting weakest sectors first	SSD, MCDI, local authorities, ASB, CVA	Annually	2005 - 2006

C. Monitoring, evaluation and supervision			
1. Supervise community health volunteers quarterly	Field Agents, SSD	Quarterly	2005 - 2006
2. Develop supervision tool for VISA mother approach	SSD, MCDI		September 2005
3. Install a committee to reward CBDs and ASBs for good performance (define criteria, evaluate and offer incentives to ASBs, choose and award prizes)	DRS, SSD, MCDI, SantéNet		November 2005
4. Extend the epidemiological surveillance system to the community level with tools for volunteers and mothers	SSD, MCDI		Starting December 2005
5. Finalize integrated supervision tools and provide to district teams	DRS, SSD, MCDI		October 2005
6. Support district health teams in periodic supervision of ASBs including direct observation during consultation to evaluate and reinforce positive attitudes and practices	SSD, MCDI, SantéNet	Twice a year	2005 - 2006
7. Conduct final evaluation	MCDI, SSD		Starting August 2006
D. Sustainability			
1.Develop MCDI phase-out plan and identify new NGO project guardians	MCDI, SSD		October 2006
2.Support health volunteer associations and advocate for the integration of these associations at the communal level (by communal decree)	MCDI, SSD, DAC		Starting June 2005
3. Create district health budget line items for health cards and drug management tools to support the FANOME system and ensure adequate stocks	DRS, SSD		Starting January 2006
4.Support NGO project guardians in use of monitoring and supervision tools for community-based distribution	SSD, MCDI, DAC	5 days	November 2005
5.Develop social conventions (DINA) in favor of key health practices at the commune level (by communal decree)	DRS, SSD, MCDI		Starting October 2005
E. Coordination			
1.Hold monthly technical coordination meetings between MCDI and EMAD	SSD, MCDI	1/2 day, monthly	2005 - 2006
2.Hold quarterly coordination meetings between EMAD, MCDI, SantéNet, DRS (regional health authorities) and other actors to harmonize activities	DRS, SSD, MCDI	1 day, quarterly	Starting September 2005
3. Update DRS on important activities acomplished	SSD, MCDI	As needed	2005 - 2006
4.Create a platform for technical coordination between the DRS and the SSD, involving other partners	DRS, SSD, MCDI		September 2005

5.Explore realistic measures for reducing the absenteeism among health workers and the need to travel to the capital to deposit their paycheck	DRS, SSD		Sep-05
F. Program management			
1.Hold monthly technical meetings	Project head	Half day, monthly	2005 - 2006
2.Hold all staff quarterly planning meeting	Project head	2 days, quarterly	2005 - 2006
3.Prepare quarterly activity report	Project head	Quarterly	2005 -2006
4.Prepare annual activity report	Project head	Annual	2005, 2006
5.Prepare financial report	CP, Administrator	Monthly	2005 - 2006
G. Mutuelle (Community insurance scheme)			
1.Extend mutuelle to "Kaominina Mendrika" sites with SantéNet	DRS, SSD, MCDI, SantéNet		Starting July 2006

H. Attachments

Attachment 1: Baseline information from the DIP

Targets have been revised. See pages 7-20 of this report for the new 2006 targets. Also see Attachment 7: Mid-term KPC survey summary

Attachment 2: Evaluation team members

Karl Blanchet, Consultant (team leader)
Dr. Joséa Ratsirarson, MCDI Project Coordinator
Dr. Rija Fanomeza, MCDI Monitoring and Evaluation Specialist
Mahefa Ratefinjanahary, Adjoint Technique SSD Toliara II
Dr Raymond Daniel, Facilitator
Dr Ratolojanahary Philippe, Chef SMS DRSPF
Alijimy Fabien, Logistics Assistant
Victor Modeste, Logistics Assistant
Rasoanirina Elysée, Logistics and Administration

Attachment 3: Evaluation assessment methodology

The methodology used for this mid term evaluation is described in Judi Aubel's Participatory Program Evaluation Manual on the CSTS website. An evaluation planning workshop was convened by the evaluation team on June 6 and 7. The 33 participants included MOH staff at provincial and local levels. At the workshop, it was decided that the evaluation would be conducted in three days by five four-person teams comprised of district health staff, Field Agents and CHVs. Seven interview guides were developed for different audiences including DRS, EMAD, health agents, Field Agents, CHVs and MCDI staff and mothers. Two weeks after the planning workshop, a second workshop was conducted to review evaluation results and draft a revised action plan for 2005-2006. The evaluation also included a Health Facility Assessment and a KPC survey (see Attachment 7) with 180 mothers responding.

Attachment 4: List of persons interviewed

Persons interviewed by the team leader:

Dr. Ramanantenahariso Claudia, Health Inspector of Toliara II
Members of the District Management Team of Toliara II
Toliara Regional Health Director -RSO
Technical Staff of the Regional Health Direction of Toliara
Dr. Emile and Dr. Joséphine of SALFA
Head of Aide et Action School Program, Toliara
Six MCDI Field Agents
Dr. Rosa Rakotoarisoa, Quality of Care Advisor, MCDI
Dr. Oliva Andriamahefa, BCC Coordinator, MCDI
Mrs. Moma, President of Vemima and Community Education Delegate of Betioky Sud

Persons contacted during the evaluation planning:

Dr Rakotomanga Raymond, Child and Adolescent Health, MSPF
Mr. Benjamin Andriamitantsoa, USAID Mission CS and FP Manager
Mrs. Wendy Benazerga, USAID HPN Team Leader
Regional Health Director of Toliara

Persons interviewed by members of the evaluation team in each commune:

Health center manager
Community health agents
Mayor or deputy mayor
Village chiefs (Présidents des Fokontany)
Mothers/women's groups
Health volunteers and Community Health Workers
Opinion leaders and traditional leaders

List of participants in evaluation planning workshop

N°	Name	Position
1	Karl BLANCHET	Consultant
2	Joséa RATSIRARSON	Coordinator
3	FANOMEZA Rija	Monitoring and Evaluation Manager
4	Raymond DANIEL	Facilitator
5	RAMANANTENAHARISOA Claudia	Head of EMAD SSD Toliara II
6	RATOLOJANAHARY Philippe	Chef SMS DRSPF
7	RATOVOMANANTSOA Rasoanandrasana	IEC/BCC Coordinator DRSPF
8	RAKOTONANDRASANA Alfred	Nutrition Coordinator DRSPF
9	RAKOTOARISOA Norbert	Resource Person IMCI DRSPF
10	BUSCOTIN Eugénie	Nutrition / IMCI Coordinator SSD Toliara II
11	MOMA	Community Activities Coordinator Betioky
12	RASOAMANAHIRANA Emilienne	Resp MSR SSD Toliara II
13	RAZANAKOLONA Aimé	EMAD SSD Toliara II
14	RAKOTOARISOA Rosa	Quality Assurance Advisor / MCDI
15	TOMBOARIVO Fanera Jhon	CSB1 Efoetse
16	RATEFINJANAHARY Mahefa	Technical Assistant SSD Toliara II
17	ENOMENY	EMAD SSD Toliara II
18	RAZAFIMAMONJISOA Monique	CHV Soahazo
19	LAZANDRAINY	CHV Manombo
20	LARS Armand	CHV Manombo
21	VAHA Zafindratsara	VEMIMA Betioky
22	Marie Madeleine	VEMIMA Betioky
23	RASOARIVELOMANGA Lalatiana	Resp FP SSD Toliara II
24	RAKOTOBE Jeanne	Field Agent
25	RAKOTONDRAMAMY Andry	Filed Agent
26	RABEKOTO Heritiana	Field Agent
27	RAZAKASON Oly	Field Agent
28	RANDRIANTSOA Edmée	Field Agent
29	RAZAFINATOANY Dany	Field Agent
30	TSAKOBO William	EMAD SSD Toliara II
31	VICTOR Modeste	Logistics Assistant
32	RASOANIRINA Elysée	Administrative Assistant
33	TSAVAJONY	EMAD SSD Toliara II

Attachment 5: Training activities summary

Trainings for Community Health Volunteers and Field Agents in fiscal year 2004

Topic	Toliara II	Betioky Sud	Comments
Basic communication techniques	Training of 116 new CHVs	Training of 77 new CHVs. 100% (453/453) of operational CHVs are trained Training of six environmental conservation agents of Beza Mahafaly Special Reserve (RSBM).	The training of the environmental conservation agents is in the framework of the collaboration between MCDI and the RSBM and of the launching of an integrated health-environment-population approach. In Betioky Sud, the majority of the trainings of the CHVs were carried out by the MCDI Community Activities Manager in collaboration with the Vemima.
Home-based management of childhood illnesses	Training of 12 trainers: 6 Field Agents and 6 EMAD members Training of all operational CHVs (440) Refresher for 402/440 operational CHVs	Training of 126 CHVs. Now, 289 of 453 CHVs are trained in home-based management of childhood illnesses Refresher for 70 CHVs	This new training module includes recognition of the danger signs, referral, sick child feeding, care-seeking, home-based treatment and follow-up of the sick child. MCDI plans to offer this training to all CHVs. But first the module will be reviewed with respect to its length and the pathway to child survival session.
EPI promotion	Training of 11 trainers: 6 Field Agents, 5 of the EMAD members Training of 394 CHVs (394/445 trained operational CHVs)	Training of 84 CHVs (100% of the CHVs of Betioky Sud trained on EPI promotion)	The TOT in EPI of Toliara II was facilitated by the Health Information System Manager. Training of the CHVs was slightly delayed by the vertical programs and the priorities of the MOH. Consequently, the refresher training for CHVs has been deferred to 2005. The average amount of knowledge gained is 12 points per participant.
Essential Nutritional Actions (ENA)	Training of 116 new CHVs in breastfeeding promotion Training of 388 CHVs (including 116 new CHVs) in complementary feeding, nutrition during pregnancy. Refresher training for 52 CHVs.	Training of 77 new CHVs in breastfeeding promotion Training of 126 CHVs in complementary feeding, nutrition during pregnancy	Initial training for CHVs includes both breastfeeding promotion and basic communication techniques. Additional training includes complementary feeding, and nutrition during pregnancy.
Birth-spacing promotion		Training of 84 CHVs. 100% of operational CHVs are trained	Birth-spacing training of CHVs in Toliara II will take place in FY 2005.

Training of Traditional Birth Attendants (TBAs) in 2004

District	Axis	Sector	Number	Trainers
Toliara II	Center–East	Manorofify, Antanimena, Mahaleotse, Ambohimahavelona	11	Members of EMAD
	North	Betsioky Somotse, Soahazo, Ankililoaka, Ankaraobato, Milenaky, Tsianisiha, Beravy haut, Tsiafanoky, Beroroha Marofoty, Benetse	20	Head of Center, or the midwife of the place of training; MCDI's Quality of Care Advisor
	Center	Behompy, Miary, Maromiandra, Belalanda, St Augustin, Manombo, Andranovory	14	
	South	Beheloka, Anakao, Soalara, Ankilimivony	8	
Betioky Sud	South–East	Lazarivo, Soaserana, Soamanonga, Sakamasay, Ambatofotsy Belalitse	25	MCDI's Quality of Care Advisor
	Center 1	Betioky, Ambatry, Beavoha, Antohabato, Ankazomanga Ouest, Maroarivo, Beza Mahafaly	18	District Safe Motherhood Program Officer
	Center 2	Maroarivo, Betioky, Tongobory	14	Head of HC's, or the midwife of the place of training

Attachment 6: Evaluation of the quality of care at health centers

At the end of fiscal 2004, MCDI and the EMAD of Toliara II conducted a health facility assessment focused on the quality of care provided by the basic health centers in Toliara II to assess: (1) the status of the effective clinical implementation of IMCI; (2) the level of equipment and supplies; and (3) the level of supervision. To do this, the survey team developed four questionnaires:

- an observation guide for health agent consultation of sick children, to evaluate case management and quality of care
- a health center inventory to evaluate the stock of IMCI equipment and supplies
- exit interviews with mothers to evaluate health agents' quality of communication and client satisfaction
- an interview with health agents to evaluate IMCI knowledge, the level of coaching/supervision provided and problems with clinical IMCI implementation.

The survey was carried out with the collaboration of the INSPC and the DPS of Toliara. Under the Coordination of the Project HIS Manager, the survey team was divided into groups. The members of the survey team were trained in clinical IMCI before data collection. The survey itself was conducted in 22 health centers out of 33 (66.6%) in the Toliara II District, including 8 CSB1 and 14 CSB2. One hundred and three consultations were observed including cases of ARI, fever and diarrhea.

Principal findings: In summary, there has been a clear improvement in health centers' capacity to provide a higher quality of care to children. The competence of the ASBs improved as did case management according to IMCI protocols. Service quality itself requires further improvement, although improvement since the project began is clear.

Use of IMCI protocols by the care providers: The indicators here measure the ASBs' correct use of the IMCI protocol. The indicators do not assess if the child received a correct diagnosis or treatment.

Indicator	**Baseline Dec 2002**	**HFA Aug 2004**
% of outpatient children who received proper management of their illness according to the IMCI protocol	0%	27%

The Evaluation Index is a systematic assessment of ten tasks that must be performed during the examination of a sick child according to IMCI protocols.

Indicator	**Baseline Dec 2002**	**HFA Aug 2004**
Integrated Evaluation Index (average)		8.1

Indicator	**Baseline Dec. 2002**	**HFA Aug 2004**
% of children with cough or difficulty breathing who are correctly classified according to the IMCI algorithm	20.8	82.2

% of children with diarrhea who are correctly classified according to the IMCI algorithm	-	53.4
% of children with fever who are correctly classified according to the IMCI algorithm	12.7	75.5
% of children whose treatments prescribed for the principal symptoms correspond to those of the IMCI algorithm		80.4%
% of mothers who received counseling during the consultation of their sick child		100%

Quality of care received by sick children: The indicators below assess if the child received a correct diagnosis and treatment of his/her illness according to what he/she should have received for the particular case, as perceived by the evaluator.

Indicator	**Baseline Dec. 2002**	**HFA Aug 2004**
% of ARI/pneumonia cases which are correctly evaluated	0%	5.8%
% of diarrhea cases which are correctly evaluated	0%	9.5%
% of fever cases which are correctly evaluated	0%	7.8%

Although the ASBs correctly apply the IMCI protocol for the evaluation, their evaluation is incorrect in more than 90% of the cases. This would suggest that neither the classification nor the treatment is correct for these 3 principal symptoms in more than 90% of the cases. The project seeks to rectify this problem during the two next years. In spite of this, this indicators below show a clear quality management improvement in the areas of immunization catch-up, Vitamin A supplementation, nutrition evaluation (weight compared to the growth monitoring card) and the de-worming component of IMCI.

Indicator	**Baseline Dec. 2002**	**HFA Aug 2004**
% of children who need vaccine and who leave the CSB after having received all the vaccines they need the day of the visit	25.9%	50%
% of children who need Vitamin A and who leave the CSB after having received the dose of Vitamin A they need the day of the visit	80%	88.9%
% of children who need a de-worming and who leave the CSB after having received the dose of mebendazole they need the day of the visit	73.7%	86.8%
% of children whose weight was compared with the growth monitoring curve	59.3%	73.8%
% of children who received a correct evaluation of their nutritional state and anemia status	0%	26.2%

3. IMCI technical equipment: Despite improvement of the IMCI technical equipment status in the CSBs, the current status remains below acceptable norms and requires further effort in order that the CSBs can provide adequate services with an acceptable level of quality.

Indicator	Baseline Dec. 2002	HFA Aug 2004
% of CSB with at least one ASB trained in IMCI	10%	100%
% of CSB with at least 80% of IMCI equipment and materials available	10.5%	63.6%
% of CSBs with at least 80% of IMCI oral drugs available		45.5%
% of CSBs with at least 80% of IMCI injectable drugs available		59.1%
% of CSBs whose 6 vaccine antigens are available the day of the survey	38.9%	45.4%

The quality of the communication provided by the ASB is evaluated by the mothers'capacity to recall the information. It was observed that ASBs focus on the messages related to drug administration and miss key messages on danger signs and home-based care. These messages will have to be reinforced both in health centers and at the community level.

Indicator	Baseline Dec. 2002	HFA Aug 2004
% of ASBs who give at least 2 correct messages on oral treatment administration at home	5.6%	100%
% of mothers able to describe correctly how to give the oral treatments at home (each drug prescribed)		74.7%
% of mothers correctly advised on at least 3 danger signs to be detected that warrant an immediate return to the CSB	3.7%	15.6%
% of mothers advised to give their child more liquids than usual and to continue to feed their child for the duration of the disease	59.3%	38.2%

Conclusion and recommendation: Health centers show an acceptable level of performance in IMCI clinical care. Equipment and supplies are available. MCDI efforts must now focus on improving the quality of care through formative supervision of ASBs.

Attachment 7: Mid-term KPC survey summary

As part of the Toliara mid-term evaluation, a rapid KPC survey was conducted in October 2004 to assess progress toward objectives and to collect information to orient strategies for the remaining two years of the project. The indicators evaluated at the time of this mid-term survey are the 18 specific indicators of the project in addition to several secondary indicators directly related to project activities. Using the LQAS methodology, the survey was conducted in seven supervision areas corresponding to the responsibility zones of each of six Field Agents, and one zone in which all six Field Agents converge. The sample size per zone was 19. As recommended by the KPC 2000+ guidelines, the application of over sampling and parallel sampling methodologies increased the number of respondents to 142. MCDI developed four questionnaires which were administered to mothers with a child under two years old.

Main findings: Project indicators showed a clear increase in knowledge and positive behaviors related to breastfeeding, family planning, diarrhea home-based case management and child immunization. However, malaria indicators did not improve and the indicator for malaria prophylaxis during pregnancy regressed (from 31% in 2002 to 21% in 2004). These situations could be explained by the fact that the project has not yet implemented the full effort in malaria intervention. The main reason is that the MOH is about to introduce new policies and protocols for intermittent preventive treatment, community distribution of SP, and ITN distribution. MCDI did not want to invest in new activities that would promote out-of-date information.

In addition, the tetanus toxoid indicator for mothers declined (from 35% in 2002 to 20% in 2004). MCDI has faced this problem since the Betioky Sud project and it is likely due to underreporting of tetanus vaccinations. MCDI will perform an analysis to explore the reasons for persistent underperformance in this area.

In regard to the indicators on home-based case management of childhood illnesses, there was no change in mothers' recognition of these danger signs (ARI/pneumonia, diarrhea) or in care-seeking behavior in the presence of danger signs. Project effort for next the two years will be focused on these weaknesses.

Breastfeeding and nutrition indicators	**2002 Baseline**	**2004 objectives[7]**	**2006 Final**	**2004 mid-term KPC**
% of children aged 0-5 months who are exclusively breastfed	**2%**	**20%**	**35%**	**34%**
% of mothers who initiate breastfeeding within one hour after giving birth	**20%**	**40%**	**55%**	**42%**
% of children aged 12-23 months who receive 5 or more feeds per day (meals and snacks) in addition to breastfeeding	**19%**	**35%**	**50%**	**36%**

Birth spacing and RH indicators	**2002 Baseline**	**2004 objectives**	**2006 Final obj**	**2004 mid-term KPC**

[7] Linear projection for a two-year period

% of mothers who are not pregnant, do not want another child in the next two years or are not sure, and are using a modern method of contraception	9%	20%	25%	22%
% of mothers who can cite exclusive breastfeeding as a method of child-spacing	1%	20%	40%	4%
% of women who can cite at least two ways to reduce the risk of HIV infection	21%	45%	60%	22%

ARI/Pneumonia indicators	**2002 Baseline**	**2004 objectives**	**2006 Final obj**	**2004 mid-term KPC**
% of mothers of children aged 0-23 months with fast/difficult breathing during the last two weeks who sought treatment from a health facility by the end of the day	**11%**	**30%**	**45%**	**19%**
% of mothers of children aged 0-23 months who can identify at least two danger signs of pneumonia that indicate the need to seek treatment	**25%**	**45%**	**65%**	**45%**

Control of diarrheal diseases indicators	**2002 Baseline**	**2004 objectives**	**2006 Final obj**	**2004 mid-term KPC**
% of children aged 0-23 months who had diarrhea in the past two weeks and who were given the same or more than usual amount of breast-milk during a diarrheal episode.	36%	50%	65%	60%
% of children aged 0-23 months who had diarrhea in the past two weeks and who were given more than the usual amount of fluids during a diarrheal episode	34%	50%	65%	58%
% of children aged 0-23 months who had diarrhea in the past two weeks who were given the same or more than the usual amount of foods during a diarrheal episode	24%	40%	55%	64%
% of children aged 0-23 months who had diarrhea in the past two weeks and whose mothers sought advice or treatment for the illness within 24 hours of the first sign of danger	52%	65%	80%	55%
% of mothers of children aged 0-23 months who can cite at least two danger signs for diarrhea as a reason to seek advice or treatment at a health facility	33%	50%	65%	45%

Malaria prevention and treatment indicators	2002 Baseline	2004 objectives	2006 Final obj	2004 mid-term KPC
% of children aged 0-23 months who slept under an insecticide-treated bed net the previous night	3%	15%	20%	7%
% of mothers who took anti-malarial medicine to prevent malaria during pregnancy	31%	60%	80%	21%
% of mothers of children aged 0-23 months with a febrile episode ending during the last two weeks who gave correct treatment at home	13%	35%	50%	25%

Immunization indicators	2002 Baseline	2004 objectives	2006 Final obj	2004 mid-term KPC
% of children aged 12-23 months who are fully immunized per the vaccination card	30%	45%	60%	52%
% of mothers who received at least two tetanus toxoid (TT) injections before the birth of their last child	35%	50%	65%	20%

Attachment 8: Project Data Sheet

Child Survival and Health Grants Program Project Summary
Sept -20- 2005
Medical Care Development Inc. / Int'l Division
(Madagascar)

General Project Information

Corporative Agreement Number: FAO-A-00-98-00027-00
Project Grant Cycle: 18
Project Dates: (9/30/2002 – 9/29/2006)
Project Type: Cost XT

MCDI HQ Backstop: Joseph Carter

Field Program Manager Information:

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Funding Information:
USAID Funding ($US): $1,229, 843 PVO Match: $460,099

Description:
MCDI's Toliara Province Child Survival Project (TPCSP) is a cost extension grant program designed to reduce morbidity and mortality among children under five, and to improve the health status of women of reproductive age. This is accomplished through continuation of limited maternal and child health activities in the Betioky Sud District and through the initiation of activities in the neighboring Toliara II District. The results-based objectives measure mothers' improved health knowledge and practices in six key intervention areas:

- Pneumonia case management
- Malaria control
- Control of diarrheal disease
- Immunizations
- Breastfeeding and nutrition
- Birth-spacing and reproductive health

The strategies focus on (1) strengthening capacity at the community level through the development of sustainable community institutions, networks, and community-based personnel; (2) institutional strengthening of MOH by improving case management, BCC, and the management/supervision skills of facility and district health personnel; and (3) promoting and facilitating of synergies with other donor partners on supplies and equipment, training materials and the exchange of technical knowledge and lessons learned.

Project Partners:
Population Services International
SantéNet

Project Sub Areas:
Toliara II

General Strategies Planned:
Social Marketing
Private Sector Involvement
Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:
KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Organizational Capacity Assessment for your own PVO
Participatory Rapid Appraisal
Lot Quality Assurance Sampling
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:
Social Marketing
Mass Media
Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Governmental Partners	Other Private Sector	Government	Community
US HQ (CS unit) Field Office HQ	Local NGO Networked Group	Traditional Healers Private Providers	Dist. Health System Health Facility Staff Other National Ministry	Health CBOs Other CBOs CHWs

Interventions / Program Components:

Immunizations (20%)
(IMCI Integration)
Pneumonia (15%)
(IMCI Integration)
(CHW Training)
(HF Training)
-Case Management. Counseling
- Recognition of Pneumonia Danger Signs

Control of Diarrheal Diseases (15%)
(IMCI Integration)
(CHW Training)
(HF Training)
-ORS / Home Fluids
-Feeding / Breastfeeding
-Case Management / Counseling

Malaria (15%)
(IMCI Integration)
(CHW Training)
-Adequate Supply of Malarial Drugs
-Access to providers and drugs
-ITN (Curtains and Other)
-Care Seeking, Recognition, Compliance

Child Spacing (20%)
(IMCI Integration)
(CHW Training)

Breastfeeding(15%)
(IMCI Integration)
(CHW Training)
-Promote Excel. BF to 6 Months
-Support baby friendly hospital

Target Beneficiaries:

	Toliara II	Default Sub-Area 2	Total Beneficiaries
Infants < 12 Months			
Children 12-23 months:			
Children 0-23 months:	25,516		25,516
Children 24-59 months	38,275		38,275
Women 15-49 years:	81,510		81,510
Population of Target Area:			