Medical Care Development International

Final Evaluation Report

TOLIARA REGION EXPANDED IMPACT PROJECT (TREIP)

MADAGASCAR

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Acronyms

ACT	Artemisinin-based combination therapy
ADB	African Development Bank
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infections
ASOS	Action Santé Organ Secure (A local NGO)
BASICS	Basic Support for Institutionalizing Child Survival
BCSP	Betioky Child Survival Project
BCC	Behavior Change Communication
BHC	Basic Health Center (Centre de Santé de Base-CSB, MSPF)
CBD	Community-based Distribution
CBSA	Community-based sales agent
CDD	Control of Diarrheal Diseases
CCM	Community Case Management
BHC	Community Health Center
CHD	District Hospital Center
CHV	Community Health Volunteer
CHW	Community-based Health Worker
C/IMCI	Household and Community IMCI
CS	Child Survival
CSST	Child Survival Support Team
CSTS	Child Survival Technical Support Team
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DHPM	District Health Program Managers
DHO	District Health Office (Service Santé de District)
EBF	Exclusive breast-feeding
ENA	Essential Nutrition Actions
EPI	Expanded Program of Immunization
FG	Focus Group
FP	Family Planning
GOM	Government of Madagascar
HCIF	Health Credit Insurance Fund
HF	Health Facility
HFA	Health Facility Assessment
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System

IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illnesses (WHO)
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
IR	Intermediate Result
ITN	Insecticide-treated bednet
IUD	Intra-Uterine Device
KFP	Key Family Practices
KM	Kominina Mendrika (Champion Commune program)
KPC	Knowledge, Practice, and Coverage
LLITN	Long Lasting Insecticide-Treated Nets
LAM	Lactational Amenorrhea Method
LQAS	Lot Quality Assurance Sampling
MCDI	Medical Care Development International
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MEM	Ministry of Energy and Mines
M&E	Monitoring and Evaluation
MNC	Maternal and Newborn Care
MOC	Ministry of Communication
MSPF	Ministry of Health and Family Planning (Ministère de la Santé et du Planning Familial)
MTE	Mid-Term Evaluation
NCST	Child Survival National Technical Committee
NGO	Non Governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PNLP	National Malaria Control Program
PNSE	National Policy for Child Health
PQI	Performance and Quality Improvement
PSI	Population Services International
PVO	Private Voluntary Organization
RAA	Région Atsimo Andrefana (formerly the South West Region)
RBM	Roll Back Malaria
RHO	Regional Health Office (Direction Régionale de la Santé Publique)
RSC	Regional Steering Committee (Comité Regional de Pilotage)
SIGS	Système d'Information Pour la Gestion Sanitaire (Health Information Management)
SO	Strategic Objective
SP	Sulfadoxine Pyrimethamine

SSD	Statistique Sanitaire de District (District Health Statistics)
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TPCSP	Toliara Province Child Survival Project
TREIP	Toliara Regional Expanded Impact Project
TT	Tetanus Toxoid
U5	Children Under the Age of Five
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VEMIMA	Vehivavy Miara-Mandroso
VISA	Visit, Identify, Sensitize, Accompany
VS	Voahary Salama
WB	World Bank
WHO	World Health Organization
WRA	Women of Reproductive Age

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Our partner, Voahary Salama provided invaluable training support to the project and their leadership and commitment to community-based management will continue to provide communities in the Ihorombe Region with improved health access over the coming years.

Thanks to PSI, TREIP's community-based distribution model was well-received in rural regions, and hundreds of people were able to access previously unavailable supplies such as ITNs, oral and injectible contraceptives and condoms.

We also thank the Ministry of Health from the central, regional and district levels for its coordination of the many stakeholders involved in TREIP implementation. The Ministry of Communication in both Betioky Sud and Toliara was instrumental in the distribution of key BCC messages that reached thousands of households over the course of the project. We also wish to acknowledge other bilateral programs and organizations working in the region such as SantéNet, BASICS and the United Nations whose collaboration with TREIP was crucial to meeting project targets.

Finally, we would like to express our appreciation to all community leaders and partners, particularly community mayors and all Fokontany level participants (including the Fokontany Chiefs and community volunteers) for their effective implementation of the project, and their achievement in improving maternal and child health in their communities.

Section A: Executive Summary

1. Project description, goal and objectives

Since October 2006, MCDI has implemented the Toliara Region Expanded Impact Project (TREIP) in the Atsimo Andrefana (Southwest) Region of Madagascar, a scale-up of the successful Betioky Child Survival project. Originally scheduled to continue through 2011, political turmoil in the country in early 2009 caused USAID to terminate this project two years early. The main goal of TREIP was to "decrease morbidity and mortality of children under 5 and improve health status of women of reproductive age in the Atsimo Andrefana Region". Its area of intervention covers nine districts and has a total population of 1,073,915 people living in 1,379 Fokontany (administrative groupings of towns and villages).

The original project objectives aimed to increase access and quality of maternal and child health services as well as expand use of key family health practices among a total beneficiary population of 440,305 residents in 105 communes in nine districts of the Southwest Region. The beneficiary population was comprised of 247,000 women aged 15 – 49 years old and 193,305 under-5 children, including 42,957 infants less than 12 months of age, 40,809 infants between 12 – 23 months, and 109,539 toddlers between 24 – 59 months.

TREIP organized its strategies around four intermediate results: (IR1) Improved Knowledge and Interest in Key Family Health Practices, (IR2) Improved Quality of Care, (IR3) Improved Access to and Availability of Health Services and Products and (IR4) Improved Social and Policy Environment. Project technical interventions were (1) Malaria Prevention and Treatment, (2) Pneumonia Case Management, (3) Prevention and Control of Diarrheal Diseases, (4) Breastfeeding and Infant Nutrition, (5) Immunization and (6) Community and Household IMCI. In addition to the technical interventions, TREIP also included capacity building components in order to ensure sustainability.

2. Main accomplishments of the project

A central component of TREIP's approach included the support and coordination among stakeholders. TREIP representatives served as a Secretariat on the Steering Committee, Regional Steering Committee (Comité de Pilotage), a committee for TREIP and its partners in the RAA, including non-governmental organizations and USAID HPN representatives. The Committee meets bi-annually to discuss maternal and child health strategies, approaches and results, and to ensure intervention synergies. The MOH and its regional representatives ensure partners' coordination at different levels while local NGOs act as key partners in the field. TREIP ensured that its interventions remain complementary and in synergy with those of other organizations, in particular with PSI, SantéNet projects (phase 1 and phase 2), and BASICS.

During the two years of project implementation, TREIP covered a total of 52 out of 105 communes in the RAA, a total of 1,379 villages or Fokontany. The main achievements are as follows:

Improving Knowledge and Interest in Key Family Health Practices

- The KM approach was introduced in all municipalities. This approach allowed the community to be actively involved in defining clear health objectives and have a voice in designing health-related community activities

- Two years before the original end of the project, MCDI achieved noticeable community capacity building; it recruited and trained 2,332 community health volunteers comprised of 1,140 community volunteers responsible for social mobilization, 1,140 VISA Mothers in charge of coaching and support for women, and 52 community TOTs responsible for training and supervising community health workers

- A Maternal and Child Health manual was developed for everyday use among CHWs

Improving Quality of Care

- MCDI introduced a Quality Assurance System (QAS) in 58 health facilities, 35% of total health facilities. Twelve of these facilities used an integrated model that was introduced with the KM approach

- MCDI established a supervisory/mentoring system for all levels of health facility staff (regional and community) through the development of a pool of 9 supervisors and mentors at the regional level and 18 for the 9 districts

- Developed a tool for integrated supervision and distributed it to 82 Community-based Health Centers

Improving Access to and Availability of Health Services Products

- Engaged in a major advocacy and awareness campaign in four communes

- In collaboration with PSI, the 1,140 Community-based Sales Agents sold a total of 115,141 INTs, 2,595 Pilplan (oral contraceptives), 679 condom displays, 2,937 Collier cycle, 4,229 “Sur'Eau” (water filters), 635 units of ACTipal, and 8,820 ViaSur (Zinc tablets and low osmolarity ORS)

- MCDI trained 124 clinical health workers in IMCI practices, and 224 community health providers in community care (TLC). By October 2009, 197 community workers are at the “Operational Level” at 127 sites serving 46 Basic Health Centers

- In collaboration with FHI, MCDI trained 8 community health volunteers in the provision of injectable contraceptives at community level in two sites

- MCDI trained 181 community health volunteers in Newborn Care (NBC) in Betioky

Improving Social and Policy Environment

- MCDI assisted with the establishment of various technical committees and integrated TREIP's activities within regional and district plans

- Developed a regional strategy for BCC / Community Mobilization deriving from the national community health policy that was largely based on the experiences of MCDI and other NGOs

- Regular participation in national technical committees to review and update Child Survival, Newborn Care and Family Planning

- MCDI actively contributed to the development of different health policies, such as the National Community-based Health Care Policy in December 2008 and the review of IMCI technical implementation in January 2009

3. Improvements in project indictors

Due to political situation, a final evaluation survey was not implemented at the end of the project, as the situation affected the quality and reliability of project indicators. However, despite this some project outcomes were able to be measured, including the following:

- A positive trend in the use of INTs and a significant improvement of antimalarial treatment during pregnancy-IPT

- The number of RAA residents with access to a health care delivery site within 5 km was increased by 30.75% for ARI treatment and 53.82% for the management of diarrheal diseases

- Over 80% of patients at community level received the necessary clinical treatment for pneumonia, malaria and diarrhea

- Basic Health Coverage was extended to 6% of communities in the RAA

The civil strife and related security concerns did not allow field trips within the Southwest Region (RAA) to verify the completeness and reliability of the latest TREIP M&E indicators.

4. Summary of conclusions and key recommendations

TREIP contributed to improving the knowledge and behavior of populations in the RAA with respect to malaria, pneumonia, diarrhea, infant and child nutrition and immunization. IEC/BCC

programs, innovative approaches such as VISA Mothers and expansion of the C-IMCI approach were used to target vulnerable populations living in remote villages.

TREIP expanded the health impact achieved by its earlier projects in two districts to all nine districts of the RAA through strong partnerships with local authorities and NGOs. In addition, TREIP worked with the MOH and its technical partners at the regional and national levels to develop policies and programs that build on the innovative and successful approaches implemented in the RAA.

TREIP contributed to the global learning for child survival and health by sharing its experiences, innovative approaches, and tools and materials used in the intervention area. MCDI took advantage of each opportunity to share lessons learned with the child survival community, both nationally and internationally.

Due to the early termination of the project, MCDI recommends the following actions be taken by the MOH and Voahary Salama in order to maintain the project goals: :

- Finding ways to continue some form of assistance to community workers to enable them to operate despite the closure of the project
- Strengthening the capacity of districts to support the BHC in community activities
- Developing alternative approaches to support outreach and ensure the availability of social marketing products

Should technical and financial support resume MCDI recommends:

- Revising KM award amounts to avoid conflicts
- Simplifying management and reporting tools for community workers
- Revising the motivation system for Community Health Workers (CHWs) to ensure that financial incentives are distributed equally
- Providing additional motivation to CHWs working in remote areas through periodic site visits
- Strengthening coordination and leadership of mayors and Chiefs for all community-level activities
- Organizing an exchange of experiences through a best practice workshop with community stakeholders

Section B: Overview of the Project:

General context

While the Toliara Region Expanded Impact Project (TREIP) began in 2007, MCDI has a long history of working in southwest Madagascar, successfully implementing projects since 1996. MCDI's first child survival project, the Betioky Child Survival Project (BCSP), began implementation in the South Betioky district in 2003, and later expanded to the Toliara II district with a no-cost extension.

The TREIP project began in 2007 and was intended to run through 2011. However, political events that have disrupted the country since early 2009 led to the premature closure of the project. This report describes the activities, results, challenges and lessons learned through October 2009.

MCDI's history in the region is summarized in Table 1 and schematically in Figure 1.

Table 1: CSHGP grants to MCDI in Madagascar since 1996

Time	Type of Grant	Cost
1996-1997	Planning	$500,000
1998-2002	Phase 1: Betioky	$ 996,739
2003-2007	Phase 2: Betioky and Toliara	$1,229,843
2007-2011	Phase 3: RAA 9 Districts (TREIP)	$2,499,986

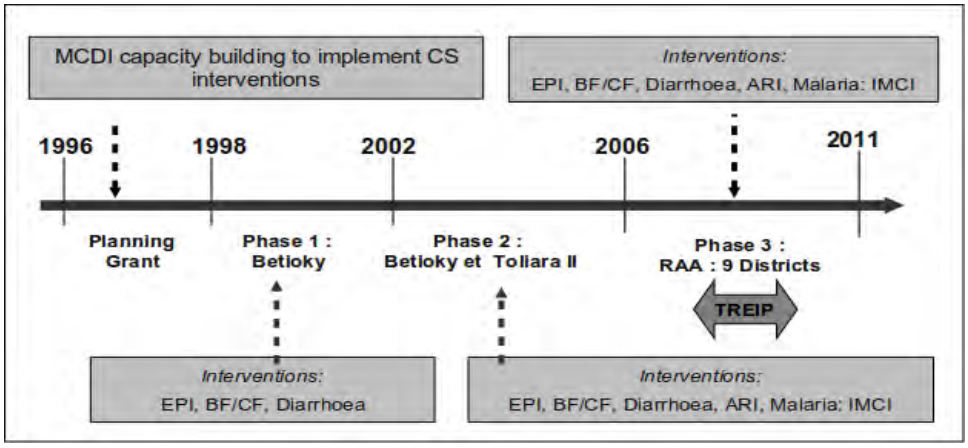

Figure 1: Record of timeline of MCDI's Child Survival Interventions in Madagascar

Project Goal and Strategic Objectives

Project Goal: Decrease morbidity and mortality of children under 5 and improve health status of women of reproductive age in the Atsimo Andrefana Region

Strategic Objectives: Increased use of quality services, disease prevention and case management practices in the areas of malaria, pneumonia, diarrhea, breastfeeding, immunization and IMCI. Specific project targets are as follows:

MALARIA PREVENTION AND TREATMENT

- Increase the percentage of children 0-23 months who slept under an insecticide treated bed net during the previous night from 26% to 60%.

- Increase the percentage of mothers who took anti-malarial medicine to prevent malaria during pregnancy from 30% to 60%.

- Increase the percentage of children with a febrile episode that ended during the last two weeks who were treated with an effective antimalarial drug within 48 hours after the fever began from 17% to 55%.

PNEUMONIA CASE MANAGEMENT

- Increase the percentage of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks who were taken to a health facility or received antibiotics from an alternative source from 28% to 60%.

PREVENTION AND CONTROL OF DIARRHEAL DISEASES

- Increase the percentage of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness from 26% to 60%.

- Increase the percentage of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness from 36% to 65%.

- Increase the percentage of mothers who sought treatment at health center in the 24 hours of the first danger sign for diarrhea from 33% to 60%.

BREASTFEEDING AND INFANT NUTRITION

- Increase the percentage of infants aged 0-5 months who were given breast milk only in the 24 hours preceding survey from 24% to 40%.

- Increase the percentage of children aged 0-23 months put to the breast within 1 hour of birth from 27% to 50%.

IMMUNIZATION

- Increase the percentage of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines (card confirmed) before the first birthday from 33% to 60%.

- Increase the percentage of mothers who received at least two tetanus toxoid injections (card-confirmed) before the birth of the youngest child less than 24 months of age from 29% to 60%.

- Decrease the percentage of drop-outs between DPT1 and DPT3 from 19% to 10%.

COMMUNITY AND HOUSEHOLD IMCI

- Increase the percentage of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment from 43% to 60%.

- Increase the percentage of clinical encounters with HW in HF for which treatment is appropriate to the diagnosis for a child with malaria, pneumonia, or diarrhea (from Clinical Observation in HF) from 36% to 60%.

- Increase the percentage of clinical encounters with a CHW in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea from 0% to 60%.

Project location and target population

The project was implemented in the *Région Atsimo Andrefana* (RAA) of the former Toliara Province of Madagascar, consisting of 9 districts. The project expanded operations from the districts of Toliara II and Betioky Sud - where MCDI was operating during the Toliara Province Child Survival Project (TPCSP) - to the remaining seven districts: Toliara I, Sakahara, Beroroha, Morombe, Ampanihy, Ankazoabo and Benenitra. These 9 districts are divided into 105 Communes and support 173 health centers. The project decided to "showcase" or highlight the Betioky and Sakaraha districts. Betioky was chosen because it served as the starting point for many of MCDI's earlier innovative approaches and has received technical assistance from MCDI over ten years. The second, Sakaraha, was chosen for its proximity and likelihood to replicate best practices and effective approaches.

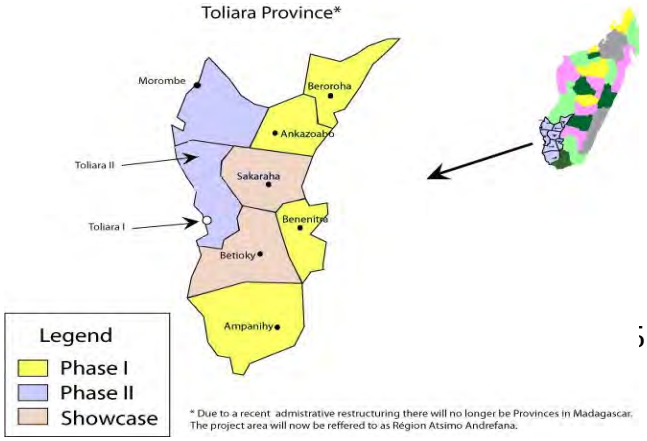

***Figure 2:* Map of the Atsimo Andrefana Region**

The RAA is the largest region of Madagascar, covering 66,687 km^2 with the highest poverty rates (87%) in the country. The project area has a total population of 1,073,915 people living in 1,379 villages (Fokontany), 105 Communes and 9 Districts.

The beneficiary population comprised of: 193,305 children under age 5, 42,957 infants under 12 months, 40,809 infants from 12-23 months, 109,539 infants from 24-59 months, and 247,000 women aged 15-49, for a total beneficiary population of 440,305. Table 2 below breaks down the intervention populations by districts and age.

Table 2: Project area population

DISTRICTS	TOTAL population	0-11 months	12-23 months	23-59 months	0-5 years	WRA
	(100%)	(4%)	(3.8%)	(10.2%)	(18%)	(23%)
Toliary I	115,734	4,629	4,398	11,805	20,832	26,619
Toliary II	207,459	8,298	7,883	21,161	37,343	47,716
Ampanihy Ouest	240,929	9,637	9,155	24,575	43,367	55,414
Ankazoabo Atsimo	53,852	2,154	2,046	5,493	9,693	12,386
Benenitra	29,960	1,198	1,138	3,056	5,393	6,891
Beroroha	56,353	2,254	2,141	5,748	10,144	12,961
Betioky Sud	188,084	7,523	7,147	19,185	33,855	43,259
Morombe	109,198	4,368	4,150	11,138	19,656	25,116
Sakaraha	72,346	2,894	2,749	7,379	13,022	16,640
Total	1,073,915	42,957	40,809	109,539	193,305	247,000
Source : DRSPF Atsimo Andrefana						

Program design

Overall strategy and project approach:

The program design was integrated, addressing the demand for services through behavioral change communication (BCC) and through quality improvement in health facility services. The program design was three-pronged, addressing the gaps and deficiencies identified at community, service delivery and regional/managerial levels.

At the community level, the BCC program was designed to have a multidimensional approach using proven methods such as CCM and CBD, along with household visits by VISA Mothers described in further detail below. BCC messages are further enhanced by the use of mass media (including community radio) to broadcast messages towards the general population and in

particular towards the numerous “listening groups”. The overall BCC is given a regional breadth through festivals. Health was celebrated during festivals that include the awards of champion communes, or “Kominina Mendrika”.

At service delivery and managerial levels, the six-step quality improvement approach was adopted, using tested performance and quality evaluation tools, to gradually bring the quality of care towards the health centers standards defined by the MOH.

Technical interventions:

TREIP focuses on four of the six child survival interventions identified as priorities by the MSPF, including pilot testing of zinc, low-osmolarity ORS and cotrimoxazole; and transition to ACT as the first-line drug for treatment of malaria in health facilities.

As presented in the DIP, the revised level of effort devoted to each TREIP intervention at the end of project implementation was as follows: malaria 20%, diarrhea 20%, breastfeeding 20%, ARI/pneumonia 20% and immunization 20%.

MALARIA (20 %)

- Training in malaria case management using ACT
- Adequate supply of malarial drugs
- Access to providers and drugs
- ITNs
- Care seeking, recognition, compliance
- IPT
- Community-based treatment of malaria

PNEUMONIA CASE MANAGEMENT (20 %)

- Pneumonia case management.
- Case management counseling
- Access to provider antibiotics
- Recognition of pneumonia danger signs
- Community based treatment with antibiotics

CONTROL OF DIARRHEAL DISEASES (20 %)

- ORS/Home fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Management/Counseling
- Community based treatment with Zinc

IMMUNIZATION (20 %)

- Cold chain strengthening
- Service improvement and availability
- Community Mobilization and BCC for immunization

BREASTFEEDING (20 %)
- Promote Exclusive BF to 6 Months
- Early BF initiation after birth

Cross-cutting interventions

TREIP assisted the Ministère de la Santé, Population et Famille (MSPF) in scaling-up innovative cross-cutting interventions. These include Champion Commune Approach, CBD and CCM agents, VISA approach, Community Radio and Quality Improvement Approach.

i. CHAMPION COMMUNE (KOMININA MENDRIKA):

Kominina Mendrika (KM) or Champion Commune is a USAID-supported initiative through SantéNet that mobilizes communities to achieve self-selected health objectives and provides an environment to maximize the impact of all health interventions. The KM approach promotes important and practical actions designed to improve the social, economic and cultural development of each commune.

Communes that achieve their goals are certified as "Champion" Communes, and are recognized as such during a community festival. During the implementation of TREIP, 52 communes were identified as "Champions". Champion communes are empowered to exert pressure on both health facilities and community members to adopt changes that the commune has identified as priorities. Exit interviews enabled TREIP to identify areas of client dissatisfaction, and to develop a plan to address any concerns raised.

The KM cycle lasts from 9 to 12 months. To be certified, each commune must pass through the following seven steps:

- Preliminary step: Raising Awareness and Information of key actors on KM approach
- Step 1: Introduction and technical training of key decision makers at the commune
- Step 2: Negotiation of the objectives, development of the community action plan and signing of an agreement contract
- Step 3: Training of the community teams
- Step 4: 100 days Follow up of activities
- Step 5: 200 days Follow up of activities
- Step 6: Self evaluation by the Commune and validation by the District

- Step 7: Celebration and certification

During step 7, celebration and certification, stakeholders are publicly recognized at a festival where commune representatives are presented with an award recognizing the community's efforts. KM festivals are important opportunities to transmit health messages to a wide audience, to advocate health issues and seek support from authorities, to recognize CHWs' efforts and motivate them, and finally to encourage mothers to adopt positive behaviors through public acknowledgment. Communication activities include mass education campaigns, village theaters, songs, dances, exhibitions, posters, and demonstrations. After the ceremony, the commune will assess potential new challenges and goals, thus beginning a new KM cycle. Several communes in the Toliara II and Betioky districts have already completed three KM cycles.

CBDs AND CCM AGENTS:

The new policy of the MSPF authorizes and promotes community-based management of major childhood illnesses to increase basic health care access to remote populations. This includes treatment of diarrhea with zinc and low osmolarity ORS, treatment of pneumonia with cotrimoxazole, and treatment of malaria with ACT.

MCDI's experience with the implementation of Community Based Distribution has led MCDI to identify the CCM approach as a key approach for project scale-up. As such, MCDI simultaneously scaled up the CCM activity package and CBD approach.

Betioky Sud - one of the showcase districts - was chosen by the MOH to be a pilot site. With the assistance of TREIP, initial activities have begun in the Betioky district including CCM and the introduction of Zn/ORS at the health facility level. Based on recommendations from the October 2006 Cotonou workshop on the management of childhood illnesses, project allocations were revised to include more CCMs and CBDs.

The CCMs worked as agents of behavior change by encouraging families to: (1) seek care for a sick child if needed (2) adhere to treatment and advice (3) use the KFP behaviors.

VISA APPROACH

VISA refers to the main role played by the mothers enrolled in the program and stands for Visit, Identify, Sensitize and Accompany: visit new mothers, identify with them inadequate behaviors, sensitize them on how to adopt optimal behaviors, and accompany them during the process of behavioral change. The VISA approach is a form of peer education, applied at the community level to promote healthy behaviors and practices for the children. The VISA Mother's role is to promote key messages from the immediate household surroundings, and assist and mentor women to adopt these behaviors. The final purpose of the VISA approach is to "automatically" recruit new volunteers to replace the ones who may leave the program. Over the course of the project, MCDI has maintained and even increased the number of CHWs compared to its earlier projects. The following illustrate the four main steps of the VISA Mothers approach:

Step 1: CHWs who are already applying KFP are recruited and trained as VISA Mothers. Health centers are responsible for this recruitment.

Step 2: Each identified, newly trained VISA Mother is assigned five mothers; they are encouraged to identify mothers in their immediate circle such as sisters, cousins, aunts, daughters or friends. In addition to the classic CHW activities such as door-to-door visits and village theatres, VISA Mothers are asked to frequently follow-up their five mothers at their homes. During these visits, VISA Mothers accompany or guide the mothers in the adoption of key behaviors through encouragement and repeat this activity until the mothers adopt the recommended behaviors.

Step 3: The VISA Mothers invite mothers who have adopted the key behaviors to become members of the VISA Group. This group supports the activities of the CHWs while providing testimonies about the benefits of the positive behaviors.

Step 4: Each new VISA Mother in turn recruits five new mothers to be supervised, who in turn eventually will recruit five new mothers. This is a continuous process, creating new generations of CHWs who continue to promote behavior change.

COMMUNITY RADIO

MCDI used radio education at the community level. Since 2004, in collaboration with ALT Project Radio, a British NGO, MCDI has implemented a program in the TPCSP. This program consists of:

- *Developing, with this assistance of community members, educational radio messages and program.* Community members assist with the formulation of messages, incorporating the goals of the project, identifying a socially-contextual message, and encouraging members to adopt the messages. Each program lasts 3-4 minutes and addresses issues in a way that community members can relate.

- *Broadcasting the message to all local radio stations.* In collaboration with ALT Radio, MCDI had free access to circulation platforms in 6 to 8 local radio stations in the project zone. Local DJs are trained in key messages on the project interventions of the project as well as encouraged to enliven the education programs. TREIP utilizes training modules previously developed by JSI and UNICEF for the region.

- *Establishing and strengthening community listening groups.* Under the supervision of the CHWs, this strategy engages 10-12 community members who receive free transistor radios. They are asked to listen to the health education programs broadcast on local radio stations as a group. After listening to the messages they discuss issues raised and try to find realistic solutions and actions to adopt KFP and spread the similar messages to other members of the community

QUALITY IMPROVEMENT STRATEGY

The Quality Improvement approach, which uses health facility standards and quality evaluation tools, was introduced in 10 staging sites and 46 health training sessions. The tools were adapted to the local context and were ready for national scale up. The CS standards have already been defined by MOH.

Following are the six steps of the Quality Improvement approach:

- Establish desired performance standards for each BHC.
- Measure the current level of performance (baseline). The analysis of the surveys, compared with the desired performance, allows identification of performance gaps.
- Analyze performance gaps to find primary causes, understand why the gaps exist and suggest appropriate solutions.
- Select priority interventions and develop action plans in order to overcome any deficiencies and identify available resources.
- Develop an action plan.
- Measure performance improvement and assess what corrective measures or rewards are needed for improvement, or rewards are deserved to acknowledge success.

TREIP Strategies

TREIP's strategies were specifically designed to address the four Intermediate Results (IR) targeted by the project, including (1) Improving Knowledge and Interest in Key Family Health Practices, (2) Improving Quality of Care, (3) Improving Access and Availability to Health Services Products and (4) Improving Social and Policy Environment. Main strategies for each IR are as follows:

IR1: IMPROVED KNOWLEDGE AND INTEREST IN KEY FAMILY HEALTH PRACTICES

- Use of locally available resources including CHWs and available mass media, especially local radio, to disseminate regular messages on key CS practices.
- Develop and/or adapt IEC/BCC messages and support tools
- Involve local authorities in the implementation of BCC activities
- Implement the KM approach in all RAA communes
- Implement VISA approach in all RAA communes
- Strengthen follow up/supervision of BCC activities

IR2: IMPROVED QUALITY OF CARE

- Implement QAS for child health measures
- Implement IMCI in all BHCs
- Implement IMCI in all Fokontany (including introduction of Zinc, new formula ORS and Cotrimoxazole) and set up a referral system
- Set up a system to measure clients' reaction and feedback to the health services they receive

- Strengthen the supply system at the level of the PHAGEDIS and FANOME (CSB2)
- Strengthen institutional standards, procedures and policies
- Strengthen follow-up/supervision

IR3: IMPROVED ACCESS AND AVAILABILITY TO HEALTH SERVICES PRODUCTS

- Implement IMCI in all BHCs comprising of the promotional components within the framework of CS
- Implement C-IMCI/CCM
- Set up a community distribution and sales network (ITN, Cotrimoxazole, ORS, Zinc, antimalarials, Sur'eau, etc.)
- Re-impregnation (re-treating) of bed nets at the community level
- Strengthen nutritional surveillance
- Support the SSME campaign

IR4: IMPROVED SOCIAL AND POLICY ENVIRONMENT

- Support institutionalization of community partners (national policy and regional BCC plan)
- Involve NGOs/local associations in the implementation, monitoring and evaluation of CS program
- Strengthen the application of existing standards, procedures and policies in CS
- Support to the implementation of national strategies (including MCHW)

Partnerships and Mission Collaboration

Partnerships

This section discusses partners that played a major or supporting role in project activities. These include the national government, international organizations, NGOs and communities.

*Ministry of Health***:** The primary partner for the TREIP was the MSPF at the central, regional and district levels. The ROH plays the primary role in partner coordination. The concrete technical and financial support received by one particular region or district often depends on the capacity of the RHO or DHO to plan for, and to effectively implement, this support. By collaborating with and strengthening the capabilities of the RHO and DHOs, TREIP improved their ability to access and effectively utilize this support to complement TREIP efforts. TREIP facilitates the flow of resources and training programs to its target districts.

Ministry of Communication: Collaboration with the Ministry of Communication in both Betioky Sud and Toliara continued through TREIP with a coordinated CS BCC message development and message broadcasting through community radio.

Office of the Chef de Region: As part of its decentralization policy, the GOM has established regional administrative offices to coordinate all development activities and government initiatives in the regions. This includes health planning and implementation. MCDI worked with this office to establish the Secretariat of a regional steering committee (Comité de Pilotage) for TREIP and its partners in the RAA.

SantéNet, is the Mission's bilateral health program. The first phase, implemented by Chemonics International, ended in September 2008 and the second phase, implemented by RTI, started in April 2009. It established a multisectoral platform for governance, environment and economic growth programs. SantéNet focuses on four health areas: preventing malaria, promoting family planning, fighting STIs and HIV/AIDS, and improving maternal and child health. At the national level, the project helps apply policies, norms and standards in health systems and delivery. At the local level, the first phase supported stakeholders in implementing the KM approach in 300 communes. The second phase targets 800 communes. MCDI is an implementing partner in Toliara Province. SantéNet phase 1 provided additional resources for the implementation of the KM approach by funding the implementation of the principal steps of the approach, providing in-kind gifts and those areas not covered by TREIP (Maternal Health and Family Planning). TREIP covered the cost linked to child survival interventions. After SantéNet's funding, TREIP maintained KM activities at the community level.

PSI: Population Services International receives funding from USAID to implement social marketing programs. PSI's products include, malaria treatment, ITNs, oral and injectable contraceptives, condoms and STI treatment kits. Usually, areas covered by social marketing programs are the most easily accessible by roads. Therefore, additional networks, such as Community-based Sales Agents or other health volunteers supported by MCDI and its NGO partners help reach the more isolated communities in rural areas.

BASICS is one of the partners providing support to the MOH at the national and regional levels in implementing CCM program in Madagascar. BASICS and MCDI are both members of the National CCM and Neonatal Care Committees through which tools and guidelines are developed for use countrywide. MCDI also plays an important role in the implementation of the two pilot districts for the CCM activity and is committed, along with the MOH, in supporting the RAA districts during the scaling up. Even without a formal MOU between MCDI and BASICS there is collaboration and synergy through cost sharing and technical support for program implementation (joint supervision of pilot activities in the pilot zones, training support for the community agents).

United Nations Organizations and other institutional partners: The UN largely focused on capacity building for health care facilities and on health system strengthening. Although there is no

significant resource allocation for community-level interventions and activities, UN organizations express full support for community health approaches; TREIP complements their efforts by implementing community-based activities. These institutions are in training of health agents, provision of equipment for the health centers, infrastructure. The coordination is done at the district level and led by the RHO during the development of annual work plans. The most important organizations involved in RAA are:

UNICEF, whose programs include facility-based IMCI and the EPI Reach Every District initiative. EPI support focuses on cold chain, supply of vaccines, and the enhancement of both facility-based and outreach immunization services. UNICEF also works to improve child nutrition and embraces a rights-based approach.

The *World Bank*'s country plan (CRESAN) emphasizes health planning, health worker training and the construction, rehabilitation and equipment of health care facilities. The World Bank's Second Community Nutrition Project supported the expansion of nutrition services in the TREIP project area.

UNFPA whose focal area is Reproductive Health: training of health workers, Family Planning products, supplies and equipment. UNFPA developed an FP program for two of TREIP's intervention districts (Morombe and Ampanihy).

The Global Fund also supports malaria initiatives in Madagascar and in the Southwest Region.

Malagasy NGOS: TREIP's community-level implementation relied strongly on its partnerships with local NGOs. USAID encouraged MCDI to work closely with Voahary Salama, a consortium of NGOs that acts as an umbrella organization. TREIP joined this partnership by training Voahary Salama to assist small NGOs (such as VEMIMA, MAMPIFOHA and MIAINGA) in each new district to initiate and manage TREIP's community health initiatives. These included the VISA approach, community-based management of childhood illnesses through CBDs, TBA training and the child-to community approach.

Mission Collaboration

Toliara Province is one of the USAID focal areas. To ensure that consistency and synergies are achieved, the USAID Mission is represented in the Regional Steering Committee, an MCDI-organized coordination and review committee that aims to ensure that USAID, national MSPF and other high-level partners are fully supportive of TREIP interventions.

USAID has participated fully in the DIP planning workshop and continues to provide regular monitoring of TREIP activities. TREIP's package of interventions directly supports USAID objectives. The KM and QAS approach (Quality Assurance System) demonstrate TREIP's use of lessons learnt and best practices put forth by the USAID Mission.

Through its support to health workers, community health and BCC activities, TREIP contributed to USAID's SO#5: "Use of Selected Health Services and Products Increased, and Practices Improved". By training CHWs to promote the C/IMCI Key Family Practices, the program increased the use of services such as immunization and appropriate care during episodes of illness. TREIP's partnership with PSI and its community-based distribution of socially marketed products increased demand for and availability of PSI's products. TREIP also indirectly supported SO#4, "Governance in Targeted Areas Improved," by expanding the number of Community Health Credit Schemes that have enabled low-income families in pilot communities to afford health services. At the national level, TREIP provided technical assistance to the MSPF by creating guidelines for community health credit and insurance systems, and by developing policy on health financing, cost–recovery and protection of the poor.

MCDI and USAID held quarterly review meetings with USAID. In addition, USAID regularly participated in planning workshops in the field and regularly visits TREIP's sites. MCDI participated in USAID orientation and information meetings. Activity reports were regularly sent to USAID for feedback.

Activity Status

Project coverage

Since the beginning of the project in October 2007 through August 2008, a total of 52 communes out of 105 in RAA have been reached through TREIP activities. These communes were selected according to predefined increases in the DIP. The DIP called for 100% coverage of the communes in the showcase districts, and in the other regions 50% of communes were to be covered during the first phase, an additional 2-3 were to be added in phase two.

In communes with no community health centers (BHCs), supervision and guidance for community health staff was assigned to neighboring BHCs.

Table 3: Number of communes covered by the project by the end August 2008

Districts	Total number of communes	Number of communes covered
1.Ampanihy Ouest	16	5
2.Ankazoabo Sud	6	2
3.Benenitra	4	2
4.Beroroha	8	2
5.Betioky Sud	27	22

6.Morombe	8	2
7.Sakaraha	12	10
8.Toliary I	1	0
9.Toliary II	23	7
TOTAL	**105**	**52**

Key achievements

IR 1. Improved Knowledge and Interest in Key Family Health Practices

All of the 52 communes covered by the project during the first two years have introduced the KM approach. As of October 2009, these municipalities were in various stages of progression: 10 communes were in the 3rd round and 42 in the 2nd round (for a detailed explanation of the Champion Commune approach (Kominina Mendrika) please see page 18).

A total of 2,332 Community Health Workers (CHWs) were recruited and trained in all 52 communes during a two year period, far surpassing the initial goal of reaching 1,385 by the end of the project period. These CHWs are distributed as follows:

– 1140 CHWs responsible for advising and counseling pregnant mothers about malaria prevention and treatment, pneumonia case management, home-based care of diarrhea, breastfeeding, infant nutrition practices, promotion of childhood immunization, and health care seeking behaviors
– 1140 VISA Mothers who supported pregnant women and mothers to promote key behaviors and practices related to the six main intervention areas
– 52 Community Trainers who are in charge of training and supervising CHWs

MCDI staff also assisted with an update of the national Maternal and Child Health manual developed by the MSPF to better integrate community care for childhood illnesses. This manual was included in the IEC kits provided to CHWs.

For TREIP's mass-media campaign, various BCC tools and messages have been developed for radio, local newspapers and flyers. Additionally, 94 listening groups have been established, mostly in the two showcase districts of Betioky and Sakaraha.

IR 2. Improved Quality of Care

Quality Assurance:

The SAQ approach has been introduced in 58 health facilities in the RAA. 12 of these facilities have focused on universal standards of infection control using the KM approach. MCDI

developed integrated SAQ-KM implementation tools, which were included in the evaluation kits utilized during trainings, staffing of project activities. 100% BHCs were certified after achieving 75% of the required standards.

In the 46 other BHCs, specific child health standards have been added to the SAQ and a implementation plan for each BHC was developed using a process independent from the KM approach.

Coaching at all Levels: TREIP pre-identified supervisory officials to ensure more effective monitoring, better management and encourage accountability. Nine trainers at the district level, and nine regional trainers were identified and trained in management and supervisory skills for child and maternal health programs.

Supervision of BHC: An integrated monitoring tool has been developed for all health programs in Madagascar. 24 members of the DRSPF and 9 members of DSS participated in a TOT for integrated supervision techniques. During the two years of project implementation, all districts in the RAA received integrated supervision by the 82 Technical Agents. Table 4 depicts an overview of these supervisions carried out by district. Additional supervisions focused on solving specific problems identified while conducting assessments in all health facilities.

Table 4: Number of BHCs receiving integrated supervision sessions under the TREIP project

Districts	Number BHC1		Number BHC2	
	Total	Supervised	Total	Supervised
1.Ampanihy Ouest	1		15	4
2.Ankazoabo Sud	11		4	3
3.Benenitra	9	1	3	3
4.Beroroha	9		7	3
5.Betioky Sud	6		15	3
6.Morombe	13		12	3
7.Sakaraha	4		10	-
8.Toliary I	-		11	-
9.Toliary II	11		22	3
TOTAL	**64**	**1**	**99**	**22**

***Note**: Only health centers with community sites in IMCI benefitted from this activity-oriented and focused supervision.*

IR 3. Improved Access and Availability to Health Products Services

Sales and distribution of social marketing products at the community-level: In close collaboration with PSI, the 1140 community workers trained and supervised by the TREIP project sold and distributed products using social marketing techniques. Through this system, the following items were sold: 15,141 ITNs, 2,595 units of Pilplan (oral contraceptive), 679 condom displays (presentoirs), 2,937 Collier's cycle, 4229 Sur'Eau, 635 units of ACTipal, and 8,820 units of ViaSur.

Expansion of IMCI clinical sites: TREIP has provided child health technical support to health facilities, and over the two-year project period, 124 health professionals have taken an IMCI clinical course. As of September 2009, 82 BHCs of the 163 in the RAA have at least one health officer trained in IMCI.

Expanding Health Mutuelle: The process of establishing the Health Mutuelle system was launched in 4 new communes of RAA, including the Commune of Ambahikily (Morombe District), Commune d'Andranohinaly (Toliara II District), Commune of Maroarivo and Beavoha (Betioky Sud District). Following significant advocacy and awareness-raising efforts, the project was able to establish operating entities in these communes. The health Mutuelle is already operational in the two older communes of Ankazomanga and Belamoty in the district de Betioky Sud.

Expanding the Community IMCI sites: The national guide for CCM anticipated a pilot phase in the first year, through December 2006 and national scale-up activities afterwards. MCDI was compelled to abide and follow the national expansion plan for the RAA. For each commune, the three villages with the least amount of health centers were prioritized.

To ensure ownership of the regional districts, the expansion of Community IMCI began with the establishment and formation of pools of trainers at regional and district levels. Assisted by the project, these trainers identified and trained a total of 224 community providers to deliver basic services at the community level. In September 2009, 197 officers are fully functional at 127 community sites linked to 46 BHCs.

Community Distribution of Depo-Provera: (pilot project for TREIP) : Access to Family Planning services is a national priority and the provision of injectable contraceptives at the community level is included in Madagascar's standards and procedures of Reproductive Health. In collaboration with FHI, MCDI signed an agreement to pilot the introduction of the injectable contraceptives at the community level in RAA. Two sites were selected in this pilot program, and each site has identified 10-12 community volunteers to implement this initiative. After an initial screening test, only 4 officers per site met the pre-established program criteria and were accepted in the program. In total, 31 community volunteers were trained and provided with materials and starter injectable contraceptives kits, yet only 8 became officially certified. These 8 CHWs became certified to provide injectable

contraception after they received validation from both the head of the BHCs and their supervisory DSS, and demonstrated quality and technical capability to inject Depo-prevera.

Establish a Newborn Care (NBC) site in Betioky Sud: As was mentioned in the DIP, MCDI recognized the importance of addressing newborn care issues, but unfortunately, this activity has not yet been developed in Madagascar except at the health center level (Urgent Obstetrical and Neonatal care). The neonatal program at the community level is at its early stages and to date, no policy decision has been made regarding its adoption. Yet, in collaboration with Basics and UNICEF, 181 Community Health Workers (CHWs) were trained in newborn care under TREIP, as well as five regional supervisors and 8 technical advisors to monitor and mentor the CHWs.

IR 4. Improved Social and Policy Environment

A key component of the TREIP project was the involvement of regional stakeholders. In FY 2008, the TREIP Implementation Plan was integrated into the Regional Development Plan (FDP) of the RAA Health Sector as well as in the Development Plan of each Area Health District (PDD) and the Implementation Plan (PMO) of each of the 9 districts. MCDI has been actively involved in the establishment and facilitation of a Regional Steering Committee. Through this committee, the regional organizations have played a key role in the support and coordination of project priorities. This greater responsibility of regional stakeholders has been demonstrated in their involvement with the planning, technical support provided to the DSS, and monitoring of project activities. As a result, project interventions at the BHC level were more targeted, coordinated, and facilitated; BHC prioritized community activities and they developed a sense of ownership at the SSD and community level.

At the regional level, the project undertook several technical activities to further strengthen regional capacity in the RAA. These include the:
– Establishment of the technical committee for regional coordination for IMCI
– Development of a regional BCC / Community Mobilization Strategy
– Formation of an integrated supervision matrix
– Development of a mentorship/supervisory strategy

Nationally, MCDI has regularly participated in various national technical committees such as Child Survival, Newborn Care, Family Planning, and the delivery of basic health services. MCDI staff has also actively contributed to the development of different health policies, including the National Community-based Health Policy.

Activity status and indicators by technical intervention

The following sections show the progress of project activities through October 2009, as well as the available data in the M&E Matrix for monitoring indicators. The six areas of technical assistance and capacity building interventions are detailed below:

Malaria Prevention and Treatment

Objectives

- Improve malaria prevention practices among pregnant women and mothers of children 0-23 months.
- Improve malaria care and treatment seeking behaviors in mothers of children 0-23 months.

Activity status

Table 5 summarizes the planned activities for malaria prevention and control as well as achievements in 2009 over the duration of the project.

Advice to pregnant women and mothers about prevention, treatment and care of malaria was provided in the package of activities for community workers. According to the DIP, 1,385 CHWs trained in advising and counseling pregnant and mothers in malaria prevention, treatment and care seeking behaviors by the end of the project. This target was exceeded after just two years of project implementation as 2,332 CHW (1140 CHWs, 1,140 VISA Mothers, 52 community trainers) were trained to advise and counsel pregnant women and mothers on malaria prevention, treatment, IPTp and care seeking behaviors.

The project goal aimed to coach 6,500-7,000 total VISA Mothers (3,500 in the first two years) to support pregnant women and mothers on malaria prevention, treatment and care seeking support. By September 2009, 1,140 VISA Mothers had been trained by CHWs to provide coaching assistance, and these VISA Mothers had provided support to 1,435 pregnant women and mothers. However, project goals were not met because of the socio-political situation in the country which limited interventions on the Fokontany level.

Regarding the management of malaria at the community level (in association with pneumonia), the project has already far exceeded the goal of 583 CHWs set for project completion. A total of 1,140 CBDs have been trained in CCM of Malaria and malaria in association with pneumonia and are directly assisting their communities.

To improve management of malaria cases at health facilities, TRIEP planned to train 70 CHWs in IMCI during the first two years of the project. By October 2009, 124 health facility staff, by type, have already been trained in Facility-Based IMCI Protocol for Malaria, which is far above the original target. Of the 163 BHCs in RAA, 82 have at least one officer trained in IMCI.

The distribution of INTs was a key activity of the project: By project completion 24,499 households have received ITNs, in addition to the free distribution conducted by the Ministry of Health, which covered 33% of households. The management and supervision of ITNs was integrated in the training of CBDs.

Table 5: Malaria Prevention and Treatment Activity Status table

Planned Activities	2011 Expected Results	2009 Benchmark	2009 Activity status	Objective met
Training of CHWs to advise and counsel pregnant women and mothers on malaria prevention, treatment and care seeking behaviors	1,385 CHWs trained in advising and counseling pregnant and mothers in malaria prevention, treatment and care seeking behaviors	692 CHWs trained in advising and counseling pregnant and mothers in malaria prevention, treatment and care seeking behaviors	2,332 CHW (1140 CHWs, 1,140 VISA Mothers, 52 community trainer) trained to advise and counsel pregnant women and mothers on malaria prevention, treatment and care seeking behaviors	YES
Coaching of VISA Mothers by trained CHWs to support pregnant women and mothers on malaria prevention, treatment and care seeking	6,500 -7,000 VISA Mothers coached by CHWs in supporting pregnant women and mothers on malaria prevention, treatment and care seeking	3,500 Mothers coached by CHWs in supporting pregnant women and mothers on malaria prevention, treatment and care seeking	1,140 VISA Mothers coached to support pregnant women and mothers on malaria prevention, treatment and care seeking 1,435 pregnant women and mothers supported by VISA Mothers	NO
Training of CBDs in community case management of malaria and malaria in association with pneumonia	583 CBDs trained in CCM of malaria and malaria in association with pneumonia	292 CBDs trained in CCM of malaria and malaria in association with pneumonia	1140 CBDs trained in CCM of Malaria and malaria in association with pneumonia 100% of CBDs trained who are doing CCM of Malaria	YES
Training of health facility staff in Facility-based IMCI Protocol	70 health facility staff trained in Facility-based IMCI Protocol	35 health facility staff trained in Facility-based IMCI Protocol	124 health facility staff, by type, trained in Facility-based IMCI Protocol for Malaria 82 health facilities with at least one health worker	YES

			trained in IMCI	
Provision of ITNs	Insecticide treated bed nets accessible to and utilized by mothers and children at MOH subsidized rates and distributed through trained CBDs	40,400 Insecticide treated bed nets distributed/shared	115,141 ITNs distributed/shared; 24% of households provided with new ITNs; 33% of households provided with new ITNs at MSPF subsidized rates	YES
Indoor spraying	In areas where households were sprayed before the last malaria season, increase in proportion of families who adhered to safety precautions to prevent exposure to insecticide and abstained from painting/washing walls after spraying.	N/A	N/A	N/A
Strengthen logistics and supply system for essential malaria drugs	Reduced stock-outs of essential malarial drugs at health facilities	Number of stock outs of essential anti malaria drugs in past reporting period	2,332 CHWs (1140 CHWs, 1,140 VISA Mothers, 52 community trainer) trained to manage logistics and supply system for essential drugs	YES

Results

The updated M&E Matrix in Table 6 shows that - according to the limited data available on prevention and treatment of malaria - the progression generally trends towards expected project

results. The preliminary results of the 2008-2009 DHS suggest that project outcomes are not far from the target for INT utilization after two years of project implementation in the RAA.

The number of women taking antimalarial medications during pregnancy has also seen significant improvements. In just two years, the results have demonstrated a 10% increase, while the original target for years called for a 30% increase.

Other indicators on early treatment of febrile episodes in children, feeding of sick children, care-seeking behaviors and drug management could not be evaluated due to insufficient data.

Table 6: Malaria Prevention and Treatment M&E Matrix

Indicators	**Data Sources**	**Base-line Value**	**2009 results**	**EOP target**	**Explanation of progress**
Percent of children 0-23 months who slept under an insecticide treated bed net the previous night	Baseline: KPC Baseline survey 2009: deduction from DHS preliminary result (*)	26	56.6(*)	60	(*) The possession of ITN was 57.9% at national level and is 72.9% for the RAA. The use by 0-23 months was 45.8% at national level. By using the rule of three, the use by 0-23 months is estimated at 56.6% for the RAA
Percent of pregnant women who took an anti-malarial drug during their most recent pregnancy	Baseline: KPC Baseline survey 2009: DHS preliminary results	30	41.2	60	Positive progression toward the project goal
Percent of children with a febrile episode that ended during the last two weeks who were treated with an effective antimalarial drug within 48 hours after the fever began	Baseline: Baseline survey	17	ND	55	NA
Percent of mothers of children 0-23 months who continued feeding during the febrile episode	Baseline: Baseline survey		ND		NA

Percent of mothers of children 0-23 months who know at least 2 signs of malaria that indicate a need for immediate treatment outside the home	Baseline: Baseline survey		ND		NA
Number of stock-outs of essential malaria drugs in past reporting period	Review of quarterly reports		No stock-out in past reporting period	No stock-out in past reporting period	

2. Pneumonia Case Management

Objectives

- Improve pneumonia case management practices of children 0-23 months
- Improve pneumonia case management in health facilities

Activity status

Table 7 summarizes the activities planned in support of pneumonia prevention, treatment and care from project completion as well as highlights the project achievements through October 2009.

Advising pregnant women and mothers on treatment and care-seeking for pneumonia is among the responsibilities of the CHWs. According to the DIP, 1,385 CHWs were to be trained in this capacity during the full project period. As with malaria case management, this target was far exceeded as after the first two years as 2,332 CHWs (1140 CHWs, 1140 VISA Mothers, 52 community trainers) have been trained.

Similar to the malaria case management component, the project sought to have 6,500 -7,000 VISA Mothers coached by CHWs in supporting pregnant women and mothers on pneumonia prevention, treatment and care seeking support during the entire project period and 3,500 in the first two years of the project. Yet by October 2009, 1,140 VM had been trained to provide coaching assistance and these VM had provided support to 1,435 pregnant women and mothers. Project goals fell short of targets because of the socio-political situation in the country which limited interventions on the ground for the Fokontany level.

Regarding the community case management of pneumonia, in association with malaria, the project completed 77% of planned activities for 2009. Originally, 583 CBDs were to be trained in CCM of malaria in association with pneumonia. After the first two years of the project, the target was to train 292 CBDs on CCM, yet by October 2009 this target was narrowly missed with

224 documented trained CBDs.

At the facility level, the project planned to train 70 health workers in IMCI during the first two years. By October 2009, 124 health workers had already been trained, nearly doubling the intended target. Of the 146 BHCs in the RAA, 82 have at least one staff member trained in IMCI. Management aspects of the project are integrated into the training of health workers.

Table 7: Pneumonia Case Management Activity Status

Planned Activities	**2011 Expected Results**	**2009 Expected Results**	**2009 Activity status**	**Objective met**
Training of CHWs to advise and counsel pregnant women and mothers on pneumonia case management and care seeking behaviors	1,385 CHWs trained in advising and counseling pregnant and mothers in pneumonia case management and care seeking behaviors	692 CHWs trained in advising and counseling pregnant and mothers in pneumonia case management and care seeking behaviors	2,332 CHWs (1140 CHWs, 1140 VISA Mothers, 52 community trainer) trained to advise and counsel pregnant women and mothers on pneumonia case management, treatment and care seeking behaviors	YES
Coaching of VISA Mothers by trained CHWs to support pregnant women and mothers on pneumonia treatment and care seeking	6,500 -7,000 VISA Mothers coached by CHWs in supporting pregnant women and mothers on pneumonia treatment and care seeking	3,500 Mothers coached by CHWs in supporting pregnant women and mothers on pneumonia treatment and care seeking	1140 of VMs coached to support pregnant women and mothers on pneumonia treatment and care seeking 1435 pregnant women and mothers supported by VMs	NO
Training of CBDs in community case management of pneumonia and of malaria associated with pneumonia	583 CBDs trained in CCM of malaria and malaria in association with pneumonia	292 CBDs trained in CCM of malaria and malaria in association with pneumonia	224 CBDs trained in community case management of pneumonia and of malaria associated with pneumonia 100% of CBDs trained who are doing CCM of Pneumonia	NO

Training of health facility staff in Facility-based IMCI Protocol	70 health facility staff trained in Facility-based IMCI Protocol	35 health facility staff trained in Facility-based IMCI Protocol	124 health facility staff, by type, trained in Facility-based IMCI Protocol for pneumonia 82 health facilities with at least one health worker trained in IMCI	YES
Strengthen logistics and supply system for essential pneumonia drugs	Reduced stock-outs of essential pneumonia drugs at health facilities	No stock-outs of essential pneumonia drugs at health facilities	2,332 CHW (1140 CHW, 1,140 VISA Mothers, 52 and 124 health facility staff community trainer) trained to manage logistics and supply system for essential drugs	YES

Results

No 2009 data exists to update following M&E table (Table 8) regarding the treatment and case management of pneumonia. The project was expected to increase the percentage of children aged 0-23 months with cough and difficult breathing in the last two weeks who were taken to a health facility or received antibiotics from 28% to 60%. This information was not captured through routine BHC data collection nor preliminary results of the DHS 2008-2009, and the premature closure of the project did not allow for a full investigation into this indicator.

MCDI databases show that following the project intervention, 30.75% of the RAA population has access to an ARI point of care unit in a 5 km radius. Forty two percent of children with ARI symptoms were brought to a facility or a health provider, as per DHS preliminary report, suggesting that these project efforts have improved this health indicator.

The drug management indicator could not be evaluated due to insufficient data.

Table 8: Pneumonia Case Management M&E Matrix

Indicators	**Data Sources**	**Base-line Value**	**2009 results**	**EOP target**	**Explanation of progress**
Percent children aged 0-23 months with cough and fast/difficult breathing in the last two weeks who were	Baseline: KPC Baseline survey 2009: proxy (*)	28	ND	60	(*) Percentage of population with access to the point of care for ARI in a 5 km radius

taken to a health facility or received antibiotics from an alternative source					30.75%
Number of stock-outs of essential pneumonia drugs in past reporting period			ND		

3. Prevention and Control of Diarrheal Diseases

Objectives

- Improve diarrhea prevention and treatment practices in mothers and caretakers of children 0-23 months
- Improve diarrhea case management at home and at the facility leveling the case of severe diarrhea

Activity status

Table 9 summarizes the planned activities on prevention and control of diarrheal diseases and highlights the project achievements through October 2009.

CHWs received training on home-based management of diarrhea, communication skills and appropriate referrals to BHCs. Originally, the project planned to train 1,385 CHWs in home-based management of diarrhea and communication skills during the first two and a half years of the projects. By October 2009, 2,332 CHWs (1140 CHWs, 1140 VISA Mothers, 52 community trainers) were trained in educating mothers of infants on ORTs or use of available fluids, Vitamin A supplementation, and recognizing the danger signs that require outside treatment.

TRIEP planned to provide training to 6,500-7,000 VISA Mothers by the end of the project and 3,500 by the end of 2009, to support mothers and caregivers on home-based management of diarrhea and care seeking. By October 2009, 1,140 VISA Mothers were trained on home-based management of diarrhea. The original target was not reached due to the socio-political situation limited interaction on the Fokotany level. These 1,140 VISA Mothers however, had an enormous impact, visiting 29,000 mothers/caregivers and providing guidance about diarrheal diseases. This represents an average of 25 mothers/caregivers per VISA Mother (far more than the planned 5 visits per VM).

TREIP completed 77% of planned 2009 activities regarding the training of CHWs on the proper referral system for children with severe/acute diarrhea to a health facility for immediate treatment. 224 CHWs have been trained on community-care and referral of diarrhea cases, compared to the 292 CHWs the project aimed to train by the end of 2009, and 583 CHWs that the project aimed to train by the end of the project.

In order to improve the management of diarrhea cases at health facilities, TREIP planned to train 70 health workers in IMCI over the project period, half during the first two years. As of October 2009, this target has been well exceeded, with 124 health facility staff trained in facility-based IMCI protocol for diarrhea. Of the 146 BHCs, 82 have at least one staff member trained in IMCI.

The introduction of zinc for the treatment of diarrhea was introduced by the TRIEP project in RAA. Forty six health professionals have been trained in use of zinc, and currently offer this treatment to their patients.

The project intended to train 1,385 CHWs in the promotion of safe and hygienic water use over the 4-year project period. By October 2009, the project had more than doubled its target reaching 2,332 CHWs (1140 CHWs, 1140 VISA Mothers, 52 community trainers).

Table 9: Prevention and Control of Diarrheal Diseases Activity Status

Planned Activities	**2011 Expected Results**	**2009 Expected Results**	**2009 Activity status**	**Objective met**
Training of CHWs in home-based management of diarrhea, communication skills and appropriate referrals to CBD	1,385 CHWs trained in home-based management of diarrhea and communication skills Increase in referrals to CBDs made by CHWs	692 CHWs trained in home-based management of diarrhea and communication skills	2,332 CHWs (1140 CHWs, 1140 VISA Mothers, 52 community trainer) trained in educating mothers of children 0-23 months on ORT or use of available fluids, Vitamin A supplementation, and recognizing the danger signs that require treatment outside the home	YES
Coaching of VISA Mothers by trained CHWs to support mothers and caregivers on home-based management of diarrhea and care seeking	6,500 -7,000 VISA Mothers coached by CHWs in supporting mother/caregivers on home-based management of diarrhea and care seeking	3,500 VISA Mothers coached by CHWs in supporting mother/caregivers on home-based management of diarrhea and care seeking	1,140 VISA Mothers coached to support mothers/caregivers on home-based management of diarrhea and care seeking 29 000 mothers/caregivers	NO

			supported by VMs	
Training of CBDs in appropriate referrals of children 0-23 months with severe/acute diarrhea to a health facility for immediate treatment	583 CBDs trained in community case management of, and referrals for, diarrhea	292 CBDs trained in community case management of, and referrals for, diarrhea	224 CBD trained in CCM of Diarrhea	NO
Training of health facility staff in Facility-based IMCI Protocol	70 health facility staff trained in Facility-based IMCI Protocol	35 health facility staff trained in Facility-based IMCI Protocol	124 health facility staff , by type, trained in Facility-based IMCI Protocol for Diarrhea 82 health facilities with at least one health worker trained in IMCI	YES
Orientation of health facility staff, CHWs, CBDs in benefits of Vitamin A and zinc therapy	Introduction of zinc therapy in health facilities Increase in Vitamin A supplementation and introduction of zinc therapy	73 health facilities providing zinc therapy	46 health facilities providing zinc therapy 46 of health facility staff, by type, oriented/trained in zinc therapy	NO
Training of CHWs and CBDs in promotion of safe and hygienic water use	1,385 CHWs and 583 DBC trained in promotion of safe and hygienic water use Increase in safe and hygienic water use by households in project areas	692 CHWs trained in promotion of safe and hygienic water use	2,332 CHWs(1140 CHWs, 1140 VISA Mothers, 52 community trainer) trained in promotion of safe and hygienic water use	YES

Results

No 2009 data exists to update Table 10 that shows the M & E Matrix corresponding practices of prevention, treatment and referral of diarrhea. The percentage of children 0-23 months who presented with diarrhea who received ORS or other fluids recommended. This indicator does not appear in the preliminary results of the DHS 2008-2009.

According to the data routinely collected at the DRSPF, there was a small increase in the total number of diarrheal cases registered at the CSB, 20,260 in 2006 (before the project) to 22,021 in 2008. In contrast, the number of dysentery and diarrhea with dehydration among children 1 to 5 years decreased from 498 to 374 cases, representing a net decrease of complicated cases seen at CBS by 25% in 2 years.

In addition, MCDI databases show that following the intervention of the project, more than half of the population of the RAA (53.82%) has access to a new point of care for diarrhea in a 5 km radius. This data suggest the results of the effort made by the project and can predict a significant improvement of diarrhea indicators.

Other indicators of food and drink for sick children, as well as the danger signs of diarrhea could not be assessed due to a lack of data.

Table 10: Prevention and Control of Diarrheal Diseases M&E Matrix

Indicators	**Data Sources**	**Baseline Value**	**2009 results**	**EOP target**	**Explanation of progress**
Percent children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	Baseline: KPC Baseline survey 2009: MCDI and MOH Regional database	53,6	ND	60	ercentage of population with access to the point of care for diarrhea in a 5 km radius 53.82% Total number of diarrheal cases registered at the CSB: - 2006: 20 260 - 2008: 22 021
Percent children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	Baseline: KPC Baseline survey 2009: MOH Regional database	26	ND	60	
Percent children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	Baseline: KPC Baseline survey 2009: MOH Regional database	36	ND	65	

Percent mothers who sought treatment at health center in the 24 hours of the first danger sign for diarrhea.	Baseline: KPC Baseline survey 2009: MOH Regional database	33	ND	60	Number of dysentery and diarrhea with dehydration' from 1 to 5 years: – 2006: 498 – 2008: 374 cases

Breastfeeding and Infant Nutrition

Objectives

- Improve breastfeeding practices in mothers of children aged 0-5
- Improve feeding practices in mothers/caretakers of children 6-23 months

Activity status

Counseling on breastfeeding practices and optimal nutrition for children is an essential component to CHW activities. Over the project period, 1,385 CHWs were to be trained in advising and counseling pregnant and mothers on optimal breast feeding and infant nutrition practices, half of those during the first two project years. The target was exceeded with 2,332 CHWs (1140 CHWs, 1140 VISA Mothers, 52 community trainers) trained in educating mothers of children: a) 0-5 months on exclusive breast feeding practices; b) 6-23 on optimal infant nutrition practices.

By the end of project in 2011, TRIEP planned to provide training to 6,500-7,000 VISA Mothers, 3,500 by the end of 2009, in advising and counseling pregnant and mothers on optimal breast feeding and infant nutrition practices. By October 2009, 1,140 VISA Mothers were trained on optimal feeding practices, who in turn have mentored 1,435 pregnant women and mothers on the subject of breastfeeding and child nutrition.

To strengthen the promotion of breastfeeding and young child feeding in health facilities, TRIEP planned to train 70 health facility staff in IMCI clinical protocols, half in the first two years. By October 2009, the objectives have been largely exceeded with 124 health facility staff trained. Of the 146 BHCs in the RAA, 82 have at least one staffer trained in IMCI methods.

Table 11: Breastfeeding and infant Nutrition Activity Status table

Planned Activities	2011 Expected Results	2009 Expected Results	2009 Activity status	Objective met

Training of CHWs to advise and counsel pregnant women and mothers on optimal breast feeding and infant nutrition practices	1,385 CHWs trained in advising and counseling pregnant and mothers on optimal breast feeding and infant nutrition practices	692 CHWs trained in advising and counseling pregnant and mothers on optimal breast feeding and infant nutrition practices	2,332 CHWs (1,140 CHWs, 1,140 VISA Mothers, 52 community trainer) CHWs trained in educating mothers of children: a) 0-5 months on exclusive breast feeding practices; b) 6-23 on optimal infant nutrition practices	YES
Coaching of VISA Mothers by trained CHWs to support pregnant women and mothers on optimal breast feeding and infant nutrition practices	6,500 -7,000 VISA Mothers coached by CHWs in supporting pregnant women and mothers on optimal breast feeding and infant nutrition practices	3,500 VISA Mothers coached by CHWs in supporting pregnant women and mothers on optimal breast feeding and infant nutrition practices	1,140 coached in supporting mothers of children in optimal breast feeding and infant nutrition practices 1,435 of pregnant women and mothers supported by VMs	NO
Training of health facility staff in Facility-based IMCI Protocol	70 health facility staff trained in Facility-based IMCI Protocol	35 health facility staff trained in Facility-based IMCI Protocol	124 health facility staff , by type, trained in Facility-based IMCI Protocol 82 health facilities with at least one health worker trained in IMCI	YES

Results

No data exists from 2009 to update the following Breastfeeding and Infant Nutrition M&E Matrix (Table 12). Preliminary results from the 2008-2009 DHS show a small decline in the rate of exclusive breastfeeding compared to the 2004 DHS, falling from 67.2% to 51% nationally.

Table 12: Breastfeeding and infant Nutrition M&E Matrix

Indicators	Data Sources	Base-line Value	2009 results	EOP target	Explanation of progress
Percent of infants aged 0-5 months who were given breast milk only in the 24 hours preceding survey	Baseline: KPC Baseline survey	24	ND	40	
Percent of children aged 0-23 months put to the breast within 1 hour of birth	2009: MOH Regional database	27	ND	50	

Immunization

Objectives

- Expand immunization coverage of children 0-23 months
- Expand immunization coverage of pregnant women

Activity status

Table 13 summarizes planned project activities for immunization over the project period.

The training of CHWs to provide education, counseling and support to newly married women, pregnant women and mothers of infants and young children on immunization services was a key element to project activities. To achieve this objective, the project had planned on training 1,385 by 2011, half of those in the first two years of the project. After two years, 2,332 CHWs (1,140 CHWs, 1,140 VISA Mothers, 52 community trainers) had been trained in immunization practices, far exceeding project goals.

Over the project period, 6,500-7,000 VISA Mothers were expected to be trained to support newly married women, pregnant women and mothers of infants and young children on immunization services. By October 2009, 1,140 VMs were trained, who in turn advised 1,435 pregnant woman and mothers. The original target was achieved due to the socio-political situation limited interaction on the Fokotany level.

To improve services at health facilities, TREIP has collaborated with UNICEF to train 169 health professionals in immunization techniques. These trainings far exceeded the original goal of reaching 70 health professionals over the 4-year life of the project.

Support for campaigns conducted by the Ministry of Health and Family Planning is one of the key activities of the project. As such, MCDI collaborated with a MHFP campaign where 19,307 children 0-23 months were immunized, and 18,824 pregnant and newly married women were

immunized during the last two campaigns of 2008. To strengthen the planning, supervision and monitoring of immunization activities, each of the 9 Districts in the RAA has received training in integrated monitoring and supervision of their respective programs.

To overcome the obstacles and barriers to immunization in the RAA, a specific plan was developed for each District as part of the "Reach Every District" (RED) approach.

Table 13: Immunization Activity Status table

Planned Activities	2011 Expected Results	2009 Expected Results	2009 Activity status	Objective met
Training of CHWs to provide education , counseling and support to newly married women, pregnant women and mothers of infants and young children on immunization services	1,385 CHWs trained in promotion of childhood immunization services and regular checking of immunization cards Increase in demand for immunization services Increase in Vitamin A supplementation	692 CHWs trained in promotion of childhood immunization services and regular checking of immunization cards	2,332 CHWs (1,140 CHWs, 1140 VISA Mothers, 52 community trainers) of CHWs trained in educating newly married women, pregnant women and mothers of infants and young children on immunization practices	YES
Coaching of VISA Mothers by trained CHWs to support newly married women, pregnant women and mothers of infants and young children on immunization services	6,500 -7,000 VISA Mothers coached by CHWs in supporting newly married women, pregnant women and mothers of infants and young children on immunization services	3,500 VISA Mothers coached by CHWs in supporting newly married women, pregnant women and mothers of infants and young children on immunization services	1,140 of VMs coached in supporting newly married women, pregnant women and mothers of infants and young children on immunization services	NO
Training of CHWs in checking immunization cards of children 0-23 months and pregnant	1,385 CHWs trained to check immunization cards of children 0-	692 CHWs trained to check immunization cards of children 0-	ND	N/A

women to ascertain adherence, track and accompany defaulters to health care facilities for continuation of immunization schedule	23 months, track defaulters and accompany them and their mothers to complete immunization schedules Increase in defaulters tracked by CHWs and accompanied to health care facility for continuation of immunization schedule	23 months, track defaulters and accompany them and their mothers to complete immunization schedules		
Collaboration with UNICEF to assure the integrity of the cold chain, availability of vaccine and training of health staff in correct immunization techniques	Improved cold chain and increase in availability of vaccines 70 Health Facility workers trained in correct immunization techniques	35 Health Facility workers trained in correct immunization techniques	169 Health Facility workers trained in correct immunization techniques	YES
Assistance in implementation of immunization campaigns conducted by MSPF	Increased coverage of immunization campaigns conducted by MSPF	Assistance in implementation of immunization campaigns conducted by MSPF	19,307 children 0-23 months immunized per campaign conducted by MSPF 18,824 pregnant and newly married women immunized per campaign conducted by MSPF	YES
Technical support to RHO to strengthen planning, supervision, and monitoring of all immunization activities	Strengthened planning, supervision and monitoring of immunization	Technical support to RHO to strengthen planning, supervision, and	09 District Focal Points trained in supervision, monitoring of all programs (EPI,	YES

in SW Region	activities of RHO and MSPF in RAA Region	monitoring of all	Nutrition ...)	
Formative research on current knowledge and beliefs concerning vaccine-preventable diseases and barriers that prevent accessing immunization services	Development of plan with RHO, DHOs, UNICEF to address obstacles and barriers to immunization	Integration work plan in TREIP Plan implementation of the DRS and DSS	Map available for each SSD (RED approach)	YES

Results

Although data may not be entirely comparable, the updated M&E Matrix (Table 14) indicates a positive increase in project immunization indicators. Proxy indicators from the preliminary results of the DHS 2008-2009 were used to predict trends.

TREIP's objective was to increase the percentage of children fully immunized before their first birthday from 33% to 60%. The initial baseline survey used the percentage of children vaccinated, and checked through vaccination, while preliminary results from the 2008-2009 DHS includes books and audited statements from parents and gives a figure of 42.6% of children receiving vaccines before their first birthday in the RAA. This figure may be an over-estimation compared to the actual situation if one excludes the verbal affirmation from mothers.

The same issue exists for the data for the vaccination of women: According to the baseline survey, the percentage of mothers who received at least two tetanus toxoid injections (card-confirmed) before the birth of the youngest child less than 24 months of age was 29%, while preliminary data from the 2008-2009 DHS found that the total percentage of protected births is 64.7% (which also takes account of vaccines received before the last pregnancy). One must be careful when interpreting this data, as it comes from different data sources.

Table 14: Immunization M&E Matrix

Indicators	**Data Sources**	**Base-line Value**	**2009 results**	**EOP target**	**Explanation of progress**
Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines (card confirmed) before the first birthday	Baseline: HFRA Baseline survey 2009: proxy from DHS Preliminary Results	33%	42,6%(*)	60%	* According to the vaccination records.

Percent of mothers who received at least two tetanus toxoid injections (card-confirmed) before the birth of the youngest child less than 24 months of age	Baseline: HFRA Baseline survey 2009: proxy from DHS Preliminary Results	29%	64,7%(**)	60%	** Protected i.e. 2 injections during pregnancy, 2 injections within the last 3 years before last birth, or, 3 injections within the last 5 years before the last birth, or, 4 injections the last 3 years before last birth, or At least five injections before last birth
Percent of drop-outs between DPT1 and DPT3	Baseline: HFRA Baseline survey 2009: MOH Regional database	19	Toliary I, 0,4 Toliary II, 17,3 Ampanihy, 15,0 Ankazoabo, 14,1 Benenitra, 31,0 Beroroha, 50,9 Betioky, 18,6 Morombe, 44,0 Sakaraha, 10,8	10	

4. Community and Household IMCI

Objectives

- Expand community and household IMCI practices
- Strengthen facility-based Clinical IMCI practices

Activity status

Table 15 summarizes the activities planned for Community IMCI throughout the course of the project.

TREIP trained 2,332 individuals comprised of 1,140 community agents, 1,140 VISA Mothers and 52 community trainers, instead of the initial objective of 1,385 community volunteers during the four years project life to counsel and support pregnant women and mothers. A total of 86,612 pregnant women and mothers of 0 – 23 months old were counseled by these volunteers in 1,546 villages of the RAA.

With regard to the CCM, a simplified C-IMCI algorithm was prepared for the training of community agents on CCM of malaria and diarrhea. This simplified algorithm was used to train 224 community-based agents. In October 2009, 197 agents were completely operational providing services of CCM of malaria and diarrhea at 127 community sites linked to 46 basic health centers. The objective was 60% coverage of RAA villages.

At project planning stage, 583 agents were to be supplied with social marketing products for community distribution. By the end of the second year, the forecasts were largely exceeded as 2,332 community agents were supplied thanks to a productive collaboration with PSI.

As for the supervision of activities, links between community activities and health system were institutionalized through the monthly reporting and the supervision meetings. The meetings review the contribution / participation of CBD agents, community volunteers and basic health center personnel. During the last quarter of 2008, 30 monthly reporting meetings and supervision meetings took place. Nine district focal points and eleven field supervisors were trained as well as 52 community trainers. In terms of clinical service provision, a total of 46 basic health centers have benefitted from IMCI supervision: 60% of them were found using the IMCI checklist.

The field agents of partner NGOs were trained and entrusted for the regular supervision of community agents. Within the project framework, it was initially planned to train 55 NGO agents in supervision and to ensure the supervision of 1,385 community volunteers and 583 CBD agents. The project achieved the training of 17 NGO agents.

The refresher training of 162 health staff in C-IMCI for case management of malaria and diarrhea was also planned in the TREIP framework. During the year of 2008, 124 health staff benefitted of the refresher training.

Table 15: Community and Household IMCI Activity Status table

Planned Activities	**2011 Expected Results**	**2009 Expected Results**	**2009 Activity status**	**Objective met**
Training of CHWs in (a) promotion of C/ IMCI KFPs; and, (b) coaching mothers to be VISA Mothers so as to educate other women	1,385 CHWs trained to: (a) counsel and support pregnant women/mothers of young children: (b) coach mothers as VISA Mothers to educate other women	692 CHWs trained to: (a) counsel and support pregnant women/mothers of young children	2332 CHWs (1140 CHWs, 1140 VISA Mothers, 52 community trainer) CHWs trained to counsel and support pregnant women/mothers 86,612 of (a) pregnant women and	YES

	80% of villages are covered by CHWs who are trained to promote C-IMCI KFPs		(b) mothers of children 0-23 months counseled by CHWs 1,546 villages covered by CHWs trained to promote C-IMCI KFPs 29,000 of CHWs coaching mothers as VISA Mothers	
Design of simplified C-IMCI algorithm designed for training of CBDs in CCM of malaria and diarrhea	Simplified C-IMCI algorithm designed for training of CBDs in CCM of malaria and diarrhea 60% of villages have trained CBDs using simplified IMCI case management protocol, who are providing community case management (CCM) of malaria and diarrhea	291 CBDs trained in CCM of (i) malaria and diarrhea	224 CBDs trained in CCM of (i) malaria and diarrhea	NO
CBDs supplied with social marketing packages for distribution.	583 CBDs supplied with social marketing packages for distribution.	291 CBDs supplied with social marketing packages	2332 CBDs supplied with social marketing packages 100 % of CBD stocks distributed	YES
Design and institution of monthly reporting and supervisory meetings between CBDs, CHW and BHF	Institution of monthly reporting and supervisory meetings between CBDs, CHWs, and BHF		30 monthly reporting and supervisory meetings held in last quarter, by types of attendees Not captured	YES

	personnel 60% of villages with established links between communities and health facilities (at least quarterly) through monthly reporting and supervisory meetings between CBDs, CHWs and health facility personnel Strengthened supervisory system at health facility, NGO, community and household levels 75% of health facilities are supervised using IMCI checklist as adapted for Toliara		- 9 PFD and 11 supervisors trained in close technical supervision and 52 Trainers Community - 11 local supervisors, 52 Community leaders supervised trainers. 46 health facilities supervised for IMCI 60% of health facilities that are supervised using (i) IMCI Checklist	
Training of local NGO field agents to make regular supervisory visits to active CHWs and CBDs	55 NGO field agents trained in supervision 1,385 CHWs and 583 CBDs regularly supervised by NGO field agents Increase in supervisory visits to CHWs / CBDs	27 NGO field agents trained in supervision 692 CHWs and 291 CBDs regularly supervised by NGO field agents	35 NGO field agents trained in supervision 1,140 CHWs/ CBDs regularly supervised by NGO field agents supervisory visits to CHWs and CBDs by type of trained supervisor, done monthly	YES

Refresher training in C-IMCI protocol for health facility personnel	162 health facility personnel with refresher training in C-IMCI protocols in malaria and diarrhea	51 health facility personnel with refresher training in C-IMCI protocols in malaria and diarrhea	124 health facility personnel with refresher training in C-IMCI protocols in malaria and diarrhea	YES

Results

The two IMCI follow-up indicators – namely: indicator on knowledge of danger signs that call for care seeking outside the household and indicator on appropriateness of treatment offered by health facility as per IMCI protocol, could not be evaluated due to lack of data. None of the available data sources could help to assess the current situation.

However, with regard to the appropriateness of treatment of clinical episodes managed at community level, the project set an objective of 60% but at project start-up this activity did not exist. Data from supervision meetings seem to show satisfactory results, all above 80% for the three diseases: pneumonia, malaria and diarrhea.

Table 16: Community and Household IMCI M&E Matrix

Indicators	**Data Sources**	**Base-line Value**	**2009 results**	**EOP target**	**Explanation of progress**
Percent mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment	Baseline: KPC Baseline survey	43%	ND	60%	
Percent clinical encounters with HW in HF in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea (from Clinical Observation in HF)	Baseline: HFRA Baseline survey	36%	ND	60%	
Percent clinical encounters with CHW in which treatment is appropriate to diagnosis	Baseline: None 2009: MCDI Supervision reports	NA	Accurateness of treatment Pneumonia 80%	60%	

for child with malaria, pneumonia, or diarrhea			Malaria 85% Diarrhea 83%		

Capacity Building

Objectives

- Community capacity for increased access to care for families
- RHO/DHO capacity in supervision and quality assurance
- NGO capacity for community mobilization and BCC activities

Activity status

Table 17 summarizes the activities originally planned for capacity strengthening through the end of the project as well as TRIEP forecasts and achievements through 2009. Overall, this element was highly successful as nearly all of the expected outputs were met.

In order to expand families' access to health care through improved credit/equity funds, the project planned to train 240 members of steering committees, covering 15% of RAA communes, on the establishment, management, monitoring and evaluation of health Mutuelles. At the end of two years, Mutuelles were established in four new communes in addition to the two communes who were operational Mutuelle before project start-up. Thus 5.7% of the total communes have health Mutuelles.

The Kominina Mendrika (KM) approach was launched in all 52 communes covered by the project during the first two years to help communes to reach their predefined objectives. At project closeout, 10 communes are on their third cycle of KM implementation and 42 communes are in their second cycle. It should be noted that in 2008, 52 communes were all certified as Kominina Mendrika (Champion Communes).

Capacity of the regional team was built using the following strategies:

- Support in the training of district supervisors: four members of the regional team were originally planned to benefit from this activity whereas the project succeeded in supporting nine persons of the regional team during the two years.
- Training in supervision and quality assurance: Initially, nine regional program managers were targeted during the life of the project, yet the project exceeded these targets as 18 managers benefitted from and utilized learnt techniques.
- Transfer of BCC and social mobilization skills to local NGOs: The project planned to train 36 members of NGOs but within two years, 52 NGO community trainers and 11 supervisors were already trained.

Table 17: Capacity Building Activity Status table

Planned Activities	2011 Expected Results	2009 Expected Results	2009 Activity status	Objective met
Support for communes to establish mutuelles to provide funds to help families access care	240 Steering Committee members trained in implementation, management, monitoring and evaluation of mutuelle health organization 15% of communes will have established Mutuelle community credit/equity fund schemes to ensure eligible families to access health care	120 Steering Committee members trained in implementation, management, monitoring and evaluation of mutuelle health organization 7.5% of communes will have established Mutuelle community credit/equity fund schemes to ensure eligible families to access health care	75 Steering Committee members trained in implementation, management, monitoring and evaluation of mutuelle health organization The process of establishing health Mutuelles was launched in 4 new communes. The system is already operational in 2 older communes.	YES
Support for communes to achieve self-selected health objectives and be certified as "Kominina Mendrika"	30% of communes in the SW Region are certified as "Kominina Mendrika"	15% of communes in the SW Region are certified as "Kominina Mendrika"	52 communes in the SW Region, (i.e. 50%) are certified as "Kominina Mendrika in 2008	YES
Strengthening of supervisory capacities of RHO	4 RHO staff mentored in training of supervisors	2 RHO staff mentored in training of supervisors	9 of RHO staff mentored in training DHO Program Managers in supervision and QA	YES
Mentoring of RHO staff in training District Program Managers to provide supervision and quality assurance	9 Program Managers trained in supervision and quality assurance Increase in supervision and	5 Program Managers trained in supervision and quality assurance	18 Program Managers trained in supervision and quality assurance	YES

	quality assurance at health facilities			
Training for Local NGOs in BCC and Community Mobilization Approach	36 NGOs trained in BCC and CMA	18 NGOs trained in BBC and CMA	52 community trainers and 11 Supervisors trained in BCC and CMA	YES

Results

In October 2009, 6% of the RAA communes had health mutuelles, and 50% were certified "Champion Communes". NGO partners completed about 10,000 community mobilization activities through various approaches, mostly village theaters for mass communication and household visits for interpersonal communication.

Table 18: Capacity Building M&E Matrix

Data and Sources	Planned	Completed	Constraints
LQAS survey	2009	The protocol and indicators for analysis were prepared	Premature closure of the Project; Survey not conducted.
Reviews of supervisor, CHW, CBD and PVO monthly reports and checklists and trainer reports	Monthly	Data regularly collected at the DRSPF and MCDI	NEANT
Quarterly monitoring	Every Quarter	Quarterly meetings between the DRSPF and the project team	NEANT
Focus groups and interviews	Every 2 months	During the bimonthly journal conducted by local Supervisors	NEANT
Review of IMCI R-HSPA	During IMCI training	Made for the 82 CBS with at least one officer trained in IMCI.	NEANT
Under 5 child mortality impact on home care versus facility centered		DRAFT Protocol developed	Premature closure of the Project

and facility outreach			
Client satisfaction surveys	N/A		Premature closure of the Project; Not conducted
Formative Research Study	N/A		Premature closure of the Project; Not conducted

Results

In October 2009, 6% of the RAA communes had health mutuelle, and 50% were certified Champion communes. NGO partners completed about 10,000 community mobilization activities through various approaches, mostly village theaters for mass communication and household visits for interpersonal communication.

Table 19: Capacity Building M&E Matrix

Data and Sources	**Planned**	**Completed**	**Constraints**
LQAS survey	2009	The protocol and indicators for analysis were prepared	Premature closure of the Project
Reviews of supervisor, CHW, CBD and PVO monthly reports and checklists and trainer reports	Monthly	Data regularly collected at the DRSPF and MCDI	NEANT
Quarterly monitoring	Every Quarter	Quarterly meetings between the DRSPF and the project team	NEANT
Focus groups and interviews	Every 2 months	During the bimonthly journal conducted by local Supervisors	NEANT
Review of IMCI R-HSPA	During IMCI training	Made for the 82 BHC with at least one officer trained in IMCI.	NEANT
Under 5 child mortality impact on home care versus facility centered		The draft Protocol developed	Premature closure of the Project

and facility outreach			
Client satisfaction surveys	N/A		Premature closure of the Project; Not conducted
Formative Research Study	N/A		Premature closure of the Project; Not conducted

Data Quality

Technical mix

This section describes how the project used a combination of qualitative and quantitative techniques to make appropriate decisions and to monitor the results of its activities. The first section describes technical data sources for the project, followed by the M&E system, including the systematic collection and presentation of data throughout the project period. Finally, the strengths, weaknesses and limitations of the evidence presented in this final evaluation report will be discussed.

Description of Technical Data from the Project

The three techniques used to obtain project data are as follows:

First, MCDI used the Rapid Health Service Provision Assessment (R-HSPA) method developed by CSTS+ for analyzing health services in the project intervention zones. This assessment was done in early 2007 in 30 first-level public health facilities in TREIP's intervention area. As part of R-HSPA, a total of 60 observations of provider performance were conducted. Key findings have shown that only 47% of childhood illness cases had a complete history and exam exploring for danger signs; only 26% of ARI cases were assessed according to IMCI guidelines: 39% of them correctly classified, 24% treated according to IMCI guidelines; only 12% of diarrhea cases were correctly evaluated: 38% of them correctly classified, 12% treated according to IMCI guidelines; only 11% of fever/malaria cases were correctly evaluated: 39% of them correctly classified and 42% treated according to IMCI guidelines.

Based on the results of the survey, RHO and MCDI's attention were focused on poor infrastructure and equipment (such as potable clean water, cold chain), on stock outs of drugs and essential supplies and on provider performance. A large proportion was below IMCI standards for evaluation, classification and treatment of cases of fever, ARI and diarrhea. Providers provided poor counseling to caretakers in home management including lack of guidance about: continued feeding, increase breast milk and other fluids. Missed opportunities included not offering vaccines, vitamin A supplements or a dose of de-worming medicine during to clients during their visit to a health facility.

Second, a KPC cluster survey was conducted between November 2006 and February 2007, in thirty clusters with 10 children 0-23 months in each cluster. The primary objective was to measure baseline knowledge, practices and vaccination coverage in the target district prior to the beginning of project activities. The baseline survey was also aimed at contributing to the health situation analysis of the project area. The study population consisted of mothers of children under the age of 24 months. By restricting the sample to mothers of children less than 24 months of age, repeat surveys can ascertain the project's ability to reach children born during the life of the project. In addition, the indicators generated from the baseline will serve as the basis for the project's Health Situation Analysis (HSA) and Health Information System (HIS). The survey sampled children 0-23 months of age (for questions on breastfeeding and infant feeding); children of 6-23 months of age (for vitamin A coverage); and children of 0-23 months of age who were sick in the two weeks preceding the survey. The number of clusters selected per district was proportional to the population, and included six clusters in Toliara 2, five clusters in Betioky and 19 clusters in the other 7 districts conforming TREIP's intervention area.

Finally, qualitative studies were conducted to explain the KPC findings from 10 Focus Groups conducted mainly with mothers. These studies confirmed that inadequate household practices (such as prelacteal feeding of newborns) are deeply rooted in local traditions. For example, women believe that exclusive breastfeeding can only be practiced by well-fed women. Focus Groups also obtained information that women living in coastal areas work far from home and do not take the baby to their jobs, therefore they are unable to breastfed during the day. Participants in FGs said women reduce the frequency of breastfeeding given to the infant during diarrheal episodes because they believe that breast milk can make stools loose, worsening the duration or severity of the episode. Participants also said that women hide their pregnancies during the first months, to prevent rivals from being jealous (culturally referred to as the "evil eye") therefore many do not seek antenatal consultations until much later, when the pregnancy is clearly visible (six months or later). Focus Groups participants also mentioned that some women refuse to have ANC with a male provider, and some regard drugs during pregnancy a taboo. These may constitute barriers for Intermittent Preventive Treatment (IPT) initiation in the 2nd trimester of pregnancy. They also identified concerns about side effects of vaccinations as potential barriers for immunizations. In rural areas mothers are not informed about the immunization schedule, and claimed they could not afford to pay for new disposable needles to ensure safe immunizations. Mothers also mentioned increasing social instability as a reason for not traveling from rural hamlets to the health center to get vaccines.

Technical description project monitoring and evaluation

The Performance Monitoring and Evaluation Plan is designed to provide accurate and appropriate information that will allow program staff to monitor the implementation of the planned activities, measure progress toward the achievement of the expected results, and report on the overall success of the program strategy and objectives for reducing morbidity and mortality among children under the age of 60 months and improving the health status of women of reproductive age. A health information officer for the project was responsible for coordinating

and overseeing the collection of information and data within the project and with the partners. He also liaised with the MSFP statisticians, RHO and DHO information managers and Quality Assurance Teams on information sharing and data management.

A matrix including all indicators, primary and secondary data sources was developed to track progress in project activities and resulting outputs and outcomes. This performance monitoring and evaluation plan includes all the priority indicators of USAID child survival and health programs in malaria prevention and control, pneumonia case management, diarrhea prevention and treatment, breastfeeding, immunization, and HH/C-IMCI. The focus of the measurements in the matrix are children 0-23 months, pregnant women and mothers of children 0-23 months, including information on standardized indicators such as those in the IMCI Key Family Practices.

Several measurement methods were planned: both quantitative and qualitative, to routinely monitor progress and periodically evaluate performance. Methods and data sources include:

1. LQAS survey was planned to monitor changes at Mid-Term. In addition to baseline, mid-term and final surveys, sources of information will include: MSFP and partner reports on health services utilization to determine if utilization rates for key services are improving.

2. Reviews of supervisor, CHW, CBD and PVO monthly reports and checklists and trainer reports were designed as a way of collecting data for program monitoring. The training included a presentation of monthly reports for adoption both within the project and in the RAA. Nationally approved training protocols and guidelines, including reporting formats, were be adapted for the different levels of training. At the supervisory and community level, simple and easily applicable checklists and reporting/recording forms were adapted to be compatible with those used in the RAA HIS.

3. Quarterly monitoring was conducted through the District and Regional Health Information System through a limited number of key process indicators collected. This data collection system focuses on the availability and utilization of health care services provided through the public system and complements the MCDI HIS on all the major child survival, maternal and reproductive health indicators that are relevant to the goals and objectives of the project. Spot checks of clinic records and registers were also conducted to ensure that facility based reporting of information is complementary to community-based reporting of information, especially for those clients who are referred from home-based to community-based to facility-based services.

4. Throughout the project, Focus Groups and interviews involving clients, support group members, home and community-based care givers, and community leaders were planned on a regular basis to assess progress in the provision of health care and related support services. A baseline formative research study was implemented using these focus groups discussion. A BEHAVE exercise was used at baseline to identify prevailing beliefs and behaviors related to

child and maternal health that place them at risk. Information from these findings were used to design MCDI's behavior change interventions and focus group mini-studies were planned to assess changes in understanding and practices regarding child survival interventions. All CBDs and interested CHWs will be trained by MCDI trainers in the key IMCI behaviors identified through the Gaps Analysis, so CBDs and CHWs can assist communities to bridge the gap between ideal practice and actual behavior. The Gaps Analysis can be repeated periodically by communities that wish to track improvements in community practices within the framework of Champion Commune activities.

5. With the training of health facility staff in the clinical IMCI Protocols, emphasis was placed on tracking priority indicators of the baseline R-HSPA related to health worker skills, health system supports such as supervision, training coverage and drugs, equipments and supplies. The data was matched with the priority indicators for IMCI at the household and community level in malaria, pneumonia and diarrhea prevention, infant nutrition, home case management and care seeking behaviors of mothers and caregivers.

6. A study for estimating under 5 child mortality impact on home care versus facility centered and facility outreach was planned after the completion of the mid-term LQAS. The study protocol used a methodology from the CSHGP Lives Saved calculator, which is heavily based on the calculation sheets used by the Child Health Epidemiology Reference Group or CHERG. The initial focus of the study was on the following home-care interventions: (i) increased use of ITNs, (ii) use of anti-malarial drugs, (iii) appropriate treatment for diarrhea with OTR, zinc and Vitamin A, (iv) exclusive breastfeeding increased and (v) complementary feeding. Unfortunately this study was not complete due to the early termination of the project.

7. Client satisfaction surveys were also planned to qualitatively assess their levels of client satisfaction with the services received from the trained health care and service providers at the home and community levels, to complement the information from the exit interviews conducted at health facilities. A Formative Research Study was also scheduled on current knowledge and beliefs concerning vaccine-preventable diseases and barriers that prevent accessing immunization services in order to facilitate the development of plan with RHO, DHOs, and UNICEF to address obstacles and barriers to immunization.

   The wealth of methodologies planned as part of monitoring and evaluation of the project is indisputable. Unfortunately, most of them were not achieved because of the constraints summarized in Table 20.

Table 20: Summary of M&E Data for the project

Data and Sources	Planned	Completed	Constraints
LQAS survey	2009	The protocol and indicators for analysis	Premature closure of the Project

		were prepared	
Reviews of supervisor, CHW, CBD and PVO monthly reports and checklists and trainer reports	Monthly	Data regularly collected at the DRSPF and MCDI	None
Quarterly monitoring	Every Quarter	Quarterly meetings between the DRSPF and the project team	None
Focus groups and interviews	Every 2 months	During the bimonthly journal conducted by local Supervisors	None
Review of IMCI R-HSPA	During IMCI training	Made for the 82 BHC with at least one officer trained in IMCI.	None
Under 5 child mortality impact on home care versus facility centered and facility outreach		RAFT Protocol was developed	Premature closure of the Project
Client satisfaction surveys	N/A		Premature closure of the Project
Formative Research Study	N/A		Premature closure of the Project

Detailed technical data used for the final evaluation

The data presented in results tables of this final evaluation report (Table 6, Table 8, Table 10, Table 12, Table 14, Table 16 and Table 18), as well as in different sections is taken from four different sources:

a. Routine health statistics data: This data is collected at the BHC, then transferred to the district and regional health facilities. The databases are accessible at the district and regional level. The regional data managers find the completeness of data satisfactory.

b. Supervisory reports from members of the District Management Team, comprised of the MCDI project team and regional directors; These reports contain useful information such status

of indicators from supervisory training that is focused on improving the quality of service and performance of the agents.

c. Interviews conducted during the final evaluation. This is mainly qualitative information such as factors influencing project activities, procedures for collecting and using data, the effectiveness of partnerships, and problems encountered and lessons learned.

d. Preliminary results from the fourth Demographic and Health Survey (DHS) of Madagascar (EDSMD-IV), conducted between November 2008 to mid-August 2009 by the National Institute of Statistics (INSTAT). The report provides information on some indicators related to reproductive health, child health, malaria, nutritional status of children, the prevalence of anemia, infant and child mortality, and knowledge, behaviors and attitudes of HIV/AIDS. Unlike previous DHS, the reporting unit is aligned with the new administrative division by region. Unfortunately, many indicators are only presented on a national level, so it is difficult to see specific regional outcomes. The final version is scheduled to be released in April 2010.

With regard to the quality and accuracy of evidence presented in this report, the lack of specific surveys at the end of the project constitutes a major obstacle. The available evidence is clearly very weak and interpretations may be misleading. Of the 25 monitoring indicators shown in the results tables, the reliability of data can be summarized as follows:

- Only five monitoring indicators have reliable figures from valid sources: the anti-malarial drug intake during pregnancy, shown in the 2008 – 2009 DHS preliminary report; the vaccination drop outs available from the routine reports, the appropriateness of community case management through supervision reports and the communes that have health Mutuelle or those that have reached the status of Champion communes.
- For 25 indicators (table 20), either proxy computations with raw data were done to observe the trend or proxy data was used (for example the percent increase of population with access to a service point within a 5 km radius to estimate the increase of access and utilization of services.)
- Ten (10) monitoring indicators were not evaluated due to a total lack of data.

Table 21: Relationship between the Cross-Cutting Approaches and the project objectives on Malaria Prevention and Treatment

Indicators	**Source and interpretation of data**
Malaria	
Percent of children 0-23 months who slept under an insecticide treated bed net the previous night	The preliminary report of the 2008-2009 DHS has possession of ITN at the national level and also for the RAA. A rough calculation by simple rule of three is presented here, from the use of ITN by children of 0-23

	months at the national level
Percent of pregnant women who took an anti-malarial drug during their most recent pregnancy	This data is available in the preliminary report of the DHS 2008-2009
Percent of children with a febrile episode that ended during the last two weeks who were treated with an effective antimalarial drug within 48 hours after the fever began	Data not available. No alternative source
Percent of mother of children 0-23 months who continued feeding during the febrile episode	Data not available. No alternative source
Percent of mothers of children 0-23 months who know at least 2 signs of malaria that indicate a need for immediate treatment outside the home	Data not available. No alternative source
Number of stock-outs of essential malaria drugs in past reporting period	Data not available. No alternative source
Pneumonia	
Percent children aged 0-23 months with cough and fast/difficult breathing in the last two weeks who were taken to a health facility or received antibiotics from an alternative source	Data not available. Conclusion was reached by the increase in the percentage of population with access to the point of care for ARI in a 5 km radius
Number of stock-outs of essential pneumonia drugs in past reporting period	Data not available. No alternative source
Diarrhea	
Percent children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	Data not available. Conclusion was reached by the increased percentage of population with access to the point of care for diarrhea in a 5 km radius/ Interpretation of the total number of diarrheal cases registered at the CSB
Percent children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	Data not available. No alternative source
Percent children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	Data not available. No alternative source

Percent mothers who sought treatment at health center in the 24 hours of the first danger sign for diarrhea.	Data not available. No alternative source
Immunization	
Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines (card confirmed) before the first birthday	The preliminary report of the 2008-2009 DHS gives the same percentage as the APR but firsthand accounts from the mother were also taken into account
Percent of mothers who received at least two tetanus toxoid injections (card-confirmed) before the birth of the youngest child less than 24 months of age	The preliminary report of the DHS 2008-2009 shows the percentage of births covered, including 2 injections during pregnancy; 2 injections the last 3 years before last birth; 3 injections with the last 5 years before the last birth; 4 injections the last 3 years before last birth; or at least five injections before last birth
Percent of drop-outs between DPT1 and DPT3	Data is available in routine district reports
IMCI	
Percent mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment	Data not available. No alternative source
Percent clinical encounters with HW in HF in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea (from Clinical Observation in HF)	Data not available. No alternative source
Percent clinical encounters with CHW in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea	Data available by disease (Pneumonia, Diarrhea and Malaria) in the supervision reports
Capacity building	
Percent of communes with Mutuelle	Available in various project reports
Number of eligible families regularly receiving funds to access care	Not captured
Percent of communes certified as “Kominina Mendrika”	Available in various project reports

Percent of trained PMs in supervision who were assigned supervisory and QA duties in past quarter	Available in various project reports
Number of NGOs trained in BCC and CMA	Available in various project reports
Number of BCC campaigns organized and conducted by NGOs	Available in various project reports
Number and type of community mobilization activities conducted by NGOs	Available in various project reports

Data management and use for decision making

At the field level, data collection and reporting procedures in connection with the project are codified and well followed. The community – based worker filled out a pre-report form. The form is used as a draft to collect information to be included in the monthly report. The supporting technician – a TREIP project staff member – helps community workers collect information. Periphery officials play a leading role at that stage: the reports from community-based worker are checked by the Fokontany president before being forwarded to higher authorities. The supporting technician then works with the BHC manager on compiling and analysis. The transcription of all data is computerized to establish a database at the central level.

Concerning the management and sharing of data, quantitative and qualitative information collected during baseline surveys have been disseminated among program managers, NGOs and technicians in charge of collecting, processing and analyzing, and distributing health information. The analysis of this data was used for planning and developing the DIP.

Furthermore, TREIP strengthened the capabilities of project managers at the Ministry of Health, at the regional and district level, of health care providers, and NGOs partners in the use of information for decision making. The practical application occurs during periodic reviews organized by DRSPF and during planning exercises. Regional reviews are conducted every quarter – the aim is to review progress achieved during the previous semester and to plan activities for the next quarter. This process is used to stimulate the discussion about data available at the district and regional level.

Due to the present state of the national system, it has not been possible to integrate all the TREIP monitoring and assessment data into the SIGS, since the system does not allow the inclusion of further additional data.

Field actors have been supportive of the need for quality data, and have listed the following reasons data is useful:

- To define objectives and to plan related activities

- To measure the project's progress, to refocus and plan possible corrective actions
- Use as a scoreboard to measure indicator progress, to be posted in the commune office as decision-making tool
- As an advocacy tool

The same actors say they are satisfied with the efficiency of the system which allowed the supervisors to target priority the areas as well as reinforce and customize their plans. Practical examples mentioned for the use of data in program management and decision-making in the field include:

- Planning of advanced or mobile immunization strategies
- Strengthening awareness-raising activities by involving the Fokontany chiefs based on the study of their area performance
- Organizing active research on targeted programs
- Revitalizing activities of Health Mutuelles sites
- Rationalizing management of human resources based on performance, such as staff changes and the addition of extra workers.

Section D: Discussion of the Progress toward Achieving Results

Contextual Factors

Cultural, socio-economic context

Traditional beliefs and practices often have negative effects on child bearing and care seeking in certain regions of Madagascar (National Policy on Child Health, 2005). Mothers and children are often the victims, as care-seeking is frequently delayed because families choose to consult informal and traditional healers before seeking formal health services. There is at least one traditional healer in each Fokontany, and many households prefer to consult them before professional health providers. For some diseases - sunken fontanel and convulsions – the traditional healer is believed to be the most appropriate source of care. In some communities, measles are also thought to be supernaturally caused; the power of traditional healers is then acknowledged by the society.

RAA is one of the poorest regions in Madagascar. According to the CIA World Factbook, the per capita GDP is estimated at US$1,000 (2008 est.) The economic base for the RAA is agriculture, livestock, fishing, mining of precious stones and tourism; sapphire mining operations in the RAA have caused extensive labor migration. Inhabitants of the south are nomadic due to drought. Thus this group is more vulnerable as they migrate depending on the rains, impacting access to health care.

Gender equity remains poor in the region. For example, only men attend public meetings, and decisions regarding care-seeking for sick children or pregnant women are usually in the hands of the husband. Less than half of women polled for the DHS 03/04 survey reported making decisions alone on how to spend money they earn; married women were found to have significantly less autonomy than single women in these decisions. Furthermore, 28% of women polled reported agreeing with at least one of the justifications listed for a husband to beat his wife. According to 2003-2004 DHS, literacy rates in Toliara Province are 50% for females and 54% for males, however only 21% of women were found able to read an entire sentence. The age of first sexual intercourse in the RAA is the youngest in all of Madagascar at about 14 or 15 year old.

Factors which had an impact on the project's launch

During interviews conducted for this assessment, actors in the field, as well as beneficiaries, mentioned some hesitation at the beginning of the project. Some difficulties were noted concerning the way the project's approaches were understood, including KM. Much was expended to inform beneficiaries and to involve the authorities in order to obtain their commitment and support. According to the project's staff there was not enough time to prepare and explain the various aspects of the project to the authorities. The beneficiary mothers reported that some influential people within the community did not agree with the messages disseminated by the project. This situation made it difficult to gain the mothers' trust.

On the other hand, the availability of local authorities and the existence of a clear institutional framework facilitated the project launch. MDCI's field team believes that the project helped the government speed up the implementation of structures such as the CCD. This structure includes several decentralized services, such as the commune, the educational sector, the health sector, as well as regional leaders and important members of the community. The commitment of CCD members has made the implementation of those activities easier.

Community agents (or ACs) clearly played an important role during the project launch phase. Because they were already operational in the field and TAs were available contributed to a speedy and efficient launch. The same goes for the tools: the availability of reference documents about the introduction, clear guides and guidelines to establish objectives, and necessary data made it possible for the actors from the communes to get to work immediately.

Practical difficulties identified at the beginning included conflicts concerning the selection of ACs by Fokontany and the existence of infrastructures to ensure community-based case management in the framework of C-IMCI.

Factors which had an impact on the implementation

Compiling of local actors' opinions also made it possible to clearly highlight the importance of the collaboration between various stakeholders involved in the project. During the launching phase, it was reported that community-based workers already trained and operational in the villages – supported by TAs made available by the project – had a positive impact toward

changing mothers' behavior. Technical supervision by health care workers and institutional support from communes greatly facilitated field activities, and the constant presence of local VISA Mothers made it possible to maintain gains. During interviews conducted for this evaluation, beneficiary mothers said that the positive noticeable results they witnessed, helped contribute to their support for TREIP messages and activities.

The project staff considers that training and regular retraining of the actors are essential for a successful program. The quality of training modules and tools, as well as the experience of trainers, remain important to them.

In addition to the availability and the interest expressed by key stakeholders, and to their collaboration described above, the efficiency of the system has also been noticed by the community actors. The monthly reviews systematically organized at various levels have been mentioned to illustrate the system: the CDS and the ACs at the local level, the TAs, the SPs and the staff of EMAD at the district level, and the SPs with the DRS team at the regional level.

According to the ACs and the project's staff, the difficulty of access to services due to distance and security issues continue to be major obstacles. Access is considerably limited for remote villages, especially given the insufficient means of transportation at their disposal.

Intensive promotion activities during the Maternal and Child Heath Weeks, organized twice a year by the MSPF, have been very useful for the community workers in their activities. Institutional support at the national level, media support and strengthening of the community mechanism during these regular campaigns bring a particular energy to the on-going efforts of the volunteers. In addition, free distribution of insecticide-treated mosquito bednets by the MSPF makes ITNs more available at the household level.

Understanding the project's progress in its allotted timeframe

Obviously, all those involved regret the abrupt termination of the project. However, all mothers interviewed reported a remarkable improvement in their children's health. For example, some mothers from the village of Vatolatsaka confirmed a clear decrease in the number of febrile episodes with the use of ITNs and that, thanks to home-based case management, the severity and length of illnesses has decreased. Mothers from the village of Ambarimagnitse reported that before the project, four or five children would die in the village, whereas now deaths are rare. These statements were confirmed by health workers who noted a decline in emergency cases and an increased use of services at the BHC level.

It is important to note that the BHC staff has given a very positive assessment of the project. Their representatives think that the national campaigns organized by the ministry throughout the territory have helped reach the project's objectives, whereas nearly 70 percent of their performance indicators have been achieved thanks to the project.

How are implementation of strategies and key activities progressing?

This section explains how the implementation of key activities is progressing on the ground. The attention is focused on strategies that combine activities to achieve the project objectives. For each technical intervention and for each target, the contribution of the following cross-cutting approaches following is studied:

- Champion Communes
- Community Case Management
- VISA Mothers
- Community Radio
- Community-based Agents
- Skill based training and supervision
- Performance and Quality Improvement

A series of tables (from Table 22 to Table 27) illustrates which technical area results have been influenced by cross-cutting approaches and how this influence happens.

Malaria Prevention and Treatment

TREIP includes Malaria control as a key intervention because malaria is the most common cause of both morbidity and mortality in children under five in RAA and because malaria control is a priority of the MOH, which recently adopted an ambitious national plan requiring effective technical assistance for its implementation in the RAA.

In the fight against malaria, the project focused on three main objectives: (1) access and use of ITN by children under two years, (2) use of malaria medication by pregnant women and (3) early treatment with an antimalarial for children with feverish illness. Table 22 shows how the cross-cutting strategies acting on these three objectives.

The sale and distribution of ITNs are among the goals of KM. Thus, the performance of community workers on related activities are monitored by the CDS to achieve these objectives. In addition, VISA Mothers ensure close supervision of sensitization through tailored observation and guidance to mothers about the use of ITNs. These messages are reinforced by local radio programs and community workers who simultaneously sell products at the village level. They were trained specifically on the topic of prevention of malaria and especially the importance of using ITNs. At the BHC, women are encouraged to come to receive both health care and prevention advice.

The KM approach also promotes other key behaviors to prevent disease, and inform mothers about the prevention of malaria during pregnancy. VISA Mothers use personal experiences to educate mothers and radio messages reinforce these messages. Messages are focused on the health and nutrition of women during pregnancy and are part of the package of activities offered by community workers. They have been trained and technically supervised by TA and health personnel. Thus, by improving the environment and at home, women more frequently look for BHC care and adhere to advice.

The early treatment of febrile episodes (within 48 hours) of children is important in reducing mortality due to malaria. The supply of community-based care in remote villages is the rationale for the strategy of Community Case Management. With CCM, sick children are no longer obliged to be brought to the clinic to receive first aid. Awareness campaigns inform mothers about the existence of delivery points, and educate about danger signs and encourage them to seek care outside the home if necessary. These messages are transmitted through the local support of VISA Mothers, community workers and local radio programs. Product availability is ensured by antimalarial products ACTipal sold at the community level. Further, providers at community centers and CCM receive adequate training and regular monitoring and supervision to ensure quality of care. Additionally, the BHC staff have extensive training in IMCI and receive regular technical supervision.

Table 22: Relationship between the Cross-Cutting Approaches and the project objectives on Malaria Prevention and Treatment

Approaches used	Malaria Prevention and Treatment objectives		
	Increase from 26% to 60% the percent of children 0-23 months who sleeping under an insecticide treated bed net	Increase from 30% to 60% the percent of mothers who took anti-malarial medicine to prevent malaria during pregnancy	Increase from 17% to 55% the percent of children with a febrile episode treated with an effective antimalarial drug within 48 hours after the fever began
Champion Communes	Outreach activities, distribution and sale of ITN by pre-established goals	Outreach by pre-established goals	NA
Community Case Management	NA	NA	Community care of children with malaria in villages far from the BHC
VISA Mothers	Awareness, support	Awareness, testimony	Awareness, testimony

	and testimony of mothers on the use of ITN	and accompanying of pregnant women taking antimalarial	and accompanying research on parent care
Community Radio	Messages and educational programs on the use of ITN	Messages and educational programs on prevention of malaria during pregnancy	Messages and educational programs on care and danger signs
Community-based Agents	Awareness on the use of ITN Sale of ITN	Awareness on health and nutrition of women during pregnancy	Awareness on the care and danger signs Sale of Actipal
Skill based training and supervision	Training and supervision on the use of ITN	Training and supervision on the management of malaria during pregnancy	Training and supervision of health workers on IMCI clinical level of BHC, Training and supervision in the community care
Performance and Quality Improvement	Training and supervision of health workers on IMCI at the clinical level of BHC; Training and supervision in community care	Training and supervision of health workers on IMCI at the clinical level of BHC; Training and supervision in community care	Improving the environment and hospitality of BHCs, encourages women to seek care and advice

Table 23: Relationship between the Cross-Cutting Approaches and the project objectives on Pneumonia Case Management

Approaches Used	Project objectives on Pneumonia Case Management
	Increase from 28% to 60% the percent of children aged 0-23 months with cough and fast/difficult breathing taken to a health facility or received antibiotics from an alternative source
Champion Commune	Outreach by pre-established commune goals
Community Case	Community care of children with cough and difficulty breathing in the

Management	remote villages of BHC
VISA Mothers	Awareness, support, and testimony of mothers on the home care and referral of sick children
Community Radio	Messages and educational programs on care and danger signs
Community-based Agents	Awareness of the care and danger signs
Skill based training and supervision	Training and supervision of health workers on IMCI clinical level of BHC, Training and supervision in the community care, danger signs and the reference
Performance and Quality Improvement	Improving the environment and hospitality of BHCs, encourages women to seek care and advice there

Pneumonia Case Management

The original TREIP proposal did not include case-management of Pneumonia as an intervention because at the time of the project design, the MOH policy did not allow for the use of cotrimoxazole for the community case-management (CCM) of pneumonia. In 2006, the MOH conducted a pilot test of CCM using cotrimoxazole in the context of integrated community-based management of the sick child (Zinc/ORS, Cotrimoxazole, and ACT). MCDI, under TREIP, was responsible for implementing the new pilot initiative in two districts in the RAA amongst twelve districts identified at the national level. TREIP was to support the RHO extend this activity to all the RAA districts after the pilot phase.

In terms of controlling acute respiratory infections (ARI), the project aimed to provide adequate treatment to children, either at the BHC, or at a community point of delivery. Table 24 shows how the cross-cutting strategies helped reach this goal.

Awareness in the management of ARI and danger signs were included in the KM approach. The community care of children with cough and difficulty breathing - through the CCM approach - offering opportunities for children in remote villages to receive immediate appropriate treatment if necessary. VISA Mothers, community workers, and radio programming worked together to educate mothers about the existence of these alternative delivery points, on the recognition of danger signs, and the importance of seeking care in case of cough and respiratory difficulty. Using the PQI approach to train and supervise health staff to provide quality service at BHC, encouraged women to seek care and treatment at them.

Table 24: Relationship between the Cross-Cutting Approaches and the project objectives on Pneumonia Case Management

Approaches Used	Project objectives on Pneumonia Case Management
	Increase from 28% to 60% the percent of children aged 0-23 months with cough and fast/difficult breathing taken to a health facility or received antibiotics from an alternative source
Champion Communes	Outreach by pre-established goals.
Community Case Management	Community care of children with cough and difficulty breathing in the remote villages of BHC
VISA Mothers	Awareness, support and testimony of mothers on the care home and referral of sick children
Community Radio	Messages and educational programs on care and danger signs
Community-based Agents	Awareness on the care and danger signs
Skill based training and supervision	Training and supervision of health workers on IMCI clinical level of BHC, Training and supervision in the community care, danger signs and the reference
Performance and Quality Improvement	Improving the environment and hospitality of BHCs, encourages women to look for care and receive advice there

Prevention and Control of Diarrheal Diseases

Control of Diarrhea Diseases (CDD) has been selected as one of TREIP's interventions because of the following reasons:

- Diarrhea is one of the three primary causes of both mortality and consultations at health care facilities in the RAA
- 85% of Toliara households lack access to piped water (DHS 03/04)
- TREIP baseline surveys showed suboptimal household hygiene practices
- TPSCP have demonstrated success in implementing CDD interventions
- CDD is a priority for both USAID and the MOH at all levels

In 2006, the MOH in collaboration with BASICS, WHO and UNICEF, began pilot-testing its new diarrheal diseases control policy on the treatment of diarrhea with zinc and low-osmolarity

ORS in two districts of the RAA (Betioky and Sakahara). MCDI applied lessons learned from its experience introducing zinc therapy in South Africa under the MOST.

TREIP's diarrhea intervention combined prevention and treatment strategies. TREIP adopted a broad approach to the prevention of diarrhea, in which optimal breastfeeding, Vitamin A supplementation as well as measles immunization were key components. Other preventive measures are detailed in the behavior change strategy below. For treatment, TREIP extended CCM and clinical PCIME including new recommendations and guidelines on the treatment of diarrhea.

Four objectives were established in TREIP for diarrhea control: (1) increased amount of water given to sick children with diarrhea; (2) increased amount of food given to sick children; (3) bringing sick children to get adequate care at a health center at the first danger sign; and (4) use of oral rehydration therapy. Table 25 shows how these cross-cutting strategies have an effect on this package of objectives.

In order to reach the first two objectives, TREIP integrated diarrhea awareness in the KM approach. Thus, CHWs included messages about the importance of an abundant amount of fluids and good nutrition during diarrheal episodes in their home-based case management. VISA Mothers helped mothers adopt those simple measures into their regular routines and radio broadcasts reinforced messages at the community level. Training and supervision of community workers and VISA Mothers ensure an optimal quality for the techniques used to relay messages and to support practice at the household level.

The third objective of care-seeking at the BHC at the slightest sign of danger is also targeted through multiple strategies. As for the other objectives, awareness-raising in connection with the KM approach, testimony and support of VISA Mothers about signs of danger and referral are crucial for the strategies. Furthermore, care providers trained at PCIME-C sites played a specific role in this objective: during CCM, VISA Mothers recorded the transfers to BHC in cases of danger signs and encouraged mothers to bring their children in to seek the most adequate care. Training and supervision of health workers insure quality care at the BHC level, while the improved environment and reception at the BHC using the PQI approach encouraged women to come.

The last objective regarding the use of oral rehydration therapy was supported by health-care providers at C-IMCI community sites. Furthermore, the sale of ViaSur products improved the availability and access to care, especially among people living in isolated areas. A well-codified training, regular monitoring and close assistance ensured that the quality of advice and care was maintained.

Table 25: Relationship between the Cross-Cutting Approaches and the project objectives on Prevention and Control of Diarrheal Diseases

Approaches Used	Project objectives on Prevention and Control of Diarrheal Diseases			
	Increase from 26% to 60% the percent of children aged 0-23 months with diarrhea offered more fluids during the illness	Increase from 36% to 65% the percent of children aged 0-23 months with diarrhea offered the same amount or more food during the illness	Increase from 33% to 60% the percent of mothers who sought treatment at health center in the 24 hours of the first danger sign for diarrhea.	Increase from 18.5% to 32.9% ORT use
Champion Commune	CAs provide KFP diarrhea messages according to the original community objectives; These messages include the care home of diarrhea	CAs provide KFP diarrhea messages according to the original community objectives; These messages include the care home of diarrhea	CAs provide KFP diarrhea messages according to the original community objectives; These messages include danger signs and care seeking	CAs provide KFP diarrhea messages according to the original community objectives; These messages include danger signs and care seeking
Community Case Management	Community Providers and AVBCs improved availability and access to care among the population by distributing ViaSur; The AC has provided KFP messages on diarrhea	Community Providers and AVBCs improved availability and access to care among the population by distributing ViaSur; The AC has provided KFP messages on diarrhea	The AC provided key messages on diarrhea, use of transfer forms by C-IMCI sites for signs of danger; Mothers trusted community providers and followed their referral	Community Providers and AVBCs improved availability and access to care among the population by distributing ViaSur; The AC has provided KFP messages on diarrhea
VISA Mothers	Awareness, support and testimony of mothers on the management of diarrhea at home	Awareness, support and testimony of mothers on the management of diarrhea at home	Awareness, testimony and accompanying mothers about signs of danger and the reference of complicated case to the basic	Awareness, support and testimony of the mothers on the management of diarrhea at home

			health center (BHC)	
Community Radio	Messages and educational programs on the management of diarrhea at home	Messages and educational programs on the management of diarrhea at home	Messages and educational programs on the signs of danger and the reference of complicated case to the basic health center (BHC)	Messages and educational programs on the management of diarrhea at home
Community-based Agents	Education and health continued using multiple approaches (VAD, CIP)	Education and health continued using multiple approaches (VAD, CIP)	Education and health continued using multiple approaches (VAD, CIP)	Education and health continued using multiple approaches (VAD, CIP) Supply Viasur
Skill based training and supervision	Training and supervision over the management of diarrhea at home	Training and supervision over the management of diarrhea at home	Training and supervision on the signs of danger and the reference complicated case to the basic health center	Training and supervision over the management of diarrhea and BHC Home
Performance and Quality Improvement			Improving the environment and hospitality at BHCs, which encouraged women to seek care and advice	Improving the environment and hospitality at BHCs, which encouraged women to seek care and advice

Breastfeeding and Infant Nutrition

Toliara has the lowest levels of exclusive breastfeeding and immediate breastfeeding in Madagascar. Findings from the baseline KPC survey showed that a large gap exists between current practice and optimal breastfeeding and complementary feeding behaviors.

TREIP included breastfeeding as intervention because 1) it is one of the interventions in which the greatest impact was achieved during the BSCSP and TPCSP, 2) it is one of the six focus child survival interventions slated by MOH to be implemented as a priority in all districts; and 3) nutritional improvement in Toliara Province is a high priority for the national government. In addition, breastfeeding not only is a key TREIP intervention in itself, but also a strong entry point for other initiatives in nutrition improvement and diarrheal control.

For breastfeeding and infant nutrition, the project focused on two clear objectives: exclusive breastfeeding until six months of age, and breastfeeding within an hour of their birth. Table 26 shows how cross-cutting strategies have had an effect on those objectives.

In the KM approach, clear objectives for awareness-raising activities on exclusive breastfeeding were developed and followed by the CDS. Even at the CCM health-care delivery sites, mothers who bring their children to seek treatment automatically received breastfeeding advice. An environment encouraging the adoption of positive breastfeeding behaviors was created through tailor-made awareness-raising activities through the direct mentoring provided by VISA Mothers, a media program on local radio and the continual work of community workers. Training, retraining and supervision of community workers on exclusive breastfeeding maintain their commitment, while the improved environment and reception at the BHC encourage mothers to seek treatment and receive additional advice.

To promote the initiation of early breastfeeding (within one hour of birth) TREIP used three main strategies: awareness-raising activities at the community level targeting pregnant women; individually developed advice was provided during the antenatal visit; and women received assistance and advice from health workers when delivering their child at the BHC.

Table 26: Relationship between the Cross-Cutting Approaches and the project objectives on Breastfeeding and Infant Nutrition

Approaches Used	Project objectives on Breastfeeding and Infant Nutrition	
	Increase from 24% to 40% the percent of infants aged 0-5 months who were given breast milk only	Increase from 27% to 50% the percent of children aged 0-23 months put to the breast within 1 hour of birth
Champion Communes	Awareness activities on exclusive breastfeeding by pre-established goals	Advocacy on breastfeeding early by pre-established goals
Community Case Management	Integration of messages and support on exclusive breastfeeding for mothers who bring their children to community center	NA

VISA Mothers	Awareness, testimony and accompanying mothers on exclusive breastfeeding	Awareness, support and testimony of mothers breastfeeding early after birth
Community Radio	Messages and educational programs on exclusive breastfeeding	Messages and educational programs on breastfeeding early after birth
Community-based Agents	Awareness and support for mothers on exclusive breastfeeding	Awareness of pregnant women and childbirth preparation
Skill based training and supervision	Training and supervision of community workers on exclusive breastfeeding	Training and supervision of community workers and health personnel on early breastfeeding after birth
Performance and Quality Improvement	Improving the environment and home to BHC, which encourage women to look for care and receive advice	Improving the environment and home to BHC, which encourage women to come to antenatal clinics and receive advice and for delivery and have the assistance of staff

Immunization

TREIP identified Immunization as one of its key interventions because:

- Immunization is among the three highest priorities of the RHO, and one of the six priorities identified by the MOH in the National Child Survival Policy
- USAID/ Madagascar identified immunization as a priority
- TPCSP was able to demonstrate successful results in increasing childhood immunization coverage
- Childhood immunization coverage remain low on the other RAA districts
- TREIP thus fills the gap by instituting a community component and in revitalizing immunization service.

The project's objectives included: (1) increasing the percentage of children fully immunized before the age of one; (2) increasing births protected against neonatal tetanus by tetanus toxoid injections given during pregnancy; and (3) lowering the drop-out rate between DTCPHb1 and DTCHb3 among children. Efforts made by communities to reach these objectives show the importance of community commitment and participation in health programs. For example, in order to receive KM Status, communes often helped with the transportation of consumables and

inputs to the BHC. Table 27 shows that cross-cutting strategies worked for the three immunization objectives.

First, in order to support the full immunization of children, the KM approach defined precise awareness-raising objectives. Community workers were closely monitored and supported by the CDS in order to reach these objectives. All actors in the commune were involved in awareness-raising, census and active research. At the level of CCM sites, community-based health workers systematically used the PCIME-C checklist in order to verify the children's immunization status and to detect possible gaps. VISA Mothers also conducted awareness-raising, testimony and active research activities and they supported mothers to have their children immunized. Furthermore, educational messages and programs on child immunization were regularly broadcast on local radio. Training and supervision activities targeted health workers on PEV program management and also community workers on active research, checking of immunization cards and BHC referral. The improved environment and reception at the BHC encouraged mothers to bring their children to be vaccinated and to receive advice.

Concerning the immunization of pregnant women, awareness-raising objectives and activities were also defined and followed using KM tools. As for children immunization, the combined effect of VISA Mothers, community workers and radio programs encouraged pregnant women to use immunization services. Training and support to BHC, as well as the improved environment and reception through the Performance and Quality Improvement approach, improve the quality of care offered and increase patients' confidence.

Table 27: Relationship between the Cross-Cutting Approaches and the project objectives on Immunization

Approaches Used	Project objectives on Immunization		
	Increase from 33% to 60% the percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday	Increase from 29% to 60% the percent of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age	Decrease from 19% to 10% the percent of Percent of drop-outs between DPT1 and DPT3
Commons Champion	Awareness activities on immunization by pre-established goals Involvement of all stakeholders on the	Awareness activities on immunization by pre-established goals Involvement of all stakeholders on the	Awareness activities on immunization by pre-established goals Involvement of all stakeholders on the

	identification and active research	identification and active research	identification and active research
Community Case Management	Using the C-IMCI checklist can detect immunization status of children	N/A	Using the C-IMCI checklist can detect immunization status of children
VISA Mothers	Outreach, Testimony, action research and support for mothers on immunization of children	Outreach, Testimony, action research and support for mothers on immunization of pregnant women	Outreach, Testimony, action research and support for mothers on the continuation of the vaccination of children
Community Radio	Messages and educational programs on childhood immunization	Messages and educational programs on immunization of pregnant women	Messages and educational programs on childhood education.
Community-based Agents	Awareness, action research and support for mothers on immunization of children	Awareness, action research and support for mothers on immunization of pregnant women	Awareness, action research and support for mothers on the continuation of the vaccination of children
Skill based training and supervision	Training and supervision of community workers on immunization of children; Training and supervision of health staff on the management of EPI program	Training and supervision of community workers on immunization of children; Training and supervision of health staff on the management of EPI program	Training and supervision of community workers on immunization of children; Training and supervision of health staff on the management of EPI program
Performance and Quality Improvement	Improving the environment and hospitality of BHCs, which encourages women to bring children to receive	Improving the environment and hospitality of BHCs, which encourages women to bring children to receive	Improving the environment and hospitality of BHCs, which encourages women to bring children to receive

	vaccinations and advice	vaccinations and advice	vaccinations and advice

Community and Household IMCI

IMCI is by itself a cross-cutting component since it includes the control of the following childhood illnesses: malaria, pneumonia, diarrhea and malnutrition. However, three other objectives have been specifically defined in the DIP: mothers' knowledge of childhood illness, knowledge of signs indicating a need for a specific treatment, compliance with treatments offered during BHC visits at the community level. Table 28 shows the impact of cross-cutting strategies on those objectives.

For the first objective – reinforcing mothers' knowledge of childhood illness signs requiring treatment at the community and BHC level – activities and strategies used were similar to those described above. Those strategies consisted of: developing objectives and activities to be implemented through the KM approach; large-scale participation of local authorities and influential people within the community; mass media to sensitize mothers to the need to seek treatment outside the household; systematic advice and referral for danger signs by the CCM provider; awareness-raising activities and peer support by VISA Mothers based on their personal experience in childhood illness; and strengthening the capabilities of community workers through training and monitoring/supervision.

For the other two objectives regarding the compliance of treatments offered to sick children, efforts focused on the strengthening of heath workers' capabilities at the BHC level and of community workers at the level of CCM sites. The strengthening of skills was achieved through training, retraining, monitoring and formatives supervisions.

Table 28: Relationship between the Cross-Cutting Approaches and the project objectives on Community and Household IMCI

Approaches Used	Project objectives on Community and Household IMCI		
	Increase from 43% to 60% the percent of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment	Increase from 36% to 60% the percent of clinical encounters with HW in HF in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea	Increase from 0% to 60% the percent of clinical encounters with CHW in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea
Champion Commune	Awareness activities	NA	NA

	on immunization by pre-established goals		
Community Case Management	Community care in remote villages of BHC followed advice and reference danger signs	NA	Support Community standards, using appropriate tools (systematic checklists)
VISA Mothers	Awareness, testimony and accompanying mothers signs of childhood illness	NA	NA
Community Radio	Messages and educational programs on the signs of danger	NA	NA
Community-based Agents	Awareness on signs of childhood illness	NA	NA
Skill based training and supervision	Training and supervision of community workers about the signs of childhood illness that indicate the need for treatment at BHC	Strengthening skills of health workers at the facility: Training and upgrades IMCI clinical Monitoring/ supervision	CCM training agents to the required standard capacity building for community providers by monitoring and supervision
Performance and Quality Improvement	Improving the environment and hospitality services of BHCs, which encourages women to seek care and receive advice	Strengthening skills of health workers on prevention of infection and universal precaution Staffing infection prevention kits monitoring/ supervision	NA

Role of key partners

This section discusses the roles and responsibilities of project's partners on key activities and strategies. Table 29 summarizes interventions by key project's partners that have helped reach the results.

Table 29 : Role of key partners

Partners	Role in Project	Result of Collaboration
MOH	Leadership and coordination Program management at regional and district level Operational interventions for training, supervision and coaching of CHWs	Integration of the supervision: MCDI is conducting joint supervision activities with the MOH Integrated project implementation, particularly training, monitoring and evaluation
SantéNet 1	Technical and financial support in KM approach Financial support for Maternal Health and Family Planning components	Implementation of KM approaches in 52 communes Improvements of MCH indicators, namely immunization, prenatal care, nutrition and breastfeeding
PSI	Logistics for Social Marketing Products Training of CBD agents Joint supervision Monitoring ns Evaluation of Social Marketing program	Implementation of sales activities for social marketing products in 52 communes Improvement of children health indicators (ARI, Malaria and diarrhea) Integration of the implementation of the sales activities for social marketing products, particularly training, monitoring of activities and evaluation
BASICS	Collaboration in technical support to MOH Cost-sharing in Region and Districts Joint training, supervision and follow-up	Complementarities of resources (human, financial and material) in the implementation of Newborn Care Implementation of Newborn Care (pilot phase) in the communes of South Betioky District of South West Region Integration of the Newborn Care implementation to project activities, particularly monitoring of activities and

		evaluation.
FHI	Technical and financial support in community provision of injectable contraceptives	Implementation of community Depo Provera (pilot phase) in one commune of South Betioky District and three communes of Toliara II District
UNICEF	Collaboration for the technical support to MOH	Complementarities of resources (human, financial and material) in the implementation of Newborn Care Implementation of Newborn Care (pilot phase) in the communes of South Betioky District of South West Region Integration of the Newborn Care implementation to project activities, particularly monitoring of activities and evaluation.
NGO: VEMIMA, MIAINGA and ZATOVO	The main mission of the NGO was to strengthen the health facility staff and to support them during the implementation of TREIP community component	These NGOs fully managed the technical aspects of the implementation, the financial control partially remained with MCDI and the transfer of financial resource depended on the approval of agreed upon activity. MCDI had substantially invested in the strengthening of technical capacities of NGO on Child Survival interventions to ensure the sustainability of Child Survival.

Through these partnerships, MCDI achieved synergies that facilitated optimal use of human and financial resources of both MCDI and its partners. For example, the MOH supported TREIP by developing policies that favor community-based initiatives, while TREIP implemented these policies in the RAA. TREIP helped the MSPF to achieve their goals by establishing CBDs to sell ITNs and other commodities on a cost-recovery basis, and by training CHVs. The MOH, in turn increased MCDI's efficiency by coordinating with key partners such as UNFPA and UNICEF drawing their resources into the project area to strengthen the health system.

In addition, the CBDs were closely connected to PSI, as they allowed PSI's products to reach small and remote communities that have no retail outlets, thereby filling an acknowledged gap in the Social Marketing program in Madagascar. PSI provides commodities and technical support for TREIP, particularly in developing IEC materials and implementing BCC activities.

MCDI has also built a collaborative relationship with Voahary Salama and other local NGOs: TREIP built NGOs' capacity to plan and implement CS activities through technical assistance from Voahary Salama, and linked them to regional government's representatives for future technical and management assistance. These NGOs assisted TREIP to achieve its objectives by training community members to serve as volunteers and CBDs, and by supervising and monitoring their activities on a regular basis.

Section E: Discussion of Sustained Outcomes, Equity, Community Health Worker Models, and Contribution to Scale

TREIP made extensive efforts on the fundamental issues of sustainability, equity, community workers' role and scaling up of its various approaches. By sharing this experience, TRIEP has contributed to worldwide learning on several current topics related to community-based programs. This section discusses how the project has taken into account those issues during its development and implementation.

Progress toward sustained outcomes

Since TREIP is an expanded impact project, sustainability issues were always at the heart of its interventions. In very poor communities, where government health expenditure is very low, MCDI carefully planned its exit strategy and prepared Government counterparts and communities to be independent. Key questions include how the health system will maintain coverage of the whole region after the end of the project and what components can be taken over by local NGOs, how the quality of technical interventions will be maintained and how community participation and financing will be factored in.

Description of TREIP's sustainability strategies

In general, TREIP always implements its activities through the MSPF's structures and NGOs. In terms of specific strategies, three topics were critical for the sustainability of MCDI's activities:

The VISA approach: VISA Mothers were initially identified by the CHWs. They were then informed and trained on behavior change strategies using the VISA approach (Visit, Identify, Sensitize and Accompany). After visiting on average five mothers per VISA Mother, the VMs were then responsible for recruiting other new VISA mothers so an "automatic" recruitment system was in place to replace VMs who stopped for various reasons. This way, CHWs will be indefinitely renewed, and MCDI maintains and even increases the number of CHWs compared to its earlier projects.

Capacity strengthening: The capacity of the MOH to implement community-based activities is weak despite the fact that only about half of the population of the country has access to health facilities. By developing the capacity of the MOH staff and by strengthening its operational structures from the BHC, district and regional levels, TREIP ensured that that the performance of

counterparts will be maintained beyond its life. In addition, local NGO's capacity to accompany the MOH was reinforced through training, supervision, coaching, sub-grant management, evaluation and grant writing. The consortium Voahary Salama was assigned to coach and to follow up local NGO partners.

« *Health Mutuelles» concept:* This strategy proved its potential of continuity and viability during the TPCSP and was reintroduced in other communes under TREIP. The idea was to increase the access of the community to health care, independently through external financial support.

Sustainability possibilities learned from TREIP

During the project's evaluation, actors in the field have identified several factors contributing to the sustainability of gains. The main ones include:

- The representatives of beneficiary mothers believe that community workers and PCIME-C providers are very competent and that they are trusted. Though it seems that many of these mothers have already adopted those key behaviors, they still feel that they need the support from community workers.
- The availability of community workers and VISA Mothers trained at the village level are perceived as an important factor. However, there was a strong need for an assigned supervisor to ensure the technical quality of their work.
- The effective involvement of district teams, from the planning of TREIP activities to the selection, training and supervision of community workers is perceived as an important gain.
- The existence of an autonomous financial incentive system for the AVBCs through the sale of social marketing products could ensure the sustainability of their activities, provided that the products remain available and that health facilities continue to promote and sell those products.
- All actors in the field concur that a demand for quality health services has been created at the level of the targeted population. There are real health needs and the beneficiaries clearly expressed their satisfaction.
- The collaborative work system between the BHC manager and the community workers contributes to the sustainability of project progress. This is seen in the joint development of an awareness-raising program.
- The greater accountability of local authorities for all the community-based health-care activities by the district through COSANs has allowed ownership up to the peripheral level.

Critical factors for the sustainability of project progress following the project

A certain number of conditions have been mentioned in order to ensure the sustainability of gains after the project, including:

- Continuation of leadership and support of ministry officials
- Seeking a type of incentive for community workers through communal structures, in exchange for performances assessed in reports
- Availability of work tools, such as IEC material
- Availability of a structure for technical support and capability strengthening. Maintaining TAs to assist the BHC managers has always been identified as an absolute necessity
- Implementation of an efficient supply system with a clear distribution line and constant supply of products

Suggestions
To reinforce sustainability opportunities, the following actions have been proposed:

- Implement an independent system to ensure the motivation of community agents (ACs) over the long term. Two practical suggestions were mentioned: (1) subsidize community workers, like teachers supported by parents associations – known as Mpampianatra FRAM – and (2) regroup them into an association to pursue an income-generating and micro-credit activity
- Make mayors and Fokontany chiefs more accountable and systematically integrate community-based health activities into communal development plans ("PCD de la Commune")
- Make the BHC managers more accountable so that they can eventually fill the gap after the departure of TAs
- Systematically integrate community-based activities into health facility monthly reports
- Continue to support community workers with TAs and sustain their motivation
- Reinforce the partner network and diversify financing sources.

Attention to Equity
Many aspects of equity have been taken into account in TREIP, even if the links to equity have not been explicitly developed in the DIP. These are essentially inequalities having to do with access to care, which affect populations in remote areas and poor people.

Inequalities due to distance

TREIP has created area health-care structures which are accessible to beneficiaries. Through the use of community workers, the sale of marketing social products at the community level and the establishment of CCM structures, the project has targeted people living in remote villages. As for

the Ampanihy district, the priority selection of remote sites was a fundamental principle during the identification of start-up sites for the project.

The monitoring and evaluation system of the project makes it possible to follow the progress of access to care. For example, the interpretation of MCDI's database indicates that 31 percent of people have access to an IRA delivery point of care within 5 kilometers. The percentage is 54 percent for diarrhea care centers.

Injustice due to poverty

It is clear that the poorest people don't have access to the same care as wealthier people. However, the cost-recovery system implemented by the Government has made it possible to improve the availability of essential drugs. Yet, even though the price of drugs is reasonable, the system resulted in inequalities. An equity fund, build up with receipts from the sale of drugs, is an integral part of the system but practical issues remain concerning its operation.

In addition to problems affecting the country as a whole, the RAA is constantly facing increased poverty issues during the season between harvests. During such periods, the income of families is low and food reserves become depleted. Families give a lesser priority to heath care, as opposed to other vital needs.

TREIP is not an anti-poverty program as such. However, the health mutuelles approach aims specifically at improving care by removing the financial obstacle.

Other equity aspects

Discussions with actors in the field during the evaluation of the project made it possible to identify other equity aspects which have been taken into account by TREIP, including mainly:

- Inequalities caused by insecurity which exacerbate the remoteness of several RAA villages: the project helped make health care more accessible through community workers, social marketing at the community level and the CCM as described above
- Various forms of discrimination at the BHC reception – to solve this problem, a better reception system has been initiated in TREIP through the IPQ approach
- Inequalities linked to the gender approach that have been systematically addressed during discussions at the CDS level and forwarded through messages from community workers.

Formal and official platforms have been used to address those inequalities. In fact, local authorities follow the KM approach and there is always a close collaboration between FKT chiefs, for example using a census to identify and to prioritize services for the lower class. The health-care system is also an important platform through which to address inequality. CCM providers and providers who distribute injectable contraceptives are directly linked to the health system, and bring affordable services to rural or poor communities.

Role of Community Health Workers (CHW)

Community Health Workers played a critical role in the achievements of TREIP as efforts were focused on mobilizing, building, strengthening and supporting cadres of community based health workers to better address the needs of communities. This section describes the CHW model utilized and how it can be replicated and scaled up.

Description of the project's model for building the capacity of CHWs

The project has been very involved with CHWs in order to improve the knowledge and practices of mothers. These CHWs were initially identified by the community, and they were then recommended to BHC Managers and community authorities by influential people and the Fokontany chiefs. Selection criteria for CHWs include:

- Respected by the community
- Physical availability
- Personal motivation and conviction
- Communication skills

For more sophisticated responsibilities, such as community-based case management or the distribution of injectable contraceptives, additional criteria based on the level of education was also required. Reading and calculation skills were necessary to work with management tools.

CHWs work on a voluntary basis and free of charge. Their only motivation is the satisfaction of contributing to the good of their communities. In exchange, the project offers them training and capacity building, as well as the tools required for their work. The project also pays for expenses related to training sessions and meetings. At every opportunity, community workers are publicly recognized for their efforts, which helps validate their work. This recognition is an integral part of festivals celebrating the KM approach.

As for financial incentives, while they are sporadic and unstable, their effect on the enthusiasm of community workers is not insignificant:

- When there are financial incentive opportunities, such as the bi-annual MOH sponsored campaigns for Maternal and Child Care Week, CHWs are given the priority
- The sale of social marketing products generates some profit margin for the AVBCs. This sort of financial incentive stabilizes the system and encourages the community workers to reach pre-set quantitative objectives.

The project is aware that the CHWs cannot be motivated to go on forever. As a result, the VISA Mothers approach was developed. This approach – presented in more detail on page 19 – is aimed, on one hand, at facilitating contact with targeted mothers for a behavioral change, and, on

the other hand, at sustaining communication activities through an automatic renewal and recruitment mechanism.

Supervision of CHWs

The supervision of community workers presents real challenges. In principle, BHC managers are responsible for technical supervision, whereas Fokontany and communes are in charge of operational supervision. In reality, TAs play a key role for facilitation and technical assistance.

In the field, TAs and SPs support community workers in their daily work and facilitate the interaction between the Fokontany and Communes officials. They provide a first level of supervision by using a pre-established grid and provide technical mentoring in the field. They help also to prepare reports.

The shortage of health professionals prevents BHC managers from conducting regular supervision in the field. They integrate the supervision of community workers into their other visits to villages. Obviously, this supervisory position is limited by a lack of time and resources. However, during each monthly reporting period, the BHC manager checks the workers' technical skills and gives updates. Individual monitoring sessions are planned based on specific needs.

Mayors and Fokontany chiefs monitor the performance of community workers by reviewing the KM objectives. Based on this analysis of performances, reinforcement or corrective measures are decided and implemented by the authorities. The Fokontany chiefs prepare commune-specific reports about community workers' activities.

This supervision system, in theory based on existing structures (BHC and local authorities) relies on the TAs' technical assistance. However, even without an effective presence of TAs, a large percentage of community workers are ready to continue. For example, in the Morombe district, the District Chief Medical Officer says that 12 out of 23 workers remain fully operational, even after the TAs' abrupt departure.

Critical factors for the sustainability of the supervision system include:

- A deeper involvement of BHC managers, possibly with financial support from the district
- Collaboration between the community workers
- Periodic and regular boosting of health authorities (by a supportive visit at the district level and above)
- Use of technical resources on the ground, such as Community Trainers.

Suggestions
Suggestions gathered from those in the field include:

- Providing means of transportation to community workers
- Review of the incentive mechanism of community workers to include more reliable means of payment
- An increased accountability of local authorities (commune) with a written and signed commitment to support and maintain community activities
- A financial support specific to the BHC for the supervision of community workers
- The introduction of new training themes (first aid)
- An effective mentoring of community workers by health workers
- An adaptation of lessons from other sectors, for example the FRAM teachers which are paid by the community in various ways
- Sharing of good practices, such ACs working as second workers at the BHC level.

Scale strategy

Description of TREIP's strategies and plan for scaling up

As an expansion project, scaling up is central to TREIP strategies. In effect, from the TPCSP project which covered Betioky Sud and Toliara II to TREIP which covered the whole RAA region, the number of districts covered went from two to nine, and the number of beneficiaries increased by about 300,000 to more than 1 million.

In order to meet the challenges related to this expansion, scaling up strategies are an integral part. These strategies have been developed since the project was conceived and they are presented in the DIP as follows:

- Expanding through MOH structures: The RHO manages and oversees scale-up of intervention activities towards the DHO and community. The RHO therefore is the cornerstone of the scale up activities. Through joint planning of child survival activities in the RAA and integration of the TREIP work plan into that of the DHO, project activities and scale-up plan are institutionalized
- Relying on local NGO to support to MOH operational Unit at the district and health facility levels in the area of community mobilization and BCC: This strategy serves also to strengthen NGOs capacities: working under a sub-grant mechanism, the NGOs are reinforced in the area of organizational capacity by Voahary Salama (VS), a consortium of NGOs working in the areas of health, population and environment and whose principal purpose is to strengthen the capacity of national NGOs in these areas. Connecting the local NGOs with VS allows smaller NGOs gain better visibility, a stronger voice to plead in favour of child survival and approaches suitable within the framework of TREIP and market these approaches beyond Voahary Salama.

- Developing training sites for "new entry districts" and pre-service trainees: "showcase and demonstration districts" serve as training sites for the other districts in the RAA. Betioky Sud was established as a community health "showcase" district while Sakaraha, a new district in the new project area, was the "demonstration" district aimed at showing effectiveness of expansion approaches for the RAA. The showcase and the demonstration districts received further support and constant follow up from TREIP during the first two years in order to ensure that implementation is within the rules of intervention strategies and that the district are able to serve as a training site for the other RAA districts as well as other districts. MCDI collaborates with the Medicine Faculty of Antananarivo and the Institute of Paramedical training to identify sites in Betioky where students will be assigned to learn CS technical interventions, BCC techniques and the VISA approach, thereby expecting the use of these methods to the areas where students will practice after graduation.
- Phasing in of health facility and community-based activities on a "commune by commune" basis: This process attempts to have a project presence in each district in lieu of a progression from district to district (four districts during the first half of TREIP and then three others in the second half). The table below shows the planned phasing of the interventions according to the "commune to commune" approach, described in the DIP.

Table 30: Project extension and exit plan

DISTRICT	Number of intervention communes					Observation
	Phase 1 : start-up March 2009		Phase 2 : extension Apr 2009 to Sept 2010		Phase 3 Transfer and retreat Oct 2010-Sept 2011	
	Intensive intervention	Reduced support	Intensive intervention	Reduced support		
Betioky Sud	27	-	-	27	27	Show case district
Sakaraha	12	-	-	12	12	Demonstration District
Benenitra	2	-	2	2	4	-
Ankazoabo	2	-	4	2	6	-
Morombe	2	-	6	2	8	-
Ampanihy Ouest	2	-	14	2	16	-
Beroroha	2	-	6	2	8	-
Toliara 1	-	-	1	-	1	-
Toliara 2	-	23	-	23	23	Former TPCSP

Total	**49**	**23**	**31**	**74**	**105**	

Lessons learned concerning the strategic choice of scaling
Following an in-depth brainstorming about TREIP's gains, the MCDI team and its partners concluded that the approaches used have been the right ones but that there was not enough time to fully benefit from them:

- For the showcase, demonstration and teaching sites, the project has reinforced the sense of accountability, professionalism and commitment of the actors – i.e. the health professionals at the regional, district and CHC level, the authorities, the influential people and the community of showcase sites – concerning health-care development in the Sakaraha and Betioky districts. On the other hand, other RAA districts did not have a really opportunity to benefit from the existence of those showcase, demonstration and teaching sites. There has been only one site visit about mutuelles but the result has been excellent because the visitors have immediately established a mutuelle when they returned to their districts. However, the sites have greatly beneficial to other actors in other regions or countries.
- As for the collaboration with Ministry, the staff of MCDI and of the Ministry are convinced that there is now a very strong collaboration to put together a single team and to develop a single work plan. It helped the implementation of the project's activities. The ministry officials have recognized that the TREIP's activities are complementary to the Government's intervention. The long presence of MCDI in the RAA has brought about a mutual confidence and has facilitated ownership of TREIP's approaches.
- The evaluation of the collaboration with NGOs shows that the NGOs have been able to reinforce the SSD and BHC operational activities. This includes technical assistance, the implementation of activities per se, additional human resources in the BHC, materialized by TAs, and in the SSDs by the SPs. The incentive for NGOs to play this role was very important for a successful scaling. Furthermore, NGOs have played a role of intermediary and facilitator between the various actors.
- Regional Committee: MCDI is a full-fledged and active member of this regional steering committee, which means that it participates in the committee's meetings, has its share of responsibility in the implementation of the committee's program, and supports the logistics and material. The responsibility of the steering committee as sponsor and main partner for support, mentoring as well as social mobilization, has been one of the lessons learned concerning the success factors for the project. The steering committee has helped with the implementation of CDS/CCD, the advocacy to local authorities during the implementation of Kominina Mendrika, and has taken part in the Kominina Mendrika celebration.
- The implementation of the concept of progressive/incremental extension was cut short by the suspension of the project; it could have been further explored and generate more worthy lessons.

- The involvement model of the Commune to reach established objectives has been adopted by all the 52 intervention Communes. It facilitated the implementation of the project's activities and the community participation in the identification of ASBCs, as well as in the ownership of the Communal Development Committee and the Social Development Committee of the Project. They have also participated in the whole process of the project, especially in the launching of each activity at the Commune level and the self-evaluation of the project. This support from the authorities has given an institutionalized aspect to the approach and the project.

Input and influence of the project outside its intervention zones

Lessons learned from previous MCDI's projects, as well as from TREIP, have benefited other regions:

- Regional officials in the Menabe region, accompanied by partners from French cooperation, visited the RAA to share and learn about child survival programs and participative planning practices.
- Officials from Anosy and Androy regions have also come to the area to learn about the implementation of the KM approach and health mutuelles in the RAA,
- The person in charge of PCIME in the Betsiboka Region came for a field visit with his counterparts from Atsimo Andrefana.

Support to the health system and skill transfer to the Ministry

TREIP's support to the health-care system has included:

- Contributions to national efforts through an active participation in the celebration of the Maternal and Child, providing logistical support, and contributions for the supervision of the implementation of the campaign. MCDI has also fully participated in the development, testing and implementation of training modules for health-care workers on PCIME-C and the neonatal component in the clinical PCIME package.
- Contributions to regional efforts through support to the regional steering committee. MCDI is a full-fledge member of this regional steering committee, meaning that he participates in all the meetings of the committee, takes his share of responsibility in the implementation of the health-care program in the region. The development of regional IEC/BCC strategies, the establishment of a PCIME coordination committee and the establishment of a training pool in PCIME are also part of the support provided by the project at the regional level.
- Contributions to districts' efforts through the integration of the TREIP work plan into the District Development plan. Through this system, MCDI helps districts supervise the implementation of community-based activities through vicinity supervisors and NGOs which are TREIP's local partners.

- The transfer of skills to local actors, in particular to the staff of the Regional Health Directorate, is included in the sustainability plan adopted by TREIP. In practice the principle of "learning-by-doing," during the implementation of activities – such as Kominina Mendrika and the Quality Assurance System – have been mutually adopted.

Influence on national strategies and policies
As already mentioned above, several lessons learned during the course of the project have been incorporated into national strategies and policies. For example:

- Updating the clinical PCME algorithm, the development of the guide and modules for the implementation of PCIME-C drew largely from the TREIP's experience.
- The lessons learned from previous MCDI's projects, as well as from the scaling experience in connection with TREIP, have also been the starting point for the development of the National Community-based Health Care Policy. Many conceptual components of TREIP have been included in this policy.
- The national guide for the establishment of health mutuelles draws largely from the credit-type health mutuelle put in place by MCDI in Ankazomanga.
- The development of a national integrated supervision grid draws upon the RAA model, which was developed jointly by MCDI and DRS through previous projects and updated in the framework of TREIP.
- The Rapid Result Initiative approach – widely used in Madagascar in 2006, 2007 and 2008 in several development areas – uses many essential ideas of the KM approach, such as the development of objectives, the implementation and monitoring of activities, as well as self-evaluation.

MCDI has actively participated in meetings of national and regional committees on child health. It shares its experience and uses it to enrich debates with realistic field solutions. For example MCDI has assisted with the following:

- The semester review of the DRS Atsimo Andrefana in July 2008
- The mid-course review of CCM in 2008
- The review of tools for Newborn Care, in 2008
- Planning and evaluation meetings of SSME, held twice a year

Several meetings with organizations skilled in various fields were held in order to promote the complementary and synergy of skills:

- Meeting with the team of SantéNet 2 to explore possible future collaborations

- Meeting with FHI for scaling of community-based Depo-provera
- Meeting with IRH on the introduction of the fixed-day method in family planning

At the international level, a PCIME-C learning visit was organized in Betioky during the Inter-Country PCIME-C review which took place in Madagascar in June 2008. Furthermore, two countries – the Democratic Republic of Congo and Malawi – sent technical delegations to learn the PCIMEC process in the Betioky district.

Advocacy
Specific advocacy actions integrated into other activities were undertaken to strengthen the influence of the project at the national level. Examples include:

- The establishment of a documentation center in the Betioky showcase district
- A continuous sharing of experiences, lessons learned, and best practices with national-level technicians, local partners, and other regions during reviews of national programs
- Sharing and learning when welcoming regional, national and international visitors
- The effective involvement of MCDI as a member of several technical committees. Those structures constitute an advocacy platform at the national level; they include the Senior Committee on Child Survival, the Committee for the Development of a National Child Health Policy, the Reflection Committee for a Social Protection Policy (Population Ministry), the Regional Steering Committee, the National PCIME-Committee, the National Newborn-Care Committee, Voahary Salama, the Social Mobilization Committee, the SSME Committee, the Roll Back Malaria partnership.

Section F: Conclusions and Recommendations

This section presents the overall conclusions regarding the key areas of progress and challenges of this project, as well as its potential contributions locally, nationally, and globally. Lessons learned will be first presented, followed by the most important recommendations to better position the project to reach its results and objectives.

Key areas of progress and contributions to global learning
TREIP contributed to improving health knowledge and behavior of populations in the RAA with respect to malaria, infant and child nutrition, diarrhea, ARI and immunization through implementation of IEC/BCC programs, through innovative approaches such as VISA Mothers and through the expansion of its C-IMCI approach, including the expansion of CCM for diarrhea and malaria. Project's strategies were specifically designed to target vulnerable populations living in remote villages.

TREIP expanded the health impact achieved by its earlier projects in Betioky and Toliara II to all nine RAA districts through strong partnerships with local authorities and local NGOs. In

addition, TREIP worked with the MOH and the community of technical partners at the regional and national level to develop policies and programs that build on the innovative and successful approaches implemented in the RAA.

TREIP contributed to the global capacity and leadership for child survival and health through the sharing of the various approaches, tools and materials developed in Betioky Sud and Toliara, and the new districts covered by the project. MCDI shared the lessons learned with the child survival community through various opportunities such as the Inter-countries review of IMCI in August 2008.

Lessons learned and challenges

Lessons learned on scaling strategies

1. The regional anchoring of programs, along with NGOs support, facilitated the scaling up of complex programs such as child survival. In those cases, the regional level constitutes the « anchoring unit » for scaling.

2. Partnership is essential to success. The "win-win" concept constitutes the basis for negotiating with partners. This concept makes it possible to streamline the use of resources and to reinforce collaboration of field actions, while helping each party reach its own objectives. The benefits of partnership is illustrated by examples from MCDI/BASICS, MCDI/PSI or MCDI/SantéNet.

3. The learning sites could boost the scaling-up of very complex interventions such as mutuelles or PQI. Since the TREIP project has not been able to fully benefit from those teaching sites due to its early termination, more in-depth research and exploration seem necessary.

Lessons learned about implementation strategies

MCDI's experience through the implementation of TREIP has made it possible to draw a number of lessons. The most important ones mentioned by MCDI's team are presented below.

Human resources: The main difficulty with the implementation resides in the management of human resources. Indeed, the frequent turnover in health-care staff, which is in short supply, the weak leadership and relational skills, as well as the conflicts of interest which appear at all levels often impede the progression of such an ambitious project.

Community-based IMCI: The CCM strategy presently implemented in Madagascar is based on the principle of the health-care hut. Through this principle, only a very small proportion of the population is covered. A deeper integration into the Social Marketing network and the community based distribution could be a solution. In addition to that, the development of a "career plan" for community workers would allow us to sustain the professional motivation and

interest of those workers over the long term and would ensure that the activities will be sustained.

The management tools presently utilized could be revised to be more in line with the skills of those using them. A significant lightening and a drastic streamlining are required.

The supervision of Community-based IMCI sites should be integrated later into the routine supervision of the Ministry of Health. In this sense, resources used for this program could benefit to other priorities at the periphery.

Integrated supervision: The technical content of the model is certainly ideal but, in practice, its implementation requires 3 to 4 days for each BHC. In its complete form, its complexity makes routine implementation almost impossible. It would be more interesting to conduct it once a year for evaluation purposes and, in the meantime, to complement it with lighter, better targeted supervisions, more in line with needs.

Quality Assurance System (QAS)

It seems difficult to maintain the quality according to the normative approach presently used. An adaptative approach could be an alternative: the objectives could be developed according to the clients' ideas. In technical terms, a study conducted by MCDI has shown that 90% of clients felt that the present quality of services is acceptable, whereas less that 40% of standards have been reached by the BHC. It will then be necessary to find answers such as the development of a culture of quality by raising the perception standard or by developing a quality marketing system (accreditation).

External support, especially coming SSDs, for technical mentoring and input supply, remains indispensable and an approach aiming at integrated interventions will be needed, rather than working in isolation on technical interventions.

The lessons learned during the test to integrate QAS and KM show that community mobilization and contribution for the BHC will be more easily obtained due to the accountability of both parties (BHC and the community). Even though much more work is needed to adapt the implementation stages, the duality "supply-demand" seems to have been better addressed with an integrated approach.

- Health Mutuelles: Through TREIP, MCDI has learned that it is much better to initiate activities based on community need and motivation, rather than trying to start when the community has not clearly expressed its needs. The establishment of a mutuelle is a long-term endeavor which required a great amount of awareness-raising and mobilization, and will be much more effective with community participation and motivation.
- Communal Committees: MCDI's successive projects, TREIP in particular, confirmed that well-structured and well-motivated CDSs are essential to succeed. They ensure undoubtedly the sustainability of community-based programs.

- Provision of service at the community level (C-IMCI and injectable contraceptives): These interventions require a rigorous monitoring by health-care professionals. The establishment of a strong monitoring and mentoring structure is therefore indispensable since their operational capacities are already overwhelmed. Contracting with community workers and an increased accountability of local NGOs are among possible solutions to meet supervision challenges.

Key Recommendations

Based on a study of opinions collected during the evaluation, and bringing its own suggestions, the evaluation team presents the following recommendations:

Recommendations for MCDI

IN THE SHORT TERM: MAINTAIN THE GAINS EVEN IF THE PROJECT IS OVER:

- Find ways to continue the periodic training of community workers and provide them with the IEC material to keep them interested and to sustain their performance
- Continue to support BHC managers and strengthen their capacity, by supporting the health-care system
- Develop alternative area support approaches, fashioned after the TA model. For example, strengthen the capacities of community-based trainers who will eventually take over
- Collaborate with PSI in order to ensure that an adequate stock of social marketing products is available at the district and commune level.

IN THE MIDDLE TERM: REVIEW CERTAIN POINTS IF ACTIVITIES RESTART

- Maintain and continue to scale up the VISA Mothers approach; beneficiary mothers have said they wish to see the continuation of the mentoring system
- Review the nature and the conditions for grants to communes since the grants become sometimes an obstacle due to conflicts of interest
- Reorganize the infrastructure or install the office of community workers at the commune level to give them greater visibility
- Institutionalize or streamline the reporting system so that health-care workers can effectively monitor community workers
- Revise the incentive system of community workers and give them adequate means of transportation for a more equitable treatment of those who work in remote villages
- Review the CCM supply system by integrating the “Circuit Salama” for essential drugs.

Recommendations for financial partners, USAID in particular

- Do not stop the financing of Maternal and Child programs in Madagascar

- When possible, reinstitute activities in the RAA to sustain the project gains
- Regularly update the work material of community workers, such as their backpacks, binders and IEC material
- Provide the community-based program with vehicles
- Leave the materials for the public organizations at the end of the project
- Strengthen the supply system for drugs for the community-based PCIME program
- Always allow for a transition period before programs are terminated
- Periodically visit intervention zones to assess the results of investments and to encourage actors in the field.

Recommendations for partners

- Equalize the amounts allotted to SSME participants and strengthen ACs' capabilities
- Coordinate with mayors/BHCs to organize activities at the community level
- Organize an exchange of experiences and cross-learning between communes and various organizations.

Recommendations for the Ministry of Health

- Continue to use the principles and methods of the KM approach to implement health-care programs at the community level
- Apply the principles of the quality assurance system to all components of the health-care system, and not only to the health-care delivery level.

Annexes

Annex 1: List of Publications and Presentations Related to the Project

Project Presentations:
- Inter-country Review of IMCI (August 2008)
- Planning meetings and evaluation of the SSME (twice per year)
- Mid-Year Review for the Regional Department of Health-Atsimo Andrefana. (twice per year)
- Midterm review of Community Case Management (2008)
- Visit of Representatives from the Democratic Republic of Congo Ministry of Health.
- Bill & Melinda Gates Foundation Presentation

Annex 2: CHW Training Matrix

Project Area (name of district or community)	Type of CHW	Official Government CHW or Grantee Developed Cadre	Paid or Volunteer	Number Trained over life of project	Focus of Training
Dhoti and Kailali Districts	Female Community Health Worker	Government	Volunteer	1893	Counseling and CB data collection/analysis Mgmnt of danger signs for Hypothermia; Birth Asphyxia; LBW
Dhoti and Kailali Districts	Maternal Child Health Workers	Grantee-developed cadre	Paid	72	Supervision Technical and counseling skills re: Hypothermia; Birth Asphyxia; LBW
Dhoti and Kailali Districts	Village Health Workers	Government	Paid	72	Supervision Technical and counseling skills re: Hypothermia; Birth Asphyxia; LBW

Annex 3: Evaluation Team Members and their Titles

- Dr Joséa Ratsirarson, MCDI Project Manager
- Dr Jerry Rakotozafy, MCDI M&E Manager
- Dr Serge Raharison, Consultant
- Dr Raymond Daniel, RHO RAA
- Joseph Carter, MCDI Director
- Dr Wendy Ravano, Consultant
- Betsy Wild, MCDI International Health Associate
- Elizabeth Monnac, Translator

Annex 4: Evaluation Assessment Methodology

The various phases below are presented in a linear fashion. In reality, they follow an iterative process, with "back-and-forths" based on needs identified during their implementation.

i. Review of documents and development of analysis matrixes

This is the preliminary stage for the work to be done. All reference material concerning the policies, strategies and activities of MCDI, put at the disposal of the consultant, will be studied. There will also be bibliographical searches and its own resources will be used to obtain a documentation as exhaustive as possible.

The review of documents will allow the consultant to grasp and to highlight the key points of the project. Analysis models (canvas) will be developed to answer key questions required for the report.

ii. Briefing with MCDI

Technical work sessions will be organized with MCDI managers at the Antananarivo headquarters. These sessions will allow the consultant to gather opinions and expectations, and they will also be an opportunity for the consultant to bring its own suggestions and insights. The following questions will be reviewed, clarified and confirmed:

- What is the current situation?
- What are MCDI's expectations?
- What are the key questions to be answered?
- What information is already available?
- What information is not available?
- How are we going to find answers?

– In practice, how are we going to organize ourselves to complete the evaluation work? – detailed calendar – appointments – practical organization.

iii. Development of data collection tools

Data collection tools will be developed based on terms of reference, information obtained from the review of documents and precisions received during the briefing. They will be developed, among others, for:

- MCDI managers,
– Partners: PSI and SantéNet (1 and 2),
– Partners in the field, including NGOs officials, community workers and health-care staff,
– Representative of beneficiaries.

The tools can be developed, if necessary, as a Managed Discussion Guide (focusing of targets, depending on the information required).

All tools will be presented and validated by MCDI before being used in the field.

Project documents and data from CSB/SSD/DRS will complement the information.

iv. Collection of data

The collection of data will be done using various methods: individual interviews, conference calls, or interactive groups.

MCDI team will decide which appropriate methodologies to use based on time and material resources available to the consultant, as well as the relevance of data for the information required.

v. Assessment workshop

Key partners will be invited to a one- or two-day workshop in Toliara. The main objectives of the workshop will include:

– The validation of results obtained by the project,
– The determination of lessons learned,
– The development of recommendations.

The development of the final objectives and the agenda will be discussed with MCDI team based on the time and material resources available to the consultant, as well as the information to be collected.

vi. Writing

The writing part per se of the Policy will be guided by the results obtained from approaches previously described, i.e.:

– The documentary review,

– The briefing of shareholders,

– Information from data collected, processed and analyzed,

– Recommendations from the evaluation workshop.

After the adoption by MCDI of the detailed calendar, a list of key persons who will contribute to the feedback on the report will be established. Feedback gathering will be conducted in two ways:

– Sharing via e-mail: preliminary documents and previous DRAFT versions will be shared by electronic mail. The consultant will gather feedback from e-mailed answers, will prepare a summary and include comments and suggestions in the documents.

– Sharing through direct interaction: Several work sessions will be organized to allow the consultant to report on the progress to MCDI, and also to gather specific recommendations.

vii. Pre-feedback

The consultant will prepare and conduct a pre-feedback session at MCDI and USAID Madagascar:

The main objectives of the session will include:

– Sharing the main results, key recommendations, and the draft of the report,

– Give an opportunity to the USAID Mission team to provide its input in order to improve the document.

viii. After the pre-feedback, the consultant will include the feedback from MCDI Madagascar and USAID Madagascar, will submit a Final DRAFT to be forwarded to MCDI USA headquarters for feedback.

KEY DATES:

- 20 October 2009	Start of consultant work
- 10 and 11 November 2009	Evaluation workshop, Toliara
- 24 November 2009	Pre – feedback meeting at USAID Madagascar
- 25 November 2009	Final DRAFT report sent for comments to MCDI HQ

Annex 5: List of Persons Interviewed and Contacted during the Final Evaluation

- Benjamin Andriamitantsoa, USAID Madagascar FP and CS Manager
- Dr Joséa Ratsirarson, MCDI Project Manager
- Dr Rija Fanomeza, MCDI
- Dr Jerry Rakotozafy, MCDI M&E Manager
- Dr Razafimanantsoa Nelson, Conseiller en Qualité de Soin MCDI
- Ratovomanantsoa Iadanako, MCDI, Program Assistant
- Moma, MCDI, Responsable Activités communautaires
- Razafinantoany Dany, MCDI, Superviseur de Proximité du district de Sakaraha
- Randriantsoa Edmée, MCDI, Superviseur de Proximité du district de Sakaraha
- Remeky Eric, MCDI, Superviseur de Proximité du district de Ampanihy Ouest
- Rabekoto Heritiana, MCDI, Superviseur de Proximité du district de Ampanihy Ouest
- Razakason Oly, MCDI, Superviseur de Proximité du district de Toliara II
- Rakotobe Jeanne Natoetse, MCDI, Superviseur de Proximité du district de Benenitra
- Rakotondramamy Andry, MCDI, Superviseur de Proximité du district de Beroroha et Ankazoabo
- Monique, MCDI, Superviseur de Proximité du district de Betioky
- Razanamonjy Calvain, ONG Zatovo
- Mme Eugénie, ONG Zatovo
- Tinahy Alexandrin, MCDI, Technicien Animateur d'Ampanihy
- Tsaboto Francis, MCDI, Technicien Animateur de Betioky
- Rasoazanany, MCDI, Superviseur de proximité de Betioky

PARTICIPANTS INTERVIEWS IN TOLIARA

- Nasolo Zafintsire, Agent communautaire de Betioky sud
- Ramaria Jeanne, Agent communataire
- Nadine Ramarson, Mère bénéficiaire du Projet sise à Vatolatsaka (District de Betioky Sud)
- Resampotse, Mère bénéficiaire du Projet sise à Vatolatsaka (District de Betioky sud)
- Nenivao, Mère bénéficiaire du Projet sise à Vatolatsaka (District de Betioky sud)
- Rasoamihanta, Mère bénéficiaire du Projet sise à Vatolatsaka (District de Betioky sud)
- Soafetinirina, membre Comité de développements social de Vatolatsaka (district de
- Betioky sud)
- Razanamahasolo, membre Comité de dévellopement social de Vatolatsaka (district de
- Betioky sud)
- Mahazoasy, Agent communautaire d'Andranovory (District de Toliara II)
- Mosa Renato, Chef de centre de santé de base d'Andranovory (District de Toliara II)
- Randriatelo, membre Comité de développements social de Andranovory (district de Toliara II)
- Rakoto Jean Brito, membre Comité de développements social de Andranovory (district de Toliara II)
- Rasiline, Mère bénéficiaire du Projet sise à Andranovory (District de Toliara II)

- Ndremamany Odile, Mère bénéficiaire du Projet sise à Andranovory (District de Toliara II)
- Narisoa Fanja, Mère bénéficiaire du Projet sise à Andranovory (District de Toliara II)
- Mbohohainy, membre Comité de développements social de Vinenta (district de Sakaraha)

Annex 6: Project Data Form

Updated and printed from www.childsurvival.com/projects/dipform/login.cfm