TOLIARA REGIONAL EXPANDED IMPACT PROJECT

ATSIMO ANDREFANA REGION, MADAGASCAR

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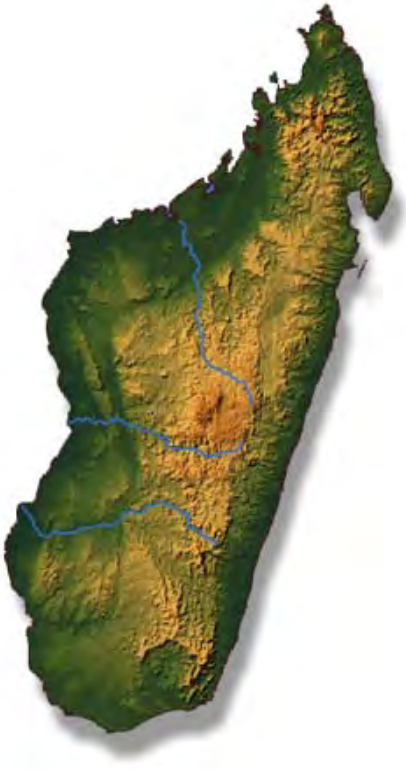

MADAGASCAR

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ACRONYMS

ACT	: Artemisinin-based Combination Therapy
AME	: Allaitement Maternel Exclusif/ Exclusive Maternal Breastfeeding
ARI	: Acute Respiratory Infections
ASB	: Agent de Santé de Base/ Basic Health Agent
ASBC	: Agent de Service à Base Communautaire/ Community Service Agent
AVBC	: Agent de Vente à Base Communautaire/ Community Sales Agent
BASICS	: Basic Support for Institutionalizing Child Survival
CCC	: Communication pour le Changement de Comportement/ Behavior Change Communication (BCC)
CCD	: Comité Communal de Développement/ Community Development Committee
CCM	: Community Case Management
CDS	: Comité de Développement Social/ Social Development Committee
CPN	: Consultation PréNatale/ Prenatal Consultation
CS	: Child Survival
CSB	: Centre de Santé de Base/ Basic Health Center
CSTS	: Child Survival Technical Support
CRESAN	: Crédit pour la Santé (Projet de la Banque Mondiale)/ Health Credit (World Bank Project)
DIP	: Detailed Implementation Plan
DRSPF	: Direction Régionale de la Santé du Planning Familial/Regional Management for Family Planning Health
DSFA	: Direction de la Santé Familiale/Family Health Management
EMAD	: Equipe de Management du District/ District Management Team
FAR	: Femme en Age de Reproduction/Women of Reproductive Age (WRA)
FAF	: Fer Acide Folique/Folic Acid and Iron
FDF	: Formation des Formateurs/Training of Trainers
FF	: Flexible Fund

FGD	: Focus Groupe Dirigé/ Focus Group Discussion
FY	: Année Fiscale/Fiscal Year
HFA	: Health Facility Asssessment
IEC	: Information Education Communication
IRA	: Infection Respiratoires Aigues/Acute Respiratory Infections
ISTs/SIDA	: Infection Sexuellement Transmissible/Syndrome d'Immuno Déficience Acquise / Sexually Transmitted Infections/ AIDS
JHU	: Johns Hopkins University
KAP	: Knowledge Attitudes Practices – KAP
KM	: Kominina Mendrika (Commune Championne)
KPC	: Knowledge, Practice and Coverage
MAP	: Madagascar Action Plan
MCDI	: Medical Care Development International
MINSANPFPS	: Ministère de la Santé du Planning Familial et de la Protection Sociale/ Ministry of Health of Family Planning and Protection
OMS	: Organisation Mondiale de la Santé/ World Health Organization
ONG	: Organisation Non Gouvernementale/Non Governmental Organization
ONN	: Office National de Nutrition/ Office of National Nutrition
ORS	: Oral Rehydration Solution
PCIME	: Prise en Charge Intégrée des Maladies des Enfants/ Integrated Management of Childhood Illnesses (IMCI)
PCIME-C	: Prise en Charge Intégrée des Maladies des Enfants niveau Communautaire/ Grassroots Integrated Management of Childhood Illnesses
PEV	: Programme Elargi de Vaccination/ Expanded Immunization Program
PF	: Planning Familial/ Family Planning
PSI	: Population Services International
PMI	: The President's Malaria Initiative
PNC	: Prenatal Consultation
QAS	: Quality Assurance System
RAA	: Région Atsimo Andrefana/ Atsimo Andrefana Region
RSO	: Région Sud Ouest: South West Region

SRO	: Solution de Réhydratation Orale
SSD	: Service De Santé de District/ District Health Service
SSEA	: Service de Santé de l'Enfant et de l'Adolescent/Child and Teen Health Service
SSME	: Semaine de la Santé de la Mère et Enfant/ Mother and Child Health Week
TREIP	: Toliara Region Expanded Impact Project
TRO	: Traitement par Réhydratation Oral/ Oral Rehydration Treatment
UNICEF	: Fonds des Nations Unies pour l'Enfance/ United Nations Children's Fund
USAID	: United States Agency for International Development
VEMIMA	: Vehivavy Miara-Mandroso
VISA	: Visiter Identifier Sensibiliser Accompagner/Visit Identify Sensitize and Accompany

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Introduction

Toliara Province has the second highest neonatal mortality and the highest mortality of children under-5 in Madagascar. The percentage of fully immunized children is only 28% and malaria prevalence is very high. About 54% of deaths occurring in children under -5 are related to malnutrition, of which sub-optimal breastfeeding is a contributing factor. The majority of households (70%) are using surface water as drinking water and do not have access to latrines. As a result, diarrhea is one of the three main causes of morbidity among children under five in the country.

Since 1998, MCDI has been providing support to the Madagascar Ministry of Health (MOH) in the execution of health policies and programs, particularly those aimed at mothers and children through its USAID-funded Child Survival project operating in Betioky Sud District and Toliara II District, in Toliara Province. Beginning in October 2006, MCDI began to expand both its intervention package and geographic coverage to include the whole Région Atsimo Andrefana (RAA). Funded by TECSPG, this new 5-year initiative is called the *Toliara Region Expanded Impact Program* (TREIP) and will continue through September 2011. The project aims to expand operations from the two districts of Betioky Sud and Toliara II to the remaining seven districts: Toliaria I, Sakahara, Beroroha, Morombe, Ampanihy, Ankazoabo, and Benenitra. This area has a total population of 1,078,000 inhabitants living in 1,379 *Fokontany* (villages), 105 *Communes* and nine Districts. The beneficiary population includes 178,400 children under-5 and 256,450 women aged 15-49 years – a total beneficiary population of 434,850.

TREIP's goal is to contribute to the reduction of mortality and morbidity among children under-5 and improve the health status of women of reproductive age in RAA. The intervention will focus on immunization, breastfeeding and household and community case management of diarrhea, acute respiratory infections (ARI), and malaria. TREIP will be supportive of four of the six child survival objectives that the Ministry of Health Family Planning and Social Protection (*MINSANPFPS*) has identified in its National Child Survival policy aimed at reducing under-5 mortality by 50%. These four objectives are pilot testing of zinc, low-osmorality ORS,

cotrimoxole, and transition to Artemisinin-based Combination Therapy (ACT) as a first-line drug for treatment of malaria in health facilities.

These interventions are being implemented in accordance with the IMCI framework and will support the RAA Regional Directorate for Health and Family Planning (*DRSPF*) for the successful expansion of child survival approaches and strategies. These scale-up strategies include:

- Expansion of successful approaches such as the Visitor Identify Sensitize and Accompany (VISA) approach, *Kominina Mendrika (KM)*, Community Radio, Child-to-Community Program, and Quality Assurance System (QAS) throughout the RAA.
- Establishment of Betioky Sud as a "Showcase District" and the Sakaraha District as a "Demonstration District" in community health for the RAA. At the request of the DRSPF, MCDI will train the SSD and NGO personnel of the seven new districts in the utilization of a range of IMCI-C approaches and tools. TREIP will gradually implement activities district by district. During Years 1 and 2, TREIP will introduce activities and provide intensive support to four of the new districts. The three remaining districts will be addressed in Years 3 and 4. In Year 5, interventions will be transferred to local partners to assure long-term sustainability.
- Creation of partnerships among MCDI and the Faculty of Medicine of Antananarivo and the Paramedical Training Institute to identify prospective practicum sites in Betioky and Toliara II where students can be assigned to apprenticeships on child survival technical interventions.
- Participation of MCDI in several national and regional committees. This will promote the approaches proven to be efficient such as *Kominina Mendrika*, Community Case Management of diseases, and *Mutuelles de santé*. The MINSANPFPS will coordinate all key partners including UNICEF, SWAP and NGOs to maximize resources in RAA, creating a synergy with TREIP.
- Decentralization of the Regional RAA programming to the health centers to strengthen the capacity of DRSPF in coaching SSDs as well as the training, supervision, and implementation of child survival programs. Supporting these activities regionally will involve expanding clinical IMCI, establishing a quality assurance system in at least 50%

of the Basic Health Centers (CSB) of RAA and developing a regional steering committee under the guidance of the RAA Bureau for the coordination of efforts in the health sector.

- Adoption (and continuous practice) of key health behaviors by families and communities through community action. This framework includes: the expansion of IMCI-C implementation, IEC/BCC approaches such as VISA[1], *Kominina Mendrika*[2], use of mass media, the introduction of case management of diarrhea, malaria, and ARI at the community level (using zinc, ORS new formula, ACT and cotrimoxazole best practices), and the accessibility and utilization of *Mutuelles de santé*.
- Creation of multiple partnerships to synergize human and financial resources allocated to the RAA**.** At each level, the main partners of MINSANPFPS include the Ministry of Communication and Voahary Salama. The Ministry of Communication will be involved in community action, the design of tools and support for Behavior Change Communication (BCC), and providing assistance to community implementers and health education programs via mass media. Voahary Salama will be involved in the integration of health, population and environmental services. The other partners, *SantéNet*, PSI and local NGOs will also be involved.

A. Main Accomplishments during FY 2007

Overall, MCDI has completed most of the activities in its 2007 work plan. Activities were directed towards establishing community partners and strengthening the capacity of health personnel working in the expanded project area and maintaining activities in the previous project area.

Preparation of the Situation Analysis and DIP for Presentation at Mini University

Health Situation Analyses:

The primary situation analyses carried out during November 2006 – February 2007

[1] VISA approach was the most successful element of the previous project. It was implemented by community volunteers (VCS) who "*Visitent, Identifient, Sensibilisent et Accompagnent (VISA)* " pregnant women and mothers. Each VCS is linked to five mothers that he/she assists and accompanies continually. After a while, "VISA mothers" are creating support groups for other women. VISA can become VCS and thereby ensuring the replacement of VCS who left the programme.

were largely based on the results of the Knowledge, Practice and Coverage (KPC) survey and the Health Facility Assessment (HFA), which evaluated the quality of care received at local health facilities. The KPC survey was supplemented with focus group discussions supportive of the BEHAVE framework. Results of the survey and HFA were presented to various levels of MINSANPFPS, and various partners and stakeholders. In addition, a five-day workshop was held to design the BEHAVE framework. The RAA person in-charge of IEC/BCC and other cadres of IEC/BCC advisors from nine districts collaborated on the development of the framework. The results of the KPC survey, HFA, and focus group discussions were instrumental in determining the priorities, objectives and implementation activities of the scale-up strategy for TREIP. Additional information and data were collected from other potential project actors such as local authorities, local NGOs, and representatives of the Ministries of Communication and Education.

Summary of Methodologies and Survey and Assessment Results

(See Annex 1)

Preparation of the DIP

The DIP preparation process was highly participatory and involved several meetings between November 2006 and June 2007. In October 2006, an official letter concerning the implementation of TREIP was sent by the MCDI Field Office to the MOH (central, regional and district levels), the Region chief, the community mayors of RAA, and district chiefs.

In November 2006, a meeting was held with the MOH at the central level during which the following points were discussed:

- The main issues and goals of the initial proposal
- DIP Guidelines
- Preliminary baseline surveys (KPC, RHSP, and qualitative research)
- Dr. Ravelomanantsoa Felicie's assignment to represent the MOH Department of Family Health during the DIP preparation process and attend the DIP Workshop

In December 2006, there were two formal meetings held respectively with two representatives of the Regional Health Office (RHO) and two representatives of the District Health Offices (DHO). Both meetings supported the following activities:

- DHO formed a regional support team to participate in the preparation of the DIP (four staff members from RHO and two staff members from DHO).
- DHO identified gaps in the work plan that the DIP should focus on
- Participants offered suggestions on modifying the commune-to-commune intervention approach and changes to the Showcase District
- Scale-up activities were confirmed including: KM, VISA at the community level, Rapid Result Intervention (RRI), Quality Assurance System (QAS) at the health center level, strengthened management techniques of districts using classic supervision methods, training, and monitoring and evaluation.

In January 2007, a meeting took place at USAID Madagascar to report on progress. A one-day introductory workshop was also organized to engage the local authorities and communities for effective participation. During this workshop, qualitative information on child health, constraints to healthy behaviors, etc. were also collected.

From January to March 2007, the KPC and HFA surveys, the Focus Group Discussion (FGD), and the BEHAVE framework workshop were conducted.

In March, a 5-day DIP workshop took place, during which the Appreciative Inquiry method was used and Constructivist Theories were applied based on a number of experiments. This marks a departure from the traditional approach and directs attention on the successes and positives according to a precise methodology. It consisted of a discovery phase, envisioning phase, design phase and the completion of an action plan. The discovery phase was important in identifying strengths, weaknesses and constraints of the project. The envisioning phase allowed participants to work together to establish goals/visions and objectives. The design phase involved identifying strategies and activities of the project based on the strengths identified in the discovery phase. The last phase focused on identifying and developing an action plan.

The primary objective of the workshop was to jointly plan activities within the framework of Child Survival (CS) with the purpose of integrating them into the health development plan of the Atsimo Andrefana Region. In order to achieve this, the health situation within the domain of Child Survival in RAA was analyzed, an initial DIP proposal was reviewed, the cooperative vision between all the actors and partners was developed, and the objectives and strategies for CS activities were finalized. The participants included MOH,

USAID, SantéNet, RHO, DHO, Ministry of Decentralization and Territorial Administration, Office of the Chief of Region, local NGOs, Voahary Salama, MCDI and community members.

DIP Finalization and Review

In April 2007, the DIP was drafted at the MCDI Home Office. In June 2007, a staff member from MCDI presented the contents of the implementation plan and discussed the significance of various strategies and activities shown within it at a meeting held in Baltimore, Maryland. The DIP was finalized after answers were submitted in response to the queries received from DIP reviewers. At the end of the review workshop, the DIP for TREIP was approved by USAID Washington.

Establishment of the Showcase and Demonstration Districts

As mentioned in the DIP, one of the expansion strategies included the establishment of a showcase district and a demonstration district. Work sessions with the DRSPF took place in May 2007 to cooperatively establish the operational modalities of the initiative. As a result, the Betioky Sud District, formerly covered under TCSP, was confirmed as the showcase district, and Sakaraha, a new district located in the expanded project area, was confirmed as the demonstration district. Both districts will serve as training sites for the other districts in the RAA for the implementation of TREIP activities. In other SSDs, intervention communes will be identified as *communes for learning* for the SSD to which they belonged to during the first phase of TREIP. The same activities will be implemented across districts during the first phase of TREIP including: a complete range of community-based activities (e.g., KM, AVBC, CCM and VISA) in all intervention communes, examples of mutuelle de santé in selected communes, support to the SSD and the RAA in implementation and assistance for the activities, experience-sharing and learning tours by other SSD and by national and international entities, and the establishment of sites of excellence as practicum sites for students at their pre-service training. For each intervention district, the DRSPF has assigned individuals directly responsible for follow-up of implementation activities.

To date, all communes in the two districts are covered with TREIP interventions and the implementation of both showcase and demonstration district activities are advancing.

Table 1 below shows the accomplishments in the two districts. DRSPF and MCDI have agreed on bi-annual evaluation of the performance in the two districts.

Table 1: TREIP - Accomplishments in showcase and demonstration districts

	SSD Betioky	**SSD Sakaraha**	**Observations**
Type	Showcase district	Demonstration district	
Community level activities			
KM	Implemented at 100% (in all communes)	Implemented at 100% (in all communes)	Communes without operating health facilities are excluded from this activity for non conformity with the requirements of KM approach
VISA	Implemented at 100% (in all communes)	Implemented at 100% (in all communes)	
AVBC	Implemented at 100% (in all communes)	Implemented at 100% (in all communes)	
CCM (full package i.e. case management that includes Zinc, Cotrimoxazole and anti malarial medication)	Implemented in 50% of communes	0% implemented	50% of communes is the MOH recommendation
CCM (Basic package without case management)	Implemented at 100% (in all communes)	Implemented at 100% (in all communes)	
Health Mutual	Implemented in 4 communes	Implemented in 0 communes	1 commune per district is the MOH recommendation
Community Radio	60 listening groups formed	0 listening groups formed	
Establishment of practicum sites for students	At negotiation stage with the Faculty of Medicine and with the Paramedical Training Institute	At negotiation stage with the Faculty of Medicine and with the Paramedical Training Institute	
Activities at health system level			
Reactivation of clinical IMCI	100% of CSB	0% of CSB	The reactivation consists of the introduction of Zinc in diarrhea treatment during a refresher training

			and a frequent follow-up
Reorganization of health sectors into supervision zones (Coaching approach)	100% of CSB are involved in this activity	0%	Coaching approach consists of assigning one person to each supervision zone. The person is in charge of all technical aspects and performance of CSB in his/her supervision zone. This approach permits a more frequent follow-up of CSB but also the implementation of all programs at once and across the board as opposed to vertical follow-up of programs
Strengthening of EMAD	Yes	Yes	Strengthening consists of training in program management and in coaching techniques
Training of ASB in project components	100% of ASB trained in case management and prevention of malaria	100% of ASB trained in case management and prevention of malaria	The training consists of the new policy change towards ACR as first line treatment. Funding partner is GFATM, technical partner is MCDI
Presence of a trained coach per district	Yes	Yes	Coaches are responsible for follow-up and support to implementation of program activities. This approach will be expand-ed to all RAA districts. Funding Partners will include MCDI and Technical Partners will include MCDI and DDDS
Study and Learning visits			
Number of visits by external entities (i.e. from outside RAA)	6	0	Entities are often mixed groups made of local or international NGOs
Number of visits from	3	0	One visit by Basics, two

within RAA			visits from local NGO partners of TREIP (Mampifoha and Zatovo)

Establishment and Start-up of Community Case Management

Community Case Management (CCM) started with the re-activation of clinical IMCI and the introduction of zinc in diarrheal treatment. Table 2 represents the number of cases of diarrhea treated children by means of community case management from January to August 2007 in the Betioky and Benenitra districts of RAA. It was then followed by IMCI-C and trainings conducted in the districts, basic health centers, and at the community levels (CCM agents at the community level, referred to as *Mpandomba).* After the introduction of training, MCDI and its implementing partners, including MINSANPFPS, BASICS and UNICEF developed follow-up and supervision tools, and an implementation guide. Table 3 summarizes the results of the CCM training.

Table 2: TREIP – CCM of Diarrhea in Betioky and Benenitra districts

Number of cases
Jan- Aug, 2007

		MONTH												TOTAL
		J	F	M	A	M	J	J	A	S	O	N	D	
Number of children (Di) without dehydration that received:	ZINC + SRO	-	72	39	64	97	102	63	66	-	-	-	-	503
	ZINC	-	1	-	3	12	27	6	-	-	-	-	-	49
	SRO	10	13	32	24	15	8	-	1	-	-	-	-	103
Number of children (Di) with dehydration that received:	ZINC + SRO	-	26	6	16	12	9	10	9	-	-	-	-	88
	ZINC	-	-	5	1	-	-	-	-	-	-	-	-	6
	SRO	-	-	1	2	1	-	-	-	-	-	-	-	4
Number of children (Dy) without dehydrated that received:	ZINC + SRO	-	3	1	2	7	13	5	1	-	-	-	-	32
	ZINC	-	-	-	1	1	-	-	-	-	-	-	-	2
	SRO	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of children (Dy) with dehydration that received:	ZINC + SRO	-	-	-	2	3	1	-	-	-	-	-	-	6
	ZINC	-	-	-	-	-	-	-	-	-	-	-	-	-
	SRO	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL NUMBER OF CHILDREN		10	115	84	115	148	160	84	77	-	-	-	-	793

TREIP - STOCK MANAGEMENT

Jan – Aug 2007		Month											
		J	F	M	A	M	J	J	A	S	O	N	D
Availability at the end of the month	ZINC	0	14 050	17 605	25 450	33 045	31 695	30 720	29 750				
	SRO	300	4 329	4 221	6 065	7 756	7 566	7 256	7 121				
Number of stock out days	ZINC	-	-	-	-	-	-	-	-				
	SRO	-	-	-	-	-	-	-	-				

Table 3: TREIP – Training on CCM

District	Number of trained ASBC	Number of CCM agent or *Mpandomba* trained	Operational community site	Number of trained trainers
Betioky	22	30	21(100%)	-
Benenitra	8	14	8	-
Atsimo Andrefana Region (RAA)	-	-	-	- The 9 district focal points for IMCI in RAA - 8 other regional program managers

Materialization of Partnerships

Contract with SantéNet

As mentioned in the project's strategies, the KM approach is among those to be scaled-up by TREIP. SantéNet has pledged to provide additional resources to do so. Therefore, MCDI developed and submitted a technical and financial proposal to SantéNet in May 2007. The proposal explicitly indicates additional resource needs for the 52 *communes* targeted by TREIP for KM (see Table 4), in accordance with the agreement written by SantéNet during the TREIP development phase. The proposal seeks to integrate interventions that were previously not addressed by the TREIP objectives, specifically under Reproductive Health (see Table 5). The contract with SantéNet for this activity was signed in July 2007,

detailing that TREIP will provide $92,777 and SantéNet will provide $217,154 for a total implementation cost of $309,931,

Table 4: Implementation of Scale-up of KM as of the end of October 2007

DISTRICT	Total Number of Communes	Number of Programmed Communes	Number of Communes Currently Being Implemented
South Betioky	27	22	0
Sakaraha	12	12	0
Benenitra	4	2	1
Ankazoabo	6	2	0
Morombe	8	2	0
West Ampanihy	16	2	3
Beroroha	8	2	0
Toliara 1	1	0	0
Toliara 2	23	8	3
Total	**105**	**52**	**7**

Table 5: Interventions in the framework of the SantéNet-TREIP collaboration

COMPONENTS	OBJECTIVES
Improving home support of sick children.	Maximum awareness of key practices in the home of sick children
Completing all the child's vaccines before his / her first birthday.	At least 80% of children under 1 are vaccinated with DTC HepB 3.
Maintaining exclusive breastfeeding for children from 0 to 6 months.	Maximum awareness of exclusive breastfeeding for children under 6 months old.
Ensuring adequate complementary foods for children 6 to 24 months.	Maximum awareness of good practices for supplementary feeding of children from 6 to 24 months.
Providing vitamin A supplementation for children from 6 to 59 months and de-worming of children 12 to 59 months, every six months.	At least 90% of children 6 to 59 months receive a dose of vitamin A each semester At least 90% of children between 12 and 59 months are de-wormed each semester.
Protecting children under-5 years of age and pregnant women against malaria.	At least 40% of households in the communes receive or buy a MID.
Ensuring water consumption by families, promoting hand washing with soap, and promoting the use of latrines.	Maximum awareness of hygiene.

Educating couples for family planning.	Increase by at least 5% the number of women 15-49 years who regularly use modern methods of family planning.
Encouraging pregnant women for PNC.	At least 80% of pregnant women attend the first PNC.
Promoting FAF supplementation of pregnant women.	At least 80% of pregnant women attending their first PNC receive 90 tablets of FAF.
Protecting pregnant women against tetanus.	At least 80% of pregnant women receive at least two anti-tetanus vaccines.
Increase knowledge in primary prevention of STD / AIDS.	Maximum awareness on the actions needed to prevent STD / AIDS.
Improving the nutritional intake of pregnant and lactating women.	Maximum awareness of nutritional intake of pregnant and lactating women.

The communes were chosen according to TRIEP's progression schedule as defined in the DIP (50% coverage for communes during the first phase of the project, with 100% coverage for the showcase and demonstration projects, and coverage of only two to three communes in the other districts).

Communes without a CSB were not covered by this approach. The Fokontany populations in those communes were served by partnering/neighboring CSBs (referred to as "reattachment" or link-up CSBs) which are in charge of supervising and recruiting community workers in communes without a CSB.

MCDI has not proposed to implement KM in the urban commune Toliara I as KM guidelines for urban interventions have not been developed to date and there is a lack of experience in this type of urban commune.

Furthermore, it was understood that the TREIP-SantéNet collaboration would explore the feasibility of integrating QAS and KM in those RSO (South West Region) communes. As a result, the QAS certification of the CSB would be among the challenges to overcome in order to obtain the KM status. The MOH-SantéNet-MCDI technical team has developed a guide for integrated implementation of KM/QAS during the current fiscal year 2007.

Collaboration with UNICEF

In order to complement efforts at the community level, MCDI suggested the development of a synergistic and complementary intervention among the various actors. To do this, MCDI requested UNICEF's support for the management of specific child survival components in the

Région Sud-Ouest, which has limited or no coverage under TREIP. These components pertain mainly to training and procurement of equipment at the health center level, which is the first reference for community workers. This request for support aims at contributing to the decline in mortality and morbidity among children under the age of five and improving the health status of women of childbearing age through the activities of MCDI's and UNICEF's interventions in the Région Sud-Ouest. The agreement on this collaboration is currently being finalized.

Contribution to National Efforts

Until now, MCDI has actively participated in the celebration of Mother and Child Health Week by providing logistical support and supervision for the implementation of this campaign. This celebration, which takes place twice a year, is a MINSANPFPS initiative that aims to reach the national objectives of Mother and Child Health. In October 2006, MCDI granted about $18,431 to support the RSO during the second campaign of 2006.

In addition, MCDI assisted in the development of an implementation guide to introduce the neonatal component (known as IMCI-C) into the IMCI package.

Collaboration with the Global Fund Round 7

The National Program for Malaria Control was established in 1998 and Madagascar has registered for various world initiatives aimed at eradicating this grave problem (Roll Back Malaria, Abuja, and Millennium Development Goals). The scaling-up of malaria control efforts to cover the whole country, however, is necessary if Madagascar wants to reach its objective of malaria eradication in the country by 2012. For this reason, MCDI participated as part of a consortium to submit a Round 7 application to the Global Fund to contribute to these efforts in Madagascar through community mobilization, behavior change communication, promotion of MIDs and community-based management of malaria cases intervention activities. Round 7 of the Global Fund was still undergoing validation as of October 2007 (since awarded).

Collaboration with Local NGOs

(See Section L)

Continuation of Activities in Previous Districts

As agreed in the DIP, MCDI has maintained its activities, especially community-based child survival activities, in previous intervention districts.

Factors Contributing to Successes

Strong collaboration with DRSPF of RAA, the nine approved SSDs and MINSANPFPS

MCDI has established a strong relationship with the DRSPF of Atsimo Andrefana, as well as with nine SSDs in the project area. This collaboration resulted in the integration of TREIP's implementation plan into the plans of DRSPF and the SSDs, transparency across program management, a high level of team work and collaboration, and ownership of the project's activities and approaches by DRSPF and SSDs, which are beneficiaries as well as actors. Having the same implementation plan that is addressed in the DIP included in DRSPF's and the SSDs' priorities and the same team working on its achievement have greatly facilitated the coordination and implementation of activities throughout the region. Decision-making was facilitated by effective communication and the sharing of information among all partners. With the DRSPF leading the implementation of activities, it has resulted in a very participative process for the development of the project, a sense of increased ownership by the main partner, MINSANPFPS, a developed and reinforced sense of team work within the DRSPF and the EMAD of supported districts, and acknowledgement by the highest level of MINSANFPS of the need for a partnership that is in accordance with government guidelines on Public-Private Partnerships. With this philosophy in mind, MINSANPFPS is making every effort to optimize the impact of the support it receives by concentrating on coordination.

At the DRSPF level, MCDI is part of ERAD (a Regional team providing support to the districts), and at the SSD level, MCDI forms an integral part of the District Management Team. MCDI also participates in monthly planning and review meetings of the SSDs and participates in organizational meetings of the EMAD. At the regional level, the DRSPF always invites MCDI for participation in regional monthly, quarterly, and weekly review meetings. The final result of this collaboration is a completely integrated program for health development across the region and in multiple districts, creating an environment for successful implementation of the project.

Central MINSANPFS has greatly contributed to the development of the DIP through the Child and Adolescent Health Care Service, which took part in all the processes for the development and finalization of the DIP. Participation of MINSANPFPS through this Health Care Service has supported the training and supervision of community workers for the CCM framework.

Collaboration with the Regional Steering Committee

In accordance with the DIP, MCDI has supported the implementation of the Regional Steering Committee, whose responsibilities include acting as a sponsor and main partner for support of the program. Effective recruitment and social mobilization have been important contributive factors to the success of the project.

Expansion of the Project's Technical Staff and Collaboration with Local NGOs

MCDI has strengthened the staff of local NGOs for the implementation of community activities by hiring an IEC/BCC Assistant and a Health Mutuelle Specialist. As agreed in the DIP, MCDI recruited, trained and supported four local NGOs (see Table 6), enabling them to facilitate the implementation of the program, transfer pertinent skills, and ensure long-term sustainability. Proximity supervisors further support the deployment, supervision and capacity building of outreach technicians as well as ASVCs. This organizational choice by MCDI to expand the project's technical staff was well-made as it has facilitated the implementation of activities as outlined in the work plan.

Table 6: Recapitulation of training received by the NGO(s)

NGO	NUMBER OF TRAINED STAFF	TRAINING
Zatovo	4	- Training of first level trainers - KM Approach - VISA Approach - Community Radio Program, - Health Insurance (Mutuelle de santé) - Interventions on Child Survival (ARI, malaria, diarrhea, Nutrition and Immunization) -Monitoring and Supervision Techniques.
Mampifoha	4	
VEMIMA	6	
Miainga	6	

Commitment of Local Political and Administrative Authorities for the Implementation of the Project

Local political ownership and commitment facilitated the successful implementation of the project's activities and the involvement of the community in the identification of ASBCs, as well as in the restructuring of the Communal Development Committees and the Social Development Committee. (See section F paragraph 2). In fact, the office of each district sent an official letter to each Mayor and Fokontany chief on the need for each authority to be involved in the implementation of the project at the community level. This support has given an institutionalized aspect to the approach and the project.

Progress Towards Project Scale-Up

TREIP will scale-up successful approaches and results obtained in MCDI's Child Survival Projects I and II using a variety of strategies. The scope of scaling-up concerns extending coverage from a population of 380,130 (Toliara II and Betioky Sud CSP) to 1,073,915 people (approximately 8% of Madagascar's total population) and from a geographic area of two districts to nine districts (about 15% of Madagascar total area) (See Table 7).

Table 7: Current Progress Towards Project Scale-up

Coverage	Beginning Status	Objective	End September 2007 Status
Population	380,130	1,073,915	480,639
District	2	9	4 (Benenitra, Sakaraha, Betioky, Toliara2)
Communes	50	107	64

Strategies for Advancing the Scale-Up Process

Strategy 1: Expanding through MOH structures

Note: The following description of Strategy 1 was taken from the DIP.

The scaling-up of intervention activities toward the DHO and the community will be carried out under the responsibility of the RHO, in terms of oversight and management.

Table 8. Current Progress in Implementing Strategy 1

Strategies	Current Status
(a) Joint planning of CS activities in the RAA and integration of the TREIP work plan into that of the DHO. This stage was carried out in the DIP workshop in March 2007 and will be continued through participation of MCDI in regional planning work-shops. The aim of this strategy is to institutionalize the activities of CS in TREIP.	Annual Plan implemented. TREIP integrated into that of the DRSPF and those of SSD.
(b) Strengthen capacity of the RHO staff on key interventions/approaches of TREIP. The overseers of the DHO in Toliara 2 and Betioky will reinforce MCDI in this stage	The training of 4 DRS program managers and members of the EMAD's SSD on the IEC/BCC approach; community mobilization and monitoring devices added to FY08
(c) Equipping the DHO and RHO in the implementation of the activities by making use of the guides and approaches, modules/ instruments, and implementation manuals of the interventions which are most successful	The development of regional strategies to IEC/BCC, including messages at the regional level (including the institutionalization strategies IEC/BCC's TREIP are underway).
(d) Strengthen the capacity of the DHO in the technical areas and implementation.	Pools of trainers of each 9 SDSPFs were trained on managerial capacity. The EMAD of Betioky and Sakaraha were trained on the VISA approach, IEC/BCC, radio programs.

Strategy 2: Support MOH Operational Unit (DHO/HF) by local NGO

Note: The following description of Strategy 2 was taken from the DIP

Local NGOs will be used to support the MOH Operational Unit (DHO) in the area of community mobilization and BCC. This partnership will enhance the implementation of activities (CCM, CBD, CHV/VISA, KM, festivals, etc.) at the community level. In addition, community health policies are in the process of being developed. MCDI will recruit NGOs through a competitive bidding process, which will both ensure the selection of NGOs with the best practices and local resources. Priority for selection will be given to NGOs who have

already worked with MCDI within the framework of the CSP I and II, such as VEMIMA, MIANNGA, MAMPIFOHA and ZATOVO. Under a sub-grant, MCDI will contract Voahary Salama (VS) to strengthen NGOs in organizational capacity. VS works in the areas of health, population and the environment and its principal goal is to strengthen the capacity of national NGOs in these areas.

The main mission of the NGOs will be to assist and support health facility staff in the implementation of TREIP's community component for which they will receive initial training. The partnership model between VEMIMA, Betioky's DHO and MCDI will be extended to the other DHOs. MCDI believes that connecting local NGOs with VS will make those smaller NGOs more visible, give them a stronger voice in child survival promotion and advocacy, and provide them with enabling approaches in the framework of TREIP, and, prove them with the ability to market these approaches more broadly.

Current Progress in Implementing Strategy 2

An expression of interest request was addressed to NGOs in January 2007 to ensure MOH's support for the implementation of community-based activities in the framework of the TREIP. Four NGOs, which had already worked with MCDI in the framework of its previous CSPs, gave positive responses. Three of these NGOs (Zatovo, Vemima and Miainga) are about to finalize their sub-grant contract and have submitted their respective proposals. The fourth NGO, Mampifoha, has not yet submitted its proposal. Following negotiations between MCDI and these NGOs, responsibilities and intervention zones were defined as follows in Table 9.

Table 9: NGO Responsibilities and Intervention Zones

NGO	RESPONSIBILITIES	INTERVENTION ZONES
VEMIMA	***1. Ensure the implementation of model approaches such as KM, VISA, radio program, Mutual Health AVBC, PCIMEC, Festival guides in accordance with the communes of intervention through the following:*** - Coordinate the implementation with district, SDSPF, CSB and the local authorities in its area of intervention. - Participate in periodic review meetings at both district and MCDI levels. - Manage the allocated resources for activities. - Provide the necessary human resources for the implementation of activities. - Regularly report achievements.	**District of South Betioky:** - Vatolatsaka - Tongobory - Tameantsoa - Betioky - Antohabato - Beavoha
	2. Supporting the SDSPF in overseeing the implementation of community-based activities through local supervisors through the following: - Contribute to the implementation of BCC/IEC strategies at the community level (KM Approach, VISA Approach / Reny limy, Community Health Volunteers, AVBC, Community Radio) - Support the SDSPF in training staff and supervision of TA - Contribute to the follow-up, M&E of the implementation of the BCC/IEC activities, and social mobilization of the district. - Assure the monthly collection and transmission of community data to SDSPF and MCDI. - Act as an interface between the TA, SDSPF and MCDI. - Hold a monthly TA and SBA meeting in its intervention zone. - Participate in the monthly review at the regional level.	- SDSPF of Betioky except Belamoty **District of West Ampanihy:** - Ejeda (Ampanihy) - Fotadrevo (Ampanihy)

NGO	RESPONSIBILITIES	INTERVENTION ZONES
MIAINGA	***1. Ensure the implementation of model approaches such as KM, VISA, radio program, Mutual Health AVBC, PCIMEC, Festivals guides in accordance with the intervention communes through the following.*** - Coordinate the implementation of model districts with district, SDSPF, CSB and the local authorities in its area of intervention. - Participate in periodic review meetings at both district and MCDI levels. - Manage the allocated resources for activities. - Provide the necessary human resources for the implementation of activities - Regularly report achievements	- Morombe (Ambahikily, Befadriana) - Ankazoabo (Ankazoabo, Andranomafana) - Beroroha (Fanjakana, Behisatsy) - Benenitra (Benenitra, Ehara)
	2. Support the SDSPF in overseeing the implementation of community-based activities through the vicinity of supervisors by the following: - Contribute to the implementation of BCC/IEC strategies at the community level (KM Approach, VISA[2]/Reny limy Approach, Community Health Volunteers, AVBC, Community Radio) - Support the SDSPF in staff training and supervision of TA - Contribute to M&E implementation of BCC/IEC activities, and social mobilization in the district. - Assure the monthly collection and transmission of community data to SDSPF and MCDI. - Act as an interface between the TA, SDSPF and MCDI. - Hold monthly meeting of TA and ASB in the intervention zone. - Participate in monthly review meetings at the regional level.	- SDSPF of Sakaraha - SDSPF of Benenitra and the Belamoty commune - SDSPF of Ankazoabo - SDSPF of Beroroha - SDSPF of Morombe - SDSPF of Toliara II
ZATOVO	***Ensure the implementation of model approaches such as KM, VISA, radio program, Mutual Health AVBC, PCIMEC, Festival guides in accordance with the intervention communes through the following:*** - Coordinate the implementation of model approaches	**Toliara District II** - Tsianisiha - Ankilimalinika - Milenaky

[2] KM approach aims to mobilize communities to achieve health objectives they select themselves and provide an environment to maximize the impact of all health interventions. Communes that achieve their objectives are certified as *Kominina Mendrika* (KM). TREIP proposes to cover 50% RAA communes.

NGO	RESPONSIBILITIES	INTERVENTION ZONES
	with district, SDSPF, CSB and the local authorities in its area of intervention. - Assure the supervision of all operations, technical as well as administrative. - Participate in developing the situation analysis, all planning phases and evaluation of TREIP, as beneficiaries and participants in the project. - Participate in periodic review meetings at both district and MCDI levels. - Manage the allocated resources for activities. - Provide the necessary human resources for the implementation of activities. - Regularly report the achievements.	
MAMPIFOHA	***Ensure the implementation of model approaches such as KM, VISA, radio program, Mutual Health AVBC, PCIMEC, Festival guides in accordance with intervention communes through the following:*** - Coordinate the implementation of model approaches with district, SDSPF, CSB and the local authorities in its area of intervention. - Assure the supervision of all operations, technical and administrative. - Participate in the situation analysis, all planning phases and evaluation of TREIP as beneficiaries and participants in the project. - Participate in periodic review meetings at both district and MCDI levels. - Manage the allocated resources for activities. - Provide the necessary human resources for the implementation of activities. - Regularly report the achievements.	**District West Ampanihy** - Ankilimivory - Androka

MCDI has developed a proposal for these four NGOs for a one-year contract beginning in October 2007 for the first phase. The exercise pertaining to the development of technical and financial proposals was conducted in order to strengthen the technical skills of NGOs by making them more familiar with TREIP approaches and technical interventions.

The technical staff of the four selected NGOs (20 in total) was trained in TREIP's technical interventions and approaches: ARI, diarrhea, malaria, vaccination, breastfeeding, Community CCM/IMCI, VISA, KM, Community radio, and community-based sale approach.

Furthermore, MCDI held several coordination and request-for-proposal meetings with Voahary Salama. As of now, negotiations with VS have led to the following provisional points:

- Management and follow-up of the sub-grants of local NGOs partnering with TREIP
- Capacity building of local partnering NGOs, including program management, compliance with procedures, and implementation
- Assessment of the technical and organizational performance of local NGOs
- Follow-up of project implementation including review and approval of reports with feedback at all levels. To facilitate this, VS will develop very precise templates
- Documentation of good practices to allow VS to take ownership of enabling approaches
- Scaling-up of VS products/approaches through TREIP for community structures, local NGOs, MSPF, financing, etc.

Due to internal restructuring, VS informed MCDI that their participation could not begin before FY 2009.

MCDI continuously advocates for the development of a national policy in community health that will facilitate the institutionalization of community-based structures and enabling approaches such as VISA, KM, and NGO involvement in the health system, to MOH and USAID. To speed up this process, UNICEF sponsored MCDI's participation in the international conference on Reproductive Health Programs in Addis Ababa in June 2007, which focused on developing the institutional framework for grassroots workers. SantéNet also sponsored MCDI's participation in a regional conference in Bamako on the institutionalization of grassroots distribution of health services in June 2007.

Strategy 3: Develop training sites for "new entry districts'' and pre-service trainees

Note: The following description of Strategy 3 was taken from the DIP

TREIP will implement a "showcase district" and a "demonstration district" which will serve as training sites for the other districts in the RAA. Betioky Sud, formerly covered under TCSP, will be established as a community health "showcase" district while Sakaraha, a new district in the expanded project area will serve as the "demonstration" district that will show the effectiveness of expansion approaches for the RAA. All of the TREIP approaches/interventions will be implemented in the showcase district intensively from the first year in such a way that

this district becomes a model in the area of community health. The members of the DHMT and the health facility workers of this showcase district will receive re-training in both the technical interventions and the implementation approaches. The showcase district will receive support and constant follow-up from TREIP during the first two years in order to ensure that implementation follows the intervention strategies and that the district is capable of serving as a training site for the other RAA districts and those outside the region. MCDI will collaborate with the Medical 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 establishing a precedent for the use of these methods in the areas where students tend to practice after graduation.

Current Progress in Implementing Strategy 3

Most of the approaches in the TREIP framework are currently implemented in the communes of both districts. All EMAD members in those two districts have been trained in technical interventions and implementation approaches.

Table 10. Approaches and Interventions in Showcase and Demonstration Districts

Approaches / interventions under the TREIP	Betioky (showcase)	Sakaraha (demonstration)	Observation
Number of Communes	27	12	
KM (Affected Communes)	23	8	4 Betioky communes don't have CSBs and 1 Sakaraha commune doesn't have access to a CSB. DRSPF's decided not to cover these communes in KM.
VISA (Affective Communes)	27	8	
AVBC (Affected Communes)	27 (455 AVBC)	8 (135 AVBC)	
Community Radio	36 functional focus groups	0	
CCM complete packet	7 (21 sites)	0	With support from the ARI, diarrhea and malaria by Cotrimoxazole, Zinc / ARI,

Approaches / interventions under the TREIP	Betioky (showcase)	Sakaraha (demonstration)	Observation
			antimal-arial. Pilot phase of the MOH.
CCM Basic package	27 (455 CCM agent)	8 (135 agent)	Detecting danger signs and reference key acts at home
Health Mutuel	5	0	
Site visits by learners outside the district	3	0	Visit from 1 member of Helen Keller International and BASICS Visit from 2 NGOs
Site probation Service reactivation	0	0	Not yet started

Strategy 4: Phasing-in community-based activities on a commune-by-commune basis

Note: The following description of Strategy 4 was taken from the DIP

TREIP will implement activities in support of the health facilities in all the RAA, and community-based activities on a commune-by-commune basis. Activities in support of health facilities include clinical training of at least one health worker in each health facility and integrated and formative supervision in all of the health facilities. Primary community-based activities include the VISA approach (with training of all CHVs), CCM of childhood illnesses (which relies on the existence of established network of CHVs and VISA mothers), and the Commune Championnes/Kominina Mendrika (KM).

In Betioky and Toliara II, TREIP will transfer responsibilities for TPCSP project activities to local NGOs, while providing technical assistance for new aspects of the program and establishing Betioky Sud as the showcase district and Sakaraha as the demonstration district. In addition to launching new activities, TREIP will also maintain activities related to the VISA approach in Toliara II. The three community-based interventions will be launched in all communes in the two showcase and demonstration districts, except in communes where they have already been implemented under TPCSP. TREIP will also launch the VISA approach and KM in one commune of all the other districts to ensure that all DHO members in all the Districts of RAA have at least some involvement in community-based activities from the beginning of TREIP implementation. MCDI will observe during the first two years

whether each district has, at a minimum, been covered by all of the TREIP activities and these communes will serve as training sites for its district, in view of eventual scale-up. If the scale-up strategy has proved successful after the mid-term evaluation, MCDI will undertake coverage in the remaining 50% of communes if resources permit. TREIP aims to implement the VISA approach, CCM, and KM in 50, 44, and 53 communes respectively, and these activities will be maintained during Years 3 and 4. As acknowledged by MCDI and MOH, the success of TREIP will depend on the ownership and competence of MOH for the expansion of activities.

Table 11 below shows the total number of communes in each RAA district, the expected number of communes that will be targeted for implementation of community-based activities during Years 1 and 2, and the current status of implementation.

Table 11: Current Progress in Implementing Strategy 4

District	Total Communes	Expected results			Current Situation		
		VISA	CCM	KM	VISA	CCM	KM
YEAR 1 and 2							
1 South Betioky	27	27	27	27	27	7	23
2 Sakaraha	12	12	12	12	8	0	8
3 Benenitra	4	2	2	2	0	2	0
4 South Ankazoabo	6	3	3	2	0	0	0
5 Morombe	8	1	0	1	0	0	0
6 West Ampanihy	16	1	0	1	0	0	0
7 Beroroha	8	1	0	1	0	0	0
8 Toliara I	1	1	0	1	0	0	0
9 Toliara II	23	23	0	6	23	0	4
Total	105	71	44	53	58	9	35

Accountability and capacity building of the MOH

MCDI is strengthening the new coaching system implemented in the health districts by MOH. MCDI has enhanced the Regional Team's capacity to coach the districts by establishing a mentoring system in each district by one or two technical managers at the DRS level. MCDI has organized training in coaching for the regional managers mentioned above. The trainings were organized by trainers who have been trained by TRG in the framework of the SantéNet project. Once trained, the coach is responsible for supporting the district he is in charge of, on

technical as well as operational matters and receive support from MCDI's team. In this fashion, MCDI helps the DRSPF to assume its responsibilities of supporting implementation. The coaches visit their district monthly and they ensure that the objectives are reached and the quality of the implementation is maintained. During the first year, DRS and the SSDs have participated actively in the implementation of activities, and real ownership and coordination have been demonstrated. This approach supports the districts and CSBs, in an integrated manner, and moves towards applying interventions more horizontally.

Strategy 5: Using a coordination to facilitate the adoption and implementation of key approaches and interventions of the project

Note: The following description of Strategy 5 was taken from the DIP

MCDI will assist the RHO in establishing a Regional Child Survival Coordinating Committee. One of its missions will be to incorporate TREIP's communication strategy into the regional strategy for health communication. TREIP will also build upon its successful model for working with CHVs, thereby creating a relationship between the DHOs, local NGOs and communities. The MSPF has agreed to play a leading role in coordinating activities of all key partners, including UNICEF, CRESAN, UNFPA and NGOs, so that these organizational resources properly converge in the RAA.

Current Progress in Implementing Strategy 5

The TREIP has supported the DRSPF in the establishment and operation of the Steering Committee for Regional Health Development. The regional communication strategy based on the successful approaches introduced by TREIP is under development. The committee meets monthly and its mission is to coordinate overlapping health interventions. This mechanism strengthens the commitment and contribution of all entities (Office of Region Chief, Decentralization Ministry, etc.) in the implementation of TREIP.

Strategy 6: Continue MCDI's participation in the various national and regional committees

Note: The following description of Strategy 6 was taken from the DIP

MCDI will participate in several national and regional committees to disseminate tools and guides and discuss the experiences of the project in order to promote the national adoption and adaptation of guidelines of effective child survival policies that have achieved impact such as KM, CCM, and mutuelles. MCDI advocates for the adoption of its successful approaches, tools and materials by participating in the Nutrition Action Group (GAIN), the IMCI Coordinating Committee, and the Child Survival National Technical Committee (NCST), which is now formulating pilot tests for introducing zinc, low-osmolarity ORS, and cotrimoxozole therapies at the community level. The NCST Committee has agreed that TREIP project sites will be pilot test sites for these new policies. Through the same mechanism, The Community IMCI policy in Madagascar was adapted from MCDI's experiences in the field during the implementation of TPCSP.

Current Progress in Implementing Strategy 6

MCDI continues to participate in national and regional committees on child health. Through those committees, the experiences and expertise of MCDI and its staff have enhanced the following national strategies: CCM, community case management of neonatal illnesses, improvement of KM tools, and mutuelles. The VISA approach has been adapted and expanded at the national level by SantéNet through its Samia Mitondra Telo program.

Through the aforementioned activities, the objectives established in the DIP are in the process of attainment. Table 12 summarizes these activities and status of their completion. Table 13 demonstrates the progress of TREIP and reaching its goal of reducing mortality and morbidity among children under the age of five and improving the health status of women of reproductive age.

Table 12: Summary of Activities and Status

MAJOR ACTIVITES	Status	OBSERVATION (Details of achievement, and reasons for non-completion)
DIP Installation and Elaboration		
Establish team and office	Completed	HCIF recruited in August 1 KM assistant recruited 27 Animation technicians recruited
Prepare and submit the DIP, Mini-University	Completed	
- Analyze the sanitary situation at the Regional Level	Completed	HFA, KPC, Behave framework, analyze quantitative data
- Hold development workshop of "Detailed Implementation Plan" (DIP)	Completed	Workshop date: 28/03/07
- Develop the " Detailed Implementation Plan" (DIP)	Completed	In collaboration with the DRS, HO
- Submit DIP for USAID approval	Completed	DIP submitted the 14/04/07
IR 1. IMPROVE KNOWLEDGE AND KEY PRACTICES IN CONTENTS OF MOTHER AND CHILD HEALTH		
LOCAL NGO LEVEL		
Recruit Local NGOs	Completed	4 Identified NGOs (VEMIMA, ZATOVO, MAMPIFOHA). MIAINGA subcontracted for activity supervision
Train local NGO staff on social mobilization, IEC/BCC and VISA approaches	Completed	Those responsible from each NGO have been selected
Train local NGO staff on supervision	Completed	
COMMUNITY LEVEL		
Select health community volunteers	Completed	614 health community volunteers for the South Betioky district and the demonstration district (Sakaraha) were selected.
Train the new 1385 CVA throughout all DSS in community mobilization, IEC/BCC including the VISA approach, the promotion of AM, and nutrition of pregnant women	Completed	At the end of September 2007, 614 community volunteers (show and demonstration districts) were trained.
Train the 1385 CVAs on the promotion of vaccination, home support for sick children (basic packet) including water sanitation.	Completed	At the end of September 2007, 614 community volunteers (show and demonstration districts) were created.

Maintain base community activities in the KM approach in the previous KM communes.	Completed	The 2nd KM cycle has started for the last 10 communes
IR 2.INPROVE QUALITY HEALTH CARE AND HEALTH CENTERS		
AT REGIONAL LEVEL		
Strengthen the logistics and the System for Vaccination and Medicine Provision (antigens, oil, replacement parts…) at the level of health centers	Completed	Support for SDSPF of Betioky concerning the transportation of the vaccines and oil in May 2007
Strengthen the capacity of the DRS on monitoring	Completed	
Approve the monitoring frame	Completed	Finalization of the User Guide (postponed to October 2007, FY 2008)
Have a planning meeting for the monitoring of the RSO	N/A	N/A
AT THE DISTRICT LEVEL		
Train the members of EMAD whom represent 9 SSD in FDF and PCIME	In Process	Training on managerial capacity of the focal point in PCIME of the EMAD for each district done before the end of the month of September
Provide SAQ training for 18 members of EMAD. Other activities and approaches relevant to EMAD should be considered for training as well	Completed	Betioky, Benenitra et Sakaraha IMAD have been trained (Total of 4)
Strengthen drug and vaccine procurement system	Completed	Support to the Betioky SDSPF was provided for vaccine transport
AT HEALTH CENTER LEVEL		
Provide medical coverage training for 70 ASBs (ARI, malaria, diarrhea)	Completed	26 of Betioky's ASBs and 12 of Benenitra's were updated on the matter
Train 70 ASBs on AEN	Completed	26 of Betioky's ASBs and 12 of Benenitra's were updated on the matter
Train 70 ASBs on VISA & KM approaches, communal radio program	Completed	20 of Betioky's ASBs and 7 of Sakaraha's were updated on the matter

Train 140 ASBs in supervision, and the SAQ approach	Completed	22 ASBs trained for Betioky, 7 for Benenitra, 4 for Sakaraha
Implement the SAQ in designated health care centers	Completed	SAQ Implementation in 32 CSBs 22 of which are in Betioky, 2 at Benenitra, 4 in Sakaraha, 4 at Toliara II
Set-up the PCIME Clinic at CSB-level	Completed	Strenghtened and restored PCIME clinics of Betioky and Benenitra
Implement 2 pilot districts for the introduction of zinc in South Betioky and Benenitra, among others	Completed	21 operational sites for Betioky and 8 for Benenitra (50% of planned activities: training, group follow-up, post-training follow-up, exchange visit with USAID, Basics, RDC, INSPC)
Strengthen the logistics and the procurement system for drugs and vaccines (antigens, oil, replacement parts…)	Completed	
IR 3. IMPROVE THE AVAILABILITY OF HEALTH SERVICES		
AT REGION-LEVEL		
Donate communication materials to DRSPF's IEC/BCC program	Completed	Distributed and updated SRE Guide to 50% of TREIP communities
Support DRS/SSD in mass campaigns (SSME, vaccination)	Completed	SSME in October 2006 and April 2007
AT COMMUNITY-LEVEL		
Set up 583 AVBC	Completed	614 AVBC to serve Betioky and Sakaraha were identified
Train AVBC on community-based sales of key health products	Completed	614 AVBC of the showcase and demonstration district are trained
Train AVBC on home and community care and referral to the CSB for malaria and diarrhea while including the new Zinc/SRO treatment	Completed	614 AVBC of showcase and demonstration district are trained on the basic package and 37 for the complete package
Ensure procurement of 583 AVBC for all health-related products	Completed	614 AVBC of Betioky and Sakaraha will be supplied by September's end
Implement AVBC activities: Sale and/or health-product distribution (MID, Palustop, condoms, zinc…)	Completed	Betioky and Sakaraha's AVBC activities have started at the end of September
IR 4. IMPROVE SOCIOPOLITICAL ENVIRONMENT		

AT REGION-LEVEL		
Support the region in setting up the workings of the steering committee of sanitary development	Completed	Participated in all steering committee meetings
Hold 2 coordination workshops for partners	Completed	1 mini workshop was held at Betioky
Participate in Technical National Committees (SE, NN, Nutrition…)	Completed	Participated in all senior committee meetings regarding child survival, neonatal, malaria, PCIMEC, PCIMEC document validation, USAID strategic plan, and PTME standards and norms
Support the completion of the quarterly review at the regional and district level	Completed	Quarterly review of DRS was conducted in June with the financial support of MCDI
AT DISTRICT-LEVEL		
Set up showcase district (Betioky) and the display district(Sakaraha)	Completed	
Promote and introduce the TREIP and KM in those 2 districts	Completed	The promotion and introduction of the KM to the Betioky and Sakaraha districts were achieved with the participation of the mayors, the chief of district and the MI
Introduce the TREIP and KM at the community level	Completed	By the end of September, the KM will be introduced to 22 communities of Betioky and 8 communities of Sakaraha
Train community development committees and social development committees in handling their local TREIP and KM interventions	Completed	All CDCs and SDCs will be trained in all 22 communities of Betioky and 8 communities of Sakaraha
AT COMMUNITY LEVEL		
Maintain community-based activities in the scope of the TREIP by the transfer of responsibilities to local NGO partners	Completed	4 NGOs selected All NGOs' executive staff members have been trained by Voahary Salama. Negotiation of sub-grants is currently in process.
Set up and train community structures on the TREIP and KM interventions (particularly in the Betioky and Sakaraha districts)	Completed	614 voluntary communities, 614 AVBCs, 468 CDCs, 260 SDCs were set up and trained

MONITORING AND EVALUATION		
KAP study at households' level (Baseline & endline)	Completed	A KPC study was conducted in January in the AA region in the scope of analyzing the health situation
Study on treatment centers	Completed	A study was conducted on health care centers in January in the AA region in the scope of analyzing the health situation
Formative research	Completed	The elaboration of the Behave framework and the FGDs were completed
Data analysis for decision-making	Completed	In the context of starting KM, the RMAs were analyzed and exploited for the purpose of setting KM objectives

Table 13: Objective Progress Report Table

Objectives – Malaria Prevention and Treatment 1. Increase from 26% to 60% the percent of children 0-23 months who slept under an insecticide treated bed net the previous night 2. Increase from 30% to 60% the percent of mothers who took anti-malarial medicine to prevent malaria during pregnancy 3. Increase from 17% to 55% the 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			
Program Strategy and Interventions			
Planned Activities	**Expected Results**	**Indicator**	**Completion**
Training of CHVs to advise and counsel pregnant women and mothers on malaria prevention, treatment and care seeking behaviors	• 1,385 CHVs trained in advising and counseling pregnant women and mothers in malaria prevention, treatment and care seeking behaviors	# of CHVs trained to advise and counsel pregnant women and mothers on malaria prevention, treatment and care seeking behaviors	614 CHVs trained to advise and counsel pregnant women and mothers on malaria prevention, treatment and care seeking behaviors
		% of pregnant women who took an anti-malarial drug during their most recent pregnancy	N/A Awaiting midterm evaluation
		% of children 0-23 months with fever during past 2 weeks who received effective malarial drug within 24 hours of onset of fever	N/A
		% of mother of children 0-23 months who continued feeding during the febrile episode	N/A
		% 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	N/A
Coaching of VISA Mothers by trained CHVs to support pregnant	• 6,500 -7,000 VISA Mothers coached by CHVs in supporting pregnant women and mothers on malaria prevention,	# of VMs coached to support pregnant women and mothers on malaria prevention, treatment and care seeking behavior	N/A

women and mothers on malaria prevention, treatment and care seeking behaviors	malaria prevention, treatment and care seeking behaviors	# of pregnant women and supported by VMs	N/A
Training of CBDs in community case management of malaria and malaria associated with pneumonia	• 583 CBDs trained in CCM of malaria and malaria associated with pneumonia	# of CBDs trained in CCM of Malaria and malaria associated with pneumonia	44 CBDs trained in CCM of Malaria and malaria associated with pneumonia
		% of trained CBDs who are doing CCM of Malaria	100% of trained CBDs who are doing CCM of Malaria
Training of health facility staff in Facility-Based IMCI Protocol	• 70 health facility staff trained in Facility-Based IMCI Protocol	# of health facility staff, by type, trained in Facility-Based IMCI Protocol for Malaria	38 health facility staff, by type, trained in Facility-Based IMCI Protocol for Malaria
		# of health facilities with at least 1 health worker trained in IMCI	33 health facilities with at least one health worker trained in IMCI (or 20%)
Provision of ITNs	• Insecticide treated bed nets accessible to mothers and children at MOH subsidized rates and distributed through trained CBDs • Increase in proportion of households with at least one ITN • .Increase in proportion of children aged 0-23 months who slept under an	# of households provided with new ITNs	N/A
		% of households provided with new ITNs at MSPF subsidized rates	N/A
		# of households with ITNs that need re-treatment	N/A
		# of households with at least 1 ITN	N/A
		(a) % of children 0-23 months and (b) % of children under-5 years who slept under an ITN the previous night	N/A (Awaiting midterm evaluation)

	insecticide-treated net the previous night. • Increase in proportion of pregnant women who slept under an ITN the previous night • In areas where household was sprayed before the last malaria season, increase in proportion of families who adhered to safety precautions to prevent exposure to insecticide, abstaining from painting/ washing walls after spraying.	(a) % of pregnant women and (b) % of mothers of children 0-23 months older who slept under an ITN the previous night	N/A (Awaiting midterm evaluation)
Strengthen logistics and supply system for essential malaria drugs	• Reduced stock-outs of essential malarial drugs at health facilities	# of stock-outs of essential malaria drugs in past reporting period	N/A
Objectives – Pneumonia Case Management 1. Increase from 28% to 60% the percent 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			
Program Strategy and Interventions			
Planned Activities	**Expected Results**	**Indicator**	**Completion**
Training of CHVs to advise and counsel pregnant women and mothers on pneumonia case	• 1,385 CHVs trained in advising and counseling pregnant and mothers in malaria prevention, treatment and care seeking behaviors	# of CHVs trained to advise and counsel pregnant women and mothers on pneumonia case management, treatment and care seeking behaviors	614 of CHVs trained to advise and counsel pregnant women and mothers on pneumonia case management, treatment and care seeking behaviors

management and care seeking behaviors		% children aged 0-23 months with cough and fast/difficult breathing in last 2 weeks who were taken to a health facility or received antibiotics from an alternative source	N/A (Awaiting midterm evaluation)
		% of mothers of children 0-23 months who know at least 2 signs of pneumonia that indicate a need for immediate treatment outside the home	N/A (Awaiting midterm evaluation)
Coaching of VISA Mothers by trained CHVs to support pregnant women and mothers on pneumonia treatment and care seeking	• 6,500 -7,000 VISA Mothers coached by CHVs in supporting pregnant women and mothers on pneumonia treatment and care seeking behavior	# of VMs coached to support pregnant women and mothers on pneumonia treatment and care seeking behaviors	N/A
		# of pregnant women and mothers supported by VMs	N/A
Training of CBDs in community case management of pneumonia and malaria in associated with pneumonia	• 583 CBDs trained in CCM of pneumonia and malaria in association with pneumonia	# of CBDs trained in CCM of Pneumonia and of malaria associated with pneumonia	44 CBDs trained in CCM of Pneumonia and malaria associated with pneumonia
		% of trained CBDs who are doing CCM of Pneumonia	100% of trained CBDs who are doing CCM of Pneumonia
Training of health facility staff in Facility-Based IMCI Protocol	• 70 health facility staff trained in Facility-Based IMCI Protocol	# of health facility staff, by type, trained in Facility-Based IMCI Protocol for Malaria	38 health facility staff, by type, trained in Facility-Based IMCI Protocol for Malaria
		# of health facilities with at least one health worker trained in IMCI	33 health facilities with at least one health worker trained in IMCI
Strengthen logistics and supply system for essential pneumonia drugs	• Reduced stock-outages of essential pneumonia drugs at health facilities	# of stock-outages of essential pneumonia drugs in past reporting period	N/A
Objectives – Prevention and Control of Diarrheal Diseases			

1. Increase from 26% to 60% the percent of children aged 0-23 months with diarrhea in the last two weeks, who were offered more fluids during the illness
2. Increase from 36% to 65% the percent 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
3. 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.

Program Strategy and Interventions			
Planned Activities	**Expected Results**	**Indicator**	**Completion**
Training of CHVs in home-based management of diarrhea, communication skills and appropriate referrals to CBD	• 1,385 CHVs trained in home-based management of diarrhea and improved communication skills • Increase in referrals to CBDs made by CHVs	# of CHVs 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 at a health facility	614 of CHVs 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 at a health facility
		% of CHV home-based management of diarrhea cases that were referred to a CBD	N/A
		% of children 0-23 months with diarrhea during the past 2 weeks who received same quantity of fluids or more (including breast milk) during the diarrheal episode	N/A (See midterm evaluation)
		% of children 0-23 months with diarrhea during the past 2 weeks who received the same or more food during the episode	N/A (See midterm evaluation)
		% of mothers of children 0-23 months who know at least 2 danger signs of diarrhea that indicate the need for treatment at a health facility	N/A (See midterm evaluation)
		% of children 0-23 months with acute/severe diarrhea who were referred to a health facility for treatment	N/A (See midterm evaluation)

Coaching of VISA Mothers by trained CHVs to support mothers and caregivers on home-based management of diarrhea and care seeking behavior	• 6,500 -7,000 VISA Mothers coached by CHVs in supporting mother/caregivers on home-based management of diarrhea and care seeking behavior	# of VMs coached to support mothers/caregivers on home-based management of diarrhea and care seeking	N/A
		# of mothers/caregivers supported by VMs	N/A
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 diarrhea and referral to a health facility as needed	# of CBDs trained in CCM of Diarrhea	44 CBDs trained in CCM of Diarrhea
Training of health facility staff in Facility-Based IMCI Protocol	• 70 health facility staff trained in Facility-Based IMCI Protocol	# of health facility staff , by type, trained in Facility-Based IMCI Protocol for Diarrhea	38 health facility staff , by type, trained in Facility-Based IMCI Protocol for Diarrhea
		# of health facilities with at least one health worker trained in IMCI	33 health facilities with at least one health worker trained in IMCI
Orientation of health facility staff, CHVs, 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	# of health facilities providing zinc therapy	47 health facilities providing zinc therapy
		# of health facility staff, by type, oriented/trained in zinc therapy	47 of health facility staff, by type, oriented/trained in zinc therapy
Training of CHVs and CBDs in promotion of safe and hygienic water use	• 1,385 CHVs and 583 trained in promotion of safe and hygienic water use • Increase in safe and hygienic water use by households in project areas	# of (a) CBDs and (b) CHVs trained in promotion of safe and hygienic water use	614 of (a) CBDs and (b) CHVs trained in promotion of safe and hygienic water use
Objectives – Breastfeeding and Infant Nutrition			

1. Increase from 24% to 40% the percent of infants aged 0-5 months who were given breast milk only in the 24 hours preceding survey 2. Increase from 27% to 50% the percent of children aged 0-23 months put to the breast within 1 hour of birth			
Program Strategy and Interventions			
Planned Activities	**Expected Results**	**Indicator**	**Completion**
Training of CHVs to advise and counsel pregnant women and mothers on optimal breast feeding and infant nutrition practices	• 1,385 CHVs trained in advising and counseling pregnant and mothers in malaria prevention, treatment and care seeking behaviors	# of CHVs trained in educating mothers of children: a) 0-5 months on exclusive breast feeding practices; b) 6-23 on optimal infant nutrition practices	614 of CHVs trained in educating mothers of children: a) 0-5 months on exclusive breast feeding practices; b) 6-23 on optimal infant nutrition practices
Coaching of VISA Mothers by trained CHVs to support pregnant women and mothers on optimal breast feeding and infant nutrition practices	• 6,500 -7,000 VISA Mothers coached by CHVs in supporting pregnant women and mothers on optimal breast feeding and infant nutrition practices	# of VMs coached in supporting mothers of children in optimal breast feeding and infant nutrition practices	N/A
		# of pregnant women and mothers supported by VMs	N/A
Training of health facility staff in Facility-Based IMCI Protocol	• 100 health facility staff trained in Facility-Based IMCI Protocol	# of health facility staff , by type, trained in Facility-Based IMCI Protocol	38 health facility staff , by type, trained in Facility-Based IMCI Protocol
		# of health facilities with at least one health worker trained in IMCI	33 health facilities with at least one health worker trained in IMCI
Objectives – Immunization 1. Increase from 33% to 60% the percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines (card confirmed) before the first birthday 2. Increase from 29% to 60% the 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 3. Decrease from 19% to 10% the percent of Percent of defaults between DPT1 and DPT3			
Program Strategy and Interventions			
Planned Activities	**Expected Results**	**Indicator**	**Completion**

Training of CHVs to provide education , counseling and support to newly married women, pregnant women, mothers of infants and young children on immunization services	• 1385 CHVs trained in promotion of childhood immunization services and regular checking of immunization cards • Increase in demand for immunization services • Increase in Vitamin A supplementation	# of CHVs trained in educating newly married women, pregnant women and mothers of infants and young children on immunization practices	614 of CHVs trained in educating newly married women, pregnant women and mothers of infants and young children on immunization practices
		% of children 12-23 months who received (i) BCG, (ii) DPT3, (iii) OPV3 and (iv) measles by age 1 year (card verified)	N/A (See midterm evaluation)
		% of children 0-23 months who received measles vaccine	N/A (See midterm evaluation)
		% of children 0-23 months who received Vitamin A supplementation	N/A (See midterm evaluation)
		% of immunizations provided at village level	N/A
Coaching of VISA Mothers by trained CHVs 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 CHVs in supporting newly married women, pregnant women and mothers of infants and young children on immunization services	# of VMs coached in supporting newly married women, pregnant women and mothers of infants and young children on immunization services	N/A
		# of newly married women, pregnant women and mothers of infants and young children services supported by VMs	N/A
Training of CHVs in checking immunization cards of children 0-23 months and pregnant women to ascertain adherence,	• 1385 CHVs trained to check immunization cards of children 0-23 months, track defaulters and accompany them and their mothers to complete immunization schedules	# of defaulters tracked by CHVs	N/A N/A

track and accompany defaulters to health care facilities for continuation of immunization schedule	• Increase in defaulters tracked by CHVs and accompanied to health care facility for continuation of immunization schedule	% of defaulters who were accompanied by a CHV to a health facility complete their 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	# and type of health facility staff trained in correct immunization techniques	135 Health Facility workers trained in correct immunization techniques
Assistance in the implementation of immunization campaigns conducted by MSPF	• Increased coverage of immunization campaigns conducted by MSPF	# of children 0-23 months immunized per campaign conducted by MSPF	24 646 of children 0-23 months immunized per campaign conducted by MSPF
		# of pregnant and newly married women immunized per campaign conducted by MSPF	11 273 of pregnant and newly married women immunized per campaign conducted by MSPF
Technical support to RHO to strengthen planning, supervision, and monitoring of all immunization activities in SW Region	• Strengthened planning, supervision and monitoring of immunization activities of RHO and MSPF in RAA Region	# and type of RHO staff providing TA in (i) planning, (ii) supervision (iii) monitoring of immunization activities	9 Focal Points of Districts trained in supervision, follow-up of all programs (PEV, Nutrition…)
Formative research on current knowledge and beliefs	• Development of plan with RHO, DHOs, UNICEF to address obstacles and barriers to	Availability of formal plan	N/A
		Extent of implementation of plan	N/A

beliefs concerning vaccine-preventable diseases and barriers that prevent accessing immunization services	and barriers to immunization	Immunization coverage rates	N/A

Objectives – Community and Household IMCI

1. 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
2. Increase from 36% to 60% the percent of clinical encounters with HW in HF in which treatment is appropriate to diagnosis for children with malaria, pneumonia, or diarrhea (from Clinical Observation in HF)
3. Increase from 0% to 60% the percent of clinical encounters with CHW in which treatment is appropriate to diagnosis for children with malaria, pneumonia, or diarrhea

Program Strategy and Interventions			
Planned Activities	**Expected Results**	**Indicator**	**Completion**
Training of CHVs in (a) promotion of C/ IMCI KFPs; and, (b) coaching mothers to be VISA Mothers to educate other women	• 1385 CHVs trained to: (a) counsel and support pregnant women/mothers of young children: (b) coach mothers as VISA Mothers to educate other women • 80% of villages are covered by CHVs who are trained to promote C-IMCI KFPs	# of CHVs trained to counsel and support pregnant women/mothers	614 CHVs trained to counsel and support pregnant women/mothers
		# of (a) pregnant women and (b) mothers of children 0-23 months counseled by CHVs	2345 of (a) pregnant women and (b) mothers of children 0-23 months counseled by CHVs
		% of villages covered by CHVs trained to promote C-IMCI KFPs	305 villages covered by CHVs trained to promote C-IMCI KFPs
		# of CHVs coaching mothers as VISA Mothers	N/A
		# of mothers coached as VISA Mothers	N/A
Design of simplified C-IMCI algorithm designed for	• Simplified C-IMCI algorithm designed for training of CBDs in CCM of malaria and	# of CBDs trained in CCM of (i) malaria and diarrhea (ii) malaria only, (iii) diarrhea only	44 CBDs trained in CCM of (i) malaria and diarrhea

training of CBDs in CCM of malaria and diarrhea	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	% of villages with trained CBDs using simplified IMCI case management who are providing CCM	100% villages with trained CBDs using simplified IMCI case management who are providing CCM
CBDs supplied with social marketing packages for distribution.	• 583 CBDs supplied with social marketing packages for distribution.	# of CBDs supplied with social marketing packages	84 of CBDs supplied with social marketing packages
		% of CBD stocks distributed	96 % of CBD stocks distributed
Design and institution of monthly reporting and supervisory meetings between CBDs, CHV and BHF	• Institution of monthly reporting and supervisory meetings between CBDs, CHVs, and BHF personnel • 60% of villages with established links between communities and health facilities (at least quarterly) through monthly reporting and supervisory meetings between CBDS, CHVs 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	# of monthly reporting and supervisory meetings held in last quarter, by types of attendees	30 of monthly reporting and supervisory meetings held in last quarter, by types of attendees
		% of villages with established links through monthly reporting and supervisory meetings between CBDs, CHVs, and BHF personnel (by type)	305 of villages with established links through monthly reporting and supervisory meetings between CBDs, CHVs, and BHF personnel (by type)
		# of trained supervisors, by types of personnel supervised, at the different levels (i) health facility (ii) NGO, (iii) community , (iii) household	9 PFD and 6 local supervisors trained in supervision techniques
		# of health facilities supervised for IMCI	40 health facilities supervised for IMCI
		% of health facilities supervised that are using (i) IMCI Checklist adapted for Toliara (ii) other checklists	20 % of health facilities supervised that are using (i) IMCI Checklist adapted for Toliara (ii) other checklists

Training of local NGO field agents to make regular supervisory visits to active CHVs and CBDs	• 55 NGO field agents trained in supervision • 1385 CHVs and 583 CBDs regularly supervised by NGO field agents • Increase in supervisory visits to CHVs / CBDs	# of supervisory visits, by type of trained supervisor, in past month to (a) CHVs and (b) CBDs	30 supervisory visits, by type of trained supervisor, in past month to (a) CHVs and (b) CBDs
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	# of health facility personnel receiving refresher training in C-IMCI protocol	38 health facility personnel receiving refresher training in C-IMCI protocol
		% of health facilities with one or more personnel who received refresher training in C-IMCI protocol	22% of health facilities with one or more personnel who received refresher training in C-IMCI protocol

Objectives – Capacity Building

1. Community Capacity for increased access to care for families
2. RHO / DHO Capacity in supervision and quality assurance
3. NGO capacity for community mobilization and BCC activities

Program Strategy and Interventions			
Planned Activities	**Expected Results**	**Indicator**	**Completion**
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 mutual health organization	# of Steering Committee members trained	N/A
	15% of communes will have established *Mutuelle* community credit/equity fund schemes to ensure eligible families to access care	% of communes with *Mutuelle*	7 % of communes with *Mutuelle*
		# of eligible families regularly receiving funds to access care	N/A
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"	# of communes seeking certification as "Kominina Mendrika" "	10 communes seeking certification as "Kominina Mendrika
		% of communes certified as "Kominina Mendrika"	100% of communes certified as "Kominina Mendrika"
Strengthening of	4 RHO staff mentored in	# of RHO staff, by type,	2 of RHO staff, by

supervisory capacities of RHO	training of supervisors	mentored in training DHO Program Managers in supervision and QA	type, mentored in training DHO Program Managers in supervision and QA
Mentoring of RHO staff in training District Program Managers to provide supervision and quality assurance	9 Program Managers trained n supervision in and quality assurance	# of Program Managers trained in supervision and QA	4 Program Managers trained in supervision and quality assurance
Training for Local NGOs in BCC and Community Mobilization Approach	36 NGOs trained in BBC and CMA	# of NGOs trained in BCC and CMA	4 NGOs trained in BCC and CMA
		# of BCC campaigns organized and conducted by NGOs	N/A
		# and type of community mobilization activities conducted by NGOs	N/A

B. Factors Impeding Progress

There are six primary factors that have constrained the previously mentioned objectives:

Lack of Security

There is an obvious lack of security in the project area (cattle stealing and attacks) that forces the project team to be very vigilant with regards to visits and activities taking place in the so-called "red zones." These zones are located in the three districts in the East of the region and in one district in the North. Therefore, some activities that had been planned had to be postponed several times or even cancelled in those zones.

Geographical Constraint

The geographical constraint, mainly the distance and the difficulty to reach some health center and communities, requires excessive traveling time, enduring poor quality roads and allocating more resources for the implementation of activities. For this reason, the field team had to work six days out of seven during the start-up phase to try to minimize the impact of time lost during traveling. Also, some participants in training or meetings cannot arrive in time for sessions. This situation requires a solid amount of support to overcome, especially as the rainy season begins.

Educational, Cultural, and Political Constraints

Other constraints mentioned in the DIP such as educational, cultural and political did not impact the results for this year (fiscal year 2007). It should be noted in effect that a decrease in staff turnover at the Ministry of Health Family Planning and Social Protection provided some stability to the operational environment of the project.

Electrical Outages

Frequent electric blackouts (selective outages) that occurred from October 2006 until April 2007 in the Toliara Province greatly disturbed training sessions, workshops, and office work for the project. These blackouts affected the project's equipment as well as the

implementation of its activities, especially training. MCDI purchased a generator in case of urgent need, but it was later damaged.

Vertical Priorities

The existence of vertical priorities at the national level often causes the DRSPF as well as SSDs to be overburdened with tasks, at the expense of requisite TREIP responsibilities included in the joint planning between MCDI and DRSPF, and SSDs in the framework. This situation has interfered with the implementation of activities and required frequent meetings for the reorganization of activity programs. It is a constant problem for the management system across Madagascar.

Elections

Various elections (presidential, referendum, parliamentary) which took place successively between December 2006 and September 2007 resulted in a quasi paralysis of the administrative system. MCDI refocused its community strategies to avoid any political connotation when visiting the communes of its agents.

C. Fields that Required Technical Assistance

Technical assistance was necessary to strengthen the capacity of health workers, as well as of MCDI's staff and of its partners.

MCDI received technical assistance from SantéNet for the implementation of the Quality Assurance System (QAS) at the health center level. To do this, a JHPIEGO specialist conducted the ASBs training (See Table 12). This specialist helped launch QAS in the SSDs of Betioky Sud, Benenitra and Sakaraha by putting in place follow-up tools and by focusing EMAD members on formative QAS supervision. The training tools for the ASBs were provided by SantéNet.

MCDI received technical assistance from a group of national independent consultants for the organizational analysis of local NGO partners in the project's implementation. The terms of reference consisted of strengthening the managerial and organizational skills of those NGOs to better facilitate the implementation of the project.

The DSFA, jointly with BASICS provided technical assistance to MCDI's Health Care Quality Advisor for implementation of the new curriculum in clinical and community IMCI training. In effect, the curriculum was adopted by MINSANPFPS as the main training tool for the health staff. MCDI's Health Care Quality Advisor was trained in this new tool and then co-facilitated the training of ASBs in Betioky Sud. Training in Benenitra (February 2007) was conducted by the DSFA/DRSPF team and BASICS.

Dr. Christopher Schwabe, a health economist, provided constant technical assistance to SantéNet and to the "Mutuelle de crédit" specialist at MCDI on setting fees and on all aspects of managing health mutuelles. He developed a protocol for fee setting and management, and he perfected the computerized program for the computing model of such an initiative.

D. Changes to be Made in the DIP

In general, no changes were made to the DIP.

E. Monitoring Plan

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 in reducing morbidity and mortality among children under the age of 60 months and improving the health status of women of reproductive age.

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 DIP M&E matrix is 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.

The TREIP project will utilize several measurement methods, both quantitative and qualitative, to routinely monitor progress and periodically evaluate performance. The measurement methods and data sources will include:

- Baseline and final KPC Surveys
- Lot Quality Assurance Sampling (Mid-Term)
- Reviews of supervisor reports
- Reviews of CBD and CHV activity reports
- Reviews of supervisor, CBD, CHV and VM Trainers' reports
- Focus groups, GAPS analysis and other qualitative research methods
- Reviews of reports from Health Facility Assessments by MSPF, UNICEF and partners
- Quarterly monitoring through the District/Regional Health Information System report
- Special surveys and studies focusing on beneficiaries of, and participants in technical assistance and training activities
- Training needs assessments for capacity building at community, RHO and NGO levels
- Monthly activity reports of the CSBs and monthly reports of the SSD

HFAs will include monitoring provider performance and client satisfaction.

Baseline and final KPC Surveys utilizing 30 cluster and Mid-Term using Lot Quality Assurance Sampling: The KPC Survey was implemented between November 2006 and February 2007, according to the standardized methodology and included related Rapid CATCH indicators. Final KPC survey will be conducted using 30 cluster sampling, with LQAS 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.

Reviews of supervisor, CHW, CBD and PVO monthly reports and checklists and Trainer reports

The training of supervisors, CBDs and CHVs will include the preparation and presentation of monthly reports for adoption both within the project and in the RAA. Nationally approved training protocols and guidelines, including reporting formats, will be adapted for the different levels of training. At the supervisory and community level, simple and easily applicable checklists and reporting/recording forms will adapted, or be designed if necessary; to be compatible with those used in the RAA HIS. In addition to the reviews of training reports provided by PVOs, the performance of these trainees will be monitored through on-site observations by the trainers, special surveys to measure the quality of the services they provide, and exit interviews to assess the levels of client satisfaction with the services they receive. Follow-on and refresher trained will be conducted both on the basis of these performance assessments, as well as on the updates and/or changes in IMCI care and treatment protocols.

Focus Groups, GAPS Analysis, and qualitative research methods: Throughout the project, focus groups and interviews involving clients, support group members, home and community-based care givers, and community leaders will be conducted 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. These findings will be used to design MCDI's behavior change interventions and focus group mini-studies will continue being carried out later in the

project to assess changes in understanding and practices regarding child survival interventions. All CBDs and interested CHVs will be trained by MCDI trainers in the key IMCI behaviors identified through the Gaps Analysis, so CBDs and CHVs 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.

Health facility assessments: To establish baseline values for quality of care in health facilities serving the program area, the project utilized the Rapid Health Provision Assessment (R-HSPA), see report enclosed. With the training of health facility staff in the clinical IMCI Protocols being a collaborative activity, emphasis will be placed on tracking priority indicators for IMCI at the facility level, related to health worker skills, health system supports such as supervision, training coverage and drugs, equipments and supplies. These will be 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. The baseline R-HSPA did not assess the quality of care provided by community-based providers and in accordance with the CCM approach embraced by Madagascar, this will be monitored regularly.

Quarterly monitoring through the District/Regional Health Information System: The project will track a limited number of key process indicators on a quarterly basis by accessing facility-based IMCI information collected routinely by the District/Regional HIS. This system is based on: 1) monthly reports prepared by each health care facility on the utilization of services and on the process of service delivery; and, 2) annual reports on services, human resources, materials/equipment and infrastructure. These data collection systems focus on the

availability and utilization of health care services provided through the public system and will complement 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. MCDI staff will also collaborate with partners to carry out spot checks of clinic records and registers, 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.

Special surveys and studies: A study will be conducted after the completion of the mid-term LQAS for estimating under-5 child mortality impact on home care versus facility centered and facility outreach using the 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 will be 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 breast feeding increased; and, (v) complementary feeding. Client satisfaction surveys will also be conducted 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, which will complement the information from the exit interviews conducted at health facilities. A Formative Research Study will also be conducted 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.

Training needs assessments for capacity building: At the start of the project and latter phases, needs assessments will be conducted to determine technical assistance and training requirements for community and organizational capacity building. The beneficiaries will be: 1) communes that are preparing to be certified as “Kominina Mendrika”; 2) RHOs that are strengthening their supervisory and quality assurance systems; and, 3) NGOs that will be expanding their BCC and community mobilization activities.

Sharing and use of data for decision-making: Quantitative and qualitative information collected from the baseline surveys, assessments, and special studies will be shared with program managers, health facility staff, NGOs and key technical personnel who are responsible for the collection, processing, analysis and dissemination of health information.

In addition, TREIP will build the capacity of the District Health Program Managers, health facility staff and NGOs to use information for decision-making by participating in the RHO review and planning exercises. These meetings will be held every quarter, and their purpose will be to review the previous quarter’s progress and plan the next quarter’s activities. This mechanism will be used to share program information with district and regional MSPF personnel. It is not anticipated that TREIP’s monitoring data will be integrated with the SIGS, as MSPF does not permit the inclusion of any additional information. Findings from the application of the Lives Saved calculator will be shared with the MOH to determine the feasibility of expanding the scope of the comparison of the project’s data sets for these lives-saved intervention and the corresponding data sets for vital events registration, to estimate the impact of reducing mortality from the major causes of under-5 deaths.

Current progress and existing gaps on each of the objectives and corresponding indicators laid out in the DIP for regular review under the monitoring plan are outlined in Table 13: Objective Progress Report Table and more specifically in Annexes 2 and 3.

F. Sustainability Plan

Steps Taken and to be Taken

Seeking to ensure the sustainability of what has been achieved during the implementation of TREIP, and as agreed upon in the DIP, MCDI hired local NGOs it previously worked with directly. These four NGOs benefited directly from MCDI for attaining necessary skills. They will act as relay structures to ensure continuity in the implementation of community activities on the organizational, relational, and technical levels.

During the implementation of the KM approach, MCDI jointly with the Région Sud-Ouest, DRSPF and SSD revitalized the structures of public assistance at the commune level for CCD and CDS. The purpose of this revitalization was to integrate the political and administrative authorities in all the processes of program implementation so that they would take ownership of adoption and institutionalization of the long-term approach.

The cornerstone for the TREIP scale-up program is strengthening capacity regionally, which is based on the success of the DRSPF team in coaching SSDs and CSBs, training, supervising and implementing child survival programs so that the various levels of MINSANPFPS can take ownership of the program.

MCDI is in the process of working with the Antananarivo Medical School and the Paramedical Training Institute to identify training sites in Betioky and Sakaraha where students will be assigned to learn the intervention techniques of child survival at the community and health center levels.

Targets Completed and to be Completed

At the level of local NGO partners, MCDI has finalized the collaborative one-year contracts with two of the four NGOs. At the CCD and CDS level, a contract committed to

reaching the objectives set forth in the KM framework was signed by all the Mayors of the intervention communes. In addition, those NGOs and the CCD/CDS members in each commune have already benefited from MCDI's range of training on the TREIP approaches, including KM, VISA/Reny Limy, AVBC, CCM, Community Radio Program, health mutuelles, and follow-up and supervision techniques with all the tools developed by MCDI (See section IV. Tableau de réalisation, les nombre de CCD/CDS et staff ONG formés). The assistance and support provided to those structures during the implementation process has remained a crucial step.

G. Answers to Dip Reviewers

(See Annex 4)

H-K. Not Applicable for TREIP

L. Description of the Program Management System

Financial management system

MCDI prepares a quarterly budget based on the quarterly work plan. The budget is submitted at the end of each quarter to headquarters for approval and for funds to be transferred. In addition, a monthly financial expense report is sent to headquarters.

Human resources

All of the staff described in the DIP has been hired and is in place. The Director of the International Division provides oversight and direction for the program at the MCDI Headquarters, in Washington D.C. The Child Survival Coordinator is responsible for backstopping at the Headquarters, as well as providing technical and managerial support for the Field Office Program Manager and the Field Team. The M&E Advisor is responsible for compliance with CSHGP M&E requirements and the formative supervision of the MOH staff. All CSP implementation activities are managed and coordinated in country by the Field Office Program Manager who liaises with other project partners and supervises the field staff, which includes a Field Administrator, a Deputy Administrator, a HIS Specialist, a

Regional HCIF Advisor, a Health Education/IEC Coordinator, and a Quality of Care Advisor.

Administrative and Financial support of Headquarters are provided by the Headquarters Administrator and Community Financing Advisor whom respectively backstop the Program Manager and liaise with the MCD Administrator in Augusta, Maine.

An organizational capacity assessment will be conducted under the OMB Circular A-133 Audit that MCDI undergoes annually.

Expansion of the office staff

- Local NGO staff members who implement community activities help strengthen MCDI's activities. NGOs strengthen the district team in the deployment of ASBCs and in assistance during the start-up phase in the project area.
- An IEC/BCC Assistant was recruited in January 2007 to ensure a rapid start of project introduction activities and the training of ASBCs.
- A Health Mutuelle Specialist was recruited to follow-up on existing mutuelle sites and to expand this initiative throughout the Atsimo Andrefana Region.

Capacity building of staff

- The headquarters Monitoring and Evaluation Specialist and the Coordinator of the IEC/BCC activities attended the Mini-University on DIP approval, held at Johns Hopkins University in Baltimore, in June 2007. The conference was an opportunity for these specialists to update and increase their skills on the technical and programmatic aspects of Child Survival interventions with the objective that they would later apply them to improve the implementation of the program.
- The local Monitoring and Evaluation Specialist received various types of training, :
    - in basic training techniques and application of the principles of andragogy to engage adults in training
    - of high-level trainers
    - in Management and Leadership

- in Coaching

This series of training included qualitative notations to make it possible to evaluate how thorough the training was facilitated.

- Proximity Supervisors and local NGO staff were also trained in the basic techniques of training others and applying the principles of andragogy, training of high-level trainers, and training in the conduct and supervision of KAP surveys.
- The Quality of Care Advisor was trained on the new algorithm of integrated management of childhood disease, the introduction of zinc, and the new ORS formula in the framework of clinical and community IMCI.
- The Project Coordinator was trained in the new policy for malaria management, organized by MINSANPFPS and Global Fund Malaria.

The System for Communication and Team-Building

The field office maintains regular communication with the home office, and holds a quarterly staff meeting to facilitate communication and to direct the team on the new guidelines. Planning takes place on an annual and quarterly basis. This work method facilitates the staff in understanding the project and allows for increased efficiency. Moreover, teamwork is a leading motivational factor in the mission. The field office also produces both Annual and Activity Reports that are submitted to the headquarters office, the DRS, and MINSANPFPS for approval. In addition, the project's key staff members hold a monthly technical meeting to review planning, the implementation of activities, and the technical aspects of interventions. With the key partners DRS and SSD, MCDI holds monthly meetings, at the regional and district level, in order to review progress in the implementation of activities, analyze health data for decision-making, analyze and strengthen collaborative relationships, joint planning, and review new MSPF guidelines and initiatives. These monthly meetings also provide an opportunity for the whole project team to strengthen teamwork.

MCDI's relationship with local partners

- MCDI was involved in the development of the new strategic plan of the USAID Mission through its participation in three workshops organized by the mission.

- MCDI took part in these workshops to strengthen the management capacities of Betioky Sud's EMAD, in collaboration with the Coach of Betioky SSD. This workshop consisted of reorganizing the CSBs in supervision zones, each being coached by a member of the EMAD (this model will be replicated to the whole of the RSO with MCDI's support). The TDRs of the CSB chiefs were also reviewed in order to better directly reflect their responsibilities in community activities and CCM, and the needs for both training and EMAD strengthening were assessed.MCDI met with UNICEF and agreed that UNICEF will provide additional resources to the TREIP to fill the gaps in IMCI (clinical and community)
- MCDI participated in the New Born Care Committee and the Project is in the approval phase.
- MCDI participated in the celebration of the World Population Day on July 10 2007 and supported social mobilization for this event.
- MCDI held a work session with the Regional Chief and his team to further clarify the project's activities in July 2007
- MCDI participated in a meeting to assess the achievements of MAP RSO health during its first semester

Coordination and collaboration in the country

MCDI continues to be active in the coordination and collaboration of field activities at the national level.

(a) During the current fiscal year MCDI has been a member of the following:

- Senior Child Survival Committee
- Committee for Development of a national policy in Child Survival
- Reflection Committee on Social Protection Policy (Population Ministry)
- Regional Steering Committee
- National IMCI Committee
- National New Born Care Committee: project is in approval phase
- Voahary Salama
- Health Social Mobilization Committee

- SSME committee

(b) MCDI took part in the following workshops during the current fiscal year:

- The Experience-Sharing Workshop on community-based health programs organized by UNAIDS, WHO AFRO, World Bank, and UNICEF, held in Ethiopia in November 2006.
- Workshop on Planning Communal Interventions in Nutrition organized by MINSANPFPS, ONN in February 2007

(c) Other MCDI Activities during the fiscal year included participation in:

- a meeting to assess the first semester of MAP RSO health, in June 2007
- an experience-sharing workshop on community-based Reproductive Health, organized by the Malian Ministry of Health, WHO, USAID and Project " Frontières", in June 2007
- the celebration of World Population Day, in July 2007
- the DIP review in Baltimore (USA), in June 2007
- the semester review of the Mother and Child Health Directorate (Direction de la Santé de la Mère et de l'Enfant), in August 2007
- the joint review on health in October 2007 (it is the top steering authority in the field of health programs in Madagascar)
- meetings for PMI introduction and planning
- the review workshop of the Child Survival Program organized by UNICEF in September 2007
- the workshop on Project Design and Monitoring Evaluation organized by CSTC/FF in August 2007
- a workshop on results dissemination for the Child Survival Project implemented by ADRA
- a virtual conference on the repositioning of Family Planning with USAID – MSH
- reflection meetings on the implementation of the integrated KM/SAQ model organized by MINSANPFPS, USAID, SantéNet

- A work meeting with FHI to explore the possibility to integrate community-based Depo injectable activities into CCM sites
- A work meeting with IRH/Georgetown University to explore the possibility to include the Fixed-day Method into the AVBC package.

M. Collaboration with the mission and its bilateral project

MCDI has been in regular contact with the USAID/Mission in Madagascar. In February 2007, MCDI presented the results of the baseline KPC to USAID and its partners. USAID was also involved in the planning and development of the DIP. Also, feedback received from USAID was taken into account by MCDI. Additionally, MCDI is involved in the development of the Mission's new strategic plan for FY 2008. The TREIP's framework complements PSI's effort for the provision of social marketing products at the community level, which addresses the gap found in this program.

Collaboration with the bilateral project (**see section 1.4: Contract with SantéNet**)

Visit to the Child Survival Health Grant Project Team Leader: This visit was preceded by a presentation on TREIP at the USAID Mission, before going to Toliara to visit the SSD of Betioky Sud, the CSB Ambatry, as well as the CCM site in Andranokitoto.

N. Timeline of Activities (October 2007-September 2008)

Action plan FY 2008

ACTIVITIES	Year 2008				OBSERVATION
	Q1	Q2	Q3	Q4	
IR 1. IMPROVE THE KNOWLEDGE AND KEY PRACTICES REGARDING MATERNAL AND CHILD CARE					
AT REGION LEVEL					
Train 8 managers from the DRS RSO program on coaching	**x**				
AT LOCAL NGOs' LEVEL					
Finalize contract with partnering NGOs	**x**				
AT COMMUNITY LEVEL					
Identify community health volunteers in 15 remaining communities		**x**			SDSFP Morombe : Befandriana, Ambahikily SDSPF Ankazoabo : Ankazoabo, Andranomafana SDSPF Beroroha : Fanjakana, Behisatsy SDSPF Benenitra : Benenitra, Ehara SDSPF Ampanihy : Fotadrevo, Ejeda SDSPF Toliara II : Miary, Betsinjaka, Tsianisiha, Ankilimaliniky, Milegnaky
Train 415 new ASBCs, among the 5 remaining SSDs, in community mobilization, IEC/BCC including the VISA approach, promotion of the AM, and nutrition of pregnant women	**x**				SDSPFPS de Morombe, Ankazoabo, Beroroha, Benenitra, Ampanihy, Toliara II
Train those 415 ASBCs in the promotion of vaccination, home care of sick children (basic package) while including water hygiene	**x**				
Launch & execute the VISA approach in new districts (Morombe, Ankazoabo, Beroroha, Tiara II Benenitra, Ampanihy)	**x**	**x**	**x**	**x**	In 15 communities amongst the 5 districts
Sponsor 6 500 - 7 000 VISA mothers	**x**	**x**	**x**	**x**	

ACTIVITIES	Year 2008				OBSERVATION
	Q1	Q2	Q3	Q4	
mothers					
Launch and execute the KM approach in 15 communities	x	x	x	x	In 15 communities amongst the 5 districts
Maintain community-based activities within the KM approach in old KM communities	x	x			Extension of the implementation of the KM in the 10 old communes
Execute the community radio program (starting with Betioky and Sakaraha district)	x	x	x	x	
- Diagnose community	x	x	x	x	
- Create supervised focus group to elaborate messages	x	x	x	x	
- Identify the largest radio audience groups	x	x	x	x	
- Box messages	x	x	x	x	
Broadcast messages of each program to all existing stations	x				
Organize sanitary sector health festival				x	
IR 2. IMPROVE QUALITY OF CARE AND HEALTH SERVICES					
AT REGION-LEVEL					
Assist coaches of new 5 districts in training and oversight of SSD and EMAD	x	x	x	x	
Introduce new algorithm in PCIME at health care centers	x	x	x		
Reinforce health system (in collaboration with UNICEF, World Bank, SanteNet): logistics, training, SIG, and other resources….	x	x	x	x	
Strengthen the logistics and the Provision System of Medicine and Vaccines (antigenes, oil, replacement parts) at the level of Health Centers	x	x	x	x	Practical Application of the new module of logistics management PEV
Strengthen the Capacity of DRS on monitoring :	x		x		
- Validate the monitoring grid	x				

ACTIVITIES	Year 2008				OBSERVATION
	Q1	Q2	Q3	Q4	
- Hold a planning workshop for the RSO monitoring		x			
- Develop a program on PDA		x			
- Train the DRS Supervisors on the instruments (PDA included), the analysis and the use of monitoring			x	x	
Support the region in the implementation of the sponsoring system of the Districts and CSB.	x	x	x	x	
AT THE DISTRICT LEVEL					
Train the members of EMAD of the 5 new SSD in FDF : PCIME	x				
Train the members of EMAD of the 5 new SSD on the VISA approach, IEC/BCC, and radio program	x	x	x		
Train the EMAD members of the 5 new SSD on the monitoring capacity		x	x	x	
Support EMAD in the implementation of SAQ		x	x	x	
AT THE HEALTH CENTER LEVEL					
Train 70 ASB on Medical Coverage (ARI, PALU, Diarrhea)	x	x	x	x	
Train 70 ASB on the AEN	x	x	x	x	
Train 70 ASB on the VISA and KM approach, community radio program	x	x	x	x	
Train 140 ASB in monitoring and the SAQ approach	x	x	x	x	
Continue the implementation of the SAQ in the SDSPFPS of Betioky, Benenitra, Sakaraha	x	x	x	x	
Refresh 162 ASB on the PCIME					
Set-up the PCIME Clinic at the CSB level	x	x	x	x	

ACTIVITIES	Year 2008				OBSERVATION
	Q1	Q2	Q3	Q4	
Continue the implementation of 2 Pilot districts for the introduction of zinc amongst others Betioky sud and Benenitra	**x**	**x**			
Strengthen the logistics and Medicine and Vaccine provision Systems (antigens, oil, replacement parts…)	**x**	**x**	**x**	**x**	
IR 3. IMPROVE THE ACCESS TO HEALTH FACILITIES					
AT THE REGIONAL LEVEL					
Apply the norms and standards, especially on the health training without trained personnel	**x**	**x**	**x**	**x**	
Fund the IEC/BCC program of the DRSPF in communication equipment	**x**				
Support the DRS/SSD in mass campaigns (SSME, vaccination)	**x**	**x**	**x**	**x**	
AT THE COMMUNITY LEVEL					
Set-up 415 AVBC in the 5 remaining SDSPFPS	**x**				SDSPFPS of Morombe, Ankazoabo, Beroroha, Benenitra, Ampanihy, Toliara II
Train 415 AVBC of the 5 remaining SDSPFPS on community level sales of key health products	**x**				
Support the 415 AVBC of the 5 remaining SDSPFPS on household and community coverage and the reference to the CSB on malaria, diarrhea, including the Zinc therapy/new SRO formula	**x**				
Assure the provision of the 415 AVBC for health products	**x**	**x**	**x**	**x**	
Implement the AVBC activities: sale and/or distribution of health products (MID, Palustop, condom, sur'eau, zinc…)	**x**	**x**	**x**	**x**	

Extend the Health Insurance ("Mutuelle de la santé") in the 5 communes of the RSO	**x**		**x**		
Carry out a feasibility study at the level of 5 new communes		**x**	**x**	**x**	
Carry out sensitization to the new communes for the implementation of the Health Insurance ("Mutuelle de la santé")		**x**	**x**		
Train the management committee members of these 5 new communes			**x**	**x**	
Set up the Health Insurance “mutuelle de santé” in these 5 new communes			**x**	**x**	
Follow-up on the existing “mutuelles de santé”	**x**	**x**	**x**	**x**	
Follow-up on the implemented “mutuelle” in the Toliara II district	**x**	**x**	**x**	**x**	
Follow-up on the implemented “mutuelle” in the Betioky Sud district	**x**	**x**	**x**	**x**	
IR 4. IMPROVE THE POLICAL AND SOCIAL ENVIRONMENT					
AT THE REGIONAL LEVEL					
Equip the DRSPF with computers and peripherals	**x**	**x**			IEC/BCC Service of the DRS
Support the region in the set-up and operations of the Steering Committee for Health Development	**x**	**x**	**x**	**x**	
Participate in the national technical committees (SE, NN, Nutrition…)	**x**	**x**	**x**	**x**	
Support in the execution of the quarterly review at the regional and district level		**x**		**x**	
Develop the regional strategies of IEC/BCC, including the messages at the regional level (including institutionalization of TREIP’s IEC/BCC strategies)	**x**	**x**	**x**	**x**	

AT THE DISTRICT LEVEL					
Set-up the stage sites in the showcase district (Betioky sud) and the demonstration district (Sakaraha)		**x**	**x**	**x**	
AT THE COMMUNITY LEVEL					
Set-up and train the community structures on TREIP and KM's interventions in the 15 communes of the 5 new SDSPFPS	**x**	**x**			

O. Results Highlight

Innovative Ideas: The Coaching System

The Coaching System was initiated by MINSANPFPS throughout Madagascar and piloted in the RAA region. The purpose is to speed-up, facilitate and better coordinate the implementation and the achievement of the objectives of MAP's health component. The initiative consists in making each manager of the DRS program, as well as each officer, responsible for one or two health districts under his authority to supervise, assist, follow-up and train. The manager/coach provides his support to solve problems in connection with the implementation of the health program, at the relational and organizational level. This way, each EMAD member in the district has one or two CSBs under his authority. In effect, the coach is, in some manner, a supporter or a guide towards the achievement of operational objectives. The coaching system is functional in two RSO districts, and it is in the process of being replicated in the other districts in the project area, based on preliminary evidence of success in the two pilot areas.

Description of Promising Practices: Community Case Management

Since 2002, MCDI's Madagascar program has given a particular importance to community-based management (CCM) of childhood illnesses, while promoting other key practices defined in Madagascar's IMCI policy.

MCDI began with a basic CCM package that promoted simple key actions at home when a child becomes sick, and since the end of 2006, MCDI has began to introduce what it calls a “complete package” consisting in the coverage of sick children at the community level.

MCDI focuses on the CCM in the DIP and has considered it an achievement that BASICS already supports MINSANPFPS central in the programming and implementing of this CCM program, which has benefited the TREIP.

Components of the CCM basic package and complete package

The following table outlines the components of both packages:

Package	Components	Type of community agent in charge	Education Level	Training Method	Recruiting Method
Base Package	- Research of danger signs for children's sickness and reference - Increase in the fluids given, continued feeding, continued breastfeeding in the case of illness - Increasing the food ration after two weeks after being cured (increase by one extra meal) - Following of children's illness evolution and the adherence to treatment according to the recommendations of the health staff - Treatment of fever by an	Community Animator	There is no specific education level required Considering the situation, literate people.	It is based mostly on audio-visual memorization techniques (singing, posters, video) Theory Training for 2 days Practical Session for communication techniques in the community	Health Volunteers approved by the community Average Ratio of 1 Animator per 500 people

Package	Components	Type of community agent in charge	Education Level	Training Method	Recruiting Method
	anti malaria medicine following the recommendations of the RBM - Increasing fluids in the case of diarrhea				
Complete Package	- All the components of the base package - Diarrhea Coverage by the Zinc and the osmolarity based ORS (children under-5) - Pneumonia Coverage by Cotrimoxazole (children under-5) - Coverage for Fever Cases by ACT (children under-5)	Agent for Sick Children Coverage (CCM Agent). In the local language, this type of agent is called a "*Mpandomba''* i.e. a first resort agent.	Can at least read and write. The Average education level on the site is the 7^{th} grade. (i.e. 7 years of basic schooling) Minimum level is 5^{th} grade (i.e. the end of elementary school)	Theory Training with hands-on training in a health center (5 days total) with a certificate at the end of the training This certificate is to be validated annually during the recycling sessions	Recruited amongst the best community animators suggested by the HFW. Average: 3 sites ''Mpandomba'' by HF. These sites are located more than 5 km from an HF

Examples of problems encountered by the trained staff during the implementation of CCM activities:

- Low technical skills in training, especially with regards to andragogy
- Low technical skills in supervision
- Difficulty in conducting follow-ups
- Low reporting: data from community sites not integrated into the information system of health centers
- Resistance to the implementation of the complete package
- Difficulty in managing the procurement of medicines, management tools, equipment for the sites

For the whole package, MDCI requires observation of five visits during the practical training session. MCDI's experience has shown that, on average, from the fourth visit observed, the *Mpandomba* are able to perfectly master the management process.

A review of patient cards at the community level has shown that the "*Mpandomba"* are able to master the management process after two visits of post-training follow-up. In most cases, the newly trained "*Mpandomba"* have some difficulty with the treatment of ARIs – they break the protocol by giving cotrimoxazole to children suffering from an ARI, even if the children do not have pneumonia. One of the reasons for this may be the belief of "*Mpandombas"* that for each visit, they must offer something to treat the case.

Kominina Mendrika, an approach which has enhanced the institutional strength of community approaches in place, in order to obtain better results and an efficient partnership

MCDI is in the process of implementing the KM approach in RSO. The use-of-services indicators collected at the CSB level in these communes show a sharp jump as compared with the progression observed during the 12 months prior to the KM launch.

An analysis of the reason for this "surplus" increase has revealed that the KM approach has not only expanded the number of local health actors by involving all the community actors available (schools, communities, leaders, communes, etc.) but it has also created a new functional relationship between the community, the Health Center and the Commune. The introduction of the KM approach has involved the Commune in this network, which added an institutional force to the community approach in place and gave more credibility to the activities of BCC, social mobilization and to the actors. The Commune has even taken the lead for all health actions.

One of the reasons for the success of MCDI's interventions in its KM Communes is the greater availability of critical resources, including social marketing products such as the Supermoustiquaire® and the Pilplan®. This is the result of a successful partnership between SantéNet and PSI that prioritized the procurement of those products for KM targeted communes. Since the implementation of KM, MCDI and its

community-based networks have no longer experienced stock shortages for those products and they have at their disposal an appropriate security stock. Demand at the community level is constantly increasing and collaboration with PSI has made it possible to meet this increasing demand.

Description of Improvement in Local Institutions Capacity- Capacity Building for local NGOs

In order to insure support to MINSANPFPS for the implementation of community-based activities in the framework of the TREIP, and to contribute to the project's sustainability, four NGOs were selected by MCDI. Members of those four NGOs beneficiated from capacity-building in IEC/BCC to enhance the social mobilization, follow-up and supervision of community actors in order to participate in the follow-up, monitoring and assessment of activities. They also received various kinds of training, among others on the Kominina Mendrika Approach, the VISA[3]/Reny limy approach, Community-based Health Volunteer training, AVBC, and Community Radio Program training.

Restructuring Local Development Committees

In connection with the implementation of the KM approach, assistance structures at the commune level were revitalized to facilitate the implementation of this approach. The Communal Development Committee and the Social Development Committee were restructured in order to participate actively in the health development of the commune. The TREIP has provided its support to these structures in the area of training in the Kominina Mendrika Approach, the VISA/Reny limy approach, Community Health Volunteers, AVBC, Community Radio Program. The TREIP has also helped to strengthen the skills of the members of these committees in IEC/BCC, supervision and follow-up of community activities.

Training Regional Officers

As mentioned in the DIP, the TREIP takes an active role in capacity building at all levels of MINSANPFPS. This capacity building involved the training of regional officers in the various approaches implemented by the TREIP (KM, VISA/Reny limy, Health Mutuelle), the training of district focal points in managerial techniques, IMCI-C, as well as supervision, the training of ASBs in the various above-mentioned approaches, and the introduction of zinc and the new ORS formula for diarrhea management.

Annex 1: Methodology for Surveys Conducted

TREIP's KPC Baseline Survey 2007

The primary objective of the survey has to measure baseline knowledge and practices on immunization, breastfeeding, modern contraceptive methods, complementary breasting and vaccination coverage in the target district prior to the beginning of project activities. The baseline survey will also contribute to the health situation analysis of the project area. The study population consisted of mothers of children under the age of 24 months living in the project area. 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 baseline survey will help the project set measurable objectives and assess achievements of project objectives.

Methodology

The Questionnaire

The generic questionnaire of the KPC 2000+ unit had been the initial tool to conduct the basieline survey and had included the rapid CATCH (variables introduced after the KPC survey began last year may have not been included). The five questionnaires described below were used:

- 1 questionnaire, including most Rapid CATCH indicators, was for mothers of children between 0-23 months.
- 1 questionnaire, with information on exclusive breastfeeding practice, was applied to mothers of children under 6 months.
- 1 questionnaire, for mothers of children between 6-9 months, to assess the introduction of complementary food. As discussed before, this survey included areas in which the previous CS project had collected information from children in this restricted age group.
- 1 questionnaire, for mothers of children 12-23 months to assess the child's immunization status, and feeding practices.
- and 1 questionnaire, for mothers between 15-45 years, to assess the use of modern contraceptive methods (applicable to Toliara and Betioky, where the previous CS had included a birth spacing intervention)

Final questionnaires were translated into the local language. Before being finalized, they were pre-tested in field-work by the survey supervisors as part of their training, were refined during the supervisors' training.

Questionnaires included questions relevant to the interventions in the previous TPCSP (Toliara and Betioky), TREIP's interventions (all clusters included in this report) and Rapid CATCH (all clusters).

Determination of Sample Size

The sample for this survey was stratified to satisfy the needs to a) assess impact in TPCSP's area and b) to establish a baseline in TREIP's new districts. Thirty clusters with ten children per cluster were included in Toliara II and Betioky. TREIP's cluster distribution, proportional to the population, was 19 clusters in the new TREIP districts, 6 clusters in Toliara II, and 5 clusters in Betioky (which were included in the final Toliara KPC report).

Districts ->	Betioky Sud	Toliara 2	New districts in TREIP	All
Number of clusters for this baseline survey	(Pop BS / Pop Tot) x 30 clusters= **5 clusters**	(Pop T2 / Pop Tot) x 30 clusters = **6 clusters**	(Pop ND TREIP / Pop Tot) x 30 clusters = **19 clusters**	30 clusters
	Those surveys will be also used for the final evaluation of the TPCSP			

Within each stratum, sample sizes were calculated with the following formula :

$$n = z2(pq)/d2$$

where n = sample size; **z** = statistical certainty chosen; p = estimated prevalence/coverage rate/level to be investigated; q = 1 - p; and d = precision desired.

The value of p was defined by the coverage rate that requires the largest sample size (p = .5). The value d depends on the precision, or margin of error, desired (in this case d = .1). The statistical certainty was chosen to be 95% (z = 1.96). Given the above values, the following sample size (n) needed was determined to be:

$$n = (1.96 \times 1.96)(.5 \times .5)/(.1 \times .1)$$
$$n = (3.84)(.25)/.01$$
$$n = 96$$

It takes a long time to randomly select an identified individual from the survey population, and then perform this selection 96 times to identify a sample of n = 96. Time can be saved by doing a 30 cluster sample survey in which several individuals within each cluster are selected to reach the required sample size. However, in order to compensate for the bias from interviewing people in clusters rather than randomly selecting individuals, experience has shown that a minimum sample of 210 (7 per cluster) should be used,

given the values of p, d, and z above (Henderson, et. al., 1982). In general, when using a 30 cluster sample survey, the sample size used should be approximately double the value of n, when: n = (z x z)(pq)/(d x d). In this case, a sample size of 300 (10 per cluster) was selected so as to ensure that sub-samples would be large enough to obtain useful management type information.

The estimates of the confidence interval for the survey results were calculated using the following formula :

95% confidence interval = p $\pm$ z(square root of {pq/n})

where : p = proportion in population found from survey; z = statistical certainty chosen (if 95% certainty chosen, then z = 1.96); q = 1 - p; and n = sample size

EXAMPLE : If the proportion of children in the survey who were completely and correctly immunized is 37% and **n** = 297:

95% certainty = $.37 \pm 1.96\sqrt{0.37 \times 0.63 \div 297}$

(z = 1.96)

1.96 = .37 $\pm$ .03 (or, 34% to 40%)

In other words, we are 95% sure that the actual proportion of children in the survey area who are completely and correctly immunized is between 34% and 40%.

Selection of the Sample

Within each stratum, each questionnaire was administrated to 300 mothers of children between 0-23 months from households selected at random. The selection process for households was compatible to that described in the KPC 2000 field

guide; instructions for supervisors were developed prior to their training.

To reduce the homogeneity of samples that is, the sampling effect (d_{Ef}), the first household was one which was identified as the principal household in the selected village quadrant and the next household was the third one down from the preceding household.

Parallel sampling was applied to the following specific groups :

- ✓ mothers of children between 0 and 23 months;

- ✓ mothers of children under 6 months to analyze mothers' breastfeeding of children under 4 and 6 months combined with "Over Sampling" method to be applied for the specific age group of 0-4 months;
- ✓ mothers of children between 6 and 9 months to analyze the introduction of complementary feeding
- ✓ children between 12 and 23 months (for the immunization and the continuation of breastfeeding / feeding aver 12 months) combined with an "Over Sampling" to be applied for the groups of 12 to 23 months of age who have received DPT1 to analyze the loss rate between DPT1 and DPT3 ;
- ✓ women of 15-45 years of age for the use of modern contraceptives;

The "Over Sampling" method was applied to the following specific groups :

- ✓ children of 0-23 months of breastfeeding age (for the mother's breastfeeding initiation);
- ✓ children of 6-23 months (for vitamin A);
- ✓ mothers of children between 0-23 months, who are not pregnant, and do not want to be for the next 2 years;
- ✓ children of 0-23 months who were sick within the 2 weeks preceding the survey.

It should be noted that for each specific age group targeted by the Over Sampling, questionnaires were administrated to at least 7 mothers to assure a reasonable minimum number of answers.

TREIP's baseline R-HSPA

The primary objective of the R-HSPA is to assess quality and access to maternal and child services at the primary level health centers. MCDI in Madagascar works only at this level, and does not conduct any activity at the district hospitals.

Methodology

MCDI Madagascar completed a set of HFA in late 2006 for the final evaluation of TPCPS, with the tool used in its baseline. DIP Guidelines for FY07 strongly recommend using CSTS's Rapid health Service Provision Assessment, R-HSPA. This assessment was done in early 2007 in 30 primary public health facilities in TREIP's intervention area.

Tools

The generic R-HSPA was adapted to make it specific for TREIP's interventions. R-HSPA has five instruments listed below, and the first four were used during this baseline assessment:

1. Observation of Clinical Care for 5 consecutive sick children
2. Exit Interview for Caretakers of five consecutive sick children

3. Health Facility Checklist

4. Health Worker Interview & Record Review

5. Community Health Worker Assessment (this will be carried out as CCM agents are identified in the new districts)

R-HSPA's core and optional indicators collect information about access and quality. Detailed information was obtained for TREIP's interventions (management of malaria, ARI, diarrhea and nutritional disorders).

Determination of Sample Size and Sample Selection

There are 163 HFs in the project area, out of which 30 primary level health facilities were selected. The distribution of these 30 facilities, proportionate to the population, was 19 facilities in new TRIP districts, 6 facilities in Toliara II and 5 clusters in Betioky (the later included in the final Toliara KPC report).

Districts ->	Betioky Sud	Toliara 2	New districts in TREIP	All
Number of facilities for this baseline survey	(Pop BS / Pop Tot) x 30 clusters= **5 facilities**	(Pop T2 / Pop Tot) x 30 clusters = **6 facilities**	(Pop ND TREIP / Pop Tot) x 30 clusters = **19 facilities**	**30 facilities**

As part of R-HSPA, a total of 60 observations of provider performance were conducted.

Annex 2: Main Results of Household Surveys (KAP) Conducted up to Present:

Household surveys were conducted in the area of both Projects Toliara II and South West Region (Région Sud-Ouest) between the end of 2006 and the beginning of 2007, in order to carry out the final assessment of the project conducted at Toliara II, and in order to study the health status in Région Sud-Ouest. Surveys focused on the Knowledge, Attitude, and Practice of mothers in maternal and child health.

ACUTE RESPIRATORY INFECTION COVERAGE

	TOLIARA II		**SOUTH WEST REGION**	**EDS**	
Indicator	**Base line Survey 2002**	**Final Survey 2006**	**2007 Survey on the 9 DS**	**Toliara**	**Madagascar**
Incidence of ARI	70%	68%	63%	33% (0-23 months) ARI Case associated to a fever	16% (0-59 Months) ARI Case associated to a fever
Proportion of children that had difficulty breathing or rapid breathing and whose mothers looked for treatment at the health center	15%	56%	28%	Not Available	Not Available
Proportion of mothers who know at least 2 danger signs of ARI.	25%	63%	29%	Not Available	Not Available
Proportion of mothers of children from 0-23 months who look for treatment at the CBS when their child has ARI, after 48 hours from the first sign of ARI.	10%	36%	10%	Not Available	Not Available

CONTROL OF DIARRHEA RELATED ILLNESSES

	TOLIARA II		**SOUTH WEST REGION**	**EDS**	
Indicator	**Baseline Survey 2002**	**Final Survey 2006**	**2007 Survey on the 9 DS**	**Toliara**	**Madagascar**
Incidence of diarrhea	61%	39%	49%	21% (0-59 months)	42% (0-23 months)
Proportion of mothers with children from 0-23 months who give the same	36%	66%	32%	Not Available	Not Available

	TOLIARA II		SOUTH WEST REGION	EDS	
amount of breast milk or more to their child with diarrhea					
Proportion of mothers with children from 0-23 months who give their child with diarrhea more fluids	34%	52%	26%	32% (0-59 months)	35% (0-59 months)
Proportion of mothers with children from 0-23 months who give their child with diarrhea the same amount or more of food	24%	54%	36%	ND	- 29,4% have received the same amount of food as usual - 9,1% have received more food than usual
Proportion of mothers with children from 0-23 months who wash their hands with detergent, soap, or ash before preparing food, before feeding the child, after having defecated and after cleaning a child who has defecated	2%	5%	3%	Not Available	Not Available
Proportion of mothers with children from 0-23 months who give their children with diarrhea any amount of fluids from home	Not Available	Not Available	54%	Not Available	Not Available

MALARIA CONTROL

	TOLIARA II		SOUTH WEST REGION	EDS	
Indicator	**Baseline Survey 2002**	**Final Survey 2006**	**2007 Survey on the 9 DS**	**Toliara**	**Madagascar**
Incidence of Malaria	61%	49%	26%	33% (0-59 months)	74% (0-23 months)
Proportion of kids who slept under an impregnated bed net the night before the survey	3%	58%	26%	19%	Not Available
Proportion of mothers with children from 0-23 months who had anti-malaria prophylaxis during their pregnancy	31%	72%	30%	55%	58%

	TOLIARA II		SOUTH WEST REGION	EDS	
Proportion of mothers with children from 0-23 months who gave an appropriate treatment from home for a malaria syndrome	13%	36%	17%	Not Available	Not Available
Proportion of households/mothers possessing an impregnated bed net.	Not Available	74%	27%	28% (Mothers of children from 0-59 months)	39% (Mothers of children from 0-59 months)
Proportion of mothers with children from 0-23 months who sought treatment at the level of the health center for malaria within the first 48 hours of the apparition of the first sign of malaria	32%	51%	15%	Not Available	Not Available

IMCI

	TOLIARA II		SOUTH WEST REGION	EDS	
Indicators	**Baseline Survey 2002**	**Final Survey 2006**	**2007 Survey on the 9 DS**	**Toliara**	**Madagascar**
% of mothers of children 0-23 months who know at least two signs of danger of childhood illnesses which necessitate treatment.	21%	77%	43%	Not Available	Not Available

VACCINATION

	TOLIARA II		SOUTH WEST REGION	EDS	
Indicators	**Baseline Survey 2002**	**Final Survey 2006**	**2007 Survey on the 9 DS**	**Toliara**	**Madagascar**
Proportion of children from 12-23 months who are completely vaccinated (against the 5 illnesses prevented by vaccination) before their first birthday (according the vaccination record)	30%	71%	33%	28%	53%

Proportion of mothers with children from 0-23 months who received at least two doses of VAT before the birth of their youngest child	34% (record)	50% (record) 34% (mothers' reports)	10% (according to the PNC record) 31% (mothers' reports)	35%	40%
Proportion of losses \between DTCP1 and DTCP3	21%	10%	19%	Not Available	Not Available

BREAST FEEDING AND NUTRITION

	TOLIARA II		**SOUTH WEST REGION**	**EDS**	
Indicators	**Baseline Survey 2002**	**Final Survey 2006**	**2007 Survey on the 9 DS)**	**Toliara**	**Madagascar**
Proportion of children from 0-6 months fed exclusively by breastfeeding in the last 24 hours	2%	41%	24%	Not Available	67%
Proportion of mothers who started Amenorrhea in the first hour following birth	24%	54%	27%	51%	62%
Proportion of children from 0-23 months having 2 ET less (-2 ET) compared to the median weight by age, according to the reference population of the OMS/NCHS	19%	**18%**	36%	Not Available	Not Available
Proportion of children from 12-23 months who received 5 meals or more, aside from breast milk.	19%	48%	2%	Not Available	Not Available
Proportion of mothers who gave their child the colostrum	72%	78%	39%	Not Available	Not Available
Proportion of children who received breast milk and additional food amongst children of 6-9 months in the last 24 hours.	97%	100%	65%	Not Available	Not Available
Proportion of mothers of children from 0-23 months who received iron supplements while they were pregnant	24%	59% (Mother's report)	27%	18% (In the form of syrop or a pill)	32% (In the form of syrop or a pill)

BIRTH SPACING

	TOLIARA II		SOUTH WEST REGION	EDS	
Indicators	**Base Survey 2002**	**Final Survey 2006**	**2007 Survey on the 9 DS**	**Toliara**	**Madagascar**
Proportion of mothers of children from 0-23 months who are not pregnant, who do not want another child in the following 2 years, or who are not sure about it, and who are using a modern form of contraception.	9%	24%	15%	12% (Any type of modern method)	18% (Any type of modern method)
Proportion of mothers who know that AME is a method of pregnancy delaying	1%	3,7%	1,3%	Not Available	Not Available

PRE-NATAL CONSULTATION

	TOLIARA II		SOUTH WEST REGION	EDS	
Indicators	**Base Survey 2002**	**Final Survey 2006**	**2007 Survey on the 9 DS**	**Toliara**	**Madagascar**
Proportion of mothers who have done at least 2 PNCs during the pregnancy of their last child	41% (according to health records) 68 % (according to what was said)	41% (according to health records) 725% (according to what was said)	9.7±3.4% (according to the PNC record) 31.4±5.3% (according to what the mothers said)	74% (Mothers having done at least 1 PNC)	80% (Mothers having done at least 1 PNC)
Proportion of children from 0-23 months whose birth was assisted by qualified health personnel	58%	41%	49%	53%	51%
Proportion of children from 0-23 months whose birth took place with someone who had been given health training	30%	43%	27%	-25,50% (public sector)	- 29,2% (public sector)

Annex 3: Main Results of Health Center Surveys Conducted

In addition to the household surveys, health center surveys were also conducted.

Type of Analysis	Indic. #	Domain	Indicator	2007 Situation
ACCESS	**1**	Availability of service*	% CSB offering the 3 basic childhood health services (nutritional monitoring, vaccination, treatment of sick children)	80%
INPUTS	**2**	Staffing*	% of personnel who offer clinical services and who worked on the day of the survey	88,5%
	3	Infrastructure*	% of essential infrastructures available on the day of the survey (running, improved water source, working latrines for the clients, communication equipment, emergency transportation method, beds, installation allowing for confidentiality)	36%
	4	Supplies*	% essential supplies which support children's health in the CSB on the day of the survey (functional and accessible balance for children and infants, stopwatch/ watch for pneumonia diagnosing , spoon/mug/container for administration of the SRO)	50%
	5	Medicines*	% of primary line medications available in the CSB on the day of the survey (SRO oral antibiotics for pneumonia, primary line antibiotics for dysentary primary line antimalarials, vitamin A)	32%
PROCESSUS	**6**	Information System *	% CSB who maintain daily records for children under-5 (age, diagnostic, treatment) to % of CSB who have the reports of the last 3 months and who have evidence for the use of the findings	Currently Being Analyzed

Type of Analysis	Indic. #	Domain	Indicator	2007 Situation
	7	Formation	% CSB in which the personnel interviewed reported having been trained in children's health on the job or beforehand in the last 12 months	93%
	8	Supervision	% CSB having received at least one external supervisory control in the last 6 months (including one or more of the following activities: verification of the reports or records, observation of work, feed-back emission, giving of updates, discussion of problems)	100%
OUTPUTS	**9**	Use of treatment services	Number of cases of sick children seen annually (CS) over the children under-5	83%
	10	Performance of Health Agents	% of key evaluation tasks carried out by the health agent (looking for general danger signs, evaluating the nutritional practices, evaluating the nutritional status, verifying the vaccination status)	20%
	11	Performance of Health Agents	% clinical cases seen to whom the treatment given by the ASB is appropriate for the diagnosis made (by observation for the ASB)	36%
	12	Performance of Health Agents	% clinical cases of children seen to whom the ASB prescribed antibiotics, anti-malarial medication or ORS and whose guardian can correctly describe how to administer all the medication	62%

OPTIONAL INDICATOR DEFINITIONS - RAPID HEALTH SERVICE PROVISION ASSESSMENT

Type of Analysis	Indic. #	Domain	Indicator	Baseline Situation
ACCESS	**Opt1**	Geographic Access to Curative Services	% of the population who has geographic access to a children's health care treatment provider	42%

OPTIONAL INDICATOR DEFINITIONS - RAPID HEALTH SERVICE PROVISION ASSESSMENT

Type of Analysis	Indic. #	Domain	Indicator	Baseline Situation
INPUTS	**Opt2**	Availability of Immunizations	% CSB having a stock of all the vaccine antigens on the day of the survey	39%
	Opt3	Availability of Guidelines	% CSB having all the national guides available and accessible for child care on the day of the survey	0%
	Opt4	Infection Control	% supplies and equipment for infection control available in the CSB on the day of the survey	42%
PROCESSES	**Opt5**	HF-Community Coordination	% CSB that have routine community participation during the management meetings (with documentation) OR having a system to collect the clients' views AND having evidence that the clients' feedback is reviewed	0%
	Opt6	Community Referral	% CSB who receive at least one referral from the community Agents in the last month	33%
	Opt7	Quality Improvement Process	% CSB having documented the routine quality assurance activities of the last 3 months	N/A (Program currently taking place)
OUTPUTS	**Opt8**	Utilization of Preventive Services	Average number of children under-5 seen annually in each CSB in the project zone for: a. vaccination and b. for monitoring and promotion of growth	Vaccination = 1003 contacts/year CS monitoring of growth= 306

Annex 4. ANSWERS TO DIP REVIEWERS

DIP Comments from Madagascar Mission and MCDI Responses
Benjamin Andriamitantsoa & Nazo Kureshy

The Mission looks forward to its continued partnership with MCDI and its local partners through the Expanded Impact project that will scale up high impact interventions and MCDI innovations for child survival in the Southwest Region. The Mission hopes that MCDI and the Regional MOH will be able to facilitate the development of a regional model of successful programming through its continued investment in partnerships and programming in the Southwest region.

Overall the DIP is well organized and presents a strong rationale for the overall strategy and describes well each technical intervention area. The following are comments to further strengthen the DIP:

1. **The workplan presented in Annex 15 does not provide sufficient operation information. Please develop a more comprehensive workplan that provides key operational insights and details, particularly since the project that is attempting to scale up and has been asked by the MOH to change its scale up strategy to work in communes of all districts rather than phase in districts.**

See revised detailed workplan

2. Scale up activities: the MOH had asked MCDI to change its scale up strategy to a "commune to commune" approach and trying to have a 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 phasing of the interventions according to the "commune to commune" approach, as MCDI attempts to address the MOH's requests

DISTRICT	Phase 1 : start-up (7-9 March 2009)		Phase 2 : extension to rest of Communes (April 2009 to Sept. 2010)		Phase 3 Transfer and retreat (Oct 2010-Sept 2011)	Observations
	Intensive intervention communes	Communes with reduced support	Intensive intervention commune	Commune with 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	

The choice of communes was established by the DRSPF. The table below shows the main activities planned in the different intervention phases in the Communes:

Intensive intervention phase	Reduced support phase	Transfer and retreat phase
- Set up and organization of community relay structures - Set up of community-based approaches : KM, VISA, CBD/CC, Community Radio program, BCC, community mobilization - Recruitment and training of relay NGOs to support the SSD in the implementation of community activities - Training of health agents on community-based activities	- Maintain activities in place through follow up, supervision and refresher training - Strengthening of the local NGO capacity, EMAD, ASB for the implementation - Strengthening of the collaboration between SSD, NGOs and the community	- Transfer of responsibilities to the NGOs, EMAD, CSB for the implementation under aegis of DRSPF - Documentation of good practices and identification of opportunities to continue activities (resources) - Updating of tools according to lessons learnt during the implementation

Note that from the first year, MCDI will cover all of the districts in terms of the interventions, at the level of the health system, including the strengthening of the DRSPF and EMAD.

3. The <u>interface with SanteNet and other partners</u> should be clearly delineated, as SanteNet will overlap with TREIP for a year.

SanteNet is providing 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 is covering expenses linked to child survival interventions. After termination of SanteNet project activities in 2008, TREIP is proposing to maintain KM activities at the community level. In effect, the implementation costs for maintenance of KM activities at community level will surpass the budget capacity of TREIP and MCDI cannot commit to continuing to implement this approach without additional resources. This was discussed with SanteNet, who understand the importance of this proposition. All the same, TREIP will continue to adopt the key stages of the KM approach for the communes that are going into their second and third years (set up of objectives, monitoring and evaluation). This adoption of the key stages in the KM approach will be the main focus of a workshop with DRSPF and will be the prelude to the design of a model which is more sustainable financially. Actually, SanteNet is in the process of testing an implementation model by the SSD without intervention of NGOs. The lessons learnt from this pilot study will be taken into account for the follow up of the implementation of KM within the framework of TREIP.

4. Please include the <u>project's exit strategy for communes</u>, particularly as it pertains to products for CBDs and incentives for CHWs.

In Betioky and Toliara II, TREIP project activities will be transferred to local NGOs, while technical assistance for those new aspects of the project will continue to be provided by TREIP and Betioky district will be established as a "showcase district".

Continued provision of products for the CBDs could be sustained through 2 mechanisms: (1) Supply to the public health infrastructures: this supply model has been approved by the MOH and seems to have the most potential to ensure continuity as long as the supply system of the CSB and SSD is efficacious and is supported. TREIP is putting efforts into this last point.
(2) Through PSI, who supplies social marketing products (subsidized). Just as the community-based establishments, comprising CBDs, are linked to the CSBs and will be part of the health system, the withdrawal strategy in the Communes will consist mainly of transferring responsibility for teaching and follow up of community-based establishments to the CSBs'. This responsibility will be supported by the development of the Regional Behavior Change Strategy from the beginning of the project.

With regard to CHW incentives: See #2 of the response to Talens' comments.
In addition, MCDI will contribute to the development of a National Community Health Policy which will define further the motivation methods to be used for the CHWs. Prior to the development of this policy, MCDI had proposed to the MOH, in the form of a concept paper, the reorganization of the Community Health System in Madagascar. The MOH showed their interest in this proposition (see annex).

5. **Since supervision is a key element of success of the integrated CCM strategy, please describe project strategies to address quality through supervision (identification of issues, follow-up, joint problem**

   solving and coordination) in greater detail. Please indicate potential weaknesses in supervision strategy for integrated CCM and how the project may be able to benefit from additional technical support in this area.

Having addressed the quality of the CCM, the supervision will focus on 4 points:

- Technical platform of the CCM sites,
- The competence/performance of the CCM agents by evaluation of recent cases managed and/or direct observations via consultation if possible,
- The management of the CCM sites (data, tools, inputs, etc.)
- The perceptions of the community vis-à-vis services offered by the sites.

Supported by the DRSPF and MCDI, l'EMAD will ensure the supervision of the CSBs, who in turn, will assure the supervision of CCM activities. They will be supported by EMAD and the local NGOs. For the supervision, MCDI will use the tools developed by the Child Survival Technical Committee (MCDI was part of this Committee), which are described in the Madagascar CCM implementation guide. Moreover, MCDI developed a complementary supervision tool for the CCM inspired by the PCIME supervision tool for the CSBs. This tool comprises of:

- Interview of CCM agents
- Observation and consultation
- Interview of a parent with an infant whose illness was recently managed
- Inventory of the CCM site
- Interview of the community.

This tool was developed based on standards of a CCM site.

The potential supervision problems are accessibility to the CCM sites, EMAD's weak capacity for technical supervision and the lack of human resources and materials for the achievement of these supervisions. In order to address these problems, MCDI proposes to focus efforts on strengthening the supervision capacity of the ASB and NGOs. Since BASICS is in the process of following and strengthening the pilot experience in Madagascar, MCDI hopes to benefit from their support in this area of supervision.

6. **Since supervision is critical to the project, please <u>delineate supervision frequency and roles and responsibilities</u> (e.g. BCC advisor, Health center nurse/staff, joint supervision teams) for supervision and joint-problem solving and coordination. How will the quality of supervision**

be assessed as the project expands and what may be strategies to reinforce supervision in areas that may prove to be problematic? Please include details of the integrated supervision tool and include the tool as an annex, if possible (official letter from USAID)

The table below summarizes the supervision plan of the project:

Personnel	Supervisor	Frequency of supervision	Type of Supervision
CCM Agents, CBDs, CHVs, VISA mothers	local NGO's, Health agents	Monthly	Site visits, group supervisions
Members of the Management Committee for the Mutuelles	local NGO	Quarterly	Site visits to village offices
Local NGOs	Chief of Project, HIS project officer	Monthly	Monthly review
Health Agents	EMAD	Quarterly and monthly (for the review)	Monthly reviews, site visits
EMAD	DRSPF	Quarterly	Site visits
MCDI Technical team	Chief of Project	Monthly	Monthly review

MCDI staff is not mandated to take direct responsibility for the supervision of health personnel but to strengthen technical capacity of the DRSPF and EMAD so that they in turn are able to conduct quality supervisions.
The quality of the supervisions will be evaluated using the following points:

- Use of an appropriate form
- Providing feedback to the concerned personnel including an action plan for observed weaknesses to be corrected to resolve the problems
- Improvement of indicators/performance of the center/site/concerned agent
- Appreciation of the quality of the supervision by the person supervised (with regards to the identification and resolution of the problems, supervision, and acquisition of new knowledge/competences).

This information will be received regularly by the DRSPF at each contact with EMAD and the AS. Corrective measures will be taken jointly with the concerned supervisors after feedback.

Integrated supervision tool : see annex

7. <u>Review and update missing Rapid CATCH data</u> (e.g. ORS, immunization indicators [DPT1, 3], and POU indicator) in the CSTS project data form

Indicators	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	45	147	30.0%	11.0

Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	66	226	29.0%	9.0

Percentage of children age 0-23 months whose births were attended by skilled personnel	143	299	47.0%	9.0
Percentage of children age 0-23 months who received a post-natal visit from an appropriate trained health worker within three days after birth	0	0	0.0%	0.0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	49	210	23.0%	8.0
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's Recall)	104	210	49.0%	11.0
Percentage of children age 12-23 months who received a measles vaccination	132	226	58.0%	11.0
Percentage of children age 12-23 months who received DPT 1 vaccination before they reached 12 months	101	226	45%	6.5
Percentage of children age 12-23 months who received DPT 3 vaccination before they reached 12 months	82	226	36%	6.3
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	11	67	16.0%	13.0
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids	75	140	53.6%	8.3
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate	33	118	28.0%	12.0

Percentage of households of children age 0-23 months that treat water effectively	10	300	3.0%	2.0
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during a 24 hour recall period	10	300	3.0%	2.0

Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night	79	300	26.0%	7.0
Percentage of children age 0-23 months who are underweight (-SD for the median weight for age, according to WHO/HCHS reference population)	110	300	36.0%	8.0
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	47	226	20.0%	8.0

Measles immunization coverage is based on maternal recall only.

8. **The integrated CCM intervention needs to be described in greater detail (e.g. drug supply/re-supply issues in the community, monitoring/documentation to strengthen evidence base for promoting approach to national and international stakeholders)**

The CCM is one of the key TREIP interventions and will ensure improvement of access to care for children. MCDI defines two different sets of activities for the CCM:

- Reference packet
- Complete packet

The reference packet consists essentially of health education for the promotion of simple key behaviors at the home when the infant gets sick. The reference packet will be implemented by all of the Health volunteers (around 1-2 per Fokontany).
The complete packet consists of the integrated management of the sick child at the community level, as well as education activities. This complete packet thus consists of the use of authorized medications (Zinc, new formula ORS, Cotrimoxazole, and ACT) at the community level and conforms to the MOH directives for this activity. Up to the end of 2007, two districts in the TREIP zone will be covered by a pilot study for this activity. The scale up will commence from 2008. This complete package will be implemented by the CBDs, selected according to their performance. The objective is to put in place 3 CCM sites with the complete packet, in each health sector. The implementation guide for this activity was developed by the National PCIME committee in which MCDI participates and BASICS provide support.

Drug supply/re-supply system and issues:
TREIP will use the supply system adopted at the national level for supply to CCM agents (i.e. the CBDs that apply the complete package). This supply system ensures that the CCM agents will be supplied medications via the CSBs, as per MOH policy. The Community PCIME Committee is actually in the process of negotiating the inclusion of introduction of Zinc and the new formula ORS into the official distribution circuit for medications for the public sector. The effectiveness of SALAMA's supply to the CSBs will in turn affect effectiveness of supplies to the CCM sites. This fact was identified during the 2007 Health Facility Assessment (HFA) when it was found that the supply of essential medications to the CSBs for the health of the infant and essential first line drugs is quite weak, at 50% and 32% respectively. TREIP will address this problem by strengthening supervision, training health agents and EMAD on management of stocks and supply. As mentioned in point #3 above, the supply to the CCM sites will be done through PSI's social marketing.

Monitoring/documentation to strengthen evidence base for promoting approach to national and international stakeholders:

As this CCM activity is conducted in collaboration with BASICS, MCDI will count on their technical assistance for monitoring and documentation.

The table below shows the components of the paquet de Base and the paquet Complet:

Packet	Components	Type of Community agent responsible	Level of education of the agent	Training method	Recruitment method
Paquet de base	Look for danger signs for childhood illnesses and referral Increase of liquids, continuation of feeding, continuation of breastfeeding when child is sick Increase of feedings during the two weeks after cure (increase feedings by one supplementary feeding) Follow up of the progress of the sickness of the child and adherence to treatment according to recommendation of health personnel Treatment of fever by antimalarial according to RBM recommendations Increase of fluids in cases of diarrhea	Community animator	No level of education really required As much as possible, use people that know how to read	Based especially on audio visual memory techniques (songs, posters, films) 2-day theory training Practical session on communication techniques in the community	Health volunteers with support from community In each fokontany

Packet	Components	Type of Community agent responsible	Level of education of the agent	Training method	Recruitment method
Paquet complet	All components of the paquet de base Management of diarrhea by Zn and low osmolarity ORS (children <5yr) Management of pneumonia by Cotrimoxazole (children <5yrs) Management of cases of fever by ACT (children <5yr)	Agent in charge of management of childhood illnesses (CCM agent) In local terms, this type of agent is called « Mpandomba" i.e. agent with whom to seek initial help	At the minimum, knowing to read, write and count. The minimum level in the actual pilot sites is class 5 (i.e. 7 years of elementary education) We think that the minimum level is class 7 (i.e. completion of primary school education)	Theory training with a practical session in a health center (5 days in total) with an aptitude certificate at the end of the training This certificate is validated yearly during refresher meetings	Recruited among the better CBDs as proposed by the health agent On average: 3 « Mpandoma » sites per health facility(HF). These sites are found more than 5km from a HF

9. **It would be helpful to understand what <u>criteria will be used to select new NGOs and how their capacity will be built over the course of the project</u>. It is important to highlight the improved areas of capacity and understand how MCDI intends to monitor progress and report outcomes associated with local partner capacity building as this is a critical factor in scaling up in the region. Please include information on strategies, roles of MCDI, local NGO network, etc., indicators/milestones of progress for empowering and building the capacity of local NGOs, and indication of continued support that they may need beyond the life of the project (official letter from USAID).**

MCDI response (p. 33 of original DIP document)

a. **VOAHARY SALAMA** is an umbrella NGO that represents an array of smaller local NGOs:
b. **VEMIMA**: has worked with MCDI in the implementation of MCDI's child survival projects and has acquired great experience and the capacity for project planning and implementation. They hope to be able to share their experiences with other local NGOs and intervention districts
c. **MIAINGA:**
d. MAMPIFOHA
e. ZATOVO

What are the criteria for selection of NGOs?

MCDI will recruit NGOs through bidding, a process that will constitute a strengthening approach of the NGOs' capacities. Priority will be given to those NGOs that have worked with MCDI within the framework of CSP I and II (VEMIMA, MIAINGA, MAMPIFOHA, ZATOVO).

Capacity building for the local NGOs:

As mentioned in the DIP, one of the weaknesses of Madagascar's health system is the weak capacity of the MOH in the implementation of community-based activities. Health facilities cover only about half of the population of Madagascar. TREIP will attempt to address this gap by developing the capacity of the local NGOs in order that they will be able to support the MOH in the implementation of community activities and the strengthening of operational structures of the MOH (SSD and CSB) for these activities. In order for the NGOs to effectively execute this responsibility, TREIP will strengthen their capacity in:

- Those technical domains touched on by TREIP,
- TREIP's approaches,
- In program and financial management
- In communication and presentations

The strategy for strengthening the NGOs' capacity will be training, supervision, coaching, sub-grant management, evaluation and grant writing. Voahary Salama (VS) will be given responsibility to follow up the local NGOs. This will allow VS themselves to strengthen their capacity in these areas. Objectives in each domain to strengthen will be identified jointly with the local NGOs at the beginning of the program and will be

evaluated annually. Based on these evaluations, recommendations will be suggested. Below is a table illustrating examples of indicators to follow.

Area to be strengthened	Indicators	Expected results
Technical	Number of staff on the ground from each NGO trained in the technical interventions of CS and the key TREIP approaches (CCM, KM, VISA, supervision, etc.)	Availability of trained staff in each NGO
	Number of communes covered by each local NGO	Progressive increase in the operational capacities of each NGO
	% of tasks carried out (in relation to those defined in their TDR) % of activities achieved (in relation to the work plan)	NGOs' ability to execute activities strengthened
	% of CSB who have attained their annual objectives or who have seen an increase in their indicators % of KM-certified communes % of QAS-certified CSBs	Effectiveness of NGOs' interventions
Managerial	% of funds withdrawn (in relation to the program budget)	Capacity to use resources strengthened
	% of funds withdrawn without discrepancies in the accounting or withdrawal procedure Number of NGOs with all the management procedure manuals up to date and in place	Capacity to manage resources strengthened
	% of NGOs with financial and technical reports up to date and according to the framework	Reporting abilities strengthened
Coordination and communication	Number of reviews held with MCDI and EMAD	Coordination abilities strengthened

	Number of internal reviews for NGOs held	
Organizational	Number of NGOs who have held an organizational self-diagnosis in terms of strengthening plan	Organizational abilities strengthened
	Number of NGOs who have submitted a project proposal for CS to a funding body	Ability to mobilize resources and sell their assets strengthened

At the end of TREIP, MCDI hopes to leave in place the local NGOs who will be able to support the SSD and CSB, be able to support the implementation of community-based activities and be connected to a platform (Voahary Salama) which will ensure their visibility, the values of their competence as well as further strengthening of their abilities.

The table below shows the roles and responsibilities of MCDI, Voahary Salama and the NGOs. These roles and responsibilities will be detailed in the sub-grant contracts with the NGOs and Voahary Salama.

Entity	Responsibilities
Local NGOs	Implementation of the rules for activities in their action plans and according to the implementation guides Support the SSC and CSB in the implementation of community-based activities as in the DIP (CCM, KM, VISA, Mutuelle, Community Radio, etc) Ensure supervision of execution of activities and their staff both technically and administrative Participate in situation analyses and all planning phases and evaluation of TREIP as beneficiaries and actors of the project Coordinate the implementation with the districts, the SSD, the CSB and local authorities in the intervention zones Participate in periodic review meetings both at district level and with MCDI Effectively manage resources allocated to activities Provide necessary human resources to the implementation of activities

	Regularly report achievements
Voahary Salama	Support MCDI and DRSPF in training and teaching of local NGOs Strengthening of supervision of local NGOs in execution of their activities Follow the management of the sub-grants and put in place management tools for the NGOs Ensure implementation of self-diagnostic organizational and institutional activities of the local NGOs Provide an opportunity for the local NGO partners to share and exchange their experiences with other NGOs working in CS with the aim of gaining new knowledge on good practices and showing value for their achievements. Provide an opportunity for better visibility of the local NGOs and their good practices Support MCDI in the capacity and performance evaluation of the local NGOs
MCDI	Train the local NGOs and VS in the technical, managerial, and administrative areas, in line with TREIP interventions Provide necessary resources during the implementation of sub-grant mechanisms Supervise the implementation Ensure the inclusion of the implementation into the objectives of TREIP Evaluate the performance and acquisition of the capacity of the local NGOs and VS

10. **MCDI has developed strong national and sub-national partnerships and should consider integrating a stakeholder analysis process (in consultation with the Mission) that actively engages and involves various stakeholders for maximizing joint learning for new areas such as integrated CCM from the beginning of the project.**

This will be considered

11. **The project strategy to monitor quality of implementation as the project expands to all districts in the Region and the mechanisms for communicating and problem-solving with HQ, Mission, and local partners pertaining to scaling up (e.g. strategic refinements, need for any adjustments) should be indicated.**

The monitoring of the quality of the implementation and the communication mechanisms and problem-solving with HQ, Mission and local partners pertaining to scaling up, will be addressed with all the actors specifically during the annual implementation review workshops, during which the weaknesses in execution will be analyzed in a participative manner and appropriate solutions be identified. These workshops will be reinforced with periodic meetings with the Mission (quarterly), DRSPF (monthly with a quarterly review) and local partners (SanteNet, PSI, UNICEF, local NGOs, VS, etc.). As much as possible, the site visits with the USAID mission will be conducted in order to be able to better appreciate the quality of implementation. The MCDI Home Office (HO) will reinforce this quality of implementation by analyzing and approving the activity reports and giving pertinent directives and technical resources to the team on the ground. The Field Office (FO) and HO have established daily telephone communication as well as email exchanges to discuss these points.

12. **Please provide a <u>rationale for lack of a stronger focus on the newborn</u> and any potential plans (or lack of plans) to further replicate the newborn pilot with BASICS within the region through TREIP.**

TREIP's main objective is to replicate the successes of the preceding MCDI CS projects in Madagascar. MCDI did not have NBC interventions in their preceding CSPs. MCDI realizes that the NB problems are important to address but unfortunately, this activity has not yet been developed in Madagascar except at the level of the health centers (Urgent Obstetrical and Neonatal care). This is beyond the financial capability of TREIP. The neonatal program at the community level is at its early stages and no policy decision has been taken as of yet with regard to whether or not it will be adopted. The MOH is interested in operational research on community-based neonatal care. BASICS and UNICEF support this initiative and MCDI is a member of the Neonatal Technical Committee for the conception of this program. However, the operational research, based on experiences in India, is anticipated to last about three years before it is scaled up (the date of launch is not yet known). MCDI is proposing that one of the four pilot districts be in the TREIP zone, without they themselves being implicated in responsibilities for the funding of the study. Rather they will be involved only in implementation activities by ensuring that the NN activities are integrated into the CCM activities and providing technical support to MOH in collaboration with BASICS, WHO and UNICEF. The MOH has adopted this proposal. At the moment, MCDI cannot be involved in community NN interventions without additional resources but propose exploring the possibility of integrating this intervention after the TREIP mid-term evaluation if resources permit and if the results of the operational research are conclusive.

13. MCDI participates in quarterly meetings with the Mission and has developed a good line of communication. In order to maximize the support that HQ (CSHGP) and Mission can provide for any

issues that may arise and to adequately showcase this important effort, it will be beneficial for MCDI to share information about critical decisions and lessons with both the Mission and CTO/CSHGP Team as relevant (e.g. NGO selection criteria, final selection of NGOs, any scale-up strategy refinements/changes and monitoring of scale up process, maximizing learning of integrated CCM and role of international NGOs in scaling up regionally, cross-country learning options with Rwanda, etc.)

This will be taken into account

14. Details of <u>certification of KM approach</u>:

Champion Commune [Kominina Mendrika (KM)] is a USAID- supported initiative through SantéNet; it is an approach aimed at mobilizing members of a commune to achieve important and feasible actions of social, economic and cultural development. A community is mobilized to select, amongst themselves, health objectives to be achieved within a fixed time period. These should provide maximum impact of all health activities. Communes that achieve their goals within the set time period are certified as "Champion Communes." A certificate, signed by the Health Minister, as well as a KM plaque, is presented to the Mayor of the commune. Also SanteNet gives a prize in the form of something that the community has identified as lacking in their community e.g. a well could be built for the community. TREIP expects to expand the KM program such that half of all communes in the AAR will be certified. Champion communes will be empowered to exert pressure on both health facilities and community members to adopt changes that the commune has identified as priorities. Exit interviews will enable TREIP to identify areas of client dissatisfaction, and to develop a plan to redress these problems. The agreement with SanteNet is $500 per certified commune. MCDI is exploring the possibility of other sources of contribution (in kind or monetary) with other actors, notably DRSPF, PSDR, FID to strengthen the compensation already defined in the framework of the program.

15. Stronger strategies for <u>community-based monitoring of fever</u>:

For community-based monitoring of fever, active case detection can be used. The TREIP project zone is a combination of high (seasonal) and low transmission areas. In children under-5 years of age, in areas with high transmission, presumptive treatment can be used (syndromic approach). It must be noted though that TREIP has not budgeted for RDTs.

Malaria Case Classification in children under-5 years, by type of facility and level of malaria transmission inside TREIP area

Malaria transmission		Comments
Low	**High** (including seasonal or epidemic)	
Health Facility ***without*** a lab: --**RDT** (subset of blood samples sent to a lab for microscopic examination for quality control of RDT) Health Facility ***with*** a lab: --**Microscopy**	Health Facility ***without*** a lab: --**Syndromic classification/treatment** (using IMCI guidelines) Health Facility ***with*** a lab: --**Microscopy or RDT**, depending on case load (see comment)	Health Facilities with *large case load* will use **microscopy** (if infrastructure and human resources permit), while Health Facilities with *fewer cases* will use **RDTs**

Assumptions:

1) Syndromic classification can be used by CHWs for active case detection during outreach activities

Jim Ricca/CSTS Comments and MCDI

Responses

PVO/Country: MCDI / Madagascar Reviewer's Name: Jim Ricca, CSTS+

Part B – Areas for Improvement of the DIP and Recommendations

1. Preliminary Sections (Executive Summary, Data Form, DIP Preparation, Revisions)
In the CSHGP data form (pages 11-12), why do some of the CASTHC indicators have no data (i.e., Post natal care, DPT1, DPT3, ORT use, POU)? They seem not to have been included in the KPC.

See response #7 to USAID comments

Site Information and Baseline Studies (DIP sections 1&2)
2. I don't see in the baseline KPC the data reported for ORT, DPT1 or 3, even though these are in the Results Frame.

Done

3. Minor point – although the quality treatment indicator for CHW CCM is a good one, have you thought about how you will collect this data? From record review (more feasible, less valid) or from spot supervisory direct observations (much less feasible but more valid)?

Both record reviews and spot supervisory direct observations will be done at the same time. The analyses of the registers will be done monthly during the monthly reviews with EMAD and direct observations will be done on a quarterly schedule during the on site supervisions of the CHW CCM. MCDI has adapted the RHPA observation tool for the direct observations of the CHWs during the supervisions.

4. In general I like the concise analysis and presentation of the HFA data. This is an excellent form to have it in for planning and decision making; however, it would have been good to see a more complete report of the HFA, describing a bit more of the process of data collection and construction of indicators. Some disaggregated tables would also be useful. For instance, we see that only 32% of had a stock of all essential drugs on the day of the survey. Were all drugs problematic, or was one in particular more likely to be out of stock?
Our understanding is that the DIP should contain a concise summary table. However, we will provide a more detailed table if needed.
5. Also on the HFA, for each of the relevant LOEs (malaria, diarrhea, pneumonia), the HFA data is reported as having given an idea of the correct classification of cases; however, the R-HFA does not have a gold standard examination of cases that would allow one to say if the case was correctly classified. Instead, it only can say that **if** the

HW's classification was correct, that the treatment given was or was not appropriate. This is the meaning of R-HFA Core Indicator #11.
In the structuring of our RHPA questionnaire, the analysis was based on the examination of cases according to the IMCI algorithm. We have evaluated both children correctly "evaluated, classified and treated", as well as the level of classification and treatment by the health agents. In annex 1 of the HFA report, you will find the following indicators:

- % children with fever/malaria for which this condition was correctly treated=42%
- % of children with diarrhea for which this condition was correctly treated=12%
- % of children with ARI for which this condition was correctly treated=24%

The percentage of children with ARI, Diarrhea, Fever for which these conditions were correctly treated=27% and 36% of health workers had correctly treated ARI, Malaria, Diarrhea.
(Changed these in the RHPA form in the annex: core indicator #11)

6. Also on the HFA, I suppose that an assessment of CHWs delivering CCM was not done using the CHW assessment format of the HFA, but it is not clear. If not, will this or some other format be used to monitor and evaluate progress in terms of CCM delivery?

The evaluation of CHWs CCM has not been done. This will be done periodically during quarterly supervisions using the format adapted to the RHPA for the health workers. See point #3 above.

Program Description & Intervention Specific Approaches (DIP sections 3&4)
7. I still think, as in the proposal reviewers' comments that the big variable here will be how well the new CCM strategy will be rolled out. I feel like I still need more detail on how this will be supported.

See responses #4 and #8 to the USAID comments

For the implementation, MCDI will follow exactly the implementation guide developed by the IMCI National Committee. Below are the stages:

The key steps for the implementation:

Identification of CSB: is based on epidemiologic criteria, accessibility, minimum staff and materials required, engagement/integrity of health personnel and of EMAD, optimal performance of the centre, management capacity of EMAD

Identification of community sites: location (more than 10km from a health center), community with enough of a population (>500); elevated prevalence or prior epidemic of ARI, diarrhea, malaria; community engagement; 3 CCM community sites per CSB and 50% of CSB in the district

Identification and selection of actors: volunteers, 2 community agents per site ; they should know how to read, write and count ; motivation : interest in the outputs of the site, moral motivation, small equipment, certification and public recognition

Training of different actors: development of all training and management tools at the Central level; set up of a pool of national, regional and district trainers. The training of CCM agents is done in a hospital with a pediatric service that is up to the standards required for training on clinical IMCI, with a ratio of 1 teacher for 2-3 CCM agents and duration of 5 days where emphasis will be put on the practice.

Support to different actors after the training : (1) supervision comprising the review of the management tools of the site, the physical verification of medications, home evaluation of recent cases of sick children that were managed, discussions with other volunteers, discussions with the community, evaluation of the implementation of past decisions if applicable, direct observation of AC during management and

Set up of the logistics for the implementation. A minimum packet of materials, CCC support, management tools and medications were defined for this activity. The list is in the annex

Activities to mobilize and disseminate information to the communities: the matrix for this component is shown below:

Level Of Intervention	Target Population	Activities/Tasks	Personnel	Expected Results	Means Of Support
Central	- members of the Government - Region	-make a case	- MINSANPF - DSF/SSEA - MDAT - ONN	- institutionalize PCIME at community level	-Documents to make the case -implementation guides
	- Faculty of	Make a case	- trainers/supervisors (4 agents dont	-legislative text registering the implementation of PCIMEC with the application decree promulgated -PCIMEC, community ARI	- animator guide -implementation guides,

	medicine Training institution for Paramedics - DRSPF - STAFF REGION	Make a case	deux instructeurs cliniques - Partenaires - DSF/SSEA - MDAT	in particular, integrated into the pre-service training program - DRSPF and Regional staff trained	- training modules -supervision modules -implementation guides,
DRSPF	- SSPFD, - Districts - Communes	- inform sensitize, orientate	- DRSPF - focal points Regional PCIME	- health agents, political authorities administrators trained and sensitized	Legislative text mplementation guide Documents to make the cases IEC support
SSPFD	CSB, Communes	Inform, Sensitize, Orientate	- Inspecting Doctors - Focal points for district PCIME -trainers supervisors (2 agents of which one is a clinical instructor)	-Health agents, political/administrative authorities trained – sensitized - A pool of trainers set up	Legislative text -Implementation guide, - IEC support (quarterly bulletin)
CSB	COSAN, Community agents, Community	Train, sensitize, orientate	- CSB chief	- Community trained and sensitized	- Implementation guide, IEC support
Community site	Community, President of the Fokontany	- Train - Educate -Communicate - Mobilize	- CSB Chief - Community agents, Community animators - COSAN - Opinion leaders	- Community mobilized - Community agents and animators identified	- IEC support:posters, media, leaflets, gazettes

			- Political/Administrative authorities		

Monitoring and Evaluation activities:

- Support for data collection at the community sites: the data will be collected at the sites with the help of individual management forms ; consultation register ; referral form ; stock registers for each medication ; monthly report forms ; supervision booklet
- Support for data collection by the trainers and supervisors: individual AC evaluation forms, evaluation forms for home-based management of cases recently treated by the AC (follow up visit and home visit), supervision forms for each level integrating the related activities
- The indicators: a minimal list of indicators has been established by the national level

Results Indicators :

Coverage:

- Percentage of cases treated at the sites
- Proportion of cases/sites envisaged open or proportion of target population covered
- % resident population about 5km from a site offering treatment for diarrhea/ARI/malaria (communities and CSB)

Quality of Care:

- % of infants referred who are presenting with a danger sign
- % of cases correctly classified
- % of pneumonia cases who have received the correct dose of Cotrimoxazole
- % of diarrheal cases who have received the correct dose of Zinc
- % of infants correctly managed by the AC according to the national protocol

Training Indicators/Orientation

Process

- Proportion of teams trained (concept of essential members)
- Proportion of CCM agents trained who correctly fill out the consultation forms
- Proportion of community bodies orientated or trained

Quality

- Proportion of AC who correctly measure respiratory movements and have them agree with that of the instructor
- Proportion of AC who know the danger signs

Indicators of support after training

- Process
  - Proportion of follow ups planned that have been realized according to the standards
  - Proportion of supervisions envisaged and achieved according to the standards at least once a quarter
- Quality
  - Proportion of cases in concordance between the AC and instructor
  - Proportion of AC who fill out consultation forms, registers and stock forms correctly

Logistical Indicators

- Results
  - Proportion of sites with one of the recommended essential medications out of stock in a month
  - Number of days that recommended essential medications are out of stock per month
  - Number of days without a functioning stop watch/timer in the month

Indicators on Behavior Change Communication

- Process
  - Proportion of planned communication activities realized (by type of activity)
- Results
  - Proportion of mothers who know at least 2 danger signs

8. Page 51 - I like the lead-in with the core IMCI indicators in the box to give clarity as to the main objectives and metrics for the project; however, I wonder if this might be slightly modified for greater clarity of the key outcomes. Let me explain my reasoning: Given that CSHGP projects achieve impact through three main strategies, all of which you will employ with improvement of IMCI - increasing access to services, improving quality of services, and improving health related behaviors. There is a quality indicator here (appropriate treatment by both CHWs and HW). The community level offered indicator is knowledge. This is an important intermediate outcome. But how about using behavior (i.e., appropriate careseeking for one or all of the target diseases)? And how about measuring geographic access to a skilled (or trained) provider of curative services (which the project will affect through its CCM improvement strategy)? These four indicators (the 2 service quality indicators already in the table, along with an indicator of access and one of appropriate HH-level behavior) would give a very clear picture of how the project achieves its impact.

The reviewer's comment is definitely pertinent and merits to be addressed as it reflects IMCI activities of TREIP. Unfortunately, none of these indicators of access and research on care were measured during the baseline analyses. MCDI will measure the following proxy:

- Increase from 43% to 60% 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
- Increase from 42% to 60% the proportion of the population who have geographic access to a health center for the child (HF or CCM sites).

This indicator for access does not mention if it is for trained or competent personnel or not.

Monitoring and Evaluation (DIP section 5)
The M&E plan states that the Lives Saved calculator will be used to measure the differential impact of community versus facility-based services. One of the services of interest, appropriately enough is ORT use for diarrhea; however, this indicator seems to have been omitted from the baseline KPC and is not in the Results Framework in Annex 10.

ORT use inserted

Note as above, the absence of several Rapid CATCH indicators. Especially critical is that the ORS indicator is missing as this is central to the interventions for diarrhea (with roll out of new ORS).

See #6 responses to USAID comments. Note that the indicator on postnatal consultation missing in the data form is due to the fact that this indicator was not required by CSHGP/CSTS at the time that MCDI conducted their baseline survey (the updating of the KPC tool occurred much later).

Program Management (DIP section 6)
None

Training and Work Plans (sections 8&9)
None

Annexes
The reviewer comments were included as an annex, but I do not see the responses to them. It would be good to see them directly responded to in Annex 18.

Annex : Logistics for a CCM site

1. Logistics for site
   - Location for the CCM site: responsibility of the community (could be at office of the Fokontany or an existing community site)
   - Furniture: a table, 4 chairs, secured safe to store medications
   - Ruler, pens, erasers, pencils
   - Stop watch
   - Scale or baby scale
   - Badge

- TRO kit (cuvette, measuring cup up to 1L, 12L bucket, 4 measuring cups, 4 small spoons, pot)
- Stove

2. IEC tools : counseling cards, posters,

3. Simplified management tools in Malagasy
   - Management forms to use by the community agents
   - Forms for medical stock
   - Consultation register
   - Referral forms
   - Report forms
   - Bank book
   - Medication request forms
   - Guide for the Community agents
   - Materials to write on paper and flip charts (markers in 4 colors)
   - Flip chart for the posters with statistics

4. Medications and other
   - Medications (cotrimoxazole 200-400mg, a box of 1000 per site if possible in blister packs
   - ORS kit/Zinc
   - Antimalarials following the updating of the National policy of management of malaria
   - Paracetamol (infant and/or adult)
   - Insecticide-treated bed nets
   - Sur'eau

The medications will be sold to the communities at the same price as in the CSB. The supply system and tariffs is as follows:

Level	**Supply site**	**Purchase price**	**Sale price**	**Use of profit margins**
PhaGDis	Centrale d'Achat SALAMA			
PhaGCom	PhaGDis	Prix PhaGDis	increase of 35%	see FANOME instructions
Community Sites	PhaGCom	Prix PhaGDis	Increase of 35%	To identify: what % are refund sales

Nb:

- The medications used for the management of the ill are accounted for and obtained from the CSB according to the FANOME system. The community sites renew their medication stocks at the CSB.

- The routing of medications is assured by the Commune
- The receipts for the sites are secured in a locked safe

Alan Talens Comments and MCDI Responses

PVO/Country: MCDI/ Madagascar

Reviewer's Name: Alan Talens

Intervention(s) Reviewed: Toliara Region Expanded Impact Project, Madagascar

Part B – Areas for Improvement of the DIP and Recommendations

There are some areas in the DIP that need clarification:

1. In #2 on page 16: "Rather than work in districts, the MOH in district, the MOH has requested that we choose communes for all of the seven regions during the first half of the project implementation". I assume that these are the seven districts in the RAA.

There are nine districts total in the RAA. These include seven new districts and two old ones. These were Betioky sud (BCSP) and Toliara (TPCSP).

The table bellow shows the phasing-in approach in the area of community based activities. However, TREIP will cover all the 9 districts, including the 7 ones, in the area of facility based activities through its partnership with the RHO.

DISTRICT	Phase 1 : Start-up		Phase 2 : extension to rest of Communes		Phase 3	Observations
	Intensive intervention communes	communes with reduced support	Intensive intervention communes	communes with reduced support	transfer and retreat	
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**	

2. The DIP proposes a significant role of the CHVs (as unpaid volunteers) in the improvement of mothers' knowledge, but there is no mention of any strategies to assure retention of this group. Also, how many CHVs are envisioned to be recruited? What is the proposed ratio of volunteers per district? What is the optimum population each volunteer will be responsible for? What is the structure for volunteer supervision for the whole region? What are the possible incentives for them?

The CHVs will initially recruit the VISA mothers. Then they will inform them on behavior change through the VISA approach (mostly through home visits). These VISA mothers are responsible for recruiting new VISA mothers. The main point of the VISA approach is that we do not anticipate maintaining the CHVs indefinitely. Instead, new volunteers will be recruited "automatically" to replace those no longer active. This way, MCDI will be able to renew, maintain or even increase the number of CHVs compared to the TPCSP (where there was a 10% attrition rate of CHVs due to various reasons : deaths, change of address, demotivation, etc. vs. 12% recruitment rate in relation to the original numbers).

Presently, TREIP is in the process of piloting the management of diarrhea, pneumonia and malaria, using Zinc, Cotrim, and ACT respectively, in collaboration with MOH, UNICEF, and BASICS. This is giving rise to a new status of Community Health Workers (CHWs). Our initial follow up of this initiative has shown that the CHVs are very motivated to achieve this position while realizing the fact that this title/position will not be received without going through the work of the CHVs. This CCM initiative could be an efficacious way of retaining the CHVs. MCDI and SanteNet are in the process of proposing to the MOH a restructuring model for community-based workers as a basis for a National Community Health policy (see Table in Annex).

TREIP will use classic ways to motivate the volunteers (provide training; provide work tools, certificates, badges, etc.). During national campaigns (held twice a year), they will be recruited to help the health workers in different activities and will be paid by the MOH. Incentives paid in kind are not planned for the volunteer.

The VISA approach is the most effective strategy to assure the continuation of the activities to promote behavior change. It is a continuous process.

It is envisaged that one CHV per fokontany will be recruited. As mentioned above, with the VISA approach, MCDI thinks that they can progressively increase the number of CHVs during the course of the project. Each volunteer will be responsible for about five hundred population, but on the other hand, each volunteer has five mothers to supervise for the VISA approach.

There is an illustrative organogram on Page 93 (annex 9) which explains the organization and the project organogram. So, for the whole region, there are NGO field agents who are implemented in the commune and assure the supervision of the volunteer with the health worker.

3. On page 46, there is mention of the integrated tool for the supervision of CHV by the health worker but the tool is not described.

The integrated tool for supervision of CHV by the health worker is the same that MCDI had used during the TPCSP. This tool integrates supervision of the CHVs by the HFWs during the latter's routine activities such as during campaigns, during HFW meetings with village authorities, etc.

4. One of the constraints identified by the Health Facility Assessment is the lack of a steady supply of consumables. While a plan to strengthen procurement is mentioned, there is no specific description of the intervention other than training.

During TREIP, MCDI plans to provide technical and management support to the different levels of the health system (Region, district and commune). TREIP will not finance supplies e.g. if there isn't a refrigerator in a health center, TREIP cannot buy it for them. They can only provide training on maintenance of the cold chain to health agents; it's therefore capacity building rather than strengthening/supply of equipment. During the implementation of the QAS, in which one of the quality standards to achieve is the availability of principal "intrants", as well as strengthening of supervision, TREIP hopes to improve on the problems of steady supply of consumables.

5. On page 49, MCDI will work closely with Malagasy NGOs such as the Voahary Salama and one local NGO per district. What will be the relationship of the NGOs with MCDI in their role (e.g., training of CHVs) in implementation of the project? Is this on a sub-contractual or voluntary basis? What support will be given to these civil society organizations?

The NGOs will be trained by the MCDI team, and then these NGOs will assist the DHO and HFs in the training and supervision of the CHVs. Voahary Salama supervises the local NGOs as it is the umbrella NGO; both VS and the local NGOs are sub-recipients. In terms of support, MCDI will provide supervision and training. They have already received training in leadership and management and modules on intervention programs (e.g. breastfeeding, home-based management of the sick child, etc.).
The connection between the local NGOs and VS will allow for

(1) Scaling up of good practices in project zones while sharing experiences with their other members;
(2) The connection of these local NGOs to sources of potential child survival project funding (sell actual TREIP approaches);
(3) Strengthening of presentations of potential child survival projects at the national level.

6. Since this is an expanded impact project, sustainability of interventions is not explicit in the DIP. In very poor communities, where government health expenditure is very low, the need for a well planned sustainability and exit strategy is required. Some possibilities may include absorption within the health system after five years, ongoing plans for MCDI to maintain coverage of the whole region or a takeover by local NGOs. Other aspects of a sustainability plan must describe how quality assurance of technical aspects of interventions will be maintained, how community participation and financing will be factored in.

Main sustainability strategies:

- VISA approach
- Capacity strengthening is a sustainability approach
- The « Health mutuelles» concept which has proven its potential of continuity and viability during the TPCSP, outside of all external input
- TREIP will implement across all structures of the MOH (region, district, HF) and the NGOs. The sustainability/continuity will depend essentially upon the level of uptake of good practices (quality, community mobilization, BCC, etc.) during the implementation as well as its adoption within the region's health development strategy (institutionalization).
- As was the case during TPCSP, MCDI's participation in technical committees at the national level will enrich the strategies and national health policies with regards to experiences gained during TREIP. In terms of policies and/or national strategies, the good practices of TREIP will be continued.

Thank you for the opportunity to review this DIP.

Diana Silimperi/BASICS comments and MCDI Responses

PVO/Country: MCDI/Madagascar

Reviewer's Name: Diana Silimperi and Emmanuel Wansi

Intervention(s) Reviewed: diarrhea, ARI/pneumonia, malaria, breastfeeding, immunization

Part B – Areas for Improvement of the DIP and Recommendations

Overall

The proposal suffers from the lack of a final edit; some sections are still in French, other sections retain the directions without content, and finally, several key sections lack any narrative at all, but only refer to an Annex. The organization and order of the sections is choppy and detracts from the content. Although the proposal contains some innovative approaches, especially at the community level, the linkage and relationship between diverse elements is not well described, which diminishes their strength. Specific content is sometimes missing which would validate the broader statements made ie building on prior lessons and successes, but then not describing or giving a concrete illustration of one or two. The proposal focuses on implementation at provincial level, but does not explain how the provincial effort will fit into a larger national context. Finally, as will be discussed below, the core delivery platform, at community level, is confusing, without a clear description of how the diverse community-based providers will relate to each other, or the health system.

Design and Interventions

1. The proposal focuses on provincial level implementation, but does not address how this province will be fitting into the national context, especially in terms of consistent messages, materials, forms and data collection. If the successes are to be sustainable, they must also be replicable in other provinces, but also consistent with national level guidelines and formats, including training, counseling and BCC messages and supervisory as well as HMIS formats. The reviewer is aware that MCDI is communicating with the national level MSFP, and participating in policy groups, but the proposal seems to read as if MCDI is introducing new training materials, supervisory formats and community messages in the TREIP, instead of building on the work already established by the MSFP, most notably in CCM.

1.1 Linking of regional operations to those at the national level: the operational planning process of the Madagascar MOH is bottom-up i.e. the SSD to region to central. The main responsibilities at the central level are to give general directives regarding development of policies, strategies and centering of operational planning of objectives and general policies of the state. All of the programs proposed by the decentralized SSD and DRS must centralize objectives, policies and national strategies. TREIP will support these decentralized levels in the realization of their objectives with regards to child survival especially at the level of interventions where the SSD and DRS show a weak capacity for the implementation of community activities. To do this, TREIP will use the approaches that have already been proven successful and others such as KM, VISA, CBD/CCM, etc.

1.2 With regard to BCC messages and support, the central level has developed generic one that TREIP proposes to adapt to the context of the intervention region since there are lots of differences socio-culturally as well as different dialects depending on the region. These messages had already been developed during the preceding CSPs and TREIP proposes for the most part, to use these and develop others based on need. The BEHAVE framework conducted during the development of the DIP will help the project team and DRF to better define the needs to satisfy in terms of development of BCC messages and support. In May 2007, MCDI updated the child health component, with a maternal and child health booklet as the main BCC support integrated into the national strategy. The implementation focused on CCM. SanteNet will take responsibility for the reproduction of this new version for use at the national level. This example shows very well how TREIP contributes and is in line with efforts at the national level.

1.3. With regard to training materials : TREIP is proposing to use the training modules already developed at the national level. MCDI has always participated in the development of these modules. However, certain domains are specific to TREIP (VISA, Credit Mutuelle) and MCDI will use their own modules for these activities.

1.4. Forms, data collection, supervision tools: TREIP will use those that have been developed at the national level. However, it must be mentioned that these tools do not address all of the needs on the ground, notably supervision of quality of services or collection of information at the community level. In this case, MCDI will use tools that they had developed during their previous CSP e.g. the integrated supervision form which focused on PCIME, the tools for collection of community information. For the CCM, MCDI will use the supervision tools developed at the national level to better address capacity strengthening of the CCM agents. The current tool focuses more on the process.

1.5 CCM : note that MCDI is a member of the CCM committee and supports both the MOH at the central level in the conception of the program, in collaboration with BASICS, WHO and UNICEF, as well as the peripheral level in the implementation. The implementation tools of the program were all developed by this CCM Committee. MCDI does not have the intention of developing parallel tools but proposes to complement the existing ones, based on need so that they respond better to the specific objectives of the region and TREIP.

2. Although a number of alliances and partnerships are mentioned in the proposal, the specifics of the relationship, in terms of functions, contributions, even coverage/scale are not clearly detailed (SanteNet, UNICEF, WBank, etc).

SanteNet: see point #2 in response to USAID. TREIP and SanteNet will co-finance KM and QAS activities in 50% of the TREIP zones. SanteNet activities will end in September 2008 and from then on TREIP will maintain these KM and QAS activities. Eventually, if resources permit, MCDI will replicate these interventions in the remaining 50% of TREIP zones, if the TREIP mid-term evaluation shows evidence of need. This has been shared with Chemonics.

UNICEF, WB, and others: it has been established that these other institutions are muich more focused on the health facility system (CSB, EMAD). TREIP will complement their efforts by implementing community-based activities that are still weak within the Madagascar health system. The investments of these institutions will be in training of health agents, provision of equipment for the health centers, infrastructure. The coordination of support between TREIP and these other institutions will be done at the SSD level during the development of their annual work plan. The DRSPF will take the leadership of this coordination process while taking into account all of the input of potential contributors. This exercise was done in January 2007 for the year 2007. The result has been that TREIP activities have been integrated into both the SSD and DRSPF work plans.

3. Furthermore, there is a conspicuous gap in terms of collaboration with the USAID-funded, BASICS which is playing a leading role at MSFP and regional level, in terms of supporting common, consistent training, supervision, job aids and support systems for sustainable CCM .

Just as with BASICS, MCDI provides support to the MOH at the national and regional levels in the process of implementation of CCM in Madagascar. Beyond this, 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. BASICS and MCDI are both members of the National CCM and Neonatal Care Committee which develops tools and guidelines for this activity for the country. TREIP uses these tools for implementation. There isn't a specific MOU between MCDI and BASICS with regard to this activity but on the ground, there is always collaboration in terms of cost sharing, technical support from BASICS for implementation (joint supervision of pilot activities in the pilot zones, training support for the community agents, etc.). MCDI will formalize this collaboration with BASICS later during the scale up phase of this activity. It must also be noted that MCDI has established regular communication with the Madagascar BASICS PCIME personnel for continuous review of the implementation.

4. It is not clear how consistency and quality will be maintained across the diverse local and international NGOs participating in community-based approaches, as well as their contribution to coverage, reaching all target families and children in a timely manner.

This issue of maintenance of consistency and quality is beyond the control of MCDI. It is more of an MOH role, who is trying to delegate to the Child Survival Technical Committee and guarantee the quality of the interventions at the community level.

5. Given that the main platform of this proposal is community-based delivery of preventive and curative interventions, a significant weakness in design is the confusion regarding roles, responsibilities (including specifically which interventions they will be responsible for) and relationships between the diverse cadre of community-based providers and distributors:CHVs, CCM providers, VISA mothers, community listener groups, CB Distributors, etc – much less how each is linked to the health system/health

facilities in terms of supplies, supervision, quality assurance, and catchments. In particular, how or when will the CB providers refer to each other, if at all; will they all use the same messages; how do they overlap in terms of coverage, etc? What is the relationship between these groups and the Champion Commune infrastructure? There can be tremendous synergy between these groups, but the current proposal does not (at least to this reviewer) make clear the heightened impact which planned synergy could bring.
The table below shows the roles and responsibilities of the different community-based providers :

Community agents	**Personnel**	**Intervention zones**	**Supervision**	**Recruitment**
VISA Mothers	A group that promotes health through testimonials of the advantages of key practices, a type of "positive deviance". They can become CHVs	In each Fokontany	By the CHVs	Sponsorship by the CHVs of model mothers
CHVs	Health education Active research CCM paquet de base (See #7 of USAID responses on the two packets)	1-2 CHVs/Fokontany	By the ASB and NGO	Recruited from the VISA mothers or selected from the community
CBDs	Packet of activities for the CHVs Promotion and sale of essential health products in bulk (ITNs, ACT, sur'eau, etc.) at the community level	Fokontany more thant 5km from a CSB	By the ASB and NGO	Recruited from the better CHVs
CCM Agents	Package of activities for the CBDs Complete CCM packet (eventually community-based NNC)	3 Fokontany/CSB (the furthest)	By the ASB, NGO, EMAD	Recruited from among the CBDs
Community listener	They are more beneficiaries than	Fokontany already with	CHVs	They are not fixed ; it is

group	actors. either way, they will share the health messages with community members in the form of support groups	access to local radio emissions		based on community volunteerism

In effect, it is more about the same person but with their responsibilities being based on the needs of the community that they serve. In other words, in a community with a CCM agent, it will be this agent that will ensure the activities for CCM, CBDs, and CHVs.

Quality assurance: see responses #4 and 5 to USAID.

This network was established in accord with DRSPF so that they are connected to the CSB and form part of the health system in these zones.

Supplies: see USAID response #3. In summary, it is mainly from the CSB, or secondarily through PSI.

It is these same groups that will work with KM activities. There will not be a community structure for KM and one for TREIP.

6. Two other technical design gaps exist: the proposal does not make clear precisely how MCDI intends to develop the civil accountability for child health among the local administration and civil authorities; nor does it adequately address how facility quality of care (including staff competency and supplies) will be strengthened to enable them to effectively supervise and support CCM.

- Civil accountability for child health among the local administration and civil authorities: This will be addressed by TREIP through the set up of the Regional Health Steering Committee. The members of this committee will be local administration personnel and civil authorities.

How will facility quality of care (including staff competency and supplies) be strengthened to enable them to effectively supervise and support CCM?
The DIP mentions the training of ASB on PCIME including, the new recommendations with regard to the introduction of Zinc, low osmolarity ORS, ACT a number of times. The supervision activities of the CSB will focus on technical capacity strengthening of the ASB with regard to PCIME and the strengthening of aspects linked to supplies. These efforts by TREIP at the level of the CSB have the goal of allowing the CSB to supervise and support CCM. The ASB will receive training on the conduct of supervision, training of community-based trainers.

7. Section 2: Factors that Influence Health, notes that traditional healers are a common first source of care for children, and that each Fonkontany contains at least one traditional

healer, yet the proposal does not currently seem to direct any activities toward this critical body of practitioners.

TREIP has not specifically mentioned this group. However, they could be included as community agents if their profiles are appropriate. MCDI does not think that it is realistic to include this category (traditional healers, TBAs, etc.) in such a project. Once again, TREIP's objective is to scale up those successful approaches from the preceding CSP of MCDI. We haven't had much interaction with these categories of practitioners in the previous CSP and do not have the evidence of effectiveness of this approach.

8. Similarly, the inclusion and focus on men as important consumers, caretakers and decision-makers is not well described. Why not create VISA families rather than mothers only? Or VISA fathers, too?

This point will be explored. All the same, qualitative analyses conducted during the preparation of the DIP have suggested that it is best to focus on the mothers than the fathers even if the latter are the decision makers in the household. The reason is that the mothers are the only child health carers in the household and the decision of the fathers depends especially upon the mothers' appreciation of the severity of the child's illness.

9. Although an expansion plan is described, the details of coverage within that expansion are not clear; numbers of CB providers do not clearly translate into coverage of all target children.

See point #5 below for the coverage of CB providers.

See point #1 of the USAID response for details of coverage for the expansion

10. The QA approach is out-of-date, and does not reflect more recent lessons learned. Certification is mentioned in terms of the Champion Communes, but the process is not described.

QA approach: this approach proposed by TREIP is one that has actually been implemented by the USAID Mission, through SanteNet. The MOH has just adopted this approach as a national approach. The health professionals in Madagascar agree to say that this approach has the potential to improve the quality of care from the health centers. The first results of this experiment are satisfying. MCDI is open to include these new lessons if necessary. For the moment, MCDI will remain with its position of maintaining QAS as their QA approach to be in conformity with the national recommendations (as suggested by the reviewers in point# 1 above).

M&E

11. This reviewer is concerned that the Health Status and Service Targets may be too high, when one takes into account baseline findings and even the gains made in prior CH projects. In a similar vein, there appear to be too many indicators and data collection instruments, to be sustainable.

The revised objectives are below:

Results Framework

GOAL

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

STRATEGIC OBJECTIVE : Increased use of quality services and prevention and case mangement practices in the areas of malaria, diarrhea, ARI, breastfeeding and immunization

MALARIA

Increase from 26% to 50% the percent of children 0-23 months who slept under an insecticide treated bed net the previous night

Increase from 30% to 50% the percent of mothers who took anti-malarial medicine to prevent malaria during pregnancy

Increase from 17% to 50% the 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

PNEUMONIA

Increase from 28% to 60% the percent 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

DIARRHEA

Increase from 26% to 50% the percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids 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.

BREASTFEEDING PROMOTION

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

IMMUNIZATION

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

Increase from 29% to 60% the 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

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 (from Clinical Observation in HF)

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 (from record review)

INTERMEDIATE RESULTS

IR 1 : Improved Knowledge and Interest in Key Family Health Practices	IR 2 : Improved Quality of Care	IR 3 : Improved Access and Availability to Health Services Products	Improved Social and Policy Environment
All existing mediums are regularly used to disseminate CS messges	80% of AS are trained in Quality Assurance	80% of CSB offer counseling services on BF and CF	BCC regional strategy including community-based services (VISA, CBD, CCM, KM etc.) in place and implemented.
90 % OF Fokontany with partners participate in CCC activities	80% of CSB implement QAS	80% of the CSB of the RSO, implement PCIME	90% OF CSB implemen the standards, procedure and policies that exist within the framework of CS
80% of Communes with access to radio broadcasts have listener groups	80% OF CSB have a supervision visit at least twice per year		
50% of Communes implement the KM approach	50% of CSB implement a system to obtain clients' views	90% of health sector have CCM services	

100% of Communes implement the VISA approach	with regard to health services Increase from 32% to 60% availability of 5 first line drugs at the level of the FS 80% of FS use all necessary management tools for CS programs 60% of standards are applied to each level of the health system 80% of CSB have received at least 2 supervision visits per year 80% of CSB of the RSO, implement PCIME 90% of health sector of the RSO have CCM sites with at least a community agent trained in CCM	100% of CSB offer regular EPV services

12. Given the momentous shift to ACTs, the project might consider the need to develop and adverse event monitoring system, especially for community based treatment or management of fever. MCDI may be in a good position to analyze the role and use of RDTs at community level, especially in tropical climates which may affect the test kit itself.

The recommendation in terms of community management of children <5yrs with fever is to treat with ACT without the use of RDT. MCDI is open to experimenting with the use of RDTs at the community level if this is available and accessible. TREIP's resources do not allow us to acquire RDTs.

13. Although extensive baseline indicators are included, the proposal does not seem to apply a deeper synthesis of findings. This reviewer does not find the described M&E system to be feasible or sustainable. Furthermore, the current proposal does not describe anticipated changes in the system over time, in particular plans to decrease the volume of monitoring after start-up, and as one moves into the maintenance phase.

Program Management

14. This reviewer has some concern about the current staffing pattern and location of proposed staff, which is focused on the regional level, with less MCDI-supported staff as one gets closer to the community level. Given the large number of diverse community-based providers, might it not make sense to have more staffing at this level?

One of the mechanisms for scaling up proposed by TREIP is anchoring of staff at the regional level, which is vital for achieving total coverage of this region. MCDI reinforces the capacity of the Regional team for "coaching" the districts. Having a District or Commune team is ideal but beyond the financial capacity of TREIP, and so it is unfeasible. To mitigate/address this gap, MCDI recommends recruiting local NGOs to support the community, the CSBs and districts in implementation of activities. These local NGOs will provide the necessary human resources at the peripheral level. They will receive training and supervision to strengthen their capacity.

15. Similarly, the proposal anticipates that the newly-strengthened regional level will be able to support all 9 districts, but this reviewer is concerned that more MCDI staff mentors will be needed at district level.

To address this point, MCDI, along with the DRS, has put in place a system of sponsorship by one or two technical personnel at the DRS (Mentoring) in each district. MCDI programmed training in "Coaching" of these regional personnel (MCDI has two "Coach" trainers who were trained by TRG within the framework of the SanteNet project). The Coach will be responsible for support of his district as well as support in both the technical and operational domains.

16. The current proposal does not appear to have clear plans and activities for transitioning (literally) functions and costs currently born by MCDI to other sustainable sources.

With the sponsorship/mentoring approach described above, MCDI is not in need of a plan for transitioning functions since from the beginning, a parallel system was not in place and everything focused on the organization of work and capacity strengthening.

The transition of costs generated by TREIP: if all goes well with the mentoring system, the only costs to be transitioned would be those linked to support of NGOs for their support of activities at the community level. It is for this reason that MCDI proposes to put these NGOs in touch with Voahary Salama. This umbrella NGO's mandate is to mobilize resources by touting the capabilities of its member NGOs. MCDI will encourage VS to submit proposals for the continuation of support of the NGOs.

17. In general, the lines of supervision for the diverse community-based providers is not well described, nor is it clear that the supportive supervision for the community health workers is feasible, given the weak state of facilities and their own support systems (eg supplies). In addition, the functioning of the Steering Committee needs more description.

See #5 above and Point #5 of the USAID response.

Training plan
The training plan would be strengthened by some narrative to supplement the tabular annex.

The training plan is already very clear for the project team

Workplan
The workplan would be strengthened by some narrative to supplement the tabular annex. The table should be more detailed, at least by quarter and with more description. One would also expect to see some changes in activities and emphasis over time.

See the updated work plan. MCDI believes that the revised work plan is detailed enough.

EIP and Sustainability
Costing for scale and sustainability is not well described.

Maria Francisco Comments and MCDI Responses

PVO/Country:_____MCDI/Madagascar _ Reviewer's Name: Maria Francisco/USAID
Intervention(s) Reviewed (if specific)___all_____

Part B – Areas for Improvement of the DIP and Recommendations

1. From p.43 – 45, I seem to have a draft copy. Some sentences are fragmented or written in French. Elsewhere there are descriptions missing and questions /question marks imbedded in the text e.g. last paragraph before 2. Case Management of Pneumonia. PCM (not in acronym list) is used interchangeably with CCM pneumonia, as are AAR and RAA . Typos exist throughout….

Done

2. The CHV model described in the DIP seems to be mainly a MCDI construct. In fact other models already do/will exist in country e.g. PNNC/SEECALINE and other volunteers, and are undertaking similar integrated community-based interventions.

The CHV model proposed in the DIP is one that MCDI is proposing for the MOH since to date nothing of this sort or an official policy on CHVs is in place in Madagascar. This will be linked to the CSB of the MOH and will maintain interactions with the CSBs. Within this model, MCDI will reinforce the MOH for the prolongation of care toward the community. On the other hand, a number of community structures such as PNNC/SEECALINE, do not maintain this type of interaction and work independently or even parallel to the MOH structures. MCDI is convinced that the only way forward with this community component is to have community structures be linked to the MOH structures.

3. It is not clear to what extent the training and incentives for CHVs in MCDI program areas are consistent with other community volunteers or otherwise build on successful models tried in Madagascar.

MCDI has developed this innovative model (especially on the question of motivation with the VISA approach) which has proven successful with the former CSPs; it is this model that we propose to scale up and to use to further the experiences of Madagascar. MCDI is actually pushing, with UNICEF, SanteNet and other organizations, the development of a community health policy for Madagascar based on the successes. The MCDI model will be proposed.

For incentives, TREIP cannot support monthly remunerations to the CHVs as is the case with PNNC/SEECALINE.

4. Moreover, given the array of interventions to be undertaken by these volunteers, there does not appear to be a clear plan for progressively phasing in or prioritizing their introduction.

See response #1 of USAID responses

5. Immunization at 33% fully immunized in project areas is still quite poor. It is unclear what changes from the previous MCDI strategy have been made to ensure that currently un-immunized and/or under-immunized children will be reached.

The question is not clear.

6. Surprisingly, there was no mention of the USAID-funded partner, IMMUNIZATIONbasics, who is working with the MOH to develop strategies for targeting poorer-performing regions and districts as well as supporting capacity building and monitoring of MLM and RED in select regions and districts (in partnership with SV, UNICEF, and SantéNet). Sharing information and experiences with IMMbasics (which is providing technical support to National Level EPI policy and guidance to field level implementation) would be mutually beneficial and complementary.

Immunization Basics is focused at the central level. TREIP has a focus from the regional to the community level. The activities at these intervention levels of TREIP have the expression of strategic concepts and policies at the central level with support of IMMBasics and other actors at this level (WHO, UNICEF, etc.). MCDI is not proposing to have direct interaction with the central level with regard to immunization but MCDI has however proposed to support the efforts such as RED (even without specifically mentioning IMMBasics). MCDI is however open to information and experience exchanges if the opportunities to do so exist.

7. From health facility data, IMCI performance with regard to health workers being able to provide effective integrated care is still weak. Again, it is not clear to what extent the current approach to IMCI training and followup support are changing under this new MCDI program and to what extent human resource issues such as motivation, retention or incentives are being addressed.

Issues of human resources, motivation, retention, incentives, and clinical IMCI are beyond the control of MCDI. These are problems that only the MOH and the state themselves can address. MCDI, USAID, SanteNet and other organizations have for a long time argued for these problems to be addressed, but without success. We cannot count on TREIP to change the situation. All the same, MCDI will continue to plead for the improvement of this situation.

8. Although the country health situation was sufficiently described, the analysis of major health systems issues and constraints was weak and in future should be strengthened in order to better couch the activities and interventions to be rolled out. Practical examples for how the QAS approach could be applied (esp. at community level) were not well described; the

description provided seemed largely theoretical. The 'integration of QAS with KM' was not fleshed out. The statement on the role of health committees "as models of support and accompaniment for the CS" seemed out of place here. Under the sections describing specific technical areas, quality assurance is a rubric for largely supervision and monitoring work --- which is OK --- but the previously mentioned 'certification' aspect is never mentioned again (presumably this could be an effective way of ensuring trained health staff reach an adequate level of technical competency). In addition, the capacity of the health system for effective monitoring and data use and reporting was not addressed. Will the purchase of PDAs really facilitate some of these basics data skills? It also is unclear how the program can/will address major barriers to access and utilization (especially for the poor), mainly cost and transport and other health systems issues like referral networks and drug supply/logistics. Only the malaria section briefly mentions the HFCI; mutuelles and equity funds are mentioned but not fully described.

This point will be considered.

9. In the text, MCDI is "to play a leadership role on several national and regional committees, using these mechanisms to scale up approaches that have achieved impact such as… CCM." Yet no mention is made of other major partners also seen by the MOH and USAID as providing leadership and support to CCM. The BASICS project is working with partners to revitalize CDD, including introduction of zinc and new ORS, and supporting integrated CCM (malaria/pneumonia/diarrhea) alongside newborn health and nutrition interventions at community level. Again, there is an opportunity here to achieve harmonization of approach as well as scale of impact by better coordinating the various approaches and learning from one another.

See response #7 to USAID

BASICS, MCDI, UNICEF, WHO, MOH, SanteNet and other organizations are working together to harmonize the CCM and NNC approaches. We will put in place the same model.

10. As a general comment, the CCM intervention was not well described. Some of the critical systemic considerations were not effectively addressed i.e. drug supply/re-supply issues in the community, monitoring/documentation (especially to strengthen the evidence base for promoting and expanding the approach and advocacating to MOH and donors) etc. Given the planned improvements to case management at facility level and the reach of CHVs into the community, critical links in the referral chain should also be strengthened to ensure (to the extent possible given the long distances to some referral sites) that mother/caretakers are able to comply with referrals and their severely ill children not lost to follow-up.

See response #7 to USAID

11. Regarding the various ENA components and contact points, which cover maternal and child health interventions as well as facility level and community interactions, it was unclear whether all or only a subset of ENA would be the focus of the program.

The complete ENA pacquet will be implemented by TREIP but the focus will be on the breastfeeding component as TREIP is committed to this intervention.

12. Also for nutrition, the USAID-financed LINKAGES project had initiated work with women's' groups for promotion of breastfeeding. The successful components of these and other programs could be tapped for use in MCDI program areas.

MCDI will explore the feasibility of this recommendation. Already, a number of reviewers are "criticizing" the fact that TREIP is proposing too may types of CHWs. Adding women's groups must therefore be carefully examined.

13. Finally, the performance monitoring and evaluation plan is certainly comprehensive, but on the surface of it appears labor intensive and largely NGO-driven. Emphasis is hopefully on improving use of data for local program monitoring, prioritization of activities and resource planning by MOH

Annex 5. Publication/Presentations:

- Presentation on the TREIP community approach to UNICEF in September 2007
- Presentation of the TREIP to USAID
- Presentation of the TREIP at the Mini-university in Baltimore/Johns Hopkins University/USA
- Presentation on the community-based Reproductive Health program of MCDI and MINSANPFPS organized by the Ministry of Health of Mali, WHO, USAID, “Frontières” Project in June 2007.
- Presentation on MCDI’s community-based health programs, organized by UNAIDS, WHO Afro, World Bank, UNICEF, held in Ethiopia in November 2006.

Child Survival and Health Grants Program Project Summary

Nov-28-2007

Medical Care Development Inc./Int'l. Division (Madagascar)

General Project Information:

Cooperative Agreement Number:	**GHS-A-00-06-00007**
Project Grant Cycle:	**22**
Project Dates:	**(10/1/2006 - 9/30/2011)**
Project Type:	**Expanded Impact**
MCDI Headquarters Technical Backstop:	**Luis Benavente**
Field Program Manager:	**Josea Ratsirarson**
Midterm Evaluator:	
Final Evaluator:	
USAID Mission Contact:	**Benjamin Andriamitantsoa**

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Funding Information:

USAID Funding:(US $): $2,499,986 **PVO match:(US $)** $880,491

Project Information:

Description:

Project Goal: To reduce mortality and morbidity of children under 60 months and improve the health status of women of reproductive age in RAA of Madagascar
Interventions:

- Prevention and treatment of malaria
- Control of diarrheal disease
- Breastfeeding
- Immunization
- Pneumonia management

Strategies:
1. Expand successful approaches such as the VISA approach, Komimina Mendrika, Health Festivals, Community Radio and the Child-to-Community Program to the rest of the RAA
2. Betioky Sud and Toliara II will be established as community health "showcase" districts for the RAA
3. MCDI will continue to play a leadership role on several national and regional committees to advocate adoption of successful approaches

Location:

Région Atsimo Andrefana (RAA), which was formerly the South West Region of Toliara Province, Madagascar

Project Partners	Partner Type	Subgrant Amount
Voahary Salama	Subgrantee	$50,000.00
MOH (MSPF)	Collaborating Partner	
Local NGOs	Subgrantee	$200,000.00
SanteNet	Collaborating Partner	
UNICEF	Collaborating Partner	
Subgrant Total		$250,000.00

General Strategies Planned:

Social Marketing
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Lot Quality Assurance Sampling
Appreciative Inquiry-based Strategy
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Social Marketing
Mass Media
Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ	Local NGO	Pharmacists	Dist. Health System Health Facility Staff	Health CBOs CHWs

Interventions/Program Components:

Immunizations (20 %)

(IMCI Integration)
(CHW Training)
- Cold Chain Strengthening

Pneumonia Case Management (20 %)

(IMCI Integration)
(CHW Training)
- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Access to Providers Antibiotics
- Recognition of Pneumonia Danger Signs
- Community based treatment with antibiotics

Control of Diarrheal Diseases (20 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling
- Zinc

Malaria (20 %)

(CHW Training)
(HF Training)
- Training in Malaria CM
- Adequate Supply of Malarial Drug
- Access to providers and drugs
- ITN (Bednets)
- ITN (Curtains and Other)
- Care Seeking, Recog., Compliance
- IPT
- Community Treatment of Malaria
- ACT

Breastfeeding (20 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Promote Excl. BF to 6 Months

Target Beneficiaries:

Infants < 12 months:	42,957
Children 12-23 months:	40,809
Children 0-23 months:	83,766
Children 24-59 months:	109,539
Children 0-59 Months	193,305
Women 15-49 years:	247,000
Population of Target Area:	1,073,915

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	45	147	30.6%	11.6
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	66	226	29.2%	9.2
Percentage of children age 0-23 months whose births were attended by skilled personnel	143	299	47.8%	9.7
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within 3 days after the birth of the youngest child	0	0	0.0%	0.0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	49	210	23.3%	8.7
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall)	104	210	49.5%	11.7
Percentage of children age 12-23 months who received a measles vaccination	132	226	58.4%	11.9
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	101	226	44.7%	10.9
Percentage of children age12-23 months who received a DPT3 vaccination before they reached 12 months	83	226	36.7%	10.1
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	11	67	16.4%	13.1
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	75	140	53.6%	14.7
Percentage of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks	33	118	28.0%	12.5

who were taken to an appropriate health provider.				
Percentage of households of children age 0-23 months that treat water effectively.	**10**	**300**	**3.3%**	**2.9**
Percentage of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing that and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview	**10**	**300**	**3.3%**	**2.9**
Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night. This indicator should be used for programs in Africa. In Asia, this indicator should be used in specific geographic areas where bed net use is recommended.	**79**	**300**	**26.3%**	**7.7**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population)	**110**	**300**	**36.7%**	**8.8**
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	**47**	**226**	**20.8%**	**8.0**

Comments for Rapid Catch Indicators

Measles immunization coverage is based on maternal recall only.

Flex Fund Project Entry Form
Sub Form 1: Project Identification

MCDI (Madagascar) MCDI (Madagascar)	
General Information	
Funding Mechanism:	**GSM / World Learning**
USAID Washington Funding:	$485,000
USAID Mission Funding:	
MCDI Match Funding:	$337,000
Cooperative Agreement No:	GSM-008"
Project Start/End Dates:	**(Jan 1, 2006 - Dec 31, 2008)**
Project Name:	Family Planning Integration through a Community-Based Approach

Project Description:

The Family Planning Integration through a Community-based approach project in Madagascar is a three-year, USAID-funded project implemented by Medical Care Development, International (MCDI) to improve the health status of women of reproductive age (WRA) by integrating FP services and promotion of water and sanitation interventions among 111,302 community members (WRA=55,817; MRA=55,485). The project is being implemented in the Ihorombe region of Madagascar, in the districts of Ihosy, Iakora and Ivohibe.

The TFR in Madagascar is 5.2 children per woman and in Fianarantsoa province, it is 5.7 (DHS 2003-04), with a population growth rate estimated at 2.8% per year. There is an urban-rural differential in terms of TFR: 3.7 vs. 5.7. With regard to the contraceptive prevalence rate, MOH statistics reveal a low prevalence rate of the use of modern contraceptive methods by women of reproductive age in the three targeted districts during the first semester of 2005 (6.38% for Ihosy, 2.7% for Iakora and 6.11% for Ivohibe), with a rate of 18% in Madagascar. UNFPA reports a large unmet need (25.6%). The maternal mortality rate remains high at 469 for 100,000 live births.

With support from USAID's Flex Fund, MCDI will achieve the following results using community-based strategies to improve access to quality FP services, improve use of FP services and improve FP and RH practices and service delivery.

The project results are as follows:

IR1: Increased Knowledge and Interest

This will be implemented with a behavior change communication (BCC) strategy based on community health volunteers (ASVs), Water Point Committees (WPC) of the AEPA project, mobilizers from 2 local associations,

implementing the VISA (Visiting, Identifying, Sensitizing and Accompany) approach, and supported by mass media.

This will also be achieved by implementing a community mobilization strategy with a view towards enhancing health consciousness, and based on the "Champion Community" approach (in which participating communities define objectives and their commitment to reach them, and the project, in turn, recognizes "champion communities" for their efforts) combined with the Rapid Result Initiative (RRI), festivals and male participation, and developing BCC resources;

IR2: Improving quality of FP services and (IR3) Increasing access to FP services by reinforcing/opening FP services at basic health centers (BHCs) in the project area, expanding the promotion and provision of services in long-term FP methods at basic health facilities, implementing the IPQ (Improvement in Performance and Quality) approach at all BHCs, implementing a community-based contraceptive distribution (CBD) program, developing formal and informal health care providers' capacities both at the BHC level and at the community level, and improving the health support system. Condoms, oral contraceptives, Depo-Provera, Spermicide and LAM will be provided by a medical doctor, nurse, midwife, or health aide.

MCDI will also build on community mobilization and training techniques learned under our USAID-funded Toliara Province Child Survival Project. Key FP program messages will be in concert with those developed by the Ministry of Health and the National IEC task force. The project will support various contraceptive methods including hormonal, mechanical, barrier and natural methods according to the national protocol. The project will not be promoting any specific reproductive health intervention integrating family planning, adolescent reproductive health, safe motherhood. However, the project will promote key practices for preventing HIV/AIDS/STIs.

Project sustainability will be ensured through the following methods:

(a) Strengthening the capacity of local partner Voahary Salama, as well as the two local associations (SOFABA and FIFAKRI) to conduct quality outreach FP interventions, including the promotion of HIV/AIDS/STI prevention and promoting double protection viz. preventing HIV/AIDS/STI transmission and pregnancies; this capacity building is based on the learning-by-doing approach.

(b) Building capacity of MOHFP staff for promotion/service delivery/management of the FP program

(c) Using African Development Bank funding to sustain the water and sanitation activities and related community-based health and hygiene advocacy efforts, and Flexible Fund funds to integrate family planning interventions;

(d) Collaborating with SanteNet to strengthen the FP component of the Champion Commune and IPQ approaches

(e) Collaborating with PSI to support/sustain provision of contraceptives and related drugs through social marketing at the community and BHC levels;

Region:	Ihorombe

District:	Ihosy, Iakora, Ivohibe

Project Coordinates: Latitude: -24.2833333 Longitude: 46.2166667

Geographic Subareas	**<Help>**
(Does this project collect, monitor and report on Flex Fund indicators for different *geographic* project subareas ?) If this is true, click *Yes* and enter each distinct subarea name: If this is false, click *No*.	☐ Yes ◉ No

Sub Form 2: Project Contacts

Key Stakeholder Contacts

Grantee HQ Technical Backstop:
Deborah Carter-Gau, Dr. Rija Fanomeza, Josea Ratsirarson, Joseph Carter, Yaikah Jeng Joof

Grantee HQ Financial Backstop:
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Grantee Regional Contact:
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USAID Mission Contact:
Wendy Githens Benazerga, Benjamin Andriamitantsoa, Yvette Malcioln, Micheal Park

USAID Washington Representative:
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Partner Information:

Name	Type	$ Allocated	Remove
Voahary Salama	Subgrantee	$60000	☐
Population Services International	Collaborating	$0.00	☐
Chemonics SantéNet Project	Collaborating	$0.00	☐

Click Plus Icon to add additional Partner --»

Sub Form 3: Project Beneficiaries

Programmatic Area A: Adults		
Type	**Age Range**	**No. Beneficiaries**
WRA	**15-49**	109,069
Married WRA	**15-49**	
Men	**15-59**	112,739

Programmatic Area B: Youth		
Type	**Age Range**	**No. Beneficiaries**
Female Youth	**10-14**	
Female Youth	**15-19**	
Female Youth	**20-24**	
Male Youth	**10-14**	
Male Youth	**15-19**	
Male Youth	**20-24**	

Population of Target Area	
Population of Target Area:	287,000

Sub Form 4: Project Focus Areas

Key Technical Focus Areas	
☐	Youth
☑	Behavior Change Communication (BCC)
☑	Community-based distribution (CBD)
☑	Health Facilities
☑	Integration
☑	Integration HIV/AIDS
☐	Contraceptive logistics
☐	Cost Recovery
☑	Social Marketing
☐	Female Genital Cutting
☐	Post Abortion Care
☐	Gender

Contraceptive Methods Distributed	
☑	Female Sterilization
☑	Male Sterilization
☑	Pills
☑	IUD
☑	Injectables
☑	Implants
☑	Male Condom
☐	Female Condom
☐	Diaphragm
☐	Foam/Jelly
☑	Lactational Amenorrhea
☑	Standard Days Method
☐	Fertility Awareness Methods (Non SDM)
☐	emergency contraception

Sub Form 5: Data Entry of Core Indicators

Project Data Phase: ***Baseline Core Indicators***

LEVEL:1

Indicator Required

Core Indicator	Number	Numerator	Denominator	Percent (Auto-Calc)	Confidence Interval (Auto-Calc)	Yes/No
Couple Years of Protection (CYPs)	3414					
Percent of Facilities Reporting No Stockouts in the last quarter		32	32	100	34.6	
Contraceptive Use Among WRA		31	201	15.4	7.4	
Unmet Need for Family Planning		119	153	77.8	15.4	
Adequate Birth Spacing		62	122	50.8	15.5	
Percent of Women with Knowledge of at least 3		196	300	65.3	10.6	

Methods of FP						
Percent of Women with a Child < 12 months old who were Counseled about Benefits of Child Spacing		23	74	31.1	16.5	
Percent Sexually Active Women who Discussed FP with Health/ FP worker within the past 12 months		38	300	12.7	5.5	
Percent of Clients who Receive Adequate Counseling		20	31	64.5	32.9	
Percent of Facilities Offering 3 or More Modern FP Methods		32	33	97	34.1	
Percent of Population Living Within 5 km of a FP Service Delivery Point		122	215	56.7	12.1	
Number of Acceptors New to Contraception	271					
Percent Sexually Active Women who Discussed FP with Spouse/ Sexual Partner		56	236	23.7	8.3	

within the past 12 months						
Program Sustainability Plan in Place						☐

Sub Form 5: Data Entry of Core Indicators

Project Data Phase: *Annual Report 1 Core Indicators (2007)*

LEVEL:1

Indicator Required

Core Indicator	Number	Numerator	Denominator	Percent (Auto-Calc)	Confidence Interval (Auto-Calc)	Yes/No
Couple Years of Protection (CYPs)	4194					
Percent of Facilities Reporting No Stockouts in the last quarter		33	33	100	34.1	
Percent of Clients who Receive Adequate Counseling						
Percent of Facilities Offering 3 or More Modern FP Methods		33	33	100.0	34.1	
Percent of Population						

Living Within 5 km of a FP Service Delivery Point						
Number of Acceptors New to Contraception	3815					
Program Sustainability Plan in Place						☐