



**USAID** | **MADAGASCAR**  
FROM THE AMERICAN PEOPLE

# **RTI/Santénet2**

## **REVISED ANNUAL REPORT**

### **No. 3**

**October 2010–September 2011**



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October 2010–September 2011

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# Acronyms

ACT	artemisinin-based combination therapy
AIDS	acquired immune deficiency syndrome
AIM	Association Intercooperation Madagascar
ANC	antenatal care
ARH	adolescent reproductive health
ARI	acute respiratory infection
ASOS	<i>Action Socio-sanitaire Organisation Secours</i>
BCC	behavior change communication
C-HMIS	community-based health management information system
CHW	community health worker
C-IMCI	community-based integrated management of childhood illnesses
CLTS	community-led total sanitation
CMIS	community management information system
C-ONE	community-based care for obstetrical and neonatal emergencies
COP	chief of party
CPR	contraceptive prevalence rate
CRS	Catholic Relief Services
CSB	basic health facility ( <i>centre de santé de base</i> )
CSO	civil society organization
CSP	community supply point
DHS	Demographic Health Survey
DMPA	Depot Medroxyprogesterone Acetate (Depro Provera)
DRV	Dinika sy Rindra ho an'ny Vehivavy
EIPM	Survey on Malaria Indicators in Madagascar
FBO	faith-based organization
FP	family planning
FY	fiscal year
HIV	human immunodeficiency virus
HMIS	health management information system
IEC	information, education, and communication
IMCI	integrated management of childhood illnesses
IPM	Pasteur Institute of Madagascar
IPT	intermittent preventive treatment
IT	information technology
KM	Kaominina Mendrika (champion commune)
LAM	lactational amenorrhea method
LTPM	long-term permanent method
M&E	monitoring and evaluation
MAR	monthly activity report
MARP	most-at-risk population
MCDI	Medical Care Development International
MCH	maternal and child health
MCP	Malaria Control Program

MOH	Ministry of Health
MSM	men who have sex with men
NGO	nongovernmental organization
NSA	National Strategy Applications
ONE	obstetrical and neonatal emergency
ONN	<i>Office National de Nutrition</i> (National Nutrition Office)
PLeROC	<i>Plateforme des Leaders Religieux et Organisations Confessionnelles</i>
PMP	Performance Monitoring Plan
PSI	Population Services International
RBM	Roll Back Malaria
RDT	rapid diagnostic test
RFP	request for proposals
RH	reproductive health
SAVA	Sambava–Vohemar–Andapa–Antalaha
SDC	Social Development Committee
SDM	standard days method
SMS	short messaging system
SMSR	<i>Service de la Maternité Sans Risque</i> (Safe Motherhood program)
SN	<i>Service de Nutrition</i> (Nutrition program)
SO	Strategic Objective
SP	sulfadoxin pyrimethamin
STI	sexually transmitted infection
SW	sex worker
TA	technical assistance
ToR	terms of reference
ToT	training of trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	U.S. Agency for International Development
VAT	value-added tax
VCT	voluntary counseling and testing
WASH	water, sanitation, and hygiene

# A. INTRODUCTION

The 5-year U.S. Agency for International Development (USAID) Santénet2 project, implemented by RTI International, is a major component of USAID/Madagascar's fourth phase of assistance to the health sector in Madagascar under Strategic Objective 5 (SO5), "Use of selected health services and products increased, and practices improved." SO5 includes the following components:

- Improve child survival, maternal health, and nutrition
- Reduce unintended pregnancy and improve healthy reproductive behavior
- Prevent and control infectious diseases of major importance
- Improve water and sanitation in target communes
- Reduce transmission and impact of HIV/AIDS.

During Year 3 of the RTI/Santénet2 project, Kaominina Mendrika (KM) salama activities were scaled up to all 800 target communes. The KM salama model aims to strengthen the community health system and build decentralized decision-making capacity at the community level to lead to improved health status. Paragraphs below highlight major accomplishments in Year 3 by the building blocks of the KM salama community health system model. Details of these accomplishments are provided in the sections of this third annual project report that follow.

**Community engagement**—All 800 KM salama communes have community-level plans, based on decentralized needs assessment and priority actions identified. More than 12,000 community leaders (4,758 women and 6,750 men) constitute Social Development Committees (SDCs) in 800 KM salama communes. SDC members received training on participative planning, awareness-raising on health prevention messages, social quality and social accountability, water system management, and community-led total sanitation (CLTS); 1,076 of those SDC members were trained in Year 3 and ongoing support was provided to those trained in previous project years.

**Program tools production and distribution**—The project inventory includes 43 tools used by KM salama commune actors on a regular basis. In Year 3, the project team has produced and distributed 651,691 tools in these 43 categories. These activities met the needs of 11,216 community health workers (CHWs), 800 SDCs (more than 12,000 members), and 1,000 supervisors (local and independent). Distribution is planned and accomplished on quarterly basis.

**Demand stimulation for health seeking behavior**—In Year 3, the project reached 3,626,763 women and 2,266,381 men in the 800 KM salama communes through interpersonal communication (home visits, group discussions), sermons in places of worship, and spots on local radio stations with key health messages on five program elements as well as on community engagement. Several service use indicators reveal a higher proportion of the target population adopt health-seeking behavior.

**Healthcare financing**—The project has produced an enhanced health *mutuelle* program to increase pool size and expand services covered. Health *mutuelles* will start enrollment and service provision in Year 4.

**Capacity building**—410 trainers and 1,000 supervisors were mobilized in Year 3 to provide expanded health package training to 11,216 CHWs. In addition, 1,192 new CHWs were identified by the SDCs and the communities to replace those who left the program, which gives an attrition rate of 11% (606 Child Health CHWs and 586 Mother Health CHWs). A total of 858 managers for social marketing product community supply points were trained.

**Quality improvement**—Using the project’s Social Quality Index tool, the quality of various elements of the KM salama approach were measured twice in Year 3 in each of the 800 KM salama communes. The results indicate steady improvement in service quality, organization, and resource availability for all 800 KM salama communes.

**Community Health Management Information System (c-HMIS)**—Information was collected in Year 3 on activities of the 11,216 CHWs. This information, aggregated and sent monthly by 204 field workers, is recorded in the project’s custom developed a c-HMIS database. The database has, as of September 30, 2011, 94,737 reports on individual CHW activities (70% completion rate with 73% of reports received sent on time following the month of activity).

**Community social marketing products supply chain**—All CHWs access contraceptives, water purification products, cotrimoxazole (antibiotic), and anti-diarrheal drugs from both the social marketing community supply chain and the national essential drugs supply chain. However, anti-malaria products (rapid diagnostic tests [RDTs] and artemisinin-based combination therapy [ACT]) constituted a major challenge with frequent and lasting stock-outs due to insufficient quantity in both of these supply chains.

**Maternal and child health (MCH)**—During Year 3, 2 566 Mother Health CHWs in 800 KM salama communes provided MCH services (pregnancy screening, early detection of obstetric and neonatal complications, and referral to health facilities) to 258,571 pregnant women who live one hour or more from the nearest formal health facility. 112,275 children under five years of age with diarrhea and 90,735 children under five showing signs of acute respiratory infection (ARI) were treated by Child Health CHWs.

**Nutrition**—Child Health CHWs provided community-based growth monitoring services to more than 1 million children under five years of age during Year 3. CHW nutrition screening for children uncovered twice as many cases of severe and moderate malnutrition than the screening conducted in health facilities (CSBs) in the KM salama communes: for red strip results (severe malnutrition), CHWs uncovered 4% and CSBs only 2%; for yellow strip results (moderate malnutrition), CHWs uncovered 18% and CSBs only 9%

**Family planning/reproductive health (FP/RH)**—Mother Health CHWs provided community-based FP services to 102,847 regular FP users in Year 3. It is estimated that the

community FP services of RTI/Santénet2 CHW accounted for an increase of three (3) percentage points of the national contraceptive prevalence rate (CPR) in Year 3.

**Malaria control**—Child Health CHWs diagnosed 138,138 children under five years of age with fever in Year 3. Among these children, 69 069 out of 85,650 tested with RDTs had positive results for malaria and were treated with ACT.

**HIV/AIDS**—In Year 3, project-trained peer educators from most-at-risk population (MARPs) associations reached almost 21,000 commercial sex workers (CSWs) and men having sex with men (MSM) through HIV/AIDS awareness-raising and prevention activities, and promotion of services. During the past year, a total of 4,769 CSWs and MSM chose to use voluntary counseling and testing (VCT) and sexually transmitted infection (STI) screening as a result of these project-supported activities. During the same period, the total number of persons seeking VCT services in all of Madagascar was 203,743, out of which 8,533 were estimated to be CSWs and MSM.

**Water, sanitation, and hygiene (WASH)**—In Year 3, the project initiated introduction of the CLTS approach in 480 communes. Through this approach 3,677 latrines used by 77,445 individuals were constructed, thus decreasing the practice of open-air defecation. In 135 KM salama communes, 340 water infrastructures were built (new construction) or were improved (existing infrastructures) by the communities' own resources through project technical assistance. 1,728 CHWs were certified as WASH-friendly (i.e., they store and use clean water at home, have hand-washing systems at home, and use latrines).

This third annual report describes project activities carried out by RTI International and its partners between October 1, 2010, and September 30, 2011. The report describes achievement in the following areas:

- Community programs
- Strengthening community health systems
- Strategic results
- Program coordination
- Administration and finance
- A gap analysis of activities by component (*Annex A*)
- Monitoring and evaluation (M&E) (*Annex B*)
- Environmental Mitigation and Monitoring Report (EMMR) (*Annex C*)
- Additional information on tools, success stories, etc. provided in the annexes.

## II. TECHNICAL COMPONENT

### I: COMMUNITY PROGRAMS

#### Introduction

In Year 3, activities of the community programs component aimed at (1) establishing a community governance framework and at strengthening the capacity of community decision-makers to assess needs, plan actions, and monitor the implementation of health interventions; (2) strengthening communication strategy for behavior change conducted by CHWs through activities implemented by faith-based organizations (FBOs) and broadcasting spots with health messages through local radio stations; and (3) supporting the implementation of health *mutuelles* for improving population access at different level of treatment. These concepts are at the center of the KM salama approach.

The actions of the SDCs in the 800 communes, as part of promoting responsibility-taking and local governance, were assessed and documented: all the SDCs developed two community-based action plans during Year 3. The community participatory work plans identified challenges relating to behavior change (use of preventive services, such as immunization, antenatal care [ANC], intermittent preventive treatment during pregnancy [IPTp], etc.) and support to health service delivery points (CHWs and CSBs), such as availability of health products and drugs, transparency in drug prices, service delivery environment, and working hours for CHWs and CSBs. The selected solutions are awareness-raising for all community members using preventive health services, support for supply chain functioning (for example, SDC members provided financial contribution to the supply point to purchase social marketing products), and improvement of CHW health huts and CSBs (including construction and rehabilitation of health facilities and water and sanitation systems, posting information on CHW working hours and drug prices, etc.). During the reporting period, community engagement materialized also in 298 investment actions that improved health facilities (safe water, latrines, garbage pits, wash houses, drainage, sanitation, etc.) and construction of 359 health huts for CHWs.

One of the challenges faced by RTI/Santénet<sup>2</sup> this year was timely distribution of management tools to community actors. These challenges were due to concomitant trainings and setting up a large number of community actors (CHWs and SDCs) in the 800 communes and 5,758 *fokontany*, on one hand, and to the large number of tools to be distributed on the other hand (see list of tools in *Annex G*). During Year 3, we enhanced needs assessments and a tools distribution information system in collaboration with SDCs and implementing partners. The enhanced system for monitoring and managing tools at the nongovernmental organization (NGO) level consists of sending proofs of receipt along with the tools to be distributed and having the final users sign the proofs. To date, 92% of the tools distributed to the NGOs in fiscal year (FY) 2011 are accounted for through the proofs of receipt. In FY 2011, 783 set of tools composed of 651,691 units (compared to 589 packages of tools for 623,030 units in FY 2010 and 34,330 units in FY 2009) were sent to the field for community actors in response to the needs expressed by partners. In addition, five tools were updated to meet the requirements in implementing activities.

The entities grouped in the FBOs' platform, *Plateforme des Leaders Religieux et Organisations Confessionnelles* (PLeROC), extended their activities to 587 KM salama communes and trained 1,100 religious leaders (bringing the total number of trained religious leaders on communicating key health messages to 3,187), reaching more than 394,000 people attending their places of worship.

Partnership contracts with 28 local radio stations have allowed coverage of 97% of the intervention zones (772 KM salama communes in Year 3, an increase from the 355 KM salama communes reached in FY 2010), with a total of 10,313 airings of 16 spots on health and 44 reports on KM salama activities. In terms of the audience reached, the messages are estimated to reach as many as 9 million inhabitants. The monitoring system through "mystery listeners" showed that many people take advantage of the spots to send personal messages and that some radio stations broadcast their messages all day long to enrich their programs. These information, education, and communication/behavior change communication (IEC/BCC) activities are complementing interpersonal communications conducted by CHWs and SDC members in their communities.

Mutual health insurance scheme foundations (health *mutuelles*) have been set up in four selected districts (Vatomandry, Ambositra, Ambohimahaso, and Ambalavao) using the new strategy developed by the project. Of the 77 communes in these four districts, 68 are implementing the KM salama approach. Enrollment in the schemes will start in December 2011 and end in February 2012 (during the harvest period). The proposed schemes will pay for the drugs at the basic health facilities (*centres de santé de base* [CSBs]), medical evacuation, and care at a referral hospital. Subscription is for the entire household, with an individual premium ranging from MGA 2,500 (Ambalavao and Ambohimahaso) to MGA 4,500 (Vatomandry). These amounts are calculated to cover the cost of healthcare services and the cost of administration and management.

## Specific Achievements

### Strategic Focus 1. Implementation of the KM salama approach in 800 communes

#### a. Approaches

The KM salama approach was strengthened in the area of promoting local governance to focus on improving service quality. This approach promotes responsibility-taking, social accountability and behavioral changes among all community stakeholders. 1,076 SDC members were trained to facilitate collecting information on the needs and demand of the community and to ensure their self-assessments. The community is able to identify their needs through meetings and to strengthen health managers' accountability through regular self-assessments. Community commitment is assessed based on the action plans and was evidenced in the analysis of the action plans of 800 KM salama communes. SDCs develop and implement community health work plans during 6 months. At the end of 6 months, SDCs assess achievements against objectives and develop new plans or update the existing plans.

#### b. Results

Community engagement permitted stimulating demands, providing assistance to CHWs and also resulted in hardware investments by the community as illustrated below:

- 298 communes improved their health facilities with safe water, latrines, garbage pits, wash houses, drainage, or sanitation.
- 359 health huts were built for CHWs with the community's participation in 209 *fokontany*.
- 1,076 SDC members were trained on the enhanced KM salama approach in 178 communes.
- 800 KM salama communes have developed and implemented a community-based action plan. Achievements against targets of the community-based action plans are monitored monthly by implementing partners' field workers. At the end of each semester, a meeting is held to assess community-based action plan performance.

The table below provides the distribution of each investment reported during Year 3.

Investment action in a health facility, decided and conducted by the community	Frequency
Sanitation plan	60
Latrine construction	49
Posting work hours	43
Posting prices of health commodities and drugs	43
Housing construction/development	37
Reception area construction	11
Borehole construction/rehabilitation	27
Organizing health product supply chain	28
Electrification	1
Setting up system for hand-washing with soap	15
Construction of barriers surrounding the health facility	18
Improving the garden	6

Source: RTI/Santénet2, 2011.

### *c. Challenges and corrective actions*

There is a need to further monitor and support the continued accountability and the community evaluation of service quality. The project will conduct advocacy and awareness-raising as part of the effort to promote the approach's sustainability.

## **Strategic Focus 2. Production of KM salama tools**

### *a. Approaches*

All community actors should receive tools used for implementing the KM salama approach to ensure the quality of their activities. To this end, the Community Programs component led the design and the updating of tools, and the project produced and distributed management tools in addition to tools intended for community-based actors. During Year 3, RTI/Santénet2 ensured the availability of tools for 11,216 CHWs, 11,328 SDC members, 410 independent trainers, more than 1,000 local supervisors and 204 field technicians.

## **b. Results**

In Year 3, five tools were updated out of the eight planned. The remaining three tools were updated as part of integrated documents. These are the Youth's Guide to Using Condoms, the Manual on Latrine Slab Design, and the Manual on the Different Types of Latrines.

To address the availability of tools, RTI/Santénet2 sent out 783 pouches with sets of tools in response to the various needs expressed by partners, including the following:

- CHWs management tools
- Training manuals for community actors
- IEC/BCC tools for community actors
- Management and supervision tools for supervisors

The 651,691 units tools distributed during FY11, is more or less equal the number distributed during the two previous fiscal years.

## **c. Challenges and corrective actions**

Challenges ahead are the following:

- Develop and/or update tools according to needs identified
- Ensure that the tools are available to the community actors in compliance with distribution plans sent by implementing partners
- Monitor effective distribution and receipt of tools by end users

RTI/Santénet2 put a feedback system in place to monitor use of tools by target actors. Information we receive indicates that tools are used by these actors. The sustainability of management and information system tools is a major challenge. These tools need to be reproduced on a regular basis to meet the needs of different actors. Ideally, the Government needs to be involved in producing and distributing these tools once the project ends. However, given the Government's prevailing resource constraints, the project is working with NSA partners to partially address this challenge; we have asked for and obtained management tools for project-trained CHWs from NSA partners.

### **Strategic Focus 3. Implementation of a IEC/BCC strategy with the involvement of FBOs and media in the KM salama communes**

#### **a. Approaches**

RTI/Santénet2 used three major channels to convey its IEC/BCC strategy:

- CHW and SDC members as frontline actors, through interpersonal communication, home visits, and group discussions
- Civil society organizations (CSOs) and FBOs in a support role, creating an environment conducive to behavioral change and group communication

#### **List of tools updated in Year 3**

- Training curriculum for mutual health insurance schemes
- Job aid on mutual health insurance schemes
- Documents for members of mutual health insurance schemes
- Self-supply manual for water and sanitation community achievement monitoring
- Referral slip for emergency obstetrical and neonatal care (EONC)

- Proximity radio stations as spearheads, disseminating and backing the same messages as the previous two channels through broadcast of project-developed radio messages

### **Collaboration with CSOs and FBOs**

FBOs communicate IEC/BCC messages at churches, temples, mosques, and traditional worship places. Project support for these activities aimed to (1) build capacity among religious leaders to communicate on health topics and (2) increase demand for health services in KM salama communes. To support these FBO activities, we conducted training sessions for 1,100 religious leaders on IEC/BCC methods and how to monitor and follow up on awareness-raising activities, and how to encourage religious leaders' participation in SDCs. FBOs deliver the same health messages as other actors in KM salama communes. The FBOs are provided with an adapted version of the IEC/BCC materials developed by the project, tailored for the context of each religion and belief system. The FBO activity monitoring is based on the monthly activity report submitted to the project by each participating FBO. An RTI/Santénet2 program manager verifies completeness, timeliness, and accuracy of data contained in these reports. The RTI/Santénet2 manager meets quarterly with each FBO to review progress, achievements, and challenges, and to define next steps. Each FBO central-level project manager ensures internal supervision and quality monitoring.

**Collaboration with local radio stations:** Radio stations are an effective vector to complement communications conducted by community-actors. It also allows for reaching the most remote population groups with behavioral change messages.

Local radio stations produced and broadcast 16 spots (see in *Annex I*) conveying health messages. All spots were translated into local dialects. The managers of the radio stations were also trained on the KM salama approach to produce radio programs on the activities of community-based actors.

### **b. Results**

The achievements with FBOs during FY 2011 are summarized as follows:

- 9 member entities were awarded small sub-grants: EEM, FSM, FJKM/KPMS, AMCM, ECAR, Network of Traditional Religions, METM, Jesosy Mamonjy, and Balsama.
- 1,100 religious leaders were trained and communicated health messages.
- The number of KM salama communes where PLeROC is active increased by 48, from 539 to 587.
- 394,391 individuals were reached with health topics in places of worship.

#### **Why were there more airings than planned?**

- Listeners find the spots attractive and use them for sending personal messages.
- The animators use the spots as illustration or enhancement of their programs.
- Radio stations air the spots in excess of what is required from them by contract to express their satisfaction with the collaboration with Santénet2.

Achievements in collaboration with radio stations are as follows:

- 772 communes (97% of the KM salama communes) have coverage with the spots aired by the partner radio stations.
- 28 contracts for airing radio spots were signed with local radio stations.
- 10,313 spots were aired, which exceeds the annual objective by 35% (see *Annex I* for number of airings per topic and airings in excess of objective).
- 43 radio animators were oriented on the KM salama approach and produced and aired 44 reports.



*Training of radio animators in Taolagnaro*  
© RTI/ Santénet2

In collaboration with DRV, RTI/Santénet2 puts in place “*Mysterious Listeners.*” 28 members of DRV are part of them, which is one mysterious listener per radio, and have achieved the follow-up of all spot broadcasts and radios programs produced by local radios. Monthly reports from mysterious listeners enabled the project to control veracity of broadcast reports from local radio stations. Furthermore, this system has served to call out radio partners that did not respect the contract details, including the airing hour for spots and the number of broadcast spots.



*A mystery listener following Rakama radio in Manakara*  
© RTI/Santénet2

Five new spots were produced and aired (see *Annex I*). They pertain to mutual health insurance (broadcast in the four targeted districts only), promotion of CHWs, social quality, the antenatal care (ANC) package for pregnant women, and diarrhea and latrines.

All of the messages developed are in compliance with Madagascar health programs policies, procedures, and standards, and they are approved by the Ministry of Health (MOH) communication department.

**Table 1. List of radio partners**

List of radio partners	
Radio Don Bosco	Akon'ny Analanjirofo
Radio Diocésaine du Boina	Feon'ny Maromaniry
Radio Ny antsika (Antalaha)	Radio Sakatovo
Radio Feon'ny Mania	Radio Tea Longo
Radio Pangalane	Radio Soatalily
Akon'ny Tsienimparihy	Feon'ny Linta
Radio Mampita	Radio AVEC
Radio Rakama	Radio Sakaraha
Radio Cactus	Radio 2000 (Maroantsetra)
Radio Vorokodohodo	Radio Lazan'ny Ladoany (Mananara)
Radio Kaleta Amboasary	Radio Feon'ny Toamasina

Radio Josvah	Radio Feon'ny Mangoro (Mahanoro)
Radio Lafa	RNM Vatomandry
Radio Mandroso	RNM Marolambo

### c. *Challenges and corrective actions*

The main challenge for the FBOs is reporting the achievements in the expected time, periodically and regularly.

Efforts were made to put the religious leaders in the field in contact with the SDCs and the NGOs' support technicians so that the religious entities can hand their reports to them in addition to forwarding reports to their central level.

To achieve broader coverage, RTI/Santénet2 contracted with 28 radio stations instead of the 19 planned. To monitor the airing of spots and reports, the project collaborated with mystery listeners from DRV. It will be essential to strengthen the collaboration with the radio stations and the mystery listeners.

Because behavioral change is a long-term effort, RTI/Santénet2 will strengthen its collaboration with local actors, especially the PLeROC member entities and the local radio stations, to better disseminate health messages in the KM salama communes.

## Strategic Focus 4. Scaling up of the community-based funding mechanisms

### a. *Approaches*

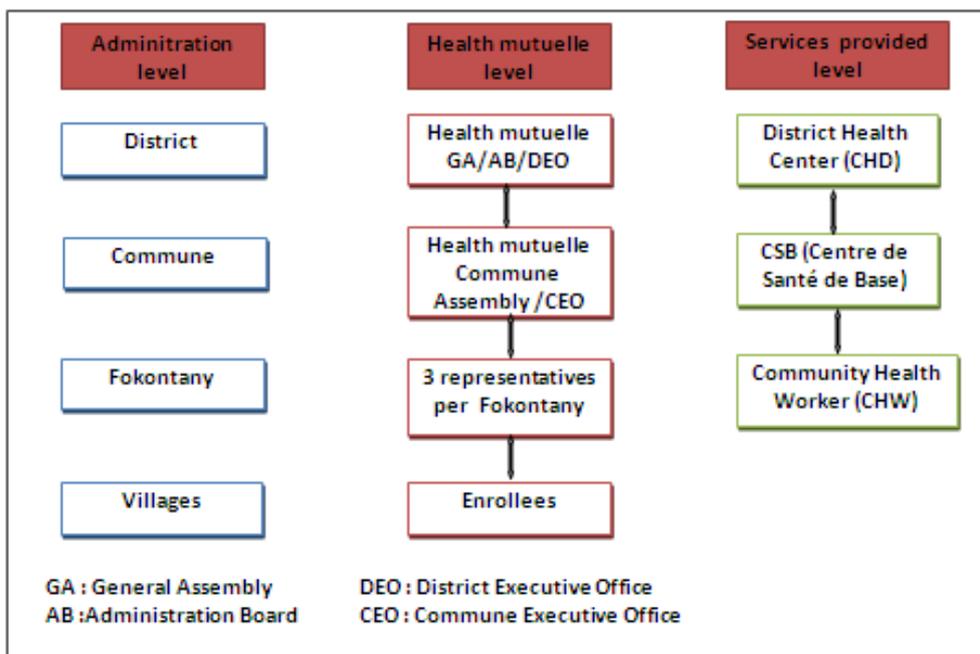
To revitalize mutual health insurance activities, RTI/Santénet2 developed a new strategy that consists of setting up the mutual health insurance schemes at the district level instead of the commune level as a way to expand membership. In this process, committees will be put in place to prepare constitution of an initiative committee at the district level and at the commune level. These committees will be dissolved when all the health *mutuelle* structures elected by the enrollees are functional.



Members of the District Initiation Committee in Vatomandry  
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The sustainable structures are composed of *fokontany* representatives; commune executive offices; the general assembly at the district level; the board of administration; and the district executive office, which is an independent entity of the health *mutuelle* in charge of *mutuelle* management and selected by a bid. This allows for expanding the package of services to include hospital care and full-time coverage (12 months out of the year). Another goal was to improve the health *mutuelle* management performance. Once the new strategy was designed, implementation started in four selected districts—Ambohimahaso, Ambalavao, Ambositra, and Vatomandry—after a series of advocacy actions among authorities and training sessions for support partners and other stakeholders. Initiation committees were set up in each district to prepare for implementation, and an action plan was drafted for each district.

The establishment of *mutuelles* at the district level allows the health scheme to increase the target population and to better meet the needs of the population. The figure below shows the schema of health *mutuelle* governance.



### b. Results

The new strategy, consisting of setting up mutual health insurance schemes at the district level instead of the commune level, has been initiated in four districts with 77 communes, including 68 KM salama communes, which exceeds the target of 50 KM salama communes for FY 2011.

We have used the following criteria in selecting the four districts participating in the health *mutuelles* scheme:

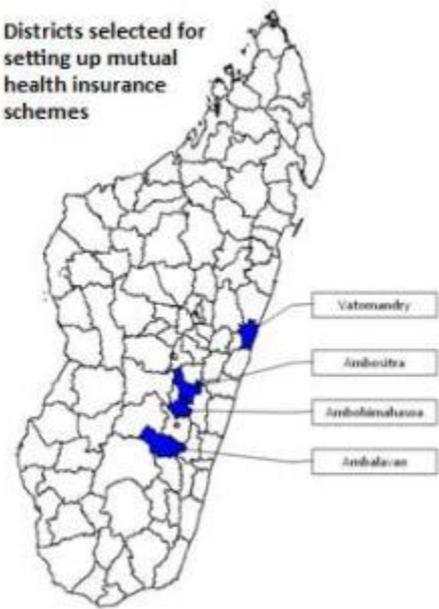
**Social criteria**—expression of need during participatory planning sessions

**Technical criteria**—high coverage of KM salama communes in the district, population size, availability of health service delivery points, and previous health *mutuelles* experience.

Tools that will be used for this process were developed (see *Annex H*).

As of the date of this report, the membership rate is not yet known because the subscription period will not end until February 2012.

Districts selected for setting up mutual health insurance schemes



The objective for each district is to target 50% of the population in mutual health insurance implementation with a whole package of services, including the following:

- Primary health care at CSB level
- Hospital care at secondary and tertiary hospital
- Medical evacuation to the hospital

**c. Challenges**

The sustainability of a mutual health insurance scheme, as a micro-insurance scheme, is closely dependent on membership size. The bigger the membership, the more sustainable the mutual health insurance scheme will be. The main challenge in implementing this strategy is to achieve a level of membership that can ensure the groups’ sustainability.

The initiation of a new strategy, especially when it concerns community-based projects such as mutual health insurance, requires raising awareness among the target communities. Establishing Initiation Committees made up of organizations operating in the fields of health and development is one way to create such awareness and obtain as many members as possible. As the promoter, RTI/Santénet2 will have to strengthen its support, monitoring, and supervision activities to the benefit of the committees.

Mutual health insurance schemes in the four districts			
District	New mutual health insurance schemes	Period with insurance coverage	Annual contribution per individual
Vatomaniry	TIAVA II—Tahiry Iombonana Arapahasalamana Vatomaniry II	Feb 1–Jan 31 Jul 1–Jun 30	MGA 4,500: 18 years and older MGA 2,700: less than 18 years old
Ambohimahaso	TIAA—Tahiry Iarovana ny Aina eto Ambohimahaso	May 1–Apr 31	MGA 2,500
Ambalavao	Ambalavao MiAi—Ambalavao Miray Aina	Apr 1–Mar 31 Aug 1–Jul 31	MGA 2,500
Ambositra	AMS—Ambositra Miray Salama	Aug 1–Jul 31	MGA 3,200

# III. COMPONENT 2: STRENGTHENING COMMUNITY HEALTH SYSTEMS

## Introduction

The activities of this component support the establishment of an effective community health system in continuation and connected to the formal health system. Actions carried out by the RTI/Santénet2 project to this end include the following:

- Ongoing improvement of social quality (local governance)
- Capacity building for community-based actors through training and supervision
- Establishment and maintenance of an effective community-based health management information system (c-HMIS)
- Support to the community-based health commodity supply chain

The strategy for social quality promotion consists of setting up, training, and supporting SDCs in each of the 800 KM salama intervention communes. To date, all of the communes have established their committees, composed of a dozen local decision-makers. In FY 2011, the project team designed an advanced strategy aimed at strengthening the SDCs' responsibility and accountability to their communities. The new strategy draws on best practices identified by the project as well as experience from the social accountability pilot project conducted by the World Bank in Madagascar. It recommends expanding the pool of participants to conduct more in-depth needs assessments (health services and information), measure the perceived quality of health services, and address challenges identified.

A training curriculum and needs assessment tools on social quality were developed and used in 178 communes during Year 3. These tools were developed to facilitate the collection of needs information and stimulation of community demand and to ensure self evaluation of SDC members. As the pool of participants was expanded beyond SDCs, the gender ratio of beneficiaries using the tools changed: typical SDCs comprised one woman for every two men; this ratio has reversed, and there are currently more women than men in beneficiary committees conducting needs assessments.

Although beneficiaries showed their satisfaction, systematic evaluation at the *fokontany* level is needed on the following matters: (1) availability of drugs with a systematic communication of their price, (2) availability of services provided by CHWs pursuant to the validation of their internship,<sup>1</sup> (3) improvement in CHW working conditions by building community sites and providing equipment, and (4) improved support to CHWs from CSBs.

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<sup>1</sup> Difficulties may occur in finding a critical number of patients (DMPA users or ill children) to validate the practice of Level 2 CHWs. Should there be not enough cases in locations where training is occurring, the required number of practice sessions may take a few weeks. As a consequence, CHWs would have passed class lessons, but they would not be able to operate their own practice because they did not complete the required number of injections or case management sessions.

The strategy used for training and supervising CHWs is one of the project's best practices. During the reporting period, 410 trainers were mobilized to provide standardized training to 4,144 CHWs (including 2,020 in charge of maternal health and 2,124 in charge of child health), bringing the total number of CHWs supported by RTI/Santénet2 to 11,216.

CHWs in the 800 intervention communes benefited from supervision during Year 3. Regular supervision sessions are conducted in a comprehensive manner to improve performance and ensure quality of services. The comprehensive supervision addresses the following aspects of CHW routine activities:

1. Service provision (case management)
2. Sensitization, promotion, and demand stimulation (IEC/BCC)
3. Reporting (use of management tools)
4. Resupplying with health commodities

The comprehensive supervision is provided through various agents. Local and independent supervisors assess the CHWs' service provision performance using the integrated supervision tools. Local supervisors and support technicians from the partner NGOs check reporting and health product availability (supply chain) by reviewing management tools and reporting and supply registers. SDCs monitor awareness-raising and demand promotion and stimulation activities through on-site visits. A booklet for monitoring the supervision was designed to keep track of the all supervisory support provided to CHWs. This tool, called the "Tantsoroka Booklet," is currently used by the CHWs in the 800 KM salama communes; supervisors fill in the booklets at each meeting with CHWs.

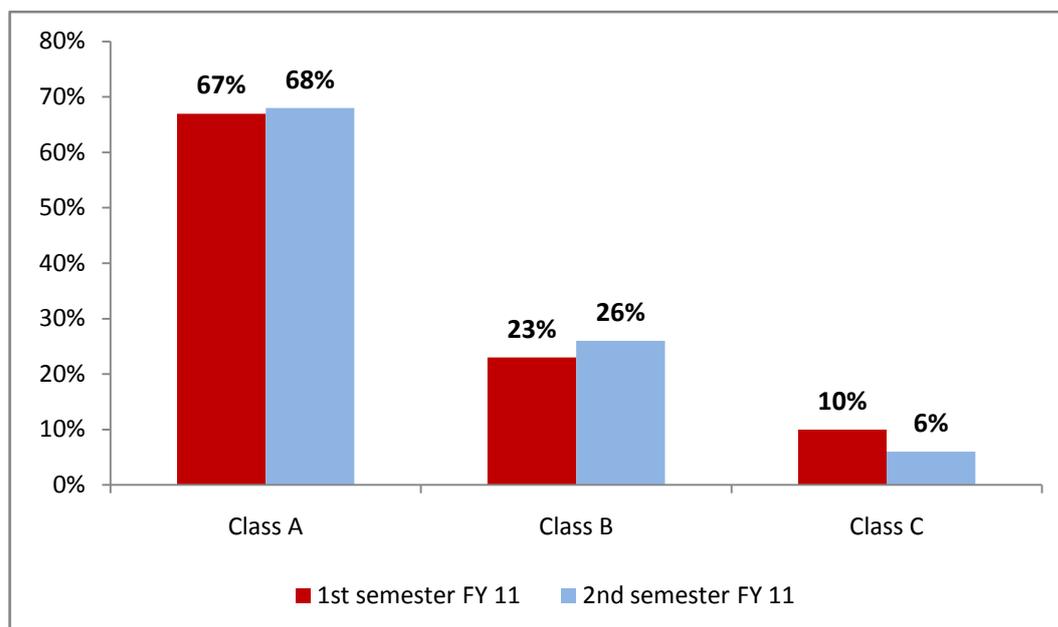
The information collected during the integrated supervision is summarized in supervision reports. The latter are received and compiled by the project's supervision manager. To date, 80% of the supervision reports have been processed, and the results show that there have been improvements in the CHWs' performance over the past year.

After the training session, according to their post-test results, CHWs are classified as:

- Class A: CHW who had a score > 70%
- Class B: CHW who had a score between 70% and 50%
- Class C: CHW who had a score < 50%

Class A and class B are considered successful and eligible for community-based service delivery, while those in class C need to attend additional training; they are authorized to participate in awareness-raising activities only.

The graph below illustrates the improvements from the first to the second semester in FY 2011.



The Social Quality Index tool was developed by RTI/Santénet2 for monitoring the results and effects of the investments made in the community-level health service delivery. The communes' qualitative performance is measured by the Social Quality Index, and the measurements allow for identifying communes that encounter special problems and therefore require closer supervision. The Social Quality Index measures the communes' performance in three areas: (1) availability of CHWs and their level of skill, (2) the organization of CHW services, and (3) the use of CHW health services.

RTI/Santénet2 developed a Community Health Management Information System (c-HMIS) to collect (in a timely manner), transmit, analyze, and disseminate project-related data for program management purposes. During Year 3, the c-HMIS manager worked with the implementing partners (their support technicians and their M&E managers) to improve reporting in terms of completeness, timeliness, and reliability of data. It should be noted that RTI/Santénet2 equipped implementing partners with information technology (IT) materials, Internet connection, and mobile phones and trained the support technicians and the M&E officers on the c-HMIS as part of the effort to ensure appropriate reporting. During this year, the CHW database was updated, with all double counting suppressed as well as dropout CHWs replaced. The updating of the database, which holds information on more than 11,200 CHWs, mobilized 250 employees from implementing partners as well as the project's team. The completion rate is currently at more than 60% for the Monthly Activity Reports (MARs) filled out by CHWs. This rate is above that of the MOH. The data collected allow program management and measuring access and use of community health services by the target groups. In addition, information is obtained from the Extranet database (developed by the project) for financial management by implementing partners and monitoring of tools dispatched to the KM salama communes.

The community supply chain system, designed in collaboration with the social marketing program, was revised. Widespread and lasting stock-outs occurred during 2011. Population Services International (PSI) proposed to directly resupply the community supply points (CSPs) in lieu of channeling products through district supply points. A training session on

logistics management was organized for the 858 CSPs, out of which 722 attended. To date, 518 CSPs are operational according to the data reported by PSI. The widespread stock-outs of artemisinin-based combination therapy (ACTs) and rapid diagnostic tests (RDTs) were also due to insufficient products in stock through the social marketing program. These stock-outs resulted in limited use of community-based malaria management services. Over the reporting period, the Level 2 Child Health CHWs managed approximately 3,000 cases of fever per month, with 50% testing positive for malaria using RDTs.

## Specific Achievements

### Strategic Focus 1. Strengthening of social quality and technical quality in the KM salama communes

Behavioral changes and accountability are required of all stakeholders if the population's health status is to improve. Social quality activities consist in strengthening community capacity to identify community needs, initiate sustainable solutions for a community engagement, and plan corresponding activities. KM salama is an iterative approach that places the community as active participants at the heart of the actions to improve their health.

#### a. Activities completed

RTI/Santénet2 initiated an approach of local governance of health under the KM salama approach. This approach encompasses quality of health services and strives to promote responsibility-taking as well as behavioral changes among all stakeholders. Practically speaking, it leads the community into identifying their needs through meetings and to strengthen health managers' accountability through regular self-assessments. The approach for local governance is intended to be fully integrated into the KM Salama approach and was therefore piloted in 56 communes in the first semester of 2011 before being gradually scaled up to an additional 122 communes.

RTI/Santénet2 has developed and implemented a comprehensive and decentralized local governance strategy based on lessons learned from previous USAID/Madagascar-supported experiences. Over the past three years, we sought to continuously improve the strategy, building on achievements and needs to foster community ownership and support skilled local decision makers. One of the key objectives of the local governance approach is to build community ownership, not just for planning and implementing health promoting activities, but also for taking community responsibility for monitoring progress against community-defined objectives and evaluating community perceived satisfaction of available health services. Evaluations conducted by the communities themselves render services and service providers accountable to the community members they serve. This best practice in good governance is the strongest and most effective driver for improvement and sustainability of community health services.

	<b>CHWs</b>	<b>General rural population aged 15 and above</b>
Male	43%	48%
Female	57%	52%
Years in school	7	3
Single	19%	36%
In union	81%	64%
Median age	40 years	35 years
Number of dependent children	5	5
First-time CHWs	30%	N/A

Source: RTI/Santénet2 Extranet, September 2011

SDC members received basic training on community mobilization and community planning based on needs assessment and social accountability. The SDC members are practicing “learning by doing” in this improved approach, with the assistance of project implementing partners’ field workers. Implementing partners organize two-day training for SDC members during which the following topics are taught in class and practiced in the *fokontany*:

1. Tools for decision making
2. Community health needs assessment methods
3. Participative planning to address community health needs
4. Monitoring and reporting

The local governance approach of health was introduced in 178 KM salama during Year 3. The approach will be scaled up to all 800 KM salama communes.

#### ***b. Results***

In all, 1,076 SDC members were initiated into the approach, and 204 support technicians from partner NGOs were trained to support implementation of social and technical health quality services. At this stage, 800 KM salama communes have community-based action plans. In more qualitative terms, the integration of local governance into the KM salama approach has caused the communities to speak up, to ask questions, and to make decisions regarding health improvement activities.

The Social Quality Index tool was used two times in each of 800 KM salama during Year 3 (once per semester) to measure the quality of community-based health services. The first application was focused on 748 KM salama communes; Medical Care Development International’s (MCDI’s) communes (52) were omitted by this study. The 52 KM salama communes supported by MCDI in the Atsimo Andrefana region had delayed start-up. We worked with MCDI to close the gap. However, Level 2 training for CHWs was not quite completed during the period when the social quality index tool was being applied. The absence of sufficient community-based service delivery information would have rendered the social quality index results for these 52 KM salama communes incomplete. The second application reached all 800 KMs.

#### ***c. Challenges and corrective actions***

For FY 2012, the approach will be gradually scaled up in 200 communes (in addition to the 178 communes from FY 2011). Because behavioral change is a progressive and cross-cutting process, there is a need to continue monitoring and supporting responsibility-taking and assessment of the quality of services in general, and specifically in these 378 communes. Project collaboration with NGOs through the trained field technicians ensures implementation and achievement of this challenge. The higher levels of the formal health system also need to be sensitized as part of promoting the approach’s sustainability.

### **Strategic Focus 2. Standardization and decentralization of the project’s trainings**

One of the major objectives of the RTI/Santénet2 project is to transfer skills to community actors to make activities sustainable; a training strategy was designed accordingly.

At the beginning of the project, training tools were developed following the “Learning for Performance” approach. Independent trainers and supervisors were identified and trained to provide training to community actors on a range of topics. At Level 1, Child Health CHWs are trained on nutrition, growth monitoring and promotion, and malnutrition screening. Level 1 Mother Health CHWs are trained to provide FP methods (pills, barriers, and natural) as well as to promote safe motherhood. Once Level 1 CHWs have performed in a satisfactory manner, as documented in supervision visits, the CHWs receive additional training to qualify them as Level 2 CHWs: Child Health CHWs are trained on community-based integrated management of childhood illness (C-IMCI) and Mother Health CHWs on community-based Depo Provera (DepoCom). In addition to CHWs, other actors receive training: SDC members are trained on community-led total sanitation (CLTS) and young leaders on adolescent reproductive health (ARH). Regular supervision is ensured by independent supervisors, local supervisors, and support technicians from partner NGOs.

*a. Activities completed*

To ensure the quality of services provided by CHWs, RTI/Santénet2 set up a continuous supervision system involving various agents. Supervisions are conducted by independent supervisors along with local supervisors (health agents at the commune level) and the field technicians every three months.

Technical and continuous CHW supervision sessions were conducted by independent supervisors in collaboration with local supervisors (health agents at the commune level). Local and independent supervisors assess the CHWs’ service provision performance using the integrated supervision tools. Local supervisors and support technicians from the partner NGOs check reporting and health product availability (supply chain) by reviewing management tools and reporting and supply registers. SDCs monitor awareness-raising and demand promotion and stimulation activities through on-site visits. All supervisory support to CHWs was recorded in a newly designed booklet called the “Tantsoroka Booklet.” It is currently used by the CHWs in the 800 KM salama communes; supervisors fill in the booklets at each meeting with CHWs.

The curricula used for training CHWs and other community actors (MARPs, SDCs, trainers, and supervisor) were revised to be in line with national standards, and the independent trainers were oriented on supervision methods and activities. The regional teams organized quarterly coordination meetings with trainers and NGO support technicians to foster experience sharing and provide refresher training on the various topics as well as reinforcement of the supervision techniques for trainers and supervisors. In addition, the SDCs and the local supervisors benefited from supervision skills building to enable them to better support CHWs in their activities.

A study was conducted on the results of the training strategy one year into its implementation to assess its overall effectiveness and determine which aspects call for improvement and/or updating.

Major findings and recommendations from the study are as follows:

1. The project should continue to support the role of independent supervisors in providing supervision visits and ensuring supervision quality.
2. There is an urgent need to work closely with partners, such as PSI, to minimize stock-outs.
3. There should be increased emphasis on community commitment and support for the program—for example, motivating CHWs.

#### **b. Results**

Approximately 620 independent trainers have been working with RTI/Santénet2 since the inception of the project. Among them, 54% were trained in basic training of trainers (ToT) and 36% on ToT for C-IMCI and DepoCom. In Year 3, we trained 20 independent trainers in ToT for C-IMCI and 17 in ToT for DepoCom. Thirty-seven (37) independent trainers were trained on supervision. About 410 trainers facilitated 656 training sessions during Year 3. These training sessions were distributed as follows:

<b>Trainer demographics FY 2011</b>	
<b>(Total number = 410)</b>	
Male:	55%
Female:	45%
Median age:	35 years
Single:	50%
Married:	50%
Number of dependent children:	2
Years of education:	16 years ( <i>Master level</i> )
Fields of studies:	
• Health:	55%
i. Medical doctors:	59%
ii. Paramedical:	41%
• Other:	45%
	(Economics, Biology, Environmental Sciences, History, Geography, Literature, Law, Pharmacy, Agronomics, Mathematics)
Profession:	
1. Private physician:	20%
2. Private nurse:	23%
3. Business:	4%
4. Farming:	3%
5. Student:	8%
6. Other:	42%
Have some training experience:	23%
Have some training in community health:	20%
Were trained in ToT by Santénet2:	72%
Average number of training session per trainer in 2011: 6	

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- 337 for Child Health or Mother Health CHWs;
- 194 on ACT Combo, a new presentation of the anti-malarial drug, provided under Global Fund Round 7 and organized by RTI/Santénet2 and partners;
- 67 on CLTS;
- 58 sessions on the commune/district-level supply points.

CHWs in the 800 KM salama communes were regularly supervised during Year 3: a total of 2,554 supervision visits were conducted, targeting 10,208 CHWs. The remaining CHWs not supervised were missing during the training because of many personal reasons. Some gave up their work, others have relocated or died.

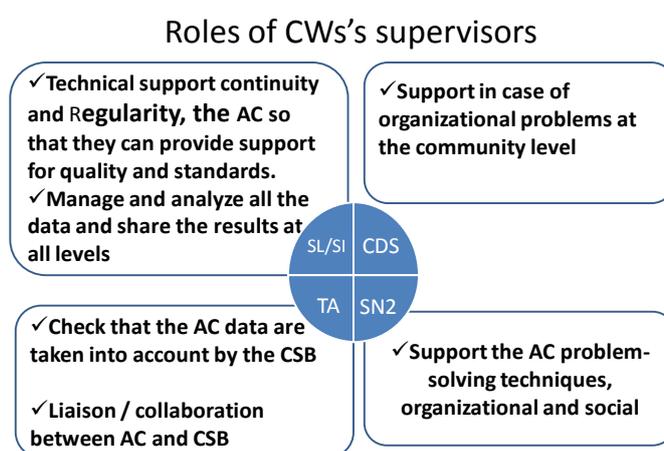
RTI/Santénet2 KM salama programs face a relatively low attrition rate (11%, or 1,053 CHWs discontinued) after 24 months of effective community-based service provision. The great majority choose to discontinue for personal convenience (982), some relocated (63), and a few passed away (8). The international literature identifies attrition as a common challenge of community-based health programs.

High rates of CHW attrition undermine program effectiveness and potential for implementation at scale. In general, an attrition rate is qualified as “high” when it is more than 30%. Because of our relatively low rate of attrition, we did not investigate in-depth determinants. In previous community-based projects in Madagascar, the attrition rate was observed at more than 50% after 12–18 months. The drop-out determinants were lack of supervision and the complexity of the approach customized to project-specific groups instead of working with existing actors.

RTI/Santénet2 and its partners work with communities to identify, recruit, and train candidates to replace discontinuing CHWs. Community involvement in recruiting and continuous supervision and support to CHWs contributes to the functionality and sustainability of the community-based services. RTI/Santénet2 chooses to train and support two (2) CHWs per *fokontany* and help replace eventual drop-outs, as opposed to recruiting and training a high number of CHWs in anticipation of a high attrition rate. In previous projects, 1% of the target population was trained as CHWs, approximately 5 to 10 individuals per *fokontany*, with no supervision or support provided. This strategy is not applicable for the RTI/Santénet2 KM salama model because of training and supervision standards.

Thirteen coordination meetings for trainers were organized at the regional and the central offices.

To allow for tracking supervision visits received by CHWs, a supervisory booklet was developed and given to each CHW. The various categories of supervisors (SDCs, NGO field



technicians, local supervisors, independent supervisors, or RTI/Santénet2) record the date of their visits in this booklet and sign it.

### *c. Challenges and corrective actions*

To ensure community sustainability of community actors' activities, Santénet2's main focus will be to strengthen the community actors' skills. Involving local supervisors to support the CHWs is one way to transfer skills to the local level, but this strategy needs to be further refined and strengthened to ensure the continuation of local services.

RTI/Santénet2's objective is to ensure functionality and sustainability of the community health system model (KM salama) put in place. CHWs are an essential element of this system. It is of paramount importance that CHWs continue to receive supportive, comprehensive supervision through sustainable mechanisms and local actors (SDCs and local supervisors). RTI/Santénet2 field workers provide on-site training to strengthen SDCs' and local supervisors' skills to provide comprehensive and formative supervision to CHWs on the following topics:

- Service provision (case management and referral)
- Awareness-raising, promotion, and demand stimulation (IEC/BCC)
- Reporting and C-HMIS (use of management tools)
- Resupplying with health products

### **Strategic Focus 3. Building a culture of data for decision-making**

RTI/Santénet2 wants to improve decision-making at all levels. This activity aims to strengthen behavior change through a decision-making culture by using the available data. Data use encourages their users to better control and double check their data and their sources. This strategy focused on the completeness, timeliness, and reliability of CHWs' MARs.

#### *a. Activities completed*

Regional and central administrative and technical managers were in charge of monitoring completeness and timeliness of reporting. NGOs have the obligation to comply with the reporting requirements set out in their grant agreements and contracts. The 204 field technicians from the NGOs received refresher training on data quality assessment and control for the MARs. During Years 1 and 2, field technicians were trained on data formatting and processing; this year, their tasks were rerouted to control data completeness and reliability plus entering data into the Extranet before forwarding them to the project. They also send a monthly summary for 12 MARs indicators by short messaging service (SMS).

The reliability of the MARs is assessed by "ground truth"—verifying the data reported through routine observations at the field level.

#### *b. Results*

Number of MARs entered into the Extranet: 82,206

Number of MARs forwarded by SMS: 101,484

The c-HMIS' performance is 73% against an annual objective of 70%. Last year, this performance was calculated at 31%.

The project uses three factors to measure C-HMIS performance: accuracy/reliability, completeness, and timeliness. The calculation of each determinant is as follows:

Reliability—comparing conformity of the reported number prevailing month’s FP regular users in relation to the previous month’s FP regular users, number of new FP users in the current month, and the number of drop-outs in the current month.

Completeness—total number of MARs received related to total number of MARs expected

Timeliness—total number of MARs received during the month following the reporting period

As of September 30, 2011, the total number of MARs in the project database is 101,484. This number is equivalent to a 63% completeness rate. In total, 82% of the MARs were sent in a timely manner—within one month after the reporting month. Reliability is reached at 43%.

The project is collecting a large number of data each month. Community-based service delivery data is collected by CHWs on a daily basis. The data is compiled monthly in standard monthly activity reports (MARs). These reports are transmitted by implementing partners to RTI/Santénet2’s automated databases. The field workers verify completeness and accuracy of each report. At project headquarters, the C-HMIS manager measures compliance of reporting using the FP regular users indicator as proxy. The method consists of verifying completeness of reported data in compliance with C-HMIS standards. The 43% refers to reports that have complete information to measure the equation below:

Number of regular FP users in the current month = Total number of FP regular users in the preceding month + Total number of new FP users in the current month - Total number of FP drop-outs in the current month.

The factor used to calculate reliability is not valid and does not serve the purpose. During Year 3, the project team conducted supervision visits and verified accuracy of data reported in CHW MARs and transmitted by implementing partners’ field workers. The level of error in reporting of FP users was less than 5%. We are currently working on developing a new indicator to calculate reliability/accuracy of MARs to better reflect data scope and limitation for both Child Health and Mother Health CHWs. We will discuss the new proposed calculation methodology with the USAID M&E team.

### *c. Challenges and corrective actions*

The project’s challenge is to maintain the c-HMIS’ overall performance at 70% (at least). The project-developed C-HMIS is in compliance with public-sector routine HMIS. The C-HMIS has adapted information needs to management functions of the community health system. The information generating process starts from the grassroots level, with heavy community involvement in data quality control. The local governance and social quality approach created an “information culture.” The project team provides systematic feedback on program performance to communities and implementing partners. The main challenge resides in spreading the “information culture” to all stakeholders, community leaders, and health providers and program managers. To achieve the 70% overall performance goal, the following actions will be conducted in FY 2012: (1) sharing information on the status of SMS and Extranet reporting as well as on the MARs received from CHWs with the NGO leaders during the monthly meetings to strengthen their commitment to ensure completeness, timeliness, and reliability of data; (2) monitoring the timeliness of reports coming into the c-HMIS on a monthly basis; (3) organizing a meeting on data quality, reliability, and use for

the NGOs' support technicians in each of RTI/Santénet2's regional offices; and (4) having support technicians go to the field to collect the MARs from the CHWs in each commune on a monthly basis. The various meetings will serve to identify deficiencies relating to data quality and needs for capacity building, and the resulting recommendations will be drafted into a corrective plan to ensure data quality.

#### Strategic Focus 4. Community supply system for health commodities

Health commodities must be available at all times if the CHWs are to perform their activities continuously in the KM salama communes. Under the community supply system, CHWs receive a free start-up batch of health commodities after their training. In addition to working with the official pipeline that goes from the central purchase department SALAMA to the district-level and the community-level pharmacies and then to the CHWs, RTI/Santénet2 has also developed a social marketing pipeline in collaboration with PSI (see figure: *Social Marketing Product Community Supply Chain*). The operation of the CSPs under this pipeline is dependent on the community's commitment to make it work and the support of the social marketing program. Procedures and the various stakeholders' roles were defined in running the system to allow for proper health commodities' management (using management tools designed for this), to establish short- and longer-term action plans. and to solve any supply issues encountered.



Figure 1: Social Marketing Product Community Supply Chain  
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The system was faced with serious difficulties in the first two years with widespread stock-outs of RDTs and ACTs. To address this problem before it became too large, workshops and meetings were held with all stakeholders: CSPs, PSI, Deliver Project, and USAID. CHWs can now resupply from all supply points, either from the commune or from the district level. PSI will ensure product deliveries in all the CSPs. CSPs are in the new supply chain process to avoid product stock-outs.

##### a. Activities completed

The availability, the visibility, and the access to social marketing products to ensure CHWs' service quality remain challenges in this area. Hence, in collaboration with DELIVER and PSI, a deep analysis of the strengths and weaknesses for all CSPs was conducted during intensive training workshops. This analysis has enabled us to perform a diagnosis of the community social marketing CSPs and to suggest recommendations on different aspects: products and the information channel, motivation, capacity, and supervision—the overall situation of the supply system and how to improve it. The complexity of the system was one of the major problems identified. To improve the accessibility and the visibility of health commodities to users, RTI/Santénet2 and PSI suggested shortening the pipeline by combining

the district-level and the commune-level CSPs into a single point. These new CSPs will be supplied directly by PSI, and CHWs in turn will get their supplies from them.

In addition to establishing the new CSPs, the project also worked to equip them with appropriate work tools, including newly designed job aids. In support of the change, the managers of the new CSPs were trained on needs forecasting and on the basics of stock management, and a new system was instituted for collecting invoices and purchase orders—PSI collects them directly or support technicians collect and forward them.

**b. Results**

- 722 CSP managers trained
- Job aid designed and distributed to the 722 CSP managers
- 518 CSPs supplied with social marketing products out of the 722 trained<sup>2</sup>
- 58 capacity-building workshops conducted
- 5,415 invoices/purchase orders (green cards) received from the commune-level CSPs
- Report on the CSP assessment available

**c. Challenges and corrective actions**

The challenges relating to this activity consist of ensuring that all of the 800 KM salama communes have their CSPs established and that the invoices/purchase orders are received to allow for assessing how well the CSPs are operating. The supply frequency established by PSI will be closely monitored to avoid stock-outs. (It currently varies from 1 to 4 months.)

Pursuant to the stock-outs of ACTs and RDTs at the national level, coordination meetings were organized with the stakeholders, and a logistics committee was established to be in charge of an information system.

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<sup>2</sup> RTI/Santénet2, in collaboration with PSI and Deliver, has conducted training for 722 supply points. At the end of the training sessions, 518 supply points were able to purchase social marketing products. The remaining did not have enough cash to purchase. However, PSI distribution managers re-supplied the remaining 204 supply points later.

# IV. COMPONENT 3: STRATEGIC RESULTS

## Introduction

Five program elements are covered under the strategic results component. These are MCH, RH/FP, malaria control, STI/HIV/AIDS control, and WASH.

The Child and Mother Health CHWs promote prevention and ensure case management of illness. This year, the range of community-based services provided in the 800 KM salama communes has been expanded. The textbox describes succinctly services provided by the Child Health and Mother Health CHWs by level. Over the reporting period, 1,192 new CHWs were identified by the SDCs and the communities to replace those who left the program, which gives an attrition rate of 11% (606 Child Health CHWs and 586 Mother Health CHWs).

### Mother Health CHWs

#### Level 1: Promotion of integrated RH/FP

- Information on FP methods, distribution of oral contraceptives, barrier methods, and SDM
- Messages on the prevention of STI/HIV/AIDS
- Safe Motherhood (ANC, IPT, Nutrition)
- Post-partum FP

**Level 2:** All the services provided under level 1 plus injectable contraceptive Depo Provera

### Child Health CHWs

#### Level 1: Promotion of child health services

- Essential Nutrition Actions
- Growth monitoring and promotion
- EPI promotion
- Malaria, diarrhea, and IRA prevention

**Level 2:** All the services provided under level 1 plus community case management of malaria, diarrhea, and ARI

Project trained and supervised functional CHWs			
CHW level	Level 1	Level 2	TOTAL
Child Health CHW (C-CHW)	287	5,269	5,556
Mother Health CHW (M-CHW)	427	5,233	5,660
<b>TOTAL</b>			<b>11,216</b>

Source: RTI/Santénet2, 2011.

Both Child Health and Mother Health CHWs provide services to pregnant women and newborns. The services include screening women for pregnancy at an early stage (3 or 4 months), raising awareness on attending antenatal consultations, and checking that the 12 elements of the pregnant women prevention and care package are available (see textbox below). The CHWs are also trained to identify danger signs in pregnant

### Package of care for pregnant women

To be monitored, checked and completed by CHWs

1. Long-lasting insecticide treated bed nets
2. Iron/folic acid (IFA)
3. Intermittent preventive treatment
4. Deworming
5. Immunization
6. STI and HIV screening
7. Pregnant women's nutrition
8. Breastfeeding
9. Delivery plan
10. Danger signs
11. Health evacuation system
12. Postpartum FP

women and newborns and to provide counseling and referral to patients as needed.

RTI/Santénet<sup>2</sup> also targeted its effort to control STIs and HIV in most-at-risk populations (MARPs) such as sex workers or men who have sex with men (MSM).

For WASH, this year the project continued to promote the CLTS approach, water and hygiene system management, and training and qualifying CHWs as WASH-friendly CHWs.

## Results

### MCH/Nutrition

The project's activities in this area are aimed at stimulating demand for child health services and malnutrition prevention services and at supporting the provision of community-based MCH services in the 800 communes implementing the KM salama approach.

Child Health CHWs trained and supervised by the project have been offering services to more than 1 million children under the age of five in villages located at more than 5 kilometers from the nearest health facility during Year 3. The following information pertains to case management reported during Year 3 of the project:

- 112,275 children under five years with diarrhea were treated by Level 2 Child Health CHWs in 800 KM salama communes, which is a coverage rate of 65%. CSBs' data indicate case management of 55,000 children, which is 4% of children under five.
- The CHWs in the 800 KM salama communes have managed 90,735 children under five showing signs of ARI (75%); this treatment rate is higher compared to Demographic and Health Survey (DHS) data, where 39% of the children with ARI sought care from healthcare facilities, and to the CSBs' data, where this number is 133,310 (9%).

For growth monitoring and promotion, more than 1 million children under five living in villages more than 5 kilometers from the nearest health facility were monitored by the CHWs in the 800 KM salama communes during Year 3. In contrast, about 750,000 children were followed up at CSBs in the 800 KM salama communes. CHWs also ensured growth monitoring for more than twice the number of children seen at CSBs.

CHW nutrition screening for children uncovered twice as many cases of severe and moderate malnutrition than the screening conducted in CSBs: for red strip results (severe malnutrition), CHWs uncovered 4% and CSBs only 2%; for yellow strip results (moderate malnutrition), CHWs uncovered 18% and CSBs only 9%.

Severe and moderate malnutrition incidences were calculated using the following numerators and denominators:

Severe malnutrition:  $45,830 / 1,245,657 = 4\%$

Moderate malnutrition:  $214,852 / 1,245,657 = 17\%$

The numerator and denominator indicate total number of GMP, and unfortunately the information does not report the number of children (head count) but rather the number of children visited during the reporting period. The C-HMIS captures total number of cases and not individuals. The information should not be read as count of children, since CHWs provide GMP regularly to children, and a child may be measured more than once for follow-up.

Referrals for malnourished children are provided to the ambulatory nutritional recuperation center (CRENA—Centre de Récupération Nutritionnelle Ambulatoire pour la malnutrition aigüe sans complications et malnutrition sévère) and the intensive nutritional recuperation center (CRENI—Centre de Récupération Nutritionnelle Intensif pour la malnutrition aigüe sans complications et malnutrition sévère). Both centers were not funded by the World Bank in the recent years. Funding is provided by the National Nutrition Office (ONN, a government agency). UNICEF continues providing financial support to CRENI and CRENA in their intervention regions.

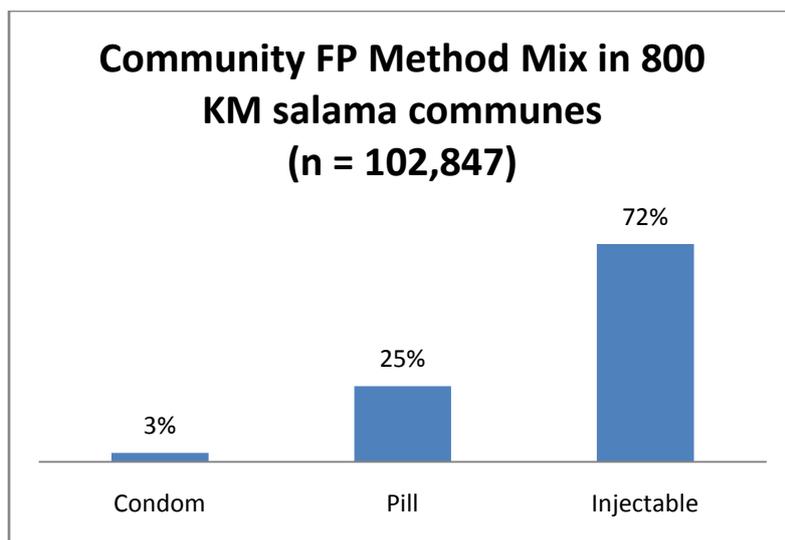
RTI/Santénet2 CHWs refer children detected with moderate and severe malnutrition to the nearest health facility, where the children receive information and eventually complementary nutrition, if available. In KM salama communes where Salohi operates, CHWs refer malnourished children to households implementing positive deviance for learning and nutritional rehabilitation.

## **RH/FP**

The project's activities are aimed at stimulating demand for FP services and at supporting community-based FP service provision in the 800 KM salama communes. To date, the Mother Health CHWs provide FP services to more than 100,000 women of reproductive age in villages located at more than 5 kilometers from the nearest health facility. In total, 72% of FP users served by CHWs choose Depro Provera (DMPA), which is aligned with the DHS IV method mix. The statistics at the CSBs indicate more than 500,000 women of reproductive age are using FP services in the 800 KM salama communes. Community-based FP services account for 20% of the users in these communes. For comparison, the DHS IV (2008–2009) reports that the share of community-based FP services in rural areas was 2.2% of the source mix.

Mother Health CHWs trained and supervised by RTI/Santénet2 report serving 102,747 regular FP users as of September 30, 2011, among which 73,022 are new users of modern FP methods. The total number of women of reproductive age in union in Madagascar was estimated to be 3,247,513 in September 2011. Both numbers were used to calculate the contribution to Madagascar's national contraceptive prevalence rate (CPR):  $102,747 / 3,247,513 * 100 = 3\%$ . The correct statement is that 3 percentage points of estimated CPR in Madagascar can be attributed to project activities. Should we take into account the number of new users only, the project has contributed to 2 percentage points in CPR increase, assuming that CPR did not go down nationwide. Indeed, the other 1 percentage point is attributed to regular FP users who choose to be served by CHWs in lieu of other service delivery points, such as CSBs.

The total number of new users for family planning (FP) served by RTI/Santénet2-trained CHWs is 73,022, as of September 30, 2011. The graph below presents the community-based FP method mix, as reported by project-trained Mother Health CHWs.



Source: RTI/Santénet2, 2011.

Project-trained Mother Health CHWs offer counseling on all modern FP methods available in Madagascar, including IUDs, implants, and voluntary surgical contraception (VSC). Mother Health CHWs offer condoms, oral contraceptives and injectables. The number of health facilities offering LAPM is still limited. Most of the facilities are operated by the public sector, and Marie Stopes International (MSI) operates outreach activities. To calculate the number of women who choose LAPM as a result of CHW counseling and referral, we need to obtain the information from the service delivery points. Unfortunately, the prevailing ban on working with the GOM does not allow us to work directly with the public health system to design tools that would provide routine information from the public health facility back to the CHWs about the outcome of women who choose LAPM. In addition to this, MSI is not differentiating their data on women who choose LAPM by source of referral. We are continuing dialogue with MSI to resolve this challenge. With respect to public service delivery points, we are waiting for USG sanctions against working with GOM to be lifted.

## **Malaria**

The recent Survey on Malaria Indicators in Madagascar (EIPM 2011) in the textbox here shows that very few women took at least two doses of sulfadoxine pyrimethamin (SP) as part of intermittent preventive treatment (IPT), and less than half of fever cases sought care. Mother and Child Health CHWs in the KM salama communes are in charge of screening women for pregnancy and referring them to CSBs for ANC, including IPT of malaria during pregnancy. CHWs encountered some difficulties in reporting data on the number of pregnant women referred, either because the CSBs do not send back the counter-referral forms, or because the pregnant women referred do not bring the forms back.

The percentage of women who attended at least 2 ANC sessions during pregnancy is high countrywide (86%) as well as in the 800 KM salama communes. However, the EIPM 2011 reports that only 20% of pregnant women indicated having received two SP doses during their pregnancy, which is well below the national target of 80%. Nevertheless, this figure constitutes a clear improvement compared to the 6% reported in DHS IV (2008–2009). The project fine tuned the maternal and newborn case management form that had been used by CHWs for one year. The new tool will improve the CHWs' capacity to monitor pregnant women and newborns in their communities. However, the restrictions on collaboration with the government and CSBs limit our capacity to provide technical assistance to the formal health system.

EIPM 2011 also reports a high rate of fever incidence (15%) among children under five over the 15 days prior to the survey. This rate is about the same as the 16% found in the Multiple Indicators Cluster Survey 2000 but is much higher than the 9% reported in the DHS IV. The surveys were conducted during the same period; the deterioration may be one consequence of the political crisis in Madagascar.

Among the children who had fever in the 15 days prior to the survey, 44% sought care according to EIPM 2011, which is an increase compared to the 20% reported in the DHS IV. Among the 44% who sought care, 22.9% turned to public facilities' services in rural areas and 1.3% to community-based services.

To date, the CHWs trained and supervised by the project have offered childhood illnesses management to more than 1 million children under five in the villages located more than 5 kilometers from the nearest health facility. In the communes implementing the KM salama approach, almost half (48%) of children with fever (based on the prevalence rate in the EIPM 2011) were treated by CHWs (138,138 children under five), as indicated in the CHWs' monthly reports. Out of the 138,138 cases where RDTs were used, 69,069 tests were positive for malaria.

The low coverage in case management services (about one case of fever out of two) was probably explained by the recurrent and lasting stock-outs of anti-malaria products during Year 3.

## **HIV/AIDS**

RTI/Santénet2's intervention in the field of STI/HIV/AIDS control focuses on strengthening the capacities of MSM and sex workers' associations to implement prevention activities and promote the use of health services in their communities.

### **Distribution of communes by MCP operational and epidemiological profiles**

<b>Malaria Control Program (MCP) operational profile</b>	<b>800 KMS</b>	<b>All the communes of Madagascar</b>
<b>East</b>	316	491
<b>Central highlands</b>	201	345
<b>Margins</b>	120	195
<b>West</b>	84	431
<b>South</b>	79	104
<b>Total</b>	800	1566
<b>Malaria transmission epidemiological profile</b>	<b>800 KMS</b>	<b>All the communes of Madagascar</b>
<b>Equatorial profile</b>	316	491
<b>Tropical profile</b>	18	168
<b>Sub-desert profile</b>	145	231
<b>Highlands profile</b>	321	676
<b>Total</b>	800	1566

Twenty (20) grassroots associations work with RTI/Santénet2 to conduct activities among MARPs. Fifteen (15) of them received small grants for these activities, and 5 are technically supported by the project.

The following table presents the 15 commercial sex worker (CSW) and MSM associations by location.

Town	CSW association	MSM association
Antananarivo	AFSA	EZAKA
Antsirabe	FIVEMIA	PLAJEHVAK
Tamatave	TODIKA	IVIA
Fianarantsoa	- VONONA MIFANASOA II - TANJONA MIRAY - MIFANASOA	TANORA TE HIVOATRA
Tuléar	- FIHAMY - FANAMBY	MANAVOTENA
Fort Dauphin	FANANTENANA	TANORA MANAN-JO

Source: RTI/Santénet2, 2011.

During Year 3, 21,000 sex workers and MSM were sensitized on the topics of human rights, STI/HIV prevention, and use of health services. As a result, 4,769 sex workers and MSM chose to use the health service centers for STI screening and voluntary HIV testing and care.

## WASH

WASH activities conducted by RTI/Santénet2 include implementation of the CLTS approach, the promotion of behavioral change at the household level through WASH-friendly CHWs, and support to 164 KM salama communes in promoting access and management of WASH-related facilities.

The CLTS approach was introduced in 480 communes and allowed for construction of 3,677 latrines used by 77,445 individuals, thus decreasing the practice of open-air defecation. The number of latrines built is two times the target set, which is due to rapid ownership by community members.

To improve access to WASH facilities, SDC members of 164 KM salama communes were trained in WASH system management. 135 communes completed WASH development plans and collected data on water resources. In total, 340 water infrastructures were built (new construction) or were improved (existing infrastructures) by the communities' own resources; this level of activity clearly indicates ownership of development by the communities. All hardware investment costs were funded by the communities.

WASH infrastructure	Number
Improved water points	239
New water points	53
New functional public latrines	48

To date, 45% of the CHWs who were recruited in the process were certified as WASH-friendly by meeting three key requirements: having safe water storage, use of a hand-washing device, and use of latrines. The strategy is ongoing to certify more CHWs and have them serve as role models for their communities.

## Specific Achievements

### Strategic Focus 1. Improvement of MCH and nutrition

#### a. Approaches

To ensure MCH and nutrition improvements, RTI/ Santénet2 participated as a member in regular meetings of the MCH activity coordination committee. The meetings served to share best practices, achievements, and challenges. We also conducted a study on the feasibility and effectiveness of community mobilization to respond to obstetrical and neonatal emergencies (ONEs). Finally, the project designed integrated pregnant women and neo-natal screening tools to expand the service package offered by CHWs. Also, it was necessary to strengthen CHWs' skills to manage MCH needs. The project trained and supervised CHWs in an expanded MCH package.

#### b. Results

RTI/Santénet2 participated in four coordination meetings and shared the early pregnancy screening form, the pregnant woman management form, and job aids on pregnancy and newborn management with the other members. The tools are considered as best practices and are currently integrated in the strategies for managing MCH.

- Two coordination meetings organized by RTI/Santénet2 on project achievements and challenges: one meeting was attended by MOH service departments, and another meeting was organized with the Boeny region MOH, where RTI/Santénet2 shared project achievements and results as well as the study on community responses to C-ONE.
- A meeting was organized by the nutrition task force with the participation of the United Nations Children's Fund (UNICEF), *Action Socio-sanitaire Organisation Secours* (ASOS), GRET, *Office National de Nutrition* (ONN), Catholic Relief Services (CRS), MOH, *Service de Nutrition* (SN, Nutrition program), *Service de la Maternité Sans Risque* (SMSR, Safe Motherhood program), and Kangaroo Babies Association.
- A meeting was organized by UNICEF in Toliary, with the participation of UNICEF, ASOS, CRS, the district health services of Ambovombe and Amboasary, and the regional health services of Anosy and Androy.

The results from the study on community responses to C-ONE showed that mobilizing communities to respond to obstetrical and neonatal emergencies is feasible. The following recommendations were taken into account and integrated into the implementation of the KM salama approach:

- Community-based actors and families will be trained on identification of danger signs.
- Awareness-raising activities will be repeated over and over.
- It is essential to secure community commitment and involvement.
- Setting up a system for transferring patients that are referred should take into account local resources, and the establishment of a solidarity fund should be optional and implemented based on the communities' needs.
- The community should be informed of the health evacuation system established in the commune or the village.

### **Study “Community mobilization to respond to obstetrical and neonatal emergencies”**

- **Study duration:** 18 months from September 2010 to March 2011
- **Location:** Region of Boeny, districts of Mahajanga II, Marovoay in 11 communes, 65 fokontanys
- **Implementing partner:** ZETRA
  - 126 CHWs and 165 SDC members trained for 2 days on danger signs in pregnant women and on organizing health evacuation.
  - 100% of the villages have a health evacuation system in place.
  - 47% have a solidarity fund.
  - 74 cases referred by CHWS to CSBs.
  - 13.5% of the cases referred used the health evacuation system.

*A life-saving activity that is both feasible and replicable!*

The meeting to disseminate results was held on August 1, 2011, in the RTI/Santénet2 office in Antananarivo. USAID and partners, including UNICEF, United Nations Population Fund (UNFPA), CARE, ZETRA, *Association Intercooperation Madagascar* (AIM), MCDI, FHI 360, ASOS, MOH: Child Health program, Health Promotion program, Mother Health program, Malnutrition Case Management program and Safe Motherhood program attended this meeting.

The curriculum for the CHW expanded package training was updated based on the assessment results and used for scale up. Community-based integrated health services are offered to mothers and children.

- During Year 3, 3,370 Mother or Child Health CHWs were trained on managing and referring pregnant women for safer motherhood, using early pregnancy screening, and community-based management of pregnant women.
- For growth monitoring and promotion, the achievements during Year 3 are as follows:
  - Children weighed: 1,245,657
  - Average number of children per Child Health CHW: 224
  - Cases of severe malnutrition seen: 45,830
  - Proportion of children referred to health facilities: 62.5% (up from 5.7% in 2010)

### ***c. Challenges and corrective actions***

The main challenge for this component is to ensure that integrated services are effectively provided in the community and to monitor these services. To this end, RTI/Santénet2 designed and used tools and job aids integrating maternal, child, and newborn health. The form for early pregnancy screening and for monitoring the actual delivery of the entire ANC care package as well as the MCH card serve as both awareness-raising and monitoring tools that facilitate the provision of integrated care and follow-up.

The project collaborated with partners, namely UNICEF and SALOHI, to ensure complementarities and synergies in its actions. The collaboration allowed for strengthening the CHWs' capacity in the field of nutrition and health, especially regarding interpersonal communication on the topics of infant and young child feeding and maternal nutrition over the life cycle as well as on the approach to these topics ("Positive Deviance for Learning and Nutritional Rehabilitation Household" and "Learning and Nutritional Rehabilitation during Pregnancy").

RTI/Santénet2 strengthened supervision by expanding the pool of supervisors through the inclusion of the NGOs' support technicians, local and independent supervisors, and RTI/Santénet2's team. Each entity uses a supervisory checklist based on the topics they address during their supervision.

## **Strategic Focus 2. Scaling-up of community-based RH/FP, ARH, and safe motherhood services**

### ***a. Approaches***

To be able to scale up community-based RH/FP, the project trained Level 2 Mother Health CHWs to provide Depo Provera at the community level (DepoCom). The project took part in the coordination meetings of the RH/FP partnership committee. Achievements and challenges in conducting FP activities were shared during the meetings.

In collaboration with Marie Stopes Madagascar, RTI/Santénet2 trained Mother Health CHWs on promoting long-term permanent methods (LTPMs) in 90 communes.

To promote youth health, the project trained youth leaders on leadership, conducted group discussions in the KM salama communes, and monitored youth leader activities. The youth leaders will convey information on early and unwanted pregnancy prevention and on STI/HIV/AIDS control to their peers. They will also incorporate gender and sexuality in the discussions that they will conduct and will orient their peers with sexual issues to health facilities, as needed. RTI/Santénet2 participated in a regional FP conference, "Effective Community Approaches to Family Planning" (Nairobi, July 2011), to share project experiences on the demand and supply of integrated services focusing on community-based FP.

### ***b. Results***

- 1,434 Level 2 Mother Health CHWs were trained on DepoCom in Year 3. Since the beginning of the project, 5,233 CHWs have been providing injectable contraceptives in addition to other methods, and 427 provide oral contraceptives (pills), barrier methods (condoms and spermicides), and natural methods (lactational amenorrhea method [LAM] and standard days method [SDM]) to the

exclusion of injectables. The CHWs served 102,847 regular FP users, out of which 73,987 use Depro Provera (72% of regular users).

CHWs are offering comprehensive FP counseling in compliance with Madagascar’s national FP program standards and procedures and international best practices, based on the principles of free and informed choices.

Regular users are women aged 15–49 who are currently using a method of contraception. New users are women aged 15–49 who choose to use an FP method for the first time. The table below presents the distribution of the cumulative number of new users, by method, served by project-trained CHWs since program inception.

**Table—Distribution of new users by method**

Contraceptive Method	New FP users
Condom	10,646
Oral contraceptive	34,201
Injectable contraceptive	28,175
<b>Total</b>	<b>73,022</b>

Source: RTI/Santénet2, 2011.

- RTI/Santénet2 took part in the national coordination meeting and shared the document on the RH/FP results as well as the challenges in the KM salama communes.
- RTI/Santénet2 plans to train CHWs on LTPMs, and related review plans were developed.

The Mother Health CHW training curriculum includes all contraceptive methods available in Madagascar. Mother Health CHWs offer choices of all methods to women of reproductive age during counseling sessions. The CHWs offer barrier and spacing contraceptive methods and refer women to health facilities with LTPM capabilities, depending on the woman’s choice.

RTI/Santénet2’s collaboration with MSI/M aimed to provide LTPM through mobile clinics to women of reproductive age in KM salama communes. MSI/M provided additional training on promoting LTPM and referring women of reproductive age to health facilities for LTPM. The collaboration between RTI/Santénet2 and MSI/M reached 90 KM salama communes in Year 3.

- 402 youth leaders were trained as part of the partnership with ASOS, and 5,572 young people were sensitized through them.

**c. Challenges and corrective actions**

The activities implemented generated conclusive results, though the following challenges remain to be solved. Challenges concern the following areas:

- The data from youth leaders did not reach the project in a timely manner. The NGOs’ support technicians were trained to collect and enter reports from the youth leaders in the project Extranet database.

- Continuous availability of contraceptive commodities at the community level remains a challenge. SDCs assist the CHWs on accessing the two health commodity supply chains (public sector and social marketing).

RTI/Santénet2 and PSI worked together to design a pull-principle community supply chain for social marketing products. The challenges are timely collection of information to forecast quantities needed and timely resupply to meet needs. RTI/Santénet2 works at two levels to address these challenges. First, at the community level, we ensure appropriate community support to the CSP (through the local governance approach) and supervision of CHWs for timely re-supply. Stock-outs are immediately communicated to the PSI distribution team. Second, we work at the national level by contributing to the contraceptive commodity quantification by sharing contraceptive consumption data with PSI.

### **Strategic Focus 3. Expanding community-based services for malaria prevention and control**

#### **a. Approaches**

To expand community-based services for malaria prevention and control, RTI/Santénet2 provided support and technical assistance to the meetings of the Roll Back Malaria (RBM) partners; ensured capacity building of Level 2 Child Health CHWs to use RDTs and of field technicians to monitor completion of the CHWs' MARs; and updated the CHW's MARs, incorporating data on RDTs. Finally, the project supported the extension of fever surveillance sentinel sites in partnership with the Pasteur Institute of Madagascar (IPM).

#### **b. Results**

Achievements during Year 3 were as follows:

- 15 periodical meetings, including 3 special meetings to prepare the Malaria Program Review, were held within the framework of coordination activities for the national-level malaria program.
- 15 meetings were held with the IMCI sub-committee of RBM partners to coordinate the implementation of C-IMCI. The tools harmonization will enhance integration of community activities.
- Our subcontract with IPM to support 15 fever sentinel sites resulted in 11 monthly issues of *Epiveille* bulletins.
- RTI/Santénet2 was involved in developing the CHW assessment survey protocol and organizing the logistics of selecting CHWs for data collection. RTI/Santénet2 has also provided a list of skilled trainers who were trained by and collaborated with the project.
- Since the beginning of the project, 4,895 Level 2 Child Health CHWs out of 5,269 were trained on C-IMCI and use of RDTs. The remaining 374 CHWs will be trained by RTI/Santénet2 during FY 2012 on use of RDTs. The information on the number of RDT and RDT + used is clearly separated from other data. The large-scale introduction of RDT at the community level is a huge success, especially when taking into account the fact that its introduction is very recent. In Year 3, 21,289 RDTs were administered, out of which 11,031 were positive (52%). All

positive cases were treated with ACTs. In addition, a total of 27,946 cases were treated by CHWs using ACT. Unfortunately, recurrent stock-outs of both RDTs and ACT have prevented the communes from reaching the full potential of community-based case management of fever and malaria.

**Table summarizing the consumption of RDTs at the community level**

MONTH	COMMUNE		RDT USED	RDT+		Simple fever case management	
	#	%	#	#	%	#	% RDT (+) + ACT
11/03	681	85	2,713	552	20	4,999	11
11/04	666	83	3,754	1,266	34	5,481	23
11/05	617	77	4,130	2,794	68	5,330	52
11/06	582	73	3,565	2,347	66	4,140	57
11/07	552	69	3,484	2,031	58	4,111	49
11/08	475	59	2,677	1,596	60	3,180	50
11/09	176	22	966	4,45	46	705	63
			<b>21,289</b>	<b>11,031</b>	<b>52</b>	<b>27,946</b>	<b>39</b>

Source: RTI/Santénet2 CHW Monthly Activity report, 2011.

### *c. Challenges and corrective actions*

Optimal use of RDTs remains the biggest challenge when encountering a case of fever. Some actions have been taken to strengthen the CHWs' capacity in this matter:

- Producing a job aid on filling out the new case management form, with a reminder on the steps for using RDTs
- Checking CHWs' use of RDTs and providing reminders on a routine basis when supervising CHWs
- Integrating the use of RDTs when training CHWs on the use of PneumoStop
- Supervising CHWs on an ongoing basis (sessions conducted by local supervisors)
- Ensuring continuous supplies of anti-malaria products. The project team participated in quantifying product needs to fill the social marketing pipeline. The project also provided continuous information and feedback on CHW product needs to the social marketing program.

### **Strategic Focus 4: Promoting prevention of STI/HIV/AIDS among sex workers and MSM**

The main objective under this strategic focus was to build the capacity of 20 local organizations having the technical and institutional capacities required to conduct STI/HIV/AIDS prevention activities as well as to promote MARPs' access to health services in 10 sites.

### *a. Approaches*

RTI/Santénet2 provided small grants to MARPs associations and provided their leaders and peer educators with technical assistance and training on integrating human rights in HIV/AIDS control. The peer-to-peer approach was always enhanced through this.

### *b. Results*

- 15 associations benefited from the small grants.
- 5 associations benefited from technical support: AVOTRA in Manakara, FIVEMAD in Ihosy, EZAKA in Boeny, and FBM and BTM in Mahajanga.
- 300 peer educators are trained and operational.
- 10,000 IEC tools suited to the sex worker and MSM contexts were produced and disseminated.
- 21,000 sex workers and MSMs have been sensitized on human rights issues, STI/AIDS prevention, and the use of health services.
- 147,512 condoms have been distributed.
- 4,769 sex workers and MSMs used health services for STI screening and care.

#### **MARPs grassroots associations that received RTI/Santénet2 support and locations**

AFSA and EZAKA (Antananarivo)  
Tanora Te Hivoatra, Vonona Mifanasoa II, Tanjona  
Miray and Mifanasoa (Fianarantsoa)  
Manavotena, FIHAMY and FANAMBY (Tuléar)  
IVIA and TODIKA (Toamasina)  
Tanora Manan-jo and Fanantenana (Fort Dauphin)  
PLAJEHVAK and FIVEMIA (Antsirabe)  
AVOTRA (Manakara)  
FIVEMAD (Ihosy)  
EZAKA Boeny, FBM, BTM (Mahajanga)

### *c. Challenges and corrective actions*

There are two main challenges:

- The quality of the sensitization conducted by peer educators needs to be improved, and refresher training was provided for this.
- The associations do not reach all categories of sex workers, especially those who do not operate openly (students, underage girls, etc.) or who are better-off economically. The associations are working with sex worker leaders in neighborhoods to address this challenge.

### **Strategic Focus 5. Establishment of a WASH strategy in communes implementing the KM salama approach**

RTI/Santénet2 has been the first project to implement the CLTS approach at-scale to promote the use of latrines and to fight against open-air defecation. Concurrently, CHWs who should act as models for their communities will be encouraged to qualify as WASH-friendly by demonstrating three key behaviors: safe water storage, use of a hand-washing device, and use of latrines. Under this strategic focus, RTI/Santénet2 reinforced its partnership with Rano HP, Ranon'Ala, WASH+, and SALOHI. Finally, to improve the capacity of the KM salama approach, activities centered around contracts management for water and sanitation works were conducted in 164 communes in collaboration with three sub-contractors.

### *a. Approaches*

The SDC members in the KM salama were trained to facilitate implementation of the CLTS approach; trainers supported them in their start-up activities before they started their own facilitation and monitoring of CLTS activities.

RTI/Santénet2's team trained the NGOs' support technicians on the process for qualifying CHWs as WASH-friendly. The NGOs, along with the SDC members, are in charge of following up and monitoring the activity in their communes.

Through subcontractors, the project strengthened the capacity of the concerned entities in each commune to manage WASH-related works contracts. Several topics were covered during the training, including the legal framework for water, planning, public-private partnership, and the assessment of facilities and water resources.

Finally, RTI/Santénet2 took part in coordination and sharing meetings with the partners of the Diorano WASH platform and USAID's WASH partners.



*Model of latrine newly built in Amoron'i Mania*  
© RTI/Santénet2

### *b. Results*

The objectives set for the CLTS approach were exceeded:

- Since the beginning of the project, 2,837 SDC members in 480 KM salama communes have been trained on CLTS by the project. Among them, 940 were trained in Year 3 (target of 750) in 135 KM salama communes.
- 3,677 latrines were built (target of 1,750).
- 77,455 people use latrines (target of 100,000).



*SDC members taking stock of the WASH facilities*  
© RTI/Santénet2

In the field of WASH-related works management, the following was achieved:

- 380 people were trained during Year 3 (400 planned). The number of communes to be supported by the sub-contractors was reduced from 200 to 164 because the other communes are located in the intervention zones of the project Ranon'ala or Rano HP. The number of trainees decreased accordingly.
- 136 communes have a WASH action plan.
- 240 people were monitored (target of 1,000). The sub-contractors under RFP #2 are in charge of monitoring works management activities. The monitoring and

follow-up activities by the sub-contractors Sandandrano and FIKRIFAMA will be conducted in October and December 2011, which accounts for the objective not being achieved.

- 340 facilities are operational, providing the communities with access to WASH. The sub-contractors' effective support and the communities' commitment contributed to exceeding the target of 200 facilities newly built or improved/maintained.

The table below presents distribution of WASH facilities which were constructed or rehabilitated by the communities and local partners.

WASH facilities in KM salama communes	Number
Improved/rehabilitated water points	239
Newly built water points	53
Constructed public latrines	48

Source: RTI/Santénet2, 2011.

Local water and sanitation management committees are managing these WASH facilities at the *fokontany* level.

27 investment actions out of 298 are improvement/rehabilitation or construction of water systems at health facilities. These 27 investment actions are also counted in the 340 WASH facilities reported in the table above.

RTI/Santénet2 provides training and technical assistance to the community (SDCs, CHWs, members of water management committees) on planning and conducting public-private partnerships in the WASH sector, water law, and project implementation.

- Number of population who have access to safe water: 16,475
- Number of population who use a latrine: 77,455

For CHWs qualifying as WASH-friendly, among the 3,875 CHWs monitored in 421 KM salama communes (reporting rate of 53%),

- 1,728 qualified as WASH-friendly by meeting three criteria: safe water storage, having a hand-washing device, and having latrines. This number represents 72% of the annual target of 2,400 WASH-friendly CHWs;
- 135 CHWs meet two criteria of having latrines and safe water storage;
- 1,481 CHWs have a hand-washing device and safe water storage;
- 531 meet only one criterion (either having a hand-washing device or safe water storage).

Among the 3,875 CHWs monitored, 48% (1,863) use latrines, 88% (3,421) use a hand-washing device, and 91% (3,528) practice safe water storage.

The main barriers that we have observed regarding construction and use of latrines are related to customs and values in certain regions. For example, in the region of Atsimo Andrefana, no CHWs in the 25 KM salama communes are qualified as WASH friendly because of the absence of latrines.

In addition, 1,220,192 individuals were sensitized with WASH messages.

### *c. Challenges and corrective actions*

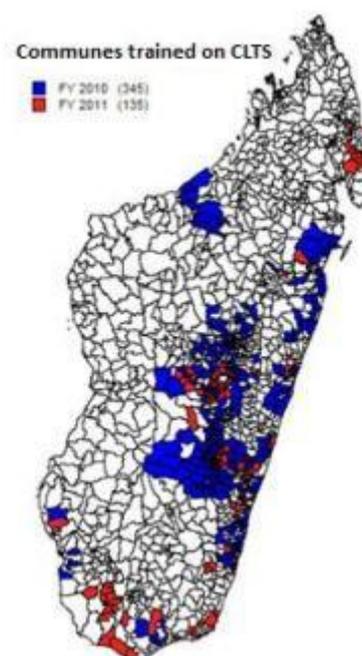
RTI/Santénet2 made it a priority to develop the population's ownership of WASH activities: the SDC members are the main actors in implementing and monitoring activities. Accordingly, the major challenges consist of the following:

- Developing the communities' ownership of CLTS activities initiation and monitoring and ensuring complete reporting
- Having the entities in charge manage the activity monitoring, along with the SDC, as well as the construction/improvement of infrastructures through the community's actions because the collaboration with the sub-contractors will end in December 2011
- Conducting a special effort to make CHWs adopt the key behaviors of using latrines, storing water safely, and having a hand-washing device
- Adopting a strategy to target CHWs individually to become WASH-friendly. Our efforts target regions where cultural barriers are strong. We will also use the local governance approach to strengthen promotion of the CLTS principles.
- Ensuring completeness and timeliness of reporting by community actors

### *d. Activities planned*

WASH activities in FY 2012 include the following:

- Monitoring and supporting the implementation of the CLTS approach in the trained communes
- Expanding the WASH-friendly CHW activity and implementing an individual targeting strategy
- Sensitizing the communities with WASH messages
- Taking part in coordination meetings and celebration of WASH world day



# V. COORDINATION

## Introduction

RTI/Santénet2 works with 16 partners implementing the KM salama approach through 21 grants and sub-contracts. As of September 30, 2011, there were 11,216 CHWs delivering health services in 5,758 *fokontany* located at more than 5 kilometers from the nearest health facility. Several actors are involved in supervising the CHWs: local and independent supervisors, NGOs' support technicians, SDCs, and RTI/Santénet2's team. PSI's distribution managers are also involved in supervising the social marketing products CSPs.

Effective and efficient coordination is essential to the smooth implementation of project activities and providing accurate support to KM salama communities. The project coordination requires efforts to converge activities of many institutional and individual actors.

The project has paid special attention to streamlining and standardizing the support that the implementing partners provide to the communes, and as part of this, has given special importance to building the capacities of the NGOs' field technicians. During Year 3, two capacity-building activities were conducted to benefit 204 field technicians from the NGOs. The capacity building included (1) training sessions on field technicians' terms of references (ToRs) in the framework of continuous supervision of CHWs (these training sessions were organized from February 2011 to May 2011) and (2) improvement of service quality.

Themes discussed during training sessions	Challenges observed	Activities to implement
Field technicians' roles and responsibilities on CHWs' continuous supervision	<ul style="list-style-type: none"> <li>Have a common understanding concerning monitoring of activities as required by the project.</li> <li>Use the tool during their monthly visit to KM salama communes. This tool was developed according to field technicians' ToRs.</li> <li>Review of data compliance in the CHW MAR form requires field technicians' continuous training in the technical programs (RH/FP, C-IMCI, growth monitoring, and CLTS).</li> </ul>	<ul style="list-style-type: none"> <li>Give a systematic reminder of field technicians' ToRs on this continuous supervision during every monthly coordination meeting with RTI/Santénet2.</li> <li>Encourage NGOs to organize an internal coordination meeting to identify challenges in implementing field technicians' activities and identify actions to overcome them.</li> </ul>
Social quality	<ul style="list-style-type: none"> <li>Ensure quality for implementation.</li> <li>Engage local governance for services quality.</li> <li>Strengthen the link and synergy between actors.</li> </ul>	<ul style="list-style-type: none"> <li>Contribution of field technicians required</li> <li>Engagement of community to assess quality of services provided</li> <li>Self-evaluation of SDC members to assess their roles</li> <li>A tool was developed to facilitate dialogue between service providers and beneficiaries within the community.</li> </ul>

RTI/Santénet2 ensures continuous monitoring of project activity implementation by partners through weekly data collection and monthly analyses that compare planned activities and achievements for each partner. It also meets with NGOs every month to coordinate activities based on the achievements of the previous month and the activity plan for the upcoming month.

The NGOs send activity reports (weekly) that provide comparisons to their annual and quarterly work plans. The project team reviews and validates these deliverables, and the results are incorporated by the NGOs into their dashboards. The project team and the NGOs define and agree on the corrective actions to be conducted during the monthly coordination meetings. In all, 187 coordination meetings were held with the NGOs during this year.

A national coordination workshop gathering all project partners was organized to share achievements and best practices in the KM salama communes and to define actions to address the challenges that were identified.

The project puts special emphasis on ensuring that implementation partners deliver their activities in a timely manner and meet quality standards.

The implementing partners' performance is monitored mainly through the review of their weekly reports and the completeness and timeliness of data transmitted through SMS or the Extranet. During Year 3, the project received and reviewed 1,079 NGO weekly reports. The results are routinely discussed with the NGOs during the monthly coordination meetings.

As part of reviewing the implementing partners' performance, RTI/Santénet2 developed a comprehensive methodology and used this methodology to assess, on a quarterly basis, the performance of partners' technical assistance to the community. The assessments enabled the following outcomes:

- RTI/Santénet2 was able to better target and improve its support to the NGOs.
- The NGOs were able to identify their successes and weaknesses as well as areas to strengthen and to provide their teams with effective, relevant, and targeted feedback to further improve the quality of their services.

#### **Key points for national coordination meeting**

**Date:** December 13<sup>th</sup> 2010

**Venue:** Hotel Panorama, Antananarivo

**Participants:** 16 implementing partners: technical and finance staff, managers, members of consortium representatives, USAID, Santénet2 staff

**Objective:** This national coordination workshop aimed to review all achievements and determine new challenges related to strengthening and capitalizing on project lessons learned, with a special stress on quality and sustainability.

#### **Recommendations:**

- Strengthen collaboration of all community actors engaged in the KM salama approach
- Ensure visibility of community achievements through sharing of best practices
- Engage community actors with coordination meetings
- Follow up NGO planning for tools and equipment
- Strengthen the links between CHWs and CSBs

**Source:** RTI/Santénet2 coordination meeting report, December 2010

## Specific Achievements

### Strategic Focus 1. Coordination of intervention in the communes implementing the KM salama approach

#### *a. Approaches and activities*

The following activities were conducted to establish effective coordination at all levels:

- Validate the implementing partners' annual and quarterly work plans
- Monitor activities against the plans through the NGOs' regular reports and reviews of data forwarded by SMS or in the Extranet
- Measure the NGOs' performance
- Organize a national meeting with all NGOs

Several strategies were applied in implementing the activities:

- Harmonizing the planning process
- Strengthening the monitoring and review of the completion of planned activities
- Improving the completeness, timeliness, and reliability of the deliverables from the NGOs
- Disseminating information on achievements and best practices

#### *b. Specific Achievements*

By the end of the Year 3, the project achieved the following:

- 21 annual work plans and 84 quarterly work plans prepared by the NGOs were validated.
- 21 dashboards were developed by the NGOs.
- 1,079 weekly reports were received from the NGOs and were assessed in terms of completeness, timeliness, and reliability.
- The data forwarded by the NGOs have been entered in the SMS database with a completion rate of 62%. The completion rate was 53% for data in the Extranet.
- The table summarizing the implementing partners' plans and achievements was updated every month.
- The achievements of the implementing partners are reviewed every quarter prior to the validation of their next quarterly work plan.
- 187 monthly coordination meetings with the NGOs were held.
- The strengths and weaknesses of the 21 NGOs in implementing activities were assessed every quarter.
- 4 assessments of the NGOs' performance were conducted.
- The results were shared with the NGOs, and action plans addressing the areas for improvement were drafted in collaboration with them.
- A national workshop was organized in Antananarivo in December 2010 to take stock of achievements, build on these achievements while maintaining quality and ensuring the sustainability, and identify new challenges for support.

- 8 NGOs were supported in conducting the assessment of CHWs in ten districts with KM salama communes.

*c. Challenges and corrective actions*

Direct communication with the NGO support technicians working in the field remains a challenge. Several meetings were held with the NGO technicians to find solutions to technical as well as organizations problems, and they were encouraged to attend the monthly coordination meetings.

# ADMINISTRATION AND FINANCE

## Personnel

A summary of the following changes took place in personnel/staffing during this period:

- The IEC/BCC Materials Manager left and was replaced by a more effective position design titled “Demand Generation Manager.”
- The WASH Manager left for a COP role on a new project, and his duties have been assumed by the Institutional Capacity Building Manager.
- The Community Health Financing Specialist position became open due to the departure of the incumbent and will be replaced.
- The Technical Director position became open due to the departure of the incumbent. The position may be restructured, depending upon the most efficient design for the remainder of the contract.
- The Program Specialist position became open due to the departure of the incumbent. The supervision of the three Program Assistants has shifted to the Director of Finance and Administration.
- Two janitors were hired in regional offices.

Hiring of new staff			
Date	Name	Title	Location
Feb 7, 2011	Mialy Noroarisanjy	Demand Generation Manager	Antananarivo
Feb 10, 2011	Onisoa Rakotomavo	Janitor	Ft Dauphin
Feb 10, 2011	Brigitte Rahantanirina	Janitor	Fianarantsoa
May 25, 2011	Sarindra Ramanitrivonony	Community Health Financing Manager	Antananarivo
June 1, 2011	Ilo Ho Vahatraina Andriamanamihaja	Technical Specialist	Ft Dauphin
July 1, 2011	Andritiana Tsarafihavy	Junior Malaria Manager	Antananarivo
July 11, 2011	Nirina Ranaivoson	DCOP	Antananarivo
September 26, 2011	Onimahery Andriamampianina	Grants Accounting Assistant	Antananarivo
Departure of staff			
Date	Name	Title	Location
Nov 3, 2010	Malalatiana Andriamahefa	IEC/BCC Manager	Antananarivo
Nov 15, 2010	Rivo Noelson	WASH Manager	Antananarivo
Dec 31, 2010	Tianamalala Rabarihoela	Community Health Financing	Antananarivo
Dec 31, 2010	Sahondra Rafamatanantsoa	Program Specialist	Antananarivo
Feb 18, 2011	Solomon Razafindratandra	Technical Director	Antananarivo
May 31, 2011	Aina Rakotonirina	Grants Program Assistant	Antananarivo
May 31, 2011	Lucie Raharimalala	Senior Malaria Manager	Antananarivo

## Financial status

Cumulative costs invoiced and accrued through September 30, 2011, are approximately \$20.4 million which is approximately equal to the cumulative USAID obligated funds through September 30, 2011.

## Procurement

The most significant procurement during the 12-month period related to enabling grantees to implement and report more effectively:

- 34 new motorcycles and spares kits were delivered to grantees in December 2010. In addition to the motorcycles, recommended policies and procedures for safe use and examples of logbooks were provided.
- 18 new desktop computers were delivered to grantees to support timely technical and financial reporting.

In terms of other procurement (non-grantee related), vehicle spare parts were imported at substantial savings relative to local costs. This allows routine maintenance to be done at other garages other than the Materauto dealership. Materauto does not honor the value-added tax (VAT) exemption; therefore, any repair work performed requires payment of VAT.

Substantial procurement of IEC materials and the outfitting of CHWs with the necessary supplies were completed.

The RTI Santenet2 Property Officer conducts monthly “cycle inventories” of equipment to maintain accuracy of the RTI headquarter-based property inventory database.

## Grant awards

Two fixed obligation type small grants program awards were made to the following groups:

- MARPS
- PLeROC (Religious groups)

<b>Santénet2 MARPs &amp; PLeROC Grants Awarded—January 2011</b>		
<b>MARPs—start date: February 1, 2011; end date: September 30, 2011; duration: 8 months</b>		
<b>MARPs—Grantee Name</b>	<b>Location of Implementation</b>	<b>Award (MGA)</b>
Mifanasoa (SWs)	FIANARANTSOA	4,584,000
Vonona Mifanasoa (SWs)	FIANARANTSOA	4,584,000
Tanora Te-Hivoatra (MSM)	FIANARANTSOA	4,584,000
Tanjona Miray (SWs)	FIANARANTSOA	4,584,000
Todika (SWs)	TAMATAVE	4,584,000
IVIA (MSM)	TAMATAVE	4,584,000
Manavotena (MSM)	TULEAR	4,584,000
Fihamy (SWs)	TULEAR	4,584,000
Fanamby (SWs)	TULEAR	4,584,000
Tanora Manan-jo (MSM)	Fort Dauphin	4,584,000
Fanantenana (SWs)	Fort Dauphin	4,584,000
AFSA (SWs)	Antananarivo	4,584,000

EZAKA (MSM)	Antananarivo	4,584,000
FIVEMIA (SWs)	Antsirabe	4,584,000
PLAJEVAK (MSM)	Antsirabe	4,584,000
	<b>TOTAL</b>	<b>68,760,000</b>
<b>PLeROC—start date: February 1, 2011; end date: September 30, 2011; duration: 8 months</b>		
<b>PLeROC—Grantee Name</b>	<b>Location of Implementation</b>	<b>Award (MGA)</b>
BALSAMA	Antsirabe- Vakinakaratra- Amoron'I Mania	10,486,342
ECAR—CES/CCLS	Vakinakaratra- Matsiatra- Ihorombe- Vatovavy 7vinany- Alaotra Mangoro- Atsinanana- Itasy	7,208,718
KPMS/FJKM	Analamanga-Itasy- Vakinakaratra- SAVA- Amoron'I Mania- Atsimo Atsinanana- Haute Matsiatra- Ihorombe- Vatovavy 7vinany- Boeny- Alatra Mangoro- Analanjofo- Atsinanana- Androy- Anosy- Atsimo Andrefana	39,792,912
AMCM	Analamanga- Itasy- Amoron'I Mania- Haute Matsiatra- Atsimo Atsinanana- Vatovavy 7vinany- Atsimo Andrefana	9,260,422
RESEAU TRADITIONNEL	Analamanga- Itasy- Vakinakaratra- Boeni- Androy- Anosy- Alaotra mangoro	19,276,652
EEM	Analamanga- Vakinakaratra- Alaotra Mangoro- Atsinanana- Itasy- Atsimo Andrefana	9,181,764
METM	Arivonimamo- Andasibe- Amparafaravola- Antanifotsy- Fandrina- Antsirabe- Miarinarivo- Soavinandriana- Arivonimamo- Anosibe an'Ala- Ankazobe	7,812,997
FSM	Vatovavy Fitovinany	3,044,014
JESOSY MAMONJY	Alaotra Mamgoro- Analanjofo- Atsinanana- Vatovavy Fitovinany- Atsimo Atsinanana	8,425,957
	<b>TOTAL</b>	<b>114,489,778</b>

\*SWs = sex workers; MSM = men who have sex with men

## Financial and administration technical assistance and capacity building of grantees

Grantees have received ongoing feedback and recommendations via the monthly review of their financial reports and quarterly review of budgets related to updated work plans.

In addition grantees have received the following other targeted technical assistance:

- Increased budget monitoring capability through assistance to input the FY 2011 monthly budgets into the CIEL accounting software. This allows for monthly and cumulative budget versus actual reporting. Analysis of variances leads to improved planning and correction of accounting errors.
- December 2010 partners meeting: presentation and question and answer session regarding annual external audits with presentations by Santénet2 staff and the external audit firm Ernst & Young.
- December 2010 partners meeting: planning for elaboration and/or improvements in grantees' written Policies and Procedures/Operations manuals.
- December 2010 partners meeting: improving accuracy and completeness of budgets and financial planning.

### RTI/Santénet2 Finance and Administration Technical Assistance and Support for Grantees

Through the RTI/Santénet2 funding, RTI has provided unprecedented capacity strengthening to local organizations in Madagascar. Grantees have benefited and will continue to reap benefits from targeted, customized organizational capacity building provided by RTI. The process is as follows:

1. Elaboration of the grants solicitation and award procedures in the **Grants Procedures Manual**, which was reviewed and approved by USAID
2. Initial assessments of applicants' financial and administrative capabilities **via questionnaires, follow-up interviews, and review of any existing audit reports**
3. Design of clear reporting requirements and explanation of grant terms and conditions as well as "clear-speak" interpretation of USAID requirements, such as "Mandatory Standard Provisions" in French via the RTI-produced "**Grantee Manual**"
4. Procurement, installation, and training in the use of the standard accounting software "CIEL" at grantee offices; production of written **CIEL Software Manuals**, customized for each organization, as required, including training in the application of CIEL for any new or existing projects; **an organization-wide solution** to processing accounting transactions and producing financial reports
5. Ongoing feedback and support in maximizing compliance, budget development, and cost analysis via monthly and quarterly **feedback on financial reports submitted to RTI/Santénet2**
6. Discussion and technical assistance provided on financial topics at periodic all-partner meetings
7. **High quality international standard external audits**, and in some cases organization-wide, conducted by the firm **Ernst & Young**. The external audits emphasized **comprehensive recommendations, focusing on compliance, capacity building, and best practices** as documented in extensive Management Letters for each organization produced by Ernst & Young. Each grantee also benefited from extensive discussions held with Ernst & Young and RTI/Santénet2 staff to review draft findings and recommendations.
8. RTI provided technical assistance and support over a year-long period in **the elaboration of detailed and customized Policies and Procedures manuals** for grantees, which will encompass and address auditor recommendations, international best practices, and local compliance.

### **External audits of grantees—strengthening grantee capacity through the adoption of organization-wide annual external audits**

Grantees have been encouraged to consider high-quality annual external audits as an important part of an annual “check-up” on organizational health. The overall goal is not only to support compliance, but also to increase awareness of best practices related to optimum operation of the financial side of their business. Particular emphasis has been placed on the external auditor-issued “Management Letter,” which contains valuable feedback on opportunities for strengthening financial management and compliance.

In 2011, all grantees received external audits of their 2010 activities by Ernst & Young. Where possible, the audits were structured to be organization-wide so that a full review resulted in the most complete audit report possible, with greatest impact in terms of potential organizational strengthening. As expected, the Management Letters generated by Ernst & Young provided a wealth of valuable feedback to the grantees.

The audit reports and recommendations may be referred to and mined for purposes of improved policies and procedures and capacity building. Santénet2 will provide technical assistance to grantees who wish to elaborate higher quality policies and procedures manuals during FY 2012.

### **Subcontracts**

Subcontractors’ rates of spending (burn rates) are nearly all consistent with budgeted costs through September 30, 2011.

The Pasteur Institute’s malaria surveillance subcontract was amended and extended to March 31, 2012.

# Annex A: Gap Analysis by Component

## Component 1: Community Programs

Strategic Focus / Intervention / Activity	Annual Objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives for 2012
<b>Strategic Focus I. Implementation of the KM salama approach in 800 communes.</b>				
<b>Intervention I: Strengthen community commitment</b>				
<b>Activity 2.1.1.1.1</b> <b>Monitor community commitment</b>	Ensure community commitment in the 800 KM salama communes	Community commitment is assessed based on action plans and was evidenced in the analysis of the action plans of 800 KM salama communes:  <ul style="list-style-type: none"> <li>- 298 communes improved their health facilities with safe water, latrines, garbage pits, wash houses, drainage, or sanitation.</li> <li>- 359 health huts were built for CHWs with the community's participation in 209 <i>fokontany</i>.</li> </ul>	Objective achieved	
	Document community commitment	The documentation is reported under the communication strategy.		

Strategic Focus / Intervention / Activity	Annual Objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives for 2012
<b>Strategic Focus 2. Production of KM salama tools</b>				
<i>Intervention 1: Ensure the availability of KM salama tools</i>				
<b>Activity 2.1.2.1.1</b> <b>Produce KM salama tools</b>	Update 8 tools and make them available to partners	5 tools designed and updated	Objective not achieved: 3 tools have not been designed. The contents of the three remaining tools (Youth's Guide to Using Condoms, Manual on Latrine Slab Design, and Manual on the Different Types of Latrines) are already incorporated in the other guides used for training community actors: <ul style="list-style-type: none"> <li>• The adolescent reproductive health (ARH) brochure, which provides information on the use of condoms</li> <li>• The CLTS brochure, which provides information on the construction of latrines</li> </ul>	Design 5 tools and update 5 tools Tools to be designed: <ul style="list-style-type: none"> <li>- Mutual health insurance poster</li> <li>- Invitation cards for mutual health insurance</li> <li>- RH/FP integrated form</li> <li>- Integrated training curriculum for CHWs</li> <li>- NGO activity monitoring curriculum</li> </ul>
<b>Activity 2.1.2.1.2</b> <b>Dispatch KM salama tools to grantees</b>	Make the tools available to the 16 partner NGOs according to the plans received	783 pouches with sets of tools sent in response to the NGOs requests for the following: <ul style="list-style-type: none"> <li>- CHWs management tools</li> <li>- Training manuals for community actors</li> <li>- IEC/BCC tools for community actors</li> <li>- Management and supervision tools for supervisors</li> </ul>	Objective achieved	Make tools available to partners according to the plans received

Strategic Focus / Intervention / Activity	Annual Objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives for 2012
<b>Strategic Focus 3. Implementation of a BCC strategy involving faith-based organizations and media in the KM salama communes</b>				
<i>Intervention I: Expand PLeROC activities to other communes</i>				
<b>Activity 2.1.3.1.1</b> <b>Scale up PLeROC's activities</b>	Assess the performance of member entities during year 2009–2010	Analysis of the member entities' performance in 2009–2010 completed <ul style="list-style-type: none"> <li>- 500,000 sensitized (300,000 were planned)</li> <li>- 93% of the activities in the 9 entities' action plans completed</li> </ul> In conclusion, the results of the PLeROC member entities were satisfactory.	Objective achieved	Activity completed
	6 entities expand their awareness-raising activities to new communes	9 member entities benefited from sub-grants to expand their activities to new communes.	Objective exceeded Difference: + 50% In general, the nine sub-grantees had satisfactory performance, which led to the decision to continue collaboration with them.	The religious leaders in the 580 KM salama communes benefit from logistic support (IEC tools suited to the religious context) in conducting awareness-raising in places of worship. <ul style="list-style-type: none"> <li>- 1,200 tools handed to religious leaders</li> <li>- 290,000 people sensitized</li> </ul>

Strategic Focus / Intervention / Activity	Annual Objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives for 2012
<b>Intervention 2: Involve local media in implementing the BCC strategy</b>				
<b>Activity 2.1.3.2.1</b> <b>Support the community actors' sensitization activities by the airing of radio spots</b>	Cover the 800 KM salama with radio spots	772 communes (96% of the KM salama communes) have coverage with the spots aired by the partner radio stations.	Achieved at 96% 800 - 772 = 28 KM salama (4%, are not yet covered by radio spots.) RTI/Santénet2 covered 772 KM salama in collaboration with partner radio stations. The other communes were not covered either because (1) there is no radio station covering them, or (2) the radio stations available cover only one or two communes, therefore it is not worth to invest in collaboration with them.	Continue airing radio spots in the 772 communes.
	Collaborate with 19 partner radio stations for airing spots	28 contracts for airing radio spots were signed with local radio stations.	Objective exceeded 9 additional contracts signed to cover the KM salama (+ 47%) RTI/Santénet2 signed contracts with 28 radio stations instead of the 19 planned to ensure better coverage of the intervention zones.	28 collaboration contracts signed with partner radio stations
	10 new radio spots produced and aired	5 spots produced and aired: <ul style="list-style-type: none"> <li>- Mutual health insurance</li> <li>- Promotion of CHWs</li> <li>- Social quality</li> <li>- Package of ANC for pregnant women</li> <li>- Diarrhea and latrines</li> </ul>	Objective not achieved Achieved at 50% RTI/Santénet2 decided to produce only 5 new spots because the 11 existing spots have not all been aired in all the intervention communes. The 5 spots produced and aired during FY 2011 cover those topics that are not addressed by the 11 spots previously produced. A portion of the budget allocated to spot production was assigned to pay for the costs of 200 CHWs who took part in the	Produce spots according to the needs of each program

Strategic Focus / Intervention / Activity	Annual Objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives for 2012
			evaluation conducted by USAID through the Global Health Technical Assistance Project.	
	Air 7,600 radio spots through local radio stations	10,313 spots were aired	<p>The difference between the achievement and the objective is 2,713 airings (+ 35%).</p> <p>The following reasons account for the excess airings:</p> <ul style="list-style-type: none"> <li>• Listeners find the spots attractive and use them for sending personal messages.</li> <li>• The animators use the spots as illustrations or enhancement of their features.</li> <li>• Radio stations air the spots in excess of what is required from them by contract to express their satisfaction with the collaboration with Santénet2.</li> </ul> <p>The airings are reported on by mystery listeners who work in collaboration with RTI/Santénet2 to monitor the airings.</p>	Air 13,440 radio spots on health through local radio stations
<b>Activity 2.1.3.2.2</b> <b>Produce reports and radiolvideo programs to back the communication activities conducted by CHWs</b>	Train 42 local radio station managers on the KM salama approach	43 radio station managers trained	Objective achieved: Difference: + 2%	14 local radio station managers trained on the KM salama approach
	42 programs on KM salama activities produced and aired	44 programs produced and aired	Objective achieved Difference: + 5%	112 programs on KM salama activities produced and aired

Strategic Focus / Intervention / Activity	Annual Objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives for 2012
<b>Strategic Focus 4. Scaling up community-based funding mechanisms</b>				
<i>Intervention 1: Scale up mutual health insurance schemes in the KM salama communes</i>				
<b>Activity 2.1.4.1.1</b> <b>Gradually scale up the mutual health insurance schemes in 50 KM salama communes</b>	50 mutual health insurance schemes initiating the set up process	68 KM salama have initiated the establishment of mutual health insurance schemes according to the new strategy.	Objective exceeded The new strategy consists of establishing mutual health insurance schemes at the district level instead of at the commune level. 4 districts with 77 communes, including 68 KM salama communes, have initiated the establishment of mutual health insurance schemes according to the new strategy.	The 4 districts complete the establishment of management structures and pay for the health care costs of their members. <ul style="list-style-type: none"> <li>- 68 initiation committees established at the commune level</li> <li>- 68 executive committees established at the commune level</li> <li>- 4 executive committees established at the district level</li> </ul>
	A monitoring plan drafted	The plan for monitoring mutual health insurance schemes is developed.	Objective achieved	16 supervision activities for the mutual insurance schemes completed Monitoring table completed and up to date
	Average membership rate above 50%	Membership rate not available at this stage	Objective not achieved RTI/Santénet2 designed a new strategy for setting up mutual health insurance schemes, consisting of creating them at the district level. It is not yet possible to measure the	Mutual health insurance schemes will group 300,000 members in the four districts.

Strategic Focus / Intervention / Activity	Annual Objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives for 2012
			membership rate because the subscription period will run until the end of February 2012. Enrollment to scheme will start in December 2011 and end in February 2012 that is during the harvest period.	

## Component 2: Strengthening Community Health Systems

Strategic Focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY2012
<b>Strategic Focus I. Strengthening of social quality and technical quality in the communes implementing the KM salama approach</b>				
<i>Intervention I: Strengthen the communities' commitment to respond to health needs</i>				
<b>Activity 2.2.1.1.1</b> <i>Train 2 members in each KM salama SDC to facilitate the quality improvement process</i>	1,000 SDC members trained on community satisfaction analysis	1,076 SDC members trained on community satisfaction analysis	Objective exceeded Achieved at 108% Objective exceeded by 8% The presence of more than one local supervisor in some communes accounts for the difference.	1,000 facilitator groups trained
<b>Activity 2.1.1.1.2</b> <i>Support technicians from implementing partner organizations in promoting social quality as part of implementing the KM salama approach</i>	204 technicians from implementing partner organizations trained on social quality promotion	204 field technicians from implementing partner organizations trained on social quality promotion	Objective achieved	Activity completed
	1 community action plan per KM salama including quality improvement activities	800 KM salama have a community action plan	Objective achieved	

Strategic Focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY2012
<b>Intervention 2: Promote quality assurance in healthcare services provision</b>				
<b>Activity 2.2.1.2.1</b> <i>Use the “Social Quality Index” tool</i>	2 applications of the Social Quality Index completed	2 applications of the Social Quality Index completed	Objective achieved The index quality tool was applied in 748 KM salama communes in Semester 1 and in 800 KM salama communes in Semester 2. This activity could not be conducted in MCDI's 52 communes in Semester 1 because the tool was not yet applicable to them.	Two applications of the Social Quality Index completed in 800 KM salama communes
	Report on the communes' level of performance	1,548 reports on the communes' level of performance available	The communes' performance is measured by the Social Quality Index. The 1,548 reports correspond to the 748 reports obtained in Semester 1 plus the 800 reports obtained in Semester 2.	Assessment of the quality of community-based services completed in the 800 KM salama communes
<b>Activity 2.2.1.2.2</b> <i>Establish a quality assurance system for the monitoring and supervision of CHWs</i>	2,400 supervision sessions performed	2,554 supervision visits performed	Objective exceeded 154 supervisions in excess Some communes received more supervision visits than planned because most of the CHWs were absent at the first visit. Additional supervision visits were organized for newly trained CHWs.	3,200 supervision visits performed

Strategic Focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY2012
<b>Strategic Focus 2. Standardization and decentralization of the project's trainings</b>				
<b>Intervention 1: Maintain standardized trainings</b>				
<b>Activity 2.2.2.1.1</b> <b>Maintain a pool of high-performing trainers to meet training needs</b>	300 qualified trainers trained to train CHWs	37 independent trainers trained on C-IMCI/DepoCom and 37 oriented on supervision, for a total of 410 trainers operational	Objective exceeded Achievement 133% Gap: +33% The objective was to have 300 operational trainers to conduct the training in 2011. Since there were already 373 trainers operational, the project had to train 37 additional trainers in 2011. In addition, these trainers had to be medical staff because they were to train Level 2 CHWs on C-IMCI and DepoCom. They represented only 43% of the trained trainers at Level I. This is why the project had to train trainers in excess of the objective set.	Activity completed
	20 coordination meetings for trainers and NGOs' technicians held	13 coordination meetings for trainers and technicians held	Objective not achieved Achievement at 65% Most of the trainings for CHWS were completed in Semester I, and most of the independent trainers are no longer mobilized. The 13 coordination meetings were sufficient for supervision and supervising trainers and supervisors.	Activity completed
	600 training sessions held by qualified trainers	656 training sessions held by qualified trainers	Objective exceeded Achieved at 110% In addition to the Level 2 training of Child Health CHWs, the trainers were requested to train the SDC members on CLTS, commune/district-level supply points on collaboration with PSI, and on ACT combo in	285 sessions to update CHWs on EONC, IFA, and ANC

Strategic Focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY2012
			<p>addition to updating them on the use of the new ACT presentation for malaria control.</p> <ul style="list-style-type: none"> <li>- 337 training sessions for Level 2 Child Health or Mother Health CHWs conducted:</li> <li>- 194 training sessions on ACT combo</li> <li>- 67 sessions on CLTS</li> <li>- 58 sessions on district- and commune-level supply points</li> </ul>	
	160 supervision sessions for trainers and supervisors	260 supervision sessions for trainers and supervisors conducted	<p>Objective exceeded Achieved at 163%</p> <p>The trainer supervision is done during coordination meetings organized by the Santénet2 regional teams and groups all trainers and supervisors in the regions.</p>	No objective is set for FY 2012 because the supervision and updating of CHWs will be performed by local and independent supervisors. The project will no longer train new independent supervisors.
<b>Strategic Focus 3. Building a culture of data for decision-making</b>				
<b>Intervention 1: Ensure data collection under the c-HMIS and the use of data for monitoring the project</b>				
<b>Activity 2.2.3.1.1</b> <b>Strengthen the system for regularly collecting quality data under the c-HMIS</b>	Data needed by the project available	Data needed by the project available on an annual basis <ul style="list-style-type: none"> <li>• c-HMIS performance is at 73%</li> <li>• Completion rate at 62%,</li> <li>• Weekly SMS status report sent routinely by grantees since 12/12/2010</li> </ul>	Objective achieved	Monthly analysis of data completeness, timeliness, and reliability performed for each NGO  Assessment results shared with implementing partners on a monthly basis  6 meetings with NGOs held at the regional offices

Strategic Focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY2012
<b>Intervention 2: Ensure project-level monitoring</b>				
<b>Activity 2.2.3.1.2</b> <i>Prepare the routine M&amp;E reports</i>	Data on the PMP indicators updated	Data on the PMP indicators updated	Objective achieved	
<b>Strategic Focus 4. Community supply system for health commodities</b>				
<b>Intervention 1: Monitor the functionality of community supply points (CSPs)</b>				
<b>Activity 2.2.4.1.1</b> <i>Strengthen the community supply mechanism</i>	Develop a job aid for the actors of the supply system	Job aid developed and dispatched to 722 CSPs	Objective achieved	Activity completed
	800 invoices/purchase orders collected from the CSPs per quarter (3,200 invoices/purchase orders per year)	5,415 invoices/purchase orders collected from commune-level CSPs ( 385 in Semester 1 and 5,030 in Semester 2)	Objective exceeded This achievement is a result from the combination of several approaches, namely sensitization by RTI/Santénet2's and the NGOs' team as well as strong mobilization of PSI's distribution team.	9,600 invoices/purchase orders entered and analyzed Operation of CSPs assessed Report on the operation of CSPs shared with all concerned actors on a monthly basis

Strategic Focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY2012
<b>Intervention 2: Assess the effectiveness of the community-based service delivery system</b>				
<b>Activity 2.2.4.2.1</b> <b>Conduct a survey on the performance of the communes implementing the KM salama approach</b>	Conduct a study based on a representative sample of communes implementing the approach	A basic analysis on a representative sample of the 722 CSPs for a total number of approximately 700 communes was conducted.	Objective achieved The CSP capacity building, in collaboration with PSI and DELIVER, allowed for assessing a large number of communes.	
	Use the study's findings to finalize the system for establishing the approach	Documentation being finalized before use	The analysis was finalized on September 25, 2011, which accounts for the documentation being late.	

### Component 3: Strategic Results

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
<b>Strategic Focus I. Improvement of Maternal and Child Health/Nutrition</b>				
<i>Intervention 1: Informing development partners of the project's MCH and nutrition activities and coordinating with them</i>				
<b>Activity 2. 3.1.1.1.</b> <i>Take part in MCH/Nutrition technical coordination forums</i>	4 meetings held	4 meetings held: <ul style="list-style-type: none"> <li>- 1 exchange and coordination meeting held with the Task Force in charge of Nutrition, Infant and Young Child Feeding (IYCF) and Maternal Nutrition. RTI/Santénet2's achievements in 2010 and work plan for 2011 were presented.</li> <li>- 1 coordination and exchange meeting with the partners in the different divisions of the Ministry of Public Health: RTI/Santénet2's achievements at mid-term were presented.</li> <li>- 1 coordination meeting with the team of the Regional Directorate of Health in Boeny, the health districts of Marovoay and Mahajanga 2: RTI/Santénet2's achievements at mid-term and the results of the community-based ONE study were presented.</li> <li>- 1 coordination meeting with nutrition actors held in Taolagnaro: UNICEF, ASOS, CRS, DHS of Ambovombe, Amboasary and RHD of Anosy and Androy. RTI/Santénet2's achievements at mid-term were presented and the project's</li> </ul>	Objective achieved	Take part in 4 coordination meetings

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
		activities in partnership with UNICEF for IYCF and women's nutrition were presented.		
	4 documents on RTI/Santénet2's achievements were presented during the coordination meetings	4 documents distributed during the coordination meetings: - RTI/Santénet2's achievements in 2010 - RTI/Santénet2's achievements at mid-term (August 08 to March 11) - Results of the study on community-based response to ONE -Tools and job aids designed by RTI/Santénet2 (early pregnancy screening, monitoring of pregnant women) were shared during the coordination meetings	Objective achieved	
<b>Activity 2.3.1.2.1</b> <i>Complete the operations research on community mobilization for ONE</i>	Study report available	Study completed and report available, including recommendations and best practices	Objective achieved	Activity completed
	A dissemination meeting held	The meeting to disseminate results was held on August 1, 2011  The results dissemination meeting involved USAID and partners, including UNICEF, United Nations Population Fund (UNFPA), CARE, ZETRA, Association Intercooperation Madagascar (AIM), Medical Care Development International (MCDI), FHI 360, ASOS, MOH: Child Health program, Health Promotion program, Mother Health program, Malnutrition Case Management program and Safe Motherhood program	Objective achieved	Activity completed

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
	CHWs' curriculum, job aids and management tools updated	CHWs' curriculum updated to include C-ONE, available, and used for training	Objective achieved	Training curriculum updated and used during CHWs' trainings 4,000 CHWs trained and equipped with early pregnancy screening and pregnant women management tools
<b>Activity 2.3.1.2.2: (II)</b> <b>Provide community-based integrated services to mothers and children</b>	1,000 Mother Health CHWs or Child Health CHWs trained in integrated services (Promotion of 4 ANC visits, delivery in a setting with qualified assistance, management of newborns, IFA supplementation for pregnant women, IPT, nutrition, growth monitoring and promotion)	3,370 CHWs trained and equipped with work tools	Objective exceeded: 237% There were 4 times more CHWs trained than planned. Pursuant to change in its strategy, the project put to profit all training/ supervision events to train CHWs to enable them to promote 4 ANC visits with the following package of services: IFA supplementation for pregnant women, IPT for pregnant women, delivery with qualified assistance, and newborn care. The training or supervision sessions were extended to allow for training on integrated services.	4,000 CHWs trained and equipped with early pregnancy screening and pregnant women management tools
	400 Mother Health or Child Health CHWs supervised (40% of the trained CHWs)	1,348 Mother Health or Child Health CHWs benefited from integrated supervision	Objective exceeded: 337 % 1,348 - 400 = 948 CHWs supervised in excess of target The increase in the number of CHWs trained accounts for the higher number of CHWs supervised; supervision occurs after the training.	Supervision checklist updated CHWs in 800 KM salama communes supervised

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
<b>Strategic Focus 2. Scale-up of community-based RH/FP, ARH, and safe motherhood services</b>				
<b>Intervention 1: Reinforce contraceptive security at the community-level</b>				
<b>Activity 2.3-2.1.1.</b> <b>Train Level 2 Mother Health CHWs</b>	2,700 Mother Health CHWs trained in 260 KM salama communes	1,434 Mother Health CHWs trained	<p>Objective not achieved Achievement: 53%</p> <p>The number of CHWs trained this year allowed for covering all the 800 intervention communes.</p> <p>Initially, RTI/Santénet2 considered training Level 1 Mother Health CHWs in all <i>fokontany</i> and only 4 Level 2 Mother Health CHWs per commune. We have since decided to offer Level 2 training to all Mother Health Level 1 CHWs. By the end of FY 2011, there are 5,660 functional Mother Health CHWs (both levels combined) in the 5,758 <i>fokontany</i> located more than 5 km from the nearest health facility. 427 Level 1 Mother Health CHWs did not succeed in passing to Level 2. They will attend a new training session. Currently, 5,233 Level 2 Mother Health CHWs are covering 91% of the target <i>fokontany</i> in the 800 KM salama communes. In FY 2012, we plan to provide Level 2 Mother Health training to 525 CHWs to close the gap.</p>	Strengthening the capacity of Mother Health CHWs on integrated RH/FP (counseling, referral for LTPMs, provision of POP methods and LAM, filling out c-HMIS tools) in the 800 KM salama communes during the supervision meetings or meetings with the SDC/CSB, support technicians, and independent supervisors.

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
<b>Intervention 2: Inform development partners of the project's RH/FP activities and coordinate with them</b>				
<b>Activity 2.3-2.2.1.</b> <i>Share achievements and challenges on community-based RH/FP services provided by CHWs through coordination meetings at the national level.</i>	1 national coordination meeting held	1 national coordination meeting provided the opportunity for sharing on RTI/Santénet2's achievements, challenges, and activities.	Objective achieved	Participation in a national coordination meeting  Document on the results of RH/FP activities in the KM salama communes distributed to partners
<b>Activity 2.3-2.2.2.</b> <i>Facilitate the provision of LTPM services in the KM salama communes</i>	Develop an annual training plan for the KM salama communes	Training plan for CHWs in charge of maternal health established for two quarters and shared with Marie Stopes Madagascar  849 clients who expressed need for LTPMs were referred to CSBs by CHWs	Objective achieved	Work plan to improve the provision of LTPMs in the KM salama communes available
<b>Intervention 3: Scale up peer education approaches to promote ARH</b>				
<b>Activity 2.3-2.3.1</b> <i>Establish youth leaders offering RH/FP services for young people and ARH services that integrate gender in the KM salama communes</i>	300 youth leaders trained (and 3,000 young people sensitized)	402 youth leaders trained	Objective exceeded 402 young leaders are trained, including 156 trained by PMPS2/ASOS.  The communes expressed the need to increase the number of youth leaders (2 per KM salama commune) given the communes' size.	Activity completed  Organize intra-regional meetings for youth leaders to share their best practices and to discuss the challenges encountered in implementing activities

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
				7 intra-regional meetings will be organized.
	3,000 young people sensitized	5,572 young people trained in the KM salama communes	Objective exceeded	
<b>Strategic Focus 3. Expansion of community-based malaria prevention and control services</b>				
<b>Intervention 1: Supporting the regular coordination meetings of the RBM partnership</b>				
<b>Activity 2.3.3.1.1</b> <i>Take part in the technical coordination forums on malaria control and prevention</i>	12 regular meetings held	15 regular meetings held	Objective exceeded Achievement at 125% 3 regular meetings in excess of target for better coordination of activities <ul style="list-style-type: none"> <li>- Meetings held pursuant to the harmonization of the strategy and tools—decisions to be made for more efficiency</li> <li>- Meetings held in application of the recommendations made by the auditors of the Global Fund and WHO/AFRO, pursuant to the start-up of activities under the new funding for malaria control, to assess the National Malaria Control Program (NCMP), the use of RDTs, and the work of the CHWs</li> </ul>	Take part in 10 regular meetings of the RBM partnership
	Project annual activity report disseminated	Project annual activity report not disseminated	Objective not achieved The report will be disseminated to RBM partners in October 2011 as the activities are coordinated with the national level	

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
<b>Activity 2.3.3.1.2</b> <i>Coordinate the implementation of C-IMCI with development partners</i>	4 meetings held	15 meetings held monthly starting in April 2011	Objective exceeded 11 meetings held in excess of target The meetings were held as part of the effort to coordinate implementing partners' intervention zones and to harmonize the various tools used (training materials, management tools)	6 coordination meetings held with the NMCP and National Strategy Applications (NSA) partners
<b>Activity 2.3.3.1.3</b> <i>Support the extension of fever surveillance sentinel sites</i>	12 issues of the <i>Epiveille</i> bulletin edited and received	11 issues of the <i>Epiveille</i> bulletin edited and received	Objective achieved at 92 %	6 issues of the <i>Epiveille</i> bulletin edited and received
<b>Activity 2.3.3.1.4</b> <i>Make available to IPM the resources needed to assess the impact of community case management services</i>	1 new contract signed	Contract signed	Objective achieved	
<b>Activity 2.3.3.1.5</b> <i>Conduct an assessment survey to measure the use of RDTs at the community level</i>	Protocol developed	The assessment of RDT use at the community level is integrated into the CHWs' assessment conducted by USAID in September–October 2011. RTI/Santénet2 provided support to USAID and paid for the CHWs' costs during the survey.	Objective achieved Survey protocol developed	Assessment of the effectiveness, sustainability, and quality of the services provided by CHWs in the KM salama communes
	Survey results available and disseminated	Survey results not available	Objective not achieved. The survey started in September 2011.	Dissemination of survey results

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
<b>Activity 2.3.3.1.6</b> <i>Ensure that villages have Child Health CHWs who manage malaria cases at the community level</i>	2,298 Level 2 Child Health CHWs trained in 383 KM salama communes 2,298 Child Health CHWs equipped with start-up lots of health commodities	1,518 Level 2 Child Health CHWs trained 1,518 trained CHWs equipped with start-up lots of health commodities	Objective not achieved Achievement at 66% The data on the training of Level 2 CHWs from the implementing partner MCDI should reach us soon.	Monitor and supervise Level 2 Child Health CHWs in the KM salama communes to ensure the provision of quality C-IMCI services
<b>Strategic Focus 4. STI/HIV/AIDS</b>				
<b>Intervention 1: Promote STI/HIV AIDS prevention activities among MARPs</b>				
<b>Activity 2.3-4.1.1</b> <i>Strengthen the MARPs associations' capacity to implement STI/HIV/AIDS prevention activities</i>	Expand collaboration with 20 MARPs associations (13 old associations and 7 new associations in 5 new towns)	20 associations benefited from technical and financial support, including 15 receiving a grant	Objective achieved	27 associations benefiting from technical and financial support, including 8 receiving a grant.
	500 peer educators trained	300 peer educators trained	Objective not achieved Achievement at 60% The number of peer educators is less than planned. The objective was set with the assumption that there will be 25 peer educators per association. However, the actual number of peer educators per association was unknown until a contract was established with them.	380 peer educators trained
	60 training sessions conducted	20 training session conducted	Objective not achieved Achievement at 33% It was initially planned to have 3 training	27 training sessions to be conducted

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
			<p>sessions per association, covering STI/HIV/AIDS prevention, fighting stigma, and techniques for negotiating the use of condoms.</p> <p>During implementation, the project noted that some of the associations had been trained on some of the topics by other actors, in particular sub-grantees of the Global Fund's 8<sup>th</sup> round. The number of trainings was reduced accordingly.</p>	
	10,000 IEC tools distributed	10,000 IEC tools distributed - 7,500 brochures for sex workers - 2,500 brochures for MSMs	Objective achieved	9,500 IEC tools distributed
	20,000 people sensitized	21,000 people sensitized on STI/HIV/AIDS prevention and fighting stigma	Objective exceeded Difference: + 2%	12,000 people sensitized
<b>Intervention 2: Promote the gender approach in STI/HIV/AIDS promotion activities</b>				
<b>Activity 2.3-4. 2.1</b> <b>Facilitate participatory discussions on gender and sexuality among SDC members and young people</b>	1,600 facilitators from DRV in the 800 KM salama are trained on leading a participatory discussion on gender and sexuality	No facilitators trained	Objective not achieved. During FY 2010, 94 facilitators in 94 KM salama communes were trained. The strategy suggested by DRV to the NGOs consisted of equipping support technicians with tools to conduct the training, but none of the NGOs responded to this call.	Activity to be integrated in social quality component
	At least 800 participatory discussions conducted	104 group talks held (31 sessions with SDC members and 73 in other meetings in the KM salama communes)	Objective not achieved The data were collected from 57 reports out of 85 (completeness rate: 67%) available from DRV.	Activity completed Activity to be integrated in ARH activities STI/HIV-AIDS program

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
<b>Strategic Focus 5. Establishing the WASH strategy in the KM salama communes</b>				
<i>Intervention 1: Promote collective behavioral change in the field of sanitation and use of latrines</i>				
<b>Activity 2.3-5.1.1</b> <i>Scale up the CLTS approach in 100 KM salama communes</i>	Build the capacities of at least 750 SDC members to serve as CLTS facilitators	940 SDC members trained	Objective exceeded by 190 Difference: 25.3% The strategy provided for training 5 SDC members per commune. However, the implementing partners trained more than 5 members in some communes, depending on the number of villages.	2,837 SDC members updated on the CLTS approach
	1,750 latrines built	3,677 latrines built in the KM salama communes	Objective exceeded by 1,927 (110%) Since RTI/Santénet2 was the first project to implement CLTS at large scale in Madagascar, it could not accurately forecast results to be achieved in one year. The results show that the population is owning the approach.	3,000 latrines built
	100,000 people using latrines	77,455 people using latrines	Objective exceeded by 67,455 (674%) The CLTS approach being highly successful, the number of people using latrines exceeded the objectives.	15,000 additional people using latrines

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
<b>Intervention 2: Promote access to WASH facilities</b>				
<b>Activity 2.3-5.2.1</b> <i>Scale up the training of community members on WASH facilities management</i>	400 people trained on the management of WASH-related facilities	380 people trained on the management of WASH-related facilities	Objective not achieved Achievement at 95% Gap: 5% The number of communes to be supported by the sub-contractors was reduced from 200 to 164, and the number of people trained decreased accordingly.	Activity completed
	150 management entities have a WASH development plan	136 management entities have a WASH development plan	Objective not achieved with a difference of 15 Gap: 10% After the management entities received training on planning, the communes received support in preparing their WASH action plans. Some of the training and monitoring activities to be done by the two sub-contractors (Sandandrano and FIKRIFAMA) have slipped to October–December 2011. This accounts for the gap.	164 communes monitored
	1,000 people monitored after their training on management of WASH-related facilities	240 people monitored after their training	Objective not achieved Achievement at 24% The monitoring of WASH-related facility management activities is implemented by sub-contractors under RFP#2. Some of the monitoring activities to be done by the two sub-contractors (Sandandrano and FIKRIFAMA) have slipped to October–December 2011.	No objective set for FY 2012 The data from the two sub-contractors will be reported in the 2012 semester report.

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
	200 facilities operational, providing access to WASH	340 facilities operational	Objective exceeded by 140 Difference: + 70% The sub-contractors' effective support and the communities' commitment contributed to this good result. The facilities are either new ones or improved/maintained ones.	Activity completed
	100,000 people have access to safe water, to public toilets, or to domestic waste management systems	77,455 people using latrines, of which 16,475 have access to potable water	Objective not achieved. Achievement at 77% Gap: 23%	No objective set for FY 2012 The data on the use of latrines are collected as part of monitoring CLTS and will be reported under this activity.
<b>Activity 2.3-5.2.2</b> <b>Work in coordination with other facilities and facility project management partners to support KM salama communes in improving their facilities</b>	100 WASH management entities have a development plan	136 management entities have a WASH action plan	Objective exceeded by 34 Difference: + 34% After the management entities received training on planning, the communes are supported in the preparation of a WASH action plan.	The contracts of sub-contractors will end in December 2011, but RTI/Santénet2 will continue the monitoring through implementing partners and SDC members.
	100,000 people have access to safe water, to public toilets, or to domestic waste management systems	77,455 people using latrines, of which 16,475 have access to potable water	Objective not achieved. Achievement at 77% Gap: 23%	No objective set for FY 2012 The data on the use of latrines are collected as part of monitoring CLTS and will be reported under this activity.

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap Analysis (expected vs. actual annual results)	Target FY 2012
<b>Activity 2.3-5.2.3</b> <i>Work in coordination with other technical partners to teach the community the maintenance or the manufacturing of low-cost wells</i>	Make 200 small WASH facilities operational by building the capacities of the WASH management entities	340 facilities operational	Objective exceeded by 140 Difference: 70% The sub-contractors' effective support and the communities' commitment contributed to this good result. The facilities are either new ones or improved/maintained ones.	Activity completed
<b>Intervention 3: Promote behavioral change at the individual and household levels</b>				
<b>Activity: 2.3.5.3.1</b> <i>Establish WASH-friendly CHWs in 800 KM salama communes</i>	Qualify 2,400 CHWs as WASH-friendly	1,728 CHWs qualified as WASH-friendly by meeting the three criteria: using latrines, using a hand-washing device, and safe water storage <ul style="list-style-type: none"> <li>135 CHWs meet the two criteria of having latrines and safe water storage.</li> <li>1,481 CHWs have hand-washing devices and safe water storage.</li> <li>531 meet only one criterion (either having a hand-washing device or safe water storage).</li> </ul>	Objective not achieved. Achievement at 72% The rate is due to the reporting rate, which is currently low at 53% (312 communes). Among the 3,875 CHWs monitored, 48% use latrines, 88% use a hand-washing device, and 91% have safe water storage. These rates reflect the lack of latrines in the villages.	2,400 additional CHWs qualify as WASH-friendly, use of latrines being the priority and being promoted under the CLTS approach
	50,000 people have been reached and understand WASH activities	1,220,192 people sensitized on WASH activities	Objective exceeded All CHWs conduct sensitization on WASH, and this intensive campaign accounts for the results exceeding the target.	400,000 people reached with WASH messages
	50,000 have access to water, practice hand washing with soap, or use latrines compliant with WASH standards	93,930 people use latrines	Objective exceeded. Difference: + 88% The effectiveness of the CLTS approach combined with the sensitization on WASH has generated social behavioral change.	

## Coordination

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. Actual annual results)	Target FY 2012
<b>Strategic Focus I. Strengthening the results-based management system</b>				
<b>Intervention I: Strengthen the harmonization of the implementing partners' planning process: annual work plan, quarterly work plan</b>				
<b>Activity 2.4-1.1.1</b> <i>Validate the annual work plans (AWPs) and quarterly work plans (QWPs) of KM salama implementing partners</i>	17 AWPs received and validated according to the procedures in place	21 AWPs received and validated according to the procedures in place	Objective exceeded Positive difference: 24% The number of AWPs received is 21 because there were 5 lots under RFA#1; 4 under RFA#2; 6 under RFA#3; and 4 under RFA#4, plus CARE and CRS	21 AWPs received and validated
	68 QWPs received and validated according to the procedures in place	84 QWPs received and validated according to the procedures in place	Objective exceeded Positive difference: 24% The number of QWPs received is 84 because there are 21 NGOs	Quarterly reports of 21 NGOs received and reviewed, i.e. a total of 84 QWPs received and validated
<b>Activity 2.4-1.1.2</b> <i>Make validated AWPs and QWPs available to NGOs to allow for establishing dashboards for monitoring</i>	68 QWPs handed to the NGOs and regional offices	84 QWPs handed to the NGOs and regional offices	Objective exceeded Positive difference: 24% The number of QWPs received and validated is 84	84 QWPs handed to the NGOs and regional offices
	17 dashboards prepared	21 dashboards prepared	Objective exceeded Positive difference: 24% The number of NGOs is 21	21 dashboards updated
<b>Activity 2.4-1.2.1</b> <i>Monitor activities against the validated plans</i>	1,144 weekly activity reports received from the NGOs and reviewed in terms of completeness, timeliness, and	1,079 weekly activity reports	Objective not achieved Achievement at 94% $1,144 - 1,079 = 65$ - 40 reports were not received because some NGOs were on vacation in late Dec. 2010 and	Weekly activity reports received from 21 NGOs and reviewed in terms of completeness, timeliness, and reliability, i.e. 1,008 reports (48 weeks x 21

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. Actual annual results)	Target FY 2012
	reliability at RTI/Santénet2's central and regional offices		early Jan 2011 and did not have any activity - 25 reports were omitted by the NGOs	NGOs) RTI/Santénet2 counts 48 weeks within the year because of NGOs' annual leave (2 weeks per year) and the end-of-year leave (2 weeks in December and January) when the NGOs have no field activity planned
	243 monthly coordination meeting reports available	187 monthly coordination meeting reports available	Objective not achieved Achievement at 77% 243 – 187 = 56 Some meetings were not held for some NGOs for the following reasons: <u>October 2010</u> : Santénet2 held its retreat in Mahajanga. <u>December 2010</u> : the semester review was held in Antananarivo and replaced the coordination workshop planned in December 2010. <u>January 2011</u> : Most of the NGOs were on vacation. <u>April to June 2011</u> : The coordination meetings were postponed to allow time for strategy adjustment advocacy. During, Quarter 2 of 2011 (April–June 2011), RTI/Santénet2 and implementing partners conducted field visits to promote a strengthened supervision strategy with local actors. Indeed, the strengthened strategy called for more active role from SDCs and local supervisors, along with implementing partners' field workers, independent supervisors, and RTI/Santénet2 staff.	176 monthly coordination meeting reports available

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. Actual annual results)	Target FY 2012
	Data sent by the NGOs available in the SMS database at a completion rate of 65%	Data sent by the NGOs available in the SMS database at a completion rate of 62%	Objective not achieved The 3% gap is due to the fact that the current completion rate (62%) does not yet incorporate the data from September.	Activity transferred to the Community Health Systems component
	Data sent by the NGOs available in the Extranet at a completion rate of 65%	Data sent by the NGOs available in the Extranet at a completion rate of 53%	Objective not achieved The 12% gap is due to the fact that the current completion rate (53%) does not yet incorporate the data from September.  A problem was noted in the offline version that prevented some NGOs from entering the CHWs' MAR data in the Extranet.	Activity transferred to the Community Health Systems component
<b>Activity 2.4-1.2.2</b> <b>Update each NGO's dashboard on a weekly basis</b>	12 monthly updates of the summary table on the implementing partners' plans and achievements	12 monthly updates of the summary table on the implementing partners' plans and achievements	Objective achieved	Activity performed concurrently with the review of the NGOs' weekly reports
<b>Intervention 3: Analysis of the achievement gaps against the project's AWP on a quarterly basis</b>				
<b>Activity 2.4-1.3.1</b> <b>Conduct a session to review each partner's implementation gaps on a quarterly basis</b>	4 gap analysis reports available	4 gap analysis reports available  A tool that allows for assessing the NGOs on a quarterly basis in terms of quality of services provided to the communities and RTI/Santénet2 was designed and used during FY 2011.	Objective achieved The NGOs' performance was assessed during Quarters 1, 2, 3, and 4.	Activity transferred to the Monitoring and Evaluation Unit
<b>Activity 2.4-1.3.2</b> <b>Prepare a QWP addressing the gaps identified</b>	4 quarterly work plans prepared based on the analysis completed	4 quarterly work plans prepared based on the analysis completed	Objective achieved The plans to address gaps were integrated in the NGOs' regular quarterly plans	Activity performed concurrently with the validation of the NGOs' 84 QWP s

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. Actual annual results)	Target FY 2012
<b>Strategic Focus 2. Monitoring of the NGOs' performance in implementing the sub-grants for KM salama activities</b>				
<i>Intervention 1: Ensure the timeliness, completeness, and reliability of the deliverables expected from the NGOs</i>				
<b>Activity 2.4-2.1.1</b> <i>Maintain permanent contact with the NGOs through the dynamic tools to ensure prompt problem solving</i>	A wrap-up form on NGOs' strengths and weaknesses in implementation sent to the NGOs every month	An assessment form summarizing monthly achievements and other information on each NGO shared with NGOs during coordination meetings	Objective achieved NGO assessment tools updated and piloted with 16 implementing partners during FY 2011's first semester	Activity transferred to the Monitoring and Evaluation Unit
<b>Strategic Focus 3. Strengthening and expanding strategic partnerships</b>				
<i>Intervention 1: Organize workshops or sessions for review, training, coordination, and dissemination of achievements, best practices, and lessons learned under the KM salama approach</i>				
<b>Activity 2.4-3.1.1</b> <i>Hold a retreat for RTI/Santénet2's team</i>	Retreat report available	Retreat report available	Objective achieved The retreat was held in Mahajanga on October 4–7, 2010.	Activity completed
<b>Activity 2.4-3.1.2</b> <i>Hold a program strategic review meeting in each region</i>	Workshop reports available	Workshop reports available	Objective achieved	Workshop reports available
<b>Activity 2.4-3.1.3</b> <i>Hold two semester review workshops at the national level</i>	Workshop reports available	1 workshop report available	Objective not achieved The first review workshop was held at Hotel Panorama on December 13, 14, and 15, 2010. The second was not held because the challenges to be addressed were more operational than strategic. Therefore, it was deemed more relevant to strengthen coordination and training meetings with field actors than to convene the NGOs' leaders.	Hold one review workshop at the national level

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. Actual annual results)	Target FY 2012
<b>Intervention 2: Strengthen collaboration with existing strategic partners and identify new partners to focus on strengthening the KM salama approach</b>				
<b>Activity 2.4-3.2.1</b> <i>Strengthen collaboration with USAID/Madagascar's partners</i>	Decision-making meeting reports available	Participation in the planning of MCHIP's activities Participation in the FP audit conducted by USAID's Regional Inspection Bureau	Objective achieved	Activity completed
<b>Activity 2.4-3.2.2</b> <i>Develop partnerships with private operators and strategic partners</i>	Terms and conditions of collaboration signed with partners	3 collaboration agreements prepared with partners (Tough Stuff, UNICEF, Marie Stopes International)	Objective achieved	Activity completed

# Annex B: Monitoring and Evaluation

Collecting and using information on the program's progress and impacts on the population are an essential part of RTI/Santénét2's management. Through the analysis of monitoring and evaluation indicators, the project's management acquires an understanding of how well implementation is performing and determines whether the activities comply with initial plans and whether the objectives set are met. Without a rigorous monitoring and evaluation (M&E) framework, it would not be possible to grasp where the efforts made have led.

RTI/Santénét2 developed the Performance Monitoring Plan (PMP) for the following goals:

- Provide information and data allowing for monitoring and assessing the annual action plan
- Assess progress against the activities planned
- Assess impact on the beneficiary population

The PMP describes the approach to use for monitoring progress toward achieving the overall strategic objective of the RTI/Santénét2 program and its three key components:

- Strengthening community systems
- Strengthening the health system
- Achieving strategic results

The project's team uses the PMP as an essential tool for planning, managing, and documenting the collection and use of performance-related data.

In conducting its activities, RTI/Santénét2 refers to 27 indicators, including 21 indicators pertaining to the five key health areas (RH/FP, MCH and Nutrition, malaria, WASH, and STI/HIV/AIDS) and six cross-cutting indicators. The results obtained under each of the indicators are reported to USAID/Madagascar every semester.

Because of the political crisis currently affecting Madagascar and the restrictions imposed by the U.S. Government on collaboration with the host country government, RTI/Santénét2 had to adjust its plans, suspending assistance to the public sector (government and public health system) and refocusing its activities on the communities. As a result, the indicators pertaining to direct assistance to the public sector and the operations of the public system were reformulated in terms of intervention at the community level or were outright suspended. Any indicator that requires information from the CSBs will not be reported until the end of the sanctions.

The project's monitoring and performance indicators over this period are classified in three categories according to their level of achievement.

The first category groups indicators for which targets have been exceeded. They number 11 and include (1) CYP provided by CHWs; (2) community-based FP services; (3) community-based ARI case management; (4) diarrhea case management; (5) community-based growth monitoring and promotion; (6) awareness-raising under the nutrition program; (7) malaria case management; (8) WASH; (9) population's access to improved sanitation; (10) community-based water resources development and management plan; and (11) capacity-building on HIV/AIDS prevention. Good performance was achieved on these indicators during the first semester thanks to the quality of training, regular supervision pursuant to training, and the quality of field activities conducted by implementing partners.

Couple Years of Protection:

We will continue reporting on CYP. The table below presents the number by method, the corresponding conversion factor, and total CYP by method for the reporting period. The

number of contraceptive products sold/distributed by CHWs is reported in the MARs. The completeness rate of MARs is 63%. Another limiting factor is missing information on source of contraceptives distributed.

Contraceptive products	Product distributed	Conversion factor	CYP FY11
Condom	35,636	1/120	297
Oral Contraceptives	411,815	1/15	27,454
Injectable contraceptives	285,445	1/4	71,361
<b>Total</b>			<b>99,113</b>

Source: RTI/Santénet2, 2011.

The second category groups indicators on target (with a variation of  $\pm 10\%$ ). They number 8 and include demand creation, referral, and services in the fields of child health, maternal health and nutrition, and newborn health; capacity building on malaria control and prevention; awareness-raising on HIV/AIDS prevention; the number of NGOs supported by the project; the functioning of SDCs; the functioning of CHWs and the H-MIS performance.

The third category groups indicators that are off target. They number 6 and pertain to the number of ANC referrals; the funding of health care; training activities on FP/RH, child health and nutrition, malaria, and maternal and newborn care. The factors accounting for being off target include the following:

- The target for ANC was not achieved because of reporting issues. CHWs referred mothers and children to the CSBs but could not routinely report on the number of pregnant women referred because the CSBs would not issue counter-referral forms or the women referred did not bring back the forms. To address this issue, we need to work directly with the health system to design tools for forwarding information on the outcome of referrals by CHWs directly from the CSBs to the CHWs. However, this collaboration (which would involve the MOH) was not possible because of the current restrictions.
- For health care funding, RTI/Santénet2 designed a new strategy for setting up mutual health insurance schemes consisting in establishing them at the district level. Since the period for subscription to the schemes established runs until February 2012, the membership size at the end of FY 2011 has not yet been computed.
- Targets set for training activities on FP/RH, child health and nutrition, malaria, and maternal and newborn care were not reached. The FY 2011 target was set based on the cumulative number of community actors trained during life of project. Upon discussion with USAID/Madagascar, RTI/Santénet2 reports only on training that occurred during the reporting period. The variance is explained by the misunderstanding while setting the FY 2011 target.

This year, RTI/Santénet2 suggests the following approaches to reporting on the following indicators:

- No longer report on the number of service provision points reporting a stock out: CHWs' supply pipeline relies on PSI, who sets up and supplies supply points where the CHWs directly purchase the products they need. The availability of products at the CHWs' level is therefore dependent on their availability at the supply points that PSI replenishes. PSI's role in the pipeline introduces an external factor that is beyond RTI/Santénet2's control.

- No longer report on the number of newborns receiving essential newborn care: RTI/Santenet2 trains CHWs on care-giving behaviors for newborns, such as baby assessment, warmth, early exclusive breastfeeding within one hour, recognition of newborn danger signs, and immediate referral. Their activities consist of awareness-raising on these issues, recognizing newborn danger signs, and referring newborns at risk to CSBs.

As defined by USAID, this indicator takes into account the effective care of newborns and not awareness-raising activities conducted by CHWs; RTI/Santénét2 cannot report on this indicator.

N°	Indicator	Baseline	Achieved 2010	Objective 2011	Achieved FY11 (Oct 2010-Sep 2011)	Objective 2012	Comments and gap analysis
<b>INDICATORS OVER-ACHIEVED</b>							
1	Couple years of protection (CYP)	10,000	58,600	65,000	99,113	118,936	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> Community-based family planning (FP) services delivered by project-trained Mother Health CHWs effectively met the demand for FP services by women of reproductive age in the remote communities. The conservative target was set based on the average number of CYP served by CHWs. During the reporting period, episodes of product stock-out were found.
2	Number of regular users (RU) of modern contraceptive methods (RUs of CHWs)	NA	50,063	72,000	102,847	123,416	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED ACHIEVEMENT AT 143%</b> Scaling up of community services in injectable contraceptive in the 800 KM salama communes contributed to the increase of RUs. 72% of RUs used Depo Provera. These results show effectiveness of communication strategy for behavior change implemented by RTI/Santénet2 involving CHWs, FBO members, youth leaders, and local radio stations
6	Number of diarrhea cases among children under 5 treated by CHWs	2,763	32,579	38,000	112,275	112,275	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> Scaling-up of community-based services in C-IMCI in 800 KM salama communes has contributed to the increase of the number of diarrhea cases managed. These results show again effectiveness of communication strategy for behavior change implemented by RTI/Santénet2 involving CHWs, FBO members, youth leaders, and local radio stations.
8	Number of pneumonia cases among children under 6 treated with antibiotics by CHWs	0	35,128	39 000	90,735	90,735	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> Scaling up of community-based services in C-IMCI in 800 KM salama communes has contributed to the increase of the number of ARI cases managed. These results show again effectiveness of communication strategy for behavior change implemented by RTI/Santénet2 involving CHWs, FBO members, youth leaders, and local radio stations.

N°	Indicator	Baseline	Achieved 2010	Objective 2011	Achieved FY11 (Oct 2010-Sep 2011)	Objective 2012	Comments and gap analysis
9	Number of children monitored or referred by CHWs for malnutrition	NA	222,688	975,000	1,245,657	1,245,657	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> These results show again effectiveness of communication strategy for behavior change implemented by RTI/Santénet2 involving CHWs, FBO members, youth leaders, and local radio stations. The result shows number of children whom CHW have visited but not the number of children as individuals. A child may benefit from CHW visits more than one time.
14	Number of children reached by nutrition programs	NA	240,000	450,000	1,020,000	1,020,000	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> These results show again effectiveness of communication strategy for behavior change implemented by RTI/Santénet2 involving CHWs, FBO members, youth leaders, and local radio stations.
15	Number of children under 5 years of age with fever who received treatment with ACT within 24 hours from onset of fever	0	56,516	58,098	69,069	71,000	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> Scaling up of community-based services in C-IMCI in 800 KM salama communes has contributed to the increase of the number of C-IMCI cases managed. These results show again effectiveness of communication strategy for behavior change implemented by RTI/Santénet2 involving CHWs, FBO members, youth leaders, and local radio stations. Fever cases managed by CHWs are 138,138 50% of RDTs used by CHWs when managing fever cases were positive for malaria.
17	Number of People reached by WASH programs	23,842	537,270	724,000	1,268,378	1,300,000	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> These results show again effectiveness of communication strategy for behavior change implemented by RTI/Santénet2 involving CHWs, FBO members, youth leaders, and local radio stations—calculated by summing up the total number of persons reached with WASH messages reported each month by CHW MARS.
18	Number of people in target areas with access to improved sanitation	0	7,733	24,000	77,455	77,455	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> Population becomes aware of the use of latrines thanks to the starting of CLTS activities. Reported data concern the use of improved latrines or not. Objective has been substantially exceeded when regarding FY 2011 achievements.

N°	Indicator	Baseline	Achieved 2010	Objective 2011	Achieved FY11 (Oct 2010-Sep 2011)	Objective 2012	Comments and gap analysis
19	Number of water resource development and management plans implemented	0	40	72	135	150	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> After the training of management entities on planning, communes were assisted by subcontractors in developing the actions plans in water and sanitation. All the development actors intervene at the commune are engaged in the implementation of planned activities. This result shows effectiveness of the collaboration between the community, different actors, and subcontractors.
21	Number of people trained on the promotion of STI/HIV/AIDS prevention through behaviors other than abstinence and/or faithfulness	0	7,188	7,500	15,454 CHWs: 11,216 ARH: 1,051 FBOs: 3,187	15,454	<b>OBJECTIVE SUBSTANTIALLY EXCEEDED</b> The number of CHWs trained exceeded the targeted objective per commune to ensure coverage of the 800 communes. FBO entities members have extended their activities to other new communes.
	<b>Men</b>				6,645		
	<b>Women</b>				8,809		
<b>INDICATORS ACHIEVED (10% over or under)</b>							
5	Number of children less than 12 months of age who received DPT3 (Referred by CHWs)	0	20,937	22,000	22,548	26,000	<b>ACHIEVEMENT AT 102%</b>
20	Number of people reached with community sensitization on the promotion of STI/HIV/AIDs prevention through behaviors other than abstinence and/or faithfulness	219,878	584 849	666,500	682,953 CHW: 262,000 FBOs: 394,381 MARPs: 21,000 Youth leaders: 5,572	682,953	<b>ACHIEVEMENT AT 102%</b> <b>OBJECTIVE ACHIEVED</b>

N°	Indicator	Baseline	Achieved 2010	Objective 2011	Achieved FY11 (Oct 2010-Sep 2011)	Objective 2012	Comments and gap analysis
22	Number of local organizations provided with technical assistance to build their capacity to implement health programs	0	37	37	39	39	<b>ACHIEVEMENT AT 105% OBJECTIVE ACHIEVED</b>
23	Number of communes with functional SDCs	0	791	800	800	800	<b>ACHIEVEMENT AT 100% OBJECTIVE ACHIEVED</b>
24	Number of functional (trained, equipped, & supervised) CHWs	NA	7,500	10,000	11,216	11,216	<b>ACHIEVEMENT AT 102% OBJECTIVE ACHIEVED</b>
25	Performance of the community Management Information System (c-HMIS)	NA	31%	70%	73%	>70%	<b>ACHIEVEMENT AT 104% OBJECTIVE ACHIEVED</b> The factor used to calculate reliability is not valid and does not serve the purpose. During Year 3, the project team conducted supervision visits and verified accuracy of data reported in CHW MARs and transmitted by implementing partners' field workers. The level of error in reporting of FP users was less than 5%. We are currently working on developing a new indicator to calculate reliability/accuracy of MARs to better reflect data scope and limitation for both Child Health and Mother Health CHWs. We will discuss the new proposed calculation methodology with the USAID M&E team. Completeness and timeliness are on target (i.e., equal or superior to 70%) except for two implementing partners. Without the data from the two partners that are lagging behind in C-HMIS reporting, completeness and timeliness are 65% and 82%, respectively. We are working closely with both partners to correct the situation. We set short-term benchmarks, and the project C-HMIS manager is providing on-site and regular technical assistance to resolve technical challenges, such as synchronizing off-line and online databases.
26	Number of communes in the project's intervention zone	NA	744	800	800	800	<b>ACHIEVEMENT AT 100% OBJECTIVE ACHIEVED</b>

N°	Indicator	Baseline	Achieved 2010	Objective 2011	Achieved FY11 (Oct 2010-Sep 2011)	Objective 2012	Comments and gap analysis
	having an SDC that has identified, planned, and implemented actions to improve quality in a participatory way						
27	Number of service providers implementing quality improvement approaches	NA	3,077	10,000	10,208	10,208	<b>ACHIEVEMENT AT 102% OBJECTIVE ACHIEVED</b>
<b>INDICATORS UNDER-ACHIEVED</b>							
4	Number of people trained in family planning/reproductive health (RH/FP)	0	8,084	8,084	3,120	202	<b>ACHIEVEMENT AT 39%</b> The FY 2011 target was set based on the cumulative number of community actors trained during life of project. Upon discussion with USAID/Madagascar, RTI/Santénet2 reports only on training that occurred during the reporting period. The variance is explained by the misunderstanding while setting the FY 2011 target.
	<b>Men</b>				1,342	87	
	<b>Women</b>				1,778	115	
7	Number of antenatal visits performed by CHWs (cases referred by CHWs)	NA	56,003	60,000	17,327	18,500	<b>ACHIEVEMENT AT 29%</b> Problem reporting references by CHWs (registration in the records, use of reference cards)
10	Number of people covered by health financing arrangements	225,000	52,340	400,000	0	300,000	<b>NOT ACHIEVED</b> RTI/Santénet2 developed a new strategy to implement health <i>mutuelles</i> . This strategy consists in creating health <i>mutuelles</i> at the district level. At the end of FY 2011, the health <i>mutuelles</i> ' implementation stage is not yet complete enough to report the total enrollment rate. Health <i>mutuelles</i> will start enrollment and service provision in Year 4.
12	Number of people trained in child health and nutrition	NA	5,434	5,434	2,124	212	<b>ACHIEVEMENT AT 39%</b> The FY 2011 target was set based on the cumulative number of community actors trained during life of project. Upon discussion with USAID/Madagascar, RTI/Santénet2 reports only on training that occurred during the reporting period. The variance is explained by the misunderstanding while setting the FY 2011 target.

N°	Indicator	Baseline	Achieved 2010	Objective 2011	Achieved FY11 (Oct 2010-Sep 2011)	Objective 2012	Comments and gap analysis
	<b>Men</b>				913	91	
	<b>Women</b>				1,211	121	
<b>13</b>	Number of people trained in maternal and newborn health	0	4,469	4,800	3,370	4,000	<b>ACHIEVEMENT AT 39%</b> The FY 2011 target was set based on the cumulative number of community actors trained during life of project. Upon discussion with USAID/Madagascar, RTI/Santénet2 reports only on training that occurred during the reporting period. The variance is explained by the misunderstanding while setting the FY 2011 target.
	<b>Men</b>				1,449	1,720	
	<b>Women</b>				1,921	2,280	
<b>16</b>	Number of people trained in malaria treatment or prevention	NA	9,895	10,610	4,144	414	<b>ACHIEVEMENT AT 39%</b> The FY 2011 target was set based on the cumulative number of community actors trained during life of project. Upon discussion with USAID/Madagascar, RTI/Santénet2 reports only on training that occurred during the reporting period. The variance is explained by the misunderstanding while setting the FY 2011 target.
	<b>Men</b>				1,782	178	
	<b>Women</b>				2,362 (6,393 [LOP])	236	
<b>INDICATORS NOT REPORTED FOR THIS PERIOD</b>							
<b>3</b>	Number of service providers reporting stock-outs of Depoprovera	NA	400	1,000	Non applicable Data not available	500	RTI/Santénet2 suggests not reporting on this indicator's results anymore to USAID. USAID conducted a CHW assessment in terms of services availability and quality. To avoid doing the same study, RTI/Santénet2 did not organize the study on CHW functionality that includes stock-out analysis. RTI/Santénet2 suggests not to report on this indicator's results anymore to USAID. CHW supply chain is as follows: PSI sets up and resupplies supply points, and CHWs buy products that they need directly from the supply points. The availability of products at the CHW level depends on the existence of the products at the level of supply points. They are equipped with products by PSI. This remains an external factor that RTI/Santénet2 has no control

N°	Indicator	Baseline	Achieved 2010	Objective 2011	Achieved FY11 (Oct 2010-Sep 2011)	Objective 2012	Comments and gap analysis
							over.
II	Number of newborns receiving essential newborn care	0	160,984	164,000	0	0	<p>RTI/Santénet2 trains CHWs on care-giving behaviors for newborns, such as baby assessment, warmth, early exclusive breastfeeding within one hour, recognition of newborn danger signs, and immediate referral.</p> <p>Their activities consist of awareness-raising on these issues, recognizing newborn danger signs, and referring newborns at risk to CSBs.</p>

# Annex C: Environmental Mitigation and Monitoring Report - FY 2011

Activity	Mitigation Measures	Monitoring Indicators	Monitoring and Reporting Frequency	Party(ies) Responsible	Results October 2010–September 2011
<b>Management and disposal of hazardous medical waste related to immunization, vaccines, and administering of DMPA (syringes/sharps, gloves, drug vials, bottles, gauzes, sachets) and RDT (sharps, gloves, sachets)</b>	Management of medical waste will be implemented based on the Madagascar National Medical Waste Management Policy and USAID's Environmental Guidelines for Small-Scale Activities in Africa, Chapters 8 and 15.	During Year 3 of USAID/Santénet2, 2,500 Level 2 Mother CHWs and 1,000 Level 2 Child CHWs will be trained respectively in community-based DMPA and C-IMCI.	The monthly review and supervision reports will provide the information for assessing the effectiveness of mitigation measures.	USAID/Santénet2 and its implementing partners	-1,434 Level 2 Maternal Health CHWs trained on community-based service delivery of DMPA. -1,518 Level 2 Child Health CHWs were trained on community-based IMCI focusing on the use of RDTs and waste management
	CHWs will be trained and equipped to ensure proper management of waste and safety of injections. The training will cover risk evaluation, safety of injections, and medical waste management and will raise awareness among CHWs. Each CHW will receive two sharp boxes at the end of the training as well as clear instructions		The Project's semester and annual reports will address the issue of mitigation measures set up.  The implementing partners organize monthly reviews in each commune to monitor the practices and achievements of community actors. The community agents trained		A total of 3,589 safety boxes have been distributed for the 2,952 AC Level 2 trained this year. The objective to ensure availability of sharp boxes to trained Level 2 CHWs was not achieved.  The allocation in sharp boxes for CHWs during training is PSI's responsibility. During the reporting period, PSI has experienced a stock-out at the national level. During the design of community health program, RTI/Santénet2

Activity	Mitigation Measures	Monitoring Indicators	Monitoring and Reporting Frequency	Party(ies) Responsible	Results October 2010–September 2011
	on the disposal and resupply of sharp boxes.		by the Project benefit from regular supervision (for instance, to assess their practices against standards and practices promoted during the training).		decided to provide two (2) sharp boxes per CHW after they completed the training, while the requirement is one (1) sharp box per CHW. All CHW trained prior to 2011 receive 2 sharp box after completion of training. In 2011, PSI that provides start up kits related to health products (including sharp box) did not have enough quantity sharp box to supply two (2) per CHW. However, each CHW received at least one sharp box. CHWs were given instructions to resupply sharp boxes from CSBs or supply points at the commune level.
	CHWs will follow the procedures included in the “Reference Manual for Immunization Program Managers on the Injection Safety Issues and Waste Disposal,” especially regarding the use of sharp boxes.	1,600 supervision visits will be conducted in the communes to assess CHWs’ compliance with environmental standards in the disposal of equipment and materials related to community-based provision of DMPA (syringes, needles, gloves, drug vials, bottles, gauze, plastic pockets). In addition, it will be checked whether CSBs comply with procedures for the disposal of waste, especially sharp boxes.			During this year, 2,554 supervisions were conducted to supervise 10,208 CHWs including 1,900 CHWs trained in community-based DPMA and 2,098 in IMCI on how to get rid of DMPA and IMCI tools (syringes, drug vials, needles, gloves, gauze, bottles, sachets), In June 2011, RTI/Santénet2 organized a third round of refresher orientation for KM salama implementing partners’ field workers. The training included a waste management compliance plan, during which field workers were reminded of their role to assist CHWs to bring all their

Activity	Mitigation Measures	Monitoring Indicators	Monitoring and Reporting Frequency	Party(ies) Responsible	Results October 2010– September 2011
					<p>medical waste, along with their 2/3-filled safety boxes and used syringes, to CSBs to be incinerated. It is a way for the project to monitor the medical waste management and to ensure their resupply.</p> <p>SDC members were trained on medical waste management and were engaged to remind CHWs and CSBs to follow the norms and standards of the policy. In the case of absence of incinerators at the CSB level, RTI/Santénet2 communicated (through field workers) to Social Development Committee (SDC) to help CSB comply with the national Medical Waste Management policy on this topic, which states:</p> <p>Each CSB should (without incinerator):</p> <ul style="list-style-type: none"> <li>-Dig a hole 1.5 m–2 m deep, 1.5 m wide, and 1.5 m long.</li> <li>-Put all used safety boxes in this hole and burn them with petrol.</li> <li>-When the fire is finished, cover the hole with dirt and protect it with a closing.</li> </ul>

# Annex D: Success Stories

## Child health: A community changed by the work of one community health worker

Ambohidava is a village located one walking hour from the main town of the rural commune of Ambatolampy Tsimahafotsy. It has 470 households and 109 children less than five years old.

Like most of people living in remote rural areas with poor access to health services, the population of Ambohidava did not give much attention to their health. RTI/Santénet2 selected Ambatolampy commune to be among the 800 communes where it implements the Kaominina Mendrika salama (KM salama—champion health commune) approach. Under this approach, the project works through more than 11,000 community health workers in villages located at more than 5 kilometers from the nearest health facility to provide community-based sensitization, prevention, and promotional services in the area of maternal and child health.



© RTI/Santénet2/AIM. Population of Ambohidava village is very confident with Honorine community base health services

Honorine Ravaozanany, a mother of seven living in Ambohidava, is one of the community health workers trained by RTI/Santénet2. She is in charge of child health and manages uncomplicated cases of illness among children under five. Her performance is excellent. As a result of her work, all the children in the village received immunizations within a year, and 376 children under five have been weighed as part of growth monitoring. In June and July 2011, Honorine referred 26 children to the basic health center and managed 29 cases of acute respiratory infections, 3 cases of diarrhea, and 30 uncomplicated cases of malaria. Her awareness-raising activities have reached approximately 700 people (most of the people in her village).

As these results show, Honorine is highly motivated. The people in the village describe her as a very dynamic and resourceful person, recounting how creative she was in setting up her own consultation hut. Every day, from 2 to 5 p.m., she serves her community. She sees about 15 children per month for care and 70 for growth monitoring.

Ambohidava has had a new start thanks to the work and enthusiasm of Honorine. Mothers are now taking good care of their children's health. In most of the communes where the KM salama approach is implemented, behavioral change occurs as a result of the strong commitment and concrete actions of community workers such as Honorine Ravaozanany.

## Maternal Health: Fewer pregnancy accidents occur in the rural communes of Mahajanga II

The rural commune of Belobaka, located in the north west of Madagascar, has made large strides in taking care of pregnant women. Despite the remoteness of the commune, with no health services in close proximity, the community of Belobaka has become aware of the importance of health care, especially maternal and child health care.

This community engagement is the concrete result of the Kaominina Mendrika salama (KM salama, champion health commune) approach implemented by RTI/Santénet2 in the district of Mahajanga II. Early detection of danger signs among pregnant women is one of the activities introduced under the KM salama approach.

Community health workers and social development committee members play an important advocacy role during all awareness-raising activities conducted at the community level. They encourage communities to set up local



© RTI/Santénet2/Zetra. Bull carts are very common in remote communes of Mahajanga II to transport pregnant women to seek delivery delivery at health facilities

transportation systems and solidarity funds at the community level or the family level. These funds serve to reduce and avoid delays in transporting pregnant women to health centers.

The majority of deaths during pregnancy or childbirth are caused by an absence or delay in health care for pregnant women. To address this issue, many communities in Mahajanga II have set up transportation systems to take care of any emergency or complicated case related to pregnancy.

These new systems, allocated for pregnant women, were set up in 65 *fokontany* (villages) in the 28 rural communes of Mahajanga II. Of these *fokontany*, 54 have established a solidarity fund to support all the costs related to delivery emergencies.

Hornestine, a young mother in the *fokontany* of Amparemahitsy, located 7 kilometers from the commune of Belobaka, was referred to a basic health facility by Marie Odette, a community health worker in charge of maternal health, trained by RTI/Santénet2.

For her delivery, Hornestine took the bus allocated by the community to the health center without paying any charge. When she arrived, the doctors observed complications with Hornestine's pregnancy. She was referred immediately to a well-equipped hospital in Mahajanga. The commune authorities paid all the transportation fees to evacuate Hornestine on time. It took her 15 minutes to arrive at the Androva hospital in Mahajanga city, where she delivered her baby without any problems.

Another baby, delivered by Natoly, a young mother in the Bealoy *fokontany* (located an hour's walk from the commune), was also saved by this system. She was saved in time, thanks to the community health worker and the community's engagement.

On her due date, Natoly was taken in a bull cart to the health center. She presented complications upon arrival and needed a sanitary evacuation to a more sophisticated health center. The commune authorities agreed to pay all the transportation costs to Androva hospital, where she delivered her baby safely.

During their pregnancies, Hornestine and Natoly were monitored by the community health workers from their respective *fokontany*. Thanks to their help, these women benefited from a package of services offered at the community level and were referred to the health center for all antenatal care.

Community practices in the district of Mahajanga remain a good example, illustrating how community engagement can save lives. This best practice should be scaled up in all the remaining rural KM salama communes.

## **Malaria: community-based malaria services supported by strong supply chain and quality services prevent fatalities among population living in remote villages.**

The commune of Mahatalaky in the district of Taolagnaro is a very remote commune with 16 villages. Eight of them are located more than 5 kilometers from the nearest health facility. The commune is the most populated in the region of Anosy, with about 26,000 inhabitants. Since April 2010, nine project-trained Child Health community health workers are providing community integrated management of childhood illness services

Malaria transmission occurs all year long in this area, with a peak in the rainy season (December–March) and post-rainy season (April–June). There were two outbreaks of malaria in the commune, from April to July 2010 and from December 2010 to April 2011. During the malaria outbreak in January–March 2010, 27 fatalities among children under five were recorded in the district of Taolagnaro. Since April 2010, project-trained community health workers reported managing 1,224 fever incidents, 338 diarrhea cases, and 473 acute respiratory infection cases among children under five in the commune of



© RTI/Santénet2/Andry N. Soja Fulgence ensures availability of products in commune of Mahatalaky

Mahatalaky. Since community health workers have become operational, no fatalities were observed in the commune. Statistics at the Mahatalaky basic health center indicate that the number of malaria cases has sharply decreased: during the second quarter of 2010, 415 cases were recorded, versus 332 cases during the fourth quarter and only 189 during first quarter of 2011.

In January 2010, the RTI/Santénet2 project introduced the Kaominina Mendrika salama (champion health commune—a community health system model based on community case management) approach in the commune to facilitate the population's access to health services. Nine community health workers were selected by the community to receive project training to conduct promotion and prevention activities as well as to provide treatment of childhood illnesses at the community level. They were given start-up kits of health commodities to enable them to provide health care. In collaboration with Population Services International (PSI), a supply point for healthcare products was established in the commune for the community health workers to replenish drugs and products. To date, 722 supply points are now functional out of the 800 KM salama communes, assisting community health workers with their product needs.

However, this community supply chain faced challenges in the first two years, with widespread stock outs of rapid diagnostic tests (RDTs, used to confirm the presence of malaria in fever cases) and artemisinin-based combination therapy (ACTs, an anti-malarial treatment for children). This was mainly due to an insufficient quantity of products kept in stock at the social marketing program and hence limited use of community-based malaria management services.

Soja Fulgence was selected by the community of Mahatalaky to manage the supply point. To avoid stock-outs of malaria treatment commodities during outbreaks, he ordered a large amount of ACTs and RDTs during the first period of malaria outbreaks.

At the beginning of the second outbreak period in November 2011, he placed another order with PSI and monitored it through phone calls to ensure the commodities would reach him in time.

Thanks to his forecasting abilities and his effort to monitor the order placed with PSI, the supply point in Mahatalaky commune has not experienced an anti-malaria product stock-out. The sick children in all the villages of Mahatalaky received care in a timely manner, and not a single malaria death was recorded in the remote communities during the outbreaks. Children in the commune of Mahatalaky are safe from malaria death because of the availability of healthcare products through the supply point mechanism as well as the community's commitment to fight malaria. The two annual periods of outbreaks had no severe effects on the population because they were protected by the integrated services offered by community health workers (in rural communities) and basic health facilities.

Thanks to Soja Fulgence's creativity and personal motivation, community health workers have continuous access to a supply of anti-malaria products that enables them to manage all fever cases and prevent fatalities

## **Reproductive Health/Family Planning: A community health workers breaks a taboo to enhance community health status**

Antaratasy is a very remote village in the rural commune of Mahavelona Foulpointe, one of the communes where RTI/Santénet2 implemented the Kaominina Mendrika salama (KM salama—champion health commune) approach, an approach that encourages communities to strengthen their health status and stimulate their health demands.

Antaratasy is a very conservative village with 1,002 inhabitants. The local population does not work on Tuesdays and Thursdays because of an ancestral belief that considers these days as taboo. People are advised not to work in the fields during these days but rather to stay home, doing nothing. Because of their remote location, health improvement remains a challenge for the local population because they have to walk two hours to reach the nearest basic health center. Those who want to take public transportation have to pay MGA 2,000 (US\$1).

Because of these difficulties, health was often neglected in Antaratasy. Pregnant women did not go to health centers for follow-up, and self medication was a very common practice in households because of a lack of community-based health care. Furthermore, family planning has never been a common practice in this village because of the lack of available services, information, and awareness-raising.

Lalao Fleurette Razafindrasoa is one person who dared break the ancestral taboo. She works during the taboo days. Lalao Fleurette is a community health worker trained by CARE, an implementing nongovernmental organization with the RTI/Santénet2 project. In May 2009, she received training on promotional and awareness-raising activities as well as service offerings related to family planning. In January 2010, she received additional information on community-based injectable contraceptives.

She now provides community-based services to the five small hamlets of Antaratasy, which are very distant from one another. She is targeting 234 women of reproductive age in these villages.

This community health worker engagement has changed the whole Antaratasy health environment. The population is now more and more confident in her community services. After six months of activities, she recruited 52 clients who use injectable contraceptives and 60 clients who use oral contraceptives—3 new clients per month. She was able to visit 31% of all women of reproductive age in Antaratasy and reached about 200 persons through her awareness-raising activities.

“I think that [the] population should always have in mind that health is important to ensure success. At the beginning of my activities, people reproached me [for] working on Tuesdays and Thursdays. But as time goes by, they have changed and understood my decision. Now,



© RTI/Santénet2: Lalao Fleurette (right) was among community health workers that have been audited during RH/FP auditors visit in Toamasina

they are always looking forward to my visit to receive more information and advice on maternal and child health,” says Lalao.

To improve her services, Lalao Fleurette always participates in reviews organized at the Mahavelona commune. Reviews constitute an opportunity to share experiences for all community actors engaged in the KM salama approach, including chiefs of village, religious leaders, educators, and elders. Lalao Fleurette shares her monthly performance with these community actors.

Community health workers trained by RTI/Santénet2 receive monthly supervision of their activities. During one of these supervision sessions, Lalao Fleurette confided to her supervisor that she has never lost a single client. This is confirmed by her monthly activity report, where she records all her clients and their appointments. Her performance is not random; she conducts home visits in the hamlets of Antaratasy to see all the clients that could not keep their appointments.

It is through the dedication and hard work of community health workers like Lalao that RTI/Santénet2 enables people all across Madagascar to improve their health and living conditions.

## Adolescent Reproductive health: A new beginning for town of Andapa, thanks to youth leaders

Andapa, a town located in the north east of Madagascar, used to be one of the country's sexually transmitted infection (STI)/HIV "hot spots." In 2004, one of the rural communes in this zone had a reported HIV infection rate of 8% (at a time when the national average was less than 1%). To curb infection propagation, RTI/Santénet2 and its subgrantee, the nongovernmental organization *Action Socio-sanitaire Organisation Secours* (ASOS), decided to work in Andapa among young people aged 15 to 24, a group among the most vulnerable to STI/HIV/AIDS.

More than 150 young people in 12 target communes were trained to sensitize their peers on reproductive health, including STI/HIV/AIDS control. In each village, a youth leader is selected. In addition to pre-service training, the peer educators benefit from regular refresher training and support.

In Andapa, 10 youth leaders were trained to work with 5,400 young people in nine villages. As a result of their work, approximately 800 young people went for HIV screening, and young people's knowledge of the HIV infection has much improved.

Andapa offers a good example of what the pilot program targeting young people can achieve in terms of social mobilization. The youth leaders have garnered the support of a large array of community actors, such as religious leaders, principals of private and public schools, health workers, and heads of villages.



© RTI/Santénet2/Asos sud:  
Julien, a very engaged youth leader

Julien Ratovoniaina is the youth leader in the village of Ankevaheva where he is well-known. Since he started his activities, he has sensitized 450 young people through home visits and an additional 550 young people through group talks, reaching about 12 young people per talk. His sensitization also accounts for 128 young people going for HIV screening. Dr. Ydriss, the program manager in Andapa, sees in Julien the best youth leader they have in the area. "He is still in school, but he knows how to find time for his studies and his sensitization work," he notes. "He has been very effective in sensitization, persuading his peers to get screened, but also working with sex workers."

Julien expresses strong commitment to his actions and explains how he achieved the results: "I gather people about my age for sports or other social activities. This makes it easier to talk to them. When I have some free time, mostly after school in the afternoon, I go for home visits. On weekends, I meet with youth associations and lead discussions."

As a result of positive actions taken by youth leaders like Julien, no HIV-positive cases were declared in Andapa during project implementation. Empowering the people of Madagascar to help each other and themselves is at the heart of the RTI/Santénet2 project.



© RTI/Santénet2/Asos Sud. Youth leaders in Andapa ready for work

## **HIV/AIDS: Attending to the needs of sex workers in Toliara: the association FIHAMY**

Toliara, a city in the south of Madagascar, is known as a tourist resort. Sex trade is flourishing in this city where about 2,000 sex workers sell their services. Sex work is much frowned upon in the Malagasy society, including among health workers, and this stigma keeps many of the sex workers away from the health system where they could get care and information. One consequence of this situation is that sex workers do not often use condoms.

To address this problem, the RTI/Santénet2 project has been supporting 15 most-at-risk population (MARP) associations through small grants, building their capacities to carry out sexually transmitted infection (STI)/HIV/AIDS control actions. The sex workers association FIHAMY is one of the groups that received a small grant from RTI/Santénet2. Working through 20 peer educators trained on a range of topics, including basic human rights, the association has achieved much for STI/HIV prevention in eight months of activity: it reached 2,279 people, sent 1,310 people to health facilities for a adequate care, and distributed more than 10,000 condoms.

Harline Kemba, a woman who has been in the sex trade for a long time, is one of the many people reached by FIHAMY's educators.

Through their work, she came to realize that she is as entitled to health care as any other person, and she now knows that she can purchase drugs at a lower price from a partner clinic. "Joining the association has had benefits for me," she states. "It brings me a feeling of security to know that I can get care and advice any time I need."

Like many other sex workers, Harline is no longer afraid or ashamed to go health facilities for STI/HIV screening. She has also made it a rule to use condoms with her clients.

Syphilis prevalence is estimated at 12.1% among sex workers in Madagascar and HIV prevalence at 0.52% (2008) versus a rate of less than 1% among the general population. In urban areas, only 15% of the women who had more than two sexual partners used a condom in their last sexual intercourse. Improving these statistics is the main goal for the STI/HIV/AIDS component of the RTI/Santénet2 project.



© RTI/Santénet2/ Nono A. Sex workers in Toliary convinced with Fihamy association awareness raising activities

## **Water, Sanitation, and Hygiene: The commune of Anteza: a champion of hygiene promotion**

Hygiene has now become the rule in the rural commune of Anteza in South-East Madagascar. Anteza's 13 villages now have 300 new latrines as a result of awareness among the population and the mayor's strong commitment to make his commune a model of hygiene.

Anteza is a remote rural commune with more than 4,600 inhabitants. When the RTI/Santénet2 project first arrived, the situation in terms of hygiene was rather alarming: there were less than 100 latrines for all the inhabitants, and diarrhea was very common among children under five.

The project conducted an approach in Anteza that it implements in all of its 800 intervention communes to promote behavioral change in the field of sanitation among communities, with a special emphasis on eradicating open-air defecation. Community leaders were trained to sensitize the communities on the benefits of implementing the approach and to support them in implementation and monitoring. Santénet2-trained community health workers supported the leaders in this effort by reinforcing sanitation messages.

As a result, most households have their own washable latrines now. The floor is made of a flat slab, built in collaboration with the nongovernmental organization (NGO) Interaide, and is fitted with a locally produced bamboo ventilation system.



© RTI/Santénet2: A typical latrine of Anteza made with bamboo ventilation

According to Dr. Naina Andriamahefa, a zone supervisor for the NGO *Action Socio-sanitaire Organisation Secours (ASOS)*, about two out of three existing latrines were built as a result of the sensitization conducted by RTI/Santénet2. "Anteza sees the fruits of its efforts now. It stands as the commune with the biggest number of latrines compared to the number of inhabitants out of the 45 rural communes of Manakara," the mayor states proudly. "This shows strong commitment by the community. We are planning to build 300 additional latrines next year."

The eradication of open-air defecation is not the only health activity promoted by the 20 community health workers in the commune. As volunteers trained to provide maternal and child health services at the local level, they visit villages and sensitize the population on hand washing before preparing food or after using latrines.

Over the last two years, the number of diarrhea cases in the commune has decreased sharply. According to the district health services, there were 180 cases of diarrhea in 2009 (when RTI/Santénet2 started working in the commune), 167 cases in 2010, and only 106 cases from January to August 2011.

## The PLeROC Program: Religious leaders' commitment to improve health

Those who know Ambatomirahavavy would sense as soon as they arrive that something has changed in this rural commune not very far from the capital city Antananarivo. This change has much to do with health. More children are immunized, latrines are being built, and pregnant women are seeking the care they need.

Despite being near the capital, the population in Ambatomirahavavy does not utilize its basic health facility very often, in part because they feel it is located too far from their villages. To address this problem, the RTI/Santénet2 project mobilized religious leaders to sensitize the community on health and promote appropriate care-seeking and

hygiene behaviors. This action in Ambatomirahavavy is part of a larger approach in which the project collaborates with nine faith-based associations, grouped in the Platform of Religious Leaders and Faith Organizations (PLeROC, *Plateforme des Leaders Religieux et Organisations Confessionnelles*), and their 1,100 religious leaders in some 2,900 worship places located in 584 communes across the country.

In the village of Imerikasindra in Ambatomirahavavy, Pastor Samuel Rajaonarivony is personally committed to helping the 700 inhabitants improve their health and is proud of what they have achieved together. The inhabitants have turned the messages they heard from their pastor on Sundays into actions: more than 50 latrines were built, 120 children were immunized at the health facility, approximately two pregnant women per month see the midwives for monitoring, and houses and their yards have become clean and tidy.



© All the kids in Imerikasindra with Pastor Samuel

now,” says a mother of three. “Our pastor had to bring me there to reassure me at the beginning. He is always there to deal with our daily concerns.”



© FJKM. Pastor Samuel (on the right) is very engaged to improve community of Imerikasindra environment

Pastor Samuel Rajaonarivony's commitment extends to accompanying children to the basic health center for immunization. “In many cases, children are afraid of doctors, and parents feel reluctant about bringing them to the health center,” he explains. “This is why I decided to go with them.”

The population in Imerikasindra is happy about how things changed in their village. “I have made it a habit to go to the health center,

# Annex E: Communication Strategy

For this reporting period, implementation of the communication strategy was continued, with a special focus on strengthening the project's visibility. The project communication strategy provided assistance to the project technical team in developing documents to facilitate information sharing on new strategies adopted for the sustainability of KM salama activities. This development includes production of a KM salama booklet in March 2011 and the production of diverse layouts on project programmatic activities.

The following summarizes all the achievements of the project communication strategy, including internal and external communication:

- **Internal communication:**

- Twenty nine (29) agendas were prepared for senior staff to use as trackers.
- 47 staff meeting minutes were prepared and available. The project organized staff meetings every week to share information and project activities.

- **External communication:**

- The Project produced three editions of the quarterly *Ezaka Mendrika Bulletin (Annex L)* in Malagasy and English to share the progress status of activities with community actors (CHWs and SDCs) and USAID on different programmatic topics: WASH, IEC/BCC, and a new strategy for the bulletin's distribution and sustainability was instituted.

These *Ezaka Bulletins* document best practices and share updates of KM salama activities per component for all community actors. A new strategy for the bulletin distribution was adopted during this reporting period to reach more of the targeted population in KM salama communes. Project-produced *Ezaka Bulletins* are distributed from now on in commune centers and CSBs.

- The project documented six success stories that were included in FY 2010 semi-annual and annual reports submitted to USAID.
- During the last twelve months, 27 stories illustrating community commitment were documented on the following topics:



© RTI/Santéné2 : Copy of booklet distributed to implementing NGO



© RTI/Santéné2: SDC members in commune of Mangabe reading *Ezaka Mendrika Bulletin*

- 4 cases illustrating community commitment to improve WASH infrastructures
  - 4 cases illustrating community commitment to enhance the community supply chain system
  - 4 actions illustrating community engagement through building community health sites
  - 4 community actions as examples of social accountability
  - 4 cases illustrating community engagement to ensure C-ONE
  - 2 cases illustrating community youth leaders' role in adolescent reproductive health
  - 6 cases illustrating improvement of mother and child health
- RTI/Santénét2 participated in a regional FP conference in July 2011. Communication support consisted of video production to share project achievements in community-based services in the KM salama communes. The two videos produced, which were broadcast during the conference, are available at: <http://c3334926.r26.cf0.rackcdn.com/FPv2.wmv> and <http://c3334926.r26.cf0.rackcdn.com/Voicesv2wmv.wmv>.
  - Nine meeting minutes were prepared during bi-weekly meetings with USAID. These meetings enabled the project team to discuss specific subjects in depth with USAID about KM salama activities advancement in the field.
  - The project shared 12 monthly bulletins with USAID during the last semester. These bulletins give an overview of the activities planned by the different components and programs each month and are submitted to USAID on the third week of each next month.
  - The project shares information about project progress (through e-mails, newsletters, information notes, and joint meetings) with all members of the consortium when the opportunity arises.
  - Three USAID field trips were organized to the KM salama communes in Toamasina, Vatomaniry, and Mahajanga to share the results of implementation activities. Additionally, the project organized two joint field trips with PSI to enable FP auditors to go into the field. Two additional joint trips were organized at USAID's request in the Sava region in beginning of April and June. These trips enable USAID to have an idea of partners' coordination in implementing activities in the field. Three trip reports on these trips were prepared, filed, and shared with USAID.

# Annex F: Social Quality Index (Internal Document)

## RESULTATS D'APPLICATION DE L'OUTIL INDEX QUALITE DANS LES KMsalama

Quatre applications de l'outil « Index qualité » ont été effectuées jusqu'à maintenant. Ce document présente le niveau de qualité des services de santé à base communautaire, après contrôle de la validité des résultats.

### 1. Contrôle de la validité :

#### 1.1 Dans un premier temps, il a été vérifié si la notation est correcte par revue documentaire et source d'information auprès des responsables.

- ✓ Est-ce que les KMs, qui ne sont pas des sites PLEROC et qui ne sont pas couverts par la radio, ont reçu une note positive ? (normalement, ces KMs reçoivent la note zéro)

Résultats : 28 KMs vérifiées : Erreur = 14% / Juste = 86%

Commentaire : soit erreur de notation, soit note positive par existence d'émissions radiophoniques non prises en charge par le projet.

- ✓ Est-ce que les KMs non CLTS ont reçu une note positive ? (normalement, ces KMs reçoivent la note zéro)

Résultats : 303 KMs vérifiées : Erreur = 47% / Juste = 53%

Commentaire : Les KMs qui ont planifié des activités d'assainissement dans leur plan d'action ont reçu la note positive.

- ✓ Sur les KMs CLTS, est-ce que la note a été positive ? (normalement, ces KMs reçoivent la note 1)

Résultats : 157 KMs vérifiées – Erreur = 3% / Juste = 97%

- ✓ Conclusion : Résultats acceptables après rectification des notes et des critères d'exclusion.

#### 1.2 Dans un deuxième temps, il a été vérifié que la notation a été effectuée à partir des sources d'information objectivement vérifiables.

- ✓ Est-ce que les notes ont été systématiquement basées sur revue documentaire ? Est-ce que l'application déléguée à un tiers a été contrôlée par Santenet2 ?

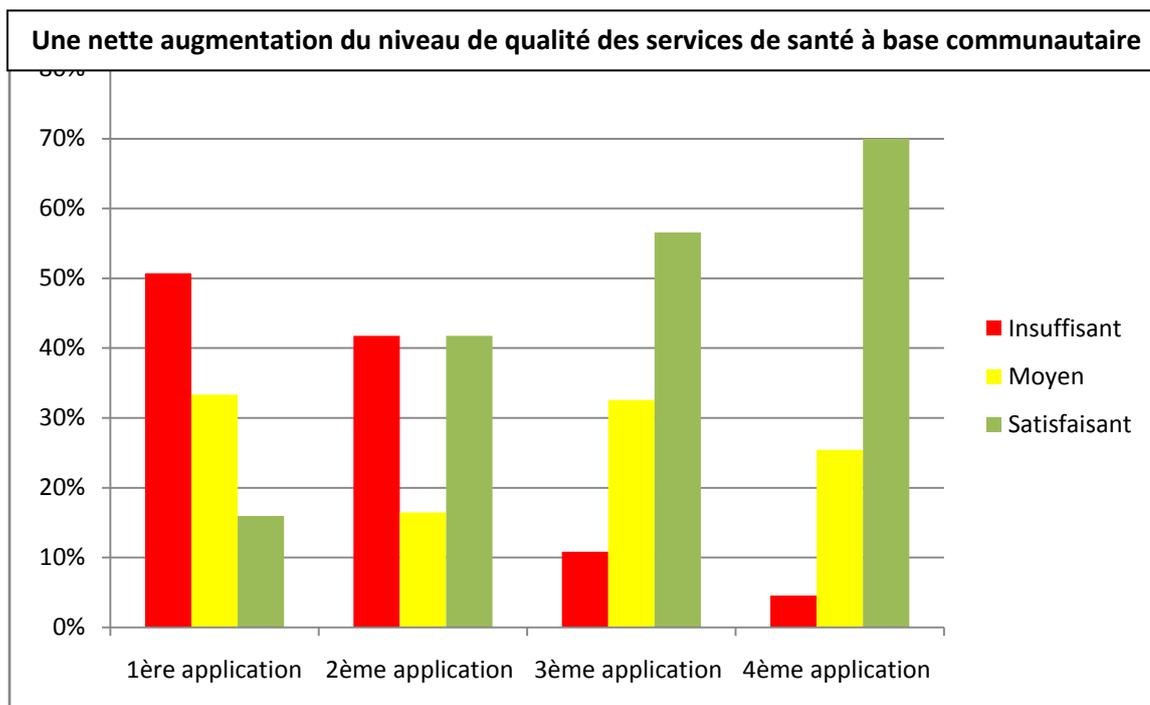
Résultats : 4 questionnaires auto-administrés remplis par les équipes régionales – 4 entretiens par téléphone – 2 entretiens directs – 2 KMs tirées au hasard au niveau de trois régions dans la 1ere, dans la 2eme, dans la 3eme et dans la 4eme application pour confrontation aux données de supervision (soit 24 KMs).

- ✓ Conclusion : Résultats acceptables selon le tableau ci - dessous

Application	Première	Deuxième	Troisième	Quatrième
<b>Nombre de KMs dont les résultats sont disponibles</b>	277	672	698	280
<b>Nombre de KMs dont les résultats sont fiables</b>	86	188	255	255

## 2. Evolution de la qualité des services de santé à base communautaire :

A partir des KMs dont les résultats disponibles ont été fiables, la graphique suivante montre l'évolution de la qualité des services de santé offerts par les AC dans les KMs.



Le niveau de qualité des services de santé à base communautaire se trouve :

- « insuffisant » quand le score de performance est inférieur ou égal à 50%.
- « moyen » quand le score de performance est compris entre 50% à 70%.
- « satisfaisant » quand le score de performance est supérieur ou égal à 70%.

La première application montre un niveau de qualité satisfaisant à 16%. La proportion est de 42% lors de la deuxième application, et 57% lors de la troisième application. Actuellement, le taux de satisfaction se situe à 70%.

L'amélioration de la qualité s'explique par l'engagement progressif de la communauté à s'organiser dans les services de santé et à l'utilisation des services offerts par les AC.

# Annex G: List and Amounts of Tools sent to NGOs

Category	Tool	Amount sent to NGOs
SDC	SDC training guide	32
SDC	SDC fact sheet	119
CLTS	FTTF brochure	236
CLTS	Support technician's FTTF monitoring	85
CLTS	FTTF monitoring	19062
CLTS	Facilitation of cleaning	48
CLTS	Results of the initiation of CLTS	597
DEPOCOM	DEPOCOM trainers' booklet (mother)	66
DEPOCOM	Community-level supervisor's guide	25
DEPOCOM	CHWs' document	2 436
DEPOCOM	Drugs to be injected for FP	2 397
DEPOCOM	Diary	98
DEPOCOM	FP individual form	3 290
DEPOCOM	MANOME	4 173
DEPOCOM	DEPOCOM checklist	2 406
DEPOCOM	Data collection form for CHWs	2 329
DEPOCOM	Calendar	2 289
DEPOCOM	Training assessment format	4 429
DEPOCOM	Practical training validation form	2 319
DEPOCOM	DEPOCOM Job aid	2 066
DEPOCOM	Pre/post-test form	4 521
WASH	Invitation card	2 372
Equipment	Syringe	114
Equipment	Alcohol	2 331
Equipment	Cotton swabs	3 134
Equipment	Towel (big size)	488
Equipment	Nail brush	3 642
Equipment	Back pack	17
Equipment	Apron	822
Equipment	Raincoat	18
Equipment	Winnowing basket with FP methods	605

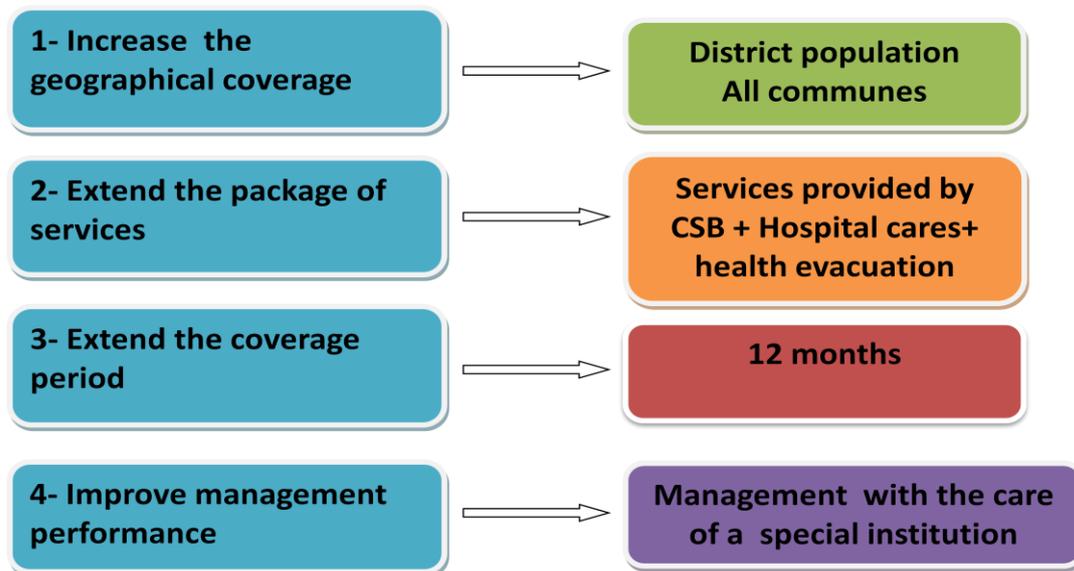
Category	Tool	Amount sent to NGOs
Equipment	Navy blue cap	2 090
Equipment	Honeycomb weave towel	363
Equipment	Soap	4 459
Equipment	Basin	2 113
Equipment	Beaker 250ml	1 978
Equipment	Beaker 1l	2 070
Equipment	Teaspoon	1 674
Equipment	Spoon	1 883
Equipment	Pail 12 l	2 167
Equipment	Upper arm measuring tape	3 454
Equipment	Baby scale	488
PCM/EQ/10	Timer	1870
Equipment	Back pack (FHI)	102
Equipment	Rain coat (FHI)	87
Equipment	Safety Box	253
Infrastructures Management	Guide	50
Infrastructures Management	Training curriculum	35
Infrastructures Management	Guide for improving access to Watsan	280
Infrastructures Management	Malagasy version of development plan guide	140
Infrastructures Management	Training curriculum (water and sanitation) -	75
Infrastructures Management	Malagasy version of the Code of water	260
Infrastructures Management	Diagnostic form	10
Infrastructures Management	Folder with dividing pages	4
Infrastructures Management	Water and sanitation (laws and regulations)	14
WATSAN	Malagasy version of Poster: Health activities on Watsan; -Potable water	1
WATSAN	Malagasy version of Poster: Health activities on Watsan, washing hands with soap, healthy child	1
WATSAN	Counseling card SODIS	1
WATSAN	Counseling card; Washing hands with soap	1
WATSAN	Invitation card; Drinking potable water	1
WATSAN	Invitation card: Washing hands with soap	1

Category	Tool	Amount sent to NGOs
WATSAN	Malagasy version of Watsan activity follow up by Structure in charge	1249
WATSAN	WASH-friendly CHW Follow-up form	2899
MARPS	SW Brochure	8 710
MARPS	MSM pamphlet	4 400
Nutrition	Booklet of CHWs in charge of child health	574
Nutrition	Child training curriculum	33
Nutrition	Table of signs observed	641
Nutrition	Pre/post-test forms	1 145
Nutrition	Multi Micro Nutriment pills	3 595
Management Tools	Sensitization register	4214
Management Tools	Referral form	4 476
Management Tools	Supply register	2965
Management Tools	Monthly report form	11 750
Management Tools	Individual CHWs form	1 863
Management Tools	Mothers' register	4 561
Management Tools	Children's register	3493
Management Tools	Performance monitoring form	60
Management Tools	Supervisor self-evaluation tool	1
Management Tools	Supervision grid C-CHW1	1 188
Management Tools	Supervision grid C-CHW1	3282
Management Tools	Supervision grid M-CHW1	1387
Management Tools	Supervision grid M-CHW2	2514
Management Tools	Supervision report C-CHW1	370
Management Tools	Supervision report C-CHW2	590
Management Tools	Supervision report M-CHW1	406
Management Tools	Supervision report M-CHW2	552
Management Tools	Invoice/ deliver slips	95
Management Tools	Purchase order (CSP)	85
Management Tools	CSP stock card	10
HMIS/EQ/01	Workbook with a plastic cover	588
IMCI	Participant's guide	2 723
IMCI	C-IMCI training of trainers' program	66
IMCI	Pre-report form	2 090
IMCI	Pneumonia management technical form	2 412
IMCI	Pre/post-test form	4 487

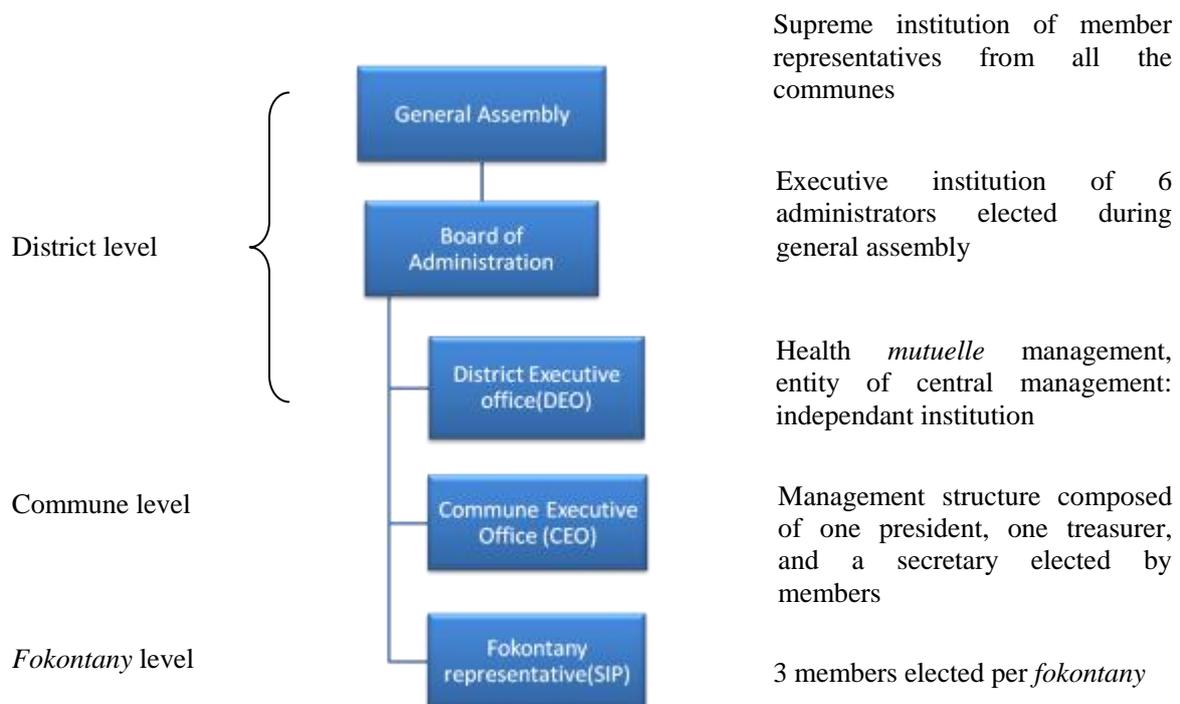
Category	Tool	Amount sent to NGOs
IMCI	Trainee CHW's individual monitoring form	734
IMCI	Case management form	161 875
IMCI	Referral form	4
IMCI	Guide for grouped monitoring of CHWs	743
IMCI	RDT use curriculum	2 109
IMCI-C	RDT job aid	1 781
RH/FP	Guide on general health for CHWs in charge of sexual health	604
RH/FP	Training curriculum for CHWs in charge of maternal health	50
RH/FP	Pregnancy checklist	921
RH/FP	Sticker	138
RH/FP	Pre/post-test	1 197
RH/FP	Monthly pre-report form for FP	620
RH/FP	Individual FP form	2653
RH/FP	Blue poster	986
RH/FP	Green poster	2 954
RH/FP	Red tickler	634
RH/FP	Blue tickler	437
RH/FP	FP job aid	878
RH/FP	Red tickler for CHWs (FHI)	55
RH/FP	Blue tickler for CHWs (FHI)	34
Crosscutting	Health card	268 794
Crosscutting	CHWs' certificate	5 938
Crosscutting	Integrated fact sheet	1 100
Crosscutting	Maternal and child health fact sheet	5 181
Crosscutting	Sensitization form for pregnant women	6 233
Crosscutting	Strengthening the link between CHW and CSB Guide	545
Crosscutting	Supervision booklet	10725
FBO	FBO Brochure	1546
c-ONE	Referral register	124
ARH	Awareness-raising activity report	75
ARH	ARH follow-up tool	58

# Annex H: Strategy for Establishing a Health *Mutuelle*

The new strategy to set up health *mutuelles* is based on scaling up health *mutuelles* at the district level. This new strategy aims to reach the following four goals:



A new structure for the governance system at the district level will go along with this new strategy implementation:



Four district pilots were selected for this first step: Vatomandry, Ambohimahasoia, Ambalavao, and Ambositra.

The implementation process aims to set up health *mutuelles* within communities, including the following phases:

Preparatory phase:

Step 1: Advocacy with district authorities to encourage their engagement in setting up health *mutuelles* and being engaged in the process

Step 2: Establishment of Initiative Committees at the district and commune levels: Members include public and private stakeholders and civil society representatives.

They will ensure the following:

- Preparation of health *mutuelle* management structure implementation
- Communities' awareness-raising
- Collection and transfer of membership fees until the effective establishment of all structures
- Report of results

These committees will be dissolved once management structures are set up.

Effective establishment phase:

Step 3: Establishment of the district executive office

Step 4: Election of enrolled member representatives at the *fokontany* level or a *fokontany* representative

Step 5: Election of members and establishment of the commune executive office

Step 6: General assembly for members and establishment of administration board

## List of documents developed and used

Principal document: new strategy for health *mutuelle* implementation

Tools: Management tools for members

- Member enrollment form
- Enrollment card
- Member register
- Enrollment dashboard
- Benefits and enrollment policy document
- Guide for member management tools
- **Premium management tools**
  - Premium collection register
  - Premium payment receipt form
  - Premium dashboard
  - Guidelines for using premium management tools
- **Administration tools**
  - Transmission slip
  - Minutes register
  - Activity reports
- **Financial management tools**
  - Payment voucher
  - Cash journal
  - Banking journal
  - General ledger
  - Profit and loss statement
  - Balance sheet
  - Guideline for completing finance tools
- **Budget tools**
  - Forecasting revenue/expenditure per month
  - Projected income statement
  - Guidelines for using budget tools
- **Materials and supplies management tool**
- **Services management tools**
  - Ordinance facture
  - Patient referral form
  - Patient CSB encounter register
  - Patient CHD inpatient register
  - Services/benefits dashboard
  - Guidelines for using services management tools
  - Contract with providers
  - Providers' monthly reports

1	KM salama	290	53	142	164	84	159	<b>892</b>
2	Latrine use	258	106	196	320		60	<b>940</b>
3	Nutrition	218	71	210	96			<b>595</b>
4	Exclusive breast feeding	250	34	174	170	96	36	<b>760</b>
5	IRA	192	60	60	213	108	86	<b>719</b>
6	Vaccination	206	19	84	41	136	84	<b>570</b>
7	ACT	253	33	164	88	151	96	<b>785</b>
8	ANC	221	39	126	84	96	50	<b>616</b>
9	IFA	158		156		48	146	<b>508</b>
10	ARH	117	50	132		264	3	<b>566</b>
11	GPL	134	60	40	122	3	290	<b>649</b>
12	Mutuelle						48	<b>48</b>
13	CHW Promotion						40	<b>40</b>
14	Latrine/Diarrhea						35	<b>35</b>
15	Social Quality						35	<b>35</b>
16	ANC Package						40	<b>40</b>
		<b>2297</b>	<b>525</b>	<b>1484</b>	<b>1298</b>	<b>986</b>	<b>1208</b>	<b>7798</b>

# Annex I. IEC with Local Radio Stations: Number of Broadcasts by Theme

## Positive gap with radio spot broadcasts

Radio Stations	Mar	Apr	May	Jun	Jul	Aug	Total
Radio Rakama	230	148	204	192	340	252	<b>1366</b>
Radio Feon'ny Mania		21	17	20	0	0	<b>58</b>
Radio Akon'ny Tsienimparihy		0	39	24	57	60	<b>180</b>
Radio Mampita		78	78	0	0	0	<b>156</b>
Akon'ny Analanjirofo		5	0	0	0	16	<b>21</b>
Feon'ny Maromaniry		1	0	0	0	0	<b>1</b>
Radio Cactus		72	0	16	38	0	<b>126</b>
Radio Lafa		1	11	53	110	0	<b>175</b>
Tea Longo				92	32	0	<b>124</b>
Radio Lazan'ny Ladoany				17	38	39	<b>94</b>
Radio Feon'ny Toamasina				2	0	6	<b>8</b>
Soatalily				18	0	28	<b>46</b>
Pangalane				6	0	0	<b>6</b>
Radio Vatomandry				0	42	32	<b>74</b>
JOSVAH				0	29	51	<b>80</b>
<b>Total</b>	<b>230</b>	<b>326</b>	<b>349</b>	<b>440</b>	<b>686</b>	<b>484</b>	<b>2515</b>

Spots produced and broadcast	
Developed in 2010	Developed in 2011
ACT (anti-malarial medicine)	Health <i>mutuelles</i>
Mother breastfeeding	Social Quality
Antenatal care	CHW promotion
IFA	Diarrhea/Latrine
Gender and planning	ANC package
ARI	
Kaominina Mendrika Salama	
Latrine	
Nutrition	
ARH	
Vaccination	

# Annex J: Communication Form with NGOs

## SOMMAIRE

### BUT DE L’EVALUATION

Évaluer trimestriellement la performance des **ONGs** de mise en œuvre à offrir des services de qualité à USAID/Santénet2 et à la communauté.

Cet exercice a une double portée :

1. il permet à l’équipe Santénet2 de mieux cibler et améliorer leur accompagnement des ONG
2. il permet aux ONGs d’identifier leurs réussites et faiblesses / points à renforcer et de donner un feedback efficace, pertinent et ciblé à leurs équipes afin d’améliorer d’avantage la qualité de leurs services.

### RESPONSABILITES ET ROLES ATTRIBUES AUX ONGS

- Gérer sainement les fonds du projet
- Mettre en place et suivre le système d’approvisionnement des AC
- Organiser/ appuyer les activités : assurer un appui logistique et financier à l’introduction, la mise en place et à la mise en œuvre du processus de l’approche KM Salama ; former les membres du CDS, appuyer le CDS à identifier les AC et appuyer/superviser le fonctionnement du CDS
- Assurer l’envoi de données de santé complètes et de qualité vers USAID/Santénet2 et communiquer efficacement avec USAID/Santénet2 sur les activités et les défis rencontrés
- Assurer l’autonomisation de la communauté dans la prise en charge de leur état de santé
- Offrir des services de qualité : mettre en place et assurer le suivi du système d’approvisionnement et assurer l’autonomisation de la communauté dans la prise en charge de leur état de santé; assurer la fiabilité des données collectées de services et mettre en place la prise en charge de tout problème détecté de qualité des services offerts lors de la vérification de la fiabilité ; faciliter le renforcement du lien AC-Superviseur Local et impliquer activement les Superviseurs locaux dans les activités

## **METHODOLOGIE DE L'EVALUATION**

Des indicateurs **disponibles** et **choisis dans le paquet de responsabilités et de rôles attribués aux ONGs** ont été identifiés pour évaluer cette performance des ONGs.

### **DOMAINES EVALUES :**

#### **1- Gestion financière** comprenant

Un tableau montrant les dépenses effectuées par l'ONG est présenté dans ce volet afin de donner des recommandations précises sur les améliorations à faire.

#### **2- Ressources et système d'approvisionnement**

Les points évalués dans ce domaine sont :

- L'adéquation des ressources dont les données sont collectées à partir les résultats de l'index qualité des communes
- Le Taux d'Accusés de réception reçus des ONGs et des membres du CDS/AC par rapport aux colis envoyés
- La fonctionnalité des Points d'approvisionnement (PA) par rapport à la vente des produits

#### **3- La performance organisationnelle par rapport aux activités**

- La réalisation des activités planifiées
- La participation des acteurs communautaires (AC, Superviseur local et membres du CDS) aux différentes activités

#### **4- Le rapportage et la communication**

- Le rapportage des données des AC (SMS et Extranet) : promptitude, complétude et fiabilité des rapports envoyés par les ONGs
- Les réunions de coordination des ONGs avec santénet2 : tenue des réunions, rapportage concernant ces réunions, participation des ONGs et thèmes discutés au cours de ces réunions

#### **5- L'engagement communautaire**

#### **6- La qualité de services des AC**

## **SCORES DE PERFORMANCE**

A chaque domaine est attribué des scores de performance allant de 0 à 100%. Le total des scores montrent le niveau de performance général de l'ONG. La performance est classée en 5 catégories :

- **EXCELLENT** si le score est > ou = à 90%
- **SATISFAISANT** si le score est compris entre 70 et 89%
- **MOYEN** si le score est compris entre 60 et 69%
- **INSUFFISANT** si le score est compris entre 50% et 59%
- **ECHEC** pour les scores <50%

Des commentaires et recommandations sont donnés à l'ONG pour chaque domaine afin de l'aider à améliorer sa performance future.

Des objectifs à atteindre pour la prochaine évaluation sont fixés

## **PRESENTATION DU DOCUMENT D'ÉVALUATION**

- Les informations concernant la période couverte par l'évaluation, les régions, districts et le nombre de communes d'intervention de l'ONG
- Un tableau montrant les scores obtenus avec les commentaires, les questions et des suggestions/actions
- Un tableau réservé à l'ONG pour qu'elle puisse mettre les propositions d'actions par rapport aux instructions de l'évaluation précédente
- Un tableau récapitulatif des résultats et les objectifs fixés pour la prochaine période
- Des tableaux montrant les informations collectées ainsi que les modes de calcul des indicateurs de performance

## I. INFORMATIONS GENERALES

Partenaire :

Début du contrat :

Période couverte :

			Total
Région			
District			
# Communes			

## II. RESULTATS POUR LA PERIODE D'AVRIL à JUIN 2011

<b>SCORE</b>	<b>&gt; ou = 90% :</b>	<b>excellent</b>	<b>→</b>	<b>si 3 évaluations avec un score &gt;90% : communication internationale sur la performance de l'ONG</b>
<b>SCORE</b>	<b>de 70% à 90% :</b>	<b>satisfaisant</b>		
<b>SCORE</b>	<b>de 60% à 70% :</b>	<b>moyen</b>		
<b>SCORE</b>	<b>de 50% à 60% :</b>	<b>insuffisant</b>		
<b>SCORE</b>	<b>&lt;50% :</b>	<b>échec</b>	<b>→</b>	<b>score à l'évaluation suivante doit impérativement être &gt;50%, dans le cas contraire pas d'avance de fonds jusqu' à ce que le score soit &gt;50%</b>

	<b>SCORE (PERIODE)</b>	<b>COMMENTAIRES ET INSTRUCTIONS</b>
<b>1. Gestion financière</b>		
<b>2. Ressources et système d'approvisionnement</b>		
<b>3. La performance organisationnelle par rapport aux activités</b>		
<b>4. Rapportage et communication</b>		
<b>5. Engagement communautaire</b>		
<b>6. Qualité de services</b>		
<b>SCORE FINAL</b>		

### III. ACTIONS PROPOSEES PAR L'ONG

ACTIONS PROPOSEES PAR L'ONG PAR RAPPORT AUX COMMENTAIRES ET INSTRUCTIONS DE L'EVALUATION	
1. Gestion financière	
2. Ressources et système d'approvisionnement	
3. La performance organisationnelle par rapport aux activités	
4. Rapportage et communication	
5. Engagement communautaire	
6. Qualité de services	

## I. RECAPITULATIF EVALUATION PERFORMANCE

	INDICATEURS	MODE DE CALCUL	Objectif (Trimestre précédent)	Score de performance pondéré	Objectif (Prochain trimestre)
<b>1. Gestion financière</b>	Taux différentiel dépenses cumulatives budgétisées et réelles	Comparaison des dépenses cumulatives budgétisées avec les dépenses cumulatives réelles :		/200	
<b>2. Ressources et système d'approvisionnement</b>	Adéquation des ressources de l'index de qualité	Moyenne des 3 indicateurs adéquation des ressources, AR et gestion de l'approvisionnement:		/200	
	Taux d'AR reçus des ONG Taux d'AR reçu des CDS/AC				
	Fonctionnalité des PA par rapport à la vente de produits				
<b>3. La performance organisationnelle par rapport aux activités</b>	Taux de réalisation des activités planifiées	Moyenne des taux de réalisation des activités planifiées et des 3 indicateurs de présence :		/200	
	1. Taux de participation des AC aux réunions 2. Taux de participation des superviseurs locaux aux activités				

	INDICATEURS	MODE DE CALCUL	Objectif (Trimestre précédent)	Score de performance pondéré	Objectif (Prochain trimestre)
	3. Taux de participation des membres du CDS aux activités				
<b>4. Rapportage et communication</b>	Taux de rapportage SMS	Moyenne des indicateurs de rapportage SMS et Extranet :		/200	
	Taux de rapportage Extranet				
	Taux de complétude et promptitude SMS Taux de complétude et promptitude Extranet				
	1. Rapportage ONG 2. Tenue des réunions de coordination 3. Taux de participation des ONGs aux réunions de coordination 4. Couverture de la communication	Moyenne des 4 indicateurs de rapportage ONG et communication :		/200	
<b>5. Engagement communautaire</b>	Engagement communautaire de l'index de qualité	Moyenne de l'engagement communautaire :		/100	
<b>6. Qualité de services</b>	1. Taux de référence d'enfants pesés en bande rouge	Moyenne des 4 indicateurs de la qualité de services :		/100	

	INDICATEURS	MODE DE CALCUL	Objectif (Trimestre précédent)	Score de performance pondéré	Objectif (Prochain trimestre)
	2. Taux d'utilisation des TDR 3. Adéquation de la distribution de FAF chez la femme enceinte 4. Qualité des données PF				
<b>Total</b>				/1200	

	Score précédent	Score actuel	Performance actuelle
<b>SCORE FINAL</b>			

ANALYS  
E DES

## INFORMATIONS

### 1. GESTION FINANCIERE

Une gestion financière saine, selon les accords contractuels et la planification budgétaire, est primordiale pour permettre à l'ONG d'accomplir sa mission complète pour USAID/Santénet2.

Source de données : Rapport financier

### 2. RESSOURCES ET SYSTÈME D'APPROVISIONNEMENT

Les ONGs sont responsables de la mise en place et le suivi du système d'approvisionnement. Sans fonctionnement efficace du système d'approvisionnement (Points d'approvisionnement PA fonctionnels, AC parfaitement outillés selon les besoins de bon fonctionnement des AC) l'offre de service de qualité ne pourra être assurée.

#### 2.1. Adéquation des ressources

*Moyenne de l'adéquation des ressources des communes: %*

Source des données : Index qualité

## 2.2. Accusés de Réception (AR)

La disponibilité des outils au niveau des ONGs, CDS/AC est mesurée par le retour des accusés de réception (AR) par ces acteurs au niveau de Santenet2.

MOIS-ANNEE			MOIS-ANNEE			MOIS-ANNEE		
Total colis envoyés (A)	Nombre d'AR ONG Reçus (B)	Taux retour AR ONG: $B / A \times 100\%$	Total colis envoyés	Nombre d'AR ONG Reçus	Taux retour AR ONG : $B / A \times 100\%$	Total colis envoyés	Nombre d'AR ONG Reçus	Taux retour AR ONG : $B / A \times 100\%$

*Moyenne des taux de retour des AR ONG pour le trimestre : %*

Total ACM 1 Formés	ACM1 outillés avec AR	Total ACM 2 Formés	ACM2 outillés avec AR	Total ACE 1 Formés	ACE1 outillés avec AR	Total ACE 2 Formés	ACE2 outillés avec AR	Total cumulé AC formés (A)	Total cumulé AC outillés (AR) (B)	$B / A \times 100\%$

*Total cumulé des AC outillés avec AR / total cumulé des AC formés x 100%: %*

*Moyenne des 2 indicateurs AR : %*

**Source de données :** Tableau de suivi des AR

### 2.3. Gestion de l'approvisionnement

La fonctionnalité du système d'approvisionnement est mesurée par la disponibilité des fiches vertes d'approvisionnement au niveau de Santenet2. Si il y a un problème d'approvisionnement de la part de PSI, ce manque de fonctionnalité ne sera pas incombé à l'ONG.

#### **Fonctionnalité PA par rapport à la vente de produits :**

Nombre de Communes	PA identifiés	Fonctionnels	%

*Fonctionnalité PA par rapport à la vente de produits : %*

**Moyenne des indicateurs adéquation des ressources, AR et gestion de l'approvisionnement: %**

### 3. LA PERFORMANCE ORGANISATIONNELLE PAR RAPPORT AUX ACTIVITES

Les ONG sont responsables d'organiser les activités en assurant l'appui logistique et financier des activités. Il leur revient d'organiser les activités en appuyant notamment efficacement le CDS à ce que les activités aient parfaitement lieu d'après la planification et en présence des participants attendus.

#### 3.1. Promptitude de la réalisation des activités planifiées

	Activités Planifiées			Total (A)	Activités Réalisées			Total (B)	Activités Réalisées (%)
	MOIS - ANNEE	MOIS - ANNEE	MOIS - ANNEE		MOIS - ANNEE	MOIS - ANNEE	MOIS - ANNEE		B/A x 100%
P									
A									
B									
C									
D									
E									
F1									
F2									
F3									
F4									
F5									
F6									
F7									
F8									
F9									
F10									
F11									
R									
S6									
S7									

	Activités Planifiées			Total (A)	Activités Réalisées			Total (B)	Activités Réalisées (%)
	MOIS - ANNEE	MOIS - ANNEE	MOIS - ANNEE		MOIS - ANNEE	MOIS - ANNEE	MOIS - ANNEE		B/A x 100%
<b>G</b>									
<b>G1</b>									
<b>G2</b>									
<b>H1</b>									
<b>H2</b>									
<b>H3</b>									
<b>O1</b>									
<b>O2</b>									
<b>O3</b>									
<b>O4</b>									
<b>QS</b>									

- il s'agit de la promptitude de la réalisation (B) **des activités planifiées** (A) : (B) ne peut être > à (A) et les activités non planifiées mais réalisées ne doivent pas être repris dans ce tableau

- si (A) = 0 il n'y a **pas de résultat** quant à (B) et (B) / (A) x 100% n'est PAS = %

**Moyenne des activités réalisées selon la planification (1) : %**

**Source de données** : Tableau de suivi de l'avancement du processus KM salama

**3.2. Présence des AC, membres CDS et Superviseurs locaux aux activités**

	<b>Total Activités Réalisées</b>	<b># AC présents (a)</b>	<b># AC attendus (b)</b>	<b>(a) / (b) x 100%</b>	<b># Superviseur local (SL) présent (c)</b>	<b># Superviseur local (SL) attendu (d)</b>	<b>(c) / (d) x100%</b>	<b># CDS présents (e)</b>	<b># CDS attendus (f)</b>	<b>(e) / (f) x 100%</b>
<b>P</b>										
<b>A</b>										
<b>B</b>										
<b>C</b>										
<b>D</b>										
<b>E</b>										
<b>F1</b>										
<b>F2</b>										
<b>F3</b>										
<b>F4</b>										
<b>F5</b>										
<b>F6</b>										
<b>F7</b>										
<b>F8</b>										
<b>F9</b>										
<b>F11</b>										
<b>R</b>										
<b>S6</b>										
<b>S7</b>										
<b>QS</b>										

*Moyenne du # de AC présents / # AC attendus x 100% sur toutes les activités confondues: %*

*Moyenne du # d'activités SL présent / # d'activités SL attendu x 100% sur toutes activités confondues: %*

*Moyenne du # de membres CDS présents / attendus x 100% sur toutes les activités confondues : %*

*Moyenne des 3 indicateurs de présence (2) : %*

*Moyenne des taux de réalisation des activités planifiées et des 3 indicateurs de présence [(1) et (2)] : %*

**Source de données** : Rapports de revues des ONGs, Rapports de formations, Rapports de supervision

## RAPPORTAGE SMS / EXTRANET ET COMMUNICATION ONG

L'ONG doit assurer la collecte et l'envoi de données de santé complètes et de qualité vers USAID/Santénet2 et communiquer efficacement avec USAID/Santénet2 sur les activités et les défis rencontrés.

La disponibilité de données complètes, fiables et suivant le chronogramme planifié et une communication de qualité contribueront à et permettront une prise de décision efficace et adaptée aux besoins réels de la population en matière de services de qualité.

### 4.1. Taux de Rapportage (TR)

RMA reçus par SMS (a)	RMA Attendus par SMS (b)	Taux SMS (a)/(b) x 100%	RMA reçus dans Extranet (a)	RMA Attendus dans Extranet(b)	Taux RMA Extranet (a)/(b) x 100%

*Taux de rapportage SMS (3): %*  
*Taux de rapportage Extranet (4): %*

**Source de données** : Extranet et SMS

## 4.2. Complétude, promptitude du rapportage SMS/Extranet

	SMS	Extranet
<i>COMPLÉTUDE</i>		
<i>PROMPTITUDE</i>		

*Moyenne des taux de complétude, promptitude et fiabilité SMS (5): %*  
*Moyenne des taux de complétude, promptitude et fiabilité Extranet (6): %*

*Moyenne des*

*indicateurs de rapportage SMS et Extranet [(3), (4), (5), (6)] : %*

**Source de données** : Extranet et SMS

## 4.3. Communication

### 4.3.1. Rapports ONG:

*Moyenne rapports ONG disponibles / rapports requis x 100%(7): %*

Types de rapports	Rapports requis (a)	Rapports disponibles (b)	(b) / (a) X 100%
Rapport de réunion de coordination			

**Source de données** : Tableau de suivi des rapports des ONGs

### 4.3.2. Réunions de coordination :

#### 4.3.2.1. Réalisation d'après planification :

# de Réunions de coordination planifiées (a)	# de Réunions de coordination tenues (b)	(b) / (a) X 100%

Source de donnée

s : Rapports des réunions de coordination

*Moyenne du # de réunions de coordination tenues / le # de réunions de coordination planifiées x 100% (8): %*

#### 4.3.2.2. Participation :

Réunion de Coordination	Décideur ONG (25% si présent ou fonction assurée)	Responsable Financier ONG (25% si présent ou fonction assurée)	Responsable Suivi et évaluation ONG (25% si présent ou fonction assurée)	TA (25%)	Addition des % pour obtenir le % total de participation
Réunion 1					
Réunion 2					
Réunion 3					

*Moyenne des % totaux de participation (9): %*

#### 4.3.2.3. Couverture de la communication durant le trimestre :

	I. Gestion financière	II. Ressources et système	III. Performance organisationnelle par	IV. Rapportage et	V. Qualité de services AC	VI. Engagement communautaire	Moyenne (a), (b)
Sujet couvert Si oui : 100% Si non : 0% (a)		<i>Moyenne des 4 indicateurs de la communication [(7), (8), (9), (10)]: %</i>					
Si défi : <u>communication</u> <u>prompte</u> : Si oui : 100% Si non : 0% Si aucun défi, ne pas remplir (b)							
<b>données</b> : Rapports des réunions de coordination		<i>Couverture de la communication (moyenne de (a) et (b)) (10): %</i>					
							<b>Source de</b>

#### 4. ENGAGEMENT COMMUNAUTAIRE

**Les ONGs doivent assurer l'autonomisation de la communauté dans la prise en charge de leur état de santé, base de l'approche KM salama, en appuyant le CDS dans son fonctionnement efficace.**

Le taux d'engagement communautaire d'une commune est obtenu en additionnant les points/scores de la commune sur les activités de sensibilisation, les activités de qualité sociale, sur le système d'approvisionnement, sur le système d'information et de gestion. L'engagement communautaire se qualifie « satisfaisant » si le score total est supérieur ou égal à 70%, « moyen » si le score est compris entre 50% et 70% et « insuffisant » si le score est au dessous de 70%.

**Moyenne des taux d'Engagement Communautaire : %**

**Source de données :** Index qualité

## 5. QUALITE DES SERVICES AC

Responsabilités des ONGs au niveau de l'offre de services des AC de qualité :

- l'offre de services de qualité n'est que possible si le système d'approvisionnement dont elles sont responsables est efficace
- l'offre de services de qualité nécessite l'autonomisation effective de la communauté dont les ONGs sont responsables
- les ONGs sont responsables du suivi de la qualité des données de services collectées et doivent lors de la vérification de la fiabilité des données mettre en place la prise en charge de tout problème détecté de qualité des services offerts
- les ONGs sont responsables de faciliter le renforcement du lien AC-Superviseur Local ainsi que d'impliquer activement les superviseurs locaux dans les activités ce qui contribue a une offre de services de qualité

### 6.1. Suivi de la croissance

Nombre d'enfants pesés en bande rouge (a)	Nombre d'enfants pesés en bande rouge référés (b)	Taux de référence (b)/(a) x 100%

*Taux de référence d'enfants pesés en bande rouge (11): %*

### 6.2. Prise en charge des maladies de l'enfant

# Testes de Diagnostic Rapide (TDR) utilisés (a)	# de cas de Palu pris en charge (b)	(a)/(b) x 100%

*# Testes de Diagnostic Rapide (TDR) / # de cas de Palu pris en charge x 100% (12) = %*

### 6.3. Prise en charge des femmes enceintes

<i>Nombre de femmes enceintes prises en charge/vues par les AC</i>	<i>Nombre de femmes enceintes référées pour FAF</i>	<i>Nombre de comprimés de FAF distribués</i>	<i>Moyenne de comprimés distribués par femme enceinte</i>

- Si Nombre de FAF distribués par femme enceinte <90 cp : 0%
- Si Nombre de FAF distribués par femme enceinte entre 90cp : 100%

**SCORE (13): %**

### 6.4. Qualité des données sur la prestation en Planning Familial

➤ Vérification de la qualité des données PF

<b>Octobre à Décembre 2010</b>		<b>Score</b>
<b># NU (Nouveaux Utilisateurs)</b>	<b># UR (Utilisateurs Réguliers)</b>	

**SCORE (14): %**

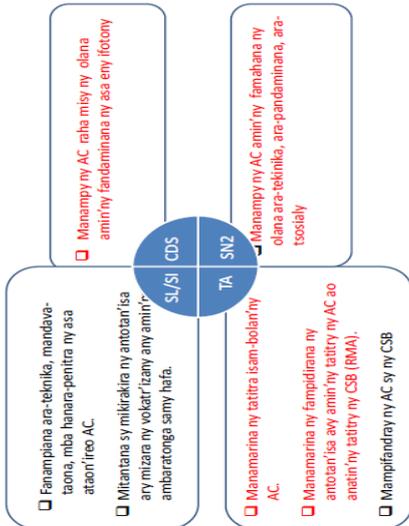
- Si NU>UR : 0%
- Si NU< ou égal à UR : 100%

**Moyenne de la qualité de services (moyenne 5 indicateurs (11), (12), (13), (14)): %**

**Source de données :** Base de données RTI/Santétenet2

# Annex K: CHW Continuous Supervision Booklet

Ny anjara asan'ireo mpitantso-roka eo amin'ny fanampiana ny AC



Daty (Date)	Sehatr'asa (Thème)	Anarana sy sonian'ny mpitantso-roka (Nom et signature du superviseur)

**Hafa**

Ny Mpitantso-roka tsiray dia manontany ny AC ny lohahevitra nore-  
rahan'ny mpitantso-roka "fanamihana manokana" raha tena lalina

- Andalana iray isaky ny Mpitantso-roka hana, anarany ary sonia
- Miresaka amin'ny AC : Daty, ny laharan'ny lohahevitra nifampidin-voalohany
- Ny AC no mameno ny mombamomba azy eo amin'ny pejy

**Ahoana no fampivoana ny KARINE**

Ity karine ity dia TSY natao ho fanaraha-maso ny AC. Fitaovana hafa no hanatanterahana izany

- Omena isaky ny AC
- Hahitana ireo ase nataon'ny mpitantso-roka tamin'ny AC ary
- Hanamaritana ny fifandraisana misy eo amin'ny AC sy ireo mpi-  
Hahatsapan'ny AC ny maha-zavadehibe ny asany
- Hahatsapan'ny AC ny maha-miasa amin'ny tomponandraitra  
teknika sy sosiàly izy
- Hahatsapan'ny AC ny maha-zavadehibe ny asany
- Hahatsapan'ny AC fa miantso-roka azy ireo mpiray ombon'an-  
toka (Dokotera, Supervisor, TA, CDS, SN2)
- Hahatsapan'ny AC fa misy manampy lalandava izy amin'ny fa-  
natanterahana ny asany

**Ity karine ity dia fitaovana :**



## TANTSOROKA HO AN'NY AC

« Tantsoroka mahomby sy maharitra antoky ny fandraisana an-tàmana manara-penitra eo anton'ny faraha-monina »

( L'encadrement efficace et continu assure la qualité des prestations de services communautaire )

Anaran'ny AC:.....

Laharana:.....

Fokontany:.....

Tobim-pahaslamana mpiahy:.....

Kaominina:.....

- Ireo mpitantso-roka manampy ny AC:**  
( Les superviseurs des ACs).
- Mpiasan'ny fahasalamana. (agent de santé).
  - COSAN/CDS
  - Teknisian'ny ONG (TA).
  - Ny Teknisian'ny SN2
  - Hafa ( ministre...)

- Ny tantsoroka dia misahana ireto lohahevitra ireto:**  
( L'encadrement concerne les thèmes suivants)
1. Fandaminana asa ( Organisation ).
  2. Tatitra. ( système d'information ).
  3. Famatsiana. ( Approvisionnement ).
  4. Lafin'ny ara-teknika ( Supervision technique ).

USAID/Santénet2 est mis en œuvre par RTI International

# Annex L: Copies of Ezaka Mendrika

4th Edition:

5th Edition

## Ezaka Mendrika Journal

**RTU/Santénét2 strategy for demand stimulation in KM salama communes**

**«Birth controlled, peaceful mind»**

Demand-stimulation activities have an important role to play in stimulating KM salama goals. Mother Health and Child Health (MHC) work in many remote villages to inform people about healthy, safe babies by teaching: *Rachibabababa*, a Mother Health CHW spoke about her community-based activities after successful months of working for community. She works in Fafany village, commune of Andraikoro, which is 30 km from the capital city of Antananarivo.

Many and more women are working for community-based family planning (FP) services.

"In the beginning, it was difficult for me to convince people in FP methods because an education/reading activity did not really attract them. But I never abandoned because after our 3-day training, I have few important one-to-one."



*A community meeting taking in Fafany.*

Finally, more and more women are keeping their appointments.

These women communicate with other women. It was established to use more and more (partner) women to see the at home, using FP counseling and activities," concluded *Rachibabababa*.

As of June 2011, *Rachibabababa* has 10 regular FP services per month in her work. Her services. She is working with the local health clinic to complement her work in this area.

As the end, more and more women come to their appointments. These were established to other women. It was established to use.

As of June 2011, *Rachibabababa* works 10 regular services per month who work services in her. She is working with the CHW to ensure all these tasks.



*A community meeting taking in Fafany.*

**Young Leaders' IEC Activities:**

RTU/Santénét2 has initiated a program to promote adolescent reproductive health (ARH) under the KM salama approach.

The program aims to improve young people's age 17 to 24 years knowledge on sexual and reproductive health including sexually transmitted infections (STI/RTV/AIDS) by increasing their use of health services and to adopt healthy and safe sex practices.

To do so, young people called "young leaders," are trained to lead participatory discussions with peers on sexual and reproductive health issues. During these meetings, young leaders improve their knowledge of ARH and their leadership skills.

The program has trained 1,000 young leaders in 108 KM salama communes who then work among peers to improve their sexual and reproductive health. They discuss STI/RTV, ARH, FP and reproductive health in general.




**Religious leaders IEC/BCC activities:**

**The protestant church motivation**

RTU/Santénét2 trained religious leaders to address community rising and health promotion towards communities. CHW deliver the same health messages as other actors in KM salama. They are provided with an adapted version of the IEC/BCC materials developed by the project, tailored for the context of each religion and belief system.

The protestant church could contribute to the scalability change in KM salama communities thanks to the engagement of all people concerned. In 113 communities, religious leaders contributed to community behavior change.

These activities aim to raise their knowledge level, build their confidence and improve their skills. Thanks to the intervention of religious leaders in 113 communities, 27 churches got more people in 2 communities and 50 have had their parishes open in 2 communities.

Now that 1,200 religious leaders of 170 churches are trained in the field, their religious perspective that in the health context improves them. Back in the area in the commune of Antananarivo-Andraikoro district of Antananarivo, where 20 villages were implemented thanks to the spiritual engagement in being there. Furthermore, many activities related to health were conducted with community-level initiatives. According to Bernard Paturel Congo, national coordinator of project in Fafany region ARH in the TROH church, religious leaders always dedicate 2 minutes during religious ceremonies on health. Communities are more and more used to have health messages delivered and to translate them into action.




**Radio program**

**Mysterious listeners a follow-up system for radio messages**

In addition to community health messages, RTU/Santénét2 uses local radio stations in KM salama communes to broadcast health messages in their regions of origin.

As of June 2011, the Project has signed contracts with 20 local radio stations.

To ensure follow-up after the broadcast, RTU/Santénét2 is working with radio stations to identify key individuals in their communities who receive the broadcast and follow up on the broadcast messages. The radio messages are an asset of the commune of these "mysterious listeners."

"I get benefits from my daily life, thanks to the health knowledge I receive every day. And because I am aware, I can help my family make better choices in the future."

The radio manager International confirmed that this broadcast more messages than originally planned because the radio station has a specific health radio program with a radio station.

According to him, these KM salama health spots are a guide to finding topics for and from developing the radio health program.

Moreover, radio managers only report on the number of messages they broadcast that are made the contact with RTU/Santénét2.



*© RTU/Santénét2. A person is speaking into a microphone for radio.*