

Madagascar Community-Based Integrated Health Program (MAHEFA)



Photos showing services of community health workers and other community actors

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MADAGASCAR COMMUNITY-BASED INTEGRATED HEALTH PROGRAM: "MAHEFA"

Cooperative Agreement No. 687-A-00-11-00013-00

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FY2014: October 1, 2013 – September 30, 2014

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Acronyms and Abbreviations

AOR	Agreement Officer Representative
ACT	Artemisinin-Based Combination Therapy
AMM	<i>Autorisation de mise en marché</i> / Marketing Authorization
ANC	Antenatal Care
AYRH	Adolescent and Youth Reproductive Health
ARI	Acute Respiratory Infection
BC	Behavior Change
BCE	Behavior Change Empowerment
CA	Cooperative Agreement
CBIHP	Community-Based Integrated Health Program
CCDS	<i>Commission communale pour le développement de la santé</i> / Community Committee for Health Development
CHD	<i>Centre hospitalier du district</i> / District Hospital Center
CHW	Community Health Worker
CHX	Chlorhexidine
c-IMCI	Community Integrated Management of Childhood Illnesses / <i>Prise en charge intégrée des maladies d'enfants – communautaire (PCIME-c)</i>
CLTS	Community-Led Total Sanitation
CLTS + H	Community-Led Total Sanitation and Hygiene
CoSAN	<i>Comité de santé</i> / Health Committee
CSB	<i>Centre de santé de base</i> / Basic Health Center
CSC	Community Score Card
CTC	Central Training Consultant
CU5	Children Under 5
DDDS	<i>Direction du développement des districts sanitaires</i> / Directorate of the Development of Sanitary Districts
DIORANO	
WASH	Local WASH Committee
DRE	<i>Direction régionale de l'eau</i> / Regional Water Directorate
DRSP	<i>Direction régionale de la santé publique</i> / Regional Public Health Directorate
DRJS	<i>Direction régionale de la jeunesse et des sports</i> / Regional Youth and Sports Directorate
DQA	Data Quality Assessment
DSEMR	<i>Direction de la Santé de la mère, de l'enfant et de la reproduction</i> / Mother, Child and Reproduction Directorate
EMMP	Environmental Mitigation and Monitoring Plan
EOP	End of Project
ESF/ERR	Environmental Screening Form / Environmental Review Report
ETS	Emergency Transport System
EVM	Earned Value Management
FP	Family Planning
GCQ	<i>Gestion communautaire de la qualité</i> / Community Management Quality
GOM	Government of Madagascar
GWG	Gender Working Group
HMIS	Health Management Information System
HWS	Handwashing with soap
IEC	Information, Education, Communication
IEE	Initial Environmental Examination

IGA	Income Generating Activity
IMCI	Integrated Management of Childhood Illnesses
INSTAT	National Institute of Statistics
IPMA	<i>Institut Pasteur de Madagascar / Madagascar Pasteur Institute</i>
IPTp	Intermittent Preventive Treatment in Pregnancy
IR	USAID Intermediate Result
ITN	Insecticide Treated Net
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JSI	JSI Research & Training Institute, Inc.
KMSm	<i>Kaominina Mendrika Salama Miabo / Champion Communes</i>
LAPM	Long Acting and Permanent Methods
LLITN	Long Lasting Insecticide Treated Nets
LMIS	Logistics Monitoring Information System
MAHEFA	<i>Malagasy Heniky ny Fahasalamana</i>
MCHIP	Maternal and Child Health Integrated Program
MCHW	Maternal and Child Health Week
M&E	Monitoring and Evaluation
MFI s	Microfinance Institutions
MNCH	Maternal, Newborn and Child Health
MOEI	Ministry of Economy & Industry
MOH	Ministry of Health
MOTP	Ministry of Telecommunications & Post
MOW	Ministry of Water
MOYS	Ministry of Youth and Sports
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organization
NL	Natural Leader
OCA	Organizational Capacity Assessment
ODF	Open Defecation Free
OL	<i>Ouvriers locaux / Local Masons</i>
ORS	Oral Rehydration Solution
PA	<i>Point d'approvisionnement / Supply Point</i>
PAFI	<i>Petites actions faisables importantes / Small doable important actions</i>
PCIME-c	<i>Prise en charge intégrée des maladies d'enfants – communautaire / Community Integrated Management of Childhood Illnesses (c-IMCI)</i>
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PNLP	<i>Programme national de lutte contre le paludisme / National Program of Action against Malaria</i>
PNSC	<i>Politique nationale de santé communautaire / National Policy on Community Health</i>
PPHP	Postpartum Hemorrhage Prevention
PPP	Public-Private Partnership
PY2, 3, 4	Program Year 2, 3, 4
QOC	Quality of Care
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RMAAC	<i>Rapport mensuel des activités des ACs / Monthly CHW Activity Report</i>
RT	<i>Responsible Technique / Technical Manager</i>
RTC	Regional Training Consultant
SDP	Service Delivery Point

SMS	Short Text Messaging
SP	Sulfadoxine-pyrimethamine
SDSP	<i>Service de district de la santé publique</i> / Public District Health Service
SSME	<i>Semaine de la santé de la mère et de l'enfant</i> / Mother & Child Health Week
STI	Sexually Transmitted Infections
TA	<i>Technicien accompagnateur</i> / Technical Assistant
TMG	The Manoff Group
TOCA	Technical Organizational Capacity Assessment
ToT	Training of Trainers
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, Sanitation and Hygiene
WUHSA	Water Users Hygiene & Sanitation Association
YPE	Youth Peer Educator

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EXECUTIVE SUMMARY

During the fourth year of program implementation MAHEFA continued to make significant headway in reaching its targets particularly in the provision of quality health services to remote communities in the program's intervention areas. By the end of FY2014, almost all of the MAHEFA Community Health Workers (CHWs) were functional in integrated health areas as per the National Health Policy. The services provided by CHWs include both preventive and treatment services. An integrated package of services is available in 2,929 *fokontany* that represent 97% of the total target *fokontany* (3,023). Thus, all communities have access to basic health services provided by the CHWs as seen in higher rates of utilization reported throughout this period. Indeed, most communes started to take an active role in managing their health as seen in the number of communes (275 out of 279) that had completed their KMSm health goals by the end of this fiscal year. During FY2014, all the important foundations of the MAHEFA program were put in place to ensure that its targets will be met by EOP.

FY2014 was also marked by the program's mid-term review which reconfirmed that MAHEFA is on course to achieve its stated goal and objectives. Due to the lifting of U.S. Government's (USG) sanctions on working with the government of Madagascar (GOM) this year, MAHEFA started to engage directly with the government. Now, the program has an opportunity to ensure the sustainability of its results in reducing maternal, newborn and child deaths via community health in Madagascar. This is a crucial moment as the program has already piloted some very important initiatives, in collaboration with the Ministry of Health (MOH) and other partners, to reduce maternal and newborn deaths in Madagascar (PPHP, CHX).

Always striving to enhance the implementation of field activities, MAHEFA improved its operations system and has established a new system of ongoing assessment and monitoring to better manage/support its NGO grantees. This was an important achievement this year as it will contribute to the sustainability of the program's interventions. Overall, in FY2014, MAHEFA has identified/tested technical components of the program and has taken steps to ensure that the operations system is successful. Details of the year's achievements are presented below:

IR 1 highlights: Increased demand for products and services

- Reinforcement of the behavior change empowerment (BCE) strategy with the recruitment, training and deployment of Field Technicians to support NGO Technical Assistants (TAs) in charge of monitoring CHWs. A significant number (1,071) of capacity building interventions for TAs enhanced their ability to support CHWs in promotion and prevention activities and in delivering quality health services.
- Increased adoption of health and water, sanitation and hygiene (WASH) behaviors by community members due to the involvement of a larger number of NGOs and community stakeholders (COSAN members, Natural Leaders (NL), WASH-friendly institutions, and water users, hygiene and sanitation associations (WUHSA)) supporting CHWs in the implementation of innovative BCE approaches (Care Groups, positive deviants, carnivals, demonstrations of health products, etc.).
- Participation of an estimated 415,850 individuals in radio listening groups in all 24 districts of MAHEFA intervention areas, resulting in reinforcement of essential health and WASH messages; overall radio programming reached 1,941,371 people with key prevention messages

through 26 partner local radio stations. Amongst them, it is estimated that 446,515 are women of childbearing age and 330,033 are youths.

- Increased number of community members who received key health and WASH messages through BCE activities (prenatal consultations, newborn and child health, family planning, STI/HIV, malaria prevention, nutrition, drinking water, handwashing with soap and use of latrines); from 3,017,808 people in FY2013 to 16,291,307 people in FY2014.
- Reorientation of the community-led total sanitation (CLTS) approach to focus on consolidating efforts invested in triggered communities; training TAs in promoting CLTS activities alongside WASH-friendly institutions and making the link between sanitation and hygiene, thus the launching of the CLTS+H approach. Therefore, by end of September 2014, 84 communities in MAHEFA intervention areas were declared Open Defecation Free (ODF), surpassing targets of 50 ODF communities set for the same period.

IR 2 highlights: Increased availability of products and services

- Training of all 279 TAs working on the MAHEFA program in the integrated program elements (MNCH, malaria, nutrition, FP/RH and WASH) by Central and Regional Training Consultants under the supervision of MAHEFA's regional units for enhanced support and monitoring of CHWs.
- Adoption of a "zero stock-out" approach of health products by MAHEFA and PSI and the development of a capacity building plan for PAs (supply points) and CHWs. As a result, all 279 TAs were trained in quantification methods to improve their monitoring of stock levels, average monthly consumption, quantities to order, and number of potential stock-out days of health products. In turn, the trained TAs provided their assistance to CHWs by gradually transferring this training to build their capacity in stock management and facilitate the use of the stock management system.
- Delivery of health commodities to remote communities by hovercraft in Boeny and Menabe in collaboration with PSI and HoverAid and in Sofia by helicopter in partnership with PSI, Helimission and the VAO VAO MAHAFALY Hospital.

JSI/MAHEFA highlights in the area of MNCH are as follows:

- Increase in the use of these services in FY2014 compared to FY2013. Thus, 234,804 children under five (CU5) were referred to basic health centers for vaccination; 47,723 CU5 were treated by CHWs for diarrhea, of which 22,531 or 47.2% were girls; while respectively 48,077 received treatment for pneumonia of which 21,559 were girls (44.8%).
- Training of 13 health (*mutuelle*) management committees established this year, with 97 members trained in 13 communes and seven districts in Sofia, Boeny, Menabe, SAVA and DIANA regions (21/23 committees are now functional). Among these communes, two in Menabe and one in SAVA were also trained in emergency transport system management which is now in place in these communes.
- 23 communes now have a health *mutuelle* with 21,099 new members registered. All but one *mutuelle* association (22) have registered formally and obtained a legal status, and signed a partnership agreement with health centers and microfinance institutions. A total of 181 committee members were trained in *mutuelles'* management.

- Provision of 22 *fokontany* with emergency transport since December 2013 in Bemanonga and Analaiva communes (Morondava district, Menabe). Nosibe commune (Vohemar district, SAVA), was provided with eight means of emergency transport in September 2014. The launching and promotion of emergency transport was initiated by the commune in Q4 with the participation of the Mayor, the *Centre de Sante de Base* (CSB) Heads, *fokontany* Chiefs and COSAN and management committee members (COGE).
- Purchase of 35,000 tubes of 7.1% Chlorhexidine gel for prevention of infections in newborns' cord stump (25,000 used at the community-level by CHWs) and 10,000 used at CSB level. Due to the USG's restriction on supporting the GOM, JSI was assisted by contributions from the Packard Foundation enabling the product to become available at the CSB level. At the end of September 2014, 2,996 newborns had received 7.1% Chlorhexidine on their cord stump immediately after their birth, bringing the total of newborns that benefited from the use of 7.1% Chlorhexidine for cord care to almost 3,100 since the introduction of this project in the districts of Mahabo and Vohémar. The post-partum hemorrhage prevention (PPHP) and newborn cord care also includes home visits by CHWs. During FY2014, 4,891 newborns were visited and 5,633 women having given birth have been referred to the CSB for postnatal visits.
- Internal review of the PPHP and prevention of infections in newborns' program. The review determined that these two programs are feasible to implement in rural Madagascar and that the beneficiaries were satisfied with the results. The main recommendations were: 1) procurement and storage of products; 2) supply chain system for the two products in both public and private sector (social marketing); and 3) strengthening of capacity of staff at CSB and community levels (CHWs) through monitoring and supportive supervision.
- In collaboration with the MOH, UNFPA and other partners, active participation by MAHEFA in the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). The results of MAHEFA's MNCH activities contribute to the overall efforts of this campaign.

JSI/MAHEFA highlights in the area of FP/RH are presented below:

- A significant increase in the number of CHWs trained which also increases the number of CHWs who provide integrated health services. At the end of FY2014, 5,929 were trained in DEPOCOM; 5,916 trained in nutrition and WASH; and 6,004 trained in BCE.
- Acceleration of the completion of theoretical courses given to CHWs and of the certification of their practical training ("*stages pratiques*") by the CSB. At the end of September 2014, 3,113 CHWs trained in DEPOCOM during the period were certified by the CSB compared to 1,619 in FY2013.
- Increase in the number of Regular Users (RU) of FP modern methods. The 88,843 RUs recorded exceed the annual objective by 107% and similarly, an increase in the Couple Years of Protection (CYP) to 69,207. Compared to FY2013, the number of RUs of modern FP methods among the 15 to 24 years age range increased by 3.4 times in FY2014, and by 3.6 times among the 25 years and over age group for all six MAHEFA regions. The interest of young people in modern FP methods has more than doubled from FY2013 to FY2014, both for the 15 to 24 years and the 25 years and over age range.
- Production of two FP calendars (one for oral and one for injectable contraception) to assist CHWs accuracy; EMMP Jobaid in order to meet environmental compliance and the program's safety; and a Jobaid on client's rights to family planning to respect the FP compliance of MAHEFA's program. All of these initiatives will contribute to enhance the quality of CHWs' service provision in family planning in FY2015.

- Training of two YPEs and two CHW mentors per *fokontany* in the program's 24 districts at the "chef-lieu" of each district to reach more youth with FP services. By the end of FY2014, 609 YPEs were trained (93% of the 656 annual target), out of which, 527 (86.5%) were operational. In addition, 264 YPEs in DIANA, SAVA and Melaky were trained and equipped to use mobile technology (SMS) to transmit FP and key health messages to their peers.
- Thanks to the efforts of the YPEs, 119,425 young men and women were reached in FY2014, with various family planning and reproductive health topics. Furthermore, 1,084 young people in the three regions of the project were recruited by YPEs and trained in the use of SMS to spread these messages to other young people in their communities.

JSI/MAHEFA highlights in the area of malaria are as follows:

- By the end of FY2014, 1,230 CHWs had been trained and equipped in c-IMCI, so that there is a total of 5,608 CHWs ready to provide child care for diarrhea, ARI and malaria.
- Increase in number of children tested with RDT and received treatment with ACT within 24 hours after appearance of fever. Out of the 97,172 children under five who presented fevers and were tested with RDT, half of them (53.7% or 52,141) tested positive for malaria. 94% of these children were successfully treated by CHWs for simple case of malaria.
- Counselling and referral of pregnant women to CSB for antenatal visits and follow-up, that are opportunities for them to have malaria prevention therapy by taking Sulfadoxin Pyrimethamin and LLINTs, Iron Folic Acid in addition to anti-tetanus vaccination. In FY2014, 69,269 pregnant women have been referred to a health facility for their first ACN visit, while 52,162 pregnant women have been referred to a health facility to complete their fourth antenatal care visit and 10,428 among them were counter-referred by the health facility to CHWs (20%).

JSI/MAHEFA highlights in the area of nutrition are presented below:

- Provision of 3,588 CHWs with nutrition and WASH training in a combined session. As a result, a total of 1,650,615 people received key messages in nutrition for children and 1,572,409 received messages on nutrition for pregnant and lactating women and promotion of exclusive breastfeeding. CHWs used mid-upper arm circumference (MUAC) measurement to CU5 in order to early detect severe malnutrition among this age group. A total of 203,410 children were measured with MUAC and their parents received counselling regarding nutrition practices. In FY2014, three percent of total CU5 seen by CHWs (6,102 out of 203,410) had their MUAC measurement under 125 mm, and were referred to the CSB.

JSI/MAHEFA highlights in the area of WASH are described below:

- Identification and training of a total of 398 local masons to build "Dalles San Plats" (or washable latrine slabs) and improved latrines in the CLTS triggered sites in FY 2014. The concept of the Village Savings & Loan Associations (VSLA) was integrated into the training of the local masons and the WUHSA.
- 299 WUHSA's were created and members were trained to ensure good water management. In FY2014, the program has put more emphasis on community participation and ownership of water, sanitation and hygiene related activities. This is how the WUA became Water Users and Hygiene and Sanitation Associations (WUHSA). Consequently, MAHEFA included CLTS practical sessions in the WUHSA's training of trainers' curriculum.

- Production of a catalogue displaying latrines to help households choose the type of latrines they would like to build. Natural Leaders, community facilitators and CHWs helped the local masons identify households in their community interested in building improved latrines. During FY2014, 342 Natural Leaders were identified and became functional.
- Launching of water tests for Menabe, DIANA and SAVA regions. The conclusions and recommendations of the IPM (*Institut Pasteur de Madagascar*) will be implemented on a case by case basis depending on the situation. The water quality analysis will continue for the remaining regions (Sofia, Melaky and Boeny) in Q1 of FY 2015.
- Supervision of the construction/rehabilitation work and monitoring of the establishment of WUHSA's and beneficiary contributions. By the end of September 2014, most of the new planned constructions, 268/311 (86.2%) and 45 rehabilitations were completed. This has enabled 78,250 people to have access to clean drinking water.

IR 3 highlights: improved quality of care by CHWs

- Exchange visits of "Champion" CHWs, TAs and COSAN members to other districts to share experiences and best practices with their peers, promote learning between districts and sustain the motivation of CHWs.
- Assessment of CHW's services by community members through the completion of total of 983 Community Score Cards (CSC). 76% of community members reported being satisfied with the quality of CHWs' service delivery. As a result of this process, 51 community sites were built (in Menabe) in the first two quarters of FY2014 in the communes that had conducted a CSC.
- Most of MAHEFA communes (278) conducted their final evaluation of the first cycle of the KMSm process and 275 were declared KMSm Champion communities. Out of that number, 254 communes conducted their Participatory Action Plan for Cycle 2 of the KMSm process.
- Supervision of an average of 75% of CHWs on site by MAHEFA at least once in a quarter for ongoing capacity building and support. On a monthly basis, CHWs receive supervision through the monthly meetings sessions. On average, 86% of CHWs attended monthly meetings and 81% of them submitted monthly reports.
- Strengthening of the Computerized Management System as an alternative to the Logistics Management Information System (LMIS) via mobile phones which did not yield expected results. The LMIS was reviewed by a mHealth expert and as a result of this assessment the design of a new information system emerged and will be launched in early FY2015.

Cross-Cutting highlights

- Delivery of a series of regional workshops on data quality assurance to those involved in the collection and reporting of data, including regional M&E staff, TAs and other technicians from NGOs. As a result of these workshops, the ongoing efforts in verifying data quality in the context of M&E daily activities were reinforced, and quarterly assessments of data quality were conducted by the MAHEFA team.
- Regular supervision and ongoing training are strategies used by MAHEFA this year to ensure compliance at all levels of the program (EMMP, FP); in FY2014, 250 MAHEFA staff, partner NGOs and regional trainers completed the online course on FP compliance.
- Participation in gender activities to ensure that gender continues to be a cross-cutting theme throughout the MAHEFA program. This included: active participation in the Gender Working

Group with other development actors and the development of gender materials aiming to help MAHEFA communities' better understanding and take actions on gender issues.

- Midterm evaluation of the program by USAID. Interviews were carried out with various stakeholders and beneficiaries; positive achievements as well as challenges in program implementation were identified. In regards to the economic analysis results, MAHEFA has completed 56% of its planned activities during 61% of its project duration, implying that only 5% of planned activities were delayed or are behind schedule.
- In FY2014, MAHEFA refined its management and reinforced its operating system based on previous years' experience. MAHEFA concentrated its efforts and resources on improving operations at the regional, district, municipal and *fokontany* level. MAHEFA also moved its central office to allow staff more room to work efficiently as well as to save operating costs.

Other major changes took place during that period, mostly in regards to staffing/ personnel, notably, a new COP began her tenure and a Finance & Administration DCOP was recruited. In addition, internal capacity building continued to be provided to staff to enhance operations. MAHEFA staff also took the opportunity to share experiences and lessons learned in various international platforms.

Finally, collaboration with MAHEFA's various partners was strengthened and a new ongoing evaluation and capacity building system for partner NGOs was conducted along with the Organizational Capacity Assessments' process to enhance implementation of program activities in the field.

I. INTRODUCTION

USAID awarded the five-year Cooperative Agreement (CA no 687-A-00-11-00013-00) for the Community-Based Integrated Health Program (CBIHP) to JSI Research & Training Institute, Inc. (JSI) on May 23, 2011. JSI collaborates with two international partners, The Manoff Group (TMG) and Transaid, and 17 Malagasy non-governmental agencies¹ for the implementation of the CBIHP. The program is referred to locally as “MALagasy HENiky ny FAhasalamana” (MAHEFA), or “MALagasy HEalthy FAMilies”. This Annual Report covers the period from October 1, 2013 through September 30, 2014, which represents Program Year Four (FY2014) of program implementation. MAHEFA works to improve access to and use of maternal, neonatal and child health (MNCH) and family planning (FP) services. The program also focuses on improving water, hygiene and sanitation (WASH) in the 24 most difficult and underserved districts of Madagascar. MAHEFA’s five-year overall objective is:

To increase the use of proven, community-based interventions (MNCH, FP/RH - including STI prevention - water, hygiene and sanitation, prevention and treatment of malaria, nutrition) and essential products among underserved populations in six northern and western regions of Madagascar.

MAHEFA will contribute to the following USAID intermediate results (IR):

IR 1: Increase demand for high-quality health services and products

IR 2: Increase availability of high-impact services and products

IR 3: Improve the quality of care delivered by community-based health practitioners

In FY2014, the JSI/MAHEFA Program continued its interventions in 24 districts in the six regions of Boeny, DIANA, Melaky, Menabe, SAVA and Sofia. The program covers 279 communes, with a total population of approximately 3.4 million. The achievements of the MAHEFA program during FY2014 are presented according to these three IRs. A list of challenges and corrective measures encountered by the program in the past year is presented in Annex 1 and the detailed activity table is included in Annex 2.



¹ Two NGOs had their contract terminated in FY2014 due to unacceptably low performance.

II. IR1: INCREASE DEMAND FOR HIGH QUALITY HEALTH PRODUCTS AND SERVICES

During FY2014, MAHEFA program activities related to increasing the demand of health services and products continued to focus on the development and strengthening of the Behavior Change Empowerment (BCE) approach initiated in FY2013. MAHEFA developed the BCE approach to increase the use of health services and products at the community level. In FY2014, MAHEFA focused on three areas to generate demand in health services and products:

- a. Implementation of high profile activities to create an environment conducive to behavior change;
- b. Strengthening of partners' capacity to use the BCE approach and share best practices; and
- c. Reinforcing and complementing the media campaign by adapting and/or developing additional print materials and audiovisual communication tools that suggest ways to address barriers identified through previous research.

Description of IR1 activities and impact in FY2014

During FY2014, MAHEFA has seen an increase in the results of the scaling-up and strengthening of the BCE strategy as well as in the new direction of the WASH strategy in all of the program's intervention areas. Due to the emphasis that was put on increasing efforts to involve more community stakeholders such as community leaders, positive deviants, witnesses, NLs, members of the WUHSA, health-friendly institutions, CARE Group members and others, the program has seen an expansion in BCE activities conducted by CHWs as well as by these other community actors. This contributed positively to an increase in the adoption of preventive health and WASH behaviors as well as health-seeking behaviors by community members.



A Field Technician explains the use of Care Group stickers to TAs in Mitsinjo, Boeny

1.1 Implement high profile activities to create an environment conducive to behavior change

Regarding high profile activities, MAHEFA put particular emphasis on training, support and intense monitoring of community actors implementing new approaches, thus, enabling greater public exposure such as with Care Groups, carnivals, advocacy with local leaders, the use of positive deviants, demonstrations of health products and nutritional recipes, and illness prevention strategies (such as guided visits to the health center to encourage pre and postnatal care and facility-based deliveries). To increase the quality of these activities, MAHEFA monitored and supported CHWs to ensure that they used the "Torolalana sy Vahaolana" (Guide & Solutions), a How-to Guide that was produced after much research, pretests and revisions, to assist CHWs in their community-based BC Empowerment activities. This helped the program to increase the impact of CHWs' activities and created an environment conducive to behavior change in communities.

Due to its potential to gather great momentum and increase visibility, this year the program expanded the Care Group component of the BCE approach. To acknowledge the efforts of Care Group mothers and/or fathers or families, MAHEFA instituted a

recognition system that includes distributing stickers to those who are successful in helping other families overcome barriers and focus on positive motivating factors. To qualify, a Care Group individual or household must “adopt” a minimum of three families with whom they work for at least a month to encourage positive behavior change. For example, André and Anicette, a couple with three children are farmers who live in Morafeno *fokontany* in the rural commune of Fanambana, in the Vohemar district, SAVA region. In 2013, they began using DEPOCOM and in 2014, at the encouragement of their CHW, they became a Care Group couple. They worked with couples from nine households who then adopted and now continue to use a FP method. Currently they are working to help another five families overcome their barriers and emphasize the benefits they have seen in their own lives: “improved quality of life and improved physical condition for the woman”. This approach continues to have a “snow-ball” effect in André and Anicette’s community.

Another exemplary Care Group couple, Jean Marie and Sesily, from Melaky region were actually selected to participate in MAHEFA’s BCE Innovations Dissemination Workshop because of their successful community work (see Section 4.4 below). This couple has been working intensely over the past year with individual families in their community, helping numerous families to adopt and maintain such behaviors as handwashing with soap, water treatment with SODIS, latrine use and others. The increase in these high profile BCE approaches mentioned above, the recognition of the additional work done by Care Group families, and the involvement of more community players in BCE activities had a positive impact on the quantity of solutions (or messages) reinforced and received by community members in FY2014. As shown in Table 1, the number of people receiving messages increased significantly during FY2014. While other contributing program factors must also be considered, it is likely that these efforts had a significant impact on behavior change in several areas.

Table 1. People received health messages through BCE activities in FY2013 and FY2014

Themes of key messages	FY2013			FY2014		
	Women	Men	Total	Women	Men	Total
Prenatal exams for pregnant women (messages include malaria prevention)	171,744	216,183	387,927	690,522	962,410	1,652,932
Child health (messages include malaria prevention)	261,544	323,917	585,461	942,214	1,328, 851	2,271,065
Newborn healthcare (CHX)			NA	100,513	130,843	231,356
Family Planning	200,061	278,670	478,731	874,088	1,207,550	2,081,638
STI and HIV	156,486	211,478	367,964	664,821	839,646	1,504,467
Drinking water	303,498	359,924	663,422	795,968	960,140	1,756,108
Handwashing with soap				804,832	972,362	1,777,194
Use of latrines				829,077	964,446	1,793,523
Nutrition for children	126,498	161,566	288,064	743,958	906,657	1,650,615

Themes of key messages	FY2013			FY2014		
	Women	Men	Total	Women	Men	Total
Nutrition for pregnant and lactating women and promotion of exclusive breastfeeding	106,988	139,251	246,239	625,304	947,105	1,572,409
Number of persons who received key messages	1,326,819	1,690,989	3,017,808	7,071,296	9,220,011	16,291,307

The involvement of other community members in BCE activities has enabled many CHWs to dedicate more time to and improve the quality of their service delivery. In addition, it has allowed them to devote more time to home visits (when necessary) giving more interpersonal support to potential clients. This new focus on: 1) involving more community members in the BCE approach; 2) helping CHWs to increase the quality of their service delivery, (see more details in the IR2 section of this report) and 3) giving more time to CHWs to conduct home visits; combined with additional on the ground capacity building and support (see Section 1.2); and MAHEFA's multimedia campaign (see Section 1.3), as well as other factors such as an increase in the number of CHWs completing their training and practical internships, has contributed to an increase in the use of services offered by CHWs.

Box 1. Festine, a regular FP user becomes a witness

Mamizara Festine Eliette, 23, married, and mother of two children, lives in a small village called Marodimaka in Anaborano Salama *fokontany*, part of the rural commune of Ambodimanga Ramena in Ambanja district, DIANA region. In July 2014, the Field Technician supported the TA and two CHWs in the organization of a BCE activity in the CHW's community site, "Vonjy". As this was the first week of July, they had chosen the theme according to the schedule indicated in the *Torolana sy Vahaolana*, "Treatment of water for drinking". The team was at the beginning of their activity when Mrs. Festine arrived at the *Toby*. She wanted to see the CHW to explain her problem.

Without hesitation, Joseph the CHW took her aside. She explained that she had faithfully used the Depo provera for five years with the CSB II of Ambodimanga Ramena. She explained that she uses the contraceptive discreetly without the consent of her husband because, "I do not want to have more children because life is hard". Unfortunately, she lost her health booklet because she hid it at her neighbor's house. The CHWs of her *fokontany* are very far from her village compared to the site of Joseph's *Toby*. Listening to her story, Joseph followed all the steps to conduct a comprehensive interpersonal communication session with Festine and encouraged her to try to talk to her husband and also to consider long term FP methods (since she no longer wants to have children). He invited her to come to his site whenever she wants. Festine insists on using DEPOCOM and accepts Joseph's suggestion of becoming a witness in her adopted village because "I want other women to take better care of their health".

1.2 Strengthen NGO partners' capacity to use the BCE approach and share best practices

During FY2014, while completing the training of community actors in the BCE approach, the program also focused on supporting and monitoring their efforts in the field. This was largely carried out through the recruitment, assignment, and monitoring of a team of seven Field

Technicians or “coaches” in the six MAHEFA regions (Sofia had two because of the inaccessibility and size of the area) for seven months. The overall goal of this field coaching approach was to build and reinforce the capacity of partner NGOs in order for them to, in turn, strengthen their own support to their CHWs in the implementation of their BCE activities and service delivery, in general. Specifically, the seven Field Technicians were recruited to:

1. Improve NGO Technical Assistants’ (TAs) skills on integrated health topics of the MAHEFA program, specifically on the BCE strategy following the actions, solutions and approaches described in the “*Torolalana sy Vahaolana*”;
2. Promote activities related to the mass media program (radio broadcasts through local partner radio stations, collective listening sessions);
3. Strengthen TAs’ capacity and clarify their roles to enable them to better monitor mass media activities;
4. Boost implementation of and sharing of best practices in BCE community activities in collaboration with the TAs, including activities requiring technical assistance such as Income Generating Activities (IGA), to increase the demand for quality health products and services; and
5. Give support to MAHEFA’s regional team to enhance integrated supervision of TAs and CHWs.

During the period between March and September 2014, the Field Technicians strengthened the capacity of NGO TAs through ongoing coaching and the sharing of best practices amongst TAs within and across regions. Table 2 below shows the different types of capacity building received by the 279 TAs in the six regions, while Box 2 highlights some of the TAs' comments on the monitoring and support given by the Field Technicians. As these comments reveal, the TAs have a better understanding of BCE activities and have improved their expertise, their confidence and ability in supervising such activities. This had an impact on the quantity and quality of BCE work conducted by CHWs and thus contributed to an increase in demand and utilization of services and health products.

Table 2. Types of capacity building received by the TAs

Types of capacity building	Number of TAs benefiting from capacity building
Strengthening of the use of the BCE guide, the “ <i>Torolalana sy Vahaolana</i> ” (via monthly meetings and field visits). Approaches reinforced and practiced: Care Groups, testimonies, demonstrations, positive deviance, listening groups, guided visits to health centers, exhibitions, advocacy and contests.	263
Reinforcing the ‘solutions’ regarding the 22 health topics and the use of the calendar already established for each theme in the “ <i>Torolalana “Torolalana sy Vahaolana</i> ” (e.g. PF, handwashing with soap, immunization, use of LLITNs, etc.).	263
Capacity building in integrated supervision of CHWs	121
Enhancing the implementation and monitoring of listening groups including training, support and supervision of facilitators and monitoring of radio broadcasts.	130
Reinforcing the correct use and distribution of new BCE tools (e.g. Care Group stickers and FP invitation cards).	251

Types of capacity building	Number of TAs benefiting from capacity building
Assistance with the preparation and implementation of World and National Days (Approaches: carnivals, exhibits of CHWs' activities, cooking demonstrations and taste-testing, sales of WASH products (e.g. tippy taps), etc.	19
Assistance in the preparation of "community restitution" celebrations	24

Box 2. TAs' comments on the support of Field Technicians

DIANA: "Zoky (big brother)" - (many TAs used this title for their Field Technician), "Mr. BCE Teacher! Mr. Facilitation Techniques" (TAs from SALFA, FAFY, SAGE, l'Homme et Environnement NGOs) ; "You ! You always find tips to add regarding BCE!", "Ah, now I understand the BCE!", "Come again next month!"

SAVA: "Ingahy BCE" or "Mr. BCE" (common names given to TAs). "BCE: now it's clear!" claimed Patrick a TA from the SAGE NGO. "Before your arrival (the Field Technician), we didn't dare broach the subject of the BCE directly in front of our CHWs. Now, not only are the tools available and the CHWs know how to use them, but also the number of consultations at the CSBs is increasing" (José, TA of CR Fanambana).

Sofia: "You are Mrs. BCE!" (TAs of all NGOs); "We appreciate the coaching so much (on the use of stickers) that you have provided and that now CHWs have more confidence in us!" (TA from Befandriana, TA from SIVE and TA from ASOS). "Regarding the *Torolalana sy Vahaolana*, we did not understand very well how to use it at first; but now, we can teach our CHWs how to use it." (TA of ASOS and TA of SAGE).



A Field Technician and TA assist the CHW in conducting demonstrations and selling ready-to-use tippy taps in Menabe.

1. 3 Reinforcing and complementing the media campaign by adapting and/or developing additional print and audio communication tools that suggest ways to address barriers identified through previous research

Behavior change requires the use of a multimedia approach to communicate solutions to behavioral obstacles and emphasize motivators to behavioral change, as well as strong and continued support from influential groups. Thus in FY2014, MAHEFA continued to complement the above BCE activities with a series of multimedia activities including the creation and

distribution of new audiovisual tools. This served to reinforce the messages given by CHWs on the various program elements. Among the printed materials adapted and/or produced this year and distributed are:

- 250,000 additional health booklets for children under five (150,000) and for women (100,000)
- 130,000 FP invitation cards
- 130,000 stickers on four health and WASH sub-themes used to reward and identify Care Group families
- Two editions of “*Zara ny Efa*” (newsletter) highlighting CHWs’ experiences and best practices
- Five WASH communication tools, including:
 - A household poster on handwashing with soap
 - A household poster on latrines
 - A brochure explaining how to use “*SûrEau*”
 - A brochure explaining how to use SODIS
 - A catalogue on the different types of latrines.

The above mentioned materials have been distributed and are being used by the CHWs, WUHSA members and individual households. In addition, the following materials were produced and will be disseminated at the beginning of FY2015:

- Six counselling cards on gender issues (a different one for each region)
- *Hita sy Re*, a booklet including skits on MNCH/FP and gender for NGOs and CHWs
- Additional health booklets for children and women.

In regards to mass media, the program also produced:

- Six health stories in three dialects (Sakalava, Tsimihety and Antakarana)
- Six radio drama episodes on health, WASH and gender issues
- 25 new radio spots (to complement the 25 spots created in FY 2013)
- 15 radio reports on community health initiatives and activities.

To ensure maximum coverage, MAHEFA collaborated with 26 local radio stations who broadcast these radio programs in 24 districts covered by radio signals in the 279 communes in the program’s six regions.

As part of the media campaign, MAHEFA organized 432 new village listening groups, (90 of which were in nine new communes). The coverage of just the new listening groups alone is estimated at 205,850 radio interventions including mothers, fathers and youths in FY2014. With the new groups (432), the total of the program is currently 607 listening groups, including those groups organized in FY2013. It is estimated that overall group listenership coverage for the period, including groups established in FY2013 (175) and FY2014 is about 415,850 radio interventions. The listening groups are



Collective listening session in Melaky

implemented in collaboration with Adventist World Radio (AWR). This partner provided wind-up radios and training of listening group facilitators who are responsible for organizing collective listening sessions within their respective communities.

In addition, MAHEFA’s baseline survey (2012) revealed that 64% of households in the MAHEFA regions own a radio. Therefore, it is estimated that approximately 1,941,371 people are currently reached by key prevention messages through the radio. Amongst them, it is estimated that 446,515 are women of childbearing age (23% of the national population according to the 2008-2009 Demographic Health Survey) and 330,033 are youths (17%).

Some comments on the usefulness of radio listening groups and how they serve to reinforce the “solutions” promoted by MAHEFA are presented below in Box 3.

Table 3. Number of listening group sessions per region in FY2014

Regions	Number of new listening groups (October 2013-	Number of sessions organized (in FY2014)	Total number of participants in FY2014
DIANA	140	5,248	131,200
SAVA	38	1,696	42,400
Sofia	115	4,536	113,400
Boeny	22	800	20,000
Melaky	41	1,074	26,850
Menabe	76	3,280	82,000
Total	432	16,634	415,850

Box 3. Testimonies praising collective listening sessions

LG Facilitator: “We need to continue this program because we see remarkable improvements in the lives of listeners. Collective listening sessions followed by group discussion are appreciated. People share knowledge. They can express themselves freely”. (*Armeline Antanambao SPM Maintirano*)

TA: “Listening groups help us a lot in our activities. We request the continuation of this program. We also want to get T-shirts and school bags for example, to distinguish ourselves from the masses”. (*Joeline - TA Maintirano*)

Fokontany Chief: “We thank all those responsible for facilitating the sessions. People’s knowledge about health is evolving. We are moving gradually towards applying this knowledge. We have six neighborhoods in our *fokontany*. However, we want to thank MAHEFA for this program that targets disadvantaged areas. If this program did not take place, many of us would have remained in ignorance. This program must be expanded, thanks to the American people”. (*Ralaisoa - Ambalakazaha Antsalova*)

Source : AWR Report 2014

1.4 Establish WASH-friendly institutions

Previously, the program’s WASH-friendly approach has been targeting active community groups such as in churches and private schools, scouts and women’s organizations to encourage these members to integrate and apply the three key WASH messages. These groups have also been encouraged to mobilize their families and communities in general to adopt and put these messages into practice. Once community groups are convinced of how crucial it is to become a WASH-friendly institution, a partnership agreement is signed between MAHEFA, represented by the Regional Coordinator in collaboration with the DIORANO WASH Regional Platform and the community group. These partnership agreements require that the institutions disseminate and promote the three key messages within their community and support the construction and use of

WASH infrastructures (wells and latrines), starting from their own institutions and expanding to the rest of the community according to a well-developed plan.



The innovative bamboo Tippy Tap that came from Antanambaon' Amberina, (Sofia), is being used by the Minister of Water to demonstrate hand-washing technique.

However, in October 2013, a review of WASH activities was conducted and one of the key recommendations made was to increase community ownership of WASH activities. Thus, the MAHEFA program went beyond the “WASH-friendly” approach to involve more TAs from NGOs who provide regular on-site support to CHWs. The TAs were trained in the CLTS+H approach so that they can monitor and provide support to communities in promoting CLTS+H activities. This strategy has yielded much more concrete results in communities (see Figure 1 and 2 below) than before. However, so as not to lose the momentum gained through the implementation of WASH-friendly activities already under way, MAHEFA continued to work with all

WASH partners or WASH-friendly institutions in FY2014 and 78 WASH-friendly institutions were sensitized. In addition, 66 of these community groups have implemented their action plan as part of their KMSm plan and achieved their targets.

Approximately 210 WASH-friendly institutions have already been evaluated and recognized for their achievements in sharing their WASH expertise with other institutions and the community.

In short, MAHEFA no longer focuses on creating WASH-friendly institutions but instead mobilizes efforts to ensure that the whole community becomes WASH-friendly. With this new strategy, MAHEFA will continue to put more emphasis on WUHSA efforts and will no longer recruit new WASH-friendly partners. The program now considers that “the entire community” should be WASH-friendly.

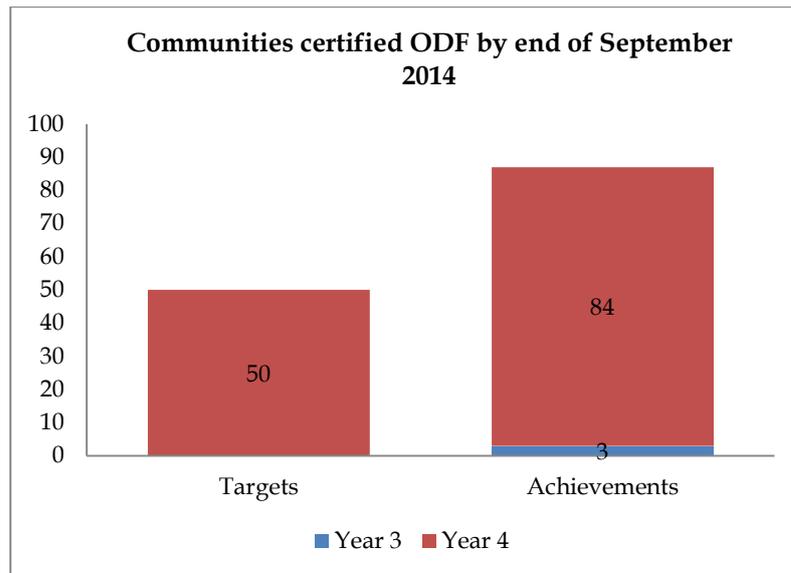
1.5 Launch and maintain community mobilization and continued participation in the CLTS+H approach

The CLTS approach aims to assist communities in attaining Open Defecation Free (ODF) status. The “H” for Hygiene is added to the acronym of CLTS to ensure that it becomes part of the process (development programs have come to realize the important link between Sanitation and Hygiene). In other words, it makes sense to promote the construction and use of latrines while also including the promotion of tippy taps for easy handwashing with soap.

In FY2014, MAHEFA concentrated its efforts on ensuring regular monitoring of communities that had previously benefitted from CLTS triggering events, and organized similar activities for a smaller number of sites planned for the second semester. This strategy was used following the recommendations issued from the above-mentioned October review conducted by three consultants (one international WASH consultant, one CLTS specialist and one Monitoring & Evaluation expert). This situational analysis was carried out to study the implementation of the CLTS approach and used the results to develop recommendations. This analysis provided guidelines with clear benchmarks for the next two and a half years of the project.

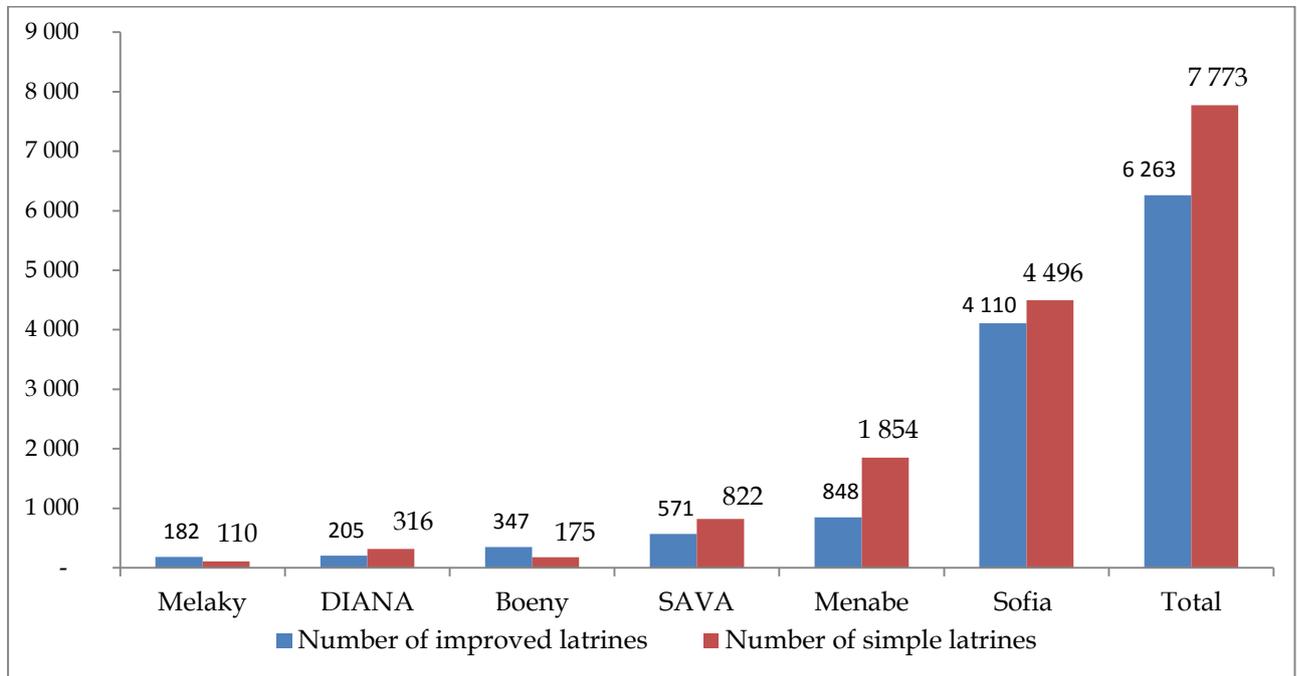
To improve expected results in regards to CLTS based on the recommendations of the evaluation team, in FY2014 MAHEFA put more emphasis on increasing its support to partner NGOs, facilitators at the commune level, Natural Leaders and community members. This was done to ensure that triggered communities continue to be committed to the CLTS approach, and to support every effort made to reach ODF status.

Figure 1 . Cumulative ODF situation in MAHEFA regions



One of MAHEFA’s strategies to improve coordination and follow-up of triggered sites is to organize monthly meetings at the level of the “*chef lieu*” (regional capital) of the commune. These monthly meetings are organized by the TA of each commune with the participation of all the community stakeholders (CHWs, communal facilitators, Natural Leaders). These meetings allow the TAs to monitor WASH activities and results on a monthly basis and follow up on the reports of the triggered sites in each commune which also helps with their overall reporting. This guarantees NGOs’ participation in the monitoring of these activities while enabling a closer collaboration between the various stakeholders including the CHWs. These and other activities will continue in FY2015 as per the program’s Work Plan.

Figure 2. Simple and improved latrines by region (end of September 2014)



1.6 Maintain KMSm activities

Box 4. Community leaders take responsibility in KMSm process

Community leaders showed their appreciation of the importance of the KMSm process for their community. The Mayor of Berevo commune, Belo sur Tsiribihina district said: *“During this 2nd cycle, we noticed that the KMSm process, together with the input of leaders in the monitoring of the implementation of our Action Plan, is of great importance to achieve our targets. Before, we left everything on the CHWs’ shoulders. Now we are closely monitoring the implementation and we are happy to take our responsibility. We are very grateful for your support.”*



During FY2014, KMSm activities focused on the organization and support of regular assessment meetings to examine progress and achievements against targets set by the communities in their Participatory Action Plan 1 or 2.

Please refer to section IR3 of the present report for more information on KMSm activities and results.

1.7 Contribute to special events (health days)

MAHEFA in collaboration with other USAID-funded partners (respecting restrictions on support to public institutions) participated in selected events such as World Water Day, World Malaria Day, World Breastfeeding Week, World Pneumonia Day and Global Handwashing Day. Activities were also organized to highlight International Women's Day and the SSME (*Semaine de la santé de la mère et de l'enfant* - Mother and Child Health Week) through its regional offices.

Table 4. List of high profile events to celebrate international health days

Date	Events	Regions/Activities
March 7	International Women's Day	<p>Boeny - A radio report was produced and broadcasted by the RNM (Malagasy national radio station) on the testimony of a woman CHW who shared her perceptions and experiences as a mother and promoter of health development.</p> <p>Menabe - A carnival was organized including a race of rickshaws pulled by women CHWs. They also did demonstrations explaining the types of products and services they provide.</p> <p>Melaky - MAHEFA women CHWs led the traditional carnival which opened the festivities, brandishing a MAHEFA/USAID banner.</p> <p>SAVA - There was a panel discussion on the theme of equality between men and women and exhibitions of CHWs' health activities as well as their own crafts, sewing, etc. In addition, CHWs and regional office staff created a banner stating that "A woman has the right to make decisions about her own health".</p>
March 22	World Water Day	<p>The 6 MAHEFA regions - The day was marked by several activities around the theme "Access to water requires good energy management": carnivals, puppet shows, practical demonstrations on the treatment of water with "Sûr'Eau" and SODIS, and making tippy taps for handwashing with soap.</p>
October 15	Global Handwashing Day	<p>All 6 MAHEFA regional offices, for example in Boeny and DIANA - Activities included the inauguration of wells, demonstrations of how to make tippy taps and how to properly wash hands with soap using this device, as well as certification of ODF villages.</p>
April 28 - May 2	SSME	<p>All 6 MAHEFA regional offices - participated in various activities for the 16th national campaign for Mother and Child Health Week (SSME), which was combined with the African Vaccination Week campaign. These events were highlighted by the introduction of the rotavirus vaccination for preventing diarrhea.</p>
April 25	World Malaria Day	<p>Sofia - More than 100 people participated in the event organized by the Ministry of Health at a MAHEFA site in Sofia region. SAGE, a MAHEFA partner NGO, presented a puppet show that included quizzes and distribution of LLITNs for malaria prevention and to increase community involvement in the fight against malaria.</p>

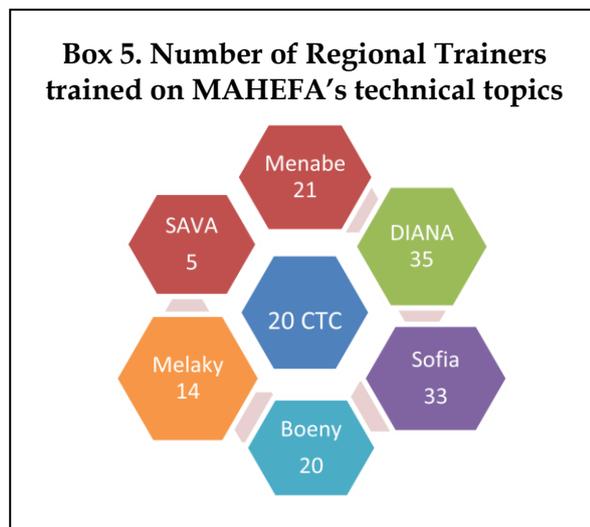
III. IR2: INCREASE THE AVAILABILITY OF SERVICES AND PRODUCTS

This part of the report is divided into two parts: a) strengthening the community based health service system and, b) analysis of health services provided by CHWs in FY2014.

2.1. Strengthening of the community based health service system

2.1.1 Support Regional NGOs and Training Consultants

In FY2014, MAHEFA continued working with 128 training consultants who were already trained in integrated program elements, in order to ensure that there would be a sufficient pool of available Central Training Consultants (CTC) and Regional Training Consultants (see Box 5). Following the lifting of restrictions by USG on working with GOM at the end of May 2014, MAHEFA started to identify and work with trainers from the public sector.



Under the supervision of MAHEFA's regional team, the trainers trained NGO staff including the TAs on the integrated MAHEFA package (MNCH, malaria, nutrition, FP/RH and WASH) and on the supervision and monitoring of CHWs.

2.1.2 Build CHWs' capacity in integrated program elements

In FY 2014, MAHEFA concentrated its efforts to ensure that CHWs received all integrated packages of training in line with MAHEFA's FY2014 Work Plan. Four types of consecutive trainings were conducted by Regional Training Consultants on FP/RH, c-IMCI, DEPOCOM, nutrition, and WASH (handwashing with soap, water treatment and storage, use of improved latrines, the WASH-friendly approach). As per the MOH guidelines, six weeks after these first trainings of c-IMCI and DEPOCOM, CHWs were assisted through the "suivis groupés".

In collaboration with the MOH (PNLP, DSEMR and the DDDS), the DEPOCOM and c-IMCI curricula for community-based service provision were revised in order for the training to be conducted within three days and testing to be carried out in MAHEFA targeted areas. MAHEFA is the first program in Madagascar to pilot the new c-IMCI training for CHWs with a revised curriculum conducted in three days instead of five.

During the same period, MAHEFA organized c-IMCI trainings for the remaining CHWs who were not previously trained by the NSA. MAHEFA gave priority to the 822 CHWs who were never trained in c-IMCI. By the end of FY2014, 1,230 CHWs had been trained and equipped in c-IMCI, thus bringing the total to 5,608 CHWs who are ready to provide child care for diarrhea, ARI and malaria.

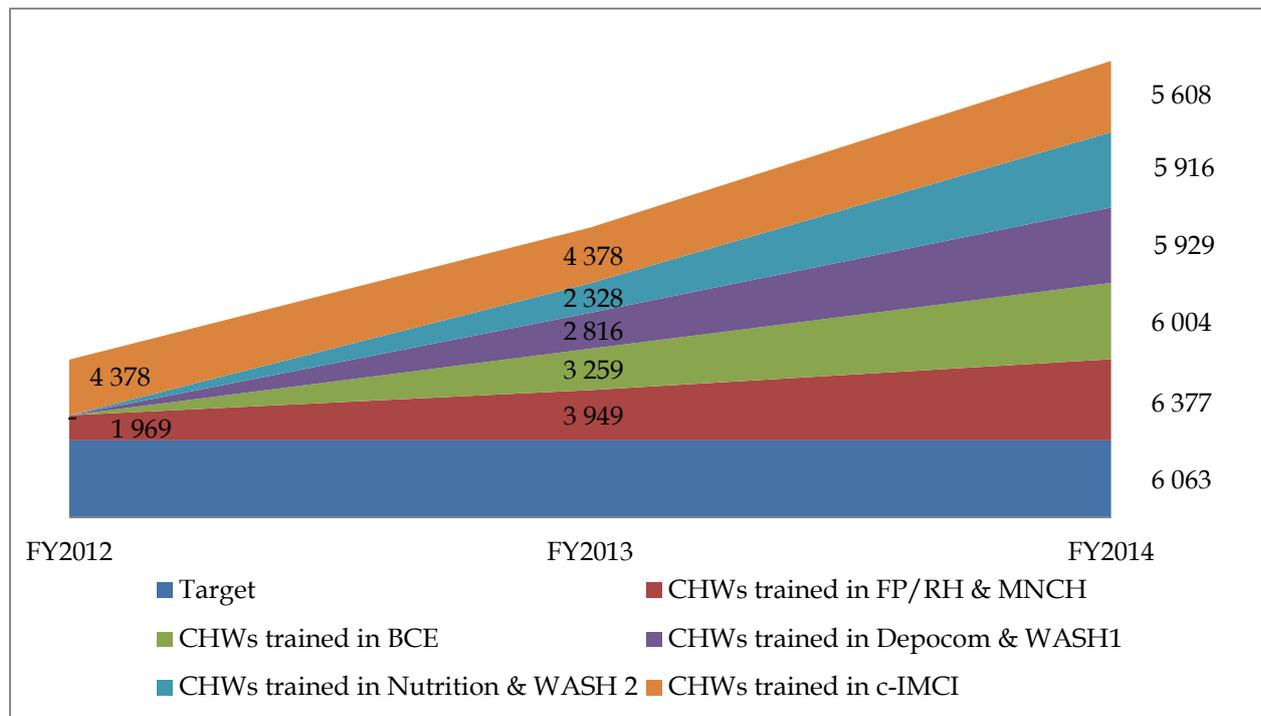
In addition, 3,588 CHWs received nutrition and WASH training in a combined session, while 2,745 were provided with BCE training to improve their skills on mobilization and awareness raising

activities, as well as service provision to increase the demand for and availability of quality services.

As a result, MAHEFA interventions during FY 2014 have contributed to the following:

- An acceleration of the completion of theoretical courses given to CHWs and especially their practical training (“*stages pratiques*”) certification at CSB. By the end of September 2014, all CHWs trained in DEPOCOM during the period (3,113) were certified by the CSB compared to the 57.5% in FY 2013 (1,619 out of 2,816).
- An increase in number of CHWs trained to provide DEPOCOM service at community level compared to FY 2013, bringing the total trained to 5,929. At the same time, the numbers of CHWs trained in nutrition and WASH increased significantly between the two fiscal years, reaching a total of 5,916 at the end of September 2014. Regarding the BCE component, 6,004 CHWs have been trained. The number of CHWs trained in the FP-4 methods exceeded the target; this is due to the number of CHWs replacing those who had resigned. Program progress trends from project start-up are summarized in Figure 3 below.

Figure 3. Trained CHWs in FY2014 by types of training



In the area of c-IMCI and BCE, the total number reported in the FY2013 annual report has been updated based on the completion of the new MIS and data verification during Q4 FY2014.

2.1.3 Participative supply chain management

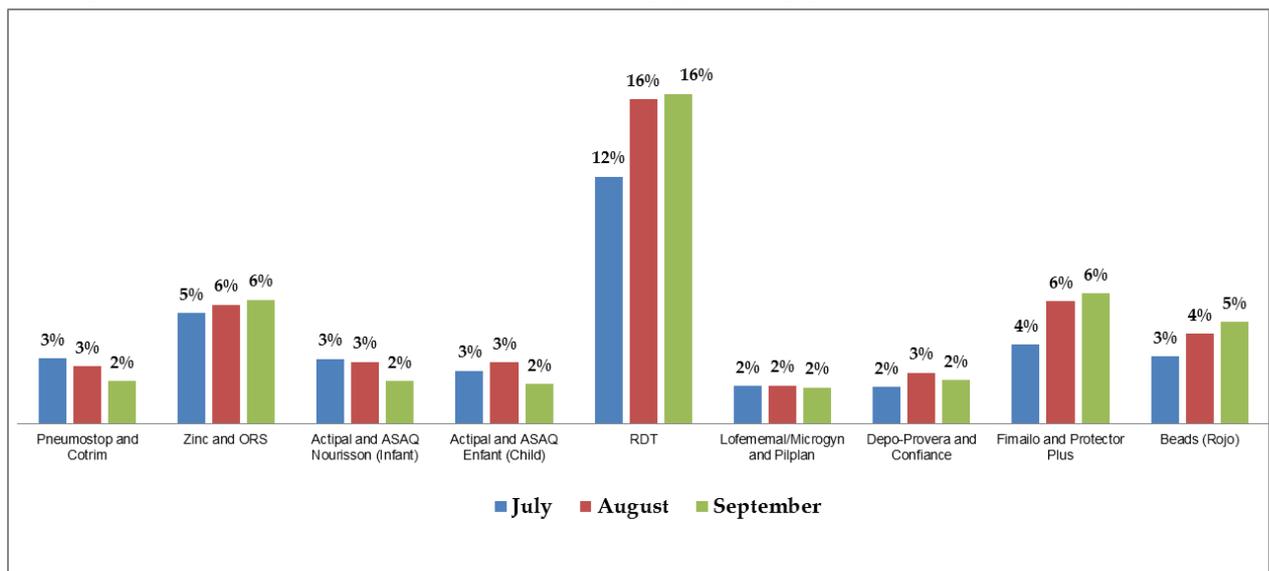
In FY2014, MAHEFA continued to maintain a strong collaboration with PSI/ISM. A joint plan to build the capacity of CHWs and PAs’ (“*points d’approvisionnement*” or supply points) was developed to facilitate the implementation of the “zero stock-out” approach at the CHW level. During the first three years of the program, MAHEFA worked closely with PSI to identify PAs and the collaboration through FY2014 was focused primarily on the steady implementation of activities and availability of products through a functional supply chain.

The “zero stock-out” approach has reinforced CHWs’ stock management capacity as a result of the regional units’ and TAs’ close monitoring. All TAs (279) were trained on quantification methods which include the calculation and monthly monitoring of maximum and minimum stock levels, average monthly consumption, quantities to order and number of potential stock-out days. In turn, the trained TAs assisted the CHWs by gradually transferring this knowledge to build their own stock management capacity.

As a result, MAHEFA was able to continue to supply remote areas with health products, building on lessons learned in FY2013:

- In Mitsinjo District (Boeny), MAHEFA continued to collaborate with HoverAid and PSI to distribute health commodities to Bekipay and Ambarimaninga communes by hovercraft. However, it remains challenging for the PA to supply a 6-month stock of products to the CHWs due to financial reasons or product transportation limitations. This has resulted in the establishment of “PA relais” in some difficult-to-reach communes.
- In Miandrivazo district (Menabe), HoverAid expanded the reach of hovercraft in order to increase the distribution of health commodities to Masoarivo, Berevo, Begidro and Ankalalobe communes in Belo-sur-Tsiribihina district. This new base has been in operation since June 2014. As a result of the Hovercraft expansion, travel duration to these areas (before by motorized canoe) was shortened respectively from 48 to 6 hours to reach Ankalalobe, and from 6 to 1 ½ hour to Berevo. In Q4 of FY 2014, PSI used the hovercraft to supervise and resupply four supply points located in Begidro (Ankiriroky), Berevo, Belinta and Ankalalobe.
- In addition to community logistics, HoverAid began to extend its mobile hospital activity in Soalala district. MAHEFA will coordinate with HoverAid to allow CHWs to conduct high visibility events during the mobile hospital week.
- During FY2014, MAHEFA’s partnership with PSI, HELIMISSION and the VAOVAO MAHAFALY Hospital allowed MAHEFA to supply isolated communes in Mandritsara district (Sofia) by helicopter during rainy season.

Figure 4. Stock-out of child health and family planning products in Q4, FY2014 (n=4,533)



During the last quarter of FY2014, MAHEFA recorded the highest level of stock-out in RDTs at the CHWs level (16% at the end of September 2014), while stock-outs in Pneumostop, Zinc and ORS respectively decreased from 51% in February to 2% in September 2014, and from 30% in January to 6% in September 2014.

2.1.4 Support, Equip and Supply CHWs and Youth Peer Educators (YPE)

In FY2014, CHWs and YPEs were provided with kits. The following table summarizes the materials and tools distributed to CHWs and YPEs in FY2014.

Table 5. Tools managed by CHWs, YPEs and community actors by the end of September 2014*

CHWs' tools	CHWs'/YPEs' tools	Other community actors' tools (COSAN, Natural Leaders, etc.)
IEC tools		
<ol style="list-style-type: none"> IEC Register Facilitation Booklet Health cards ("<i>carnets de santé</i>") for children Health cards for women Tiarht poster 	IEC technical card	
Management tools		
<ol style="list-style-type: none"> Register for women FP Register Monthly report c-IMCI register c-IMCI monthly report Reference & counter-reference forms Stock management forms Case management card 'children' 	<ol style="list-style-type: none"> Register for 'youths' Monthly reporting form CHWs/YPE's contact directory Reference & counter-reference forms 	
Work tools		
<ol style="list-style-type: none"> RH/FP4 Guide DEPOCOM Guide Blue timetable Blue and red timetable Cycle Beads Guide DEPO Jobaid DEPO checklist Pills checklist FP demonstration van Guide & solutions MUAC SALTER scale Isothermal bags Timer 	<ol style="list-style-type: none"> Training Guide for CHWs/YPEs SMS User Guide for YPE 	<ol style="list-style-type: none"> Kit for COSAN offices at the commune level "<i>Fanaraha-maso ny fanadiovana tanteraka tarihin'ny fokonolona eny ifotony</i>" for Natural Leaders Community water management forms for the WUHSA Job aid for the COSAN

***Note:** Some tools and materials distributed to CHWs that do not require specific management (notebooks, smocks, etc.) are not presented in this table.

2.1.5 Establish models for "mutuelles" / microfinance and emergency transport

FY2014 was marked by the integration of emergency transport into the service package offered by health "mutuelles" (health insurance scheme). This was to ensure the complementarity of these two

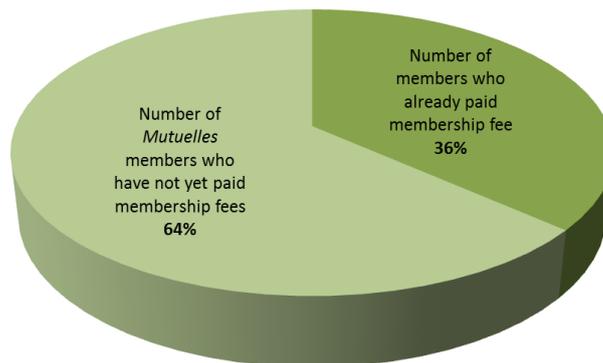
initiatives and to contribute to the improvement of healthcare while meeting the needs of communities. While still following the KMSm approach, this integrated intervention aims to involve community members in actively taking charge of their health.

Thirteen (13) management committees of health *mutuelles* were established this year with 97 members trained in 13 communes and seven districts (of the three districts planned) in Sofia, Boeny, Menabe, SAVA and DIANA regions. By the end of FY2014, 21 out of 23 total health *mutuelle* committees created in FY2013 and 2014 are functional. Among the functional committees, three (two in Bemanonga and Analaiva, Menabe and one in Nosibe, SAVA) also received training in emergency transport system management.

Table 6. Progress of health *mutuelles* activities in FY2014

<i>Mutuelle</i> Indicators	FY2013	FY2014	Cumulative
Number of communes that have a health <i>mutuelle</i>	10	13	23
Number of new <i>mutuelles</i> ' members trained	84	97	181
Number of new registered members	16,500	4,599	21,099
Number of current paying members	NA	7,700	7,700

Figure 5. Members of and contributors to *mutuelles* in FY2014 (n=21,099)



Community members' commitment to this initiative was evidenced by their determination to formalize the health *mutuelles*' associations with their respective rules and regulations. Out of the existing 23 *mutuelles*, 22 were formally registered and obtained a legal status. This commitment is strengthened by the collaboration between *mutuelles* and health centers (22 partnership agreements signed) and microfinance institutions. In addition, communities with emergency transport expressed their intention to continue to build on MAHEFA's initiative: in Vohemar, a commune would like to pay for the construction of means of emergency

Box 6. Corrective measures to improve *mutuelles* and emergency transport

A workshop (funded by DFID's AFCAP program) was organized to improve the design and production quality of bicycle-ambulances and wheeled stretchers. The support from Mike Usowicz, a Peace Corps volunteers contributed to the success of this activity;

- Change in the payment terms of the subscription fees to the health *mutuelles* (payment every six months or annually during harvest period instead of monthly), to ensure both the continuity of services and their immediate access by members.
- Promote health *mutuelles* and emergency transport via BCE activities conducted by CHWs and other community actors.

transport with their own funds, and has asked MAHEFA’s support to link them with the transports provider.

Furthermore, 22 *fokontany* were provided with emergency transport since December 2013 in Bemanonga and Analaiava communes (Morondava District, Menabe). Nosibe commune (Vohemar district, SAVA), was provided with eight means of emergency transport in September 2014. The launching and promotion of emergency transport was initiated by the commune in Q4 with the participation of the Mayor, CSB Heads, *fokontany* Chiefs and COSAN and management committee members (COGE).

Activities to establish health *mutuelles* and emergency transport systems faced challenges at various levels throughout the process such as: the development of implementation strategies, communities’ ownership, the failure of previous similar activities, the adaptation of emergency transport to the local context and the volunteer status of the individuals involved in these structures’ management.

Box 7. Success story on emergency transport

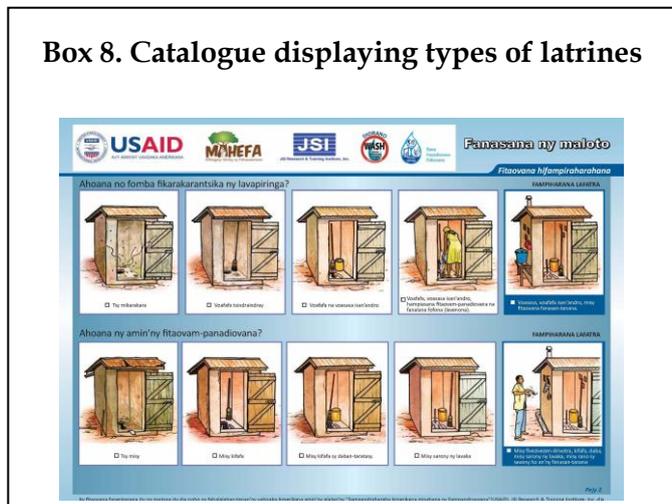
A young mother living in Tanambao Marofototra (Bemanonga commune/ Morondava district) 4 km away from a CBS and 12km from the district hospital had just given birth in her home. Three days later, the baby had difficulty breathing. The mother called upon the CHW in the middle of the night, who in turn organized the baby’s transfer by bicycle-ambulance. The *fokontany* Chief contacted the nearest driver. Upon arrival at the CSB, the baby received first aid but as he needed oxygen, he was transferred to Morondava Hospital with the same bicycle-ambulance, because there were no bush taxis available at night. However, thanks to the round-the-clock availability of the bicycle-ambulance, the baby reached the hospital in time and, after three days of hospitalization, survived.

2.1.6 Sanitation marketing

Sanitation marketing was launched within the CLTS process described earlier in IR1 at the district level in FY2013 and at the commune level in FY2014. Priority was given to the communes where there had been CLTS triggering events and where there is noticeable progress towards obtaining the ODF status and a strong demand for the construction of latrines.

A total of 398 local masons were identified and trained to build “Dalles San Plats” (or washable latrine slabs) and improved latrines in the triggered sites in FY 2014. After their training the local masons participated in the promotion of the use of improved latrines and Dalles San Plats in their communities. A catalogue displaying latrines was produced to help households choose the type of latrines they would like to have. NLs, communal facilitators and CHWs helped the local masons identify households in their

Box 8. Catalogue displaying types of latrines



community interested in building improved latrines. During FY2014, 342 Natural Leaders were identified and became functional.

Although MAHEFA did not initially plan to create Village Savings and Loan Associations (VSLA), this approach has gradually been integrated into the existing WUHSA structure. For MAHEFA, the main purpose of the VSLA approach is to ensure that all families have access to resources for the construction of latrines and access to drinking water (through access to water points such as fountains and wells).

In some CLTS triggered communities, a collective contribution system was established to enable families to buy drinking water or to hire local masons. This type of contribution system is a sustainable initiative as it stems from within the communities and MAHEFA will ensure that the WUHSA will make use of existing contribution systems.

2.1.7 Access to drinking water

During FY2013, technical studies were completed and contracts awarded for the construction/ rehabilitation of water infrastructures. During FY2014, the engineering companies (*Bureaux d'étude*) supervised the construction/rehabilitation work; monitored the establishment of WUHSA and ensured community's contributions in the construction and management of the water structures. By the end of September 2014, most of the construction work (86.2%) had been completed (see Table 7 below) enabling 78,250 people to have access to drinking potable water.

Table 7. Water structures rehabilitated and built by end September 2014

Regions	Rehabilitations			New constructions			WUHSA trained (number of groups)
	FY2014 Targets	Achieved in FY2014	Gap	FY2014 Targets	Achieved in FY2014	Gap	
Boeny	10	10	0	17	17	0	17
DIANA	17	17	0	108	78	30	99
Melaky	5	5	0	11		11	4
Menabe	0	0	0	47	45	2	38
SAVA	13	13	0	30	30	0	43
Sofia	0	0	0	98	98	0	98
TOTAL	45	45	0	311	268	43	299

The remaining 43 structures will be completed in FY2015. Among them, 16 needed to be built on new sites because the initial location did not comply with the environmental requirements or physical water infrastructure norms. As a result, MAHEFA submitted a revised ESF/ERR and the USAID's approval was granted in August, therefore required an approval.

In FY2014, 299 WUAs were created and members were trained to ensure good water management. As discussed in IR1 of this report, in FY2014, the program has put more emphasis on community participation and ownership of water, sanitation and hygiene related activities. For this reason, the WUA became Water Users and Hygiene and Sanitation Associations (WUHSA). Consequently, MAHEFA included CLTS practical sessions in the WUHSA members' training curriculum.

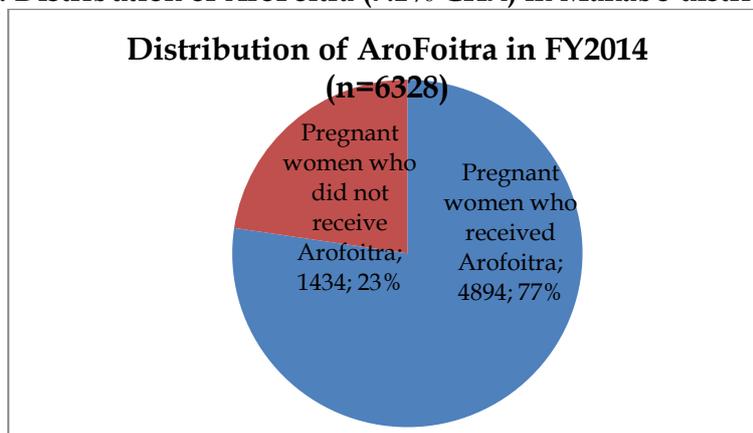
Water tests were initially planned to be conducted by the building companies as part of their contracts. However, given the inability of the building companies to conduct appropriate water testing, MAHEFA requested IPM (*Institut Pasteur de Madagascar*) to proceed with water quality analysis at all constructed or rehabilitated water infrastructures. While IPM is not on the list of recognized laboratories presented in the USAID IEE 2013-2018, it is the only laboratory in the country that can perform bacteriological analyses of water and is one of the national laboratories approved by the Ministry of Water. Tests were conducted during FY2014 for Menabe, DIANA and SAVA regions. The conclusions and recommendations of the IPM will be implemented on a case by case basis depending on the situation. The water quality analyses will continue for the remaining regions (Sofia, Melaky and Boeny) in Q1 of FY 2015.

2.1.8 Continue to support the pilot project on “umbilical cord care with 7.1% Chlorhexidine (CHX) in health facilities and at the community level” in Mahabo District

MAHEFA continued to monitor the progress of this pilot project, which started in FY2013. In collaboration with other members of the CHX Technical Working Group, MAHEFA implemented activities in Mahabo. A curriculum for CHWs’ and facility-based health workers’ training, CHWs’ Jobaid and data collection tools (newborns’ register, women’s register, CHWs’ and facility-based health workers’ monthly report) were produced or otherwise updated. These tools were made available to local service providers. In FY2014, MAHEFA purchased 35,000 tubes of 7.1% Chlorhexidine gel for use by CHWs and CSB. Due to the USG’s restriction on supporting the GOM, JSI was assisted by contributions from the Packard Foundation enabling the product to become available at the CSB level.

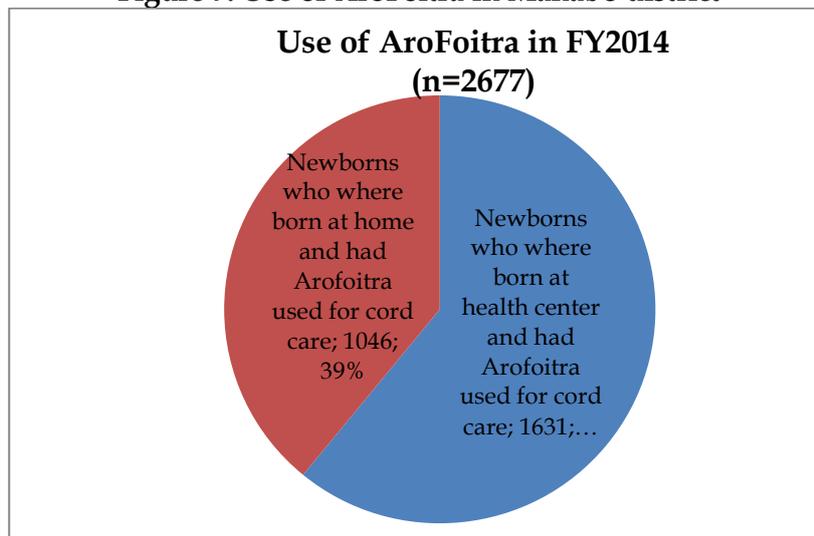
This was followed by a series of trainings for CSB workers (25) in collaboration with MCHIP, as well as for regional trainers and TAs (20). The training of CHWs was organized in groups and delivered by regional trainers and TAs. Presently, out of 280 CHWs trained, 271 CHWs are functional. Awareness raising sessions were organized by CHWs during home visits and through exchanges with women in their 34th week of pregnancy at their community sites or by facility-based health workers during the prenatal consultations. In addition, dolls with a pseudo umbilical cord were distributed to facility-based health workers and CHWs for demonstrations on the use of 7.1% Chlorhexidine. Messages were broadcasted by the local media and every pregnant woman receiving a tube of Chlorhexidine completed a consent form. In total 2,480 women received Chlorhexidine from facility-based health workers and 2,414 others from CHWs. In FY 2014, 2,677 newborns received 7.1% Chlorhexidine on their cord stump immediately after birth both at health facilities (61%) and at home (39%).

Figure 6. Distribution of AroFoitra (7.1% CHX) in Mahabo district, FY 2014



Two channels were used to distribute 7.1% CHX to pregnant women-through health facilities and through CHWs. As a result, compared to the number of estimated pregnant women in the district (4.5% of total population), CSB and CHWs were able to cover 77% of total pregnant women with 7.1% CHX. The distribution coverage via the two channels was nearly the same.

Figure 7. Use of AroFoitra in Mahabo district



Following the distribution of *AroFoitra*, CHWs conducted postnatal home visits to ensure that the newborns received umbilical cord stump care using 7.1% Chlorhexidine, to detect danger signs and to give counselling on exclusive breastfeeding. This was also an opportunity to retrieve used Chlorhexidine tubes certifying its use. By the end of September 2014, the coverage of newborns that benefitted from 7.1% Chlorhexidine cord care reached 48%, and use in the CSB was 1.6 times higher than use for home deliveries. However, we do not have any data on practices for umbilical cord care for newborns delivered at home and who were not visited by the CHWs.

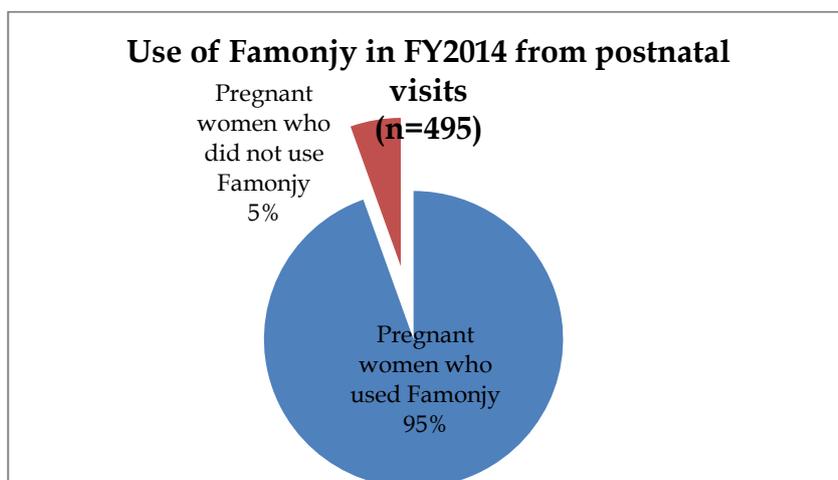
A document on the scaling-up of this initiative was developed with financial and technical support from PSI/PATH. Presently, 7.1% Chlorhexidine gel is in the process of obtaining a marketing authorization from the AMM (“*Autorisation de Mise au Marché*” or Marketing Authorization). Other partners (UNFPA, UNICEF and USAID/Mikolo) are willing to contribute to the scaling-up of the program in their areas of intervention but only the liquid form of Chlorhexidine is currently available from the Central Purchasing at Copenhagen.

The liquid form promoted by UN agencies is in the process of obtaining Marketing Authorization. In addition to the monitoring of the pilot project’s progress and conducting advocacy activities, a group of visitors (from the Ministry of Health, USAID, UNICEF, UNFPA, MSM, PSI, USAID/Mikolo and JSI/MAHEFA) went to Mahabo District. They were able to assess the relevance and effectiveness of the targets and the intervention. An international conference on use of the CHX was held in Antananarivo in May 2014 providing the opportunity to share experiences and lessons learned. This was followed by an internal review of the program in June 2014 by an international consultant to monitor the pilot project’s progress in Mahabo. The introductory phase of the project will be evaluated at the beginning of 2015.

2.1.9 Implement pilot project on 7.1% Chlorhexidine for newborns and Postpartum Hemorrhage (PPH) Prevention in Vohémar

The program began in January 2014 with the development of training curriculum and tools for data collection. This was followed by the delivery of a series of trainings starting with the training of facility-based health workers (since they will potentially become future supervisors of CHWs). In total 36 facility-based health workers and 271 CHWs were trained and became functional as of July 2014. They were provided with the necessary quantity of health products [Misoprostol (2,584 bags) by MCHIP and 7.1% Chlorhexidine (10,410 tubes) by MAHEFA] and IEC tools (counselling cards, dolls, etc.). From April to September 2014, as per the postnatal visit conducted by CHWS (520), 319 newborns reported having received cord care using 7.1% Chlorhexidine gel immediately after cord cutting. This represents 61.3% of total newborns visited by CHWs.

Figure 8. Use of Famonjy (Misoprostol) in Vohemar district in FY 2014



As a result of postnatal visits conducted by the CHWs, nine women out of 10 received *Famonjy* (95%) and have taken it after delivery (90%).

An internal review was also conducted by the international consultant (Dr. Mary Carnell). The review determined that the newborn cord care using CHX 7.1% is feasible to implement in rural Madagascar and that the beneficiaries were satisfied with the results. The main recommendations were: 1) procurement and storage of products; 2) supply chain system for the two products in both public and private (social marketing); 3) strengthening of capacity of staff at CSB and community levels (CHWs) through monitoring and supportive supervision.

The procedure for obtaining Marketing Authorization of Misoprostol (*Famonjy*) is underway despite some challenges and the Technical Working Group is advocating to obtain the official commitment of the Ministry of Health on this issue.

Table 8. List of key activities on umbilical cord care with Chlorhexidine in Madagascar

Dates	Activities	Observations
October 2013 – February 2014	Training of CSB Heads	61 facility-based health workers were trained with the technical and financial support from JHPIEGO/MCHIP in Mahabo and Vohemar districts

Dates	Activities	Observations
November 2013	Training of Trainers	6 central trainers, 6 regional trainers, 31 TAs from PENSER, Ny Tanintsika and SAGE NGOs were trained
November 2013	Recruitment of a CHX Field Supervisor	
October 2013-September 2014	Training of CHWs	559 CHWs were trained in Mahabo and Vohemar
March 2014	Joint visit to Mahabo	This joint visit led by the Ministry of Health with USAID, UNICEF, UNFPA, MSM, PSI, USAID/Mikolo, JSI/MAHEFA enabled participants to witness the progress made in this pilot project and to collect firsthand beneficiaries' perceptions.
March 2014	Expand CHX activities Vohemar (SAVA)	CHWs started 7.1% Chlorhexidine and Misoprostol distribution at community level
May 2014	International Conference on CHX experience sharing	With Pr. Luc Mullany as special guest to share experiences from other countries and make recommendations for scale-up in Madagascar.
June 2014	MOH approval to integrate 7,1% Chlorhexidine gel and liquid in the National Medicines List	AMM is still ongoing with Lomus Pharmaceuticals to register for 7.1% Chlorhexidine gel and UNICEF for the liquid form
July 2014	Review of CHX activities by Dr. Carnell (internal MAHEFA)	
August 2014	Approval from USAID to include CHX in JSI distribution list of health products for CHWs	

In collaboration with the MOH, UNFPA, and other partners, MAHEFA participated actively to prepare the Campaign on Accelerated Reduction of Maternal Mortality in Africa's (CARMMA) launch and action plan for Madagascar. MAHEFA also contributed to the review of the National Roadmap for Maternal and Neonatal Mortality Reduction 201-2019 with the aforementioned partners.

2.1.10 Improve CHWs' mobility

In FY2014, MAHEFA continued activities to improve the mobility of CHWs. Considering the experience of the previous year, the program ordered better quality bicycles directly through a supplier in England. The procurement process and production according to specifications took longer than expected. Therefore, the 700 bicycles for the CHWs will be delivered in the month of November 2014. However, 40 bicycles were distributed to CHWs in Port Bergé District (Sofia Region) in June 2014, funded through cost-share funds. According to the approach already established by MAHEFA, these 40 CHWs were trained in the riding, management and maintenance of bicycles; they also received a maintenance kit to assist them with minor repairs. Based on specific selection criteria, the 700 CHWs who will receive bicycles will be trained in

bicycle management and maintenance and a maintenance kit will also be distributed to all CHWs trained.

During FY2014, the implementation of Income Generating Activities (IGAs) in the form of bicycle stores and repair shops was completed, followed by the establishment of the first two sites of Mandroso Ebox - Antsohihy and Bealanana in the Sofia region. The development of this program's component took longer than planned as it is new to Madagascar. The Ebox Mandroso stores are social enterprises managed by cooperatives trained by community stakeholders who work with MAHEFA: CHWs, members of COSAN and health *mutuelles*. A portion of the sales' profits will be invested by the cooperative for community health activities fund, such as *mutuelles*; another portion of the profits will go to CHWs directly involved in the management of the stores and to cooperative members. The first two sites mobilize a total of 89 community stakeholders (28 cooperative members in Antsohihy and 61 cooperative members in Bealanana).

Box 9. Story of a CHWs making good use of his bicycle

Like the other CHWs in Mahabo district of the Menabe region, Gabriel Razafimaniry spends long hours walking from his home to places where he conducts his CHW activities. He has to start very early because the villages he visits are all more than 10 km away. Traveling time increases significantly, by almost three hours, on days when he needs restock commodities, as he must walk 14 km and travel by taxi for another 12 km. More than 300 CHWs in MAHEFA regions received bicycles that are adapted to local conditions from MAHEFA, and Gabriel was one of them. He reported that before he could only visit two to three houses per day, whereas now he can visit up to 10 houses in one day. Most importantly, he can stay longer when making village visits, as he loses less time traveling back to his home. He is able to improve the quality of his services by spending more time with his clients.

2.2. Analysis of Health services provided by CHWs in FY2014

Overall, MAHEFA contributed directly to making community-based integrated services available among CHWs in 2,929 *fokontany*, representing 97% of the total target *fokontany* (3,023). Disaggregated by region, SAVA has the highest coverage of availability of the integrated package of CHWs services with 151/153 *fokontany* (99%), while DIANA has the lowest with 557/588 (95%). This coverage reached 98% in Sofia region, and 96% in Menabe, while attaining 97% in Melaky and Boeny regions. Similarly, the use of CHWs' services by the community increased. The primary achievements for this year are described below.

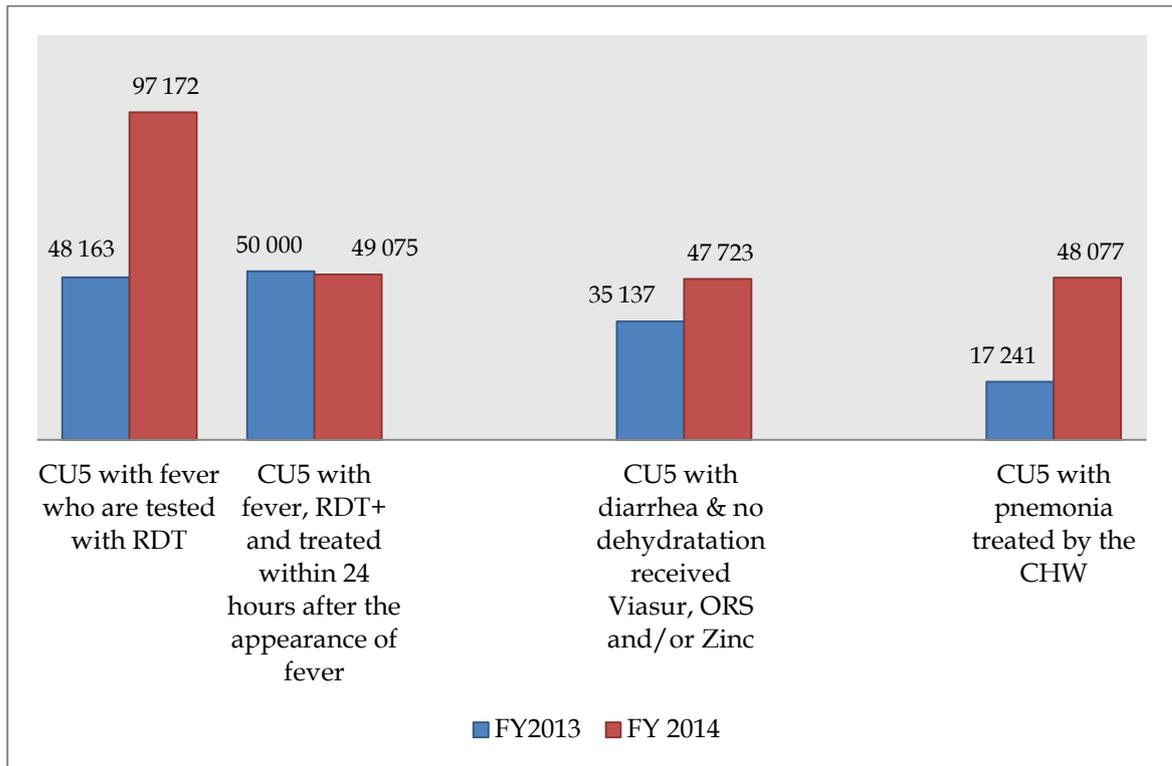
2.2.1 Case Management Services (Children under 5)

Services provided to children under five (CU5) addressed diagnosis, treatment, and counseling or referral to CSB in case services beyond the CHWs capacity were needed. Use of these services increased in FY2014 compared to FY2013. Main results are listed below:

- 234,804 children under five (CU5) were referred to CSB for vaccination
- 47,723 CU5 were treated by CHWs for diarrhea, of which 22,531 or 48.2% were girls
- 48,077 CU5 received treatment for pneumonia and 21,559 or 44.8% were treated with ACT within 24 hours after appearance of fever.

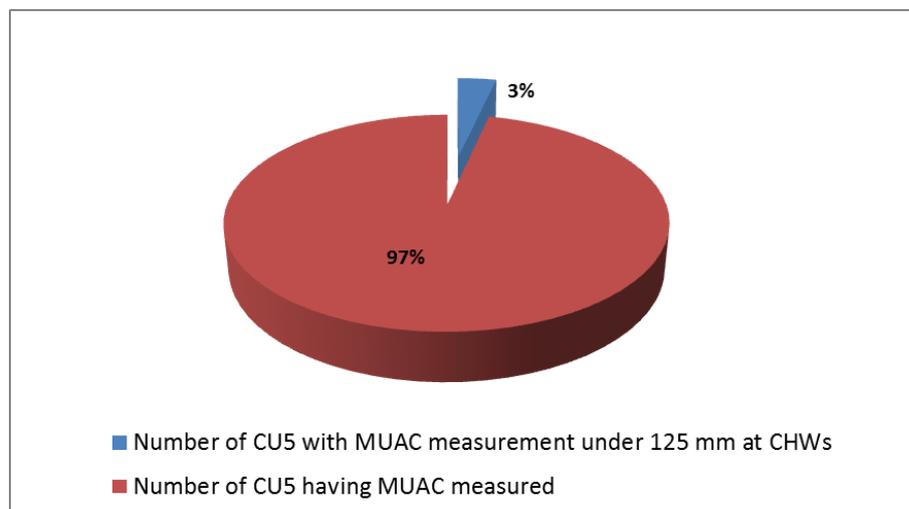
Out of the 97,172 children under five who presented fevers and were tested with RDT, half of them ((53.7% or 52,141) tested positive for malaria. 94% of these children were successfully treated by CHWs for simple case of malaria.

Figure 9. Service provision for CU5 differentiated by types of service in FY2013 and FY2014



During the same period, CHWs provided Mid-Upper Arm Circumference (MUAC) measurement to CU5 in order to detect early severe malnutrition among this age group. 203,410 children's MUAC was measured and their parents counselled on good nutrition practices. Three percent of the total number of CU5 seen by CHWs had a MUAC measurement under 125 mm. These children were referred to the CSB for additional nutritional services.

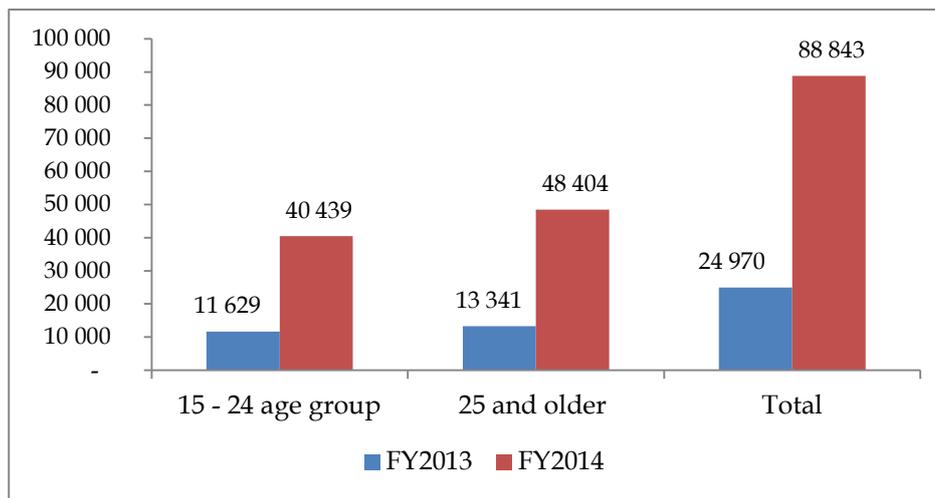
Figure 10. Percentage of CU5 with MUAC measurement <125mm in FY2014 (n=203,410)



2.2.2 Family planning (FP) and reproductive health (RH) services for women

Through the training and supervision of MAHEFA staff, CHWs, and NGOs, MAHEFA continues to ensure FP compliance according to the program's compliance plan and in agreement with U.S. Government regulations on FP services. Due to various contributing factors listed below, the program witnessed a significant increase (340%) in the number of RUs in the 15 to 24 year old group and in the 25 years and older group (360%) in all six MAHEFA regions.

Figure 11. Regular Users by age group in FY2013 and FY2014

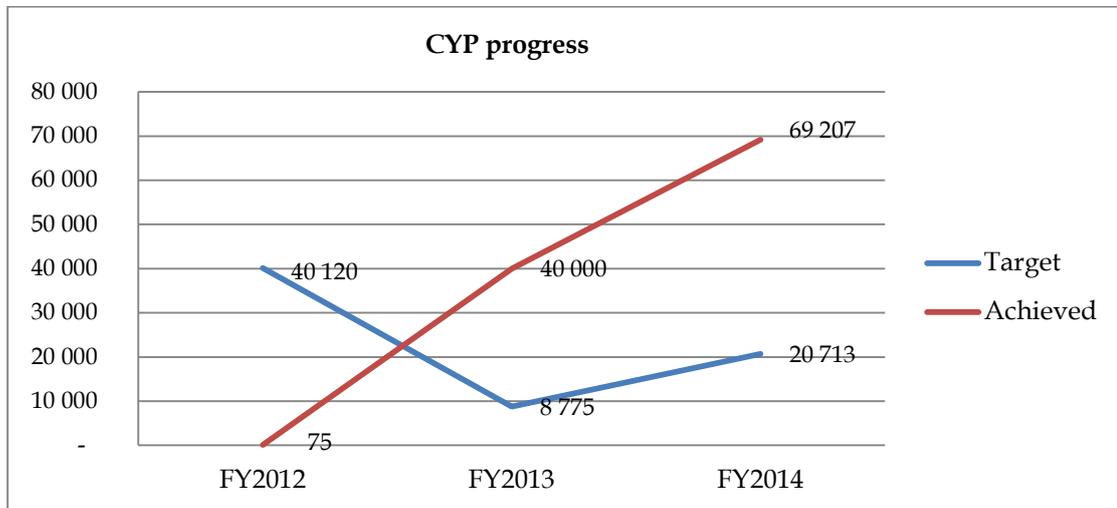


This increase is due to a combination of factors:

- Local FP behavior change empowerment activities organized by CHWs and the distribution of FP invitation cards through regular users
- Efficiency of household care group activities in FP promotion reinforced by BCE Field Technicians
- Broadcasts of FP radio spots
- Collective listening sessions on FP
- Increase in the number of CHWs trained in DEPOCOM and an increase in the number of "stages pratiques" in DEPOCOM validated which enabled them to promote the injectable contraception along with other FP methods
- Increase in the number of CHWs who participated in monthly meetings
- A 300% increase in the number of CHWs who were supervised by NGOs during Q4 of PY2014
- Awareness raising activities conducted by YPEs.

The 88,843 RUs were recorded as having exceeded the annual objective by 107%. Similarly, the program witnessed an increase in couple years of protection to 69,207, exceeding the annual objective by more than 300% as presented in figure 12.

Figure 12. Progress trends in CYP by end of FY 2014



To assist CHWs determine appointment dates with family planning clients accurately and without difficulty for follow-up, MAHEFA produced two FP calendars (one for oral and one injectable contraception) to assist CHWs’ accuracy; EMMP Jobaid in order to meet environmental compliance and the program’s safety; and a Jobaid on client’s rights to family planning to respect the FP compliance of MAHEFA’s program. All of these initiatives will contribute to enhance the quality of CHWs service provision in family planning in FY2015.

MAHEFA’s youth project is part of the program’s reproductive health and family planning component. Activities have been initiated since Q3 of FY2013. Prior to implementing YPE field activities, the program conducted advocacy activities to obtain support from local authorities and youth institutions for the project’s coordination and monitoring at the local level. The initial training of Youth Peer Educators (YPEs) and of selected CHW mentors on the youth approach began in Q4 of and was completed in Q3 of FY2014. Two YPEs and two CHW mentors per *fokontany* were trained in the program’s 24 districts, thus bringing the total of trained YPEs to 609 (or 93% of the 656 targeted). Of these, 527 (86.5%) were operational by the end of Q4 of FY2014. hundred and thirty-five (635/656) CHW mentors were trained by the end of FY2014. CHW mentors assist YPEs their peer advocacy work in reproductive health including family planning. YPEs refer youths seeking access to the various services provided by CHW mentors and CSBs (FP, c-IMCI, etc.).



PY3
Six
in

Advocacy to local authorities and launching of FP/RH messages for youth through SMS in collaboration with Fondation Telma in Antsiranana, DIANA Region

YPEs also guide young people to other services if their needs or expectations are beyond the skills of CHWs or CSBs. YPEs meet monthly with TAs who monitor their activities. Jobaids for the trained YPEs and CHW mentors were produced and distributed to reinforce their knowledge and to enhance their communication and project management skills.

During FY2014, 264 YPEs from DIANA, SAVA and Melaky were also trained on the use of SMS to convey behaviour change, thus encouraging their peers to make responsible sexual and reproductive health decisions (preventing unwanted pregnancies and STIs). During their training, YPEs were provided with mobile phones and they also receive phone units on a monthly basis to ensure that they send their monthly data reports via SMS to MAHEFA's Central team.

Thanks to the efforts of these 527 operational YPEs, 119,425 young men and women received FP/RH messages in FY2014. Concerning BCE activities conducted at the individual level, the most popular topics in sexual and reproductive health among youths which were recorded in the YPEs' data sheets were (in order of interest): the use of condoms, first sex, STIs, male and female reproductive organs and family planning.



YPE at SMS training, Antsiranana, DIANA Region

An additional 1,084 young people in the three regions of the project were recruited by YPEs and also trained in the use of SMS to disseminate these messages to other young people in their communities. The use of SMS messages by YPEs and other youths has helped raise youths' awareness by encouraging them to take responsibility for their reproductive health. The expected results of these messages are a delay in the age of first intercourse, prevention of STIs, a reduction in the age of first pregnancy, the number of unwanted pregnancies among young people and, in particular the 15 to 24 years old, as well as an increase in the young peoples' access to FP services. From June through September 2014, 54% of YPEs who were trained in the use of SMS reported their activities using SMS actually during this period. There are several reasons explaining these results:

- Repeated local blackouts
- Poor quality of some batteries and chargers
- Delay in the delivery of phone units to the YPEs in relation to their monthly meetings which are held between the 20th and 25th of each month (requests are processed within a few weeks)
- No support for YPEs by some TAs.

During early FY2015 these issues will be addressed by MAHEFA to ensure maximum efficiency of the YPEs.

Included in the myriad of services provided by CHWs is the counseling and referral of pregnant women to the CSB for antenatal visits and follow-up. These are opportunities for them to receive malaria prevention therapy, including Sulfadoxin Pyrimethamin (SP) and LLITNs, Iron Folic Acid and their Tetanus vaccination.

As a result of these counseling, high visibility BCE, and referral activities 69,269 pregnant women have been referred to a health facility for their first ACN visit, while 52,162 pregnant women have been referred to a health facility to complete their fourth antenatal care visit and 10,428 among them were counter-referred by the health facility CHW (20%).

In the meantime, CHWs made home visits to women who had recently given birth in Mahabo and Vohemar districts to follow the use of Misoprostol after delivery and of 7.1% Chlorhexidine for newborn stump cord care. During FY2014, for all MAHEFA regions, 4,891 newborns were visited and 5,633 women having given birth were referred to the CSB for postnatal visits.

Table 9. Referral to CSBs, hospitals or mobile clinics in FY2014

Referral services provided by CHWs	Number of community members who received these services	Technical themes
Prenatal consultation, tetanus vaccination, Iron Folic Acid (IFA), Intermittent Preventative Therapy (IPTp), LLITN, assisted delivery	121,431	Malaria, maternal and neonatal care
Pregnant women with danger signs	2,642	Malaria, maternal care
Long term contraception	2,426	FP
Vaccination and vitamin A for children	457,748	Child care
Sick children with danger signs (malaria, ARI and diarrhea)	12,893	Malaria, water and child care
Children with low weight (MUAC <125mm)	7,370	Nutrition, child care

IV. IR3: IMPROVE THE QUALITY OF CARE DELIVERED BY CHWS

3.1 Activities to improve local skills for enhanced health management

MAHEFA's highest priority is the delivery of high quality services. The activities under 3.1 are key elements of MAHEFA's comprehensive approach to quality. These include regular supportive supervision, KMSm activities, "*suivis groupés*", community evaluation of health services through the Community Score Card (CSC) and ensuring Family Planning (FP) compliance. These activities are not only crucial to ensuring the quality of service delivery, but also help support community stakeholders in achieving milestones in the KMSm process. IR3 related activities also focus on ensuring that CHWs are motivated and able to provide quality services. Under this IR, MAHEFA seeks to improve:

1. local capacity to identify and understand the needs of the community
2. local skills to implement local solutions to identified needs
3. the quality of health services at the community level
4. increased use of quality health services.

During this year, the need for the integration and complementarity of activities through the KMSm approach has become more apparent and thus, MAHEFA has implemented various activities in order to improve the performance of the program at the community level.

In FY2014, "Champion" CHWs were identified and, along with TAs and COSAN members from their *fokontany*, participated in exchange visits to other sites to promote learning between sites and sustain the motivation of CHWs and other stakeholders in the community. These exchange visits with other districts allowed CHWs to share their experiences and best practices with and while learning from their peers.

In order to improve the capacity of service providers, the Community Score Card (CSC) was developed. The CSC is a monitoring and evaluation process that allows health care beneficiaries in the community to assess health care providers' services and performance using a scoring system. The CSC uses the direct involvement of the community and provides an outlet for beneficiaries to demand better services. It facilitates rapid improvement in the quality of services, and is also used by CHWs as a self-assessment tool. The CSC process was conducted in the communities by NGOTAs.

Box 10. Exchange visit of CHWs

In July 2014, four CHWs and four COSAN members from the Befandriana district in the Sofia region traveled to Port Bergé to meet with other CHWs and members of COSAN from other communes in order to share their experiences and to better understand community contexts different from their own. Between meetings with regional health authorities, an orientation at the MAHEFA regional office in Antsohihy, and a tour of a newly constructed hospital, the visit resulted in a productive exchange of ideas and experiences among MAHEFA CHWs and COSAN members from across the region.



CHWs and COSAN members with regional MAHEFA staff

During FY2014, a total of 983 CSCs were conducted, thus bringing the total number of fokontany that are now able to conduct a CSC to 1,453. According to the results of the 329 CSC conducted in the Menabe region, 50% of the participating community members reported being dissatisfied with the inexistence of a community hut in their commune. As a result, 299 health huts were built during FY2014 in the Menabe communes in which CSCs were conducted. This is an example of how communities have developed plans to address shortcomings in health care service provision based on CSC results.

While Menabe’s regional CSC’s revealed this dissatisfaction that was consequently addressed, the overall evaluation process revealed that 76% of community members were satisfied with the quality of CHW service delivery. In Q3 of FY2014, MAHEFA conducted an internal review and revised its strategy for CSC activities. For *fokontany* in which community health huts for CHWs (commonly referred to as “*Toby*”) have already been built, the CSC process will be conducted during the KMSm reviews. This strategy contributes to the sustainability of the process by reducing the number of reviews/assessments so that communities will continue such activities by themselves after the end of the program.

As part of the KMSm process, once targets are set, community representatives (led by COSAN members) gather every three months for a review of their progress towards their targets. In the normal KMSm cycle, there are three reviews before communities can consider themselves ready to be evaluated. The evaluation is conducted by NGOs according to specific criteria and procedures. If the community achieved its targets, it can officially attain “KMSm” status. Figure 13 below summarizes the KMSm activities conducted in FY2014.

Figure 13. Progress in KMSm activities in FY2014

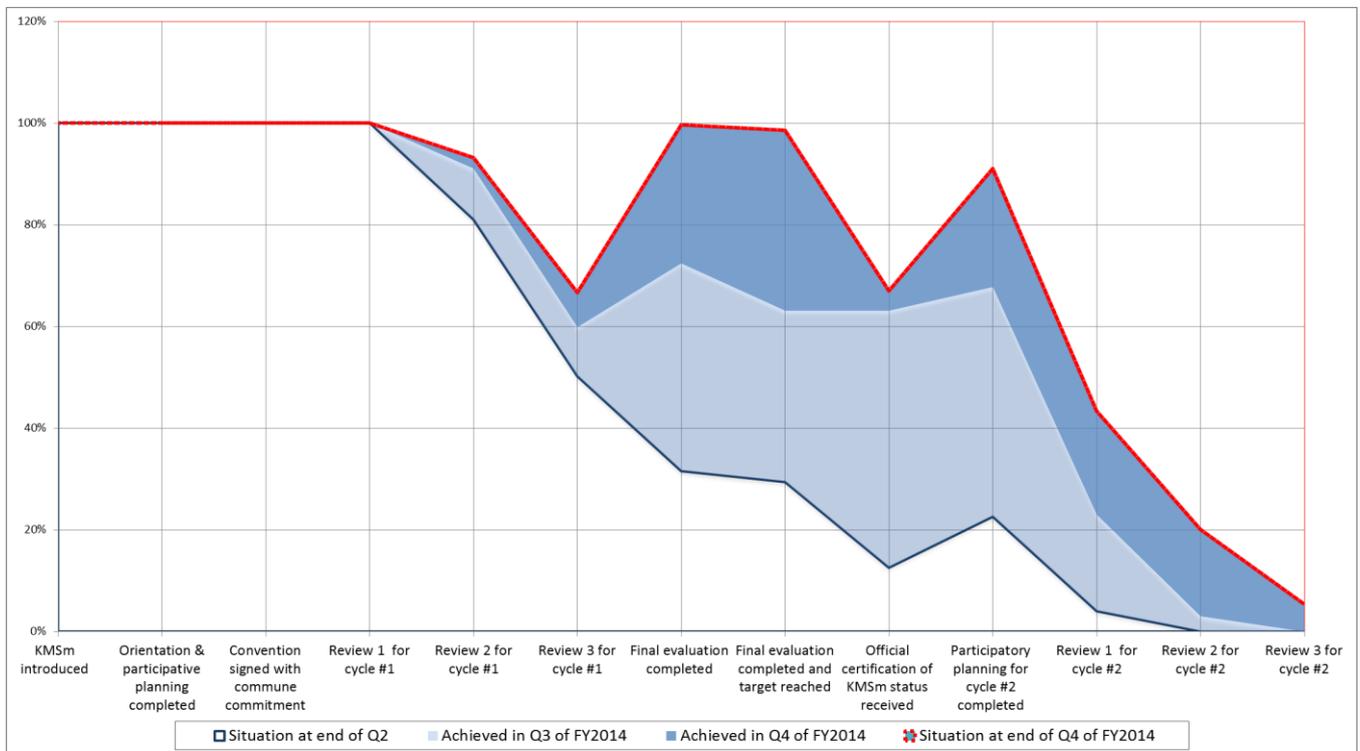
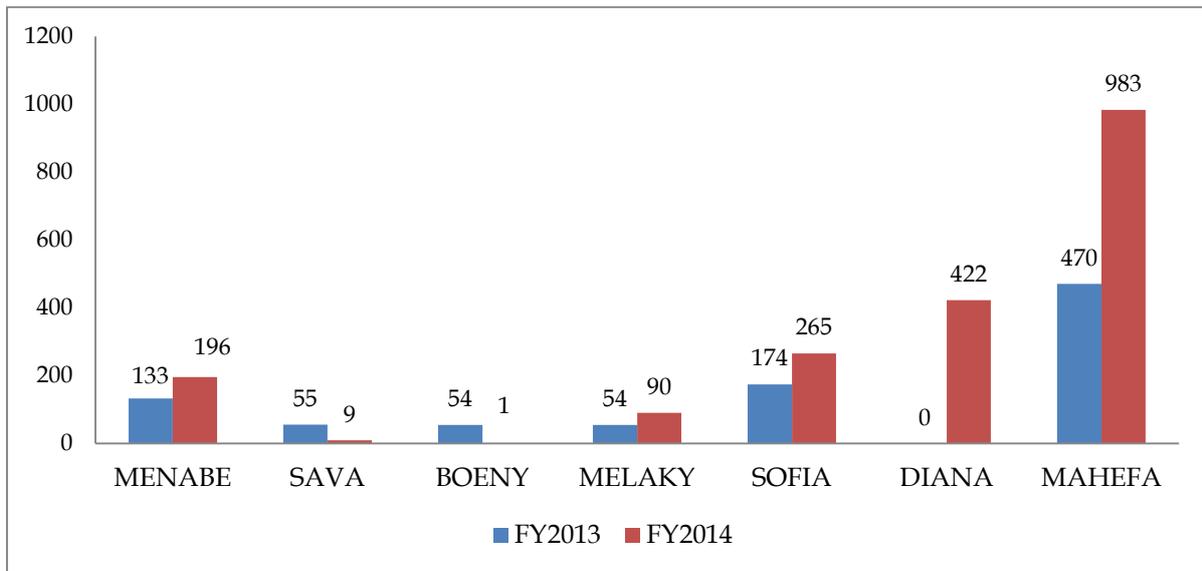


Figure 14. Number of CSCs conducted in FY2014 by region



Box 11. Improved support from the community after a CSC exercise

The Dabomandry *fokontany*, in Mitsinjo district succeeded in building a community health hut with the help of the COSAN and the SOJA BE (traditional community leader). The women’s association proudly showed the site to AJPP and MAHEFA visitors on July 9, 2014.



Dabomandry CHW with COSAN and SOJA BE members and discussions with the visitors



CHW site provided by the community in Mitsinjo

3.2 Integrated supervision of regional services, NGOs, CHWs and other community stakeholders

During FY2014, MAHEFA also continued to improve the quality of services provided by CHWs by strengthening the supervision system at all levels: monthly meetings, on site supervisions, coordination meetings of NGOs and other various meetings and exchange visit. These activities were implemented to ensure that CHWs continue to provide quality services in their community.

3.2.1. Capitalize on CHW monthly meetings organized by TAs and other community stakeholders such as members of COSAN

During FY2014, MAHEFA realized the need to include other important community actors, such as NLs, LG facilitators, community WASH facilitators, and YPEs in these monthly meetings. This expanded participation contributes to the integration and complementarity of health activities. Through the TAs and other NGO staff, MAHEFA strengthened its collaboration with directors of public health services at the community, district and regional levels during these monthly meetings. This helped to improve the quality of data collected by the CHWs and improved reporting results.

Box 12. Coordination Yields Benefits for the Health System and its CHWs

Dr. Eddie Andriamasoandro is the Chief Health Officer of the CSB in Anjiamangirana, Antsohihy district, in Madagascar's Sofia region. Recognizing the important role that CHWs play in supporting the efforts of the CSB in their work to reach communities and households, Dr. Eddie ensures that her CSB opens its doors to CHWs on a weekly basis, each market day. These meetings allow her to reinforce the skills of the CHWs, share knowledge, and streamline reporting. She is there to give technical support to her CHWs by reminding them of her technical assistance and supporting them in correctly reporting on their activities. She uses these weekly opportunities to work closely with her CHWs in achieving their health goals: children's vaccination coverage, antenatal care for pregnant women, family planning (FP), and promoting maternal and child health behaviors.



Fifteen of Anjiamangirana's CHWs meet with Dr. Eddie, Chief Health Officer of the CSB, on market day to complete reporting and improve coordination.

3.2.2. Improve and strengthen regular supportive supervision for CHWs by TAs using the integrated supervision grid newly developed.

In addition to the monthly meetings that CHW's attend with the TAs, each CHW should receive at least one quarterly supervision visit by his/her TA. The site visit allows TAs to observe the services provided by the CHWs, support or accompany them in BCE activities, offer advice on the general layout of community sites, check the availability of health products and supplies, verify data quality and provide technical updates if needed.

3.2.3. Organize monthly coordination meetings between TAs and other NGO staff and quarterly coordination meetings between NGOs and MAHEFA teams from the regional and central offices.

These meetings provide the opportunity to discuss progress made in activity implementation, challenges faced and lessons learned as well as to exchange specific ideas for improvement. These meetings also provide a forum for technical updates for the TAs and NGO staff.



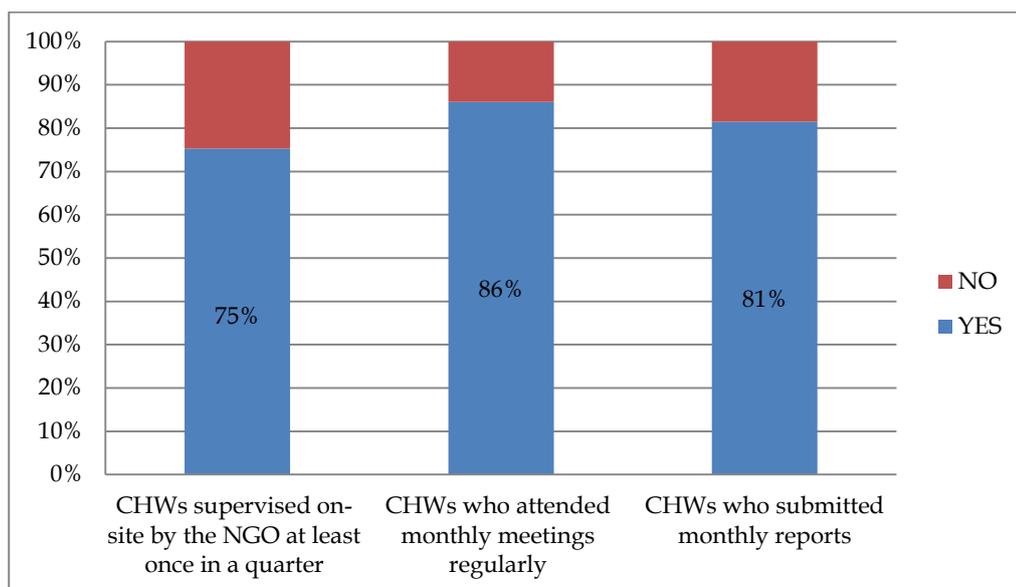
Coordination meeting with NGOs in Maintirano, Melaky (March 2014)

In addition to the tools used for regular integrated supervision, MAHEFA developed other supervision grids validated by the Ministry of Health and other partners, which highlight each health care activities provided by CHWs (c-IMCI, RH/FP, BCE, WASH, nutrition and YPE). This tool helps build CHWs' organizational capacity.

Box 13. CHWs supervision grid

In order to improve the visibility of CHWs' supervision results, a new tool has been developed to assess CHWs' capacity in prevention, promotion, case management, referrals and in data management and reporting, through a scoring process. The supervision grid is made of separate sections in which each item is scored with a 0, 1, or 2. The scores are tallied and used to classify CHWs according to their level of need for support and skills strengthening. A score of 0-49 indicates a strong need for support, 50-74, a need for regular support to strengthen acquired knowledge and skills, and 75-100 a need for regular monitoring to ensure that the level is maintained and strengthened.

Figure 15. Supervision of and reporting rate by CHWs in FY2014 (n = 5,728)



On average, MAHEFA was able to supervise 75% of CHWs on site at least once each quarter. As afore mentioned, monthly meetings were organized and to fill in the gaps in on-site visits. On average, 86% of the CHWs attended monthly meetings and as this coincided with the schedule for

submitting monthly reports, 81% of the CHWs had also submitted their reports. This means that during the year on average, 5% of CHWs did not submit their monthly reports or these had not been validated by the TA.

3.3 Logistics Management Information System (LMIS)

In early FY2014, a data management system to track the location and movement of CHWs' stock of health products was operationalized in two pilot districts (Mandritsara, Sofia Region and Ambanja, DIANA Region). On the one hand, this system uses mobile phones to transmit information on CHWs' stock status to a centralized system that conveys this information to the supply points or PAs ("*points d'approvisionnement*") assigned to the CHWs. The PAs, in turn, are able to inform the CHWs of the health products available at their level. This is meant to reduce stock-outs and the risks involved in transferring the monthly stock reports of CHWs located in remote areas from their NGOs' regional office to MAHEFA's M&E team. This was intended to help avoid the situation in which CHWs travel long distances to their PAs only to return empty handed as the health products they were seeking were unavailable.

Box 14. Summary of the results of the stock management system by SMS evaluation

Strengths of the system

1. CHWs appreciate receiving phones - good motivator
2. TAs and CHWs are already making use of the phones to coordinate their supervision visits, monthly meeting appointments, and transmit some information about stock availability informally
3. CHWs believe that the program is worthwhile, would like to use it
4. TAs like the potential for real time information on what is happening with their CHWs
5. CHWs report that in some cases, just sending in the messages has reminded them to resupply

Areas needing improvement:

1. Challenges related to the design of the system
2. End users not clearly identified
3. Too many products
4. Too many data points
5. Duplicate work considering hard copy forms

Challenges related to the use of mobile technology

1. Data entry (message codes; need to first fill out an additional paper SMS guide form; lack of constraints/validation during data entry; lack of specificity in error messages; only sending in one or two out of the five messages; high cost of resending messages many times)
2. System output messages (CHWs usually didn't receive these messages; PAs didn't send in data to populate them; messages not clear)
3. Dashboard and data visibility (No visibility into PSI/PAs' data though it was being used by the system; lack of visibility into the exact messages received and sent by the system; data collection system is different than a logistics management information system; rigidity of the platform to respond to specific requests)
4. Hardware (CHWs not comfortable with manipulating cell phones - less than 50% (maybe as low as 20%) had personal phones before this SMS pilot - Airtel network is not always available; electricity/charging of phone batteries is unreliable or expensive)

However, at the end of Q2, it was noted that the system did not bring about its expected results. The analysis of existing data and supervisions carried out in the field revealed that several improvements are needed before exploring the possibility of scale-up. In regards to sending CHWs' reports by mobile phones, the Internet connection in the communes has been very limited and at times during the pilot phase, even nonexistent. In addition, CHWs' reports sent by TAs were usually received by their NGOs at the end of the month, and by then had become obsolete.

Therefore, MAHEFA decided to strengthen the Computerized Data Management System as an alternative. Please see the “Cross-Cutting” section of this report.

Furthermore, after analyzing the options for improving the system, MAHEFA decided to shut it down at the end of Q2 and seek the support of a mHealth expert to review the pilot system and give appropriate recommendations before investing in a new system. The review was conducted at the beginning of Q4 (a few highlights are presented below) and, based on its recommendations, a new design of the system has emerged. It will be launched at the beginning of FY2015. This new system will focus only on CHWs’ stock management since the MIS is already functional for the transmission of their monthly reports. See Box 14 for areas needing improvement (based on the review results); these included approaches that will meet the needs of the end users while making the best use of the data.

3.4 Use of mobile technology to improve mobile YPE services

This activity was presented earlier in the IR2 section of this report. It is also presented in a success story in Annex 3.

V. CROSS-CUTTING ACTIVITIES

Cross-cutting activities include: program planning and review of activities, planning workshops, monitoring and evaluation (M&E), knowledge management, compliance with USAID and gender issues. In FY2014, MAHEFA continued to strengthen M&E capacities at all levels, via supervision visits from the central team to regional teams, who in turn supervise the NGOs, CHWs and other community stakeholders. M&E supervision has been incorporated into other supervision processes of the program (described in more detail in IR3) to increase efficiency and strengthen the principle of integration of each of the program's components.

To continuously build capacity and promote the exchange of experiences and good practices among staff, a workshop for all those responsible for M&E in MAHEFA, CSB and partner NGOs was organized.

4.1 Monitoring & Evaluation

In order to ensure that activities for M&E are conducted following principles and norms set, MAHEFA tried to take advantage of all opportunities that could be used to reinforce M&E capacity at all levels. These included workshops and supportive supervision at all levels. In addition, M&E concepts and mechanisms were clarified and reinforced for all participants during the FY2014 Start-up workshop in November 2013, followed by a two-day workshop for M&E staff to review the M&E system's performance, discuss areas for improvement, identify main priorities and establish an improvement plan for the program year.

Capacity in M&E, in general, was also reinforced for MAHEFA regional M&E staff and NGOs staff members (technical coordinators, M&E staff and TAs) during the training on the new electronic information system (presented below). M&E supervision visits from the central level with on-the-job coaching for regional staff were conducted. In addition to the supervision visits, which included M&E-specific supervision with other technical issues conducted by MAHEFA regional M&E officers, the M&E team developed a plan for each region to provide advanced support to NGOs in producing timely and reliable reporting. MAHEFA regional office staff accompanied NGO staff who are responsible for developing reports in order to help MAHEFA better understand their challenges and to give appropriate assistance instead of providing only feedback after their delayed report submission.

4.1.1 Electronic Information System (EIS)

Initially MAHEFA was used to a paper-based system, however during FY2014 MAHEFA collaborated with a consulting firm to finalize and implement a computerized data management program which was operationalized at the end of Q3. Before this electronic information system, data was manually inserted into MAHEFA's M&E system beginning at the level of the TA who had to compile community reports. Next, NGOs would submit the aggregated data to the regional level, which would then transmit all aggregated data to MAHEFA's central level. Therefore, data use became challenging. For example, if the central office wanted to review the data at the district level, it needed to go through the regional office since that data was only available at that level, thus creating additional tasks for staff. Most importantly, data for individual CHWs was not available for review by either the regional or central levels. Only the TAs collecting the data from the CHWs had direct access to this information. In the electronic system operationalized in Q3, data entry is done monthly for all data sources: individual CHWs' monthly reports, training reports, other community monthly reports and all aggregation and disaggregation needed is

available at each level. Thus, MAHEFA M&E staff and all NGO staff members (technical coordinators, M&E staff and TAs) were trained on the use of this new electronic information system.

It must be noted that the introduction of this system presented some challenges in switching from manual to electronic data due to the fact that the electronic system does not take into account older data from the manual system, and changes in numbers reported happened after all data was entered in the new electronic database. Therefore, corrective measures and fine tuning of the system had to be made: old data were re-entered and as some automatic data checks were integrated, some corrections had to be made within some CHWs' monthly reports. This changed previous data reported. Nonetheless, the new system was used to prepare this annual report.

4.1.2 Data Quality and Data Use

Data quality assurance is considered one of the M&E team's key activities. Therefore, MAHEFA addressed data quality from the source by updating CHW registries and reporting tools in reducing data collected to only the minimum required for the program. This enabled CHWs to lower their tasks while including simplified instructions that provide clearer explanations of how to complete the tools. In order to respond to the revised WASH strategy, MAHEFA integrated a WASH data collection and reporting system into its M&E system. Previously, WASH data were collected separately and were not part of the overall MAHEFA M&E system.

In addition to giving more attention to data quality, the MAHEFA program reinforced the importance of using data at all levels. Indeed, MAHEFA and NGO staff members' efforts to ensure data quality is leading to improve planning based on the use of data. During FY2014, many more staff and program stakeholders have begun to more fully understand the importance of data use at all levels in the MAHEFA program. At the community level, CHWs have begun to realize that if their data reporting is not complete or accurate; the results of their hard work are not represented. NGO grantees who have been informed on a monthly basis of their achievements (in real data) have been more conscious about data reporting and use in monitoring their own performance. MAHEFA staff members at the central and regional offices are more frequently evaluating and reporting on the results of their work in terms of targets reached, in addition to describing activities implemented. Data use has helped determine who needs support and at which level of the program, thus guiding the program towards higher performance levels.

In addition, MAHEFA's central M&E team (with support from the M&E Advisor from JSI/Boston) conducted an internal data quality assessment (DQA) in Diego (DIANA). The assessment results were shared with the relevant NGOs as well as other NGOs in the respective region as lessons learned during the NGOs' quarterly coordination meeting. MAHEFA regional M&E staff conducted routine DQA using the findings from this initial internal assessment. In addition to MAHEFA's internal DQA, USAID's M&E team also conducted a DQA in Diego (districts of Ambilobe and Antsiranana II). The full results and recommendations from USAID's DQA will be shared with MAHEFA and NGOs; this will enable the program to identify and conduct additional activities for ensuring data quality in FY2015.

4.2 USAID Compliance (EMMP, FP and Gender)

Through regular supervision and ongoing training, MAHEFA continues to ensure compliance at all levels of the program whether regarding family planning (FP) and the Environmental Mitigation and Monitoring Plan (EMMP, see the EMM report in Annex 4).

4.2.1 Community health huts

In FY2014, MAHEFA produced 6,500 EMMP job aids for CHWs in order to improve waste management in community sites.

4.2.2 Construction of water points

Six ESF/ERR dossiers (one per region) were completed based on technical studies conducted by professional firms and approved by USAID. These dossiers were used to ensure compliance for all EMMP constructions. In order to ensure high quality water systems water quality analyses were conducted by the *Institut Pasteur de Madagascar* on water from wells constructed by the MAHEFA program. This will help the program curtail any negative consequences of unacceptable levels of bacteria found in the water sources.

To date, MAHEFA communities have constructed 377 disposal pits to protect the environment near the health services sites.

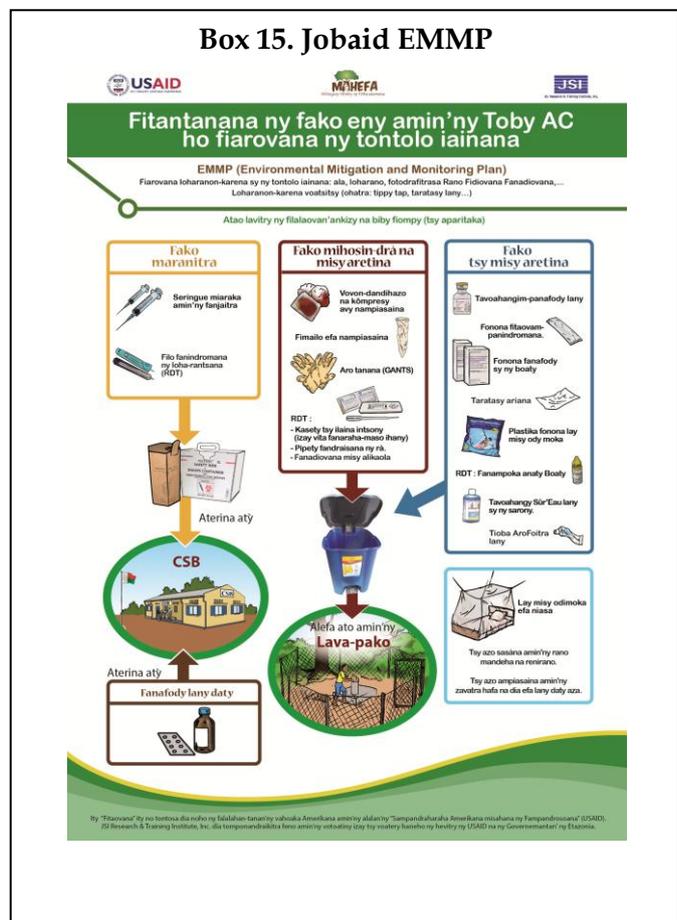
4.2.3 Family Planning (FP)

FP compliance assures that program staff and partners responsible for implementing program activities follow the legal and policy requirements that regulate USG FP assistance. Thus, in FY2014, 250 individuals, including MAHEFA and NGO staff and regional trainers, completed the online FP compliance course. These staff members are committed to heeding FP compliance requirements in their daily activities.

4.2.4 Gender

Gender is one of MAHEFA's key cross-cutting themes and has thus been mainstreamed into all program activities. In addition, in FY2014, MAHEFA spearheaded gender coordination among development partners and continued to play an active role in inter-agency collaboration to improve gender programming in Madagascar through the following activities:

Gender Working Group: MAHEFA played a leading role in establishing and continuing to move forward a USAID-partners Gender Working Group (GWG). During FY2014, the GWG accomplished the following activities: expanded its membership to include two additional partners, ADRA and CARE bringing the total group membership to seven partners; refined the working group's terms of reference; strategized creative approaches to encourage other partners and Ministry representatives to participate in the working group; conducted four working group meetings hosted by MAHEFA, MIKOLO, and MSM; invited gender experts who facilitated two



meetings with GWG members focusing on best practices in the monitoring and evaluation of gender impact; and successfully recruited the USAID gender point person into the GWG.

Development of Gender Materials: MAHEFA designed, completed individual pretesting, incorporated pretesting results and finalized six counseling cards (one for each region) and a booklet of skits to be used by CHWs to present MNCH and gender issues in the community. These user-friendly materials will be used by NGOs and the CHWs they supervise to promote gender activities in the community. These activities are not only aimed at improving the status of women, but also at inciting men to take a greater role in health prevention and care of their families. Pretesting results had revealed a need for regional modifications of the cards, such as using the local dialect terms for men (“*johary*”) and women (“*ampela*”) for the Melaky version of the counseling card. Another useful suggestion was to make the young pregnant girl on the cards look more mature (not a child, but an adolescent) and her pregnancy, more obvious; thus, her face was altered to make her look more like an adolescent, her belly extended further, and she was given a school girl’s notebook to carry.

4.3 USAID Midterm evaluation

This year, a team of evaluators from FHI 360 conducted the program’s midterm evaluation. This included: 1) qualitative interviews in three MAHEFA regions (DIANA, Sofia and Menabe), 2) an Earned Value Management (EVM) analysis, and 3) a cost efficiency study. Results will be available in FY 2015.

4.4 Knowledge management for dissemination and programmatic decision-making

During FY2014, MAHEFA continued to use a variety of methods to manage and disseminate the learning generated by the program. MAHEFA continued its efforts to implement a knowledge management system to facilitate both strong internal communications systems as well as external communications with the program’s many stakeholders. Specific activities undertaken include:

- **Summary of achievements of FY2013:** A four-page document in English and French was produced and distributed among stakeholders at both central and regional levels. The document shared information about the program and its achievements in the past project year.
- **Weekly highlights:** MAHEFA continued to produce the weekly update highlighting the program’s practices. The highlights are prepared and shared among MAHEFA’s regional offices and NGO partners, which boosts motivation among staff.
- **Direct dissemination in conferences (in-country and internationally):** As presented in the next section,

Box 16. Workshop on the Dissemination of the BC Empowerment Approach in July 2014



The *Directeur du Cabinet* for the Prime Minister of Madagascar with the Director of USAID and MAHEFA staff who listened as CHWs shared their experience (Antananarivo)

MAHEFA staff and partners disseminated MAHEFA’s program achievements and good practices in several conferences and workshops.

- In May 2014, in collaboration with PSI/PATH and the MOH, a national conference on 7.1% Chlorhexidine use for newborn cord care and Misoprostol for PPHP took place in Antananarivo to share best practices and lessons learned from Mahabo and Vohémar districts experiences. This conference was organized in order to obtain high level support and commitment for nationwide use of these lifesaving products.
- In June 2014, a workshop was organized in Antsirabe, that brought together transport technicians, trainers and engineers to review the design and quality of production of emergency Intermediate Modes of Transport (IMTs) produced by MAHEFA in collaboration with a local partner MIDAS.
- In July 2014, an Innovations Dissemination Workshop to highlight innovations in MAHEFA’s Behavior Change Empowerment strategy was organized at MAHEFA’s Central Office. More than 120 participants attended the event, including representatives from international and national health and development entities. Highlights of the event were: 1) the opportunity to hear health workers voices firsthand as they described the results of the innovative BC approaches they were using in their villages in Sofia and Melaky, and 2) the live theater skits followed by testimonials given by a Care Group couple who, because of the many families they had “adopted” and helped to overcome obstacles to behavior change in their own village, in Melaky, had been selected to come from the region to share their experiences during the workshop. Listening to their experiences helped partners better understand the challenges and accomplishments of these outstanding individuals!
- **CHW newsletter:** MAHEFA’s quarterly newsletter for CHWs was designed in Q1 and Q2, and in Q3, the first MAHEFA newsletter for CHWs, “Zara Ny Efa” was issued and disseminated. The second issue was printed and distributed in August. The Zara Ny Efa was very well-received by the CHWs who reported that they enjoyed reading it. MAHEFA is still working on making this newsletter user-friendly with more photos for CHWs.
- In response to USAID/Washington’s “Call for Case Studies on Health Systems Strengthening”, MAHEFA submitted a case study on the program’s efforts to strengthen the health system at the community level. MAHEFA will consider additional ways in which the case study can be shared with stakeholders to explain the approaches and impact of the program. In addition, MAHEFA will complete a process of evaluating the status and success of existing communications efforts, and develop a documentation and communications plan for the coming months of program implementation.

Table 10. List of meetings and regular working groups attended by MAHEFA staff

Meetings, Working Groups, Workshops, etc.	Frequency (monthly, quarterly, ad hoc)
At the international level	
CHX group	Monthly
JSI technical centers (MNCH, MHealth, Capacity Building, Family Planning and HIV/AIDS)	Ad hoc
Conference in Tanzania (Transaid/AFCAP emergency transport workshop)	Once

Meetings, Working Groups, Workshops, etc.	Frequency (monthly, quarterly, ad hoc)
Transaid annual meeting in London	Annually
SMS Conference in Addis Ababa	Once
ICCM Conference in Accra	Annually
PPHP conference in Mozambique	Once
E-Box project visit in Namibia	Once
At the national level	
Initiative H4+ Support to countries for the accelerated implementation of reproductive health, maternal and neonatal care	Monthly
PMI BC working group	Monthly
CHX and PPHP Technical Working Group meeting	Monthly
Gender Working Group/USAID	Monthly
PMI Partners Meeting Coordination	Quarterly
Nutrition Task Force	Quarterly
Gavi RSS , CCIA/CSSS meetings	Quarterly
National Coordination on RH with all the partners and 22 DRSP	Biannually
Meetings of RH partners to monitor progress in the implementation of the roadmap	Biannually

VI. ADMINISTRATIVE AND FINANCIAL MANAGEMENT INCLUDING NGO & GRANT MANAGEMENT

In FY2014, MAHEFA refined its management and strengthening of its operating system based on the experience of previous years. MAHEFA concentrated its efforts and resources on improving operations at the regional, district, municipal and *fokontany* level. The staff at the central level had a mentoring role and ensured that program activities are implemented in accordance with national policies and guidelines. A description of the administrative, finance and grants activities is presented below.

5.1 Staff

A new staff structure was put in place during this year. The new approved Key Personnel, COP Mrs. Chuanpit Chua-oon, began her tenure and the post of Finance & Administration DCOP was filled by the recruitment of Ms. Nicola Razanamparany Raharimanantsoa. A summary of the following changes took place in personnel/staffing is presented in the table below.

Table 11.Changes in personnel / staffing during FY2014

Hiring of new staff		
Title		Location
Finances & Administration DCOP		Central office in Tana
IT Assistant		Central office in Tana
M&E Officer		Central office in Tana
M&E Officer		Central office in Tana
Grants Assistant		Central office in Tana
Janitor		Central office in Tana
Technical Managers		Melaky
Regional Administration and Financial Assistant		Melaky
Technical Manager		SAVA
Regional Administration and Financial Assistant		SAVA
Regional Administration and Finances		DIANA
Monitoring and Evaluation Officer		Sofia
Driver		Menabe
Regional Administration and Financial Assistant		Menabe
Regional Administration and Financial Assistant		Boeny
Adjustments		
Title	New Title	Location
Program Assistant	Office Manager	Central office in Tana
Youth approach Consultant	Youth approach Coordinator	Central office in Tana
Administrative and Finance Assistants	Regional Administrative and Finances Officer	Sofia Menabe Boeny DIANA Melaky SAVA
Replacement of some staff		
Title		Location
Chief of Party		Central office in Tana
Finances & Administration DCOP		Central office in Tana
Finances & Administration Officer		Melaky

Departure of some staff	
Title	Location
Regional Administration and Finances Officer	Melaky
Finances & Administration DCOP	Central office in Tana
IT Assistant	Central office in Tana
M&E Officer	Central office in Tana
M&E Officer	Central office in Tana

5.2. Internal capacity building

The skills and knowledge of MAHEFA staff was improved through training sessions and internal sharing on various topics including.

- 1. Monitoring & Evaluation workshop:** six regional and three central MAHEFA M&E staff members participated in a workshop to improve the M&E system.
- 2. Training in VSLA:** six Regional WASH Officers and two Peace Corps Volunteers received training on the VSLA principles and how to integrate the approach into MAHEFA program.
- 3. Training in Administrative and Financial Management:** one MAHEFA Administration & Finance staff at the central level and seven at the regional level received in-service training from JSI finance team.
- 4. Training on Compliance:** 67/72 MAHEFA staff trained on FP Compliance, 64 on Environmental Compliance, Ethics and on MAHEFA Branding & Marketing.
- 5. Technical knowledge sharing on CSC:** ten central level staff participated in the workshop.
- 6. Participation at an international conference (Ethiopia):** two staff members (M&E Senior Advisor and Sofia Regional Coordinator) attended a conference on mhealth to share experiences, lessons learned and best practices of international projects.
- 7. International learning trips:** ten MAHEFA staff conducted international learning trips in FY2014 (see Table 10 for details).
- 8. Training on USAID's funded audit requirements:** the COP and the DCOP attended this training.

Moreover, a day of reflection was held at MAHEFA's central office in February 2014, followed by a three-day workshop in Antsohihy in March 2014. Both meetings helped develop and enhance a common understanding on data use for better planning and on effective approaches to carry out program activities, with the aim of improving NGO and CHW capacity. The workshop fostered team building and the sharing of experience.

MAHEFA will continue to prioritize internal capacity development in a variety of areas, both at the technical and management/operational levels. Activities include structured capacity building activities (i.e. English classes, thematic trainings) along with individual mentoring and training. MAHEFA will continue to use a variety of opportunities, including workshops, monthly meetings and weekly check-ins, to develop internal capacity.

Box 17. International Travel among MAHEFA staff in FY2014

International travel creates opportunities to enrich the knowledge of MAHEFA staff and partners and enable them to share lessons learned and to benefit from other similar initiatives and projects. During this year, MAHEFA staff members participated in a number of international trips.

1. Participation to an international conference in Ethiopia
2. PPH Program Implementation Workshop in Maputo, Mozambique
3. Integrated Community Case Management (ICCM): Evidence review symposium in Accra, Ghana
4. Exchange visit to Namibia
5. AFCAP Emergency Transport workshop in Dar Es Salaam
6. Orientation in Boston by JSI Home Office

5.3 Improvement in the operations system

MAHEFA works consistently to identify cost-containment and cost effective use of available funds. For example, this year, MAHEFA moved its office to allow staff more room to work efficiently while also saving operations costs. The new office included storage space which helps the program save on warehouse rent (which was paid before). Other important activities and initiatives leading to an overall improvement of MAHEFA's operations system in FY2014 are presented below:

1. The Strategic Thinking Group (STG) composed of senior management staff was created to advise MAHEFA program units on strategy and operation. The group holds meetings on a weekly basis to discuss program progress, approve work plans, and discuss/make decisions on management and programmatic issues. A consolidated activities plan per unit, including regional units, is produced and posted for general information at all levels. The STG has improved communication between program units as well as coherence and complementarity across all MAHEFA activities.
2. MAHEFA received two visits from JSI/Boston's finance team who conducted internal audits: in October 2013 and in March-April 2014. A list of recommendations from the audit team provided a clear roadmap for the MAHEFA team to make improvements. MAHEFA's finance team benefitted from capacity building and is now implementing the Action Plan from the Internal Audit.
3. Regular follow-ups and monitoring visits from the JSI/Boston team were conducted throughout FY2014.
4. Many financial planning and monitoring tools were revised or updated. This allowed constant data sharing between the regional and central offices, which further allowed quicker problem solving and reporting. Procedures manuals were also updated. Different checklists were produced to ensure completeness of payment with supporting documents. Finally, the electronic mechanism for different types of tracking has been updated and is now operational.
5. MAHEFA started using a new version of the Quick Books software to improve the quality of reports and to ease the finance team's work.

6. MAHEFA was granted additional two-year period by GOM (*Accord de Siege*) which extends the agreement until May 2016.
7. The MAHEFA IT team conducted trainings for MAHEFA's regional teams and NGOs at the regional level. DIANA, Sofia, SAVA, Melaky and Menabe regional offices now have additional access points to enhance their Internet connexion. This significantly improves regular and timely communication among team members and their ability to communicate and share electronic documents of large volume. In addition, the computer network at central and regional levels (Internet, server, back-up system, etc.) was strengthened.
8. Support was also provided to the M&E team (for the roll-out of the MAHEFA's SIG) and MAHEFA's youth program (facilitating the use of mobile phones).
9. MAHEFA continued to submit the VAT update to USAID throughout FY2014.
10. Substantial IEC materials were produced and CHWs were outfitted with necessary supplies. During this year, MAHEFA procured :
 - 20 Motorbikes for NGOs
 - 35 000 CHX
 - 153 dolls for CHX program
 - Procurement process launched for the 700 bicycles from Re-Cycle
11. The inventory of program equipment was regularly updated during the year.

5.4. Partnerships

MAHEFA continued to work with its partner NGOs and other collaborators to strengthen field operations and, in turn, ensure increase availability and better access to services provided by CHWs to remote communities. These partnerships also contributed to JSI's cost-share requirements for the MAHEFA program. In FY2014, MAHEFA collaborated with:

1. **Fondation Telma:** to support the SMS component of the youth program. It continues to jointly support the purchase of phone credit to ensure SMS use by the YPEs.
2. **Planet Finance:** to establish community health insurance groups ("*mutuelles de santé*") in Ambanja district (Ambanja commune), DIANA region.
3. **PSI/ISM:** to supply health products at community level.
4. **HoverAID:** to extend health services and products to areas that are not reachable by other means of transportation, as well as coordinating CHW services for HoverAID's intensive health care delivery in Boeny and Menabe regions, which uses a mobile team of doctors and surgeons to provide surgeries and other health treatment.
5. **Peace Corps:** to complement MAHEFA's staff efforts at the regional level (in DIANA, Menabe and Sofia).
6. **Marie Stopes Madagascar (MSM):** to provide long-term family planning methods through mobile clinics.
7. **Blue Ventures:** to provide integrated family planning and environmental conservation services in Belo sur Mer and Bemanonga communes in Menabe.
8. **Louvain Development:** to increase access to community health services and products in the most underserved commune in the district of Belo sur Tsiribihina in Menabe region.

9. **Ah-Toy Vanilla Enterprise:** to complement MAHEFA's reproductive health program for youths and to provide health discussion sessions for workers in the vanilla processing plant in Vohémar district (Vohémar commune), SAVA region.
10. **Madagascar Oil:** to provide MNCH services to MAHEFA communities in the district of Miandrivazo (Ankondromena commune), Menabe Region.

Box 17. Peace Corps Volunteers in MAHEFA program

- The volunteer in DIANA, Harry Wolberg, completed his service and left Madagascar on September 27. MAHEFA plans to recruit a replacement (third year volunteer) when the next health volunteers become available (expected in April 2015).
- Anthony Steele, who is based in Antsohihy in Sofia region, focuses his work on water, hygiene and sanitation. He works closely with MAHEFA's WASH specialist on planning, monitoring and supporting all WASH activities in Sofia region.
- Michal Usowicz, who is based in Morondava in Menabe region, focuses on the Intermediate Modes of Transport. His work involves assisting MAHEFA Transport Unit in design methodology; providing technical advice during the production stage, and overseeing quality of production and conducting final quality control checks.

Peace Corps volunteers' reports are presented in Annex 7

Due to the lifting of U.S. Government (USG) sanctions on working with the government of Madagascar (GOM) on May 28, 2014, MAHEFA started to engage directly with the government for the first time since the beginning of the program. Concretely, the GOM personnel at regional level started to provide training to the CHWs. As discussed in the previous sections of this report, in FY2014 almost all the CHWs received the training and certification which allows them to provide integrated health services.

5.5. Finance

5.5.1 Summary and Spending Against Projections

As presented below, by the end of FY2014, JSI/CBIHP has spent \$ 21,813,942 of an obligated \$23,784,883 and documented a cost-share of \$3,529,292 (\$3,043,280 in FY2014). The following table (Table 12) provides a summary by major line item of spending and allows for an analysis against projections.

Table 12. Summary of spending as of September 30, 2014

	Previous Year Report			Current Year Report		Cumulative Total	Future year Projection		Grant Total
	Actual	Actual	Actual	Actual	Projected	Actuals	Projected	Projected	Budget
	FY11	FY12	FY13	FY14	FY14	Contract to date actuals	FY15	FY16	Total
	May 2011-Sept.2011	Oct.2011-Sept.2012	Oct.2012-Sept.2013	Oct.2013-Sept.2014	Oct.2013-Sept.2014	May 2011 - Sept. 2014	Oct.2014-Sept.2015	Oct.2015 - May 2016	
	4 months	12 months	12 months	12 months	12 months		12 months	8 months	60 months
Direct Costs	270,772	1,052,069	1,662,505	1,843,312	2,310,495	4,828,658	1,814,166	1,331,579	7,974,403
Sub Awards	98,520	673,201	781,995	1,004,036	1,362,896	2,557,753	973,605	549,953	4,081,311
Program Costs	1,408	1,834,085	5,421,369	4,060,854	6,165,655	11,317,716	5,153,790	2,213,857	18,685,363
Construction	-	61,177	55,921	1,345,697	1,686,469	1,462,795	771,259	-	2,234,054
Procurement	40,612	428,429	198,040	103,600	116,645	770,680	55,647	27,052	853,379
Total Direct Costs	411,313	4,048,961	8,119,829	8,357,499	11,642,160	20,937,602	8,768,467	4,122,441	33,828,510
Indirect Costs	91,976	218,596	322,107	243,661	198,641	876,340	231,533	63,551	1,171,424
USAID Contribution	503,289	4,267,557	8,441,936	8,601,160	11,840,801	21,813,942²	9,000,000	4,185,992	34,999,934
Cost Share	-	32,323	453,688	3,043,280		3,529,292			3,529,292
Total Program Amount	503,289	4,299,880	8,895,625	11,644,440	11,840,801	25,343,234	9,000,000	4,185,992	38,529,226

² The total of accumulative actuals in this table is different from the one reported in the September 2014 SF-425 form since it does not include cash transfer (\$437,425) from HO to FO.

In the two columns for FY2014, there are several Actual Expenditures that are significantly different from the Projected Expenditures for the year. In addition, it is important to note that the Projections above are based on those submitted and approved as part of the FY2014 Work Plan submission. There were several mid-year technical and programmatic corrections based upon project learning and these are explained further below. Finally, the Direct Costs' projection in the approved FY2014 Work Plan was over-stated due to a formula error that was later corrected. The above Projected FY2014 budget figures reflect the corrected Direct Costs amount.

Direct Costs: The over-budgeting of Direct Costs was due to assumptions for expanded staffing and related costs that were not instituted; this is a reflection of several of the program changes explained below including better integrated activities, increased use of NGOs for WASH work, and streamlined human resource development support for CHWs. MAHEFA's major cost savings were realized through the office move in December 2013. The new office comes with a storage space that helps the program save the cost of warehouse rent and guard service which was projected within the FY2014 budget.

Program Costs: This budget area had projections that reflect the largest program changes applied by Q2. Per our pattern, spending is lower during the first quarters of the fiscal year, which correspond to the rainy season and limited access to many MAHEFA program communes, so that when these program changes occurred, they impacted on this budget area when spending was increasing. These changes include:

- significantly reduced training and consultant costs for training;
- increased program integration which reduced costs for regional budgets;
- major change in the strategy for implementing CLTS with the goal of more ODF communities; involvement of NGO staff in WASH programming;
- increased practical training and site-based training compared with formal training;
- linked activities conducted together (increased program integration) leading to notable local cost reductions.

This category also includes grant awards to NGO partners. In FY2014, MAHEFA instituted a more stringent management system including a monthly assessment and quarterly review of each NGO's performance. Program experience of the previous year had led to the need to invest much more program resources in managing and monitoring NGOs to try to gain more even results across program areas. This led to both more consistent results from NGO partners and more modest budgets for implementation since they set more realistic targets. In addition, by June 2014 MAHEFA was able to work more directly with government colleagues in program districts. This meant we had more direct assistance from the MOH, fewer paid clinical trainers and overall increased support to the CHWs. Finally, some activities were not implemented and this contributed to lower program cost spending. These include many of the KMSm reviews by NGOs in many communities due to competing priorities with other program activities, and the internal JSI midterm review because part of the review was done directly by USAID.

Construction: Differences in the construction budget were due to the following: changes in well sites for technical reasons or changes in which land would be donated leading to the need to acquire new USAID permission before work was begun; delays due to extended rains and flooding; and difficulty in finding bidding contractors for some remote sites which then required multiple tender cycles.

Procurement: There were some delays in developing IEC and other work tools for CHWs. All of the materials were conceived and designed before the end of the fiscal year but some were not yet produced. This explained un-used budget as well.

Overall, MAHEFA has used the experience from FY2014 projections and actuals to improve its budgeting for future program years. In Table 14, please note that the projections for FY2016 are extremely early projections, and will be updated when work planning is done for that eight month program year.

USAID planned to conduct a Financial Review of MAHEFA in September 2014 which has been postponed to October 2014.

5.5.2 Cost Containment and Cost Savings

JSI uses all available means to provide good value to the US Government and quality services to the beneficiaries of our programs. Therefore, cost-containment is a regular function of MAHEFA planning and implementation, and is monitored closely using internal budget tracking mechanisms. JSI management philosophy, applied to MAHEFA, is to control and seek ways to reduce cost whenever possible. As MAHEFA continues full-scale program implementation, the following are examples of how the program controls costs and has enhanced the value of US government funds.

Leveraging: Whenever possible, MAHEFA has leveraged activities with other donors, NGOs, communities and projects. This includes leveraging that qualifies for cost-share as well as leveraging with other USAID-financed activities including those implemented by PSI, MSM, DELIVER and Peace Corps.

Using Evidence-based Programming: Tools, methods, results of research and pilots, and program monitoring are used to make sure MAHEFA resources are used in the most efficient and effective ways.

Identifying Best Local Technical Support: MAHEFA goes beyond the usual channels to find qualified consultants based in Madagascar. This has led to significant cost savings when compared to hiring international consultants. In addition, MAHEFA has identified, trained and used consultants in our regions for key functions as much as possible.

Identifying Best Quality for Cost: When finalizing arrangements for the purchase of materials and equipment, MAHEFA goes beyond the usual suppliers if they exist to insure quality at lowest price.

Creating More Local Expertise: MAHEFA invests heavily in building local capacity among our private sector partners, including NGO grantees, COSAN members, local masons trained as latrine platform suppliers, and specialized providers of technical services in MAHEFA regions and elsewhere in Madagascar.

Exploiting JSI Expertise: MAHEFA uses experts internal to JSI to provide needed technical support, sometimes leveraged among different projects and programs working in Madagascar or in the region. These have included experts from other projects such as TA-NPI, MCHIP and DELIVER, thus leveraging US Government resources whenever possible. This includes experts from other JSI projects overseas, who have first-hand knowledge of similar conditions.

Peace Corps: Through requesting specialized PCVs for technical support to WASH and public health, MAHEFA has reduced the need for some expensive TAs while gaining additional long-term support. In addition, MAHEFA has identified additional PCVs to contribute to MAHEFA in several districts where they have brought expertise into specific program components.

Throughout this program year, MAHEFA has identified and used a variety of ways to limit or reduce costs to the US Government for this program. These are in addition to following procurement and competition regulations and requirements. We pride ourselves on providing an excellent example to our NGO and private sector partner groups in how to best utilize available resources.

The total of additional cost-share collected this year is \$ 3,043,202. The cost-shares collected this year are detailed in Table 13 below.

Table 13. Cost Share collected in FY2014

<u>ORIGIN</u>	<u>USD</u>
SALAMA	\$1,151,054
A.I.M.	\$363,252
LOUVAIN CORPORATION	\$30,884
Adventist World Radio	\$46,944
BLUE VENTURES CONSERVATION	\$22,834
Planet Finance	\$8,775
Community contributing to WASH Hard activities	\$18,479
TELMA	\$21
NGOs Partners contribution	\$152,172
PAEAR	\$1,224,067
Transaid	\$89,227
Packard Foundation (CHX)	\$3,000
Correction / PCV contribution	(\$67,430)
TOTAL	\$3,043,280

Table 14. Cumulative Cost Share collected as of September 30, 2014

<u>ORIGIN</u>	<u>USD</u>
CARTON COLLEGE	\$9,032
LOUVAIN	\$354,512
SALAMA	\$1,151,054
BLUE VENTURES CONSERVATION	\$22,834
AIM	\$363,252
Adventist World Radio (AWR)	\$46,944
Packard Foundation (Nepal study trip: DDS)	\$3,555
Packard Foundation (CHX)	\$3,900

<u>ORIGIN</u>	<u>USD</u>
HOVERAID	\$2,397
Community actors contributing to program	\$74,624
WASH Sites Community Members	\$18,479
TRANSAID (including Harvard School of Health)	\$93,673
Planet Finance	\$8,775
TELMA	\$21
Cost Share Contributions from NGO Grantees	\$152,172
PAEAR	\$1,224,067
TOTAL	\$3,529,292

Carlton College

- Contribution of scholarship to its student, Brianna Engelson, to provide assistance to MAHEFA in the preparation of the NEPAL's study tour report and the program's success stories.

Louvain

- Contribution to the strengthening of community health activities at village levels in the same five communes of Belo sur Tsiribihina district, where MAHEFA works. Activities included capacity building of public health workers, community actors and SARAGNA, an NGO that works with MAHEFA. The funding for these activities comes from the Belgium Government.

SALAMA

- Contribution to the organization of Integrated Management of Child Illness (IMCI) training and supply of management tools for CHWs in MAHEFA's six regions. This fund came from the Global Fund's NSA1 project.

Blue Ventures Conservation

- Contribution to identify and put in place additional CHWs in two communes of MAHEFA program (Belo sur Mer) in the area of family planning and community health education (commodities and supervision). The funding for these activities comes from Blue Ventures London.

Association Coopération Madagascar (AIM)

- Supply of bicycles, malaria treatment kits, and health hut furniture for CHWs MAHEFA's six regions. This fund came from the Global Fund's NSA1 project.

Adventist World Radio (AWR)

- Radio Rurales - Donation of 128 solar radios to community listening groups trained by MAHEFA across its six program regions. The community listening groups have a weekly group discussion on a health topic based on messages broadcasted by local radio. The funding for these activities comes from non-US government funds of Global Funds.

Packard Foundation

- Donation for air ticket and travel associated cost for the DDS agent: Mrs SAHONDRA Harisoa Lalao José's travel to Nepal for study tour.
- Contribution to the purchasing of 7.1% Chlorhexidine for Public health center in MAHEFA pilot district of Mahabo.

HoverAid

- Providing underserved population with essential commodities through the use of a hovercraft, in the regions of Melaky, Boeny, Menabe and SAVA (Vohémar). The funding for these activities comes from non-US Government funds of Global Funds.

Community Actors

- Contribution of their time to attend trainings and group monitoring meetings (“*suivis groupés*”) organized by MAHEFA.

WASH Sites Community Members

- Contributions from the beneficiaries of wells constructed or rehabilitated by MAHEFA. Contributions include donations of land, materials, and transportation services, as well as volunteer time for site cleaning and preparation.

Transaid

- Contribution in the emergency transportation area and IGA activities. These contributions collected by Transaid include: two container loads of secondhand bicycles for use by CHWs; shipping of the containers from the UK to Madagascar; a three-week placement at MAHEFA for an MPH student; a workshop on Intermediate Modes of Transport; emergency transport services via hovercraft; and donated time of CHWs trained on a variety of activities.

Planet Finance

- Implementation of health *mutuelles* in the commune of Ambanja and training of CHWs in the principles of *mutuelles*. As part of MAHEFA's Work Plan, MAHEFA set up *mutuelles* in 23 communes and this particular commune was supported by Planet Finance.

TELMA Foundation:

- Dissemination of reproductive health information for youth and reporting of youth peer educator activities in the regions of SAVA, DIANA, Boeny, Melaky, Sofia and Menabe.

Cost Share Contributions from NGO Grantees

- All NGO grantees contributions are through the time allocated by community actors including Natural Leaders, Community facilitators, COSAN and YPEs to attend trainings and monthly meetings organized by MAHEFA NGO partners.

Programme D'alimentation en Eau Potable Et Assainissement en Milieu Rural (PAEAR) in SAVA Region

- Construction and rehabilitation of infrastructure including the following: 54 water fountains, 100 toilet blocks, 10 family latrines, a micro dam, a reservoir with filter and 11 water points, and a water collection tank with filter and 11 water points.

5.6. NGO Management: ongoing improvements of interventions by MAHEFA partner NGOs

A new monitoring and evaluation system was implemented during FY2014, which evaluated NGO performance on a regular basis. The system was one of the program's innovative strategies to build NGOs' capacity.

5.6.1 Ongoing NGO performance evaluation (monthly and quarterly)

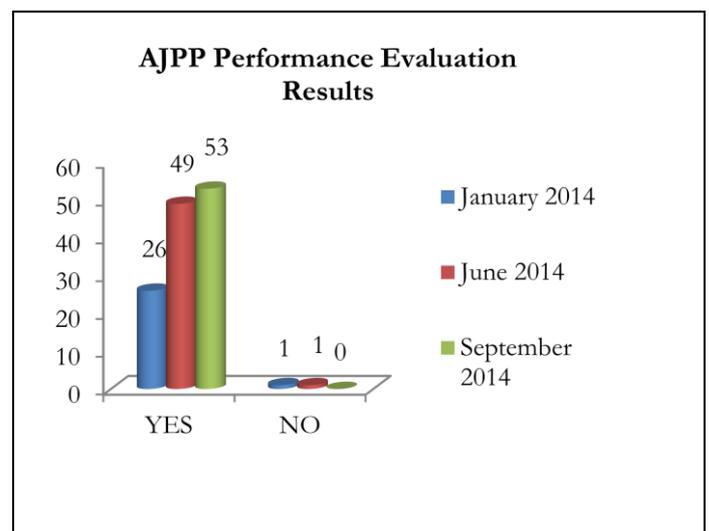
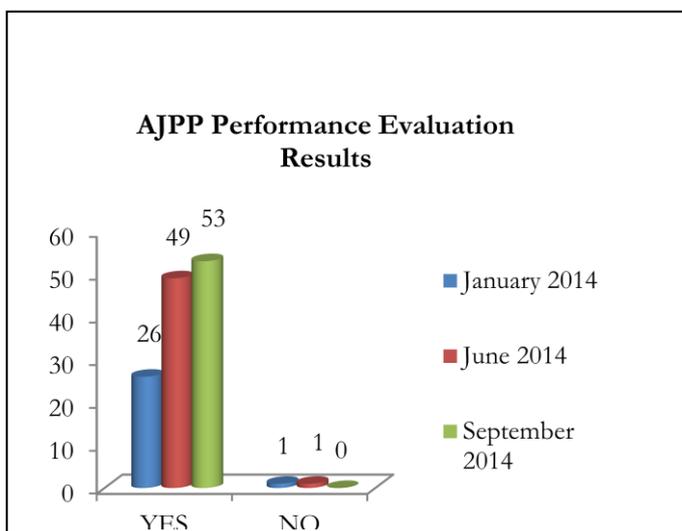
MAHEFA began to use a monthly assessment activity as a way to help NGOs conduct its own performance based on simple and objective criteria. The results of the assessment were checked

and approved by the MAHEFA regional teams. The NGO monthly assessment was used by the NGOs to improve its performance. In March 2014, MAHEFA began to put in place a quarterly review meeting. NGOs and MAHEFA staff reviewed the program progress using real data as a way to measure program progress towards its targets. This review session provided concrete information to both the NGO and the MAHEFA teams on-time and accurate information to improve the overall program performance. Additionally, the NGO staff received in-service training through one-on-one coaching during joint supervision visits. The new NGO performance evaluation system generated the following results:

1. NGO's self-assessment and self-adjustment over a short time-frame on technical, financial and M&E issues needing improvement.
2. Sharing of best practices among NGOs for improvement purposes.
3. The results allow MAHEFA to prioritize and customize the technical, financial and M&E support needed by NGOs (MAHEFA has become more strategic and structured in its support).
4. MAHEFA can quickly establish a recovery plan, coach and assist NGOs if necessary in the specific areas where they have failed.
5. MAHEFA can decide to terminate contracts before their term (often annual) with NGOs if no improvement is observed after implementation of their recovery plan (monthly, bimonthly or quarterly).
6. MAHEFA now has a tool for supporting the decision-making process regarding the institutional and organizational support that it will provide to increase NGO performance.

Two partner NGOs (AJPP in Boeny and FTMM in Melaky) performed well between January and September 2014 with a considerable number of 'YES' answers (meaning 'yes' they were able to meet the criteria set by MAHEFA) and few 'NO' answers (see Figure 16 below). Thus, these NGOs contributed to the achievement of MAHEFA's targets for FY2014. Their performance contributed to, among other things, optimize CHWs' skills in case management and counseling activities; improving the quality of CHWs' interventions through close supervision and coaching; increasing the number of people sensitized on community health issues promoted by MAHEFA; and facilitating CHWs' collaboration with other community stakeholders (COSAN, Community Facilitators, NL, WUHSA, YPE) for the promotion of positive behaviors at the community level in regards to health, hygiene and sanitation. Furthermore, significant improvements were also observed in the two NGOs' organizational management: contract, data and financial management such as with the timely submission of technical and financial reports, including reliable data.

Box 18. Evaluation Results for the two best NGOs from January to September 2014





Restitution meeting of the results of SAHI's (Sofia NGO) performance evaluation including the elaboration of a recovery plan

NGO performance of the remaining 15 NGOs also improved in FY2014. However, they still average three or more 'NO' answers in their evaluation results ('NO' meaning they were unable to meet MAHEFA's criteria). Performance improvement plan was out in place jointly by the NGOs and MAHEFA, which allowed the NGOs to achieve their annual targets, set in their contracts with MAHEFA.

5.6.2 Capacity building of NGOs managerial and operational staff

Training and refresher courses for NGO staff in technical, financial and M&E fields were initiated during FY2014. In the year, 279 received technical training in various themes of MAHEFA including stock management, 90 NGO staff received training in data analysis and use, 340 in USAID compliances, 23 in administration and finance. These trainings resulted in the:

- Improvement of NGO staff's knowledge and skills allowing them to provide better support to CHWs.
- Improvement of NGO staffs' capacity in technical, financial and data management as well as effective management resulting in better performance of the NGOs.

Box 19. TA provide on-site training on stock management to a CHW in Vohemar, SAVA



As discussed in the IR 2 section, MAHEFA trained TAs of NGOs in stock management. In turn, TAs delivered on-site training to CHWs.

In September 2014, MAHEFA conducted organizational capacity assessments (OCA) using the JSI/Initiatives for the NGO AJPP. As a result, an action plan was developed, presenting areas that need support and required technical support in order of priority. This will enable MAHEFA to develop its own support plan for this NGO in FY2015.

5.6.3 Sharing between NGOs

National coordination meeting was held in January 2014 and 24 regional coordination meetings (four times a year, one per quarter by region for the six regions) were held with NGOs during FY2014.

As a result:

- Sessions of analysis on targets' achievement or non-achievement were initiated by NGOs to immediately adjust their planning of upcoming events (quarterly regional coordination).
- Sharing of best practices and lessons learned between NGOs enabled them to adopt the best approaches and appropriate strategies in planning ahead (quarterly regional coordination).
- Sharing of MAHEFA's approaches, strategies and objectives for NGO management staff by region and by district, took place to help them properly guide their strategies to support their regional teams (national coordination).



Quarterly Coordination Meeting of NGOs in Diego (DIANA)

5.6.4 NGO financial audits

NGOs compliance with USG rules and regulations

An audit began in September 2014 for the NGO SAGE, which has reached a level of spending over US\$300,000 from USG funding source.

Table 15 below summarizes chronologically the significant improvements made by MAHEFA with NGOs in grants' management during FY2014, and MAHEFA will continue to implement FY2014's best practices for the remaining period the program.

5.6.5 Motivation system for NGOs

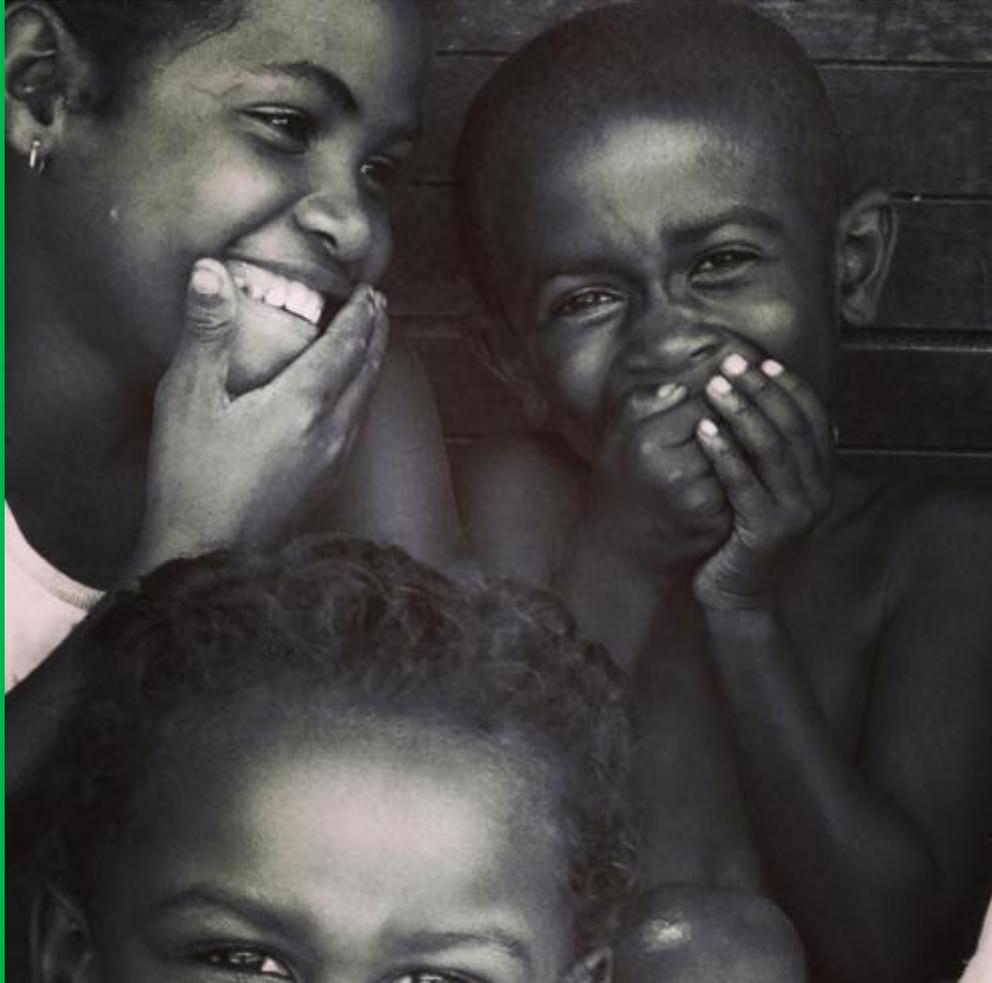
MAHEFA is finalizing the last NGOs' evaluations related to Q4 of FY2014. Certificates of recognition will be given to NGOs in FY2015.

The table below summarized important events and their impact on the overall improvements of NGO grant's management in the MAHEFA Program.

Table 15.Improvements in NGOs' grants management

Timeline	Events	Results
October 2013	Change in directorship of the MAHEFA grants' section	Improvement in the overall section: division of tasks among members of the section, better coordination with other sections and better communication / follow-ups with NGO grantees
October -November	Support from JSI/Boston to the	Improvement in the overall grants'

Timeline	Events	Results
2013	MAHEFA grants' section	management system including tools to better manage the grants and support grantees
November 2013	Start-up workshop in Tana and in the regions for all MAHEFA and NGO staff	NGO staff understand better and are more committed to the implementation of the program at the community level
January 2014	Review of all grants (document review) and a meeting was held to communicate the results to all NGO grantees. MAHEFA introduced the monthly self-assessment system to help grantees better manage their contracts and technical commitments (per their contract)	Status of each of the grantees (contractual and technical commitments) known to both MAHEFA team and the NGO team. NGO welcomed the monthly self-assessment checklist as contract management tool.
End of March 2014	Two NGO, SAF-FJKM and FAFY were performing poorly (contractually and technically) despite many supporting visits and clear communications from the MAHEFA grants' team. Additionally, their TAs complained that they were not paid by the NGOs.	MAHEFA decided to terminate its contracts with these NGOs early. MAHEFA set up "non-NGO" operations in the districts where the two NGOs worked.
January-September 2014	Monthly self-assessment is used on a regular basis.	Most NGOs improved their performance in regards to respecting the terms of their contract. Some NGOs have fallen behind and are aware of it. A few NGOs excel and maintain their high ranks and they are proud of it.



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MAHEFA Annual Report: October 1, 2013-September 30, 2014



USAID
AVY AMIN'NY VAHOAKA AMERIKANA



Madagascar Community-Based Integrated Health Program (MAHEFA)

ANNUAL REPORT: October 2013-September 2014

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Cooperative Agreement No. 687-A-00-11-00013-00

Date Submitted: November 14, 2014

This Annual Report has been prepared by JSI Research & Training Institute, Inc. in collaboration with The Manoff Group and Transaid and submitted to the United States Agency for International Development for consideration and approval.

Annex 1: Challenges and Corrective Actions

Annex 1: Challenges and Corrective Actions

Key Challenges Encountered in FY2014 and Corrective Actions

Major Challenge	Challenges Encountered	Corrective Actions	Progress end of FY 2014	Follow-up actions
1. Quality of services provided by CHWs	<p>CHWs in remote areas do not receive on-site supervision on a quarterly basis as scheduled. This is of particular concern for CHWs in counties that are inaccessible during the rainy season. (64% of counties)</p> <p>Low level of education among CHWs</p>	<p>Developed a detailed and integrated supervision plan to ensure that all CHWs receive at least one on-site supervision visit by either the CSB, NGO/TA, partner NGO staff or MAHEFA staff per quarter</p> <p>Developed a Supervision Panel to track supervisions</p> <p>Introduced a coaching system and a partnered approach where well-performing CHWs are paired with underperforming CHWs</p>	<p>Supervision plan has been implemented and CHWs have had an on-site supervision visit (306 CHWs, or 70%)</p> <p>CHWs in counties that are inaccessible during the rainy season are supervised before the rainy season begins.</p> <p>Improved quality of reporting and filling management tools (30%)</p>	<p>Continue to ensure that all CHWs receive on-site supervision, either by the CSB, NGO/TA, partner NGO staff or MAHEFA staff on a quarterly basis and that CHWs in remote areas are prioritized</p> <p>Continue updating Supervision Panel to track supervision visit progress</p> <p>A joint supervision plan is established on a bi-annual basis at the central and regional level, on a quarterly basis at the district level, and on a monthly basis at the county level</p> <p>Continue to provide target support for CHWs with low level of education</p>

Major Challenge	Challenges Encountered	Corrective Actions	Progress end of FY 2014	Follow-up actions
2. CHW stock shortages	Stock shortages of certain products (Viasur, sur'eau) remain a serious problem for CHWs in many regions. As a result, CHWs cannot provide adequate health care in specific areas	Continued to communicate shortages in stock with PSI/ISM Project and provide PSI with alternative means of transport Implemented various PSI supply points in the most remote areas during the rainy season	By the end of FY2014, certain CHWs still do not have a steady stock supply of 4 to 6 months (Viasur and sur'eau) CHWs now can replenish stocks at the nearest PSI supply point	Continue to communicate and coordinate shortages in stock with PSI/ISM Project Organize supply at each monthly CHW meetings
3. Community Ownership	Many communities (1665 <i>fokontany</i>) have not yet built community work-sites for their CHWs Insufficient engagement from local authorities and community in supporting CHW activities CCDS members are not sufficiently involved in achieving community goals	Continued to use the CSC and the KMSm magazines as a means for advocacy in support of building community work-sites for CHWs	By the end of FY2014, there are 1393 CSCs led and on average 45% of <i>fokontany</i> have a community work site	Apply an adapted CSC to add to KMSm assessments in order to facilitate the allocation of other materials like shelves and latrines Continue with the classic CSC for the 1665 other <i>fokontany</i> Strengthen CHW supervision and put emphasis on BCC approaches in order to involve the community. Continue with this mode of operation until the end of the program.
4. Electronic Database System	Electronic system does not take into account older data system Inconsistency in data reported between the manual system and	Integrated the old data in the new electronic system manually Many data forms needed to be corrected to match the original	All data (pre- and post-electronic data system) merged into one electronic database	Correct each electronic record with an error message to conform to each CHW form. Estimated completion date is

Major Challenge	Challenges Encountered	Corrective Actions	Progress end of FY 2014	Follow-up actions
	the new electronic system (after all data is put in the new electronic database)	CHW registry		December 2014.
5. Management of NGO capacity building	<p>Delay in submission of technical and financial NGO reports.</p> <p>Poor quality of implementation and the unreliability of the data presented in reports submitted by NGOs.</p> <p>Insufficient support from central NGO staff to regional NGO staff, causing delays in availability of funding for operations.</p> <p>NGO staff turnover due to resignations.</p>	<p>Implementation since January 2014 of a monthly assessment checklist that allows NGOs to self-assess their performance in compliance with deadlines for technical and financial reports.</p> <p>MAHEFA holds a regional coordination meeting on a quarterly basis with NGOs in order to review the objective of the previous quarter and discuss an action plan to improve future interventions. The decentralization of financial management is one of the proposed solutions for NGOs.</p> <p>MAHEFA periodically organizes capacity building sessions (technical, programmatic, administrative, financial) for new NGO staff so that they are quickly operational. Follow ups are carried out on-site</p>	<p>The majority of NGOs have shown a significant improvement with respect to the timely provision of technical and financial reports with MAHEFA support.</p> <p>The majority of NGOs have demonstrated an improved capacity in data analysis relating to the implementation of activities in the previous quarter, and work to improve their approach for better results in the next quarter.</p> <p>NGOs from central office showed an improvement in the availability of funds for their regional offices.</p> <p>The capacity building sessions have helped NGO staff become quickly operational</p>	<p>December 2014.</p> <p>Continue with this mode of operation until the end of the program.</p> <p>Continue to provide NGOs with capacity building sessions</p> <p>Continue to provide NGOs with support to ensure that funds are sent to regional offices in a timely manner.</p> <p>Continue to organize these sessions, whether they may be during supervisions, or other NGO staff gatherings.</p>

Major Challenge	Challenges Encountered	Corrective Actions	Progress end of FY 2014	Follow-up actions
6. WASH related challenges	<p>Lack of ownership among community leaders in WASH related activities</p> <p>Water quality tests conducted revealed that the water from certain wells was not potable without further treatment.</p>	<p>By the end of March, MAHEFA changed its WASH activities strategy so that WASH activities will be led by the water user associations and natural leaders</p> <p>TAs were trained in CLTS and ensure that communities are carrying out WASH activities.</p> <p>MAHEFA developed an action plan to address the water quality problem, based on IPM Project recommendations.</p>	<p>The majority of communities in MAHEFA program zones attribute WASH activities to their natural leaders.</p> <p>Recently, community members have begun joining CHWs in their monthly meetings in order to support activities and discuss progress.</p> <p>An action plan has been developed and certain actions have been implemented.</p>	<p>The TAs continue to support and follow WASH activities led by NLs and by CHWs during monthly meetings and on-site visits.</p> <p>The entire action plan will be implemented.</p>



Annex 2: Activity Table

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
0	1		<i>Human resource management</i>					
0	1	1	Recruit candidates as needed for technical and administrative/financial staff at central and regional levels	Candidates recruited	Candidates recruited	Recruitment of 12 new staff -COP , DCOP Finances & Admin, IT Assistant, Technical officers for Sava and Melaky, 3AAf for Diana SAVA and Melaky, 1 M&E for Sofia, a janitor, M&E for Central office, Youth approach coordinator, Grants assistant, driver for the Menabe Office		Continue to review provide human resources as needed: Recruitment of and HR assistant
0	1	2	Build staff capacity as needs and opportunities arise	Staff trained	Staff trained	1 meeting of the Capacity Building committee to identify how to address staff needs in training		
				Staff capacity reinforced	On-going	Staff were invited to 2 trainings organized internally		
0	2	-	<i>Information technology management</i>	-				

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
0	5		<i>Financial management</i>	-				
0	5	1	Quarterly submission of SF 425 finance report to USAID	4 quarterly finance reports submitted to USAID	4 quarterly finance reports submitted to USAID	3 SF425 submitted for Q1,Q2 and Q3	Q4 SF425 is ongoing	Continue to provide quarterly SF425 report to USAID
0	5	2	Update/improve program financial system as needed	Finance system improved	Continue	Implementation of the Action Plan from the internal Audit		Implement USAID ction Plan from the Financial Review
0	5	3	Submit and track VATs filed with the MOH/DLUM	Statements filed with MOH/DLUM Status of VAT reimbursed by MOH/DLUM known	VAT reported on a monthly basis	3 VAT monthly report submitted to the MOH/DLUM for reimbursement		
0	5	4	Submit annual report to the Min Foreign Affaires and Min.Finances	Activity reported to the GOM for official documentation	Accord de siege renewed	Technical report submitted to the Ministry of Foreign affairs and Accord de siege renewd for 2 years		
0	6	-	<i>Capacity building</i>	-				

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
0	6	1	Conduct OCAs with NGOs	6 OCAs conducted 6 Action Plans finalized	6 OCA conducted with 6 actions plans finalised	3 OCA conducted with 3 actions plans finalized with 3 NGOs (PENSER, Ny TANINTSIKA and AJPP)	Review level of activities as we revised our strategies for NGOs capacity buildings. OCA is only conducted for selected NGO to assist them to develop their organizational capacity to become USAID direct recipient. Therefore, the process requires high-level of resources (fund, HR and time) from both the NGO and MAHEFA side). Most importantly, it is not in MAHEFA mandate for NGOs to become direct recipient. However, we strongly believe that we can assist one or two NGOs to achieve that status during the program period	Continue OCA process with AJPP NGO in PY5

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
0	6	2	Support and assist NGO contract management	Support/assistance visits conducted	Support/assistance visits conducted	Support/assistance visits conducted in all 6 regions and at NGOs' headquarter. In addition, monthly performance assessment were implemented with the 19 NGOs. Results are shown and analyzed in the regional quaterly coordination workshops (one per region per quarter) = 24 coordination meeting in all 6 regions during FY2014 1 national coordination meeting took place in January 2014 with all 19 NGO in MAHEFA headquarter to share with NGOs' Representatives MAHEFA's expectations towards NGOs grantees, MAHEFA's results at date, the newly monthly NGOs'assessment tools		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
	6	3	Train NGO staff as needed based on OCA findings in coordination with other MAHEFA activities	NGO staff trained	NGO staff trained	90 NGOs staff staff trained use of data for decision-making 340 NGO staff trained in compliance EMMP and ethics 23 NGO staff trained in finances and administration		
0	7	-	<i>Audits</i>	-				
0	7	1	Conduct financial audits as required by the standard provisions of the NGO grants contracts	Audit reports available	Audit reports available	1 audit conducted with SAGE NGO	Audit is still ongoing and Reports will be available in early PY5	Follow -up of SAGE NGO Audit progress with auditors to get the reports as soon as possible
0	8	-	<i>NGO Motivation</i>	-				
0	8	1	Establish a system to reward high-performing NGOs in regards to grants management	Certificates given to high-performing NGOs	Certificates given to high-performing NGOs	Monthly Performance assessment conducted during FY2014	Need to finalized Q4 performance results of all NGOs in early PY5	Once, the results of Q4 NGOs performance finalized, Certificates will be given to high-performing NGOs in the 6 regions during FY2014

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
<i>IR 1: Increase demand for high quality health services and products</i>								
1	2		Reinforce partner capacity to develop strategies for behavior change (and additional supports and approaches)					
1	2	7	Conduct regional workshops on the development and implementation of different approaches to supplement BC strategies (training on listening groups; other approaches)	4 regional workshops conducted	4 regional workshops conducted	Not yet conducted	Strategy was changed. Instead of providing training through workshops, MAHEFA used intensive and comprehensive in-service training approach to assist NGO develop and implement different approaches to supplement BC strategies	
1	2	8	Technical support to the regional workshops on the development and implementation of different approaches to supplement BC strategies (training on listening groups; other approaches)	4 regional workshops supported; SAVA/DIANA et SOFIA/BOENY, MENABE, MELAKY	See above	See above	See above	

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	3		<i>Use research results to develop print and audiovisual tools/aids to address major BC barriers</i>					
1	3	1	Adapt and produce new audiovisual materials for different program elements and gender	3 Santenet stories in 3 dialects (Sakalava, Tsimihety , Antakarana) produced in audio version 6 radio theater episodes on health, WASH and gender topics produced 25 thematic spots produced	Spots produced & Broadcasting continued	3 Santenet stories in 3 dialects (Sakalava, Tsimihety , Antakarana) produced in audio version 6 radio theater episodes on health, WASH and gender topics produced 25 thematic spots produced		
1	3	3	Make audio reports on community initiatives and achievements for radio broadcasting	15 reports completed	15 reports	15 reports completed		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	3	4	Develop print materials for selected program elements and gender and for CHW BC empowerment activities	# gender pamphlets/flyers produced and distributed # FP invitation cards produced and distributed # mentoring (" <i>parrainage</i> ") stickers produced and distributed 3 information bulletins published	Gender materials produced and distributed FP invitation cards produced & distributed Mentoring stickers produced & distributed 3 information newsletters published	4 types of FP cards produced and disseminated; 4 types of Stickers for Care Groups (<i>parrainage</i>) produced, dispatch is on going; 5 types of WASH materials produced, dispatch is ongoing; 2 newsletters published and disseminated; 1 MNCH & Gender skits booklet developed, 6 regional gender counseling cards developed	Delays in overall production of gender materials due to initial graphic artist's inavailability during Q3	Gender skits Booklet and counseling cards to be finalized, produced in Q1 of FY 2015
1	3	6	Design client invitation cards to disseminate information about program elements and to increase new users (combined with 1.3.4)	# of cards distributed to CHWs	FP client invitation cards & stickers produced & disseminated to CHWs in all 3031 fokontany with instructions re: their use.	4 types of FP invitation cards designed & 130,000 cards disseminated to CHWs		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	3	8	Design IEC tools (including SMS message guide) for use by Youth Peer Educators (YPE)	# kits developed for YPE	SMS and mobile phone User-Guide: sent after activation of the sim cards	264 mobile phone user guides distributed in DIANA, SAVA and Melaky		Activity to be continued in the other areas in FY2015
1	3	10	Test the materials developed	# materials tested	Gender & WASH materials pretested	1 booklet on gender and MNCH skits pretested 2 gender counseling cards pretested in Menabe and Melaky 5 WASH IEC Materials pretested in regions: Latrine Catalogue, SODIS brochure, Sur'eau brochure, Handwashing household flyer, latrine use & maintenance household flyer	Remaining 4 gender counseling cards to be pretested, finalized & disseminated in Q1 FY2015; Pretesting of all 6 gender counseling cards delayed due to delays in initial production of gender materials (i.e. graphic artist's inavailability during Q3)	Production to be completed and all gender & WASH materials disseminated in FY 2015
1	4		<i>Implement BC empowerment activities at the community level/Roll out BCC activities in communities and districts</i>					

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	4	1	Broadcast programs and/or radio formats in collaboration with media partners	# Santenet stories in 3 dialects (Sakalava, Tsimihety , Antakarana) produced 6 theater episodes on health, WASH and gender produced 25 thematic spots produced	26 local radio stations within M AHEFA's 6 regions broadcast spots based on health themes twice a day throughout FY2014 6 Drama episodes (maternal health) &6 stories (child health) are aired 1x/week for collective listening needs during the year	26 local radio stations within M AHEFA's 6 regions broadcast spots based on health themes twice a day throughout FY2014 6 Drama episodes (maternal health) &6 stories (child health) are aired 1x/week for collective listening needs during the year		
1	4	2	Extend the implementation of community listening groups in the remaining communes (6 regions)	368 listening groups (LG) implemented	368 new LGs established in the 6 regions	432 new LGs were initiated and provided with solar wind radio in FY2014 in the 6 regions	AWR was able to give more solar wind radios than expected.	
1	4	3	Organize collective listening sessions in intervention communes	2 944 collective listening sessions organized	2 944 collective listening sessions organized	16 634 collective listening sessions organized	Following contacts with local radio stations, radio campaign for supporting listening sessions happened once a week for 12 months.	
1	5		<i>Establish WASH-friendly institutions</i>					

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	5	1	Continue to identify and make courtesy visits to local scout branches, churches, youth groups, NGO grantees as local WASH partners in new communes/districts (15 districts)	136 community groups/partners identified	136 community groups/partners identified	140 community groups/partners identified		
1	5	2	Establish partnership agreements (PAs) with selected community groups/partners (117 new communes and 19 continuing communes)	136 PAs signed with community groups/partners	136 PAs signed with community groups/partners	78 PAs signed with community groups/partners	After reviewing WASH approaches (situational analysis) , the signing of a partnership agreement is no longer mandatory	
1	5	3	Conduct WASH training and action planning for community groups/partners including COSANs (117 new communes and 19 continuing communes)	136 community groups/ partners trained and having an action plan	136 community groups/ partners trained and having an action plan	66 community groups/ partners trained and having an action plan	After reviewing WASH approaches, it was considered that each CLTS triggered site should become "WASH Friendly "	

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	5	4	Assist community groups/partners to conduct community sensitizations and implementation of the 3 key WASH strategies (117 new communes and 162 continuing communes), in coordination with supervision visits	279 community groups assisted by the TAs each quarter	279 community groups assisted by the TAs each quarter	210 community groups assisted by the TAs each quarter	One considers not only the "community group" but also triggered CLTS community to become "WASH Friendly ODF" as recommended by the situational analysis.	
1	5	6	Evaluate implementation of 3 key WASH messages by community groups/partners at household, institution and commune levels (117 new communes and 162 existing communes)	141 community groups/ partners evaluated	141 community groups/ partners evaluated	210 community groups/ partners evaluated		
1	5	7	Organize celebrations for community groups/partners achieving WASH-friendly status (117 new communes), in combination with 1.6.11	141 celebrations held in KMSm communes	141 celebrations held in KMSm communes	186 celebrations held in KMSm communes		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	6		<i>Launch community mobilization and participation in CLTS approach</i>					
1	6	4	Mobilize regional trainers and local facilitators (Facilitators, Natural Leaders, CHWs, COSAN- TA) and implement "triggering events" in strategic communes (117 new communes and 19 existing communes)	136 triggering events conducted	136 triggering events conducted	476 triggering events conducted		
1	6	5	Identify the true "natural leaders" to promote and scale-up CLTS+H in other villages (combined budget with 1.6.4)	136 "natural leaders" identified	136 "natural leaders" identified	342 natural leaders identified		
1	6	6	Train the "natural leaders" and motivated commune facilitators in promotion and scale-up CLTS+H in (117 new communes and 19 existing communes)	14 training waves conducted 272 NL/ CF trained	14 training waves conducted 272 NL/ CF trained	17 training waves conducted 342 NL trained		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	6	7	Conduct monthly supportive supervision for "natural leaders"/ commune facilitators and CHWs for triggered sites	1000 CFs & NLs attending monthly regroupement (CHWs already covered under 4.4.7)	1000 CFs & NLs attending monthly regroupement (CHWs already covered under 4.4.7)	506 attended monthly gatherings with CHWs and supported NGO's TAs	Data available only counted LNs but not the Community Facilitators	
1	6	8	Support the expansion of CLTS+H to other villages in collaboration with facilitators, CHWs and "natural leaders" (117 new communes and 19 existing Communes), in combination with 1.6.5 and 1.6.7	136 new villages with triggering events conducted	136 new villages with triggering events conducted	476 New villages with triggering events conducted		
1	6	9	Prepare to conduct a 6-month formal evaluation of community ODF objectives with the WASH committee	# 6-month formal evaluations completed	# 6-month formal evaluations completed	228 communities autodeclared ODF		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	6	10	Conduct a formal verification evaluation 6 months after community attains ODF goals	# 12-month formal evaluations completed # villages achieving 12-month ODF goals # communities achieving ODF status	# 12-month formal evaluations completed # villages achieving 12-month ODF goals # communities achieving ODF status	84 communities certified ODF		
1	6	11	Plan WASH-themed high visibility community events for ODF-practicing and non-ODF-practicing communities	# of events conducted	# of events conducted	54 events conducted		
1	6	12	Celebrate communities certified as "ODF" at their final evaluation (in combination with 3.1.7)	# of communities certified as open defecation-free # of celebrations conducted	# of communities certified as open defecation-free # of celebrations conducted	84 communities received certified ODF and 228 self-declared ODF status during the year		
1	6	13	Celebrate WASH "Days" with events and media	# of events conducted	# of events conducted	14 events celebrated (WASH day - 6 regions; Latrine - 2 regions; and handwashing -6)		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
1	7	8	Conduct KMSm participatory planning in 24 districts	279 communes with action plans and agreements signed	279 communes with action plans and agreements signed	254 communes with action plans and agreements signed for cycle 2		
1	7	9	Support and ensure the progress of participatory planning processes in the 24 new districts (carried out by central team)	# of assisted participatory planning processes conducted	# of assisted participatory planning processes conducted	254 assisted participatory planning processes conducted		
1	7	10	Support and ensure the progress of participatory planning processes in the 24 new districts (carried out by regional teams)	# of assisted participatory planning processes conducted	# of assisted participatory planning processes conducted	Same as above (same planning events)		
1	8		<i>Contribute to events (health days, etc.)</i>					
1	8	1	Participate in national and international events	# of events with MAHEFA participation	# of events with MAHEFA participation	23 national and 3 international events with MAHEFA participation		
1	9		<i>Implement high visibility activities to create an environment conducive to behavior change</i>					
1	9	1	Conduct CHW training in BC empowerment (contests, carnival, care groups, health-friendly	104 trainings conducted 2624 CHWs trained	104 trainings conducted 2624 CHWs trained	104 trainings conducted 2745 CHWs trained (6004 CHWs trained - cumulative)		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
			approach)					
1	9	2	Hold celebrations for social mobilization and promotion of behavior change empowerment (contests, carnival, care groups, journées locales PF, health-friendly approach)	43 events held	43 events held	More than 48 events held		
1	9	3	Organize Income Generating Activities (IGAs) and equip CHWs in each fokontany with launch kits (soap, simple and PET bottle, string)	# community sites equipped with IGAs launch kits	# community sites equipped with IGAs launch kits	Concept paper finalized. Some IGA activities already being conducted on initiative of CHWs; Inventory of previously distributed WASH kits conducted in 6 regions.	Inventory of previously disseminated WASH materials needed to be conducted prior to completing concept paper.	Rescheduled in FY2015

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
<i>IR 2: Increase the availability of services and products</i>								
2	2		Build capacity of CHWs in integrated program elements					
2	2	3	Train all categories of CHWs in FP/RH and MNCH	6 065 CHWs trained in FP/RH and MNH elements Number of functional (trained, equipped, and supervised) community health workers	6 065 CHWs trained in FP/RH and MNH elements Number of functional (trained, equipped, and supervised) community health workers	6377 CHWs trained in FP/RH and MNH elements Number of functional (trained, equipped, and supervised)	Due to the replacement of CHWs, additional training were conducted for the new ones.	
2	2	6	Train CHWs in Depo-Provera/WASH-1	3 323 CHWs trained in Depo-Provera/WASH-1	3 323 CHWs trained in Depo-Provera/WASH-1	3 113 CHWs trained in Depo-Provera/WASH-1	134 CHWs were no longer trained in Depocom in Sofia and DIANA and CHWs who replaced those resigning are not yet at the stage for Depocom training.	Training in FY2015
2	2	9	Provide initial c-IMCI training for CHWs who were not previously trained	40 training waves 822 CHWs trained in c-IMCI	40 training waves 822 CHWs trained in c-IMCI	45 training waves 1230 CHWs trained in c-IMCI		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	2	12	Train CHWs in Nutrition/WASH-2	188 training waves conducted 3866 CHWs trained in Nutrition/WASH-2	188 training waves conducted 3866 CHWs trained in Nutrition/WASH-2	188 training waves conducted 3588 CHWs trained in Nutrition/WASH-2	Some CHWs not trained due to resignation, death or absence. Target identified during submission of FY2014 workplan was also higher than it should have been as some were trained during September 2013.	184 CHWs to be trained in FY2015 to reach the objective of 6081 CHWs
2	2	14	Provide refresher trainings on FP/RH, Depo-Provera, MNCH, Nutrition, c-IMCI, and BCC for CHWs	# of integrated refresher trainings provided 2 059 CHWs receiving refresher training	# of integrated refresher trainings provided 2 059 CHWs receiving refresher training	At least 12 times per year 3000 CHWs receiving refresher training (via monthly meeting, suivi groupe and technical supervision)		
2	3		<i>Participative supply chain management</i>					
2	3	1	Collaborate with partners to follow up functionality of supply point in hard to reach areas	% of reporting PAs who had stock-outs of specific tracer drugs/products (1.6, 2.5, 3.4, 4.5, 5.8)	% of reporting PAs who had stock-outs of specific tracer drugs/products (1.6, 2.5, 3.4, 4.5, 5.8)	12 coordination meetings between PSI/ISM and MAHEFA	To be reported by PSI in their report	

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	3	2	Develop and implement supply chain strategies for hard-to-reach areas in collaboration with transport unit and partners	Strategies developed # of hard-to-reach communes supplied	Strategies developed # of hard-to-reach communes supplied	Strategies developed 7 hard-to-reach communes supplied		
2	3	3	Assess the status of stock levels of malaria, FP, child health, and WASH products for PAs and CHWs on a regular basis	% of reporting CHWs who had stock-outs of specific tracer drugs/products (1.6, 2.5, 3.4, 4.5, 5.8)	% of reporting CHWs who had stock-outs of specific tracer drugs/products (1.6, 2.5, 3.4, 4.5, 5.8)	6% CHWs reported stockout for 2.5 (viasur)2% CHWs reported stockout for 3.4 (pilplan et depo)16% CHWs reported stockout for 4.5 (TDR)19% CHWs reported stockout for 5.8 (Sur'Eau)Data of September 2014		
2	3	4	Update forecasts and procurement plans quarterly	Forecasts updated Procurement plans updated	Forecasts updated Procurement plans updated	Forecasts updated Procurement plans updated		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	3	5	Collaborate with partners to ensure a rational procurement plan for malaria, FP, child health, and WASH products for PAs and CHWs	% of reporting CHWs who had stock-outs of specific tracer drugs/products (1.6, 2.5, 3.4, 4.5, 5.8)	% of reporting CHWs who had stock-outs of specific tracer drugs/products (1.6, 2.5, 3.4, 4.5, 5.8)	6% CHWs reported stockout for 2.5 (viasur) 2% CHWs reported stockout for 3.4 (pilplan et depo) 16% CHWs reported stockout for 4.5 (TDR) 19% CHWs reported stockout for 5.8 (Sur'Eau) Data of September 2014		
2	3	6	Ensure storage and distribution of kits and products for CHWs, COSANs, YPEs, and households (279 communes)	% of reporting CHWs who had insufficient quantities of management or work tools	% of reporting CHWs who had insufficient quantities of management or work tools	All CHWs have sufficient management or work tools.		
2	3	7	Build CHW capacity in stock management for all health commodities, following a "zero-stockout" approach	279 TAs trained # of reporting CHWs who had stock-outs	279 TAs trained # of reporting CHWs who had stock-outs	279 TAs trained		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	4		<i>Equip and supply the CHWs and Youth Peer Educators (YPE)</i>					
2	4	1	Duplicate and disseminate IEC materials (flip charts, job aids, posters, certificates, sign boards, etc.) for CHW use (initial and resupply; 24 districts)	Availability of materials at all CHW level	Availability of materials at all CHW level	All IEC materials produced by MAHEFA and distributed to CHWs		
2	4	2	Duplicate and disseminate IEC materials (pamphlets, guides, newsletters, posters, certificates, etc.) for use at the COSAN level (initial and resupply; 24 districts)	Availability of materials at all necessary levels: certificates and COSAN guides	Availability of materials at all necessary levels: certificates and COSAN guides	All necessary materials are distributed to COSAN		
2	4	3	Duplicate and disseminate IEC materials (health cards, pamphlets, posters, certificates, etc.) for use at the household level (initial and resupply; 24 districts)	Availability of materials at all necessary levels: health books, kits for mutuelles/CSC, commemorative plaques, and fokontany certificates	Availability of materials at all necessary levels: health books, kits for mutuelles/CSC, commemorative plaques, and fokontany certificates	All necessary materials are distributed to members of mutuelle		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	4	4	Duplicate and disseminate IEC materials (flip charts, pamphlets, job aids, certificates, SMS message guide, etc.) for Youth Peer Educators (initial and resupply; 24 districts)	Availability of materials at youth level	Availability of materials at youth level	Materials are available at youth level		
2	5		<i>Establish models for mutuelles and microfinance</i>					
2	5	2	Extend the establishment of health mutuelles in appropriate communes	Nbre established mutuelles	Nbre established mutuelles	23 mutuelle established (cumulative)		
	5	4	Conduct a 2-day training for local facilitators (COSAN, CCDS)	220 local facilitators trained	220 local facilitators trained	230 local facilitators trained (cumulative)		
2	5	5	Conduct a workshop to establish management committees and boards for the mutuelles	18 workshops conducted 180 participants	18 workshops conducted 180 participants	23 workshops conducted 181 participants (cumulative)		
2	5	6	Train the management committees and boards for the mutuelles (3 days)	180 committee/board members trained	180 committee/board members trained	181 committee/board members trained		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	5	7	Conduct follow up of the management committees and boards for the mutuelles	3 per quarter	3 per quarter	3 per quarter 12 per year		
2	6		<i>Conduct Sanitation Marketing</i>					
2	6	1	Conduct Sanitation Market research (suppliers and consumers) in communes	229 Sanitation marketing studies conducted	229 Sanitation marketing studies conducted	199 Sanitation marketing studies conducted	Introduction of sanitation marketing depends on progress of CLTS activities (demand in latrine construction)	
2	6	2	Implement the sanitation marketing strategy	Training curriculum for VSLA finalized	Training curriculum for VSLA finalized	Training curriculum for VSLA finalized (integrated with training of WUA)		
2	6	4	Support the promotion of latrine slabs by local masons and CHWs	1260 improved latrines constructed	1260 improved latrines constructed	6263 improved latrines constructed		
2	6	6	Train local technicians in latrine construction, latrine maintenance, SANPLAT slabs sensitization and sale promotion techniques (24 districts)	253 local technicians trained 253 action plans developed	253 local technicians trained 253 action plans developed	398 local technicians trained 398 action plans developed		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	6	8	Train trainers in VSLA	30 Trainers trained	30 Trainers trained	64 Trainers trained (VSLA integrated into WUA training)		
2	6	9	Train NGO staff on VSLA approach and promotion	60 NGO staff trained Members of 250 WUAs trained	60 NGO staff trained Members of 250 WUAs trained	64 NGO staff trained 342 members of WUAs trained		
2	6	10	Supervise NGOs, Local masons, Commune facilitators, Natural leaders, and Water Users' Associations (WUAs) (combined with 3.1.2)	# NGOs supervised# Natural leaders supervised# WUAs supervised# supervisions conducted	# NGOs supervised# Natural leaders supervised# WUAs supervised# supervisions conducted	19 NGOs supervised506 Natural leaders supervised299 WUAs supervisedAt least 12 supervisions conducted		
2	7		<i>Establish infrastructure for improved drinking water</i>					
2	7	1	Supervise and monitor the activities of the consulting agencies/NGOs to mobilize the community and conduct monitoring and surveillance (64 priority communes)	# of consulting agencies and NGOs supervised # of mobilizations conducted	# of consulting agencies and NGOs supervised # of mobilizations conducted	7 consulting agencies and NGOs supervised 351 mobilizations conducted		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	7	2	Monitor and supervise construction companies during the construction or rehabilitation of water infrastructure (64 priority communes)	23 construction companies monitored	23 construction companies monitored	23 construction companies monitored		
2	7	3	Establish Water Users Associations and train and periodically update members on how to manage local infrastructure and on the EMMP (64 priority communes) (combined with 2.7.1 and 2.7.2 budget and including 4.1.4)	250 Water Users' Associations functional (established, trained and supervised)	250 WUA established and trained	299 WUA established and trained		
2	7	4	Rehabilitate and build water infrastructure facilities (64 priority communes)	# of wells constructed or rehabilitated # of other (non-well) water infrastructures constructed or rehabilitated	# of wells constructed or rehabilitated # of other (non-well) water infrastructures constructed or rehabilitated	313 water structures completed (268 constructions and 45 renovations)		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	7	6	Identify and train local technicians and other members of the Water Users Association in infrastructure quality and maintenance (64 priority communes) (combined with 2.7.1 for budget and 2.7.3 for training)	64 local technicians trained 250 WUA functional	64 local technicians trained 250 WUA functional	398 local technicians trained 299 WUA functional		
2	9		<i>Continue support for the pilot project on "Care of the umbilical cord with Chlorhexidine in health facilities and at community level" in Mahabo district</i>					
2	9	1	Procure CHX products	# of CHX tubes procured	# of CHX tubes procured	35,000 CHX tubes procured		
2	9	2	Duplicate monitoring tools	# of tools duplicated	# of tools duplicated	6 tools developed		
2	9	3	Conduct monitoring sessions at regional level	Quarterly monitoring meetings conducted	Quarterly monitoring meetings conducted	Quarterly monitoring meetings conducted		
2	9	4	Conduct joint field trips	2 joint field trips conducted by the TWG	2 joint field trips conducted by the TWG	1 joint field trip conducted by the TWG	Non availability of TWG members	
2	9	5	Conduct training and routine project supervision	282 CHWs trained 4 routine supervisions conducted	282 CHWs trained 4 routine supervisions conducted	271 CHWs trained 4 routine supervisions conducted		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	10		<i>Implement pilot project on chlorhexidine for newborns and prevention of post-partum hemorrhage (PPH) in Vohémar</i>					
2	10	1	Develop a project implementation protocol	Protocol developed and available	Protocol developed and available	Protocol developed and available		
2	10	2	Conduct advocacy sessions with local authorities	# of advocacy sessions conducted (Vohémar)	# of advocacy sessions conducted (Vohémar)	2 advocacy sessions conducted in Vohemar		
2	10	3	Conduct ToT on CHX/PPH	33 trainers trained: 19 TAs, 3 RT/NGO, 9 CFR, 3 MAHEFA regional team members	33 trainers trained: 19 TAs, 3 RT/NGO, 9 CFR, 3 MAHEFA regional team members	33 trainers trained: 19 TAs, 3 RT/NGO, 9 CFR, 3 MAHEFA regional team members		
2	10	4	Train CHWs in CHX/PPH	306 CHWs trained	306 CHWs trained	295 CHWs trained		
2	10	11	Launch the CHX- PPH project	Project launched officially	Project launched officially	Project launched officially		
2	10	5	Procure, package and distribute the CHX and Misoprostol products to CHWs	10440 tubes of CHX 31320 misoprostol tablets	10440 tubes of CHX 31320 misoprostol tablets	10440 tubes of CHX 31320 misoprostol tablets		
2	10	6	Provide CHX to the CHWs	306 CHWs provided with CHX	306 CHWs provided with CHX	295 CHWs provided with CHX		
2	10	7	Provide Misoprostol to the CHWs (in packs of 3 tablets)	306 CHWs provided with Misoprostol	306 CHWs provided with CHX	295 CHWs provided with CHX		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	10	8	Duplicate the CHX-PPH jobaid for CHWs	306 CHWs equipped with jobaids	306 CHWs equipped with jobaids	295 CHWs equipped with jobaids		
2	10	9	Duplicate the CHX-PPH communication tools for CHWs	306 CHWs equipped with communication tools	306 CHWs equipped with communication tools	295 CHWs equipped with communication tools		
2	10	10	Sensitize the communities using the local radio	120 programs broadcasted	120 programs broadcasted	Radio spot is produced but not yet broadcasted		Will be broadcasted in FY2015
2	10	12	Recruit field supervisors	1 supervisor recruited	1 supervisor recruited	1 supervisor recruited		
2	10	13	Conduct training supervision of CHWs (integrated with monthly reviews or group monitoring sessions)	306 trained CHWs who were supervised	306 trained CHWs who were supervised	295 trained CHWs who were supervised		
2	10	14	Duplicate the project monitoring manual	M&E manual available	M&E manual available	M&E manual available		
2	10	15	Duplicate and send the management tools to the field		Tools duplicated	Tools duplicated		
2	10	16	Conduct quarterly monitoring and coordination meetings	3 quarterly monitoring sessions completed	3 quarterly monitoring sessions completed	3 quarterly monitoring sessions completed		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	10	17	Edit and disseminate the bi-annual newsletters with information on project best practices	500 newsletters with information on best practices and success stories disseminated	500 newsletters with information on best practices and success stories disseminated	2800 Newsletters disseminated		
2	11		<i>Pilot methods designed to improve CHWs mobility</i>					
2	11	1	Procure bicycles, maintenance tools and training tools	700 bicycles, maintenance and training tools distributed to CHWs	700 bicycles, maintenance and training tools distributed to CHWs	Not completed - bicycle arrival delayed (now expected November 2014). 100 maintenance kits procured.	Delay in international procurement	MAHEFA will continue to follow up with the supplier to ensure that there are no further delays in bicycle supply.
2	11	2	Develop a strategy for areas where bicycles are not appropriate modes of transport	Strategy developed	Strategy developed for areas where bicycles are not appropriate modes of transport	Strategy discussed, updated and on-going		
2	11	3	Transport and distribute bicycles and tools (including bicycle reassembly)	700 bicycles transported and reassembled	700 bicycles, maintenance and training tools distributed to CHWs	Not completed - bicycle arrival delayed (now expected November 2014). 100 maintenance kits procured.	Delay in international procurement for the 700 bikes. MAHEFA received 40 donated bikes in FY2014. These bikes were distributed to CHWs.	MAHEFA will continue to follow up with the supplier to ensure that there are no further delays in bicycle supply.
2	11	4	Select and train implementing partner on CHW training	Trainers trained	Trainers trained	Trainers trained		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	11	5	Train CHWs in management and maintenance of bicycles	700 CHWs trained	700 CHWs trained	40 CHWs trained	Delay in international procurement for the 700 bikes. MAHEFA received 40 donated bikes in FY2014. These bikes were distributed to CHWs. Therefore, only 40 CHWs who received the bikes were trained.	Establish a new plan for bicycle distribution and CHW training once bicycles are received.
2	11	6	Monitor project progress and conduct supervision of the implementing partner	18 supervision visits conducted	18 supervision visits conducted	At least 18 supervision conducted		
2	11	7	Conduct a mid-term evaluation (depending on rainy season accessibility)	Evaluation conducted	Evaluation conducted	Not completed.	Due to delays in arrival of bicycles, this activity is postponed.	
2	11	8	Develop income-generating activities (Bicycle repair workshops)	4 workshops in place	4 workshops in place	2 completed	Due to strategy revision, the implementation of two Eboxes was postponed to FY2015.	
<u>2</u>	<u>12</u>	-	<i>Emergency Transport for medical emergencies (pregnant women, newborns and children under 5)</i>					

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
2	12	1	Procure modes of emergency transport, maintenance tools, and training materials	60 bicycle-ambulances purchased 100 stretchers purchased 40 canoes purchased	60 bicycle-ambulances purchased 100 stretchers purchased 40 canoes purchased	17 bicycle-ambulances purchased (including 5 cyclo pousse) 29 stretchers purchased 2 canoes purchased	There was an error in the indicators for this line 2.12.1 and 2.12.2 In the narrative work plan of FY2014, we planned to put in place emergency transport system in 3 districts. In reality, there were 2 districts with ETS in place in FY2014.	The remaining district (from FY2014) will be added to targets of FY2015.
2	12	2	Deliver and assemble modes of emergency transport	60 bicycle-ambulances delivered 100 stretchers delivered 40 canoes delivered	See above	See above	See explanation in 2.12.1	
2	12	3	Select and train community management committees		Committees trained	Committees trained (except in one district where ETS is not yet put in place)	See explanation in 2.12.1	See explanation in 2.12.1
2	12	4	Follow up the emergency transport activities and supervise the management		Supervision visits conducted	Supervision visits conducted at least once a month		



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IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
			committees					
2	12	5	Conduct a mid-term evaluation (depending on rainy season accessibility)		N/A	N/A		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
IR 3: Improve the quality of care delivered by community-based health practitioners								
3	1		<i>Improve the quality of community activities</i>					
3	1	1	Conduct quarterly integrated supervision visits of Regional Units (6 regions)	6 regional units supervised 2 times per quarter ; 48 regional supervision visits conducted	6 regional units supervised 2 times per quarter ; 48 regional supervision visits conducted	6 regional units supervised 180 supervision visits conducted		
3	1	2	Conduct quarterly integrated supervision visits to NGOs (24 districts)	324 supervision visits conducted to NGOs within the year	324 supervision visits conducted to NGOs within the year	313 supervision visits conducted to NGOs within the year		
3	1	3	Conduct quarterly integrated supervision visits of community actors (24 districts) (combined with 3.1.2)	1688 community actors supervised	1688 community actors supervised	On average 2152 community actors supervised per quarter		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
3	1	4	Conduct quarterly integrated supervision visits of CHWs (24 districts)	4592 CHWs supervised per quarter 3031 Fokontany visited per quarter	4592 CHWs supervised per quarter 3031 Fokontany visited per quarter	On average 4314 CHWs supervised per quarter		
3	1	5	Conduct KMS objectives review 1,2,3 for first cycle	289 reviews conducted	289 reviews conducted	438 reviews/evaluations conducted		
3	1	7	Support events with the labels "AC mendrika," "fokontany mendrika," "tokatrano mendrika" et "commune mendrika" (24 districts)	279 events held	279 events held	186 events held	Date and organization for celebration are led and determined by communities.	
3	1	8	Support and monitor the group monitoring sessions of CHWs (FP/RH in new communes, DEPOCOM and PCIMEC)	235 group monitoring (integrated in the monthly meeting)	235 group monitoring (integrated in the monthly meeting)	257 group monitoring (integrated in the monthly meeting)		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
3	1	12	Orient regional and NGO staff and CHWs on the quality improvement approach in coordination with other trainings/orientations	129 TAs trained	129 TAs trained	279 TA trained		
3	1	13	Identify community actors (e.g. CCDS, COSAN, beneficiaries, CHWs, opinion leaders) to coordinate QI activities at community level (selected NGOs in 24 districts)	70,068 community actors participating in CSC	70,068 community actors participating in CSC	21 150	MAHEFA set the indicators too high. For sustainability reason, during FY2014, MAHEFA revised strategy for CSC and integrated this into the KMSm review sessions.	
3	1	14	Conduct CSC measurement and improvement activities with CHWs (24 districts)	2575 CSC measurements conducted	2575 CSC measurements conducted	983 CSC measurements conducted	MAHEFA set the indicators too high. For sustainability reason, during FY2014, MAHEFA revised strategy for CSC and integrated this into the KMSm review sessions.	
3	1	17	Conduct quarterly supervision of CSC process	24 supervision visits	24 supervision visits	24 supervision visits		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
3	1	18	Assuring conformity with USG FP compliance guidelines through training and supervision of MAHEFA and NGO staff and CHWs (combined with 3.1.1 and 3.1.2.)	300 persons trained and supervised	300 persons trained and supervised	250 persons trained and supervised	Excluding TAs who are trained during CHWs training or monthly meetings and data were not available on these.	
3	1	19	Conduct KMS objectives review 1,2,3 for second/third cycle	672 reviews conducted	672 reviews conducted	192 reviews/evaluations conducted	Delay in KMSm cycle #1 achievements	Continued in FY2015
3	2		Motivation and incentives for CHWs					
3	2	2	Provide non financial incentives for CHWs (Combined with 2.4, 2.11, 3.1.7)	# CHWs receiving bicycle and repair kits	See 2.11			
3	2	3	Create an informal network of CHWs and organize regular peer exchanges to encourage competition among different communities	12 exchange visits	12 exchange visits	6 exchange visits conducted	Most CHWs were not available to make exchange visits due to training program.	

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
3	3		<i>Promote health among youth</i>					
3	3	2	Train youth peer educators in AYRH in pilot fokontany (2 YPE/fokontany in chef lieu for 24 districts)	462 youth peer educators trained	462 youth peer educators trained	477 youth peer educators trained		
3	3	3	Train YPEs on the use of mobile phones for raising awareness on AYRH with their peers	662 YPEs trained	662 YPEs trained	264 YPEs trained	After setting the annual indicators at 662 YPE, MAHEFA realized that it would be better to start a training in few regions, wait for the results before scaling up to all regions. This is why the number of YPE trained is lower than planned.	
3	3	4	Develop and implement action plans to pilot the use of mobile phones for sharing messages with YPE in selected communes	662 YPEs participating in sharing messages	662 YPEs participating in sharing messages	264 YPEs participating in sharing messages	Same explanation as above	

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
3	3	5	Support sensitizations conducted by youth peer educators (YPE) in 331 fokontany	662 YPEs attended formative supervisions per month	662 YPEs attended formative supervisions per month	609 YPEs attended formative supervisions per month	YPEs not available	
3	3	6	Conduct follow-up of sensitizations by youth peer educators (331 fokontany) by TAs and regions	325 follow-up visits by TAs per quarter# YPEs supervised# CHW mentors supervised74 follow-up visits by RU per quarter		609 YPEs attended formative supervisions per month combined with 335609 YPE supervised635 CHWs supervised	YPEs not available	Use of supervision tool validated for 18 follow-up on Q4
3	3	7	Conduct a refresher training for CHW mentors of youth peer educators	462 CHW mentors trained	462 CHW mentors trained	516 CHW mentors trained		62 ACm to train on Q4
3	3	8	Develop a plan for and conduct assessment of youth peer educator activities for scale-up	Plan developed Assessment conducted	N/A	N/A	National youth policy has been revised this year and MAHEFA activities were aligned with this	

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
3	3	9	Conduct team building with regional trainers and NGOs to facilitate training of YPE and refresher training for CHW mentors	24 Team building sessions conducted	24 Team building sessions conducted	24 Team building sessions conducted		
3	3	10	Procure mobile phones for YPEs	662 mobile phones distributed	662 mobile phones distributed	264 mobile phones distributed	After setting the annual indicators at 662 YPE, MAHEFA realized that it would be better to start a training in few regions, wait for the results before scaling up to all regions. This is why the number of YPE trained is lower than planned.	Remaining will be done in FY2015
3	3	11	Develop partnerships with private sector for SMS and toll free calls	# of partners	# of partners	3 partners		Contract with the green line 511 signed
3	3	12	Conduct advocacy and introduction of AYRH approach with local authorities at commune level	17 advocacy workshops 540 persons oriented to AYRH approach	17 advocacy workshops 540 persons oriented to AYRH approach	12 advocacy workshops 360 persons oriented to AYRH approach	Advocacy was reviewed to be done at regional level instead of district level except for Besalampy, Analalava and all districts of Menabe.	

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
3	4		<i>Logistics Management Information System (LMIS)</i>					
3	4	3	Develop and implement action plans for use of mobile phones for supply chain activities at PA, NGO and CHW levels	# of CHWs reporting with SMS system	# of CHWs reporting with SMS system	344 CHWs reporting with SMS (until April 2014)	MAHEFA conducted a SMS program review in June. CHWs stopped reporting while waiting for the new SMS system to be put in place.	
3	4	4	Evaluate the SMS pilot project for the supply chain and reporting system	Pilot projet evaluation report available;	Pilot projet evaluation report available;	Pilot projet review report available;		
				Scale-up plan available.				

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
Cross-cutting activities, including EMMP, M&E, operational research, and information management								
4	1		<i>Implement the EMMP</i>					
4	1	2	Conduct ToT for central, regional and NGO staff and in coordination with other trainings	30 regional staff trained	30 regional staff trained	340 NGO staff trained (15 NGO Coordinators, 28 Technical Officers, 24 M&E Officers, 257 TAs and 16 F&A Officers/ Accountants)		
4	1	3	Conduct training for CHWs and COSANs on the EMMP in coordination with PCIME-c and Depocom trainings	2,263 CHWs trained in Depocom - 822 CHWs trained in PCIME-c	2,263 CHWs trained in Depocom - 822 CHWs trained in PCIME-c	3113 CHWs trained in Depo-Provera/WASH-1 1230 CHWs trained in PCIME-c		
4	1	4	Conduct training for entrepreneurs, local technicians and Water Users Associations on the EMMP in coordination with other trainings (combined with 2.6.6 and 2.7.3)	253 of local technicians trained 253 action plans developed 250 Water Users Associations functional	253 of local technicians trained 253 action plans developed 250 Water Users Associations functional	398 local technicians trained 398 action plans developed 299 Water Users Associations functional		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
4	1	5	Monitor and follow-up compliance with environmental mitigation procedures (with MAHEFA staff supervision)	4 quarterly EMMP reports submitted	4 quarterly EMMP reports submitted	4 quarterly EMMP reports submitted		
4	1	7	Duplicate and distribute guide to Health Care Waste Management for the Community Health Worker	# guides distributed	# guides distributed	6500 EMMP jobaid instead of guide distributed		
4	1	8	Promote community disposal pits at Fokontany levels (1750 fkt)	1750 disposal pits in place	1750 disposal pits in place	377 disposal pits in place	Pits reported are ones that fit technical specification. There are many pits at CHWs site that are not reported because they are not yet to the spec.	
4	2		<i>Ensure adequate M&E capacity among staff at all levels of the M&E system</i>					
4	2	1	Hold annual project-wide M&E workshop for M&E, technical, and NGO staff	Project-wide workshop conducted	Project-wide workshop conducted	Project-wide workshop conducted		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps	
					Expected FY2014	Actual FY2014			
4	2	2	Conduct quarterly M&E supervision visits with on-the-job coaching for regional staff in coordination with other supervision visits (combined with 3.1.1)	12 of supervision visits conducted	12 of supervision visits conducted	12 supervision visits conducted			
4	2	3	Conduct quarterly M&E supervision visits with on-the-job coaching for NGO staff in coordination with other supervision visits (Combined with 3.1.2)	72 of supervision visits conducted	72 of supervision visits conducted	89 supervision visits conducted			
4	2	4	Conduct quarterly M&E supervision visits with on-the-job coaching for CHWs and COSANs in coordination with other supervision visits (Combined with 3.1.3)	4592 CHWs supervised per quarter 3031 Fokontany visited	4592 CHWs supervised per quarter 3031 Fokontany visited	On average 4314 CHWs supervised per quarter			
4	3		<i>Set up the data management system, including electronic approaches</i>						

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
4	3	3	Set up the electronic data management system	System set up	System set up	System set up		
4	3	4	Training of trainers for central and regional M&E staff on database utilization	All M&E staff trained; All regional coordinators trained; 46 RT/RSE of NGOs trained	All M&E staff trained; All regional coordinators trained; 46 RT/RSE of NGOs trained	All M&E staff trained; All regional coordinators trained; 46 RT/RSE of NGOs trained		
4	3	5	Training of NGO M&E staff on database utilization	14 batches of training 278 TAs trained	14 batches of training 278 TAs trained	14 batches of training 279 TAs trained		
4	3	8	Assess mobile phone use coverage and capacity at commune level	3024 fokontany assessed	3024 fokontany assessed	3023 fokontany assessed		
4	3	9	Develop action plans to pilot the use of smart phones by NGOs for submitting monthly reports (Combined with 3.4)	Action plans developed 24 districts with NGOs submitting monthly reports by mobile technology	Action plans developed 24 districts with NGOs submitting monthly reports by mobile technology	Action plans developed 24 districts with NGOs submitting monthly reports by mobile technology	Instead of smartphone, Mahefa suggested to use tablet as it is more compatible with the HMIS and also the new stock management system.	Decision will be made after the evaluation of the pilot stock management system.

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
4	3	10	Ensure coordination of database with other USAID and other stakeholders as appropriate	Database coordinated as appropriate	Database coordinated as appropriate	Database coordinated as appropriate		
4	4	<i>Ensure functional M&E system in line with USAID requirements</i>						
4	4	1	Conduct annual internal project performance reviews including NGO performance	One annual review for NGO performance conducted; 19 NGOs evaluated. One internal project review conducted.	One annual review for NGO performance conducted; 19 NGOs evaluated. One internal project review conducted.	One annual review for NGO performance conducted; 19 NGOs evaluated.	Internal review replaced by external review	
4	4	2	Conduct annual planning meeting	One planning meeting conducted	One planning meeting conducted	One planning meeting conducted		
4	4	3	Develop PY4 Workplan, Program Monitoring Plan (PMP) and Environmental Mitigation and Monitoring Plan (EMMP) for PY5	PY5 Work plan completed	PY5 Work plan completed	PY5 Work plan completed		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
4	4	4	Complete quarterly and annual report	3 quarterly reports and 1 annual report submitted	3 quarterly reports and 1 annual report submitted	3 quarterly reports and 1 annual report submitted		
4	4	7	Conduct monthly meeting with CHWs	6065 CHWs attending at least one monthly meeting per 2 months	6065 CHWs attending at least one monthly meeting per 2 months	6065 CHWs attending at least one monthly meeting per 2 months		
4	4	8	Conduct KMSm evaluation	317 evaluations conducted	317 evaluations conducted	254 evaluations conducted	Delay in KMSm cycle #1 achievements which delays evaluation for KMSm cycle #2	Support NGOs in supporting communes to achieve KMSm cycle # targets
4	4	9	Conduct program mid-term survey	Survey conducted	Survey conducted	Not conducted	Replaced by USAID survey	
4	5		<i>Monitor data quality periodically and address obstacles to high-quality data</i>					
4	5	1	Conduct data quality coaching during routine supervision visits (Combined with supervision activities)	12 supervisions including data quality conducted	12 supervisions including data quality conducted	12 supervisions including data quality conducted		

IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
4	5	2	Conduct internal data quality assessments with feedback and coaching	1 internal data quality assessments conducted involving 19 NGOs	1 internal data quality assessments conducted involving 19 NGOs	1 internal data quality assessments conducted involving 19 NGOs		
4	12		<i>Knowledge management for dissemination and contributing to programmatic decision-making</i>					
4	12	1	Finalize knowledge management plan	Knowledge management plan finalized	Knowledge management plan finalized	Knowledge management plan finalized		
4	12	2	Develop articles for print and electronic media reporting results and success stories for USAID and others	Articles developed and disseminated	Articles developed and disseminated	Articles developed and disseminated		
4	12	3	Disseminate results at international, national, regional, district and commune levels	# of documents with results disseminated	# of documents with results disseminated	2 documents with results disseminated		
4	12	5	Contribute to implementation of the National Community Health Policy	Meetings attended	Meetings attended	Meetings attended		
4	12	6	Contribute to other policy and programmatic decision-making at local and national	Meetings attended	Meetings attended	Meetings attended		



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IR	Activity	Sub-Activity	Planned Activities	Indicators	Results		Explanation of Gaps/Delays	Next steps to address gaps
					Expected FY2014	Actual FY2014		
			levels based on study and innovations results					
4	12	7	Contribute to staff capacity building through attendance at international conferences and program exchanges (budgeted in international travel)	# people attending conferences	NA	8 people attending conferences		



Annex 3: PPR

3.1.3.1-1 Number of health workers trained in case management with artemisinin-based combination therapy (ACT) with USG funds

	2014		DEVIATION	2015	2016	2017	2018
	Target	Actual		Target	Target	Target	Target
Total	5	6	7%	5	-		
	963	386		963	-		
Male	3	3	6%	3	-		
	578	806		578	-		
Female	2	2	8%	2	-		
	385	580		385	-		
CHWs	5	6	7%	5	-		
	963	386		963	-		

Narratives for Deviation

Out-Year Justification
In FY2015, MAHEFA will update CHWs on ACT during monthly meetings. No target was set for FY2016 since the CA ends in May 2016 and MAHEFA does not yet have the latest quality data to be able to determine priority themes for the final refresher trainings in 2016 before project close-out.

Narratives for Drop-outs

3.1.3.1-5 Number of health workers trained in malaria laboratory diagnostics (RDTs) or microscopy with USG funds

	2014		DEVIATION	2015	2016	2017	2018
	Target	Actual		Target	Target	Target	Target
Total	5	6	7%	5	-		
	963	386		963	-		
Male	3	3	6%	3	-		
	578	806		578	-		
Female	2	2	8%	2	-		
	385	580		385	-		
CHWs	5	6	7%	5	-		
	963	386		963	-		

Narratives for Deviation

Out-Year Justification
In FY2015, MAHEFA will update CHWs on RDT during monthly meetings. No target was set for FY2016 since the CA ends in May 2016 and MAHEFA does not yet have the latest quality data to be able to determine priority themes for the final refresher trainings in 2016 before project close-out in May 2016.

Narratives for Drop-outs

3.1.6.6 Number of cases of child diarrhea (CU5) treated with ORS a/o Zinc by trained facility or community health workers in USG-assisted programs							
	2014		DEVIATION	2015	2016	2017	2018
	Target	Actual		Target	Target	Target	Target
Total	46	47	2%	54	13		
	696	723		912	728		
Male	22	25	10%	28	7		
	881	192		987	247		
Female	23	22	-5%	25	6		
	815	531		925	481		
CHWs			-				
Narratives for Deviation	MAHEFA introduced new tools in March 2014, allowing us to improve disaggregation by sex for this indicator. In Q3 and Q4, the proportion of males treated for diarrhea was 53%. We applied this rate to Q1 and Q2 to estimate disaggregation by sex for all of 2014.						
Out-Year Justification	In FY2014, number of functional CHWs reached the maximum and their performance also increased. After FY2014, performance will continue to increase but at a slower rate than in FY2014 assuming that activities for diarrhea prevention would have a positive impact in household behavior change. Target for FY2016 was reduced given the estimated implementation period during FY2016.						
Narratives for Drop-outs							
3.1.6-63 Number of children under five years of age with suspected pneumonia receiving antibiotics by trained facility or community health workers in USG-assisted programs							
	2014		DEVIATION	2015	2016	2017	2018
	Target	Actual		Target	Target	Target	Target
Total	24	48	98%	52	13		
	301	077		885	221		
Male	11	26	123%	29	7		
	907	518		170	292		
Female	12	21	74%	23	5		
	394	559		715	929		
CHWs			-				
Narratives for Deviation	The total reached reflects a more regular supply of drugs available to CHVs and could also reflect that the original target was too low. Regarding the gender difference recorded, MAHEFA introduced new tools in March 2014, allowing us to improve disaggregation by sex for this indicator. In Q3 and Q4, the proportion of males treated for pneumonia was 56%. We applied this rate to Q1 and Q2 to estimate disaggregation by sex for all of 2014.						
Out-Year Justification	CHVs will maintain this level of services after FY2014. Target for FY2016 was reduced given that MAHEFA will have a shortened implementation period during FY2016.						
Narratives for Drop-outs							

3.1.6.8-5 Number of communities certifies as "open defecation free" (ODF) as a result of USG assistance								
	2014		DEVIATION	2015	2016	2017	2018	
	Target	Actual		Target	Target	Target	Target	
Total	50	84	68%	168	40			
Narratives for Deviation	The program conducted a situation analysis on the WASH approach in October 2013 and the results were used to revise its program strategy to accelerate program performance in hygiene and sanitation. Consequently, there is a significant increase in number of improved latrines.							
Out-Year Justification	The program will continue to use this efficient approach so that number of people gaining access to improved sanitation facility will continue to be increased. A low target was set for FY2016 given that MAHEFA has less than two quarters of implementation before close-out which is not sufficient time to certify a large number of communities as ODF especially since this period corresponds with the rainy season and extremely limited access to many program communities.							
Narratives for Drop-outs								
3.1.7.1-1 Couple Years Protection (CYP) in USG supported programs								
	2014		DEVIATION	2015	2016	2017	2018	
	Target	Actual		Target	Target	Target	Target	
Total	40 000	69 207	73%	71 283	17821			
Narratives for Deviation	There are two reasons why CYP is much higher than the annual target: 1) In FY2014, the majority of CHVs completed their "depoprovera/contraceptive injectables" training therefore can provide this new PF method. 2) There is a higher number of accepters than expected due to the availability of injectables.							
Out-Year Justification	CHVs will continue to provide FP services and MAHEFA expects an increased based on our FY2014 achievements. The target for FY2016 reflects the short implementation period for FY2016.							
Narratives for Drop-outs								
3.1.7.1-4 Number of additional USG-assisted community health workers (CHWs) providing family planning (FP) information and/or services during the year								
	2014		DEVIATION	2015	2016	2017	2018	
	Target	Actual		Target	Target	Target	Target	
Total	206	459	123%	459	-			
Male	124	271	118%	-	-			
Female	82	188	130%	-	-			
CHWs			-	-	-			
Narratives for Deviation	The increased number of additional CHWs who received training to provide FP information and services reflects numbers trained to replace CHVs who left the program.							
Out-Year Justification	The program expects similar turnover rate among CHVs in future years because of various reasons - resignation, economic reason (need to earn a living than being volunteer), death, moving to a new place, etc. No target was set for FY2016 since no additional training is planned for FY2016.							
Narratives for Drop-outs								

3.1.8.1-2 Number of people gaining access to an improved drinking water source							
	2014		DEVIATION	2015	2016	2017	2018
	Target	Actual		Target	Target	Target	Target
Total	13	78	480%	13			
	500	250		250	-		
Male	6	38	468%	6			
	750	343		493	-		
Female	6	39	491%	6			
	750	908		758	-		
CHWs			-		-		
Narratives for Deviation	In FY 2014, MAHEFA constructed (268) or rehabilitated (45) for a total of 313 wells, more than the expected number of 301 submitted in the PPRs in November 2013. The FY2014 target of 13,500 was incorrect; the final FY2013 PPR submitted to USAID on November 4, 2013 indicated a target of 75,250 people to be reached through the 301 wells. In October 2013, MAHEFA received CA Modification 8 which included approval to build new water infrastructures which was the basis for the 2014 PPR target.						
Out-Year Justification	Construction/rehabilitation of remaining 53 wells will be done in FY2015. No target was set for FY2016 since all planned infrastructures will be built or rehabilitated in FY2015.						
Narratives for Drop-outs							
3.1.8.2-2 Number of people gaining access to an improved sanitation facility							
	2014		DEVIATION	2015	2016	2017	2018
	Target	Actual		Target	Target	Target	Target
Total	9	28	189%	41	10		
	962	810		717	429		
Male	6	14	111%	20	5		
	686	117		442	110		
Female	3	14	349%	21	5		
	276	693		276	319		
CHWs			-				
Narratives for Deviation	The program conducted a situation analysis on the WASH approach in October 2013 and the results were used to revise its program strategy to accelerate program performance in hygiene and sanitation. Consequently, there is a significant increase in number of improved latrine. The FY14 target of 9,962 and the gender breakdown did not correspond to the PPRs that MAHEFA submitted November 4, 2013. MAHEFA submitted a total of 6,686 people (3,276 males/3,410 females) to be reached to USAID.						
Out-Year Justification	The program will continue to use this efficient approach so that number of people gaining access to improved sanitation facility will continue to be increased.						
Narratives for Drop-outs							

3.1.7.1-1 Number of people trained in child health and nutrition through USG-supported health area programs							
	2014		DEVIATION	2015	2016	2017	2018
	Target	Actual		Target	Target	Target	Target
Total	7	7	6%	7	-		
	454	893		954	-		
Male	4	5	12%	4	-		
	472	007		722	-		
Female	2	2	-3%	3	-		
	982	886		232	-		
CHWs			-		-		
Narratives for Deviation	As 79% of the COSAN are male, the number for this indicator was higher for males.						
Out-Year Justification	In FY2015, MAHEFA will update CHWs on child health and nutrition themes during monthly meetings. No target was set for FY2016 since the CA ends in May 2016 and MAHEFA does not yet have the latest quality data to be able to determine priority themes for the final refresher trainings in 2016 before project close-out in May 2016.						
Narratives for Drop-outs							
3.1.9-15 Number of children reached by USG-supported nutrition programs							
	2014		DEVIATION	2015	2016	2017	2018
	Target	Actual		Target	Target	Target	Target
Total	1 593	3 453	117%	3 798	949		
	371	338		672	668		
Male	796	1 477	85%	1 625	406		
	686	510		261	315		
Female	796	1 975	148%	2 173	543		
	685	828		411	353		
CHWs			-				
Narratives for Deviation	<p>There are two main reasons for such a high deviation.</p> <p>1) More CHWs receive training in nutrition and behavioral change techniques which increase availability and use of prevention and promotion activities.</p> <p>2) As explained in previous years' PPR, this indicator counts number of times that children reached by USG-supported nutrition programs (people time), not the number of children reached (people). One child may participate in different components of nutrition prevention and promotion activities (ENA including EBF, vitamin A referral, MUAC measures).</p>						
Out-Year Justification	The program proposes to adjust annual targets based on current performance level of CHWs. The FY14 target of 1,593,371 was incorrect. MAHEFA submitted a total target of 1,585,357 children to be reached to USAID in the PPRs of November 4, 2013. The target for FY2016 was reduced given that MAHEFA has a short implementation year before beginning close out scheduled for May 2016.						
Narratives for Drop-outs							



Annex 4: PMP

	IR	USAID IR	Indicator	Indicator Source	Data Source	Frequency of Data Collection	Baseline 2012	Midterm target	FY 2014 Targets	Achieved FY 2014	FY 2015 Targets	End-of-Project Target
			<i>MNCH</i>									
1,0			<i>Maternal Health</i>									
1,1	IR1,2	O	Percentage of women seen at ANC at least 4 times during their last pregnancy with a live birth	AO custom ⁶	Cluster survey	Every two years	33%	38%	-	N/A	-	42%
1,2	IR2,3	O	Percentage of births attended by a doctor, nurse or trained midwife from USG-assisted facilities	AO custom	Cluster survey	Every two years	50%	55%	-	N/A	-	59%
1,3	IR1,2	IR2	Percentage of women who received 2 tetanus toxoid shots (or equivalent) during their last pregnancy	Mission custom ⁶	Cluster survey	Every two years <i>Tous les 2 ans</i>	41%	49%	-	N/A	-	56%
1,4	IR1,2	IR2	Percentage of women who state they received iron folate supplements during their last pregnancy	Custom	Cluster survey	Every two years <i>Tous les 2 ans</i>	51%	62%	-	N/A	-	72%
1,5	IR2	IR2	Percentage of reporting CHWs who had stock-outs of specific maternal care tracer drugs ⁴	AO custom	Program records	Quarterly <i>Trimestrielle ment</i>	N/A ⁸	40%	-	N/A	-	20%

For 1.5: ability to achieve this indicator is based on commodity availability.

	IR	USAID IR	Indicator	Indicator Source	Data Source	Frequency of Data Collection	Baseline 2012	Midterm target	FY 2014 Targets	Achieved FY 2014	FY 2015 Targets	End-of-Project Target
2,0			Infant and Child Health <i>Sante neonatal et enfant</i>									
2,1	IR1,2	O	Percentage of children between 12-23 months of age who received their 3 rd dose of DPT ²	AO custom	Cluster survey <i>Enquête</i>	Every two years <i>Tous les 2 ans</i>	TBD ¹⁰	TBD	-	N/A	-	TBD
2,2	IR1,2	O	Number of cases of child diarrhea (CU5) treated with ORS by trained facility or community health workers in USG-assisted programs	Standard	Program records	Annual <i>Annuel</i>	---	---	46 696	47723	54 912	13 728
2,3	IR2	IR2	Number of newborns receiving essential newborn care through USG-supported programs ⁷	Standard	Program records / Cluster survey	Quarterly Annual <i>Trimestriel et annuel</i>	N/A ⁸	6900	-	2 996	-	7500
2,4	IR1	O	Number of children under five years old with pneumonia taken to appropriate care	Standard	Program records	Annual <i>Annuel</i>	---	---	24 301	48 077	52 885	13 221
2,5	IR2	IR2	Percentage of reporting CHWs who had stock-outs of specific infant and child health tracer drugs ⁵	AO custom	Program records	Quarterly <i>Trimestriel</i>	N/A ⁸	40%	-	6% ZINC/ORS 2% PNEUMOS TOP	-	20%

For 2.5: ability to achieve this indicator is based on commodity availability.



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	IR	USAID IR	Indicator	Indicator Source	Data Source	Frequency of Data Collection	Baseline 2012	Midterm target	FY 2014 Targets	Achieved FY 2014	FY 2015 Targets	End-of-Project Target
3,0			Family Planning <i>Planning familiale</i>									
3,1	IR1,2	O	Contraceptive prevalence rate (CPR) in USG-supported programs (modern methods)	AO custom	Cluster survey	Every two years	26%	32%	-	N/A	-	37%
3,2	IR2,3	IR2	Number of additional USG-assisted community health workers (CHWs) providing family planning (FP) information and/or services during the year	Standard	Program records	Quarterly	---	---	206		459	---
3,3	IR1	IR1	Percentage of mothers of children aged less than 12 months who stated a desire to wait at least 24 months to have another child or do not want to have another child	Mission custom ⁶	Cluster survey	Every two years <i>Tous les 2 ans</i>	79%	83%	-	N/A	-	86%
3,4	IR2	IR2	Percentage of reporting CHWs who had stock-outs of specific family planning tracer drugs ⁴	AO custom	Cluster survey <i>Enquête</i>	Every two years <i>Tous les 2 ans</i>	N/A ⁸	40%	-	N/A	-	20%
3,5	IR2	IR2	Couple Years of Protection (CYP)	Standard	Program records <i>Donnees du program</i>	Annual <i>Annuel</i>	---	---	40 000	69 207	71 283	17 821

	IR	USAID IR	Indicator	Indicator Source	Data Source	Frequency of Data Collection	Baseline 2012	Midterm target	FY 2014 Targets	Achieved FY 2014	FY 2015 Targets	End-of-Project Target
4,0			Malaria Paludisme									
4,1	IR1,2	O	Percentage of children under 5 years old who slept under an ITN the previous night ²	AO standard ⁶ (PMI)	Cluster survey	Every two years	75%	83%	-	N/A	-	90%
4,2	IR1,2	O	Percentage of pregnant women who slept under an ITN the previous night	AO standard ⁶ (PMI)	Cluster survey	Every two years	78%	84%	-	N/A	-	90%
4,3	IR1,2	O	Percentage of children under 5 years of age with fever in last 2 weeks who received treatment with ACT within 24 hours from onset of fever ²	AO standard ⁶ (PMI)	Cluster survey	Every two years	1%	12%	-	N/A	-	22%
4,4	IR1,2	O	Percentage of women who received 2 or more doses of SP for IPTp for malaria during their last pregnancy in the last 2 years	AO standard ⁶ (PMI)	Cluster survey	Every two years	14%	25%	-	N/A	-	35%
4,5	IR2	IR2	Percentage of reporting CHWs who had stock-outs of specific malaria program products (RDTs and ACTs) ⁴	AO standard	Program record	Quarterly	N/A ⁸	40%	-	2% ACT 16% RDT	-	20%
4,6		IR2	Number of health workers trained in case management with artemisinin-based combination therapy (ACT) with USG funds	Standard	Program record	Quarterly	---	---	5 963	6 386	5 963	---
4,7		IR3	Number of health workers trained in malaria laboratory diagnostics (RDT) or microscopy with USG funds	Standard	Program record	Quarterly	---	---	5 963	6 386	5963	---

	IR	USAID IR	Indicator	Indicator Source	Data Source	Frequency of Data Collection	Baseline 2012	Midterm target	FY 2014 Targets	Achieved FY 2014	FY 2015 Targets	End-of-Project Target
5,0			Water and Sanitation WASH									
5,1	IR1,2,3	O	Percentage of households that are practicing effective household water treatment	AO standard	Cluster survey	Every two years	22%	25%	-	N/A	-	28%
5,2	IR1,3	O	Percentage of households practicing proper storage of drinking water treated at the household	AO standard	Cluster survey	Every two years	28%	31%	-	N/A	-	34%
5,3	IR2,3	IR2	Number of people gaining access to an improved drinking water supply as a result of USG assistance ^{2,5}	Standard	Point of use, via user-fee records	Annual	0	-	13 500	78 250	13 250	-
5,4	IR1,3	O	Percentage of households with soap and water available for hand washing	AO standard	Cluster survey	Every two years	11%	14%	-	N/A	-	17%
5,5	IR2,3	IR2	Number of people gaining access to an improved sanitation as a result of USG assistance ^{2,5}	Standard	Point of use, via user-fee records	Annual	0	-	6 686	28 810	41 717	10 429
5,6	IR1,2,3	O	Percentage of households using an improved sanitation facility	AO standard	Cluster survey	Every two years	3,1%	3,4%	-	N/A	-	3,7%
5,7	IR1,2,3	IR2	Number of communities certified as 'open defecation-free' (ODF) as a result of USG assistance	Standard	Program records	Semi-Annual	N/A ⁸	-	50	84	168	40
5,8	IR2	IR2	Percentage of reporting CHWs who had stock-outs of specific water and sanitation products ⁵	AO custom	Program record	Quarterly	N/A ⁸	40%	-	N/A	-	20%

For 5.8: ability to achieve this indicator is based on commodity availability.

	IR	USAID IR	Indicator	Indicator Source	Data Source	Frequency of Data Collection	Baseline 2012	Midterm target	FY 2014 Targets	Achieved FY 2014	FY 2015 Targets	End-of-Project Target
6,0			Nutrition									
6,1	IR1	O	Percentage of children ages 6-23 months fed according to a minimum standard of infant and young child feeding practices ²	AO standard	Cluster survey	Every two years	0% (9%) ⁹	2% (11%)	-	N/A	-	3% (12%)
6,2	IR1	O	Percentage of infants aged less than 6 months who were exclusively breast-fed in past 24 hours ²	AO standard	Cluster survey	Every two years	79%	82%	-	N/A	-	85%
6,3	IR1,2	O	Percentage of children aged 6-59 months receiving a Vitamin A supplement during the last 6 months ²	AO standard	Cluster survey	Every two years	TBD ¹⁰	TBD	-	N/A	-	TBD
6,4			Number of people trained in child health and nutrition through USG-supported health area program	Standard	Program records	Annual	---	---	5 963	7 893	7 454	---
6,5			Number of children reached by USG-supported nutrition programs	Standard	Program records	Annual	---	---	187 929	3 453 338	3 798 672	949 668

Reference for 6.1 and 6.2 is the National figure (DHS 2008-2009)

	IR	USAID IR	Indicator	Indicator Source	Data Source	Frequency of Data Collection	Baseline 2012	Midterm target	FY 2014 Targets	Achieved FY 2014	FY 2015 Targets	End-of-Project Target
7,0			Management and Systems <i>Gestion et système</i>									
7,1	IR1,2	IR2	Number of people covered by USG-supported community and health financing arrangements ^{2,13}	AO custom	Program record	Semi-annuel	0	2500	-	7700	-	12500
7,2	IR2,3	IR2	Number of functional (trained, equipped, and supervised) community health workers ^{2,3}	AO custom	Program record	Quarterly	N/A ⁸	5760	-	6 004	-	5760
7,3	IR3	IR3	Percentage of project communes reporting into the extranet system	Custom	NGO partner reports	Quarterly	0	60%	-	N/A	-	75%
7,4	IR1,2,3	IR1	Percentage of KMS launched by region that achieve annual plan indicator targets	Custom	Program record	Semi-annuel	0	60%	-	N/A	-	80%
7,5	IR3	IR3	Number of innovations and models tested with results disseminated to communes	Custom	Program record	Semi-annuel	0	5	-	5	-	8

Annex 5: EMMR

ANNEX 5: ENVIRONMENTAL MITIGATION AND MONITORING REPORT – FY 2014

Madagascar Community-Based Integrated Health Program MAHEFA

Annual Environmental Mitigation and Monitoring Report (EMMR) October 1, 2013 – September 30, 2014

Title of the program: Community-Based Integrated Health Program

Implementing Partner: JSI Research & Training Institute, Inc.

Country or Region: Madagascar, Southern Africa

Award number: Cooperative Agreement no. 687-A-00-11-00013-00

Program Area: 3.1 HEALTH

In accordance with the 2014-2018 IEE covering Madagascar USAID/ Health sector portfolio – Use of selected Health services and products increased and practices improved, under which the CBIHP falls:

Concerned Program Elements and Sub-Elements are as follow:

3.1.3 MALARIA

- 3.1.3.1. Treatment with Artemisinin-based Combination Therapies (ACT).
- 3.1.3.2. Promotion on use of Insecticide-Treated Nets (LLINs) to prevent malaria
- 3.1.3.4. Promotion of Intermittent Preventive Treatment (IPT) for pregnant women.

3.1.6 MATERNAL AND CHILD HEALTH

- 3.1.6.01. Birth Preparedness and Maternity Services (including prenatal and post-partum care)
- 3.1.6.03. Promotion of Newborn Care and Treatment
- 3.1.6.07. Counseling and Treatment of Child Illness (c-IMCI)

3.1.6.08. Sensitization and promotion of improved products or techniques for household drinking water treatment and proper storage of water, sanitation, hygiene and environment.

3.1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH

3.1.7.1. Community-based service delivery of Family Planning methods including injectable FP commodities, and management of medical waste related to FP products.



3.1.8 WATER SUPPLY AND SANITATION

3.1.8.1. Small-scale construction or rehabilitation of potable water systems

3.1.8.2. Promotion of construction and use of improved household latrines, using slabs.

3.1.9 NUTRITION.

Life of Activity: FY2011 - FY 2016

Fiscal Year of Submission: FY 2014 - Annual

Funding Begin: 05/23/2011	LOA Amount: \$34,999,935
Funding End: 05/22/2016	FY2014 Amount: \$23,784,883
ESR Prepared by: Chuanpit Chua-oon Chief of Party JSI/MAHEFA	Date: 10/30/2014
Date of Previous EMMR: July 31, 2014	Date of Most Recent IEE: October 7, 2013

A. Status of the IEE

No revisions or modifications of the IEE are needed.

An amended IEE is submitted.

B. Status of Fulfilling Conditions in the IEE, including Mitigation and Monitoring

All mitigation measures were successful at preventing environmental impact as specified in the original IEE. An Environmental Mitigation and Monitoring Report (EMMR) describing compliance measures taken is attached.

Improved mitigation measures were adopted to reduce environmental impacts. An EMMR describing these improved compliance measures taken is attached.

Approval of the Environmental Status Report (as appropriate)

AOR

[Signature] Date: 05/15/2014

MEO

[Signature] Date: 07/15/2015

REA

Date: _____

Please document all results of water quality analysis
Note Dept. water table / MEO

[Signature]
07/15/2015

BEO

Date: _____

Environmental Status Report

B. Status of Fulfilling IEE Conditions

In October 7, 2013, USAID issued a new IEE to cover the USAID/Madagascar Health, Population and Nutrition (HPN) portfolio "Use of Selected Health Services and Products Increased and Practices Improved" for the period 2014 – 2018. The CBIHP/MAHEFA program constitutes an integral part of the HPN portfolio and will continue to comply with the new IEE for all Environmental Mitigation and Measures related activities. As per the classification defined under the IEE 2014-2018, the intervention categories that follow are appropriate to the program:

- Healthcare worker/delivery agent training and capacity building; healthcare workforce training, strengthening, and development; strengthening support for health service delivery
- Education and behavior change communication (BCC), excluding WASH
- Procurement, storage, management, distribution and disposal of public health commodities and equipment
- Small-scale water supply and sanitation.

These document reports activities planned under MAHEFA's FY 2014 period as per the annual workplan approved by USAID in October 2013.

1. Environmental Mitigation and Monitoring Report - table for activities under Categorical Exclusion.

As per the new intervention categories mentioned above, MAHEFA conducted following activities that are eligible for categorical exclusion of 22 CFR 216:

- Training of CHWs in Behavior Change Empowerment (2,745 CHWs), DEPOCOM (3,113 CHWs), c-IMCI (1,230 CHWs), Chlorhexidine 7.1% (551 CHWs), and nutrition (3,588 CHWs).
- Training of Youth Peer Educators or YPE (609) and their CHWs mentors in youth approach (635)
- Monthly supportive supervision workshops for CHWs and local facilitators (30,757 people time by end of September)
- Quarterly workshop review of KMSm progress (8,780 people time).

Classes of actions as per 22 CFR 216.2(c) (2)	Actions implemented	Remarks
(i) Education, technical	In order to prevent and reduce waste, MAHEFA continued to : - Use double-sided printing for curricula, management, and IEC/BCC	

assistance, or training programs	<p>tools (e.g., technical documents, check lists, registers)</p> <ul style="list-style-type: none"> - Limit excessive distribution of handouts at trainings - Provide large bottles of water during meetings and workshops instead of individual bottles <p>To recycle and manage waste, MAHEFA continued to systematically collect and recycle water bottles used during meetings or workshops for community tippy-tap conception and use.</p>	
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2. Environmental Mitigation and Monitoring Report - table for activities under negative determination with conditions.

During FY2014, activities classified under negative determination with conditions in the 22 CFR 216.3 (a) 2 (iii), and as described in the IEE 2014-2018 include:

1. Healthcare worker/delivery agent training and capacity building; healthcare workforce training, strengthening, and development; strengthening support for health service delivery

Under this category, MAHEFA conducted training and supportive supervision activities for CHWs, in particular in C-IMCI including malaria (1,230 CHWs), and DEPOCOM (3,113 CHWs).

Planned activities	Recommended mitigating actions	Status of mitigative measures/actions taken	Any outstanding issues relating to required conditions	Remarks
<p>Training/supportive supervision</p> <p>Activity 4.1.3 Conduct training for CHWs on the EMMP in coordination with c-IMCI, and DEPOCOM trainings</p>	<p>- Use of ACT for community-based-service, with CHWs making the diagnosis by RDT that implies: train CHWs in:</p> <ul style="list-style-type: none"> - handling and disposal of used lancets, gloves using a safety box, and on transportation of full safety box to health facility (CSB) for disposal - potential effects of zinc on the environment, required conditions for stocking and handling waste (ViaSur/SRO-zinc) - checking for date of expiry of medications and infection prevention practices <p>-Train CHWs in and provide</p>	<p>- 1,230 additional CHWs trained on C-IMCI and updated with the waste management using appropriate jobaid</p> <p>- 6,916 CHWs updated on the use of the RDT with the new packaging and used bottles management (in Q4)</p> <p>- 3,113 additional</p>	<p>The number of CHWs trained exceeded the prevision due to existing additional CHWs not yet trained identified (replacement or not trained by NSA)</p> <p>Results</p>	

Planned activities	Recommended mitigating actions	Status of mitigative measures/actions taken	Any outstanding issues relating to required conditions	Remarks
	<p>FP products:</p> <ul style="list-style-type: none"> -Storage and waste management of FP products (condoms, COC, CI) to facilitate separation of ordinary and contaminated waste - Use of safety injection steps - Syringes waste management - Assembling sharp boxes - Managing sharp boxes (syringes etc) according to NPWM and referring to existing CHWs supervision tool and job aids on FP injectable waste management for disposal. 	<p>CHWs trained on DEPOCOM including EMMP related to dispose of used syringes and needles in respect of injection security as per the National Policy for Medical waste Management (2005).</p>	<p>exceeded the expectation due to replacement and estimation error during planning</p>	

2. Social marketing, Education, and behavior change communication (BCC), excluding WASH

Planned activities	Recommended mitigating actions	Status of mitigative measures/actions taken	Any outstanding issues relating to required conditions	Remarks
4.1.7 Adapt Guide to Health Care Waste Management for the CHW	Based on the USAID DELIVER Project CHWs waste management guide, develop a poster that will serve as CHWs waste management.	6,500 posters distributed for CHW and partner use in the 6 targeted regions.		
4.1.8 Promote community disposal pits at fokontany level	In the areas where the health facility is closed or has no incinerator or other medical waste disposal system, CHW will be trained on, and assisted in building burial pits as needed for correct disposal at community level	- 377 disposal pits built.	Pits construction could not begin until the dry season that coincided in part with the lifting of the USG restriction, and MAHEFA revised its strategy to	

			refocus to CSB without incinerator or to sites located 30 km or more from the CSB for building in FY2015.	
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Procurement, storage, management, distribution and disposal of public health commodities and equipment

Planned activities	Recommended mitigating actions	Status of mitigative measures/actions taken	Any outstanding issues relating to required conditions	Remarks
Distribution of Chlorhexidine gel and use under activities 2.9.1 and 2.10.5 Procure, package and distribute the CHX and Misoprostol products to CHWs	Train CHWs on handling, storage and disposal of the <i>AroFoitra</i> tubes	- 551 CHWs trained on use, storage and disposal of <i>AroFoitra</i>		

3. Small-scale water supply and sanitation.

Planned activities	Recommended mitigating actions	Status of mitigating measures/actions taken	Any outstanding issues relating to required conditions	Remarks
4.1.4 Conduct training for entrepreneurs, local technicians and Water Users Associations on the EMMP in	Part of the water supply building process developed by the recruited consulting agencies, training for local entrepreneurs, technicians and Water Users Associations will	- 175 Water Users Associations trained - 325 local technicians trained in infrastructure maintenance		

Planned activities	Recommended mitigating actions	Status of mitigating measures/actions taken	Any outstanding issues relating to required conditions	Remarks
coordination with other trainings	include: - EMMP preparation, implementing and monitoring - Water supply point management, maintenance and small repairs.			

Planned activities	Recommended mitigating actions	Status of mitigating measures/actions taken	Any outstanding issues relating to required conditions	Remarks
4.1.5 Monitor and follow-up compliance with environmental mitigation procedures	MAHEFA regional staff and implementing NGOs will conduct on site supervisions for CHWs, and Water Users related to EMMP action plans progress and its compliance with the 22 CFR 216 procedures. In addition, particular supervision of the construction of wells will be conducted by the consulting agency and WASH officers of MAHEFA to ensure the compliance of the mitigation measures adopted is met.	<ul style="list-style-type: none"> - Four EMMR submitted for FY 2014 - 8,923 supervision visits conducted by NGOs and MAHEFA - 18,226 CHWs supervised by NGOs and MAHEFA - 313 water infrastructures built or rehabilitated supervised by consulting agencies and/or MAHEFA - Water quality analysis has been completed in Menabe, DIANA and SAVA regions 	<ul style="list-style-type: none"> - Water quality analysis in remaining regions will be continued in FY2015 by IPM. - Corrective measures related to water quality will be implemented and reported to USAID in FY2015 as necessary - location of 29 water infrastructures in four regions has been changed and construction activities started in late Q4 to be completed in FY2015 	

REF: EGSSAA: Water and Sanitation. March 2009. www.encapafrika.org/egssa



Annex 6: Success Stories

Annex 6: Success Stories

Well Rehabilitation in Milanoa Supports a Healthier Community (Q1)

Milanoa is a commune located 45km from Vohémar, the district capital in SAVA Region. The people of Milanoa have gained income from the local gemstone industry. In early 2013, this commune had four functioning pump wells.

As a result of climate change and drought, water levels in Milanoa's wells decreased significantly. The wells became a gathering place in the community because so many people had to wait in lines for extended periods of time in order to obtain water. As the drought period persisted, the four wells provided less and less water. The little water provided was not sufficient for the inhabitants of Milanoa. Some people were forced to wait all night in order to obtain water.



A technical reception marking the completion of the well rehabilitation project introduces community members to the new wells.

Community members who could not wait at the wells turned to the Anovankary river that runs through the commune. Even so, the river had its limits and also dried up. To survive, people dug a well in the river bed for daily water use (the preparation and cooking of food). The



Before the rehabilitation, this well provided less than 1 liter of water per bucket drawn.



The rehabilitation occurred over a 20 day period.

commune also sent young people to a community 8km to the east to bring drinking water back on ox-drawn carts. Those who had the means transported their drinking water in 20 liter cans from Vohémar via bush-taxi. Even still, there were large crowds at the riverbed at the end of each day during the dry season. Those who could not afford to obtain water from neighboring communities had no choice but to drink water from the riverbed.

In order to improve access to clean water, Milanoa's leaders requested help from the MAHEFA program with their drinking water supply. After a study by the regional water, sanitation, and hygiene (WASH) specialists, it was suggested that MAHEFA rehabilitate three of the four existing wells by adding at least two meters in depth and installing one hand pump on each well. The rehabilitation work was completed in a 20 day period.

Now, thanks to the three newly functional wells in Milanoa, an average of 750 people have access to an improved drinking water source. Not only does the available water improve the community's health by reducing the incidence of diarrhea compared to using or drinking river water, but community members have more available time for productive activities.

Woman President of Community Health Insurance Scheme Exceeds Expectations and Empowers Her Community (Q1)

As a result of a MAHEFA initiative to empower communities to plan for future health care costs, people in the Antsohihy district in Sofia Region now participate in a community health insurance scheme.

A significant percentage of the population in MAHEFA's regions cannot meet the costs of providing for health care in case of illness. To this end, MAHEFA has assisted selected communities in its intervention areas to establish "community health insurance schemes," or *mutuelles*.



Members of a women's association listen to Elisa's presentation on mutuelles in the Sofia Region

A *mutuelle* is a community-managed group.

MAHEFA assists in introducing the concept and potential benefits associated with the groups, and then supports interested communes in establishing their own *mutuelles* through training, provision of materials, advocacy support, and connections with financial and health institutions. While operating separately by an elected management committee, the three *mutuelles* in the District of Antsohihy are managed under the district-level oversight committee or board.



Elisa registers a woman to become a member of her mutuelle

To introduce and discuss the concept and mechanism of *mutuelles* in Antsohihy, MAHEFA organized a workshop for decision-makers, community leaders (in MAHEFA sites), NGOs, and representatives of local groups, associations, and centers concerned with the well-being and health of vulnerable people. After the initial workshop, interested communities contact the MAHEFA team for more training on how to create, register, and manage the *mutuelles*. The last day of the workshop is

entirely run by the group themselves, including electing their board members as well as their management committee members.

Elisa, who also works as the president of Antsohihy's orphan center, has seen how poverty and vulnerability prevent people from accessing health services. She is determined to help them. When she heard about MAHEFA's *mutuelle* program, she decided to join. On the last day of the *mutuelle* training in her district, Elisa was first elected as the president of her commune's *mutuelle*. Then, she was elected as the president of the board governing the *mutuelles* of three communes in the district.

Elisa has not only joined and managed the *mutuelles*, but her *mutuelles* have exceeded expectations, enrolling 10,000 members in only a few months. Among the three districts where *mutuelles* were established at the same time, Elisa's counts for more than half of the total enrolled members (18,572). Elisa has committed to educating as many people as possible on the benefits of *mutuelles* because she is convinced that insurance for good and quality health care and treatment is essential, especially for poor and vulnerable people.

Youth Peer Educators: Preventing Infections and Improving Access to Services (Q1)

Josiane is a MAHEFA youth peer educator (YPE) in SAVA Region's Vohémar district. She is 18 years old and lives with her single mother and two sisters, one still an infant. Josiane is lucky to be able to study in a college near her home. MAHEFA has been working in Vohémar district since 2011.

MAHEFA trains community health workers (CHWs) as well as youth peer educators in its approach for working with youth. Together, the CHWs and peer educators provide family planning (FP) and reproductive health education and services to youth in their community.

As a YPE, Josiane makes home visits. During one of her visits, she met a 23-year-old single mother who already has three children. Josiane was very touched by this woman's predicament. Josiane wondered how the woman could have given birth to her children at such close birth intervals and how will she be able to support them financially in the future.

Josiane shared information on FP with the woman, informing her about modern FP methods that are available with the CHWs and at the basic health centers (CSB). She explained the benefits and limitations of the different methods, and of birth spacing, while respecting the concept of free choice. Convinced that these solutions could help her in preventing unwanted future pregnancies, the woman decided to go for FP services at the health center using the referral sheet she received from Josiane. Since then, the young mother has been using Depo-Provera as a contraceptive method. Josiane also discussed the need options to generate income to provide for her three children. As a result of this discussion, the young mother decided to work by selling fish at the Nosy Fara Ampisikinana market in a neighboring town.



Josiane at her home with her young mother and infant sister

Josiane is one of many MAHEFA-trained YPEs who is making an impact on her neighborhood and her community. YPEs are MAHEFA's allies in encouraging and supporting the prevention of sexually transmitted infections and early pregnancies among youth and promoting access to FP services within their communities. Youth activities started in September 2013 and, as of the end of December 2013, MAHEFA has trained half (333/662) of all YPEs who will be trained and provided support including supplies and links with trained CHW mentors so that the YPEs can

be key resources for youth health in their communities.

Coordination between a Primary Health Center and its Community Health Volunteers (CHVs): Improving Community-Level Reporting and Referrals (Q2)

According to Madagascar's National Public Health Policy, community health volunteers (CHVs) play an important role, serving as health agents within the communities, and linking communities with the Ministry of Health (MOH) system. CHVs are connected to the formal health system and supported by a medical health officer who works in a primary health center, locally known as the *centre de santé de base*- CSB. To support a stronger health system in which decision-making is guided by data, CHV reporting must be included in MOH reporting.

Sustained reporting and coordination often falter when the CHVs are not well-connected to their local CSB. In some cases, regional MOH representatives do not complete stakeholder mapping therefore do not take into account the work of CHVs in their area i.e. not integrating CHV data into their own. In other cases, health officers at the CSB level do not accept CHV-level reporting, Data quality is less consistent when reporting is not standardized.

Dr. Eddie Andriamasoandro is the Health Head Officer of the CSB in Anjiamangirana, District Antsohihy, in Madagascar's Sofia Region. Recognizing the important role that CHVs play in supporting the efforts of the CSB in their work to reach communities and households, Dr. Eddie ensures that her CSB opens its doors to CHVs on a weekly basis, each market day. These meetings allow her to reinforce the skills of the CHVs, share knowledge, and streamline reporting. She is there to give technical support to her CHVs by reminding them of her technical assistance and supporting them in correctly reporting on their activities. She uses the weekly opportunities to work closely with her CHVs in achieving their health goals: promoting children's vaccination, antenatal care for pregnant women, family planning (FP), and promoting maternal and child health.



Fifteen of Anjiamangirana's CHVs meet with Dr. Eddie, head of the CSB, on market day to complete reporting and improve coordination.

MAHEFA works through its partner NGOs at the community level to facilitate connections between CSBs and the CHVs who are supported by MAHEFA. Louise, the NGO representative for Anjiamangirana, coordinates with Dr. Eddie to ensure that she has all of the information she needs to work with the CHVs. She visits the CSB during her supervision visits, and provides Dr. Eddie with information on all of the CHV trainings scheduled, along with her formal meetings with CHVs. The CHVs welcome the opportunity to develop their own capacity to provide services and connect with their local CSB. They know that this practice is not yet common across Madagascar, and value the support they receive at the CSB. They also know that the face-to-face meetings will allow them to clarify any questions about the data they report on and to enhance their service performance. They are very proud to know that their health data will be integrated into the reporting circuit of the national health system.



Dr. Eddie, CSB Head, meets with a CHV to review reporting and discuss the CHV's weekly activities.

In providing a forum for discussion and coordination, the meetings motivate CHVs as they provide an additional opportunity for technical capacity building. Reporting quality increases, and most importantly, the work of the CHVs is reported into the national health system, allowing decision makers at all levels access to community-level data. Increased performance of the CHVs in Anjiamangirana is evident. KMS[™], or champion commune approach, is a process by which any area working with MAHEFA is assessed to review if the community has reached its health goals. Anjiamangirana reported a score of 95% for cooperation in the most recent assessment. Anjiamangirana's KMS[™] scores are higher when compared to four other areas in the district. The community has also reported satisfaction with its CHVs through the community score card (CSC) process. Scores from the CSC process are some of the highest in all of MAHEFA's regions, with 93.5% of respondents indicating satisfaction with health sensitization, 91% indicating satisfaction about health care availability, and 85% satisfied with the diversity and availability of drugs at the community level. In addition, the number of pregnant women referred to the CSB for antenatal care increased along with the number of under-five children referred for vaccination.

MAHEFA will continue to support the CHVs in Anjiamangirana, knowing that when the program closes, a sustainable link has been forged between the CHVs and the health system they support.

Public-Private Partnership Supporting Sustainable Gains in Communities: TELMA and MAHEFA Expand Reach in Communities (Q2)

MAHEFA recognizes that sustained improvements in health at the community level must be supported by partner NGOs and private sector firms alike. The MAHEFA program model aims to encourage collaboration with local development stakeholders and establish mutually beneficial relationships.

MAHEFA became aware of the Telma Foundation's interest in reducing teenage pregnancies and sexually transmitted infections in young people (15-24 years). The Telma Foundation is closely associated with Telma, a large telecommunications company in Madagascar. As Malagasy youth are increasingly utilizing mobile forms of technology, Telma and MAHEFA agreed that an SMS campaign with reproductive health messaging would help both entities reach their goals. Telma would utilize its own technology and network to achieve the goals of the Telma Foundation in partnership with MAHEFA. Telma will increase its user base and generate goodwill through the partnership, gaining credibility with the Ministry of Health. The country will gain a private sector partner that contributes in a meaningful way through a project that is carefully designed to improve health at the community level.



Youth Peer Educator held a discussion session with youth group in Ambilobe District of DIANA Region

In February 2014, a Memorandum of Understanding between the Telma Foundation and MAHEFA was signed. MAHEFA has worked to strengthen the technical capacity of youth peer educators in all six of MAHEFA's regions in advocacy, support and referrals. Telma's support of over four million free SMS messages to youth peer educators and other young people will raise awareness and promote responsible sexual behavior, reinforcing MAHEFA's work. The partnership will put mobile phones in the hands of MAHEFA's youth peer educators, allowing MAHEFA to communicate with the cohort for reporting purposes. Phones will also serve as a form of recognition and motivation for the educators who volunteer their time to support health improvements in their communities.

Telma will subsidize the cost of 662 phones distributed to youth peer educators, also subsidizing the development of software specifically designed for them. MAHEFA will take over the cost associated with the peer educators reporting their activities and communicating with MAHEFA.

Telma and MAHEFA will hold a coordination meeting every two months to monitor and evaluate the success of the project. The two programs will share the peer educators' monthly activity reports to improve the project's messaging, targeting and outreach activities. The project will initially be conducted in two districts of Vohémar, in SAVA Region, and will extend to four districts by the close of the project year. MAHEFA and Telma are also exploring an expanded partnership to promote health services in all of MAHEFA's regions. Telma may sponsor community awareness events such as International Youth Day or Madagascar Community Health Volunteer Day, or may work to support the development of a health information system that will eventually be able to integrate with the Ministry of Health System.

MAHEFA and Telma are committed to the same cause and to a continued partnership to improve health in Madagascar that sustains through the life of the MAHEFA program and beyond.

Mobilizing Communities to Become Champions for Improving Health (Q2)



Analamamoko Fokontany in Madagascar's Melaky Region

A community or *fokontany*, Analamamoko, near the town of Maintirano in Madagascar's Menabe Region is home to a relatively young population of 477 individuals who make up more than 100 households. The village subsists on rice, corn, and other crops. There is a large soccer area where youths train every day for inter-*fokontany* matches on Sundays. Two years ago, 100% of the population practiced open defecation, which posed health risks, especially during the rainy season. Now, the community is on a path toward improving its own health, having recently been certified as an open defecation free community.

April 2013 marked Analamamoko's participation in first part of a MAHEFA triggering event, whereby a MAHEFA program member visited the village to discuss the benefits of latrine use, among other health practices. The triggering event is an open dialogue between community members. Robinson, a leader in his community, a father, and a former member of the Malagasy armed forces, recognized the value in using a latrine. Not wishing to wait for others in his community to join him, Robinson acted independently, and built a latrine within a week of the triggering event.

Robinson's community followed his lead. The community members were able to observe the benefits of behavior change before committing to adopt the behavior. The community reveres its leaders, and so Robinson's example made a significant impact on the opinions of others.

Robinson also made active steps to bring his community toward the end of open defecation. When he noticed that a family was not using latrines, Robinson brought the leaders of the family into his own home to speak with them about the benefits of latrine use. In some cases, he helped families build latrines.

On March 10, 2014, Analamamoko received an official certification from the Regional Directorate of Water for Melaky Region confirming that the community was open defecation free. The community is the first in its region to receive this certification.



Robinson shows MAHEFA staff his own latrine (with a tippy-tap system for hand washing next to it).



Robinson, Justin and Reline, (community health volunteers) and Andre, fokontany chief, received an award for their contribution to make their community open defecation free.

Being certified as ODF is a major step towards the right direction. “We are very proud of our achievement. With MAHEFA, we will continue to improve our community’s sanitation and hygiene and we will share our experience and success with other *fokonatny* nearby,” said Robinson and his *fokontany* chief.

Enabling Access to Care through Sustainable Community Health Financing: *Mutuelles de Sante (Q3)*

In Malagasy culture, relationships have always been governed by the rule of "*Fihavanana*," meaning, "join hands and solidarity in all circumstances." This is why the first community pharmacy was established in Madagascar in 1973. Although the community pharmacy helped support many families in accessing health services and products, the cost recovery system was not sustainable. The *mutuelle* model, which encourages pooling of resources based on insurance principles to support the reimbursement of health care costs, has existed in the country since 1999, and a number of donors have subsidized their development.



Mutuelle office in Mitsinjo.

However, the model was primarily adopted for the purpose of income-smoothing, by individuals and communities who rely on agriculture and cattle breeding. The *mutuelles* launched through these efforts were highly subsidized, and as a result, did not continue when the projects that supported them ended.

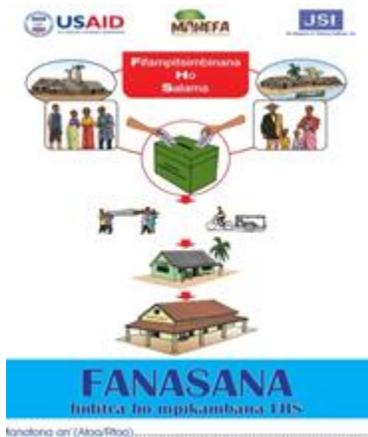


Joint training with mutuelle managers and the MAHEFA team.

With the ultimate goal of reducing maternal, newborn, and child mortality, MAHEFA aims to improve the affordability, use, and quality of health services in the communities served by the Program. The establishment of a *mutuelle de santé*, organized and managed by the beneficiary population, is one of solutions to help communities meet their health financing needs.

MAHEFA recognized that the *mutuelle* model would support this goal in a number of ways:

- Enable households with low and irregular income to stabilize funding for primary care and hospitalization;
- Allow health workers to focus on quality of services rather than collecting fees for services as *mutuelle* groups sign longer-term contracts with providers; and



Invitation card which is used to attract mutuelle members.

- Facilitate access to care for children under-five, pregnant women, and new mothers.

Recognizing the challenges that *mutuelles* have faced in the past in Madagascar, MAHEFA examined the key success factors, along with the factors that contributed to failure of previous efforts. The Program aimed to develop an innovative model to improve efficiency and access that could be scaled. Recognizing the critical role that financial sustainability plays in the success of mutuelle efforts, MAHEFA opted to implement a model articulated by a number of microfinance institutions in Madagascar. In applying this model which requires the formation of *mutuelle* groups over an extended period of time, MAHEFA committed to encouraging long-term sustainability and results that are realized for many years to come over immediate group formation.

For MAHEFA, the process for establishing a *mutuelle* includes a number of steps, and as the process mandates community buy-in, it can sometimes take an entire year.

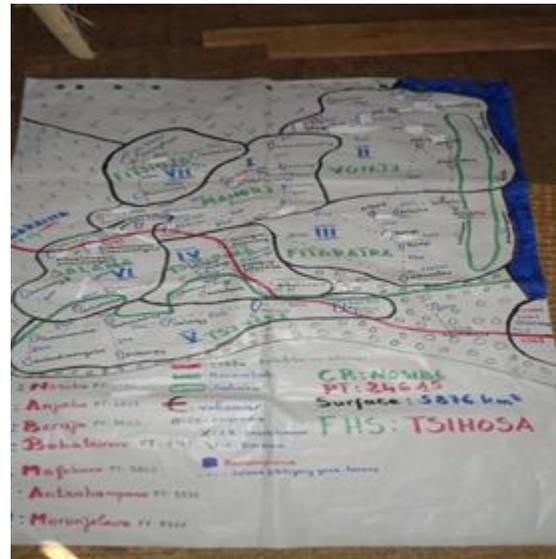
Process for Formation of a Community *Mutuelle*:

1. Survey and visit with community leaders to understand challenges, the existing infrastructure, the motivation of the community to apply the model, and to describe the procedures for establishing a health mutual in the community;
2. Training of trainers;
3. Public awareness raising, collection of the names of interested members;
4. General assembly event to establish and formalize the group, study available supply of health commodities and services, assess modes of operation, and train managers;
5. Develop memoranda of understanding and contracts with health centers and pharmacies for the provision of services to mutuelle members;
6. Develop contracts with financial institutions including private banks and microfinance institutions; and
7. Launch the mutuelle, with members initiating contributions and the mutuelle initiating payment for care, along with recruitment of new members.

The process ensures that communities truly own and manage their own *mutuelles*. Although MAHEFA staff participate in the process, ultimately, the process does not move forward without leadership and involvement from within the community.

In FY 2013, MAHEFA implemented a pilot program for the formation of *mutelles* in three districts, (Morondava, Antsohihy, Mitsinjo). The program extended into five additional districts in FY 2014. TSIHOSA is the first *mutuelle* to become fully functional, with members contributing funds and the *mutuelle* deferring payment to the CSB for services delivered. So far, ten cases have been financed through the group. These cases include two children under-five treated with antibiotics for diarrhea and respiratory problems, one new mother with an infection treated with antibiotics, a pregnant mother tested and treated for sexually-transmitted infections. For each of these cases, the health financing system offered through the *mutelle* has offered a critical means for seeking and accessing proper health care.

MAHEFA ensures that *mutuelle* efforts are integrated with additional activities to support improved community health, including emergency transport and behavior change. The *mutuelle* provides a means for members to finance emergency transport and to implement many of the health behaviors supported by MAHEFA's community health workers.



*Members map their community to identify new potential members. They understand that *mutuelles* are most successful and sustainable when more community members contribute to the group insurance scheme.*

Exchange Visits Motivate and Develop Capacity of Community Health Actors (Q3)

In MAHEFA recognizes that sustained improvements in health at the community level must be supported by both public and private actors. The program aims to encourage collaboration with local development actors and to establish mutually beneficial relationships in order to consistently improve the quality of health services in communities.

Community health workers (CHWs) play a critical role in supporting basic community health in Madagascar. They serve as volunteers, and despite a great number of daily challenges, including security concerns, inconsistent supplies, and lack of facilities, they display remarkable effort and conviction in their efforts to improve health care quality in their respective *fokontany*.



Visitors are briefed before their site visit.

MAHEFA's community champion approach, known locally as Kaominina Mendrika Salama miabo (KMSm), allows communities to support themselves in improving the health of their own people by analyzing health needs, setting goals, and monitoring progress against targets. The KMSm approach encourages experience exchanges between community stakeholders, including CHWs and the community health



CHWs in Morondava explain the practices they use to encourage families to work together to improve healthy behavior.

committees who support them (known locally as COSANs). The exchanges stimulate and encourage health actors to continue to serve their communities while also strengthening capacity. Participants are selected for exchange trips based on a set of evaluation criteria, including attendance, cleanliness of the work site, and reporting rate. In this regard, the exchange visits also serve as a means of incentive and motivation for CHWs and for their community supporters.

Four exchange visits, the first of many, were recently conducted for health actors in Belo tsiribihina district, Menabe Region, with Morondava district serving as a host. In addition to

facilitating the exchange of information among community actors, courtesy visits to the local authorities in both Morondava and Belo tsiribihina provided education on the critical importance of the work of CHWs and the challenges that they face in their work to improve health services in communities and on the KMSm process.

Mama Celestine, CHW in Adimaky Commune describes that the visit motivated her to improve her work : "In preparing for the visit, I thought we would simply discuss our work with other CHWs. However, we actually exchanged knowledge, expertise, and ideas. Our motivation has improved, and we are encouraged to return to our commune to improve our work at home. " According to Fazoe Arthur, CHW for Tsimafana Commune, "The visit helped us see what we are missing, for example, cohesion in our water users' group and the model household approach. We are going home with ideas for how to improve our work."

In including COSANs, the visits aim to engage those who support the CHWs as well. According to Ramaroson Seta, COSAN member, "We saw so many new things. We will return and improve many things. We're going to change the way we interact with our CHWs and aim to demonstrate that improvements have been made. "



Tippy-tap demonstration in Morondava.

At the end of the visits, participants develop action plans to outline future activities. MAHEFA staff will continue to monitor the action plans as participants return to their daily work, and will continue to provide support and supervision. Future exchange trips have been planned not only for This is the first trip for the exchange program in Menabe Region, but also planned to make in the other regions and also in other districts of the Menabe Region.

The exchange visit represents one of a number of activities that MAHEFA's CHWs and community actors engage in with the ultimate goal of improving access to community-based health services. They reward high-performing health volunteers and support them in expanding their reach. Olga Tsimiambina, a high-performing CHW in Belo tsiribihina district who has been awarded the title of « Champion CHW » and who recently participated in an exchange visit, has recorded a measurable increase in the services she provides with the support of MAHEFA. Whereas in FY 2013, Olga recorded two regular family planning users under her care, she now has 52 women who receive family planning services with her support. In

addition, she referred nine women for CPN, she has already referred 17 women this year. Comparably, Emmanuel, a CHW who has not received this recognition, currently records three family planning users (seven in FY 2013), and has referred nine women for CPN this year (three were referred in FY 2013).

Through the exchange visits, MAHEFA improved the knowledge and capacity of community stakeholders to improve their routine activities as well as motivation to take responsibility for efforts related to future improvements in community health services.



Participants gather for a photo at the close of a successful exchange visit.

Mobilizing Youth in Remote Communities: The Positive Impact of Youth Peer Support (Q4)

MAHEFA's youth program aims to empower youth to make responsible reproductive health decisions and sensible family planning choices through direct mentoring by youth peer educators (YPEs) and the dissemination of SMS messages on reproductive health.

These interventions are much needed in MAHEFA's program regions, where youth between the ages of 15 and 24 years old make up one-fifth of the population. MAHEFA surveys in these regions have shown that one in two girls under the age of nineteen already has a child, compared to one in three at the national level. In addition, a 2012 MAHEFA study showed that some girls in two of MAHEFA's regions (Sofia and Melaky) initiate sexual relations as early as 12-14 years of age¹.



Vladine discusses family planning methods with girls from her community

Peer education is based on the premise that young people are more likely to change their behavior if peers they admire and trust are the ones advocating for change. Because, by definition, peer education consists of a dialogue between equals it can be a very effective tool for mobilizing youth.

Twenty-two year old Vladine Razafinikambana, a YPE from the Manja II district in the Menabe Region, is an example of a youth advocating for change in her community. Vladine is well known among her peers for her passion for basketball, and as someone who leads by example on and off the court. Although initially interested in educating herself on health issues, Vladine came to view the opportunity of becoming a YPE as a way of taking on a leadership role in her community: "After being trained on sensible family planning choices, I was eager to share what I had learned with my peers. I decided to become a YPE with MAHEFA as a way of providing guidance and counseling to youth in my community." She often takes advantage of sporting events like basketball games to share her knowledge with fellow teammates and spectators. She also uses these occasions as opportunities to collect the phone numbers of her peers, and their permission to receive health education messages by SMS. She provides these numbers to the MAHEFA team, and the youth are subsequently sent two SMS messages per month on reproductive health. A total of 625 youth received reproductive health messages in FY2014 through this model.

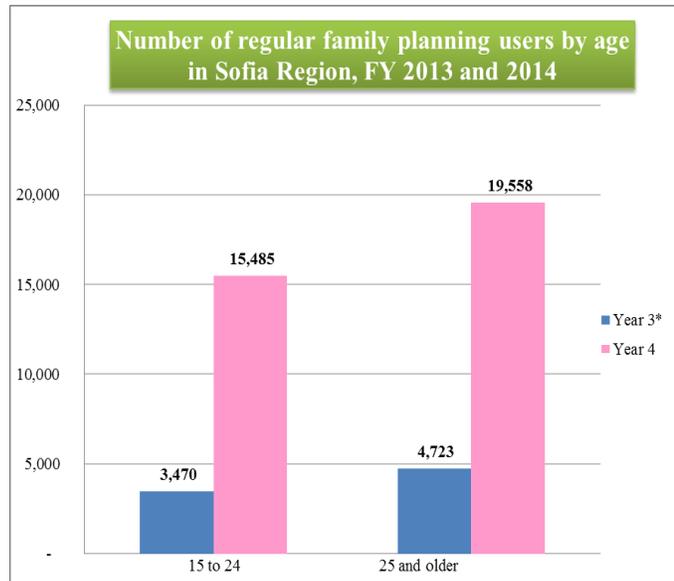
¹ *Rapport sur l'étude ethnographique, régions Melaky et Sofia, MAHEFA, 2012*

Vladine says that her peers come to her hoping to find accurate information pertaining to sex, sexually transmitted infections (STIs), and HIV and AIDS, but admits that by far the most commonly asked questions she receives have to do with family planning. “Many of them ask me about family planning methods and where they can access these family planning methods in a confidential way.” Vladine counsels them, and if needed, refers them to a community health worker (CHW), as she did with twenty-four year old Josephine.

Josephine had been walking several hours to the nearest hospital to receive Depo-Provera injections for over one year. The long distances she was required to walk for each visit had resulted in her missing several injections, which made her reluctant to continue using the method. Instead, Josephine decided to consult with Vladine, her neighbor, who had recently become a YPE. Vladine explained to her that the CHW in their community could provide her with the same Depo-Provera injections, only without having to walk the long distances. Josephine has been going to her *fokontany’s* CHW ever since.

In FY2014, reproductive health topics addressed by MAHEFA’s 609 operational YPEs included STIs, condom use, family planning, and unwanted pregnancy. In the Sofia Region, where the YPE program was first implemented in September of 2013, MAHEFA observed an increase of over four times the number of new family planning users supported by CHWs within the 15-24 year age group since the start of the YPE program (15,485 in FY2014 compared to 3,470 in FY2013). This increase can be contributed to the work of YPEs.

As Vladine’s experience can confirm, clear and accurate information about sex, sexuality, reproductive health, HIV and AIDS, and STIs is often hard for young people to find. This can be a result of cultural norms and taboos, or an overall lack of access to information. Providing youth in MAHEFA’s regions with the appropriate knowledge and resources to make healthy decisions about sex remains a continuing priority for MAHEFA as the Program transitions into its fifth year of implementation.



This graph illustrates the increase in regular family planning users in the Sofia Region in FY14.

**Note: MAHEFA’s youth program began in Q3 of FY13*

MAHEFA Supports CHWs in Recognizing, Diagnosing and Treating Children with Malaria (Q4)

In October 2013, MAHEFA and its local partner NGO AJPP (*Association des Jeunes Pionniers du Progrès*) visited Pelandrova, a community health worker (CHW) in the Mitsinjo district of Boeny Region who has been working as a CHW since the inception of MAHEFA in 2011. Pelandrova's community recently built her a work site in the Bemangoboka *fokontany*. Her family lives in Mitsinjo District town, which is a 45-minute bicycle ride from where her work site is located. Pelandrova spends her week at the work site and travels home on Friday afternoons to spend weekends with her daughter in Mitsinjo.



Pelandrova tests a boy using RDT, Boeny Region

On the day of the visit, Pelandrova examined a three-year old boy suffering from a high fever. As she had expected, the boy tested positive for malaria, so Pelandrova treated him with artemisinin-based combination therapy (ACT), a highly effective and safe antimalarial treatment. After the treatment, she counseled the boy's grandmother on the importance of having him sleep under a mosquito net and of clearing any undergrowth around the house that could serve as a mosquito habitat. Pelandrova also discussed with the boy's grandmother the



Weighing day at Pelandrova's work site

need for children to be brought in during the critical hours after malaria symptoms begin, when prompt treatment will prevent any serious complications or even death. With severe cases, Pelandrova refers patients to the nearest basic health center or *centre de sante de base* (CSB).

Pelandrova explained that in the past few months she had seen a rise in the number of children under the age of five testing positive for malaria. She believes one

reason for this increase could be that her health services are more accessible now that she has her

own work site. Pelandrova explains that she also receives patients referred to her from the CSB since the CSB often runs out of rapid diagnostic tests (RDTs) for malaria testing.

On a recent “weighing day” at Pelandrova’s work site, a day when parents bring their infants to be weighed, Pelandrova continued to educate her community on malaria prevention and other healthy behaviors. As she weighed the children, Pelandrova gave counseling on malaria prevention, nutrition and other key health messages for pregnant women and children under the age of five.

The bike that Pelandrova received from MAHEFA makes her commute to and from work more manageable and enables her to make house visits in parts of the village that are too far to reach by foot. Pelandrova used her bike recently to attend the monthly CSB meeting during which she received extra training on correct use of RDTs and ACT therapy for those testing positive for malaria. “I regularly attend the monthly CSB meetings,” she explains, “they give me the opportunity to meet with other CHWs and to learn from their experiences.”

MAHEFA is committed to improving the quality of health services in Madagascar, and CHWs like Pelandrova play a critical role in supporting the provision of basic healthcare. By building the capacity of CHWs like Pelandrova and supporting them with equipment and supplies, MAHEFA helps CHWs to recognize malaria symptoms, diagnose using a rapid test, and treat children for malaria.

MAHEFA CHWs also took part in this year’s World Malaria Day, a day each that provides an opportunity for individuals to participate in activities that lead to improved malaria prevention and treatment-seeking. *“Mosquitoes, flies, ticks and bugs may be a threat to your health - and that of your family - at home and when traveling”* was this year’s message. In support of the message, CHWs from all MAHEFA regions participated in the clearing of undergrowth and the cleaning of houses, health centers, and schools to eliminate existing mosquito habitats

As a result of these combined efforts from MAHEFA CHWs, during FY 2014:

- A total of **1,652,932** people (*690,522 women and 962,410 men*) received messages malaria on prevention for pregnant women;
- A total of **2,271,065** people (*942,214 women and 1,328,851 men*) received messages on malaria prevention for children under 5;
- A total of **97,172** children under 5 were treated with ACT by CHWs after being diagnosed positive using rapid diagnostic tests (RDTs)

MAHEFA: A Pioneer in Growth Monitoring and Promotion of Essential Nutrition Actions at the Community Level (Q4)

According to the National Action Plan for Nutrition II 2012-2015, the reduction of malnutrition, including stunted growth, remains a major challenge in Madagascar. National Health Surveys in 2012-2013 revealed that 8.6% of children under five in Madagascar are affected by acute malnutrition and 1.4% are affected by severe malnutrition. The rates of malnutrition in three of the six MAHEFA regions surpass these national averages. Because over 80% of the Malagasy population lives in rural areas with limited access to public health services, tracking malnutrition at the community level is crucial to facilitate appropriate and timely management.

Since the inception of the program, MAHEFA trains community health workers (CHWs) on nutrition, and provides them with the equipment necessary to provide nutrition services, including scales, mid-upper arm circumference (MUAC) measuring tapes, and *Child Health Record Books*. The *Child Health Record Book* is a national standard health and development record which includes the new WHO monitoring growth standards. MAHEFA was the Ministry of Health's first partner to make these standards available at the community level in 2013. With the Ministry of Health's lead and technical support from WHO, MAHEFA was among the pioneers in adapting the WHO tool to the CHW level in Madagascar. CHWs now have a tool that allows them to ensure the appropriate management of malnutrition. Since 2013,



Adapted Child Health Record Book and Nutrition Disc

MAHEFA CHWs have distributed approximately 250,000 record books to children under five in all six program regions.



An infant taste-testing a delicious and nutritious recipe made with local ingredients while his mom receives nutrition counseling, Menabe Region

This year's official celebration of the National Day of Nutrition was held on June 21 in Morondava, in the MAHEFA program region of Menabe. The theme was "*Investing in the first 1000 days of the child to prevent chronic malnutrition.*" The Prime Minister, who also serves as the Minister of Health, attended the event and expressed his commitment to eradicating malnutrition by speaking with CHWs and encouraging them to continue their work. The event was attended by mothers and children, and provided an

opportunity for MAHEFA CHWs to promote nutrition activities, including consultations for pregnant women on their nutritional habits, weighing of children under the age of five, and cooking demonstrations and tastings of nutritious foods for pregnant women and children older than six months.

The cooking demonstrations were a highlight for many during the celebration. Visitors were impressed by the ease with which recipes were prepared, using simple ingredients, and consisting of the complete nutritional intake required. The MAHEFA booth was very popular among mothers and future mothers during the event. In total, 25 children were weighed and 17 mothers were able to taste the nutritional recipes.

MAHEFA Program Contributing to an Increase in Use of Maternal and Child Health Services in Madagascar (Q4)

Twice yearly, the Ministry of Health and its partners organize a National Maternal and Child Health Week (*Semaine de la santé de la mere et de l'enfant, or SSME*) as a platform for the promotion of activities related to maternal and child health. This year's activities included routine immunizations for pregnant women and children under two, detection of severe and acute malnutrition, the delivery of Vitamin A supplements for children between 6 months and 5 years, and deworming tablets for pregnant women and children between the ages of 1 and 5.

Following the May SSME this year, a results dissemination meeting was held. The results from the six MAHEFA program regions were remarkably higher than other regions:

- Improved vaccine coverage by appointment (0-11 months) and by catching up (12-23 months). For the rotavirus vaccination, vaccination coverage in all six MAHEFA program regions surpassed the national median of 81%.
- Coverage in Vitamin A and in deworming tablets for children was at 90% in MAHEFA regions, with an exception for Melaky Region, which was at 85%. The national averages for Vitamin A and for deworming tablets coverage were 96%.

CHWs are at the center of the MAHEFA program, and ultimately, it is their commitment and efforts which drives these results. Their capacity in MUAC and administering oral vaccines, Vitamin A, and albendazole reflects the close support of the MAHEFA program.



A CHW measuring a child's MUAC

MAHEFA has also made large strides in its contribution to MNCH progress a program piloting the use of Chlorhexidine (CHX, brand name AroFoitra) for umbilical cord care in the Mahabo District of the Menabe Region.

Since 2013, MAHEFA has been working with USAID's Maternal and Child Health Integrated Program (MCHIP), Population Services International (PSI), and UNICEF through a CHX Technical Working Group that is working with the Ministry of Health to develop a CHX expansion plan to other regions of Madagascar. This year, MAHEFA introduced CHX to one district in the SAVA Region as well.

Overall, the pilot project has been successful in meeting its objectives, and users and health staff have responded positively to the product with no serious challenges reported. Since the inception of the pilot program, 559 CHWs from 30 different counties have been trained and are distributing AroFoitra in the Menabe and SAVA Regions. In FY2014, 3,744 tubes of AroFoitra were distributed by CHWs to women in these two regions, in addition to 2,617 tubes distributed by CSBs in these same regions. The CHX program will be scaled up in 2015, and JSI/MAHEFA, along with USAID/Mikolo and other partners, will introduce CHX in all of its program regions.



Dr. Jocelyne Andriamiadana (USAID/Madagascar and Deborah Armbruster (USAID/Washington DC) have a discussion with women who recently used AroFoitra in Vohemar, SAVA

As it begins its fifth year of implementation, the MAHEFA program will continue to build on the great strides made this year in contributing to an increase in maternal and child health services.

Great Strides in WASH Practices in Menabe MAHEFA Program Region (Q4)

Antsirabe commune is located in the Ambanja district in DIANA Region, and consists of 16 *fokontany* and 8,770 inhabitants. Before the introduction of the MAHEFA program in this commune, sanitation practices were practically nonexistent. Very low rates of latrine use, poor knowledge of water treatment techniques and water conservation, and a lack of drinking water infrastructure were all defining characteristics across this commune. Members of the communities defecated openly along the river, which also served as the communities' primary water source. With the introduction of MAHEFA at the beginning of 2013, however, Antsirabe made great strides in becoming "WASH Friendly".

As the only WASH program in its operating regions, MAHEFA's goal was to mobilize these communities to define and achieve targets for improving their health. MAHEFA's community champion approach, known locally as *kaominina mendrika salama miabo* (KMSm), is the foundation of the program's community health strategy, mobilizing community actors to take over health management in their own communities.



A demonstration on water conservation techniques by a CHW in Antsirabe county

The first interventions in Antsirabe included the training of community leaders by community-led total sanitation (CLTS) consultants. These trainings stressed the importance of abiding by the three basic behaviors: washing hands with soap, improved latrine use, and correct water treatment and conservation practices. CLTS consultants work with their communities to educate them on the connection between unhygienic practices and preventable diseases like diarrhea as well

as the benefits of using pit latrines. Community members are then shown how hygienic latrines are constructed. These messages were reinforced by an overview of the technical construction of sanitary latrines, followed by a training for local masons on the production of latrine slabs.

The CLTS initiative was launched shortly after, and the communities began constructing and using latrines. Leaders of the community who had been trained by CLTS consultants supported the CLTS consultants in explaining the importance of using the latrines to the rest of the

community.

After further sensitization on water treatment and conservation given by the CHWs, community members gained a better understanding of the importance of having clean water sources. Recognizing now that clean water and sanitary food are critical for the prevention of diarrheal diseases, members of community volunteered their time to help MAHEFA construct 10 new wells so that they could ensure the availability of clean drinking water.

Filled with a new sense of pride for their land, the commune also took initiative in cleaning and beautifying their towns with support from community facilitators. Previous defecation areas were cleaned and transformed into small gardens with bamboo benches where women and children can sit to pound rice.

Committing to building latrines and using WASH friendly practices is the first step to safer sanitation and healthier lives for these remote communities, and may not have happened for many years without the enabling assistance of the CLTS consultants and the CHWs. With MAHEFA's support, the commune of Antsirabe has gone above and beyond this commitment and are well on their journey towards safe sanitation and a healthier life.



The mayor of Antsirabe commune attested: "In a matter of months we have 10 villages that are on the way to becoming self-declared open defecation free (ODF), with members of our communities using hand washing devices like tippy taps and who no longer defecate in the open air. The population has shown remarkable responsibility and commitment to almost completely changing their behavior in order to improve its collective health."



Annex 7: Peace Corps Volunteer Reports

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Peace Corps Volunteer: Anthony Steele

I have been working with the MAHEFA program for close to a year and a half as an Environmental and Water Resources Engineering Specialist within the Health Sector of Peace Corps Madagascar. The original scope of my work was to assist the MAHEFA team in the Sofia Region with their work in WASH (Water, Sanitation, and Hygiene). I have been working in collaboration with my counterpart, Jean Emilien, who is the WASH Officer for the Sofia Region.

With Jean Emilien as my counterpart, I have traveled all over Sofia Region to participate in trainings and supervisions. I have assisted and participated in three mason trainings during the past year. These trainings provided 10-25 local masons with the skills and knowledge to construct improved latrines using the Sanplat model. As their communities request latrines to be constructed, these masons will be able to provide a needed skill while receiving a small income. Over time, as my Malagasy language skills have improved, I have become increasingly involved in these trainings.



Masons-in-training with a finished Sanplat



Workers constructing a well in Mandritsara

In addition to masonry training, I often travel around the region to observe and supervise engineering projects, particularly well and latrine construction projects. Usually I travel with Jean Emilien to the well construction sites to check up on the progress and note any issues. As different companies are contracted to build the wells, there are often issues that vary by area and by company. On several occasions I have traveled on independent supervision missions to Bealanana, Befandriana, Mandritsara, and the surrounding areas. On these independent missions, I travel by taxi-brousse (local transportation) to the sites. Once at the site, I contact the local NGO's *Technicien Accompagnateurs* (TAs) that are responsible for the area, and travel with them to the well and latrine construction sites. One of the issues that we commonly encounter on our supervision missions is problems with the local roads. Outside of the primary highways in the Sofia Region, the roads can be in very poor

condition, sometimes in such poor condition that MAHEFA program vehicles are unable to access program sites. These poor road conditions are only accentuated during the rainy season.

While I continue to work with Jean Emilien, the scope of my work has slowly been changing over the past fiscal year. The team and I have recognized that my skills are more needed on the community level than on the regional level. One issue that has particularly been of note during the past year is the coordination of the responsibilities of the MAHEFA team, the NGOs, and the CHWs in the community. As of now, my intended scope of work is to act as a liaison between the CHWs, TAs, and the MAHEFA team. To accomplish this, I will work in two communes that are within bicycle distance of Antsohihy (where the Sofia team is based). I will coordinate with the TAs of these two communes to visit these communes, their CHWs and other community agents. Ideally, while coordinating between these different agents, I will be able to identify any confusion regarding work responsibility or issues having to do with knowledge gaps. These issues can then be brought to the attention of MAHEFA staff and the NGOs. Unfortunately, due to frequent travels, I have been unable to establish any real routine with these communities or TAs. I hope to begin visiting the communes at least on a bi-weekly schedule, with or without the TA. I will help to coordinate health events with the CHWs and the TAs, particularly those that are WASH-related.

In addition to my work in the nearby communes, I have begun to work more closely with the TA in Antsohihy, particularly regarding the Youth Peer Educators (YPE). We are currently planning a Grassroots Soccer event with the YPE for youth in the area. Grassroots Soccer is a multi-day camp that educates local vulnerable youth on AIDs and safe-sex practices through various soccer activities. This event will likely take place during the month of November. If successful, the JPE in other communes in the Sofia Region can utilize the tools provided by Grassroot Soccer to carry out similar events in their own communities.



A Malaria Day parade in Anahidrano

I have also been involved with a few non-WASH related activities with MAHEFA. One notable event was a Malaria Day festival held in the community of Anahidrano. Several hundred people attended this event. I assisted in the overall organization of the event and helped to organize the children's activities and the distribution of prizes. MAHEFA has also made sure to include me in other team events, such as the Women's Day parade in Antsohihy.



As I continue working with the team, I believe I can have an impact on the regional level through my work at the local level, in the small communities that I work in. While I enjoy the supervision trips and regional trainings, these do not utilize my skills as a Peace Corps Volunteer. Thus far, MAHEFA has been very accommodating to my work as a Peace Corps Volunteer, and in supporting my new scope of work. Hopefully, as I continue to organize Grassroots Soccer events in Antsohihy, MAHEFA can help me expand the activity to the YPE in other communities by coordinating between the TAs and the YPEs in those communities.

Peace Corps Volunteer: Harry Wolberg

In August 2013 I began working with MAHEFA for the third year of my Peace Corps service. My responsibilities included the development, implementation, and evaluation of the Mhealth commodities Management and reporting pilot project in the district of Ambanja in the DIANA Region of Madagascar. I spent the first half of the year working on this project. The second half of the year my responsibilities changed due to programing decisions aimed at revamping the Mhealth program. My new duties focused on the implementation and supervision of the Youth Peer Educator program. I completed the year supervising the YPE program in the DIANA Region and implementing the mobile technology program that the YPEs used to submit their reports to MAHEFA.

At the beginning of the year, I attended and participated in MAHEFA's sessions with HNI to develop the Mhealth commodities management program in Antananarivo. In September 2013, I moved to Ambanja in order to implement and supervise the program. Along with the regional M&E team in the DIANA Region, I observed the trainings of the pilot program in several communes in Ambanja, including trainings in Bemanevika and Antsakoamanondro. After the trainings were completed I conducted monthly follow-up visits with community health workers using the program to submit their medical reports, and with local NGOs in Ambanja.



SMS database training in DIANA Region

My supervision of the pilot program focused on coming up with solutions to various challenges within the project, including technical issues that CHWs had with their phones, little or no network coverage in reporting areas, and a lack of power sources where CHWs could charge their phones. I communicated my observations to my supervisors in the regional office in Diego and in Antananarivo. In order to resolve these issues that were limiting the effectiveness of the Mhealth reporting program, MAHEFA decided to revamp the program using different strategies.

While reworking the design of the program, my work with the Mhealth program was put on hold. After talking with my supervisors in MAHEFA and Peace Corps we agreed that my work would shift to other aspects of MAHEFA's integrated health program. My new duties focused on the implementation of the Youth Peer Educator program. In the spring of 2014, I attended several YPE trainings in Diego, and oversaw the distribution of YPE materials to local

NGOs, and then to the YPEs. In July I implemented the Mhealth reporting and youth outreach program of MAHEFA's new partnership with the Telma Foundation. I attended and helped lead the training of trainers for local NGO workers in the DIANA Region, and afterwards I supervised the YPE Mhealth trainings in Nosy Be, Ambanja, Ambilobe, and Anivorano. After the trainings were complete in the DIANA Region, I traveled with the YPE supervisor to the SAVA and Melaky Regions to lead the training of trainings for the local NGO workers in each of those regions.

My work with MAHEFA has been a phenomenal opportunity to participate in on the ground international development work. Although my responsibilities changed mid-way through the year, I was able to begin working on another project that had a similar focus. In the future I hope to continue the work I have started with MAHEFA so I can continue to have a positive impact on the world.

Peace Corps Volunteer: Michael Usowicz

In December 2013, I started working with MAHEFA's emergency transport program, a program that produces bike ambulances, wheeled stretchers, and canoe ambulances for use in rural areas of Madagascar. Prior to my work with the emergency transport program, I was working with MAHEFA's WASH program, but because the emergency transport program was a better fit for my skillset, I decided to change the scope of my work. I replaced another Peace Corps Volunteer with an engineering background after he had to return home for medical reasons.

I started working on the emergency transport program after the first set of emergency transport devices were produced and distributed to two communes in the Menabe Region near Morondava. Since then I have worked extensively with the monitoring and evaluation of emergency transport devices, their designs, and with MIDAS, the Malagasy manufacturer of MAHEFA's emergency transport devices. The emergency transport project benefited from my presence since it needed a technical person to work with MIDAS on the designs of the emergency transport devices and to perform quality checks during production. Had I not been a part of the project, it is possible that lower quality products may have been distributed to communities for use. Personally, I have benefited greatly since having a project here in Madagascar that has pushed my skills as an engineer and as a designer for products in developing countries. The time I've spent working on this project thus far has given me valuable experience that I will use in other design projects that I hope to work on for developing countries in the future.

Monitoring and evaluation of emergency transport devices: I was responsible for leading the monitoring and evaluation of the emergency transport devices in the Menabe Region. During these trips I identified problems with the emergency transport devices that occurred during manufacturing. I also discussed designs with TransAid employees working with the same bike ambulance design in other countries during this time and discovered that there was miscommunication and confusion with the design of the bike ambulances that needed to be corrected with the in-country manufacturer.

Design workshop: TransAid obtained a grant from AFCAP to bring in consultants to help with the project after the problems with the emergency transport devices were discovered during monitoring and evaluation. The consultants worked on re-designing the wheeled stretcher and provided quality assurance for the production of both the wheeled stretcher and bike ambulance. I helped to coordinate the logistics for this workshop, assisted in the documentation of the design changes, and supported the development of a quality control plan for production.

Clarification of design with in-country manufacturer: I worked with MIDAS to document and agree to the design changes to the emergency transport devices after the workshop and after consulting with bike ambulance projects in other countries. This was an important step to assuring that mistakes were not made during production and that communities were receiving the best quality bike ambulance possible.

Production of emergency transport devices: I assisted and will continue to assist with quality checks during production of the emergency transport devices for the expansion districts in SAVA and Sofia Regions.

Training of Trainers: During our training of trainers workshop in Vohemar, in the SAVA Region, I led the portion of the workshop on the maintenance and use of the emergency transport devices as well as overseeing the first training of communities on the emergency transport devices. I also made sure that all the emergency transport devices were in working order before being sent to the communities. I will do the same work for the training in Mandritsara, Sofia Region.

Future Work: The final task I plan to carry out for the project is to produce drawings and videos of the production of the wheeled stretcher and bike ambulance that will be posted on the TransAid website. During our prior art review for the wheeled stretcher design, we only found one other project that had produced a wheeled stretcher for rural areas in developing countries, and this project had very little documentation of their design. All other designs found were made for developed countries. There have been several different bike ambulance projects, however, there is no complete documentation of the design variation being used in Madagascar and for most of the projects there is not sufficient documentation readily available. This lack of documentation limits the ability of other emergency transport projects in other countries to produce quality emergency transport devices in-country and will lead other programs to “re-invent the wheeled stretcher”. The documentation that I plan to produce will provide other programs with a product that they can reproduce or modify slightly based on what materials are locally available.



Testing a prototype of the wheeled stretcher with a consultant at the design workshop



Annex 8: MAHEFA Program Highlights

Annex 8: MAHEFA Program Highlights

Date	Topic	Thematic	Region
24-Oct	<i>CHW Mobility: USAID/MAHEFA Bicycles Increase the Mobility of Community Health Workers</i>	CHW	MENABE
28-Oct	<i>USAID/MAHEFA Supports Community Health Workers to Provide Services in the Community</i>	MNCH	ALL REGIONS
4-Nov	<i>Fokontany Improves Infrastructure to Meet Community Needs through Score Card Approach</i>	Community Score Card	SOFIA
11-Nov	<i>MAHEFA to Celebrate World Toilet Day: November 19</i>	WASH	ALL REGIONS
25-Nov	<i>Overcoming the Barriers to Improved Community Health: The TIPs Approach</i>	BC	ALL REGIONS
2-Dec	<i>Saving Newborn Lives with Chlorhexidine (CHX)</i>	MNCH	SAVA
9-Dec	<i>Improving the Continuity of Community Health Services and Household Behavior in Early Care Seeking Through Referrals</i>	PCMEI	SOFIA
16-Dec	<i>Engaging Youth to Improve Health Outcomes in Their Communities</i>	YPE	ALL REGIONS
23-Dec	<i>Menabe Community Achieves Health Goals Set by the Community Itself</i>	KMSm	MENABE
30-Dec	<i>Developing and Implementing Community-Based Emergency Transport Systems</i>	Emergency Transport	MENABE
6-Jan	<i>Peace Corps Volunteers Partner with MAHEFA for Improved Health</i>	Peace Corps Partnership	MENABE/SOFIA/DIANA
27-Jan	<i>MAHEFA'S Strategic Thinking Group: Strengthening Program Management</i>	MAHEFA Program	TANA
27-Jan	<i>Community Health Insurance or Mutuelle</i>	Mutuelle	SAVA
3-Feb	<i>Building NGO Capacity to Use Data for Decision-Making</i>	NGO Partnership/M&E	ALL REGIONS
10-Feb	<i>Community Radio and Listening Groups</i>	BC	ALL REGIONS
28-Feb	<i>USAID Director Visit in DIANA</i>	MAHEFA Program	DIANA
8-Mar	<i>Gender Equality at Home</i>	BC	MELAKY

Date	Topic	Thematic	Region
14-Mar	<i>USG Partner Collaboration: MAHEFA and Peace Corps</i>	Peace Corps Partnership	TANA
21-Mar	<i>Champion Commune Changes Practices for Improved Health</i>	KMSm	MELAKY
28-Mar	<i>Celebration Of World Water Day</i>	WASH	SOFIA
4-Apr	<i>Spotlight on Community Health Volunteer Security</i>	CHW	MENABE
7-Apr	<i>Expansion of Newborn Cord Care Through the Use of Chlorhexidine 7.1% in Madagascar</i>	MNCH	MENABE
11-Apr	<i>Celebration of World Health Day (April 7) in Vohemar</i>	WASH	SAVA
25-Apr	<i>Communities Take Health into Their Own Hands by Supporting Sites for their Volunteers' Work</i>	CHW	SOFIA
9-May	<i>Mother and Child Health Week in Melaky</i>	MNCH	MELAKY
16-May	<i>Strategic Partnerships with the Private Sector</i>	Public Private Partnership	DIANA
23-May	<i>Designing and Implementing New Approaches and Innovations</i>	MAHEFA Program	ALL REGIONS
30-May	<i>Technicians' Added Value: Evaluation of Behavior Change Impact within Communities</i>	BC	SOFIA
6-Jun	<i>Establishment of Water, Hygiene, and Sanitation User Associations (AUEAH)</i>	WASH	SAVA
20-Jun	<i>MAHEFA Contributing to Maternal and Child Health Progress in Madagascar</i>	MNCH	ALL REGIONS
27-Jun	<i>Voluntary Community Support of CHWs to Improve Village Health</i>	CHW	MELAKY
4-Jul	<i>Community Family Planning in SAVA Region</i>	FP	SAVA
15-Aug	<i>Income Generating Activities (E-Boxes)</i>	Income Generating Activities	SOFIA
30-Aug	<i>Customer Rights in Family Planning (FP): Application at Community Sites</i>	FP	MENABE
8-Sep	<i>Gender Approach: Community Radio and Community Health Worker Experiences</i>	BC/Gender	MENABE



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Date	Topic	Thematic	Region
29-Sep	<i>93 Families Benefit from Emergency Transport in One Commune of Menabe Region</i>	Emergency Transport	MENABE



**Annex 9: List of MAHEFA NGO
Grantees**

Annex 9: List of MAHEFA NGO Grantees

N°	NGOs proposed	Budget amount (\$)	Region	District	Number of communes	Contract status
1	ACDEM	\$76,179	Menabe	Manja	6	Approved
2	AINGA AIDES	\$87,013	Diana	Ambanja	10	Approved
3	AJPP	\$181,000	Boeny	Mitsinjo	7	Approved
				Soalala	3	
4	ASOS	\$180,882	Sofia	Bealalana	8	Approved
				Antsohihy	4	
		\$84,323	Diana	Ambilobe	7	Approved
5	FAFY NGDC	\$159,357	Sofia	Befandriana	9	Approved
		\$94,344	Diana	Ambilode	8	Approved
6	FISA	\$42,754	Diana	Antsiranana I	1	Approved
7	FIVOARANA	\$148,965	Sofia	Bealalana	10	Approved
8	FTMM	\$249,605	Melaky	Maintirano	9	Approved
				Morafenobe	3	
			Menabe	Miandrivazo	4	
9	HOMME ET ENVIRONNEMENT	\$120,742	Diana	Ambanja	13	Approved
10	IVOMPANDROSOANA	\$269,991	Sofia	Boriziny	9	Approved
				Analalava	7	
11	MSIS	\$411,784	Menabe	Belo surTsiribihina	7	Approved
				Miandrivazo	11	
			Sofia	Mandritsara	11	
12	NY TANINTSIKA	\$106,636	Menabe	Mahabo	5	Approved
13	PENSER	\$279,976	Menabe	Mahabo	6	Approved
				Sofia	Befandriana	
				Mandritsara	8	
14	SAF FJKM	\$357,600	Melaky	Maintirano	8	Approved
				Antsalova	5	
				Ambatomainty	4	
				Besalampy	8	
15	SAGE	\$441,697	Sava	Vohemar	19	Approved
			Sofia	Boriziny	8	
				Antsohiy	4	
		\$135,494	Diana	Antsiranana II	9	Approved
				Nosy-Be	5	

N°	NGOs proposed	Budget amount (\$)	Region	District	Number of communes	Contract status
16	SAHI	\$55,956	Sofia	Analalava	4	Approved
17	SALFA	\$162,858	Menabe	Morondava	2	Approved
			Diana	Antsiranana II	12	
18	SARAGNA	\$207,124	Menabe	Belo surTsiribihina	6	Approved
				Morondava	3	
19	SIVE	\$176,948	Sofia	Mandritsara	9	Approved
				Antsohihy	4	
Total		\$4,031,228			279	



Annex 10: MAHEFA Staff List

Annex 10: MAHEFA Staff List

N.	Position
1	Chief of Party
2	Senior Advisor for Behaviour Change, Gender, Strategic Partnerships
3	Deputy Chief of Party Technical
4	Deputy Chief of Party Admin Finances & Grants
5	Senior Community Health Advisor
6	KMS and Community Health Senior Advisor
7	Human Resources and Administration Specialist
8	Monitoring and Evaluation Senior Advisor
9	Office Cleaner
10	Behaviour Change Coordinator
11	Finance Officer 1
12	Administrative Assistant Receptionist
13	Senior Finance Specialist
14	WASH Advisor
15	Maternal Neo Natal and Child Health Coordinator 1
16	Maternal Neo Natal and Child Health Coordinator 2
17	Menabe Regional Coordinator
18	Grants Manager 1
19	IT Manager
20	SAVA Administrative and Financial Assistant
21	Menabe Administrative and Financial Assistant
22	SAVA Regional Coordinator
23	Melaky Regional Coordinator
24	Central Office Driver
25	Menabe Driver
26	Melaky Driver
27	SAVA Driver
28	Program Assistant 1

N.	Position
29	Transport Coordinator
30	SOFIA Technical Officer
31	SOFIA Regional Coordinator
32	Melaky Administrative and Finance Assistant
33	SOFIA Administrative and Finance Assistant 1
34	M&E Coordinator
35	Transaid Transport & Logistics Advisor
36	Melaky M&E Officer
37	SAVA WASH Officer
38	Melaky WASH Officer
39	SOFIA WASH Officer
40	SOFIA M&E Officer 1
41	Logistics Coordinator
42	SOFIA Driver 1
43	SOFIA Driver 2
44	Program Assistant 2
45	DIANA M&E Officer
46	Menabe M&E Officer
47	Central Office Driver 2
48	Office Maintenance
49	Procurement Assistant
50	Grants Manager 2
51	Logistics Assistant
52	Finance Assistant
53	DIANA Technical Officer
54	DIANA Administrative and Financial Assistant
55	DIANA Driver 1
56	DIANA Regional Coordinator
57	DIANA WASH Officer
58	Menabe Technical Officer

N.	Position
59	Family Planning Compliance Officer
60	SOFIA Administrative and Financial Assistant 2
61	SOFIA M&E Officer 2
62	SAVA M&E Officer
63	Senior Technical Advisor
64	Melaky Technical Officer
65	Boeny WASH Officer
66	Maternal Neo Natal and Child Health Coordinator 3
67	Menabe WASH Officer
68	DIANA Driver 2
69	Central Office Driver 3
70	Procurement Manager
71	Chlorhexidine Coordinator
72	WASH Coordinator
73	DIANA Senior M&E Officer
74	Finance Officer 2
75	Central M&E Officer 1
76	Boeny Administrative and Financial Assistant
77	Director of Grants
78	IT Assistant
79	SAVA Technical Officer
80	Office Maintenance
81	SAVA Administrative and Financial Officer
82	SOFIA Administrative and Financial Officer
83	Menabe Administrative and Financial Officer
84	DIANA Administrative and Financial Officer
85	Melaky Administrative and Financial Officer
86	Boeny Administrative and Financial Officer
87	Central M&E Officer 2
88	Youth Program Coordinator



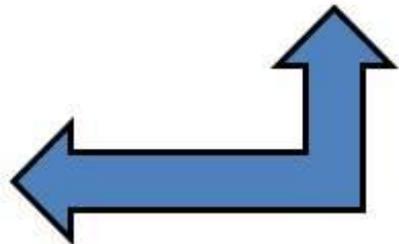
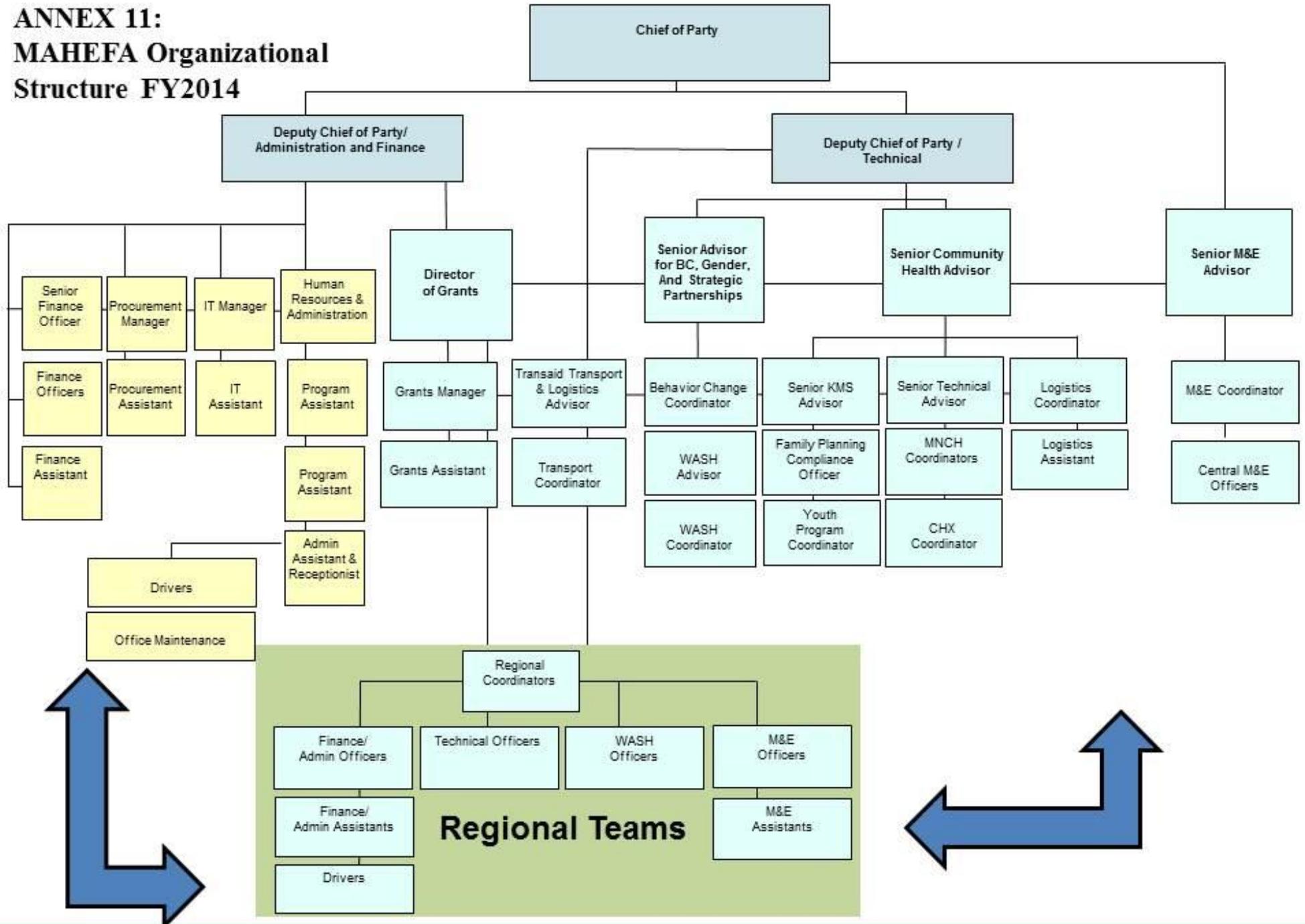
N.	Position
89	Menabe Driver 2
90	Grants Assistant

These are staff members hired since the beginning of the program until Q4 FY14, listed in chronological order.



Annex 11: MAHEFA Organizational Structure

ANNEX 11: MAHEFA Organizational Structure FY2014



Madagascar Community-Based Integrated Health Program: MAHEFA

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