



USAID/Madagascar and Community Health Volunteers: Working in Partnership to Achieve Health Goals



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VOLUNTEERS: WORKING IN PARTNERSHIP TO
ACHIEVE HEALTH GOALS



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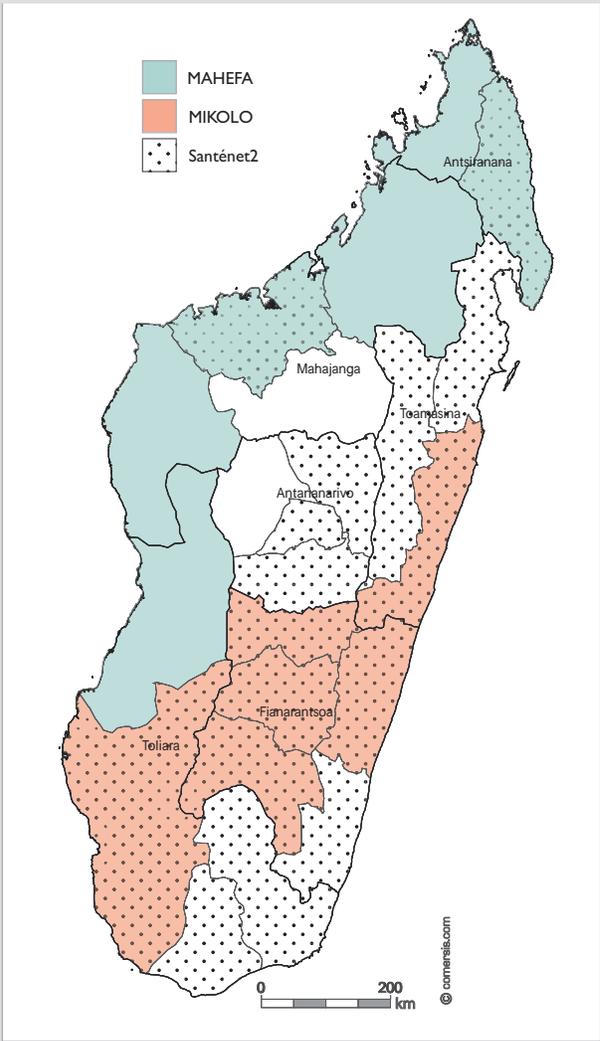
INTRODUCTION

For more than 30 years, the United States Agency for International Development (USAID)/Madagascar has played a pivotal role in Madagascar’s health sector—strengthening a weak and severely constrained system—as one of the leading health donors in the country. USAID supports integrated programs with the goal of ending preventable child and maternal deaths. Community health volunteers (CHVs) have played a critical role in the success of USAID assistance. CHVs are individuals who, with limited training, offer basic health care services and health education at the community level. CHVs have brought innovative techniques and medicines to their communities, helping to sustain USAID’s investment and improving the health of their villages, while facing the challenges of working in remote and often difficult-to-access regions that are far from health clinics and hospitals. CHVs are part of the national health system, as stated in the national community health policy.

This report highlights the successes and challenges of USAID/Madagascar’s investment in CHVs—focusing on innovations, community engagement, and sustainability—and concludes with challenges, lessons learned and next steps.

Background: From 2009 to 2014, USAID health assistance was limited by US government restrictions, focusing only on private sector health services such as social franchising, nongovernmental organization (NGO) service delivery, social marketing, and community-based service delivery through CHVs to provide family planning, maternal and child health, and malaria services. Despite these challenges, over the past five years alone, Americans invested over \$250 million in population and health programs in Madagascar to improve the survival, well-being, and productivity of the Malagasy people. USAID has

Figure I. Geographical Coverage of Three USAID-funded Projects in Madagascar



Note: Geographical coverage is not exact, but is an approximation of each project’s coverage.

Sources: Project reports.

worked with a network of more than 17,000 CHVs who cover about 1,200 communes in Madagascar. The majority of CHVs are women; they are selected by their own communities. The CHV system

provides health services to 9.5 million people or about 64% of the population in rural areas.

Over the past eight years, three USAID-funded projects—Santénet2 (2007-13), MAHEFA (2011-16), and MIKOLO¹ (2013-18)—have worked in partnership with CHVs. Together, the projects have implemented innovative community health services and systems, scaled up the provision of community-based diagnosis and treatment for simple pneumonia, diarrhea and malaria, as well as of oral and injectable contraceptives through family planning and reproductive health. USAID projects have also supported CHVs to improve water, sanitation, and hygiene (WASH) systems. CHVs work with community structures such as the COSANs (*Comités de Santé*)—local health committees that provide technical supervision of CHVs; the CCDS (*Commission Communale de Développement Sociale* or Community Social Development Committee)—that coordinates health interventions in each commune; and the *Centres de Santé de Base* (health centers or CSBs). The CSBs provide basic health services, community outreach, and vaccination.

Moving Forward: As this report highlights, much of USAID’s investment in health has demonstrated lasting value. Participatory community-based approaches have rapidly expanded access to life-saving health services for rural and remote populations. Over the coming years, USAID’s primary focus will be on consolidating these gains and ensuring the continuity of quality service provision through close collaboration with the Government of Madagascar.

To further its impact, USAID/Madagascar is actively identifying and scaling-up innovative breakthrough solutions to accelerate reductions in maternal and newborn mortality, working in concert with CHVs. Specifically, USAID/Madagascar plans to support the Government of Madagascar to scale-up low-cost, evidence-based interventions. USAID/Madagascar will also reinforce the public health sector by: strengthening the national commodity supply chain system and improving the skills and capacity of health care workers; fully integrating CHVs into the

¹ MAHEFA = *Malagasy Heniky ny Fahasalamana* (Malagasy Healthy Families); MIKOLO = Madagascar Primary Health Care Project.



Image Credit: Chuanpit Chua-oon.

CHV tests a child for malaria in Katsepy commune, Boney region.

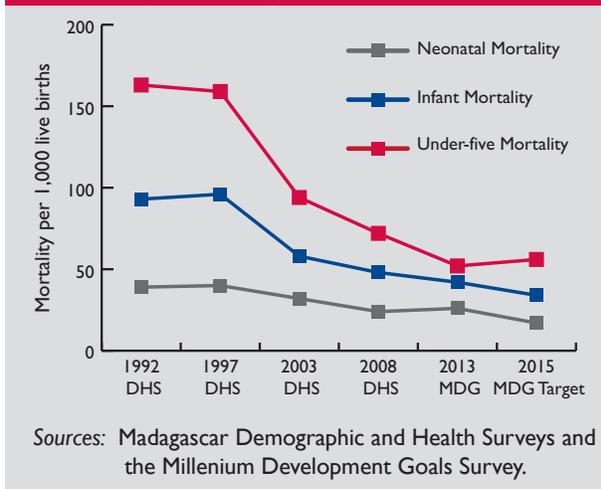
public health sector with public sector providers providing the bulk of CHV supervision and training; and strengthening and formalizing the referral system between the community and health facility.

SUPPORTING THE HEALTH SECTOR AND CHVS IN MADAGASCAR

Madagascar faces major health challenges. Respiratory infections, diarrheal disease, malaria, malnutrition, maternal and neonatal mortality, poor hygiene and sanitation, and limited water infrastructure are a burden on Madagascar’s families, its communities, its health system, and the economy. With limited access to basic health services, every day 100 Malagasy children die primarily from common and preventable illnesses and 10 Malagasy women die from complications related to pregnancy and childbirth. The country’s high maternal mortality rate has essentially remained unchanged for more than two decades. Over 18 million Malagasy people do not have access to clean water and sanitation. In contrast, USAID/Madagascar’s Community-based Primary Health Care Program has helped the country reach its Millennium Development Goal (MDG) target of reducing under-five mortality to 52 per 1,000 live births (see figure 1). Similarly, Madagascar has seen a dramatic increase in its modern contraceptive rate, attaining 33% from 5% in 1992, based on the 2012 MDG survey.

Across Madagascar utilization of health services is low; over the past several years, use of health services has remained at about one-third, the key reasons being cost of and distance to services. According to the 2008-2009 Demographic and

Figure 2. Under-five, Infant and Neonatal Mortality in Madagascar, 1992–2013



Health Survey, only 41% of children under five with fever, 34% of children under five with diarrhea, and 42% of children under five with acute respiratory infection (ARI) accessed care from a facility. Among women residing in rural areas, the 57% included in the survey stated that distance to the facility was a major barrier to seeking care.

CHVs have long been recognized for their role in reducing mortality and morbidity, and in expanding access to health services in low-resource settings. CHVs play a critical role in linking their communities to the health system and often serve as the first point of care. They provide care that is culturally appropriate and cost-effective, while also encouraging the community to be more engaged in health results. Working in many of Madagascar’s 22 regions, 119 districts, 1579 communes, 17,485 *fokontany* (here “villages”), and 121,679 localities, many CHVs receive a small income from socially-marketed products. Under the MAHEFA and MIKOLO projects, for example, CHVs earn money from user fees from the sale of medicines and commodities, and receive per diem for attending trainings and meetings. Selected CHVs may have access to credit through project-established Savings and Internal Lending Communities (SILCs) or may be chosen to participate in certain income-generating activities.²

² ASH 2015.

CHV PACKAGE OF SERVICES

CHVs promote preventative child health practices; treatment of ARI, diarrhea, and malaria are the prime responsibility of CHVs. They also assist in improving hygiene and sanitation, home point-of-use water treatment, growth monitoring promotion, appropriate complementary feeding, malaria prevention, and dietary quality and diversity. CHVs provide a range of maternal care services such as screening, early recognition of pregnancy danger signs, and the promotion and referral of pregnant women for antenatal care. CHVs counsel women on birth preparedness including the promotion of facility delivery as well as essential newborn care. CHVs were also trained on the community-level management of maternal and newborn complications, in particular how to recognize danger signs and assist women and newborns who are experiencing complications before their transfer to a health facility. CHVs expand the delivery of quality antenatal care by distributing iron/folic acid and de-worming medication, and provide preventive treatment of malaria in pregnancy.

Volunteers also provide community-based family planning services. These services include counseling, pregnancy screening, method eligibility screening, and provision of short-acting contraceptive methods. CHVs inform and refer clients for long-acting and permanent methods available through mobile outreach and private and public service providers. CHVs socially market many of the products that they distribute; this modest income serves as a motivation for CHVs and sets Madagascar apart from other countries that pay direct stipends. CHVs also



CHV Theresia gives Viasur to treat baby’s diarrhea in Cap Diego, DIANA Region.

Image Credit: Tshiana Andriantsoa

provide a link to youth peer educators in the community to reproductive and other health services.

Working in the WASH sector with CHVs, USAID projects catalyzed the national scale-up of the Community-led Total Sanitation (CLTS) approach, an innovative behavior change methodology, which empowers and mobilizes communities to eliminate open-air defecation and improve overall hygiene practices. Community stakeholders, including CHVs, were trained in this approach.

The CHV package of services also includes malaria prevention and treatment. Madagascar was among the first of 15 focus countries in the U.S. Government’s President’s Malaria Initiative (PMI). PMI has scaled up promotion and distribution of insecticide-treated mosquito nets, indoor residual spraying, improved rapid diagnostic testing, and highly effective antimalarial drugs, often distributed through CHVs. These interventions have made a major contribution to the health of the Malagasy people—reducing by 23% all causes of mortality in children under five years of age. PMI is a USG initiative led by USAID and implemented in partnership with the Center for Disease Control and Prevention (CDC).

IMPACT OF CHVS ON HEALTH CARE

The impact of the CHVs on health care in Madagascar cannot be underestimated. CHVs provide services for three of the most lethal childhood



Image Credit: Fanja S. MIKOLO Project.

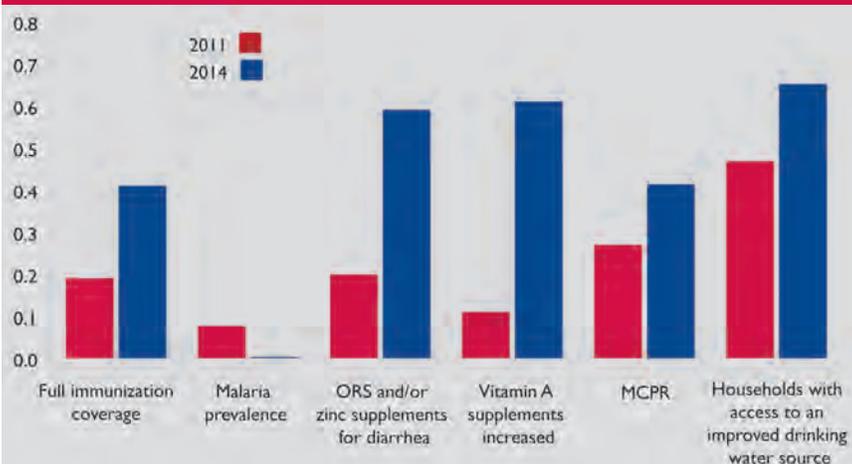
CHV Célestine Razanabao showing family planning methods to a new couple in her workplace.

illnesses—ARI, diarrhea, and malaria—and play a significant role in their treatment.

As stated in the recent African Strategies for Health (ASH) Project study, “Based on the estimated utilization and assuming only positive cases were treated, MIKOLO-supported CHVs treated 46% of pneumonia cases and 48% of fever cases. MAHEFA-supported CHVs treated 22% of pneumonia cases and 15% of fever cases.” Further, the 2014 Outcome Monitoring Survey (OMS) report on the MAHEFA Project highlighted an overall better status for several maternal and child health indicators (figure 2) as compared to data from the 2011 baseline survey. There was a significant rise in full immunization coverage, although there were regional variations.

Malaria prevalence also decreased over this time period, and CHV interventions were seen as an opportunity to reinforce malaria diagnosis and treatment at the community level. Similar positive results were seen in ORS and/or zinc supplement treatments for diarrhea, and in the dramatic increase in the provision of vitamin A supplements. The modern contraceptive prevalence rate (MCPR) rose significantly, with CHVs providing almost half of the family planning messages to women of reproductive age. Gains were also seen in the percentage of households having access to an improved drinking water source.

Figure 3: Improved Maternal and Child Health Indicators, MAHEFA Project, 2011 and 2014



Source: USAID/Madagascar OMS Report in the MAHEFA Areas, April 2015.

SUCCESS STORIES: INNOVATIONS, COMMUNITY ENGAGEMENT, AND SUSTAINABILITY

INNOVATIONS

CHVs are making a positive impact on the lives and well-being of the Malagasy people. In USAID/Madagascar's Community-based Primary Health Care program, an expanded network of more than 17,000 CHVs implement innovative integrated community case management (iCCM) and provide referrals for severe cases for children under five years of age. Among the innovations that CHVs have been involved in are the following:

- Piloting and rolling out the community-based distribution of chlorhexidine, a low-cost antiseptic to reduce neonatal mortality;
- Scaling up a pilot program to provide misoprostol, a drug that can decrease the incidence of postpartum hemorrhage for use during home births;
- Providing early detection of at-risk births; and,
- Scaling up a pilot program to distribute free pregnancy testing services as a way to increase the use of contraceptives among potential clients.

Other innovative procedures include the use of delivery systems to ensure that clients with limited access can be transferred rapidly to clinics and hospitals, and the availability of socially-marketed products to CHVs in remote areas. Recently, an mHealth CHV reporting system was implemented that allows CHVs to report results and commodity stocks and confirm nearby stock availability.

Perhaps most importantly, CHVs can increase the availability of and access to life-saving primary health care services to rural and remote populations. While the CHV system exists all over the country, CHVs receive training through the support of the donor program that operates in their region.

CHVs Bring Fast-Working Medicines to Help Prevent Infections in Newborns and Reduce Maternal Mortality

To accelerate progress in reducing under-five mortality and address one of the leading causes of maternal mortality in Madagascar, USAID pioneered the introduction of two innovative, life-saving, community-based interventions: chlorhexidine to prevent umbilical cord infection, and misoprostol to prevent postpartum hemorrhage (PPH). In FY 2014, as part of the pilot program, the USAID-funded MAHEFA and MIKOLO projects trained 559 CHVs in the use of chlorhexidine for umbilical cord care in two districts of Madagascar; home visits by CHVs have helped to introduce this medicine. In a similar pilot program in 2014, CHVs distributed misoprostol for PPH prevention. Based on lessons learned from the introductory study and advocacy by USAID and its partners, a new national policy has enabled the scale up of the program. USAID is expanding community distribution of misoprostol in all 15 regions where its community health programs are operating.



Erika, in her 8th month, receives counseling about Misoprostol and Chlorhexidine before her delivery, in Antanamiketrika Community, SAVA Region, MAHEFA Project.

Image Credit: Tahiana Andrianosa

CHVs' Distribution of Pregnancy Test Kit Results in an Increase in the Number of New Contraceptive Clients

While the use of modern contraceptive methods can substantially reduce maternal mortality and morbidity by preventing unintended pregnancies and ensuring birth spacing, many women in remote rural areas of Madagascar have difficulty accessing contraceptive methods. To improve access to contraceptives in difficult-to-reach areas, CHVs distribute hormonal contraceptives. However, before offering these contraceptives, the volunteers must first determine the client's pregnancy status but often lack a reliable way to do so. Because of this situation, non-menstruating women are denied service until their next menses and they may become pregnant in the interim. To address this issue, a recent USAID/Madagascar randomized control trial found that low-cost, accurate urine pregnancy tests are a simple tool that can be used to rule out pregnancy for some women and help increase access to same-day provision of family planning methods. Madagascar is one of the first (and perhaps one of the only) countries in Africa using pregnancy tests with CHVs.

The trial found a statistically significant increase (24%) in the number of new contraceptive clients among CHVs who had offered free pregnancy test kits to ascertain that their clients were not pregnant. There was also a strong uptake (27% increase) in the number of clients obtaining injectable contraception per month among women in the intervention group as compared to those in the control group.

Pregnancy test kits require minimal training, are easy to administer, and, at under \$0.10 per unit, are low-cost. The trial proved that the use of CHVs is an effective approach that leads to increased family planning methods (such as hormonal oral and injectable contraceptives) among potential clients. USAID partners are scaling up this community-based intervention to 15 regions.

Source: A. Comfort, et al. 2015.

Transport and logistics are among the major challenges that CHVs face in performing their tasks. Many CHVs work in locations that are largely inaccessible by road, making it difficult and sometimes impossible to get clients to emergency care at the nearest CSB or hospital. To address this issue, the USAID projects have been involved in testing innovative transport solutions such as motorized cyclo-pousse ambulances, bicycle ambulances, wheeled stretchers, and canoe ambulances that are funded by emergency transport insurance schemes. Each family pays about \$0.10 per month for the insurance. This demonstration activity makes emergency transport services available to over 42,500 people. Thanks to the actions of the CCDS, one of the most tangible

improvements is an evacuation system to take patients to the CSB with the community organization's support, using local transport (such as a rickshaw, porters, or other means) (see text box).

Reliable access to commodities on a timely basis is also essential for CHVs to provide health products and services. The volunteers acquire commodities through a network of more than 1,080 commune-level supply points. CHVs provide antibiotics for pneumonia treatment; diarrhea treatment kits; malaria testing using rapid diagnostic tests; artemisinin-combination therapies for malaria treatment; point-of-use water purification solutions; and cycle beads, condoms, and oral and injectable contraceptives. Most products are socially marketed, and

CHVs sell them at a highly subsidized price in their communities. However, it is a continuing challenge to bring these products to CHVs and to their clients who live in very remote communities. Hovercrafts are providing an innovative way to assist CHVs to meet this challenge (see text box next page).

COMMUNITY ENGAGEMENT

Community engagement has always been at the core of the USAID-funded health, nutrition, and WASH programs in Madagascar. Given that the Santénet2, MAHEFA, and MIKOLO projects have focused on reaching populations in remote rural areas, involving communities to take control of their health needs has been critical to their success. In addition, in a cross-sectional study, CHVs reported that official recognition in their communities was an important benefit in their work.

Beginning with the Santénet2 project, the *Kaominina Mendrika Salama* (KMS) approach—developing certified champion communes that reach agreed-upon health indicators—has been used to empower communities and make health services accountable (see text box). KMS seeks to strengthen participatory community development by: 1) setting up an organizational framework that includes establishing a social development committee in each community, and 2) building the capacity of local leaders.

Operating alone and often disconnected from official health facilities, it is not easy for CHVs to do their work. However, the Santénet2 Project's participatory community-based approach provided them with significant support, successfully building healthier communities by working in concert with community members. With this approach, the community was included in all decision-making processes. For example, in the 800 communes where Santénet2 worked, 11,483 community evaluation meetings were organized from 2010 to 2012, to allow beneficiaries to express their health needs.

The follow-on project to Santénet2, MAHEFA, uses an adapted version, KMSm (Champion Communes for Health), to give CHVs purpose and direction; it continues to reap positive results. Through KMSm, CHVs are connected to local health committees

A CHV Responds to a Middle-of-the-Night Call for Emergency Transport

With a newborn baby who was having difficulty breathing, a young mother who had just given birth in her home called on her CHV in the middle of the night for help. The family lived in Tanambao Marofotra, in Morondava district (4 km away from a CSB and 12 km from the district hospital). Working with the MAHEFA Project, the CHV organized the baby's transfer by bicycle-ambulance. The baby was taken to the nearest CSB, but as he needed oxygen, he was transferred to Morondava Hospital with the same bicycle-ambulance, as no bush taxis were available. 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.



Image Credit: Robbin Hammond

Robin Erninesy, bicycle ambulance driver in Bemanonga Community, Menabe Region.

(COSANs) and go through a process of health planning, self-monitoring, and community-level evaluations. MAHEFA's Regional Director for Menabe, Dr. Echah Mady, explained: "KMSm is about teamwork. Through periodic coordination meetings between us, NGO partners, COSAN members, and CHVs, we exchange experiences, boost commitment, share performances, identify bottlenecks, and adopt new strategies."

Using Hovercrafts to Boost Commodity Access and Availability for CHVs

USAID partners piloted the use of hovercrafts to improve commodity access and availability to help CHVs and their clients in isolated areas. Hovercrafts are ideal for very specific geographical conditions such as rivers that are prone to significant changes in depth. Seasonal rivers can often be just a few centimeters deep and impassible by boat. Hovercrafts can traverse these conditions easily because they hover just above the surface, reaching distant communities. The pilot program also established additional supply points to reduce the travel distance and time spent for CHVs to restock their commodities.



Image credit: Fanja, MIKOLO Project.

A quantitative evaluation conducted to measure the intervention's impact found very positive results. By the final evaluation, all the CHVs in the seven pilot communes had been resupplied and stockouts at the CHV level were dramatically reduced. The number of family planning users in the pilot district was more than three times that of the comparison district. Likewise, the number of children with fever who were treated within 24 hours in the pilot district was double that of the comparison district. The quarterly hovercraft delivery to the two most difficult-to-reach communes served approximately 16,800 women of reproductive age and 11,200 children under five years of age who would otherwise had no access to basic health services

Using the KMSm process, as of September 2014, 275 (out of 279) communes had achieved champion status; 983 fokontany had completed the community scorecard process to measure client and community satisfaction, and about 75% of users reported being satisfied with CHV service quality. There were 21,099 members enrolled in a community health insurance program in 23 communes, and 181 committee members trained in community health insurance management.

The MAHEFA Project has expanded the reach of CHVs in the process of improving local communities' access to health, water, and sanitation products and services; its approach goes beyond identifying and training CHVs to ensure that each CHV has a commune-level *Technicien Accompagnateur* (accompanying technician) and *Point d'Approvisionnement* (supply point) to ensure close support and access to products. The core health services are complemented not only by the behavior change and quality improvement services, but also by transport, community health insurance, and community engagement activities to allow people work together to address a variety of challenges and achieve better health.

Continuing on the path begun by Santénet2 and followed by MAHEFA, the MIKOLO Project works in 6 of Madagascar's 22 regions, reaching a population of about 5.5 million. The project initially conducted a situational analysis to identify the state of community health services. CHVs were found to be present and providing a limited number of services. However, they had not had refresher training in



Image Credit: Fanja, MIKOLO Project.

Children in Talata Ampano take up the hand-washing habit.

Using the Certified Champion Communes Approach to Make Health Services Accessible to All

To apply the KMS approach, SantéNet2 contracted with 16 implementing partners—3 international organizations and 13 local NGOs. The KMS approach puts communities at the center of a process for assessing needs and planning, and implementing interventions to improve community health. The Community Led Quality Management (CLQM) system was developed and embedded in the KMS approach, establishing a large-scale CHV training strategy that is associated with the creation of supervisory teams to support communities and CHVs. The approach also included the “learning for performance” methodology to conduct participatory planning at the community level.

several years. Consequently, to ensure provision of community-based health services in areas located at more than 5 km from the nearest health center, MIKOLO conducted refresher training with 4,489 CHVs. To motivate the CHVs and the community to improve their living conditions and invest in their health needs, the project established the SILC, a community-based savings and loan system, described later in this report. The project’s approach is strengthening CHV skills, knowledge, tools, and mo-



Image Credit: MAHEFA Project.

A CHV counsels mothers in a hut, Besalamp district, Melaky region.

A Champion Commune Takes Health Matters into its Own Hands

Located along the Tsiribihina River, the Tsimafana commune, population 10,000, is often wet and flooded. Hanta Marie Hélène, a CHV trained in 2011, explained: “In 2012 my baby girl often had high fever, as did many other children in my village. I think it was malaria, but I could not be sure. I wanted to help her and other mothers, but did not know how.”

MAHEFA launched the champion communes approach in Tsimafana in June 2012. A year later, Tsimafana became a certified community. Through regular reviews with its partner NGO, MAHEFA found that all CHVs had largely achieved their targets, which are based on population size and demographic statistics provided by the Ministry of Health. As of September 2013, health workers were able to reach over 4,000 men and women with awareness raising on malaria, WASH, and nutrition.

The statistics say it all: 1,200 children diagnosed with fever have been tested for malaria in Tsimafana, out of which 80% tested positively and were treated. Thanks to the supply point put in place that sells anti-malaria medication, CHVs were able to access and prescribe the medication to children and infants diagnosed with malaria.

CHVs in Tsimafana are now connected to locally define the commune’s goals for improving health. “We were able to avoid a malaria outbreak,” a CHV stated at the official certification ceremony. Dr. Echah Mady added, “By connecting CHVs to other actors and restoring the culture of target-based performance, we have been able to record champion results.”



Image Credit: A. Ramadany.

Members of a water users association in front of a well built in MAHEFA Melaky.

tivation to provide health services that comply with quality standards and behavior change messages.

Youth Peer Education

All three projects integrated youth peer education as part of their community outreach strategies, often connecting youth to the CHV services. Under the MAHEFA Project, for example, a key part of the youth approach is linking youth peer educators (YPEs) with CHVs in their communes who are also trained in providing services to youth, including family planning/reproductive health methods and counseling. This linkage provides a foundation for YPEs to refer youth needing services to CHVs, as well as being able to refer them to CSBs.

The midterm evaluation of the MAHEFA Project reported outcomes that included fewer childhood illnesses and greater uptake of family planning, more vaccinations, and more people practicing good hygiene.

A MIKOLO Project goal is to include young people in decision making about their health. CHV trainers are trained in modules that include a youth approach. As part of this strategy, the project trained



A youth peer educator conducting a home visit in Vohemar district, SAVA region.

114 YPEs in 19 communes in youth and adolescent reproductive health in 2014, with the goal of empowering them to set up and lead youth groups. Similarly, the project trained 111 women leaders to set up groups of model women.



CHV and child.

Image Credit: MIKOLO Project.

SUSTAINABILITY

Achieving program sustainability after USAID funding ends is a continuing issue in development, however, Santénet2 established systems and procedures that continued to flourish even after its USAID funding ceased.

From 2007 to 2013, USAID/Madagascar's Santénet2 project equipped and trained about 11,200 CHVs in rural and remote villages of Madagascar. Remarkably, nine months following the end of the project, CHVs continued to provide services and demand for these services continues to increase. The Santénet2 final evaluation found that 90% of women of reproductive age in the former project areas reported receiving at least one service from a CHV. This evidence highlights the sustainability of USAID's community health programs. The CHVs are continuing to provide services in areas where USAID support has ended but where health commodities are still made available.

In a spirit of mutual respect, Santénet2 and its partners collaborated with communities to identify, recruit, and train CHVs. The communities played a critical role in CHV program sustainability. The community's involvement, as well as their ongoing support of CHVs, contributed to the proper operation and sustainability of community services. Santénet2 trained and supported two CHVs per fokontany—a Mother Health CHV and a Child Health CHV—and helped find replacements in the case of dropouts.

CHVs served as an important link between the villagers and their health center (CSB). As a result, the project not only had an impact on the health sector, but its influence was also felt in the overall community development and the welfare of families.

Following in the footsteps of Santénet2, the MAHEFA and MIKOLO projects are showing positive results. In the December 2014 MAHEFA midterm evaluation, CHVs noted positive health outcomes as a result of the sensitizations they conducted in their communities in all but one focus group discussion. Outcomes included fewer childhood illnesses, greater uptake of family planning, more vaccinations, and more people practicing good hygiene. Messages regarding maternal and child health and family planning resonated more strongly with the community, while WASH topics were more difficult to convey in a manner that made changes in the population's activities. The CHVs' ongoing practical training has strengthened their skills in family planning and reproductive

health; the impact can be seen in the increased number of clients in these areas.

The mayors of communes were very positive about the MAHEFA Project's impact and noted many positive outcomes, including the proximity of CHVs for people seeking care, affordable drugs and medications, a move away from traditional medicine, better data on health events, better sanitation, and decreased morbidity. Interviews with CSB directors revealed a broad appreciation for the sensitization work that the CHVs carried out. Community members readily seek out CHV assistance before they become very ill because of the CHVs' proximity to the community and their expertise, increasing the likelihood of positive health effects.

When the MIKOLO Project began in 2013, it was charged with rapidly resuming community-based service provision of primary health care services in its first year. When these activities resumed in March 2014, almost 5,000 people—local authorities, religious and traditional leaders, and representatives of various associations working in the communes—participated in the commune-led advocacy meetings, underscoring the strength of the communities and their interest in promoting positive health outcomes. The MIKOLO Project's 2014 situational analysis of 375 communes in Madagascar found that almost all of the CHVs interviewed were still providing services and wanted to continue to do so; more than 70% still had commodities on hand. This evidence further highlights the sustainability of USAID's community health programs.

CHVs Are Working with Families to Promote Positive Behavior Change

In 2014, in the Morafeno fokontany in the rural commune of Fanambana, a CHV encouraged a young couple, André and Anicette, who had three children, to become a Care Group couple. A Care Group household must "adopt" a minimum of three families with whom they work for at least a month to encourage positive behavior change. André and Anicette were using a family planning product and began to work with couples from nine households who then adopted a family planning method. Currently they are working with another five families to 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 "snowball" effect in André and Anicette's community.

The chance of sustaining project-facilitated health improvements is greatest when local system actors have sufficient capacity and viability to carry out the key tasks needed to produce key health outcomes within an enabling environment.

Sarriot et al. 2008.

A Trustworthy CHV Is an Important Pillar of the Community



Image Credit: MIKOLO Project.

At 56, Sabotsy Florine seems younger than her age. She is an important leader in promoting health in the fokontany of Bonaka in eastern Madagascar and a key reason why her services have continued since 2007. The community elected Florine to be a CHV because of her friendly and helpful character. She has been the mother community agent since 2007 and took courses on community worker services for children in 2009. Florine was also one of the 4,330 community workers who received cross-training by the MIKOLO Project in June 2014 to upgrade their skills into full-service CHVs. This training upgraded CHVs' knowledge and their capacity to be a polyvalent CHV (that is, able to treat childhood illnesses and provide counseling and contraceptives to women of reproductive age).

With this training, Florine is better equipped and truly committed to meet the health needs of the people of Bonaka and in the larger commune. People come to see her from other towns. She has the respect and confidence from the head of the CSB because of her professionalism and performance. She follows 50 regular family planning users and receives a new client each month, higher than the CHV monthly average of 32 regular users. The community is grateful for her services.

"I love what I do even if I do it voluntarily. My greatest joy is to see people healed and healthy thanks to my small contributions," Sabotsy Florine said smiling. Her activities are not limited to consultations. She also organizes awareness sessions on hygiene and sanitation issues, family planning, seasonal topics, and vaccinations. Sessions are organized through home visits, group discussions, and public meetings. Florine takes these activities to heart because she knows their importance. "To all the CHVs, let's be trustworthy. Greet people with smiles if you want to succeed and help others," says Florine.

CHALLENGES

Regional coordinators noted that the capacity to manage stock varies among the CHVs and that occasional stockouts occur. The MIKOLO Project is addressing this problem by establishing a SILC that will provide funding to keep medicines in stock. The strategy is to train SILC technicians who will identify and train field agents who will, in turn help establish SILCs in the communities. However, a group of CHVs recently came together on their own initiative to form a SILC to raise funds for local medicines.

CHVs also face issues involving motivation, supervision, training, referral systems, and compensation; they must ensure cultural sensitivity and good community relations, and coordinate program and health system efforts as well as address sudden political crises. The MIKOLO Project is addressing many of these challenges in its approach, providing enhanced group and increased on-site supervision, quarterly data reviews, evaluation and certification of CHVs, and introducing CHV peer supervisors.

Another major hurdle that CHVs confront in their efforts to promote better hygiene and sanitation are



Image Credit: Tahana Andriantsoa.

Mutuelle de Santé members meeting in Bobatsirevo community, SAVA Region.

CHVs Build a SILC to Ensure the Local Availability of Medicine

In Beravy Haut fokontany, 7 km from the main road, in the southern part of Madagascar, CHVs are helping their communities to ensure medicines remain available and improve their health. To satisfy demand, the CHVs founded the AC MIRAY group as part of the SILC. The AC MIRAY group was created by 18 CHVs, including 6 women and 12 men, following the refresher training that the MIKOLO Project provided. The group follows the SILC standards and was acknowledged by the CCDS. A SILC technician helped the members form the group. The group began organizing the savings account through the frequent meetings that they organize for members, with credit beginning in late 2014.

For CHVs, being in an AC MIRAY group is an opportunity to create a fundraising activity as most of them work as volunteers or in farming. The SILC is also a way to assist CHVs so that they can sustain their health products and avoid stockouts.

According to the implementing NGO's technician, this SILC was not supposed to be in place just one year after the program began. Despite the long distance between the CHV sites, the CHVs proved that it is possible to achieve good results as long as there is good will, community commitment, and dedication.

deeply entrenched social norms that are resistant to change, particularly those related to water and sanitation—such as eliminating open defecation, promoting latrine construction, and making hand-washing a routine exercise. To help make these important social changes, CHVs are involved in



Image Credit: Robbin Hammond.

CHV Helena measures the mid-upper arm circumference of Angeline's son, Bemanonga Community, Menabe Region.

Community-led Total Sanitation (CLTS), which was launched in Madagascar in 2000. This remarkably successful approach catalyzes communities to construct unsubsidized latrines and improve handwashing practices. Social pressure, mutual support, and appropriate local solutions lead to greater ownership and sustainability. Once all households have a latrine, the community is recognized with an open defecation-free (ODF) certification. Initially, however, many of the newly built latrines did not meet the definition of an improved latrine, thus increasing the risk that it might not be maintained. Now CLTS is linked to the construction and sale of low-cost, washable, hygienic latrine floor slabs. Local masons are trained to produce and market the slabs, and village savings and loan associations are established to generate capital so community members can purchase the slabs. CHVs also support the WASH activities through information, education and communication activities, and materials such as posters that promote key WASH messages.

Making a Difference in Water, Health, and Sanitation

Working with the communities, 1,169 local CLTS facilitators (also volunteers) were trained by MAHEFA-supported CLTS trainers who conducted 710 triggering events in six regions. As a result of these events, a total of 3,621 latrines were constructed, of which 247 are improved latrines with washable slabs. There were 76 sites that were self-declared ODF and 3 of which officially declared ODF by a regional committee in Menabe Region.

Working with the MAHEFA Project, a local women's group ensured that all 102 households would have access to a latrine; now there are three latrines for each household. Handwashing stations are widely visible. The community is clean and proud of it.

LESSONS LEARNED AND NEXT STEPS

CHVs in Madagascar face many challenges but since 2008, the three USAID-funded projects have helped them to improve their service delivery, grow in numbers, extend their reach, involve and empower community members, and ultimately, bring positive changes to the health and welfare of many Malagasy people.

To move forward and continue in this upward trek, lessons learned from the projects can help inform next steps:

- **CHV support programs** were found to be strongest in recruitment, initial training, community involvement, advancement opportunities, and documentation and information management. Future efforts should seek to sustain these strengths and address identified weaknesses in equipment and supplies, individual performance appraisal, and country ownership. Filling these gaps presents opportunities for shared learning, greater coordination between stakeholders, and the application of improved methods to develop and test interventions to address programmatic weaknesses and improve the effectiveness and sustainability of CHV programs.
- **Ongoing trainings** should continue to build skills among CHVs, not only around service delivery, but also in supply chain management and using effective ordering procedures as a mechanism to reduce the number and duration of stockouts. In addition, other factors affecting the supply chain should be addressed—such



Image Credit: Fajna S. MUKOLO Project.

In June 2015, 10 CHVs in the Ambalakely rural commune were certified during a ceremony attended by U.S. Ambassador Robert Yamate.

as ensuring the presence of supplies in central stores and optimizing mechanisms for transporting supplies to CHVs. Lessons may also be gleaned from experiences in other countries.

- **Linkages with the formal health system** at all levels should be strengthened, including those with respect to the referral system. Training should be conducted, with CHVs encouraged to refer clients in need of services to the health system. Health system providers should also be trained to provide counter-referrals to ensure continuity of care and follow-up for their clients. Other forms of more direct communication could also be developed and supported to enhance the links between CHVs and health facilities.

BIBLIOGRAPHY

- Adamchak, S., et al. 2014. "Mid-Term Evaluation of Malagasy Heniky ny Fahasalamana (MAHEFA) Program." FHI 360, Durham, North Carolina.
- ADAPT / CAETIC Consortium. 2014. "Community Healthcare SANTENET2 Project Final Evaluation." USAID/Madagascar, Antananarivo, September. USAID.
- Agence CAPSULE. 2015. "Outcome Monitoring Survey in the MAHEFA Areas." USAID/Madagascar, Antananarivo.
- ASH (African Strategies for Health). 2015. "Community Health Worker Incentives in Madagascar: Lessons Learned." USAID/Madagascar, October.
- Agarwal, A., M. Gallo, and A. Finlay. 2013. "Evaluation of the Quality of Community-Based Integrated Management of Childhood Illness and Reproductive Health Programs in Madagascar." USAID/Madagascar, Antananarivo, February.
- Comfort, A., et al. 2015. "Providing Free Pregnancy Test Kits to Community Health Workers Increases Distribution of Contraceptives: Results from an Impact Evaluation in Madagascar." *Contraception* 2015, Elsevier, September 17.
- JSI Research & Training Institute. 2014. "In Review: A Summary of MAHEFA'S Fourth Program Year, October 1, 2013 – September 30, 2014." Flyer, USAID/Madagascar, Antananarivo.
- . 2011. "MAHEFA Annual Report, Program Year 1: May 23, 2011 – September 30, 2011." USAID/Madagascar, Antananarivo.
- JSI Research & Training Institute, Inc. in collaboration with The Manoff Group and Transaid. 2012. "MAHEFA Annual Report, Program Year 2: October 1, 2011 – September 30, 2012." USAID/Madagascar, Antananarivo.
- . 2013. "MAHEFA Annual Report, FY2013: October 1, 2012 – September 30, 2013." USAID/Madagascar, Antananarivo.
- . 2014a. "MAHEFA Annual Report, FY2014: October 1, 2013 – September 30, 2014." USAID/Madagascar, Antananarivo.
- . 2014b. "MAHEFA Annual Report FY 2014: October 2013 – September 2014: Annexes." USAID/Madagascar, Antananarivo.
- . 2015. "MAHEFA Annual Report FY 2015: October 1, 2014 – September 20, 2015." USAID/Madagascar, Antananarivo.
- Kolesar, R. 2014. "PSI Commodity Distribution Figures." Presentation at USAID/Madagascar, Antananarivo, March.
- Ratovo, H., et al. 2015. "Outcome Monitoring Survey in the MIKOLO Project Intervention Zones." USAID/Madagascar, Antananarivo.
- RTI International. 2009. "USAID/ Santénet2 Annual Report No. 1, October 2008 – September 2009." USAID/Madagascar, Antananarivo.
- . 2010. "USAID/ Santénet2 Annual Report No. 2, October 2009 – September 2010." USAID/Madagascar, Antananarivo.
- . 2011. "USAID/ Santénet2 Revised Annual Report No. 3, October 2010 – September 2011." USAID/Madagascar, Antananarivo.

- . 2013. “Santénet2 Final Report, July 2008 – July 2013.” USAID/Madagascar, Antananarivo, July.
- Sarriot, E. et al. 2008. “Taking the Long View: A Practical Guide to Sustainability Planning and Measurement in Community-Oriented Health Programming.” Macro International Inc., Calverton, Maryland.
- Smith, S. C., et al. 2013. “Community Health Volunteer Program Functionality and Performance in Madagascar: A Synthesis of Qualitative and Quantitative Assessments.” Research and Evaluation Report. University Research Co., LLC (URC), Bethesda, Maryland.
- Strengthening Health Outcomes through the Private Sector (SHOPS) Project. 2014. “Pregnancy Tests Increase Contraceptive Clients among Health Workers: Evidence from a Randomized Controlled Trial in Madagascar.” *Research Insights*. Abt Associates Inc. for USAID/Madagascar, Antananarivo, June.
- USAID/Madagascar. 2014a. “Ending Preventable Child and Maternal Deaths: 10 Innovation Highlights from Madagascar.” USAID/Madagascar, Antananarivo.
- . 2014b. “USAID 30th Anniversary.” USAID/Madagascar, Antananarivo, December.
- Wiskow, C., et al. 2013. “An Assessment of Community Health Volunteer Program Functionality in Madagascar. Technical Report.” USAID Health Care Improvement Project, University Research Co., LLC (URC), Bethesda, Maryland.
- Yanulis, John. 2013. “Primary Health Care Project: Annual Progress Report: Period: 1 August to 30 September 2013.” USAID/Madagascar, Antananarivo.
- . 2014a. “MIKOLO Annual Report, October 1, 2013 to September 30, 2014.” USAID/Madagascar, Antananarivo.
- . 2014b. “Situation Assessment in 375 Communes.” USAID/MIKOLO for USAID/Madagascar, Antananarivo, February.



Image Credit: MIKOLO Project.

CHV and child.

A 2011 Santénet2 /IntraHealth report examining CHV training and support praised the role of CHVs and the community in improving health, stating: "...the community seems to show a strong commitment, and CHVs serve as an important link between the villagers and their CSB."

Front cover: CHV and youth peer educators conducting education on family planning methods in Soamahavelo Fokontany, Menabe Region.

Image credit: Robbin Hammond.

Writer: Dina Towbin

Design and Layout: IBI

Produced for USAID/Madagascar under Global Health Program Cycle Improvement Project (GH Pro) Contract No.AID-OAA-C-14-00067.



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November 2015