

# **Child Survival XVIII**

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## **Toamasina II & Vavatenina Districts, MADAGASCAR**

**Cooperative Agreement GHS-A-00-03-00008-00**

**October 1, 2003 – September 30, 2007**

## **ANNUAL REPORT 2003 -2004**

**Submitted by**



**ADRA Madagascar**

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In collaboration with ASAP Staff

## GLOSSARY and ACRONYM LIST

<b>ADRA</b>	Adventist Development and Relief Agency
<b>ALPHA</b>	One of ASAP's local radio stations chosen to broadcast health messages, it serves only the Vavatenina district
<b>ANC</b>	Antenatal Care
<b>ARI</b>	Acute Respiratory Infection
<b>ASAP</b>	Ankohonana Salama Project ("Healthy Family Project"; the acronym ASA means "work" in Malagasy)
<b>ASBC</b>	Agent de Santé de Base Communautaire (Community-based health volunteer under the TCSP, primarily doing family planning promotion)
<b>BEOC</b>	Basic Essential Obstetric Care
<b>BPP</b>	Birth Preparedness Plan
<b>C-IMCI</b>	Community-IMCI
<b>CARE</b>	Cooperative Assistance and Relief Everywhere, Inc.
<b>Carnet de santé</b>	Health booklet for immunization records, clinic visits, etc.
<b>CASC</b>	Commune-based health management committee
<b>CBD</b>	Community Based Distributor
<b>CDD</b>	Control of Diarrheal Disease
<b>CHA</b>	Community Health Agent
<b>CHD</b>	Referral Hospital at the District Level
<b>CISCO</b>	Circonscription Scolaire (administrative district for schools)
<b>COPE</b>	Client-Oriented, Provider Efficient
<b>COSAN</b>	Health compliance committee at the level of the fokontany
<b>CQ</b>	Chloroquine
<b>CRENA</b>	Center for Recuperation & Nutritional Education (Outpatient)
<b>CRENI</b>	Center for Recuperation & Intensive Nutritional Education (Inpatient)
<b>CRS</b>	Catholic Relief Services
<b>CS</b>	Child Spacing or Child Survival
<b>CSB I</b>	A community health center with no doctor, and only basic services
<b>CSB II</b>	A community health center with a doctor, and more extensive services
<b>CSHGP</b>	Child Survival Health Grants Program
<b>CSSA</b>	Child Survival Sustainability Approach
<b>CSTS</b>	Child Survival Technical Support
<b>CtC</b>	Child-to-Child
<b>DIP</b>	Detailed Implementation Plan
<b>DPS</b>	Provincial Health Administration Office
<b>DPT</b>	Diphtheria/Pertussis/Tetanus vaccine
<b>EMAD</b>	Equipe de Management de District, SSD District Management Team
<b>ENAs</b>	Essential Nutrition Actions
<b>EOC</b>	Emergency Obstetric Care
<b>EOP</b>	End of Project
<b>EPI</b>	Expanded Program of Immunization
<b>F-IMCI</b>	Facility-IMCI
<b>FGD</b>	Focus Group Discussion

<b>Fokontany</b>	Administrative unit presiding over several villages, but smaller than the level of the commune; sub-commune
<b>FP</b>	Family Planning
<b>FPO</b>	Field Project Officer
<b>FRAM</b>	Association of Parents of School Children
<b>FTA</b>	Field Technical Assistant
<b>GAINT</b>	Groupe d' Action Intersectorielle en Nutrition de Toamasina (Toamasina Region Intersectoral Nutrition Coordination Group)
<b>GM</b>	Growth Monitoring
<b>GTZ</b>	Gesellschaft für Technische Zusammenarbeit (German NGO)
<b>HH</b>	Household
<b>HIS</b>	Health Information System
<b>HIV/AIDS</b>	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
<b>HMIS</b>	Health/Management Information System
<b>HQ</b>	Headquarters
<b>HOPE</b>	Household Opportunity for People Empowerment
<b>IEC</b>	Information, Education and Communication
<b>IMCI</b>	Integrated Management of Childhood Illnesses
<b>IPT</b>	Intermittent Preventive Treatment
<b>ITN</b>	Insecticide-Treated Net
<b>IUD</b>	Intra-Uterine Device
<b>JSI</b>	John Snow Incorporated (Jereo Salama Isika, Malagasy)
<b>KPC</b>	Knowledge/Practice/Coverage (Survey)
<b>LOP</b>	Life of Project
<b>LQAS</b>	Lot Quality Assurance Sampling
<b>MATEZA</b>	One of the local NGOs
<b>MCDI</b>	Medical Care Development International (INGO)
<b>MCH</b>	Maternal and Child Health
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MNC</b>	Maternal and Newborn Care
<b>MoH</b>	Ministry of Health
<b>MOU</b>	Memorandum of Understanding
<b>MTE</b>	Mid-Term Evaluation
<b>MWH</b>	Maternal Waiting House
<b>NGO</b>	Non-Governmental Organization
<b>NAC</b>	Nutrition à Assise Communautaire (UNICEF's community nutrition program)
<b>NID</b>	National Immunization Day
<b>Olo-maventy</b>	"Elders"
<b>ORS</b>	Oral Rehydration Solution
<b>ORT</b>	Oral Rehydration Therapy
<b>OTJ</b>	On-the-Job (Training)
<b>PaluStop</b>	Pediatric, pre-packed anti-malarials of correct single treatment
<b>PCV</b>	Peace Corps Volunteer
<b>PD</b>	Project Director

<b>PHN</b>	Population, Health and Nutrition
<b>PRA</b>	Participatory Rural Appraisal
<b>PSI</b>	Population Services International
<b>PVO</b>	Private Voluntary Organization
<b>QA</b>	Quality Assurance
<b>QI</b>	Quality Improvement
<b>RH</b>	Reproductive Health
<b>RFT</b>	One of ASAP's local radio station chosen to broadcast health messages in Tamatave I and Tamatave II
<b>SALAMA</b>	MoH central-level supplier of essential medicines
<b>SCM</b>	Standard Case Management
<b>SD</b>	Standard Deviation; also <b>sd</b>
<b>SEECALINE</b>	Surveillance et Éducation des Écoles et des Communautés en matière d'Alimentation et de Nutrition Élargie (A food distribution project funded by the World Bank to improve nutrition inside schools and communities)
<b>SM</b>	Safe Motherhood
<b>SP</b>	Sulfadoxine Pyrimethamine; Fansidar (Paludar, in Madagascar)
<b>SSD</b>	District Health System
<b>STI</b>	Sexually Transmitted Infection
<b>Stratégie Avancée</b>	MoH's outreach strategy to reach remote areas w/ immunization services
<b>Sur'Eau</b>	One of PSI's Social Marketing Products used in purifying water
<b>Tamatave</b>	Name for Toamasina under colonialism; still commonly used
<b>Tangalamena</b>	Village spokesman (traditional)
<b>TBA</b>	Traditional Birth Attendant
<b>TCSP</b>	Toamasina Child Survival Project (Oct 1998-March 2003)
<b>TIPs</b>	Trial of Improved Practices (approach to promotion of improved nutrition)
<b>TMM I</b>	Toamasina I or the town of Toamasina
<b>TMM II</b>	Toamasina II District
<b>ToT</b>	Training of Trainers
<b>TRMs</b>	Technical Reference Materials
<b>UNICEF</b>	United Nations Children's Fund
<b>UNFPA</b>	United Nations Population Fund
<b>USAID</b>	United States Agency for International Development
<b>VISA 5/5</b>	Innovative, school-based vaccination promotion campaign
<b>VS</b>	Vohary Salama
<b>VVT</b>	Vavatenina District
<b>WRA</b>	Women of Reproductive Age (15-49 years)

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## Executive Summary

The ANKOHONANA SALAMA PROJECT (ASAP)" was implemented in the district of Toamasina II (TMM II) and Vavatenina (VVT), under Cooperative Agreement/Grant No: "GHS-A-00-03-00008-00", with a joint funding by United States Agency for International Development (USAID) and Adventist Development and Relief Agency (ADRA) International. The project was supposed to start beginning October 1, 2003. However, due to some unavoidable circumstances, such as the fact that the Project Director had not been appointed by that date, the program officially began on December 1, 2003. This report is part of the Implementation Agreement between ADRA International and the Implementing Office in Madagascar, and it describes in detail the circumstances surrounding the successes and failures of the activities which took place during the fiscal year beginning October 1, 2003 and ending September 30, 2004.

ASAP, which is a follow-up of activities established by Tamatave Child Survival Project (TCSP) in the district of Tamatave II (TMM II), has begun its activities first in TMM II and is slowly starting to expand to the neighboring district of Vavatenina (VVT), which borders the northwest corner of the current project area. Both districts are in Toamasina Province, which is located in the central east coast region of Madagascar. The two districts are extremely poor and populations depend largely upon subsistence slash-and-burn agriculture. Limited means of transport, minimal communications infrastructure and isolation are predominant in many villages and contribute to ongoing poverty and poor health indicators. The leading causes of mortality are: malaria, malnutrition, diarrhea, poor home delivery practices, hemorrhage, ectopic pregnancies, obstructed labor, rupture of the uterus and infection. Hence the main components of the project will be 60% IMCI and 40% MNC effort. The target population is 163,070.

Beneficiaries	TMM II	VVT	Total
Women of Reproductive Age (15-49)	50,776	39,959	90,735
Children Under Five Years of Age	<u>41,062</u>	<u>31,273</u>	<u>72,335</u>
Total Beneficiaries	91,838	71,232	163,070

## I. The Main Accomplishments Since the Start of the Program

### 1. Project Start-up and Initial Assessment

The project started with a rapid assessment and inventory of assets from the previous CS project. A survey of local and international partners, including those in the private and public sectors was also completed. The main findings were:

- The project office is still housed in the District Health System facilities (SSD TMM II) in Tamatav.
- Office equipment and furniture, although outdated, are still available.
- One old project vehicle is still functional.
- A few staff (Finance Officer and Courier) remained from the previous project.

- The local partners are the administrative district for schools (CISCO), and a number of NGOs, including: a Malagasy church-owned NGO named FJKM, Vohary Salama (VS), Mateza, Household Opportunity for Providing Empowerment (HOPE), Flexible Fund, and the Center for Recuperation & Intensive Nutritional Education (CRENI) (the last three are run by ADRA Madagascar). The international partners are: Cooperative Assistance and Relief Everywhere (CARE), Surveillance et Education des Ecoles et des Communautés en matière d'Alimentation et de Nutrition Elargie (SEECALINE-- a food distribution project funded by the World Bank to improve nutrition in schools and communities), PSI, UNICEF, and CRS.
- Public sector partners include: partners in all levels of the Ministry of Health (MoH), the commune-based health management committee (CASC) and health compliance committee at the village level (COSAN).

## 2. Project Staff Hiring

Staff hired for this project include the following (also, please see Annex C for Organogram):

### Technical Staff

Dr. NDIAMANANA Raymond, the IMCI Coordinator  
Dr. Holy Heritiana, the MNC Coordinator  
Dr. RAZAFIMAHEFA Sylvain Noël, the Vavatenina district Coordinator  
Dr. ANDRIAMITANTSOA Edmond, a Field Technical Assistant  
Mr. FIDINIRIACA ANDRIANANDRASANA Rakotobe, the M & E Coordinator  
Mr. Parfait Nasinto, the MIS Coordinator  
Mr. ANDRIAMIHANTA Harison Gérard Olivier, a Field Technical Assistant  
Mr. RALAHIROARISOA Marie Christophe, a Field Technical Assistant  
Mr. RAMIARAMANANAHARISON Jean de Dieu, a Field Technical Assistant

### Support Staff

Miss RAMAHEFARISON Lalaina, the Administrative Assistant and Accountant  
Miss RASAMIMANANA Tsiry Onjanahary Christiane, the Secretary/Cashier  
Mr. RABOROKAY Solohery, the Logistics Assistant  
Mr. RANDRIANARIVONY Joelimina, a driver (1)  
Mr. RAJOELIARISOA Herilala Jean, a driver (2)  
Mr. RAKOTOARIMANANA Hary Samoelinirina, a driver (3)  
Mr. RANDRIANANTENAINA Rolland, the messenger  
Mr. RAMARIKOTO, a Guard (1)  
Mr. RANDRIAMAHANDRY Joel, a Guard (2)  
Mr. RAMAHANDRY Pierroda, a Guard (3)

### Administrative Staff

Miss RAKOTOARIVELO Rosa, the Financial Officer  
MPAYAMAGURU Josué, the Project Director

### 3. Private and Public Partnership Program

One of the first moves for ASAP was to meet with key public and private partners and local community authorities in order to introduce the program and seek their cooperation. This was completed successfully as it led to the drafting of a memorandum of understanding spelling out the roles and responsibilities of selected key project partners.

### 4. Entry into Community

In February 2003, ASAP conducted the Baseline Survey (BLS) under the supervision of Mr. Joseph Hayuni, the Monitoring and Evaluation officer assigned to the ADRA Africa Regional Office. Following is a summary of the findings of the Baseline Survey of VVT compared to the KPC of TCSP.

#### Key Indicators

Scope	Indicator	Tamatave II	Vavatenina	Comment
<b>IMMUNIZATION</b>	<b>EPI access:</b> - % of children 12-23 months who have received DPT/Polio 1	47.3% (n = 133)	68.8 [n=109]	Verified from cards
	- % of children 12-23 months who have received BCG	43.6% (n =133)	73.4 [n=109]	
	<b>EPI coverage:</b> - % of children who have received DTCP3	25.7% (n = 300)	55.3 [n=300]	Verified from cards
	- % of children 12-23 months fully vaccinated	28.6% (n = 133)	33.0 [n=109]	
	<b>Measles coverage:</b> - % of children 12-23 months who have received measles vaccine	43.6% (n = 133)	59.6 [n=109]	Fully and before 1 <sup>st</sup> birthday
<b>EPI drop out:</b> - % change between DTCP1 and DTCP3 doses for children 12-23 months	19%	24.7	Verified from cards	

<b>NUTRITION</b>	<b>Initiation of breastfeeding:</b> - % of children less than 24 months who were breastfed within the first hour after birth	51.7% (n = 300)	49.3 [n=296]	
	<b>Exclusive breastfeeding:</b> - % of infants less than six months who were exclusively breastfed	45.5% (n = 91)	53.9 [n=89]	
	<b>Introduction of foods:</b> - % of infants who were being (or will be) given solid or semi-solid foods after 6 months	-	Vague definition	Vague definition
	- % of infants over 6 months that were given semi-solid foods	45.5% (n = 208)	58.0 [=205]	Computed for > 5 months
	<b>Persistence of breastfeeding:</b> - % of infants between 20 and 24 months who are still breastfed	56.3% (n = 32)	62.1 [n=29]	
	<b>Vitamin A:</b> - % of children under 2 who have received 1 dose of vitamin A in past 6 months	60.0% (n = 300)	20.5 [n=205]	For children at least 6 months old
	<b>Growth monitoring:</b> - % of children under age 2 who have been growth monitored	34.0% (n = 300)	26.3 [n=300]	
<b>CONTROL OF DIARRHEAL DISEASES</b>	<b>Continued breastfeeding:</b> - % of infants/children less than 24 months with diarrhea in the past 2 weeks who were given the same amount or more of breast milk	55.5% (n = 63)	53.9 [n=65]	
	<b>Continued fluids:</b> - % of infants/children less than 24 months with diarrhea in the past 2 weeks who were given the same amount or more fluids other than breast milk	74.6% (n = 63)	50.8 [n=65]	
	<b>ORT use:</b> - % of infants/children less than 24 months with diarrhea in the past 2 weeks who were treated with ORT (ORS or homemade 1/ 8 solution) at home	19.0% (n = 63)	21.6 [n=65]	

<b>STI/HIV/AIDS PREVENTION</b>	<b>STD – HIV prevention:</b> - % of mothers of children under 2 who can cite at least 2 methods of avoiding STI/HIV infection	25.3% (n = 154)	12.0 [n=300]	
<b>Family planning</b>	<b>Family planning use</b> - % of mothers using modern contraceptive methods	18.8% ( n = 277)	12.5 [n=275]	

**The Following Table Presents the Priority Child Health Indicators From VVT District**

INDICATOR	VALUE	
	(-2 SD)	(-3 SD)
Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	Boys: 51.8% Girls: 54.7% All: 53%	Boys: 23.5% Girls: 20.0% All: 21.7%
Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child	79.7% [n = 143] <sup>1</sup>	
Percentage of children age 0–23 months whose births were attended by skilled health personnel	21.3% [n = 300]	
Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	30.7% [n = 300] <sup>2</sup>	
Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours	53.9% [n = 89] 0-5mo.	43.0% [n = 114] 0-6mo.
Percentage of children age 6–9 months who received breastmilk and at least two complementary foods during the last 24 hours	69.2% [n = 65]	
Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	33.0% [n = 109] 25% no cards	49.5% [n = 109] incomplete records
Percentage of children age 12–23 months who received a measles vaccine	59.6% [n = 109]	
Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night. (Net verified by observation).	2.3% [n= 300]	
Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection	12.0% [n = 300]	

<sup>1</sup> Calculation of age differences was not possible for some children, due to insufficient information on birth dates.

<sup>2</sup> 166 mothers out of 300 interviewed had no cards.

Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	3.3% [n = 300]	
Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment	35.0% [n = 300]	
Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	9.3% [n = 65] children with diarrhea	

## 5. Pre-DIP and DIP Workshop Activities

The DIP workshop was preceded by one week of pre-DIP workshop activities (March 8-12, 2—4) and held in collaboration with ADRA International and with Technical Assistance from CSTS. These activities had the following three-fold objectives:

- Engage in a systematic review and examination of local health systems, approaches, priorities, gaps and potentials through the eyes of Appreciative Inquiry (AI) and a sustainability framework.
- Introduce ADRA Madagascar CS XVIII project staff to sustainability concepts and create an appropriate evaluation tool.
- Articulate and document findings, which later would feed into visioning activities critical to planning the CS XVIII project DIP.

In order to achieve these objectives, several activities were undertaken during that week:

- Lectures and discussions on the definition of sustainability and the new Child Survival Sustainability Assessment (CSSA) model
- Development and testing of data gathering tools (questions) and methods
- Creation of interview guidelines and establishment of teams for data collection
- Finalizing logistics and collecting data through interviews and document review (common knowledge, baseline surveys, final evaluation, national/regional/country health statistics)

To get first-hand information, field project sites were visited and related partners were interviewed in both Toamasina I (Toamasinaville) and II. This took place under the guidance of Mr. Karl Blanchet, Director of Handicap International, UK, who served as a facilitator and key resource person. Interviews were held with the following groups:

- Health care providers (public/private health facilities, local health authorities, community health workers, traditional birth attendants, etc.)
- Health service recipients/clients (men and women beneficiaries)
- Community groups (local government authorities such as mayors, women's groups, volunteer community organizations, etc.)

- Non-Governmental Organizations (NGOs: PSI, CARE, CRS, GTZ)

It was during this preparatory week that concepts and issues pertaining to the present health situation began to emerge. These issues and themes were further discussed, analyzed, documented, and presented as key findings during the subsequent DIP workshop. This provided one of the major resources which helped to develop collective visioning during the actual DIP workshop.

## 6. DIP Workshop Activities

On the opening day of the DIP workshop, there were approximately 60 people in attendance, including a working force of approximately 40 staff, partners and key stakeholders. Due to the presence of the high-level provincial government officials during the opening and the closing ceremonies, both Madagascar television and radio covered the DIP event. Participants included governmental officials from the district and provincial health authorities, mayors, civil servants, public education and health department workers, NGOs such as CARE, CRS, GTZ, and PSI, bi-lateral agencies like Peace Corps, a USAID Madagascar representative who attended the last two days, community representatives (Traditional Birth Attendants—TBAs), Community Health Workers (CHAs) and other health workers from both Toamasina and Vavatenina districts (Annex A DIP list of participants).

On the first day of the DIP workshop, an overview of the project was given, which covered the various partners and different actors, the work environment and the roles and expectations of the ASA Project and district health system/office known locally as Service de Santé de District (SSD). The various levels of Madagascar's health care system were described and strategies were reviewed. This was followed by an overview of the complementary areas between the ASA Project and its partners.

On the second day, Mr. Karl Blanchet, the DIP facilitator, introduced the definitions, concepts, and measurements of the CSSA framework. These were used as tools to guide in the development of a realistic project implementation plan. The afternoon began with some storytelling and drawing of personal timelines, followed by development of pictorial depictions representing each person's dream for development.

The third day began with a review of the activities and lessons from the previous day, after which the DIP participants were encouraged to brainstorm about what they



considered to be the most important dreams and visions for the future of health care in their districts. Participants were divided into three groups. Some co-facilitators worked with each group, not only to keep creativity flowing, but to also help keep the groups focused and realistic and to ensure that all suggestions were compatible with the three main dimensions that comprise the essence of the CSSA framework.

On the fourth day, after the dreams had been defined, and the availability of resources and needed tools ensured, participants began to define interventions and activities.

The following resources and tools were used:

- *Toamasina Child Survival Project (TCSP) documents*: Analysis, key findings and lessons learned, in addition to past and present statistics from the TCSP mid-term (MTE) and end of project (EOP) evaluation reports (see brief description of the TCSP, Section 2, Introduction);
- *Proposed dreams and vision* identified by other staff, partners and key stakeholders during personal interviews during the pre-DIP evaluations, and as proposed during the DIP workshop;
- *ASAP LogFrame*, outlining the goals, objectives and indicators from the original proposal; and
- *Current situation analysis* of the health context in the **Vavatenina and Toamasina II Districts** (VVT and TMM II).

Using these resources, the participants began to brainstorm about the most important and/or appropriate activities to correspond with the proposed objectives. Three groups were created and each one assigned to a component of the triangular CSSA diagram shown on page 12. The proposed dreams and activities were fine-tuned and consolidated, with development of more realistic strategies, action plans and monitoring/evaluation approaches. These were later summarized and presented to the public.

On the final day, the draft ASAP action plan was completed with the successful introduction of the Star Diagram Method (Annex D Star Diagram Indicators), which is an easy, yet efficient and effective, monitoring/evaluation approach. The workshop concluded on a high note, with top provincial governmental and USAID representatives in attendance and with the television and radio media covering the closing ceremony.

The DIP was written immediately, with the aid of a local consultant, Mr. Colin Radford. It was presented by Becky De Graaff and Dr. Ron Mataya during the Washington "Mini-University" and the final copy was submitted by ADRA headquarters in Washington.

## **7. Changes from original application**

There are no substantial changes from the program description and DIP which require modification in the cooperative agreement. Project goals, strategies or objectives, sites, targets and beneficiaries remain the same. However, one adjustment made from the original proposal was the decision to introduce the new Child Survival "Sustainability Assessment" framework developed by Child Survival Technical Support (CSTS) as described in the DIP.

## 8. Project Activity Progress

### Integrated management of child illnesses (IMCI)

#### Malaria

*Objective:* Improved prevention and treatment of malaria among children <24 months and pregnant women

*Activities already undertaken:*

- *ITNs promotion:* In partnership with PSI's new strategy of social marketing through SSD's district drug store (PHA-GE-DIS), ASAP motivates and sensitizes health agents in community-based health centers (CSBs) to regularly replenish their reserve in order to avoid stock depletion. For this reason, ASAP contacted PSI on several occasions in hopes of enhancing access to ITNs, but was unsuccessful. During the second week of October, ASAP received a delegation from PSI Madagascar. This group was headed by the Operations Director, who was accompanied by the nationwide ITNs coordinator and the Tamatave Regional Coordinator. In our discussion, PSI presented to us a new approach to social marketing. There will be marketing rates for individuals, for small community associations, and for NGOs like ADRA. In making this change, PSI plans to transfer the management of selling mosquito nets to community health centers. ASAP understood PSI's new approach to be one that will favor a long-lasting solution to the problem of availability of nets within communities. We also discussed the possibility of our CHAs obtaining nets from CSBs at \$1.25 each and reselling them at a price of \$1.50 to anyone who could afford them. Although we have not come to a firm conclusion yet, we wish to pursue this since it would serve as a motivation to the CHAs to earn a little bit of cash while sensitizing the community and distributing nets for greater coverage.
- *Radio broadcasting:* As mentioned in the proposal, ADRA has contracted the local radio station (RFT) through HOPE Project. Health messages have been scheduled, including weekly education on malaria prevention methods. ASAP will intensify these awareness-building activities this coming year when HOPE Project ends. VVT also has a local radio station (ALPHA) through which ASAP, together with SSD VVT, plans to broadcast messages and other radio spots beginning in November 2004. A theme song for the program is being composed, which will be broadcast throughout the intervention area.
- *Handouts:* In accordance with the DIP, ASAP is to increase awareness through handouts and posters, plus counseling cards for women and children. Right now, 400 posters about MNC, specifically on child spacing, have been printed and are to be distributed right after the immunization campaign. 10,000 handouts on modern family planning and IST/HIV/AIDS have been printed and will be distributed gradually. There are 5,000 copies on each subject.

- House to house visits for BCC by Field Technical Assistants (FTAs): We have opened five satellite offices in our intervention areas: four in TMM II and one in VVT. From these offices, the FTAs go house to house talking heart to heart.
- Recruitment and training of CHAs and TBAs: Following the outlined set of recruitment criteria, FTAs have identified CHAs and TBAs to be trained and deployed as our community liaisons. Part of their curriculum is malaria prevention and treatment among children < 24 months and pregnant women.

### Immunization

*Objective*: Increase the percentage of children who are fully vaccinated by their first birthday.

#### *Activities already undertaken*:

- Coordinate planning with SSDs to ensure that they have a continuous supply of mother and child cards, vaccines and IEC resources. This is done as part of our regular routine during supervision and is particularly emphasized during periodic meetings of CSB agents.
- Coordinate planning and reviews with SSDs to ensure effective functioning of their cold chain system, guarantee a regular supply of kerosene, provide replacement parts as needed, and obtain regular reports on equipment/supplies. The strong relationship between ASAP and the SSDs has facilitated communication in times of need. Hence ASAP has helped to transport SSD personnel when both organizations were conducting routine immunizations (fixed and mobile). One major concern is that this year's budget for kerosene proved to be insufficient, due mainly to inflation. At current rates, there will only be enough fuel for three to four months at most. Since this problem came to light quite recently, ASAP does not yet have a concrete solution in place. However, we are studying the question and hope to coordinate with SanteNet for assistance during the remaining months.
- Support active participation campaigns during the National Measles Campaign: Preparation for the National Immunization Campaign began in June this year and continued after National Health Week. As immunization is one major component of IMCI, ASAP took an active role:
  - a. Financial support: Both prior to and during the campaign, ASAP sponsored several local SSD efforts along highways and on local radio stations.
  - b. Logistic support: During this campaign, ASAP facilitated telephone communication in VVT. In addition, a vehicle and a driver were assigned to each SSD to facilitate supervision and provide transportation to and from the campaign sites.

- c. *Technical support*: Five ASAP technical staff actively participated in the campaign. Three served as vaccinators, one as regional supervisor, and the other helped to mobilize the remotest areas of TMM II (Ambodilazana Commune).
- Equip all CSBs with refrigerators: In preparation for the campaign, new refrigerators were added in many SSDs, including TMM II and VVT. This facilitated the immunization campaign. ASAP assisted in transporting the equipment from place to place to ensure that each CSB had a cold chain.
  - BCC training for social mobilization/immunization by the CHAs: A number of CHAs have been identified. More than 120 received training in Community IMCI and MNC while others await the next training which is scheduled for December, 2004.

### Nutrition

*Objective*: To improve the nutritional status of children under five through improved breastfeeding, weaning practices and micronutrient supplementation (specifically vitamin A).

#### *Activities already undertaken:*

The Malagasy MoH has several objectives to achieve by the end of 2005 and a variety of approaches will need to be utilized.

In cooperation with its closest partner, HOPE (Household Opportunity for People Empowerment), ASAP has broadcast many radio messages about proper nutrition practices and exclusive breastfeeding. The same messages are being adapted by Radio ALPHA in VVT where ASAP will focus its efforts during the second year. Besides house to house sensitization by the FTAs, ASAP sponsored TMM II's Nutrition Day in one of the communities.

ASAP was very active during the two annual Vitamin A Distribution Weeks, especially last September (as stated in the DIP) during the nationwide campaign against measles. CHAs have been trained in proper nutrition counseling and encourage women to make use of the Health Booklet (Carnet de Santé) which is now free under the new MoH policy and is available in all Community Health Centers. ASAP is also emphasizing Essential Nutrition Actions (ENAs) in its curriculum for CHAs and TBAs, including exclusive breastfeeding, food supplementation and intake of vitamin A, proper feeding of pregnant and lactating women, adequate intake of iodized salt, etc.

### Pulmonary Case Management (PCM) and Control of Diarrheal Disease (CDD).

*Objective:* The main objective for the control of diarrheal disease is improved home management and care-seeking for children with diarrhea and an improved treatment of pneumonia among children <24 months.

#### *Activities already undertaken:*

CHAs and FTAs have provided personal and family counseling during house to house visits, radio broadcasts have been utilized and handouts have been distributed. These activities will be intensified during the second year of the program.

### Maternal and Newborn Care (MNC)

*Objective:* The main objectives include improved overall maternal healthcare with emphasis on pregnancy, delivery and post-partum wellness, and increased use of modern methods of contraception and prevention of STIs/HIV/AIDS. This intervention also targets men in regards to involvement in pregnancy, preparations for the delivery, and discussions on child spacing, modern contraceptives and the prevention of STIs/HIV/AIDS.

#### *Activities already undertaken:*

Along this line, several ambitious objectives have been formulated by the Malagasy Ministry of Health, among which there is one that particularly concerns ASAP: the reduction of the Maternal Mortality Rate (MMR) from 488/100,000 live births (LB) in 2003 to 285/100,000 LB by the end of 2005. As mentioned on page 96 of the DIP, every effort has been made to contribute to this indicator. The main activity of ASAP is to identify and train up to 400 TBAs from remote villages who normally perform a significant number of deliveries and are more likely to perform below standard. It is hoped that once these TBAs receive training, they can help ensure safe delivery in their respective communities. Unfortunately, due to the resignation of the former Malagasy Health Minister, this activity has been suspended for some time. One of the reasons is that most of the physicians who head community health centers are not sure how they will work with the TBAs. In other words, some health agents do not believe that anything good can come from the illiterate men and women in remote areas. The ASAP team communicated with the two heads of the district health services (TMM II and VVT) to determine their feelings about the subject. The two Médecin Inspecteurs are very much in favor of training TBAs.

#### *ASAP's action:*

In spite of these obstacles, ASAP visited the Ministry of Health (Reproductive Health Service) to get first-hand information. After a one hour discussion with the service representative in charge, we understood that the Ministry of Health did not terminate this program. In other words, the policy remains the same. However, the people

responsible are developing a new approach to the TBA program to address some of the issues raised, such as lessening theory and introducing more practicum in their new curriculum. Hence, the program will continue as soon as the document is refined. Our agreement is to endeavor to come up with a common curriculum to be used beginning in 2005. Since ASAP had already developed a module for training, we are sending it to the Reproductive Health Service to be reviewed and validated, after which we hope to schedule the first trainings in partnership with the MoH representatives. Although this will depend on the final approval of the Health Ministry, ASAP hopes to begin its TBA training by January, 2005. More than a hundred TBAs have been identified, including some famous male practitioners. We believe this will add more interest to the training as they share experiences and describe how males are being accepted as village birth attendants.

While waiting for approval, ASAP decided to carry on with Information Education Communication (IEC) and Behavior Change Communication (BCC) approaches. These include radio messages to motivate people to visit Community Health Centers for Antenatal Care (ANC) and to be vaccinated. We support the program started by the WHO in some districts, including VVT where mosquito nets were distributed in accordance with the following guidelines: a) to pregnant women coming for ANC, b) to women delivering at a CSB and c) to women with children attending the growth monitoring program. This has motivated women and improved health care-seeking behavior in remote areas. ASAP seeks to work closely with the WHO under the new policy of the MOH, which targets women for free ITN distribution during ANC visits. According to the report given by Medecin Inspecteur, since July 2004, almost 3,000 mosquito nets have been distributed to this target group in VVT.

Posters have been printed for distribution in strategic places including CSBs, Communes, public market places, public schools, etc. 7000 handouts on modern family planning and STIs/HIV/AIDS have also been printed and are being distributed among the CSBs and to our CHAs as IEC supporting materials. During house to house visits, FTAs will also distribute these materials.

During the next quarter, ASAP will print more IEC materials (Gazety, Health booklets, counseling cards and more handouts along the same line of intervention). In terms of equipment support to the Ministry of Health, ASAP has distributed to the two SSDs some medical equipment worth US\$170,752.50. Please see the following table for general estimation of overall program status.

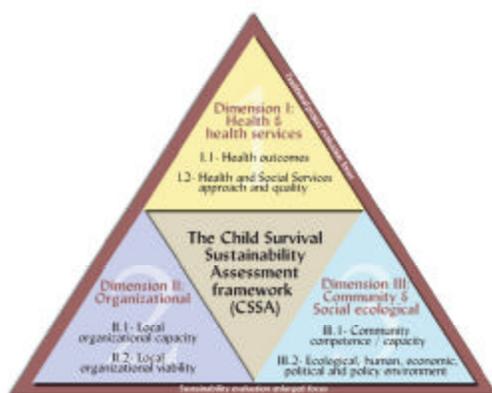
<b>Program Component</b>	<b>Overall estimate</b>	<b>Comments</b>
Building partnership with MoH / ONG	Yes	
Preparation and signature of MOU	Yes	
Negotiation with local and international stakeholders	Yes	

Hiring/staffing of personnel	Yes	
Procurement of supplies and equipment	Yes	All that was needed for the first year
Baseline survey for VVT	Yes	
In-depth situation analysis	No	Delayed due to interference with National Measles Immunization Campaign. Scheduled to commence shortly.
Formative research	No	
Participatory Rural Appraisal	No	
Nutrition intervention	Yes	Started activities
Malaria consultants	No	Looking for a consultant
Introduction of LQAS methods	No	
Training for staff capacity building	Yes	
DIP Preparation/ DIP workshop VVT and TMM II.	Yes	
DIP submission	Yes	
Management training	No	Difficult scheduling due to mandated participation in National Immunization Campaign
Interpersonal communications training/team building activities	Yes	
Technical training for FTA/refresher training for FTA	Yes	
Computer training HMIS	Partially	Training has been done in VVT and it is still to continue this year
Capacity building at SSD level	Yes	
Strategic planning workshops	No	Non-availability of participants due to Mandated National Immunization campaign
Training of trainers workshop	Yes	
CSB IMCI training	No	Non-availability of a consultant, scheduled for this quarter
CSB MNC training	Partially	Training in Modern Family Planning methods has been done in Tamatave and is to be done also in VVT
Integrated supervision trainings	No	For the current quarter
Recruitment of CHA and TBAs	Yes	
Focus group priority	No	Postponed due to mandated participation in National Immunization Campaign
CHA trainings/supervision	Yes	The first four batches have been trained and are deployed in their respective communities

TBA trainings, refresher, supervision	No	Change of Government policy, still negotiating the feasibility
COSAN trainings VVT	No	Formal training has not been done yet. However, ASAP has mobilized all local authorities in VVT and has held meetings with them to introduce the institution of COSAN. Training follows this quarter
Visa 5/5 promotion	No	When ASAP entered the community, schools had closed. Scheduled for this quarter
IEC materials development	Yes	
ADRA technical staff training	Yes	
Festivals	Yes	
Donation of medical equipment	Yes	
Active participation in EPI/Vitamin A campaigns	Yes	
Active participation in Anti-Measles campaign	Yes	Official results are not in yet. However, VVT District covered up to 95%, which is the national objective for children between 9 months and 14 years of age. TMM II is still waiting for data from remote communes. The latest unofficial value was 65%-70%.
Local Nutrition day	Yes	
<b>Research / Reporting</b>		
Quarterly LQAS field work	No	Waiting for a training workshop in LQAS
Annual report	Yes	
Formative and Operational Research	No	To be scheduled for the coming quarter

## 10. Plans for Phase-out at the EOP

ASAP was greatly privileged to have sustainability concepts introduced into the program during its DIP Workshop. Following the Sustainability Framework shown below, the project will attempt to introduce and integrate plans for phase-out by EOP. ASAP is committed to improving services provided to patients by promoting a *Client-Oriented, Provider Evaluation* system among the CSBs in the two districts. Performing Client-Oriented Provider Evaluation (COPE) will ensure quality and client satisfaction for MNC/CS and other services provided at CSB and at household levels.



The next dimension is the capacity and the viability of existing local institutions. The major problem is that most qualified people do not want to stay in remote areas, especially when there is limited or no equipment in CSBs. ASAP's role is to help build the capacity of these CSBs at SSDs by providing some medical equipment and supplies. The challenge is to rehabilitate or rebuild CSBs which are really in bad shape.

ASAP will encourage CSB health agents to develop proposals for private funding. ASAP will help develop a small project proposal and facilitate funding through partners. ASAP also plans contact Medicin Inspecteur and mayors of Communes regarding including plans for rehabilitation of CSBs in their Business Plan for the year 2005.

The third dimension is the base of the Pyramid and focuses on building community capacity. ASAP is training more than 640 CHAs who will help mobilize people for change of behavior and improved health. All these men and women are volunteers. ASAP plans to encourage CHAs to continue to market PSI mosquito nets plus the other PSI products (Protector, Sur'Eau, Pilplan etc). Community distribution of essential products will improve the availability of family planning products and potable water. The higher the sales, the greater the motivation will be to expand these activities.

*Training for Trainers (ToT):* ASAP is also building up a pool of Trainers through ToT seminars organized for local MoH personnel. These trainers will work with ASAP technicians in training CHAs and TBAs so that they will continue working beyond the life of the Project (LOP).

## II. Factors that Have Impeded Progress Toward Achievement of Overall Goals and Objectives and Actions Being Taken by the Program to Overcome Constraints

Factors that impeded progress toward achievement of overall objectives fall into two categories, internal and external:

### 1. Internal factors

#### a) Delays in project start-up

ASAP was scheduled to start on October 1, 2003, however, as mentioned at the beginning of this report, there was delay in hiring staff (the project started officially on December 1, 2003). Most of the experienced former TCSP Team had already left due to lack of bridge funds to fill the gap between the end of the last CS project and the start

of this one. This scenario impacted the project negatively as far as institutional memory and continuity is concerned. Nevertheless, new qualified staff were hired and oriented.

b) Lack of joint planning with local stakeholders (Local District Health Services)

Although this has now been addressed, at the beginning, there was limited joint planning and coordination of activities with the two District Health Offices in TMM and VVT. This issue was also raised in the DIP review comments (i.e., ASAP's activities did not appear in the Business Plans of the Districts it is supposed to work with). One of the reasons was that we were a little late (two months) in starting project activities. This affected our joint planning since our stakeholders, namely SSD TMM II and SSD VVT, were already closing their Business Plans (by January/February 2004). At that time, ASAP had not even conceptualized the DIP yet. The next reason is that the person responsible for the District Health Services in TMM II was not available during the DIP planning workshop. Fortunately, the heads of various MOH departments were present and we are working closely.

Both TMM II and VVT, had their BPs completed, with the assistance of GTZ personnel, before our DIP was developed. Nevertheless, since most of the activities start in VVT during the second year, we agreed to plan together for the year 2005. This was negotiated and agreed upon during our subsequent strategic planning meeting, which was attended by the two Medecin Inspecteurs of the district health offices. We believe our activities will be included and harmonized with their Business Plans for the year 2005.

c) Loss of quality project staff

As early as last April, Madagascar faced an economic crisis of critical proportions. The Malagasy franc lost its value to a US dollar and Euro by up to 40 percent. This affected everyone, including our key staff who started moonlighting to supplement their income. This interfered with their project duties and responsibilities. Eventually, some of our qualified staff (i.e., M&E Coordinator, IMCI Coordinator) left Tamatave for Antananarivo in search of better paying jobs. Although finding qualified staff was a challenge, these vacancies are now filled.

**2. External factors**

a) Leadership instability in the country

ASAP started implementing the project exactly when the Malagasy Health Ministry was reshuffling its personnel. Dr Gabriel Ranjalahy, the former Médecin Inspecteur for SSD TMM II was replaced by Dr Ratsara, the current district MoH representative. As this may have been a political appointment, Dr. Ratsara has shown little interest in working in remote areas. Some of the other MOH staff with whom ADRA worked closely in the past were also replaced or relocated. The Provincial Health Director (DPS) is well aware of the situation and we are told that the MOH will reshuffle its

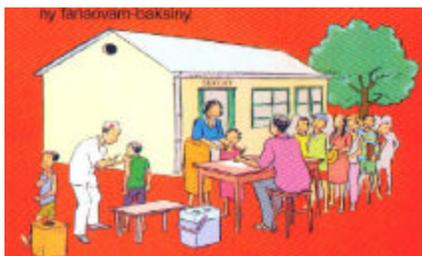
personnel again right after this National Measles campaign and that the problem will be addressed in that context. One of the possibilities is the return of Dr Ranjalahy, whom we feel would be the right person for the job. This problem is chronic and happens at all levels of the MOH. Newcomers usually bring new policies and approaches, which affect project activities positively or negatively.

#### b) Change in national policy

During the third quarter, right after the Malagasy Health Week, the Health Minister resigned. This affected the MNC component of the project, especially our plans for capacity building of TBAs. The previous MOH policy encouraged the training of TBAs and acknowledged the role they could play in reducing Maternal and Infant Mortality. In accordance with this policy, the project held TBA trainings and provided delivery kits through some health centers. Currently, under the new MOH leadership, the policy on TBA training is, at best, unclear. We are discouraged from training TBAs due to concerns that they may try to compare themselves with physicians who spent many years in school.

ASAP met with the Safe Motherhood Department Head of the MOH on this issue. We agreed to work together to refine a module (curriculum) that will be used to train TBAs. Although implementation of this component was delayed by a change in the previous approach, we hope to catch up once we come to a common understanding in terms of the training modules and approaches.

#### c) National Measles Immunization Campaign 2004



The National Measles Immunization Campaign is known locally as '**HIAKA 2004**' (Hetsika Iadiana, Amin'ny Kitroto mpahaso ny Ankizy). It falls quite well in the main project activities (IMCI). ASAP participated actively in the planning and implementation of the campaign in both districts. However, although this campaign was welcomed, it did hinder some of our other activities. For example,

Health Agents spent their time in planning and launching the campaign. We were forced to postpone or reschedule activities, including training in Community IMCI and the computer training in TMM II. Plans are in place to catch up on this training.

#### d) Criteria for staff recruitment

Qualification, experience and ability to speak local dialect are the criteria used by ASAP to recruit staff. ASAP experienced difficulty finding candidates who met all three criteria. This was especially true when we needed to hire the District Coordinator for VVT. It took six months and repeated announcements and consultations with our local and international partners to find Dr. RAMAHEFARISOA Sylvain Noel, who now fills the position.

### **III. Areas of the program which need technical assistance**

Based on the experience from this year, ASAP needs consultants for the Monitoring and Evaluation aspect of the project. During the first quarter of the second year, our priority is to find an expert in LQAS and COPE methods. We will also need Malaria consultants for effective roll-back as we apply the sustainability approach, and some support is needed in Nutrition, to help conduct formative research. These are supposed to be local consultants. However, since the CSSA approach is still new to most of the team members, and even to ADRA Madagascar as whole, ASAP would be glad to have someone do a follow-up on what was introduced during the DIP workshop. Mr. Karl Blanchet would be our first choice if CSTS will support this request.

### **IV. Changes from the program description and DIP which require modification to the cooperative Agreement**

The project has not made any substantial changes from the program description or objectives in the DIP which require a modification to the Cooperative Agreement.

In accordance with the DIP, ASAP's primary partner in distributing ITNs will be PSI. However, it appears that, although the MoH had previously supported PSI's ITN social marketing to everyone, this is no longer the case.

A few weeks after ASAP's DIP workshop, PSI changed its leadership, which may have contributed to changes in their approaches and strategies. PSI would no longer honor the TCSP MOU. According to PSI, ADRA (as an NGO) falls in the category of organizations who should buy mosquito nets at higher cost per unit. ADRA Madagascar and ASAP studied this scenario and found it impractical since, although unofficial, the price per unit of net will be around US\$5. This is too expensive for the CHAs, will not serve as a motivation to them and may impact sustainability. The new policy from the Ministry of Health is to discourage selling ITNs to the poorest families in remote areas.

In response to that, MINSAN-PF, in partnership with the WHO, agreed to provide ITNs to a certain target population composed of children, women with children under five years of age and pregnant women. Beginning in May/June 2003, the WHO started providing free nets to some districts in Tamatave Province including VVT. So far, 4,000 ITNs have been given to the CSBs in the VVT district, of which more than half have been distributed to pregnant women, mothers with children under five years or age and those delivering in CSBs. This has motivated women to the point that the number of ANC attendees increased in CSBs and in the VVT Referral Hospital.

Considering the new approach of the MoH and the WHO, ASAP made contact with the WHO regarding the possibility of receiving and managing the distribution of INTs within TMM II and VVT. This offer was received with great appreciation and now

ADRA Madagascar is working on signing a Memorandum of Understanding with the WHO.

Even if ASAP can no longer obtain nets from PSI, the project will maintain partnership with PSI in its social marketing approach to other products such as family planning supplies, the newly introduced prepackaged pediatric dose anti-malarial (Palu-Stop) and a water purifying additive (Sur Eau). In addition, ASAP will continue encouraging CHAs to market INTs distributed by PSI to the CSBs through SSDs.

## **V. Specific information requested during DIP consultation for the program (reviewers comments)**

Following the DIP review, a few issues were raised which are discussed below.

### **1. Business Plans:**

The issue raised regarding these two BPs was significant. ASAP's activities did not appear in the district MOH business plans as they should have. As explained earlier, this was due to delays in start up activities. Our stakeholders (SSD TMM II and SSD VVT) closed their Business Plans by January and February 2004, long before our DIP was conceptualized. Please review explanations given on this issue earlier. We have made arrangements with the appropriate MOH authorities to draft next year's business plan together.

### **2. Stratégie Avancée (AS): Immunization program**

The approach to "Strategie Avancee" incorporates community-based interventions, including immunization of children and pregnant women with TT, health promotion and education, and distribution of Vitamin A. All these activities are conducted in VVT. In TMM II, in addition to the above, we also conduct regular deworming of children. CSBs take advantage of the strategy to provide additional facility-based services to those who are referred and seek health care.

During the recent National Measles Campaign (HIAKA 2004), the plan was to immunize, provide vitamin A supplementation and deworm (using mabendazole) all children from nine months to 14 years of age.

### **3. Health Mobile team's major activities**

The MOH supports a health mobile team whose specific tasks are the following:

#### *a. Basic Health Care:*

Maternal and Child Health (check-up, IEC)

Prevention of STI, HIV/AIDS (IEC, diagnosis/treatment)

Diagnosis and treatment of various illnesses

*b. Health Priority Interventions*

Immunization (IEC, vaccination)

Family Planning (IEC, contraceptive distribution)

Provision of essential medicines

*c. Environmental Hygiene*

Water treatment (IEC, distribution of water purifiers)

Promotion of a clean environment (IEC, sanitation)

Distribution of ITNs and chloroquine tablets (IEC, and distribution of nets)

They also have a disaster preparedness program (rehabilitation support after cyclones).

Briefly, the health mobile team's approach is multi-dimensional and targets individuals, families and communities. During the recently concluded Immunization Campaign, for example, the Mobile Health Team took an active part in supervising and conducting vaccination in some remote areas.

**4. Will there be an anti-measles campaign?**

The issue of whether or not there will be an anti-measles campaign has already been addressed. There is an annual National Anti-measles Campaign supported by the WHO/MoH. This year's planned Immunization Campaign took place from September 13 to October 8, 2004. The whole country, including ASAP staff, participated. The event was well planned and we are waiting for the final official results. There was a guideline to implement this campaign. Several training activities took place before the campaign started, which was one of the reasons why we had to postpone our regular project activities. This was clearly included in VVT's business plan, unlike TMM II where the planner failed to differentiate between the National Campaign and routine immunization activities.

**5. Is UNICEF or UNFPA planning to donate any TBA Kits to the SSDs?**

To our knowledge, UNICEF/UNFPA has not donated any TBA kits to the SSDs this year. UNFPA did hold a training of TBAs in Moramanga, one of the regions in the Tamatave province. These trainees received kits. In SSD Tamatave II, 20 TBA kits were given, which were distributed to CSBs. ASAP had a telephone conversation with UNFPA and learned that there is no plan to give TBA kits this year since it appears UNFPA is phasing out its program. Their supply has already been exhausted. UNICEF promised to provide some kits to TMM II, though this has not happened. We are still negotiating; however the likelihood of actually receiving any seems minimal.

The possibility of ASAP developing its own simplified kits is an option worthy of further consideration.

Regarding culturally acceptable practices in the target population, TBAs outside Tamataville do not ask their clients to bring any supplies when they seek assistance during delivery. When a woman comes, she is normally received by a well-known TBA who uses her own materials which are often contaminated. It is often culturally

acceptable for the client to give some form of compensation to the TBA, depending on the gender of the baby. For instance if the baby is a female, the TBA ask for some salt. If the baby is a male, the TBA may demand something more significant, depending on the region.

## **6. Availability and use of Basic Essential Obstetrical Care (BEOC)**

In the Vavatenina district, 12 out of 19 CSBs have delivery rooms providing BEOC. Ten out of 19 have delivery kits. All 19 have obstetrical stethoscopes, regular stethoscopes, and sphygmomanometers.

In the local health system, both CSB I and CSB II can perform deliveries and are expected to provide BEOC. For example, a woman who has been visiting the center for ANC who is delivering her second normal child and was found to have a proper presentation can easily deliver at CSB I where she will be assisted by, most likely, a midwife or a nurse. On the other hand, complications related to pregnancy cases are referred. At this level, the facility is expected to be better and referred cases are managed by a physician.

## **7. LQAS and COPE Technical Assistance**

With regards to LQAS and COPE, Dr Gaby, Director of Flexible Fund and HOPE Projects (both sponsored by ADRA) and I (Josué Mpayamaguru) will continue to work together to incorporate the two models into our projects. We hope to do it jointly. Although Eric Sariat did not arrive as planned, the LQAS/COPE workshop was held as scheduled in July. This was introductory in nature and perhaps not sufficient. In November, there will be a LQAS workshop in which ASAP and Flexible Fund staff will participate. This workshop will be followed by a COPE seminar facilitated by local consultants from the MoH.

## **8. COPE Training**

It has been recommended that we work with the Provincial MoH Office (DPS) regarding COPE training in TMM Province. Due to the Immunization Campaign everyone was occupied. Nevertheless, we have been able to contact Antananarivo and make arrangements for training.

## **9. The Word “DIDO”**

In both the MoH BP and the TMM II BP, the term “DIDO” is used in conjunction with the COPE model. DIDO is an acronym in French (Développement Institutionnel et Développement Organisationnel). This refers to a minimum of equipment that health institutions should have in order to provide quality services. This model falls in line with the COPE model. The two aim at improving the quality of services and the sustainability of the program.

## 10. Role of Commune/Community-Level Partners

ASAP supports existing community committees and commune systems in accordance with MoH policy. ASAP developed handouts to be distributed in communities so people may have access to information on who the existing community-based partners are (CASC, COSAN, COGE and CHA) and what their role is. It is important to note that some of these organizations are not fully functional. The role of reviving these committees is being performed jointly with the Health Mobile Team. Below is a summary of their role:

### CASC:

CASC is a committee which plans COSAN's activities:

- Coordination
- Liaison between CSBs and Commune
- Liaison between NGOs and Commune
- Planning and developing social activities
- Coordinating role during natural disasters, epidemics, etc.
- Planning for community mobilization
- Supervision of community health related activities (hence, there should be periodic meetings)

### COSAN:

COSAN is a committee which executes activities planned by CASC and:

- Serves as liaison between CSBs and the community
- Closely monitors community health needs
- Implements emergency activities
- Assists in community sensitization
- Meets regularly with CSB personnel for feedback information.

### COGE:

COGE is committee formed to manage the drugstore in the community.

There is what is known as **Beneficiaries' Financial Participation** and it has to be carried out with transparency. Hence, a committee with one representative from the commune, CSB and each village was created. The main role is:

- Stock replenishment
- Hiring of personnel such as guards and distributors of such items as mosquito nets and contraceptives
- Managing salary of personnel
- Coordinating activities between commune and CSBs

ASAP will endeavor to clarify their role in order to reduce confusion and help make these bodies more functional.

### Malagasy Red Cross and the EPI mobilizers

These are young men, different from CHAs, who are called when there is any urgent intervention which requires manpower. They are volunteers and receive few incentives to motivate them. ASAP will take into consideration their availability for coordination of activities.

CVAs: CVAs were a group of community partners who worked as CHAs under CTSP in TMM II to voluntarily mobilize their respective communities. They are encouraged by ADRA to regularly meet at CSBs to share experiences, give reports and work with the ADRA technical advisors who supervise them.

ASAP's aim is to continue to clarify the importance of each committee and how they relate one to the other. For example, on June 22, 2004, a meeting was held in VVT with the Chief District leader "Sous-Prefet," local Ministry of Health representatives, Education representatives and other units in VVT. Later in July, a meeting of the same nature was also held in TMM II for the same purpose with the TMM II Sous-Prefet and Mayors of the TMM II Communes.

### **11. Regarding Newborn Care (algorithm for neonates):**

The Malagasy MoH does have an IMCI treatment algorithm for neonates. The existing document is 36 pages long. Pages 1-21 are dedicated to children aged two months to five years. The rest of the pages (22-36) contain information regarding newborns (one week to two months of age). There are no separate guidelines for other ages.

### **12. Is the White Ribbon Alliance still active in Madagascar?**

According to Mr. Benjamin of the local USAID Mission, the White Ribbon Alliance seems to be defunct.

### **13. Spider diagram indicators**

The spider diagram indicator is part of ASAP's monitoring tools. The team has revised and translated it into English (Annex D Star Diagram Indicators).

### **14. JSI counseling cards and ITNs**

In the future, ASAP use the local dialect more frequently when preparing new printed materials and whenever possible will include new pictures. However, the Ministry of Health prohibits the use of any picture or message which has not been approved by the appropriate office. Presently, we have some new handouts awaiting approval, but in the meantime, we continue to duplicate the existing ones. PSI offers a card which shows the ITN and describes its use and advantages in the local language. This will be copied and disseminated in the project area.

### **15. Work/Action Plan /LogFrame**

The project work plan has been revised and sent as part of the final copy attached on the DIP document. Activities which were overlapping, such as training in IMCI and MNC, have been separated. We are trying to work with the SSDs in scheduling these training events. We have also taken note of some campaigns and festivals included in the Logframe that were not found in the work plan (Annex F Work Plan revised).

### **16. Recommended Family Practices**

ASAP has C-IMCI copy from the state-of-the-art checklist provided by CSTS and we have taken measures to include these in our curriculum for the CHA training program.

### **17. Consistency regarding the use of acronyms in every document submitted to USAID and ADRA AFRO/HQ, including all Annexes**

We have taken note of this recommendation and will endeavor to be consistent to avoid confusion during review of documents.

### **18. Has PSI introduced a multi-vitamin plus iron tablet?**

PSI has not yet introduced multi-vitamin + iron tablets to benefit WRA. PSI continues to market ITNs under the name of "Super Mama" and PaluStop to combat malaria. They also market Sur'Eau for cleansing drinking water, and contraceptives (condoms) under the names "Protector," "Cura 7," "Genicure," "Pilplan" and Confiance.

### **19. What do "Red Zones" as mentioned in TMM II's BP mean?**

The "Red Zones" refer to places where HIV positive cases have been identified. There are four sites/communes which are considered red zones in TMM II. These are:

- Analamangahazo
- Ampasimbe onibe
- Foulpoint and
- Ambodriana

### **20. Is Norplant used in both SSDs?**

Following our consultation with the District Ministry of Health Representative (Médecin Inspecteur) concerning Norplant in VVT, it was determined that there is only one CSB in VVT town, which is equipped to perform the operation. In addition, the only physician who had been trained to perform this operation is now leaving for Public Health School.

As a solution, SSD VVT plans to train a midwife. For cultural reasons, the Médecin Inspecteur in Vavatenina thinks that it is much better for a woman to perform this

operation than a man. The SSD in VVT has the following resources available to facilitate the use of Norplant: electricity, sterilizer, water, personnel trained in FP, and two staff (a medical doctor and a nurse). In TMM II, no one has been trained. UNFPA trainings seem to have ended this year. However, the services will likely be supported by MOH and will continue.

## **21. “Packet of Minimum Resources (PMR)” in TMM II’s BP**

“Packet of minimum resources” refers to essential services and the category of health agent serving a particular health center. For instance, according to the policy, a CSB I is supposed to be operated by at least a nurse and a helper, and the kind of services offered in a CSB I are:

- External consultations
- ANC
- Deliveries
- Immunization for children and pregnant women
- Care for lepers
- IMCI
- Family Planning
- Injection
- Oral contraceptives (pills)
- Growth monitoring
- Monthly activity reports

On the other hand, a CSB II is supposed to be managed by a physician, although in some cases you may find only a nurse due to lack of personnel to work in remote areas.

The basic services are essentially the same in both CSB I and II. However, CSB IIs should be able to admit a patient (hospitalization). In addition to having a medical doctor, CSBs also have a nurse and a helper

## **22. The availability of laboratory services in VVT**

Well equipped laboratory services are not available in VVT health facilities. In the past, they have received donations from the ministry of health, but the hospital has exhausted these. The reason this is included in their BP is not clear.

## **23. Sources of Chloroquine in VVT (2/communes)**

The two sources of chloroquine refer to types of "epiceries." During the former government, these centers existed. However, there are none today. The reality is that in most cases, they were stores which simply sold chloroquine. SSD Vavatenina proposed the idea of revolving drug stores, but this has not been implemented. ASAP does not see it as a problem since we are working with SSDs to make anti-malarials available through community marketing by CHAs.

## **24. Special Festivals, “Fetes”**

This recommendation has been considered seriously the work plan includes scheduled festivals for each year. As a matter of fact, ASAP is organizing a festival to be held in VVT on December 1, 2004. This is also the World AIDS' Day.

## **25. Acronyms in Vavatenina's Business Plan**

The word “FANOME” in the Malagasy language is equivalent to Beneficiaries Financial Contribution, which has to do with COGE and management of the community drugstore.

The word “ORSEC” refers to a multi-sector plan for disaster management. “RPI” is a French word which means proper internal resources.

## **VI. Programs Which Receive Flexible Fund Support**

Not applicable.

## **VII. Description of the Programs Management System and discussion of factors, which have positive or negative impact on the overall management of the program**

ADRA ASAP believes in management by objectives (MBO), which is an important tool for planning at the micro level (i.e. at the level of a superior and his subordinate in a section or department). It is also used as a process for arriving at performance objectives for an employee or an organizational unit when these cannot be conveniently expressed in the form of a financial target.

Under MBO, the manager and the employee discuss together the goals to be met by the employee for a particular planning period, with the understanding that the extent of accomplishment will be a major factor in evaluating and rewarding the subordinate's performance. Advocates of the MBO technique stress the necessity of genuine subordinate participation in goal setting to improve the chances that employees will be committed to the achievement of those goals. Hence, ASAP's management system stresses that:

1. Managers communicate to all staff the higher organizational goals and all expected team accomplishments.
2. Managers discuss goals and objectives with all staff in order to agree on what is verifiable or measurable for a period of time.
3. They discuss resources required to attain goals.
4. Some periodic reviews are recommended to discuss reasons for deviations of actual performance from targets.
5. Managers discuss evaluations of subordinates, rewards given (promotion, salary adjustment) or punishments such as no pay increase or no promotion.

This type of management is being stressed not only for setting performance targets against which subordinates will be held accountable, but also for communicating upper management's expectations of an employee and to clarify the key contribution he or she can make towards the attainment of those goals.

For better understanding, the following topics are further discussed below:

## **1. Financial management system**

ASAP, as part of ADRA Madagascar, follows ADRA Madagascar's financial policies and procedures dated 1999. These procedures are in accordance with the USAID regulations.

Responsibility for financial management resides in the following parties, in descending order of authority:

1. ADRA-M Board
2. ADRA-M administrative committee (ADCOMM)
3. Project committee (PROCOMM)
4. Finance officer (logistics officer at the same time)
5. Accountant and cashier

Duties and responsibilities are adequately segregated. The project director approves all requisitions for purchases of goods and services and the finance officer authorizes the payment.

A copy of the Operations Manual is available from the office. This manual was revised in June 2004 and final approval is pending.

ASAP is using the AAA software developed by the ADRA Network for its accounting. This is a 'DOS' program and is almost obsolete. We find it problematic to use since data entered should be printed for verification. ADRA International is currently developing a new version, which we eagerly anticipate since it will make the accounting process much easier.

Besides from the AAA software, ASAP also has access to online banking resources. With Internet accessibility, ASAP's financial management system has improved since several transactions can be done within seconds.

## **2. Human resources**

As indicated in the Organizational Chart, ASAP has a total of 21 staff and personnel. This number includes the management and support staff. There are criteria for hiring, which are recommended based on gender, cultural practices, language, and professional experience and prior exposure to living conditions in rural areas. Meeting these conditions in Tamatave, especially in the Child Survival project intervention area, has really been one of the biggest challenges which we have faced. Tamatave is located on

the coast and most experienced people leave the region for Antananarivo where the living conditions are more attractive. Antananarivo has many educated people who could easily do the job, but the language barrier hinders the progress of activities by limiting the flow of information as messages may be distorted due to dialectical differences between regions. Sometimes prejudice hinders some employees from performing their duties and management has to be vigilant about this. The year 2004 was marked by a growing inflation rate and this "de-motivated" some employees. This is no longer an issue since it has been addressed rather successfully by ADRA's Human Resources Committee. The committee suggested a buffer system to counter any change in exchange rate from US\$ to FMG. Management feels that this year will be free from this type of problem.

### **3. Communication system and team development**

In terms of communication and team development, ASAP is trying its best to promote communication and team building among its employees. Last year, there was a one week team building event at a place called Mahambo, which was very much appreciated by the team members. As a matter of fact, ASAP planned another team building event, which was held from October 12 to 14. The plan is to conduct team building activities at least twice a year. Apart from local interpersonal communication, ASAP does have means of long distance communication among local and international partners, which it accomplishes through electronic e-mails, and telephone conversations (landlines and mobile technology are utilized). There was a plan to acquire HFI radio to be used in remote areas, but this proved impossible due to the cost of operation. Before the start of the project, it was practically impossible to communicate with our regional office in VVT (inter-district communication). However, following a concerted effort initiated by ASAP's Management to motivate VVT local authorities (Sous-Prefet and the Mayor), the SSD Vavatenina, the Education Department in VVT, etc., we've been able to install a telephone line which made electronic communication possible.

### **4. Local partner relationships**

ADRA Madagascar has name recognition nationwide due to its commitment to helping the needy people of all walks of life without distinction between race, ethnicity, region or religion, and most especially because of a willingness to go into the most remote areas. At a recent festival organized by HOPE, one of ADRA Madagascar's Tamatave Health Programs, the Malagasy Deputy publicly emphasized to all the people who were present, including several key persons of the community and local authorities, that ADRA distinguishes itself through its successful interventions in the remotest areas of the country. He added that, while other international NGOs work in various locations, it has been noted that these are mostly accessible places, whereas ADRA goes to the most remote villages which are ignored by most. The same good relationship is maintained in the private sector among local and international NGOs.

## **5. PVO coordination/collaboration in country**

Although there is still much to do in terms of PVO coordination in the country, the local USAID Mission encourages all its partners to cooperate and coordinate their activities to complement each other. Following that recommendation, one of the very first tasks was to make courtesy calls to local partners to introduce the new program and to discuss their program approaches and areas of intervention. Although every NGO has its own approach, there has been, and still is, a very good working relationship among the PVOs working in the country, particularly in the Tamatave Province. The goal is to maintain this relationship through sharing of experiences, telephone calls and visits whenever the opportunity arises.

## **6. Other relevant management systems**

ASAP follows procurement policies and procedures as stipulated in the manual of procedures. Logistics and Asset Management are part of this document. These procedures deal mainly with vehicle and communications policies. All equipment and resources are to be used for the fulfillment of the project's responsibilities to donors and beneficiaries. Following these procedures has been proven cost effective and is strongly recommended.

Following are some forms used in the ASAPs Management System

- Requisition forms and log books for any vehicle movements
- Cash vouchers for various payments
- Bank vouchers
- Phone/Fax record books
- Leave and absence request forms
- Timesheets
- Budgeting forms
- Cash replenishment forms
- Forms for transport in public and private vehicles
- Expense reimbursement forms
- Mission order forms
- Borrowing forms
- Routing slips, etc.

## **7. Organizational capacity assessment**

This point is not applicable for this year. Since the project started, there has not been any organizational capacity assessment of any kind and no financial or management audit has been done.

## **VIII. Timeline of Activities for the coming year and explanation for changes to the original plan**

Please see Annex E Timeline Activity Table for FY 2005.

## **IX. Key issues, results or successes identified by the program**

The program has identified several key issues which are likely well noted by the Malagasy MoH though it may be challenged as it tries to address them. One major issue is the high maternal mortality rate (488/100,000 LB) due to abortion and other complications linked to delivery. It is important to note that more than 50% of deliveries are performed by non health professionals, of which 39% are performed by TBAs. In addition, Community-based Health Centers are underutilized due to lack of facilities and infrastructure and their distance from the villages. Malnutrition is a fact of life in the Tamatave region; low immunization coverage and many malaria cases in rural areas of the province cause additional concern.

### **1. Maternal Mortality Rate**

ASAP wishes to highlight the fact that 89-90% of women deliver at home, almost all assisted by untrained attendants. Obstructed labor, infections, uterine rupture, hemorrhage and ectopic pregnancy are all very common occurrences and the main causes of Maternal Mortality in the province. The Malagasy MoH is well aware of this and had planned to include Traditional Health Practitioners as close partners in the health system where they would be supervised by CSB Health Agents. Although there has been a delay, we hope this program will soon become a reality.

The dilemma is that this initiative seems to be dying off. An informal survey reveals that most medical practitioners do not see how these illiterate village men and women can be trained to perform the delicate and noble service of delivering children. To some, it seems that "competition" would in reducing the number of women who visit the CSB because they would have access to trained individuals within their communities.

### **2. ASAP's Action**

Following the MOU signed between MoH and ADRA Madagascar, it is well established that the MoH wants to reduce the Maternal Mortality Rate. Hence it was crucial for ASAP to get first-hand information from the MoH. On September 23, 2004, the ASAP director met with the Safe Motherhood Department Head and concluded the following.

- The MoH is concluding a new approach to the development of a training module for TBAs.
- ASAP will be invited to contribute to this session.

- ASAP will be allowed to carry on the planned training of TBAs, provided the first few trainings are assisted by MoH representatives.
- ASAP will train, provide kits and then, together with SSD personnel, supervise those trained during the LOP while progressively transferring full responsibility to the CSB health agents.

### **3. Immunization Coverage and Drop-outs.**

Immunization coverage in Madagascar remains a problem and the objective for immunization intervention is to increase the rate of coverage for children fully vaccinated by their first birthday as measured in children 12-24 months of age. The current status of immunization against measles, for example, among children is 44% in TMM II and 60% in VVT. Children who are fully and correctly immunized by their first birthday (with card) compose only 29% in TMM II and 33% in VVT. The same problem exists in Tetanus Toxoide (TT) coverage (51% in TMM II and 46% in VVT, which is slightly below the provincial rate of 52%).

Fortunately the MoH is well aware of this and has made it an objective in the BP to achieve at least 80% vaccination for all EPI vaccines for children less than 1 year and 80% coverage of TT2 among pregnant women. ASAP is committed to assisting in meeting this objective in its intervention zone (TMM II and VVT). The target objective in the National Campaign was to attain 95% immunization coverage for all children aged nine months to 14 years, with each one also receiving a worm medication (Mebendazoles). The third operation was to administer Vitamin A to every vaccinated child aged nine months to 4 years.

### **4. Outreach Strategy HIAKA 2004**

The immunization campaign was conducted in three phases.

- In phase one, immunization was conducted in schools and other institutions such as orphanages where the target group is easily found. At least 200 children per day were to be immunized.
- In phase two, immunization was done in health centers, in temporary places such as communes and at provincial offices. At least 150 children per day were to be vaccinated.
- In the third phase, immunization was conducted in locations beyond 10 km from health centers. This was known as a mobile strategy. At least 80 children per day were to be vaccinated.

In some places, there was a shortage of worm medications, but this was quickly remedied by the authorities. Supervision was tight to ensure vaccination stayed on schedule until the last day of the campaign on October 8, 2004. Unfortunately, we shall not give the official result in this report since it is a Nationwide Campaign. However, it was a pleasure to know that Vavatenina District has reached the national objective to vaccinate up to 95% of children between nine months and 14 years of age (Annex B

letter of thanks, Annex B1 letter of thanks translated). Tamatave II is still waiting for data to come from remote communes. The latest unofficial report indicated 65%-70%.

**5. What was the Project's input to support and facilitate the accomplishment of the objectives?**

During the "HIAKA 2004" Campaign, ASAP committed itself to fulfilling project objectives in three ways: technically, logistically and financially:

**a) Technically**

ASAP has five health technical advisors who monitor health/EI activities. Two technicians were assigned to the Vavatenina district. One worked as a vaccinator while the other served as a sub-regional supervisor. In TMM II, three other technicians were assigned: two as vaccinators, while the other supervised and assisted in vaccination activities in Ambodilazana

**b) Logistically**

ASAP assigned one pickup truck in VVT to help with logistics and supervision until the end of the campaign. Another vehicle was made fully available to SSD TMM II throughout the campaign for the transport of personnel, equipment and supervision purposes. The project facilitated communication in VVT by making available the telephone line. Additionally, vehicles were also made available to move refrigerators between SSDs and CSBs according to a Time table set up before the start of the campaign.

**c) Financially**

ASAP covered radio broadcasting costs during the campaign for both districts. ASAP sponsored training for marionettes, participant training and a sensitization campaign as requested by SSDs. On the whole, ASAP had a close working relationship with the two districts which was greatly appreciated by the two district Medical Inspectors, as expressed in the letter from VVT district (Annex B).

**6. High rate of Malaria Cases**

One of the major health problems threatening the two districts is the endemic malaria which results in morbidity and mortality amongst both young and old people. Efforts have been made to fight this problem, yet the situation is still critical. The Government and its partners are trying to address the problem. The bed nets are unaffordable to most people, particularly to those targeted by the project.

This is the reason why the WHO and MoH sought a policy of free ITN distribution to those who cannot afford to purchase them. This strategy is now part of the WHO/MoH Roll Back Malaria program in Madagascar.

The WHO expects to freely distribute 3,000,000 ITNs among pregnant women and children under 5 years of age who live in remote areas of the country. PSI also expects to market 900,000 ITNs to those who can afford them. ASAP will work with the WHO/MoH to help them attain their goal and an MOU regarding this is being drafted.

**X. Program Guidelines**

The issues under section "X" of the annual CS report guideline do not apply as the program has not yet obtained sufficient information for reporting to the US Congress.

**XI. Other relevant aspects of the program that are not covered in the guidelines**

We need to mention how much ADRA's work is appreciated by the local Government officers, particularly the decision to work in remote locations. In a recent festival hosted by ADRA, one of the local authorities officially commended ADRA for its work in remote areas of Madagascar and for being a dependable partner.

## Annex E

**ASAP SECOND YEAR ACTION PLAN**  
( FY 2004-2005 )

Objective / activity	Period												Responsible	Methodology / Strategy	Expected results		
	O	N	D	J	F	M	A	M	J	Ju	A	S					
<b>MONITORING AND EVALUATION</b>																	
SSD HIMS supervision															MIS coordinator	Field visit	Improved capacity
CSB HIMS supervision															MIS coordinator	Field visit	Improved capacity
Community HMIS supervision															MIS coordinator	Field visit	Improved capacity
<b>Staff capacity building</b>																	
Management training															Consultant	Formal training	10 ASAP technical trained
RPA training for the CASC/supervision															Consultant	Formal training	10 ASAP technical trained
LQAS/COPE training															Consultant	Formal training	10 ASAP technical trained
Business Communications/Team building															Consultant	Formal training	
Integrated supervision training															Consultant	Formal training	10 ASAP technical trained
<b>SSD capacity building</b>																	
Computer training															coordinator, consulta	Formal training	20 personals trained
Management training (HIMS,LMIS)															consultant	Formal training	20 personals trained
Integrated supervision training															consultant	Formal training	20 personals trained
Training of trainers															consultant	Formal training	20 personals trained
Interpersonal communication training															consultant	Formal training	20 personals trained
<b>CSB capacity building</b>																	
Management training (HIMS,LMIS)															consultant	Formal training	CSB/ 3 sessions )
Integrated supervision training															consultant	Formal training	30 personnels ( 3 sessions)
LQAS/COPE training															consultant	Formal training	30 staff
<b>Community capacity building</b>																	
RPA training for the CASC															consultant	Formal training	
<b>Research/reporting</b>																	
Quarterly LQAS M&E intervention															coordinator	survey	report
PRA Intervention Development															coordinator	method	report
MTEvaluation workshop															ME coordinator	survey	report
Quarterly reporting/work plan															ME coordinator		report

Annual report																	Project Director		report
In-deph situation analysis																	consulant	survey- interview- Focus group	report

### MATERNAL NEWBORN CARE

Objective / activity	Period												Responsible	Methodology / Strategy	Expected results				
	O	N	D	J	F	M	A	M	J	Ju	A	S							
<b>CSB LEVEL</b>																			
Training of CSB agents in MNC																	Consultant SSD	Formal training	30 agents trained
Dotation of medical equipment																	ADRA	Dotation	50 CSB
Training of CSB agents in modern family planning methods																	Consoltant with coordinator	Formal training	30 agents trained
Safemother hood and roll back AIDS' day in both districts																	Team ADRA	Festival meeting	01 Festival
Training of CSB agents in STI, HIV/AIDS.																	Consoltant with coordinator	Formal training	30 agents trained
<b>Community level</b>																			
TBAs training																	Census.Coordinator ,	Formal training, Foc	285 TBAs trained
CHAs training																	consultant	Formal training	640 CHAs trained
Local radio broadcasting																	Coordinators	radiobroadcasting,	

### INTEGRATED MANAGEMENT FOR CHILD ILNESSES

Objective / activity	Period												Responsible	Methodology / Strategy	Expected results				
	O	N	D	J	F	M	A	M	J	Ju	A	S							
<b>SSD level</b>																			
Training of SSD logistics officers and technical assistant to improve LMIS.																	Consultant	Formal training	30 personals trained
<b>CSB level</b>																			
IMCI training for CSBs agents in Standard Case Management for Malaria / improved quality of treatment against malaria, and promotion of drugs against uncomplicated malaria cases in children.																	Consultant	formal training	50 agents trained

Upgrading training for the CSB personnel on IMCI															Consultant, coordinator	formal training	50 agents trained
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CHAs training in danger signs										Coordinator, SSD	Formal training	30 agents trained
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## Annex F

### ADRA MADAGASCAR / ASAP TOAMASINA

Activity schedule	Both Districts				Vavatenina District				Tamatave II District				Others(Follow up/Supervision)			
	2003 - 2004				2004 - 2005				2005 - 2006				2006 - 2007			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>Building MoH / ONG Partnerships</b>																
Preparation and signature of MOU																
Initial meeting with key partners																
<b>Start - up and Expansion</b>																
Selection and hiring personnel																
Procurement of supplies and equipment																
<b>Monitoring and Evaluation</b>																
International (MTE +EOP) Evaluation																
Baseline survey for VVT																
Mid-Term Evaluation workshop																
In- depth situation analysis																
Local Mid-Term Evaluation																
Final EOP survey																
Formative Research																
Participatory Rural Appraisal																
Nutrition intervention																
Malaria consultants																
HIS/LQAS methods																
Training for Staff Capacity Building																
Operational Research																
<b>Project Planning</b>																
DIP Preparation																



