

UNITED STATES  
AGENCY FOR INTERNATIONAL DEVELOPMENT

USAID / ANTANANARIVO  
DEPARTMENT OF STATE  
WASHINGTON D.C. 20521-2040



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TEL: 254.89 FAX: 261-2-34883

February 12, 1996

Mr. Remko Vonk  
Director  
CARE MADAGASCAR  
B.P. 1677  
Antananarivo 101

Subject: Grant No. 687-0107-G-00-6024-00,  
Child Survival.

Dear Mr. Vonk:

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the U.S. Agency for International Development (hereinafter referred to as "USAID" or "Grantor") hereby awards to Care International Madagascar (herein after referred to as "Care International Madagascar" or "Recipient"), the sum of \$2,460,000 to provide support for a program in Child Survival as described in Attachment 1, the Schedule of this agreement, and Attachment 2, entitled "Program Description".

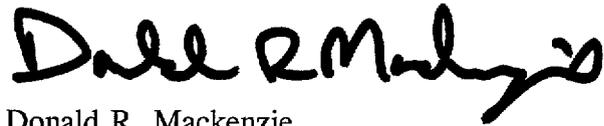
This agreement is effective and obligation is made as of the date of this letter and shall apply to commitments made by the Recipient in furtherance of program objectives during the period beginning with the effective date and ending May 31, 1999. USAID shall not be liable for reimbursing the Recipient for any costs in excess of the obligated amount. See paragraph C.2 of the Schedule for amount obligated.

This agreement is made to Care International Madagascar, on condition that the funds will be administered in accordance with the terms and conditions as set forth in 22 CFR 226, entitled "Administration of Assistance Awards to U.S. Non-Governmental Organizations"; Attachment 1, entitled "Schedule"; Attachment 2, entitled "Program Description"; and Attachment 3 entitled "Standard Provisions."

**GRANT No. 687-0107-G-00-6024-00**  
**CHILD SURVIVAL**  
**2 of 3 Pages**

Please sign the original and each copy of this letter to acknowledge your receipt of the grant, and return the original and all but one copy to the Agreement Officer.

Sincerely yours,



Donald R. Mackenzie  
Mission Director and Acting Grants Officer  
USAID/Madagascar

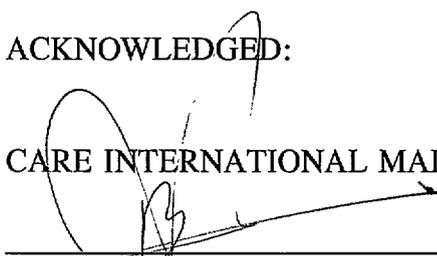
Attachments:

1. Schedule
2. Program Description
3. Standard Provisions

CF: AID/W/FM (Ms. Ruth Hughes, when countersigned)

ACKNOWLEDGED:

CARE INTERNATIONAL MADAGASCAR



By: Mr. Remko Vonk

Title: Director, Care International Madagascar

Date: 02/21/96



Vicki J. Huddleston

Title: United States Ambassador

Date: 02/21/96

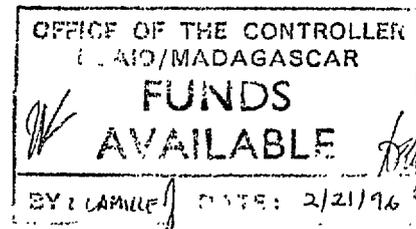
FISCAL DATA

A. GENERAL

1. Total Estimated USAID Amount: \$2,460,000
2. Total Obligated USAID Amount: \$500,000
3. Cost-Sharing Amount (Non-Federal) : N/A
4. Project Number: 687-0107
5. USAID Project Office: Population (APPROPOP)
6. Tax I.D. Number: \_\_\_\_\_
7. CEC Number: 00270318
8. LOC Number: 72-00-1483

B. SPECIFIC

1. PIO/T Number: 687-0107-3-50006
2. Appropriation: 725/61014
3. BPC: GSS5-95-21687-KG13
4. ECN: A550006      Amount: \$500,000.00



Funding Source: USAID/Madagascar Child Survival Activity

ATTACHMENT I

SCHEDULE

A. Purpose of Agreement

The purpose of this Agreement is to provide support for the program described in Attachment 2 to this Agreement entitled "Program Description."

B. Period of Agreement

1. The effective date of this Agreement is February 12, 1996. The estimated completion date of this Agreement is May 31, 1999.
2. Funds obligated hereunder are available for program expenditures for the estimated period February 12, 1996 to December 31, 1996 as shown in the Agreement budget below.

C. Amount of Award and Payment

1. The total estimated amount of this Award for the period shown in B.1 above is \$2,460,000.
2. USAID hereby obligates the amount of \$500,000 for program expenditures during the period set forth in B.2. above and as shown in Budget below. USAID shall not be liable for reimbursing the recipient for any costs in excess of this amount.
3. Payment shall be made to the Recipient in accordance with procedures set forth in 22 CFR 226, by USAID Letter of Credit. CARE's USAID Letter of Credit Number is 72-00-1483. CEC # 00270318K
4. Additional funds up to the total amount of the grant shown in C.1 above may be obligated by USAID subject to the availability of funds, and 22 CFR 226.25.

D. Budget

The following is the Agreement Budget, including local cost financing items, if authorized. Revisions to this budget shall be made in accordance with 22 CFR 226.25.

	Feb 12, 1996 to Feb 11, 1997	Feb 12, 1997 to Feb 11, 1998	Feb 12, 1998 to Feb 11, 1999	Feb 12, 1999 to May 31, 1999	TOTAL
1. Technical Assistance	290,597	316,658	296,497	203,500	1,107,252
2. Procurement/Materials, equipment	138,907	71,917	122,094	76,138	409,056
3. Sub-Agreements	16,000	33,600	35,280	9,261	94,141
4. Training	64,800	71,715	63,173	36,928	236,616
5. Other direct costs	33,688	35,373	37,141	22,194	128,396
Subtotal A	543,992	529,263	554,185	348,021	1,975,461
CARE Madagascar Overhead (15,44%)	83,992	81,718	85,566	53,734	305,010
Subtotal B	627,984	610,981	639,751	401,755	2,280,471
CARE USA Overhead					
- Regular (7.17%-Subtotal B)	45,026	43,807	45,870	28,806	163,509
- Audit (0.62% - subtotal B)	3,894	3,788	3,966	4,372	16,020
TOTAL USAID Contribution	676,904	658,576	689,587	434,933	2,460,000
CARE Contribution					
Procurement/Materials equipment	17,734	0	0	0	17,734
OVERALL TOTAL	694,638	658,576	689,587	434,933	2,477,733

5

E. Reporting and Evaluation

The Recipient shall submit monthly to the project officer not later than 60 days after the close of the month a project report entitled Modified Expenditure Analysis Report by Fund (MEARF). This report shall be in the format similar to that presented in the CARE "Expenditure Analysis Report by Fund" monthly report so that the report shall only contain direct expenditures to the USAID-financed grant. That is, it shall not include any apportioned field office indirect costs either for international staff nor for local direct expenditures. These field office indirect costs shall be charged at a rate of 15.44% as described in the local NICRA rate with USAID Madagascar dated March 17, 1995. These costs shall be included under the sub-total for direct expenditures as a separate line item along with separate line items for the CARE NICRA overhead rate and the CARE A-133 Audit overhead rate. Along with the monthly Modified Expenditure Analysis Report by Fund the recipient shall submit a detailed listing of the individual expenditures making up the totals on the summary MEARF report including columns for date, reference, check number, and description. If adjusting entries are charged to USAID, a full and understandable description shall be provided for each entry. Finally, the standard CARE Expenditures Analysis Report by Fund (CEARF) shall be submitted along with a reconciliation between the MEARF and the CEARF.

If for financial management purposes, during the life of the grant, the Recipient shall track and advise the project officer if any individual line item is exceeded by more than fifteen percent. The Recipient must obtain project officer approval in writing, before exceeding the budget for any individual line item by more than fifteen percent.

F. Special Provisions

1. Care International agrees to fully participate as a member of the USAID/Madagascar Strategic Objective Team Number 4, Results Package 2, extended team in order to achieve the following:

- a. Joint strategic planning to achieve the objectives of Results Package Number 2;
- b. Standardized Information, Education and Communication (IEC) messages;
- c. Standard protocols for service delivery;
- d. Priorities and standards for grant-financed training programs;
- e. Development of a common set of indicators for measuring child survival program impact and implementation of an information system and/or surveys to capture these data,
- f. Application of national policies and strategies, where they exist; and
- g. Participation in lessons-learned workshops and technical updates sponsored by

USAID or its child survival partners.

2. The Grantee shall submit a revised program evaluation plan, specifying its program specific indicators and program baseline data no later than three months following award of this Grant. These indicators will be jointly defined by USAID and its Child Survival partners, as described in (e) above. The Grantee will submit an annual workplan in a format and on a schedule to be determined by USAID. The Grantee further agrees to report progress against select program indicators and to provide to USAID program implementation information required for its reviews held twice annually.

3. If the Grantee proposes or contemplates the construction or rehabilitation of structures, or other activity which could have a significant environmental impact, an initial environmental examination could be required before any Grant funds are expended for the purpose, and prior USAID approval as required by 22 CFR 216 must be obtained.

G. Indirect Cost Rate

The following CARE Indirect cost rates apply to this agreement:

1. CARE USA NICRA, approved by USAID/W on May 8, 1995.

- a. Type: Overhead  
Rate: 7.17%  
Base of Application:

Total direct costs excluding ocean freight, contributions in kind (including donated agricultural commodities), exchange fluctuations, and U.S. Government grants that due to legal restrictions do not permit indirect cost recovery. "Cash Grants" include PL-480 monetized proceeds.

- b. Type: A-133 Audit  
Rate: 0.62%  
Base of Application:

All U.S. Government cash grants and cost type contract expenses that are subject to audit. "Cash Grants" include PL-480 monetized proceeds.

2. CARE/Madagascar Indirect Cost Rate Agreement with USAID/Madagascar, March 17, 1995,

- Type: Overhead  
Rate: 15.44%  
Base: Cost to run the CARE Madagascar Office divided by the sum of Total Project Expenses, minus their contribution to the CARE Madagascar Office,

**Grant No. 687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment I**  
**5 of 5**

expressed as a percentage. The Specific Methodology is set forth in CARE Madagascar's 17 September 1994 letter to the USAID/Madagascar Grant Officer.

H. Title to Property

Vested in the recipient under the section 226.32 of 22 CFR 226.

I. Authorized Geographic Code

Procurement of goods and services shall be done in conformance with Optional Standard Provision No. 4. The complete text is found in USAID Handbook 13, App. 4C.

ATTACHMENT II

**PROGRAM DESCRIPTION**  
**CARE International Madagascar**  
**TOUCH 2000**

**I. INTRODUCTION**

Despite its status as a relative newcomer to Madagascar, CARE has gained considerable respect from government, donors and non-governmental organizations for its dynamism and program achievements to date. In the first two-and-one-half years of its presence in Madagascar, CARE focused primarily on natural resources management, sustainable agriculture and related economic development activities of women - all in rural settings. CARE delivered emergency assistance during and after the cyclone of 1994, and it was this experience in part that led the organization to consider developing its health sector. CARE will continue to be active in emergency response and rehabilitation as needs dictate, but health care programming will emphasize cooperative interventions promoting sustainable development at the community level.

As CARE became more familiar with the capital city of Antananarivo's urban socio-cultural and economic environment, the acute health situation of children under five became evident. Combined factors of killer infant diseases, a steadily deteriorating hygiene and sanitation environment, inadequate and/or overburdened health services, and the current economic crisis all converge at the household level to imperil the survival chances for infants under one. Children who survive are still extremely vulnerable before age 5. The combination of stunting due to chronic malnutrition, developmental disabilities due to nutrient deprivation, continual parasitic and respiratory infections and closely spaced births all exponentially jeopardize the child's physical status and ability to grow, thrive and resist. The child's critical early development becomes a downward spiral through an ever unraveling safety net.

**II. PROBLEM STATEMENT AND PROJECT SETTING**

**A. Problem Statement**

A Precarious Demographic and Economic Situation

The fourth largest island in the world, Madagascar has an area of 587,041 square kilometers and a population of nearly 12.1 million. The average population density is 17 per square kilometer; however this is very unevenly distributed, with over half the population living on 13% of the land, compounded by 6% annual urbanization. Children under fifteen years and women of childbearing age (15 to 49 years) constitute 16.5% and

24.3% of the population respectively. Madagascar has a fertility rate of 6.6%. No decline in this rate has been registered over the last 35 years, indicating a strong pronatalist tradition<sup>1</sup>. Over the last twenty years, urban salaries have progressively declined, and consumption patterns have followed suit. Urban environmental pollution has increased with no apparent solutions in view, and random civil violence is becoming a way of life in urban centers.

#### Deteriorated Hygiene and Physical Conditions

For the city of Tana in particular, the precariousness of this situation is compounded by a degenerating physical environment. The bulk of the urban poor live in slums that ring the center of the city and older, established neighborhoods. Population density in these slums is high, with 6 to 7 people often sharing a single room. Crowding has implications for environmental health, food security, violence, and general social adjustment for all members in the household, but in particular for a small child with few defenses. Contagious diseases, such as respiratory infections and scabies are easily passed from one child to the next.

The western part of Tana is a flood plain contained within the Andriantany Canal to the east and the Ikopa River to the west. In earlier times, this flood plain was a peri-urban agricultural basin during the dry season and a water runoff area in the rainy season. Under the pressure of urbanization, it has since become densely and haphazardly populated. Free community water systems in the areas were not designed to service the current demand (three public standpipes for 5000 people on average). During the rainy season, the community water taps and latrines are often under water and people are forced to drink contaminated flood water.

The rains notwithstanding, water supply and sanitation infrastructure has fallen into such disrepair and is so abused that all matter of fecal, household and industrial waste pollutes the community environment and feeds into the canals. Standing water becomes a breeding ground for mosquitos and diarrhea-producing pathogens. Epidemic outbreaks of cholera, hepatitis and plague are highly conceivable.

#### Multiple Childhood Disease Opportunities

In Tana, mild-to-moderate malnutrition is estimated at 48% in under-fives (resulting in stunted growth); moderate-to-severe at 40% (chronic underweight); and severe 5% (famished). The relationship between the hygiene environment and a child's health and nutritional status is intimate. Urban slum disease profiles show heavy frequencies of infectious parasitic diseases, including ascariasis, enterobiasis, gastroenteritis, and

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<sup>1</sup> Statistical references are compiled from a variety of sources. Care was taken to verify and cross-reference where possible, however current opinion holds that statistics for Madagascar are generally considered to be unreliable. Refer to Appendix IX for a complete list of references used in this document.

giardiasis. The mode of transmission for all of these parasites is the ingestion of focally contaminated water and food. In densely populated neighborhoods, dust-borne infections can occur as well.

High morbidity figures can be attributed to the heavy parasite burdens, causing digestive and nutritional disturbances, diarrhea, abdominal pain, vomiting, and not infrequently, bowel obstruction and migration of the worms into the liver and other organs. A child can become infected at less than one year. The debilitating effects of parasite-related diseases increase the child's vulnerability to still other diseases, including iron deficiency. And of course, the diseases can be fatal. The high incidence of dehydration due to diarrhea and other parasitic diseases are primary contributors to the infant mortality rate. Acute respiratory infections also present a serious menace to children's survival. In 1992, ARIs constituted the number one reason for medical consultations and were the leading cause of morbidity in children in Tana.

The vicious cycle of protein deficiency caused by repeat episodes of diarrhea leads to nutrient deficiency, which brings on other disease manifestations with their own serious consequences. Iodine deficiency (goiter) in its most severe form leads to mental retardation and neuro-motor handicaps. Statistics indicate that in Madagascar, goiter's highest prevalence (48%) is in the highlands which include the province of Antananarivo. Vitamin A deficiency, the leading cause of night blindness in children, is directly related to the inadequate composition of a small child's diet. Despite the absence of reliable statistics for Tana, a descriptive Malagasy phrase indicates that night blindness in small children is well-known ("*ankizy pahina rehefa hariva*").

#### Harmful Beliefs and Practices

Food consumption habits borne out of tradition and taboos aggravate the already perilous nutritional status of mother and child. Numerous harmful practices govern the realm of home remedies, from withholding nutritive foods during a bout of illness, to forceful ingestion of detrimental elements (chicory for a baby at six months to prevent thievery). Cultural taboos compromise the small child even in utero, as the pregnant woman is denied all manner of protein and nutrient-rich foods. There are "fady" (taboos) regulating the consumption by women and children of many foods - from eggs to meat and vegetables. In contrast, these very foods are often reserved for adults of solid social and physical stature. Traditionally, children eat last and least.

Other contributing factors include inconsistent breastfeeding and weaning practices. Less than half of all newborns are put to the breast at birth, and many mothers cannot breastfeed on demand due to work constraints. Sugar water is introduced even shortly after birth, and solid but nutrient-poor weaning foods as early as three months, long before the recommended 6 months.

### Food and Nutritional Insecurity

By and large, chronic malnutrition appears to be the status quo for urban children, where the majority of households are dependent on a cash income and not able to produce foodstuffs. About 75% of Tana's urban households are food insecure - meaning they are less and less able to purchase a nutritionally adequate market basket. The quality of food purchased and consumed has been steadily deteriorating, as micro-nutrient and protein-rich foodstuffs are priced out of reach. Rice is the main staple, and a meal is considered incomplete without it. Often its vegetable/protein complements are not nutritionally prepared. When a family cannot afford rice, it turns to even less nutritionally substantial foodstuffs, such as boiled manioc. Meal provision is random, and may not constitute three meals a day. Whole families, including small children, routinely experience food shortages at the end of the month and on a seasonal basis, as income dwindles. Food intake is reduced, eating fewer meals per day or eating less particular foods. Often children are put to bed before sundown so they sleep through the supper hour. There may be whole days without food.

### **B. Project Context**

#### Socio-Economic Environment

Over a quarter of the Malagasy population lives in urban areas, with an unemployment rate of 30%. Madagascar exhibits a classic indicator of urban socio-economic deterioration in the steady decline of urban revenue against rural revenue. A five percent growth in the non-formal sector is deceptive, because the average revenue from this type of activity is 40,000 FMG per month (\$9.00). The majority of operators in the non-formal sector are women. A recent study by the World Bank-financed Bureau de Projet de Développement de la Plaine d'Antananarivo (BPPA) attests to a phenomenon of "new poor" - families whose coping strategies were sabotaged by the recent fluctuation in the monetary system. Sometimes the financial impact of one single incident of illness can push a barely "moderate income" family below the security net.

For the populations living in Tana's urban slums, the combined pressures of financial decline, population growth, and the erosion of infrastructures and institutions - medical, social, government and family - have contributed to a general backwards slide across all development categories since the mid-1980s. The past year has seen an even more alarming decline, due in part to the devaluation of the Malagasy franc and to the flooding, wreckage and homelessness caused by the 1994 cyclones.

The social and physical environment of the typical urban child is increasingly precarious. The current economic situation in Madagascar distracts overburdened families from providing adequate care for their children. More time and energy is devoted to scrounging for the next meal. Adding to this is a disturbing trend which has been gaining attention: that of the "absent" father. Social and economic pressures lead many urban fathers to abandon their households, either permanently or in cycles. This situation appears to be

- 12 -

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**5 of 34**

accompanied by a distressing rise in alcohol intake, purchased with the limited available revenue. Women-headed households were recently estimated at close to 80% in one slum neighborhood of Tana. The urban child is often left in the care of an older sibling or grandparent while the mother spends several hours, if not the whole day, trying to earn money. For breastfeeding mothers, this consigns the child to a mediocre sugar water or porridge complement. The coping strategy for one adverse situation such as borrowing or selling small items to compensate for lack of money for food, compounds the all-around precarious situation.

Policy Environment

Policies proposed under the Structural Adjustment Program (SAP) are expected in the long run to be economically and politically beneficial for the country and its people. However, at present, there are adverse social and economic effects on the low-income sectors of the population, especially the urban poor who can no longer count on government subsidies for commodities and services. The most vulnerable groups suffering from the impact of economic policies are female-headed households and small children living in the slums.

The Government of Madagascar (GOM) has endorsed the Universal Declaration on the Rights of the Child and Program of Action approved at the 1990 UN World Summit on Children. It has included the study of the rights of the child in the Constitution of the Third Malagasy Republic. However, legislation governing the treatment and rights of the child has not been updated since 1963, and the reference text used for studying the Convention on the Rights of the Child is the 1889 French law concerning maltreated or abandoned children. There is no concrete evidence that the small child benefits from government policy.

It should be noted however, that the Ministry of Health has begun to address the plight of the country's malnourished children. At the national level, there exists the Service for Diet and Nutrition, and another Service for Human Nutrition and Diet within the Department of Mother and Infant Health. Food supplement distribution activities are conducted under the auspices of SECALINE (World Bank funded Nutrition and Food Security Project). The "Baby-Friendly" Hospital Initiative which promotes breastfeeding became policy in 1992. Unfortunately however, any program under government auspices is in all likelihood at a near standstill due to total absence of funds.

Operational Environment

Results of a literature review and of a survey conducted in the proposed project intervention zones, i.e. the western low-lying plains of Tana (see Appendix II.) reveal a profile of a population of about 125,000 people living in 22 fokontany (lowest urban administrative sector - see map of zone in Appendix III.). Of these, approximately 30,000 are women between the ages of 15 and 49 and about 20,000 are children under five. These are population estimates based on projections from the 1993 census. Real

figures are assumed to be higher.

In many of the fokontany the majority of households are headed by women. Their main economic activities are street food vending or laundering, which brings in about 25,000 Malagasy francs/month (@ \$7.00). As earlier indicated, public water standpipes are few and far between, and a number of them are non-functional. The rare toilet facilities consist of random above-ground latrines, occasionally suspended over a canal. Housing varies in form from post-cyclone constructions in wood and brick to haphazard combinations of scavenged materials.

The urban community may not enjoy the same sense of cohesiveness and kinship usually found in rural communities. There are, however, discrete mutual support networks - borrowing small foodstuffs, assisting at a funeral, etc. In terms of community organization, there are promising indications that the urban populations can initiate actions. Some dynamic neighborhood initiatives have borne fruit in the form of a primary school, a dispensary, a garbage collection system, and latrine-building.

At the community level, local non-governmental organizations play a significant role as service providers and catalysts for action. A few of them have developed networks at the household level using women leaders; others have helped organize water committees to manage public standpipes, and even initiated hydroponic vegetable gardening. Scale is necessarily small, but manageable for the communities.

Communication in the urban setting is more diffuse than in rural settings; people are influenced by a variety of channels that include electronic media as well as traditional forms adapted to the metropolitan profile. Radio is an extremely popular medium for both men and women. The written press enjoys wide readership, even in rural settings (Madagascar in general has a fairly respectable literacy rate). A recent phenomenon that offers interesting IEC possibility is the explosion of video clubs. In Tana alone, there are over 140 small outlets that show entertainment films. People somehow manage to find the 300 FMG.

#### Health and Social Services Environment

In the urban and peri-urban setting of Tana, health services are offered through the MOH "Circonscription Médicale" and in many cases, via private or NGO health centers. In general, the population is extremely dissatisfied with the quality and accessibility of care at the public centers, but can ill afford the fees of the private centers. Discussions with the doctor in charge of a public dispensaire which covers one of Tana's Firaisana (130 000 people) and receives many patients from the low-lying slums, revealed a grim situation: 60-80 patients for free consultations a day, no equipment or medicine at all, no supervisory visits from the Circonscription Médicale, no operating budget. They are minimally informed about MOH policy via "notes de service".

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**7 of 34**

The central public hospital of Tana, Befelatanana, runs a "CRENI" (Centre de Récupération Nutritionnelle Intensif) for severely malnourished children. This is a referral point for the numerous "CRENA" (Centre de Récupération Nutritionnelle Ambulatoire) spread around the city for mild-to-moderate nutrition rehabilitation. The CRENA are mostly run by local NGOs through a health and social center, and supported by food from SECALINE and World Food Program.

Most current responses to infant and child malnutrition employ critical intervention strategies that concentrate on immediate physical survival. However, small children then return to a community and household environment that continues to breed the very same diseases that led to the ill and malnourished condition. The causes and subsequent solutions are clearly multi-dimensional.

Recent visits to a number of private/NGO centers gave the following picture: heavy infant/child caseload (diarrhea and malnutrition or nutrition-related complications); significant presence of environmental and sanitation-related diseases (scabies, diarrhoea, parasitic infections); little household level outreach capacity. The centers all charge nominal fees, basic medicines and equipment are for the most part available. Health education activities at or out from the centers are practically non-existent. Interest for extending to the household level appears high, however, providing good points of entry for strengthening clinical and outreach child survival interventions. Educational outreach to the community and household and networking among organizations will be key project activities.

Each of the project's potential local NGO partners has a particular set of strengths and weaknesses in delivering child survival services (see discussion in Appendix IV). However, all share a desire to improve their capability to respond to the dire needs surrounding them. This can lead to a much stronger health care and outreach network throughout the project zone to address the needs of small children who are currently suffering without adequate care.

#### CARE's Organizational Environment

CARE began operations in Madagascar in 1992. The mission has projects dealing with natural resources management, sustainable agriculture, integrated conservation and development, and development of economic activities with women. The mission also has an emergency response program as well as a post-emergency rehabilitation project. CARE's portfolio has grown significantly, and is now managed by a staff of seven expatriates and 143 nationals throughout Madagascar (Masoala, Diego Suarez, Ambovombe, Tamatave, Antananarivo).

#### **USAID Program**

The United States Agency for International Development is re-orienting its approach to development assistance through the mechanism of "Results Packages", which identify

priority intervention areas and approaches. One Results Package focuses on reproductive health, and another on nutrition improvement of the under-five child by applying basic child survival strategies. A consortium of collaborating agencies and partners will be recipients of grants to implement these activities in harmony with their execution capacity and organizational vision. The USAID centrally-funded BASICS project is represented in Madagascar and will serve as a technical resource to USAID child survival grantees.

#### Other Partners in Child Survival

As indicated earlier, the child survival arena is host to a variety of players. Other international agencies intervening at various levels include: UNICEF, Coopération Française, Catholic Relief Services, Médecins Sans Frontières and Peace Corps. The challenge for the project will be to inspire appropriate collaboration, quality programming and effective technology transfer among these key agencies and the project NGO partners. CARE envisions participating in a consortium of USAID child survival grantees to coordinate and share technical resources and strategies.

### **C. The problem and the challenge**

#### i) The problem

Small children between the ages of 0 and 5 in the slums of Antananarivo are extremely vulnerable to a variety of health and social adversities that threaten their survival and seriously impede their developmental process. Debilitating parasitic and diarrheal diseases, deadly respiratory infections, nutrient deprivation due to chronic food insecurity, harmful practices due to lack of health and nutrition education, produce an effect on the small child that inhibits his capacity to survive and develop. His existence is defined by a chain of health and social handicaps. Environmental health hazards are so profound that health interventions alone will not produce the necessary impact. The existing services and networks do not form a sufficiently strong safety net for this particular age group.

#### ii) The challenge

The challenge for CARE Madagascar will be to transform available municipal, community and household structures into a network of health and social services and resources that will be both responsive and pro-active to these needs in the target zones. This sector needs assistance to redress insufficient infrastructure, poorly trained personnel, and inadequate response systems for the welfare of the small child. The points of entry for the project will be nutrition improvement and related child survival strategies. Mechanisms must be developed to reach all the way to the household level, where behavior change will be the key indicator that project efforts are having the desired impact. Community and household-level health and environmental improvement actions should become catalysts for other community and economic development activities.

## II. TASKS

### A. Ultimate objective

Over a period of 3.5 years (1996 - 1999) the TOUCH Project will improve the nutritional status of at least 20,000 children ages 0 to 5 in 22 "fokontany" or neighborhoods in the urban slums of Tana, through child survival interventions at the public and private health facility, community and household levels.

To accomplish this, the project will act to reduce the prevalence and fatality in children under five of malnutrition (protein, calorie, micronutrients), diarrheal and parasitic disease, acute respiratory infections, and other preventable childhood diseases (measles, tetanus, polio, diphtheria, whooping cough).

### B. Strategic Points of Entry and Component Overview

The project has chosen the improvement of nutritional status in under-fives as a key entry point for influencing small child health. The preceding problem analysis discusses the multiple factors influencing the severely compromised health and nutrition situation of small children in Tana's slums. CARE believes that in order to positively affect this situation, an approach is required which addresses the interrelationship of health facility, community, and family factors, be these socio-economic, behavioral, or environmental.

Through such an approach - described in detail below - the potential beneficiaries of the TOUCH Project are automatically far greater than the children under 5 in the slum zone. The entire families of these small children stand to benefit directly from improved environmental conditions, health and social support services, and better economic opportunities.

### C. Activities

Four key linked project components are proposed to assure maximum positive impact on the causes of preventable childhood illness and malnutrition.

i) The first two components (component 1 & component 2) are the primary technical interventions and concern the improvement of:

- 1) health/social services delivery, and
- 2) community sanitation and hygiene conditions.

Through these components, CARE will provide assistance to local NGOs and other existing health services to widen the availability and improve the quality of treatment for sick children and prevention services for families at risk. The project will also work with community groups and municipal services for the improvement of environmental hygiene and sanitation conditions which are disease breeding grounds. Through these actions

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**10 of 34**

CARE will to attack key factors influencing child survival in Tana's slums: multiple disease opportunities, inadequate health services, poor provider training, lack of information on prevention, and insufficient sanitation infrastructure.

ii) The third component, Strengthening the Capacity of Local Institutions, supports both main technical ones and ensures the sustainability of inputs proposed for Components One and Two. CARE, through the project, plans to engage partner institutions in a diagnostic analysis and action planning process leading to more capable and effective local organizations.

iii) The fourth and final component, Household Income Opportunities, is perhaps the most critical as it addresses the root cause of malnutrition: poverty. CARE will prepare a separate proposal for this activity which will be integrated with the TOUCH project. It's aim will be to improve the purchasing power of households, especially those headed by women, in the same slum areas of Tana targeted by TOUCH. CARE's experience elsewhere in urban food security provides a bank of resources for this component. CARE will submit this proposal to USAID and other potential donors for funding.

**Component 1: Improving Health Services Delivery**

The goal of this principal component over the period of 3.5 years will be to expand and improve the delivery of health and social services already operating in the project zone to treat and prevent key childhood illnesses: malnutrition, diarrheal

disease, ARI, and communicable childhood diseases such as measles, DPT, polio.

**Results Indicators**

- 1a. Percentage of children 12 to 23 months age with signs of stunting reduced by 20% below baseline and measured by standard deviations from norm of height for age, as recommended by USAID.
- 1b. Percentage of children under 5 with signs of acute malnutrition (weight for height 2 standard deviations from norm) reduced by 20% below baseline
- 1c. Percentage of children receiving oral rehydration therapy (including fluid administration, continued breastfeeding and food, and referral) for diarrheal disease incidence increased by 20% above baseline.
- 1d. Percentage of children 0 to 6 months who are reported to be exclusively breastfeed increased by 25% above baseline.
- 1e. Percentage of women who practice improved weaning and feeding techniques of children under five increased by 20% above baseline.
- 1f. Percentage of children under 5 with signs of an acute respiratory infection who are taken to an appropriate provider for assessment increased by 25% above baseline.
- 1g. Percentage of children who are fully vaccinated by antigen before their first birthday increased above baseline by:

DPT1 (indicates access to services)	25%
Measles (proxy for...)	40%
Fully (card verification)	35%
- 1h. Percentage of pregnant women vaccinated with 2 or more doses of Tetanus Toxoid increased by 35% above baseline.
- 1i. Percentage of family planning acceptors increased by 10% above baseline.

Main Outputs

As a result of project activities, participating health centers will be expected to have most if not all of the following:

- At least one medical staff member trained in integrated management of the sick child
- Pre/post natal services with counselling
- Ongoing breastfeeding and nutrition counselling
- Regularly scheduled vaccination sessions
- Oral rehydration unit or corner for diarrhea patients
- Family planning clinical and counselling services or referral system
- Community outreach and home visit program for education and follow-up of cases
- Referral system for ARI, malnutrition, and other cases beyond the capability of the center
- Regular supply of essential drugs and contraceptives
- Cost recovery scheme
- Educational materials
- Regularly scheduled preventive health education sessions

Activities

- Technical in-service training for medical and paramedical personnel
- IEC materials development and user training
- Center refurbishing/expansion
- Personnel performance monitoring and supervision
- Provision of certain materials and equipment (essential drugs, ORT equipment, contraceptives, diagnostic tools, etc.)
- Identification, development and dissemination of technical resource materials (journals, "fiches techniques", etc.)
- Counselling/outreach training for social work/paramedical staff
- Baseline studies, progress and impact monitoring
- Short term technical assistance (e.g., cost recovery, specific disease management training, micronutrient supplementation program, family planning methods)
- Network creation for technical and peer support to centers

**Component 2: Improving Community Environmental Conditions**

The goal of this component will be to reduce the risk of sanitation and hygiene-related disease transmission in the home and community by providing safe means for excreta disposal, access to safe drinking water, and instruction/training in domestic, food and personal hygiene.

**Results Indicators**

- 2a. Percentage of households using excreta disposal systems increased from baseline to 40%.
- 2b. Percentage of households using safe water transport and storage methods increased from baseline to 25%.
- 2c. Percentage of street food vendors using soap and water for hand and dish washing increased from baseline to 15%.
- 2d. Number of community planned and managed environmental improvement actions increased from 0/year to 2/year per fokontany.
- 2e. Percentage of households with good hygiene practice trails that indicate adoption of at least three practices (e.g. hand soap, place to wash clothes/self/children, clean floors, safe water/dishes/utensils storage, aerated cooking space) increased from baseline to 20%.

Main Outputs

As a result of project activities, target communities (fokontany) will be expected to have:

- A Community Action Committee
- A public water tap with apron for every 1000 inhabitants
- Safe, appropriate and affordable family excreta disposal facilities (latrines) for 1/2 of the households in participating fokontany
- Ongoing community-based system for monitoring and assuring hygiene of trouble spots (canals, market places, "hotely", street food vendors etc.)
- Household-level community-run outreach and surveillance system (water storage, hygiene education etc)
- User-managed financing system for improved water supply, along the model of the Comité de Développement d'Andohatapenaka

Key Component Activities

- Creation of committees and training of community leadership
- Training and supervision of community "animateurs"
- Peer education through home visits and counselling by community volunteers (such as women "chefs de quartier")
- IEC strategy and materials development
- Peri-urban sanitary engineering technical assistance
- Latrine construction
- Water tap and apron rehabilitation
- Community-based progress monitoring
- Short term technical assistance for special needs

**Component 3: Institutional and Community Capacity Building**

The goal of this component is to assure sustainable impact by developing or strengthening the institutional capacity of partner organizations (community groups, local NGOs and government services as possible) to respond to the evolving health and environmental situations in their setting. In addition, capacity-building at the household level will involve promotion of sustainable behavior change and skills needed by families to better manage factors within their control.

**Results Indicators**

- 3.a Availability of child health prevention and treatment services increased by 25 % per participating center.
- 3.b Clientele for maternal/child services increased by 25 % per partner center.
- 3.c Community actions initiated, financed and executed without TOUCH project facilitation increased from 0/year/committee to 1/year/committee.
- 3.d Training programs designed and carried out without outside technical assistance increased from 0/year/partner NGO to 1/year/partner NGO.
- 3.e Development and execution of strategic plans of action without external impetus increased from baseline to 90% for partner NGOs.
- 3.f Long term financial viability of partner NGOs demonstrated by obtention of funding from a variety of sources to support strategic plans.

**Main Outputs**

As a result of project activities, partner organizations (local NGOs and community-level organizations such as Action Committees) will be expected to have:

- Institutional attributes including mission statement, bylaws, Board of Directors, registered with GOM.
- Programming capacity to be able to perform problem analysis, solution conceptualization, and strategic planning for their purposes.
- Training and skill transfer capacity if this capacity is part of the organization's mission.
- Operational capacity to execute and supervise activities; monitor and evaluate their organization's effectiveness, and to assure access to necessary information and resources (human and material).

- Financial capacity through budgeting, expense monitoring and the development of cost recovery and cost-cutting schemes, at the organizational, community and household levels. Also to access outside funding through proposals.

**Key Component Activities**

- Institutional strengths/weaknesses/absorptive capacity diagnosis
- Assistance in organizational mission, structure and bylaws definition
- Assistance in legalization of NGO status with GOM
- Training and periodic technical assistance for partner organizations in basic management and administration, long range planning, fundraising and financial planning, monitoring, etc.
- Networking with NGO umbrella organizations and other NGO sector initiatives in Madagascar.
- Development of manuals and guidebooks for NGOs

**Component 4: Urban Household Income Opportunities**

An indispensable component will address the root cause of malnutrition - poverty. It will involve creating economic opportunities at the household level, and for women in particular, to address the problems of food and nutritional insecurity. Models for creative and successful urban poverty alleviation efforts elsewhere (small credit/loan programs, marketable skill training, cooperatives, labor-intensive remunerative activities, etc.) will be adapted for this component. Since this component is critical to the ultimate success of its urban community health efforts, it will be the subject of a separate project proposal which will be aligned with the TOUCH target zones, implementation timeframe, and intended beneficiaries. This proposal will bring the lessons learned in other urban food security programs and best available expertise to bear on the design and execution of the sub-project. The proposal will be developed in early 1996 and will be submitted to USAID and other potential donors for funding.

**C. Project Implementation Approaches**

**1. Grouping and Phasing of Activities**

Within all three components, activities will be grouped into and carried out by phases. These follow each other logically and provide a structure for component coordination:

- a. Organizational/Situational Diagnosis  
(Needs/Capacity Assessment, Problem Identification)

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**16 of 34**

- b. Program (Action Plan) Development, including
  - Work plan
  - Training plan
  - Procurement Plan
  - Monitoring and evaluation plan
  - Funding requirements
  
- c. Program Execution, including
  - Work plan implementation
  - Training and supervision
  - Monitoring
  
- d. Evaluation and Reprogramming

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**17 of 34**

The following tables group a representative sample of activities by phase for each of the three components to provide an overview of the project in action over its allotted timeframe:

**COMPONENT ONE: HEALTH SERVICE DELIVERY**

DIAGNOSIS/ NEEDS ASSESSMENT	PROGRAM DEVELOPMENT/ ACTION PLANNING	PROGRAM IMPLEMENTATION	MONITORING EVALUATION
<ul style="list-style-type: none"> <li>- Conduct baseline mortality and malnutrition and disease prevalence surveys and community/family socioeconomic profiles</li> <li>- Conduct knowledge, attitude, coverage surveys</li> <li>- Conduct training needs assessment of health center personnel</li> <li>- Health center service delivery capability assessment: space, equipment, personnel, supplies</li> <li>- Conduct "willingness and ability to pay for services" study</li> </ul>	<ul style="list-style-type: none"> <li>- Finalize project results indicators</li> <li>- Develop home visiting and community outreach program plan</li> <li>- Develop IEC strategy for key interventions: CDD, EPI, BF, FP ARI etc.</li> <li>- Develop training plan for health center medical and outreach staff</li> <li>- Develop center-based action plan to improve service delivery</li> </ul>	<ul style="list-style-type: none"> <li>- Set up reporting and monitoring system at project, center and community level</li> <li>- Carry out preventive programs at centers and in community</li> <li>- Carry out multi-media and group/face to face IEC program</li> <li>- Design and carry out TOT and technical trainings</li> <li>- Refurbish centers</li> <li>- Carry out regular performance-based supervision of personnel</li> </ul>	<ul style="list-style-type: none"> <li>- Monitor the following using project-generated or refined indicators :</li> <li>- Performance of trained personnel</li> <li>- Performance of centers in service delivery</li> <li>- Effectiveness of IEC program</li> <li>- Effectiveness of project management</li> <li>- Readjust different program areas as needed</li> <li>- Evaluate results of program activities against indicators stated at outset</li> <li>- Reformulate component as needed</li> </ul>

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**18 of 34**

**COMPONENT TWO: COMMUNITY HYGIENE/SANITATION IMPROVEMENT**

2

DIAGNOSIS/ NEEDS ASSESSMENT	PROGRAM DEVELOPMENT ACTION PLANNING	PROGRAM IMPLEMENTATION	MONITORING EVALUATION
<ul style="list-style-type: none"> <li>- Baseline surveys on hygiene practices and sanitation</li> <li>- Participatory community mapping exercise</li> <li>- Assessment of capacity of existing community groups</li> <li>- Training needs assessment of animateurs</li> <li>- Technical engineering assessment of current water/sanitation infrastructure</li> <li>- Study willingness and ability to pay user fees for water maintenance</li> </ul>	<ul style="list-style-type: none"> <li>- Develop or finalize results indicators and monitoring plan for this component</li> <li>- Develop community sanitation improvement plan based on mapping exercise</li> <li>- Develop IEC strategy for household hygiene behavior change</li> <li>- Develop training strategy for animateurs and local committee members</li> <li>- Develop appropriate excreta disposal program for peri-urban area</li> <li>- Develop community financial management plan for water &amp; sanitation infrastructure</li> </ul>	<ul style="list-style-type: none"> <li>- Establish progress monitoring mechanisms</li> <li>- Help communities form or enhance action committees</li> <li>- Help communities to carry out clean-up program</li> <li>- Identify and train women community leaders</li> <li>- Carry out household hygiene education program with animateurs and women leaders</li> <li>- Carry out community-wide IEC</li> <li>- Carry out training of trainers for animateurs</li> <li>- Carry out community management skill training for committees</li> <li>- Carry out latrine construction and water source rehabilitation program</li> <li>- Train committee members in financial management, etc.</li> </ul>	<ul style="list-style-type: none"> <li>- Monitor effectiveness of household, community and project hygiene and sanitation initiatives using indicators and mechanisms established at outset</li> <li>- Evaluate results and readjust program areas</li> </ul>

— COMPONENT THREE: INSTITUTIONAL STRENGTHENING

DIAGNOSIS/ NEEDS ASSESSMENT	PROGRAM DEVELOPMENT ACTION PLANNING	PROGRAM IMPLEMENTATION	MONITORING EVALUATION
<ul style="list-style-type: none"> <li>- Collaborative diagnostic exercise with partner NGOs to determine institutional strengths and weaknesses</li>   <li>- Finalize or revise results indicators and monitoring mechanisms for this component</li>   <li>- Training needs assessment for NGO and community admin/management personnel</li>   <li>- Inventory services and NGO capacity-building actions elsewhere</li> </ul>	<ul style="list-style-type: none"> <li>- Draft contract agreement between NGO and project</li>   <li>- Produce procurement plan for materials and equipment needed by organizations</li>   <li>- Install monitoring mechanisms</li>   <li>- Develop training plan for different categories of personnel and skill needs</li>   <li>- Plan collaboration and coordination with larger NGO sector</li> </ul>	<ul style="list-style-type: none"> <li>- Procure necessary equipment and materials</li>   <li>- Develop guidebooks, procedural manuals and other support materials as needed</li>   <li>- Carry out trainings, technical assistance, special events for strengthening partner NGOs</li>   <li>- Participate in national or local NGO functions</li> </ul>	<ul style="list-style-type: none"> <li>- Monitor progress and effectiveness of activities carried out in this component according to indicators and mechanisms established at the outset</li>   <li>- Adjust workplans as needed</li>   <li>- Evaluate results obtained from carrying out institutional capacity building activities</li>   <li>- Redesign component in function of evaluation data</li> </ul>

**2. Project Implementation Zones**

The proposed project area (see map in Appendix III) comprises two distinct zones of Antananarivo city. The northern part has numerous small NGOs and community groups, and embryonic community initiatives. The southern area has next to no facilities or NGOs, and is worse off. CARE proposes to begin immediately (January '96) in the northern zone in two areas grouping about four to five fokontany each. Each area allows for intensive work in either Component One or Two, but each has ample opportunities for carrying out the other components as well.

The first area (Tsaramasay) has a small cluster of health and social NGOs, some nutrition recuperation efforts and an embryonic household outreach system using women leaders. Here, the conditions are ideal for starting with an emphasis on strengthening both treatment and prevention services and institutional capacity of local NGOs.

The second area (Antohomadinika) has an active community association which has already accomplished a number of small projects with outside help, including construction of 100 post-cyclone houses. The sanitation and hygiene conditions, however, are greatly lacking. Here, the preconditions are ideal for testing out approaches for improving community environmental health factors, and for strengthening local community capacity.

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**20 of 34**

Health service delivery and NGO capacity-building improvements would occur here as well.

CARE confirms that all NGOs mentioned below are serving in the target zone and have expressed their willingness to have a partnership with CARE in the implementation of the project.

At Tsaramasay

- Centre Social de Tsaramasay
- Association MIARISOA
- Dispensaire du Foyer Evangélique

At Antohomadinika III G Hangar

- Association Soa Iombonambe
- Terre des Hommes-Suisse
- ATD Quart-Monde

At Antohomadinika Sud

- Association Fanavotana
- Terre des Hommes France

At Ankasina

- ATECOM

At the municipal level

- Centre de Travail Social (School of Social Work, Antanimena)
- Lutheran SALFA
- CARFEM (Carrefour des Femmes)

During the first year, project staff will study the situation in the southern zone more closely to define the best overall approach to take, to identify potential collaborators and community leaders, to prepare the communities for the project, and possibly to conduct some baseline data collection. Full start-up in this zone is anticipated for January '97. The whole range of activities (see tables above) is planned for the rest of the life of the project in the whole region.

### **3. Particular Implementation Approaches for Components**

#### **Component 1: Health Services Delivery**

The basis for working with health/social centers will be a contract between the project and the local organization. The agreements in the contract will be based on the results of the needs and capacity assessment exercise at the beginning of the project. Through the contract, the organization will commit to expanding and improving its facility-based and outreach child health and nutrition services. Technical, material and other assistance to be provided by the project will be specified in the contract. This document then becomes the basis for a work plan. The project's commitment to the institution will be either to provide the required assistance or to facilitate its obtention elsewhere. A sample of contractual agreements which CARE applies in other projects has been forwarded to USAID.

Additionally, a cadre of social workers will be recruited for the project through Tana's only (and non-governmental) school of social work located in Antanimena. They will be assigned to participating health centers for outreach, community education and families-at-risk-for-malnutrition casework activities. CARE hopes to thus create a resource pool of well-trained community outreach workers, as well as to strengthen the capacity of the School for Social Work to train and place professional social workers.

Partnerships with UNICEF and other international donors will provide the project with primary health care equipment and supplies such as essential drugs and nutrition surveillance materials. Family planning equipment and supplies will be obtained through USAID's APPROPOP Project.

#### **Component 2: Community Hygiene/Sanitation Improvement**

The approach envisioned for this component is for "animateurs" hired and trained by the project to work as community organizers to help residents in target fokontany to form community organizations and to plan and carry out environmental improvement actions. This will need to be a step-by-step process in an urban, poor, often fragmented environment. The animateurs will be expected to collaborate closely with the fokontany president and officers who are elected by the community, and local NGOs. They will be assisted by project technical advisors competent in community sanitary engineering.

CARE has begun a collaboration with the French government's "filet de securité" Programme Accélééré d'Initiatives de Quartier (PAIQ) which has permitted it to begin identifying qualified community animateurs and the process of rapid urban appraisal to define solutions to local environmental conditions.

CARE expects that the project's process of community organizing and support will help to attain both the technical goals of environmental hygiene improvement, and the goals of strengthening community and family institutions.

**Component 3: Strengthening the Capacities of Local Institutions**

The contractual approach presented above for Component One will also serve to accomplish the goals of Component Three, Institutional Capacity Building.

- For local NGOs, the project will engage in a collaborative diagnostic exercise with each to determine strengths and weaknesses in the areas of organizational vision and structure, financial management, funding and cost recovery, training, personnel management, adequacy of location and equipment. The project will enter into a contractual arrangement with the NGO through which the project provides training and technical assistance in weak areas, certain necessary materials, and the NGO carries out direct health care, health education and community outreach services as part of the TOUCH strategy to improve the health and nutrition status of small children. The project will, of course, provide technical training and support, but under the Strengthening Health Service Delivery component.

CARE expects certain capacity weaknesses to be relatively common among partner NGOs, and to conduct group trainings in these areas, with follow up to the individual organizations. This will also serve the purpose of encouraging networking, resource-sharing and collaboration among local institutions, which is currently a problem in the project area.

- For community committees (Associations de Quartier), the project will help neighborhoods to form and legalize such committees. It will then provide training in such areas as community mobilization and organizing, community financing and maintenance of improvement actions, hygiene behavior promotion and monitoring, peer counselling, and other topics as identified during the assessment process.

- In addition to the two categories of institutions above, the project will work with larger NGOs such as Carrefour des Femmes (CARFEM), the Antanimena School of Social Work, and the Lutheran SALFA, to contract for specific services such as providing a number of social and other outreach workers to the project or implementing special activities (studies, work with slum youth, etc.). The project will provide technical and some material assistance to each of these institutions after capacity diagnosis in order to strengthen their capability of delivering health and social services to populations far greater than in the project zone.

CARE is aware of the current efforts to coordinate and strengthen local NGOs through umbrella organizations and other means, and will assure partnership between collaborating NGOs and these efforts through the TOUCH project.

The candidate for TOUCH NGO Liaison has legal training and part of her terms of reference will be to provide guidance to partner NGOs in legitimizing their existence before the government. CARE will not enter into a contractual arrangement with an NGO unless it has the required legal status. The contractual approach accommodates the partnership element of the project, and allows for flexibility in program development. In some cases, partners may not be capable of nor inclined to engage in certain types of activities, though others may choose to deal with the whole range for greater impact.

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**23 of 34**

**D. Strategies**

Across all components, the Project will deploy three key strategies designed to produce optimal results from the inputs:

- \* Information, Education and Communication (IEC),
- \* Training, and
- \* Outreach/Home Visiting

The first "Results Strategy", IEC, will foster behavior changes required for improved child health and nutrition status. Facilities, communities and households will be the channels for Project IEC, with emphasis on in-home, face-to-face contact, peer education and counselling rather than message dissemination.

**1. Information, Education, Communication (IEC)**

Results of the TOUCH project will be measured in terms of behaviors which, when applied routinely by mothers, health care providers and other persons influencing the health of small children, can be expected to have a significant positive impact on their health and nutritional status. An unused latrine is no better than no latrine, and costs more. People must know not only why they must be used, but actually do so.

CARE views IEC and training efforts as the critical investments for assuring that correct, helpful behaviors are permanently adopted by the target population (which includes outreach workers, community organizers, and trainers). The likelihood for success of a behavior change program is an emphasis on face-to-face counselling and group discussion which takes into consideration the circumstances of individuals and families. It also creates the possibility of dialogue and indicates respect for the target groups which "message dissemination" cannot achieve. This approach will be a characteristic of the TOUCH project's IEC efforts.

The TOUCH project's IEC strategy will include but not be limited to the following activities:

- Collection, assessment, adaptation and reproduction of IEC materials on subjects related to project goals (control of diarrheal disease, acute respiratory infection, family planning, immunization, nutrition, hygiene, food safety, breastfeeding, safe water and excreta disposal ;
- Development of culturally appropriate multimedia IEC strategies aimed at urban slum populations using best available expertise and coordinating/collaborating with BASICS and APPROPOP who already have a wealth of IEC resources and experience ;
- Introduction of innovative IEC methods such as community video clubs and popular musical artists as channels for IEC;
- Relying heavily on peer in-home counselling ;
- Monitoring of message and approach consistency for all project components, in collaboration with other USAID child survival partners;
- Intensive training in IEC methodologies for health center staff, outreach and social workers, community

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**24 of 34**

"animateurs," members of peer counselling networks (e.g. local women "chefs de quartier"), in coordination/collaboration with other USAID child survival partners

- Development or procurement and adaptation of guidebooks and other support materials for workers as required.

The TOUCH approach does emphasize improvements in hygiene and child health promotion behaviors at the household and health center levels to be accomplished through IEC and hygiene education strategies. To track the effectiveness of this approach, CARE will use a version of behavioral risk analysis and behavior-based monitoring which has been developed jointly by CARE Bangladesh and the USAID centrally funded Environmental Health Project (former WASH Project). This methodology combines qualitative and quantitative data collection methods to define both the content of baseline surveys, measurable indicators to monitor and educational strategies which are appropriate to the culture and community. The approach collects and analyzes disease prevalence survey results and data generated through focus group discussions, community mapping, rapid appraisal techniques for knowledge, attitude and practice assessment.

2. Training

The skills required to execute this project will be new for a great number of players. CARE anticipates that training activities will be ongoing throughout the life of the project. Each new phase will require training for those who must help communities manage their environment, establish new services at their health center, conduct baseline surveys, monitor hygiene behavior change, transfer technical skills, etc.

The projected training requirements for the different levels of project staff and partners are presented in the table that follows:

Grant No.687-0107-G-00-6024-00  
**Child Survival**  
**Attachment II**  
**25 of 34**

<b>ANTICIPATED TRAINING REQUIREMENTS</b>		
<b>Participants</b>	<b>Skill/Subject</b>	<b>Trainer</b>
<b>Health workers:</b> - doctors - nurses - paramedicals	*Integrated Clinical Management of Sick Children * Nutrition * Preventive Medicine (Immunization, Breastfeeding) * Clinical Family Planning * Counselling	Project Training Specialists with technical specialists
<b>Midwives</b>	* Nutrition * Pre/post natal care * Family Planning * Counselling * Breastfeeding support	Project Training Specialists with technical specialists
<b>Outreach Workers</b> - Assistantes Sociales - Animateurs	* Training of Trainers * Communicable Disease Prevention * Nutrition * Community Outreach and Organizing * Casework and Counselling	Area Specialists with Project Trainers  Animateurs
<b>NGO Managers</b>	* Strategic Planning * Monitoring/Evaluation * Fundraising * Program Management	Specialists with project Trainers
<b>Community Leaders</b> (committee officers, fokontany presidents)	* Action Planning * Meeting skills * Community Mobilizing * Community Financing * Environmental Health Issues	Animateurs  Assistantes Sociales
<b>Community Peer Educators</b> Femmes Chef de Quartier	* Hygiene * Nutrition * Counselling * Community-based Sick Child Management	

Training of trainers will be an important element of the project's training strategy. Toward the end of the project, CARE hopes to have established a cadre of competent local trainers who are versed in the project's technical areas (child health and nutrition, community hygiene/sanitation, organizational development), and can participate in future activities of a similar nature.

The project will use a practical skill-based, experiential training methodology suitable for adults, literate or semi-literate. It expects to assemble, assess and adapt training modules on skills necessary for the project. Many

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**26 of 34**

such modules are currently available from U.N. and other international agencies. CARE promotes the notion of collaborative sharing of training resources (trainers, sessions, modules, techniques) among the group of USAID child survival partners as well as with BASICS.

Through the project, CARE intends to improve the potential for positive impact by casting a net wider than the selected project zones to identify people who might benefit from trainings offered, and who in turn can improve services to benefit the project target population. Such persons will include medical or social work personnel working in reference hospitals and health/social centers which regularly accept patients from the slum areas. This strategy would also serve to harmonize treatment protocols and preventive IEC messages and methods throughout a given zone.

**3. Outreach and Home Visiting**

Families most at risk in Tana's slum areas are the least likely to present themselves at a health center. Often, shame compels them to keep malnourished or ill children out of sight. The TOUCH project will develop a systematic community outreach/home visiting program using social workers ("Assistantes Sociales") contracted for the project and based at participating health facilities, and women leaders ("chefs de quartier") - preferably ones who have had malnourished or ill children who were successfully and simply treated, and are thus credible peer educators. The women leaders will be trained and supported by the social workers.

Through this special approach, the project intends to identify families at risk and enroll them in a project-sponsored but center-based support program which would include a range of simple support services:

- Nutrition rehabilitation and family education for mild to moderate problems,
- Income generating and child care possibilities, and
- Counselling through intensified home visits to develop appropriate coping strategies (such as more rational household economics) in the face of food insecurity.

The basic purpose is to strengthen the home environment of the mild to moderately malnourished child to prevent a "rehabilitation until the next episode" scenario which is so common for nutrition rehabilitation programs.

**4. Special Low Cost, High Impact Interventions**

**a) Deworming**

People in urban slum areas carry a heavy burden of intestinal protozoan and helminthic parasites. These infections produce diarrhea, abdominal pain, nutritional disturbances, and anemia. Where malnutrition prevalence is greater than 25% and until sanitation services are available for all, international health organizations are recommending periodic massive deworming programs through the primary health care system to reduce the parasite burden in the population.

The cost is low, the results clear and sometimes even dramatic: Mass single dose chemotherapy in Kenyan schoolchildren improved their overall growth and development, since reduction in hookworm has a positive effect on iron deficiency. Cost estimates are 20 cents per child per year for a single dose of vermifuge, procured through the project's partnership with UNICEF.

UNDP has begun large-scale deworming programs in other African countries (see Appendix VII) which can inspire similar actions in Madagascar. The TOUCH project intends to conduct deworming campaigns on a trial basis in

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**27 of 34**

neighborhoods where urban latrines will be built and used to complement the effectiveness of the measures. Young children are the ideal target for such a program since they have higher worm burdens than adults. The network of local health/social centers, community organizations and local NGOs which TOUCH hopes to foster will provide the necessary vehicle for carrying out such campaigns.

b) Micronutrients

It is now well-documented that deficiencies of Vitamin A, iron and iodine cause numerous grave intellectual, physical, and developmental problems in small children and also in women of childbearing age. These deficiencies are so serious and so simple to prevent and treat that 3 of 26 sectoral goals in the Universal Declaration of the Rights of the Child are devoted to improving micronutrient malnutrition.

In Madagascar (especially in the highlands), iodine deficiency is a significant problem. UNICEF, in collaboration with the MOH, has launched a national salt fortification program. Research into Vitamin A deficiency has barely begun. No studies whatsoever on iron deficiency in children 0-5 exist, but given the general poor nutritional and sanitation status of Tana's slums, in all likelihood it represents a serious problem. Anemia in women of childbearing age is also a likely problem given poverty, poor nutrition and closely spaced numerous pregnancies.

The TOUCH project proposes to support the MOH/UNICEF national nutrition strategy for micronutrient malnutrition prevention, and to initiate local efforts where appropriate. This can be done by carrying out small scale studies and developing appropriate programs to carry out within the context of the project. Depending on study results, interventions might include supplementation at health centers, diet diversification education and training, advocating use of fortified foods, anti-hookworm interventions, and nutrition education at all levels of the project. UNICEF is expected to play a partnership role for these special interventions which are current objectives related to the Universal Declaration of the Rights of Children.

Avenues for technical assistance in operations research from the USAID centrally-funded OMNI project will be explored.

**IV. RESPONSIBILITIES**

1. CARE's Role in Project Execution

In this project, CARE's approach will be to operate in a mentoring capacity, rather than directly operational in the field. Local organizations already working at the community level have experience and advantages that merit reinforcing. CARE will serve as intermediary for these organizations, facilitating access to funding, technical assistance, materials and equipment, information and intellectual resources in measure with the organizational capacity to absorb and capitalize on these assets. CARE will conduct a diagnostic exercise with its potential NGO partners to assess strengths and weaknesses, material and human resources and competencies, constraints and biases before drafting together a contractual agreement that will determine the obligations of both parties.

2. Consistency of the TOUCH project with existing policies and programs

The rationale for the TOUCH 2000 project is consistent with government, donor and CARE policies:

Consistency with Government Strategy. The TOUCH 2000 project contributes to the GOM principles outlined in the Constitution of the Third Malagasy Republic, and more specifically with SECALINE.

Consistency with USAID Strategy. In the Invitation for Applications Draft Document for Integrated Child Survival January 1995, one of the stated goals is to "... improve nutritional status of children under five years of age in selected areas... primarily through control of diarrheal diseases, proper prevention and treatment of acute respiratory infections, correct breastfeeding and weaning practices, and support to the national expanded program of immunization..."

CARE's target population of urban children aged 0 to 5 and their mothers is part of the larger USAID target population. In addition, TOUCH 2000 will work through the community via local organizations, community associations and health/social centers to access the household.

Integration with CARE International and CARE Madagascar Programming Vision. The overall goal of the Primary Health Care Unit of CARE International states:

*" The goal of the PHC sector is to improve and protect the health status of the economically and socially disadvantaged populations by reducing and preventing mortality and morbidity among the most vulnerable households and communities, with special emphasis on the plights of women and children." (CARE International/USA, PHC Unit Strategy: Draft, July 1994.)*

In addition, the Children's Health Component of the PHC Unit has a mandate to achieve nutritional improvement through all of its projects no matter what the approach, to use peer education as a means of behavior change, and to strengthen the operating capacity of partner institutions. All of these elements are found in this project.

3. Collaboration with other Donors and Partners.

CARE will collaborate with the BASICS and APPROPOP Projects in any area related to TOUCH interventions, to assure maximum impact and harmonization of child survival programs. CARE will maintain close contact with other USAID child survival partners for resource sharing and mutual support

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**29 of 34**

purposes.

With contacts established and maintained through its earlier Emergency and Rehabilitation interventions, CARE International Madagascar already has the prerequisite rapport with other non-governmental agencies and donor organizations who will be able to complete the network and complement the services that CARE has to offer. Among these are the French government and UNICEF.

**V. MONITORING AND EVALUATION**

The project will hire a full time specialist to design and manage the project's health and management data and information systems.

**A. Monitoring**

The project's information system will track project inputs and outputs, and monitor performance of personnel and institutions. It will measure behavior change at the community and household levels. It thus measures impact and supports the learning curve (and strategic planning process) of CARE International Madagascar and its partners (local NGOs, institutional partners, USAID).

Monitoring will thus have the following components:

The **basic management system** will track activities development, information transfer, service agreements, reporting requirements, etc. between CARE and its international and local partners. In addition, CARE's policy for monitoring assistance will be to consolidate, refine and scale up health information systems across local NGOs to be compatible with MOH standards and complementary programs. It also requires that monitoring be participatory, with community feedback opportunities to learn how the community perceives project performance.

Annual management system reviews will be conducted allowing for input by all project partners. Round table reviews of the results will allow for maximum process-oriented learning and feedback to both partners and the donors. The project will use CARE's Annual Operating Planning system to set annual goals and to define indicators for achievement.

To familiarize the project staff with the planning and management monitoring system, a workshop will be organized once all the key staff are on board. After two full cycles, the whole management system will be reviewed and improved if necessary. The results of the review feed into CARE International Madagascar's second Long Range Strategic Plan which will cover the period July 1998 - June 2001.

The **results indicators for each component** found in this document are part of an initial proposal. These indicators will be further refined together with the assistance of BASICS and in coordination with other USAID child survival partners to assure maximum comparative value of the data collected. CARE will work with UNICEF, the GOM and USAID to assure that the data collected can feed into more national level data collection efforts. CARE expects the project monitoring/evaluation specialist to be responsible for refining the indicators and developing the monitoring system as part of project start-up activities.

Data collection will take place at different stages, using different methods as the situation and purpose warrants.

Baseline data:

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**30 of 34**

This will cover current preventive health knowledge and practices, community sanitation risk status, institutional strength/weakness diagnosis. Baseline data will be collected using both (complementary) formal quantitative survey instruments and participatory assessments. The latter will involve the use of Participatory Urban Appraisal (an urban variation of Participatory Rural Appraisal) techniques to get communities to define indicators for their preventive health knowledge and practices, community hygiene and sanitation knowledge and practices and for institutional development. CARE will work closely with USAID and BASICS to determine whether and how other child survival indicators such as disease prevalence and mortality should be included in the TOUCH project.

Monitoring of key behavioral indicators:

Again, both formal instruments and participatory methods will be used to assess progress towards goals. Hygiene and other preventive health behavior change at the household level is the ultimate success indicator. To track progress toward this goal, CARE will use a version of behavioral risk analysis and behavior-based monitoring which has been developed jointly by CARE Bangladesh and the USAID centrally funded Environmental Health Project (former WASH Project). This methodology combines qualitative and quantitative data collection methods to define both the content of baseline surveys, measurable indicators to monitor and educational strategies which are appropriate to the culture and community. The approach collects and analyzes disease prevalence survey results and data generated through focus group discussions, community mapping, rapid appraisal techniques for knowledge, attitude and practice assessment. For instance, "behavior trails" are defined and checked: physical evidence that people are engaging in certain types of behavior which were absent before IEC and home visiting (presence of soap for handwashing).

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**31 of 34**

**Special studies:**

Special studies to be conducted are "Willingness and Ability to Pay for Services", and studies on the structure and ethnography of Tana's slum communities. These will provide data for developing cost recovery and user fee schemes, and for community participation strategies.

The project team will also develop easily measurable performance indicators for all persons employed by and trained by the project. Performance indicators for local NGOs will be developed with them as part of the institutional capacity strengthening component, which will lead to the establishment or improvement of a monitoring system for each participating NGO. Individual staff performance indicators will be developed as an integral part of the CARE performance management approach. Individual Operating Plans will be defined in line with each staff persons responsibility to achieve project objectives.

The project will consider setting up a simple sentinel site system in the project zone to monitor health and nutrition status trends in more detail.

**B. Evaluation**

The project will be evaluated on the degree to which results indicators have changed for the better after approximately two years of project implementation, and toward the end of the project's five years. These two evaluations will require outside evaluators.

The first evaluation will above all assess progress towards the project results, but, more importantly, whether systems and processes are effectively going to permit full attainment of the goals during the life of the project. Since the activities of the first two years are designed as a somewhat experimental microcosm for the full project, this evaluation will be critical to the redesign of the final three years.

In contrast, the primary emphasis of the final evaluation will be on the actual attainment of all of the stated results indicators. Where applicable, the same tool of measure will be applied to both the first and the final evaluations.

Additional participatory evaluation exercises will be conducted to allow communities, and partners to provide valuative feedback on project performance. For the communities, annual round tables will be organized to structure their feedback and suggestions for improvements in the year to come.

**C. Reporting**

Reporting will address the information needs of the three key players:

- 1) The communities and project partners :

.The annual round table meetings will be the principal structured communication channel to report on project progress. In addition, through ongoing interaction with project staff, partners and communities will be kept abreast of key project developments.

- 2) The donor, the GOM and key institutional partners (UNICEF, WHO, APPROPOP):

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**32 of 34**

Reporting procedures, formats and calendars will be negotiated with the donor, the GOM and key institutional partners to assure maximum compatibility of data, integration of CARE data in larger data bases and to assure optimum use of CARE project data collection efforts.

**3) CARE :**

CARE internal reporting needs and calendars are flexible and can be synchronized with other reporting needs.

**VI. RESOURCE**

CARE's location in Antananarivo means that no time will be wasted in setting up a new office. Costs can be kept low by the relative ease of project monitoring and supervision logistics (i.e. short distances). CARE International Madagascar has expertise in and existing systems for management of human and financial resources, for procurement and logistics.

**A. Project Staffing**

**1. Permanent Staff**

The following technical staff is needed on a permanent basis for the life of the project:

- \* **Project Manager**  
(in charge of overall technical and administrative coordination of various project components and activities)
- \* **Public Health Specialist**  
(responsible for technical strategies and activities related to improvement of child health services and center-based outreach programs)
- \* **Sanitation Specialist**  
(responsible for strategies and activities related to improving community environmental hygiene and sanitation conditions)
- \* **Monitoring and Evaluation Specialist**  
(responsible for setting up and deploying project management and health information systems)
- \* **NGO Partner Liaison**  
(responsible for all program activities related to strengthening NGO institutional capacity and liaison with the NGO universe in Madagascar)

CARE expects to hire all but the project manager locally.

Other staff needs are expected to be:

- \* **Field Operations Supervisor**  
(responsible for coordinating and supervising all components at the implementation level, assures administrative and logistical support for implementation)

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**33 of 34**

- \* Chief of Admin/Finance

These positions will also be filled locally and strengthened by CARE's in-house capabilities in Administration and Finance, and Human Resources Development.

The project will also hire "animateurs" (community extension agents) and social workers for health center, community and household level work (training, organizing, facilitating, counselling, follow-up, supervising). They will be recruited via local NGOs and the School of Social Work in Tana through a capacity-building effort targeting these institutions.

Support staff such as secretary, drivers and guards will be engaged by the project.

## 2. Short term technical assistance

CARE expects to engage specialists for training and IEC (strategies which cut across all components) on a part-time retainer basis to consult with component specialists in developing overall component training and IEC strategies and specific activities within each component.

As much as possible, CARE will use local consultant expertise for technology transfer, product and skills development, and is already developing a human resource bank for required skills. On an as-needed basis, consultants will be brought in to perform short-term assignments where local expertise is not readily evident. CARE will establish relationships with individual consultants or consulting groups to assure consistency and follow-up of technical assistance.

Anticipated outside technical assistance requirements include:

- \* Training of Trainers/Supervisory Skills
- \* Project start-up
- \* Peri-urban slum sanitation
- \* Technical child survival interventions
- \* Clinical nutrition and education
- \* Community/health center financing
- \* Project evaluation
- \* Finances (cost recovery, fee structuring)

## **B. Material Requirements**

The proposed project budget includes the purchase of bicycles and motorbikes for field staff, the purchase of a minibus and two smaller vehicles for staff transport, funds for development and dissemination of educational materials, including equipment.

The budget reflects the project's emphasis on institutional strengthening through its sections related to training, center refurbishing and block grants to NGOs.

Funds for construction materials (especially for sanitation infrastructure), other equipment needed for refurbishing centers and community infrastructure, essential medicines and medical equipment are already being provided by the French Government and expected by other donors such as UNICEF, through agreements with CARE.

**Grant No.687-0107-G-00-6024-00**  
**Child Survival**  
**Attachment II**  
**34 of 34**

Contraceptives and family planning supplies will be obtained through USAID.

**VII. REPORTS AND DELIVERABLES**

1. Implementation plan

At the beginning, CARE International Madagascar will develop an implementation plan in conjunction with its partner organizations. Actually, CARE International will update its implementation plan.

2. Annual financial report

CARE International Madagascar will prepare annual financial reports that will present information on the cost of supporting various activities.

3. Annual report

CARE International Madagascar will submit annual reports which will provide a brief description of project activities implemented during the reporting period, a plan for the forth coming year, a brief description of issues, problems encountered and lessons learned.

- 42 -