



USAID | **MADAGASCAR**
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Santénet2

REVISED ANNUAL REPORT No. 4

October 2011–September 2012



©Santénet2/ASOS Central: Community members in village taking patient to CSB of Marofotra commune, Manakara

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Acronyms

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

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

INTRODUCTION

For four years, Santénet2 has been implementing integrated community health activities in 800 out of 1,566 communes, covering 16 out of 22 regions and 70 out of 111 districts, in collaboration with 16 nongovernmental organizations (NGOs) (13 national and 3 international). The Project has designed an integrated community health program building on past work by the US Agency for International Development (USAID)/Madagascar and other donors' investments in primary health care, complemented with new approaches and tools to meet the health needs of almost 11,000,000 persons in 800 Kaominina Mendrika (KM) salama communes.

Santénet2 achievements and challenges

In Madagascar, there is a sharp divide between urban and rural population behaviors conducive to better health and access to health services. The rural population has less information and knowledge on health-seeking behaviors, and they have less access to health services because 54 percent of the rural population lives 5 km (or 1 hour's walk) from the nearest primary healthcare center (*centre de santé de base* [CSB]). The implication of this divide is observed in a higher percentage of early and undesired pregnancies among rural women compared to urban, lower modern contraceptive use, higher malnutrition, fewer parents who seek treatment when children show symptoms of illness, a substantially lower rate of complete immunization coverage among the rural population, and rural mothers who are less likely to provide exclusive breastfeeding to their child during the first six months. As a consequence, in rural areas the total fertility rate, child mortality rate, maternal mortality rate, and malnutrition rates are higher among the rural population compared to the population in urban centers (DHS, 2008/2009; EPM 2010).

Madagascar's weak economic and political context inhibits sustainability, suggesting that a return to institutional normality and addressing broader development issues are necessary before expecting significant sustainability of a health program in Madagascar. Considerable literature in health and development found that the strength of the national and local institutions implementing health and social programs was an important variable for sustainability, suggesting that donor attention also be shifted toward strengthening institutional development to assure sustainability.

Santénet2 Objectives

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

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

The KM salama model aims to strengthen the community health system and build decentralized decision-making capacity at the community level to lead to improved health status.

In 2008, Santénet2 was designed to assist the Ministry of Public Health (MOPH) to design and implement community-based integrated healthcare services in 800 targeted rural communes. The 2009 coup resulted in US Government (USG) restrictions banning work with the Government of Madagascar (GOM). Santénet2 has allocated resources initially planned to support MOH to community-based interventions working through nongovernmental actors. There were two major implications of the unforeseen political crisis and its consequences. First, the Project could not interact with GOM, a major actor for creating a policy environment. Second, the Project was initially relying on MOPH regional and district staff to help conduct trainings and supervision of community actors. The Project has coped with these two unexpected challenges by strengthening partnership with other development actors, relying on local NGOs, and identifying and training nongovernmental (independent) actors to carry out community actors' trainings and supervisions.

In addition to coping with contextual factors, the Project aimed to help remote communities, often the poorest segments, to adopt behaviors conducive to better health outcome by proposing improved access to community health services. This section offers an assessment of Santénet2 interventions and their demonstrated effectiveness in meeting mothers' and children's needs.

Santénet2 conceptual framework: scope and implementation process

The Santénet2 conceptual framework has three building blocks: (1) developing and strengthening key community health system components; (2) empowering community participation and accountability in setting and achieving community health goals; and (3) linking the two for at-scale impact to reduce maternal, child, and infant mortality; fertility rate; chronic malnutrition in children under the age of 5; and prevalence of malaria (particularly among children under 5 and in pregnant women), as well as to expand access to water, sanitation, and hygiene (WASH) and maintain a low HIV prevalence rate.

Chronology of KM salama implementation in summary:

2008—Santénet2 start-up (August through September)

2009—Design implementation tools and strategies, adjust to consequence of political coup, award 18 grants through a competitive process. Implement the KM salama approach through two implementing partners operating through a subcontract mechanism.

2010—Roll out training on the KM salama approach to all 800 communes.

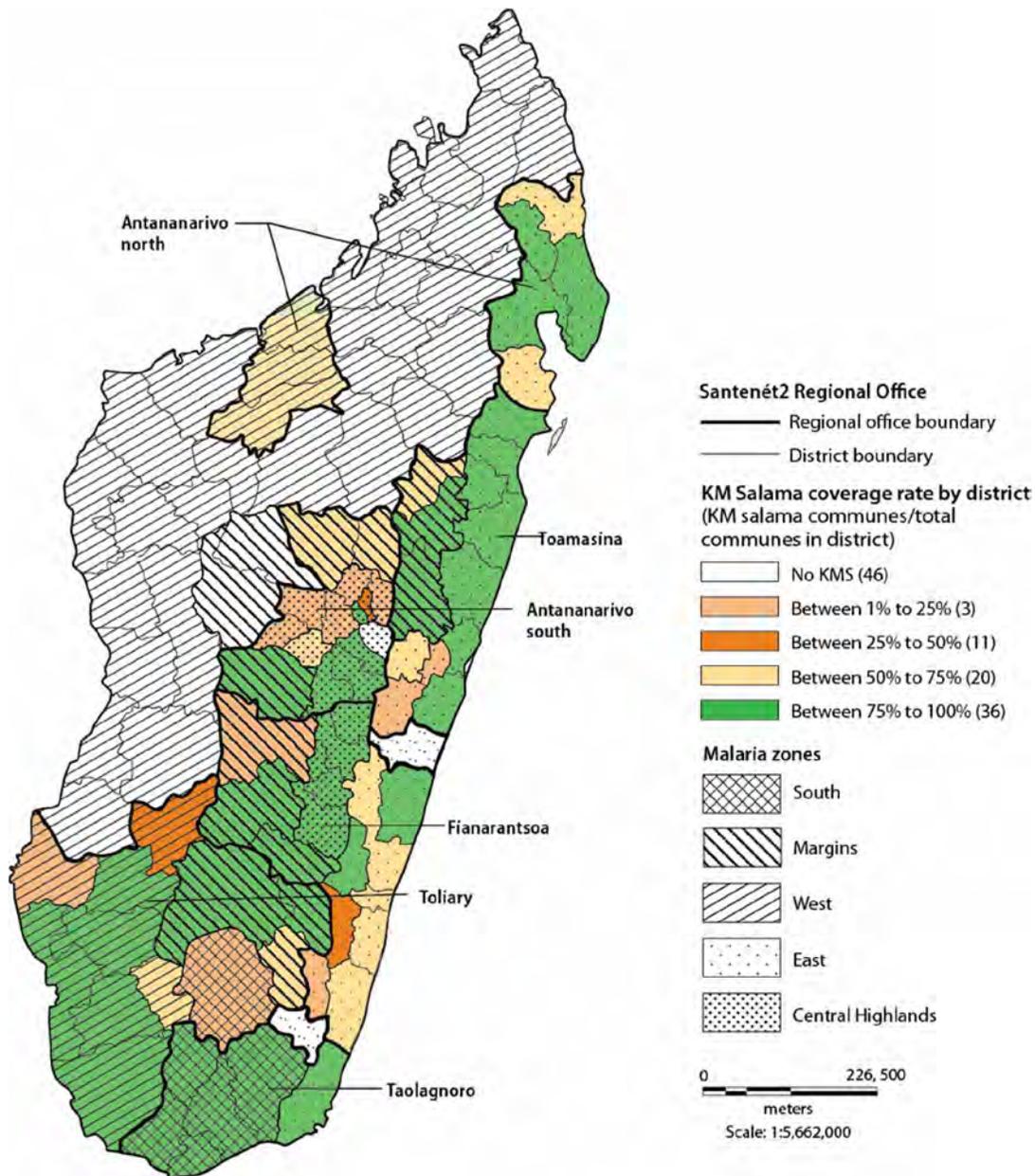
2011—Complete and expand training to include new skills, operate community health system, invest in Communal Health Development Commissions (formerly Social Development Committees) (CCDS) to increase ownership in the perspective of sustaining achievements.

2012—Refresher training, monitor and evaluate program performance, continue investment in community actors (CHVs and CCDS), deepen and widen sustainability.

Process achievements for the reporting period are elaborated in Section 2. In this section, we will conduct a comparative analysis of program outcomes that can be attributed to Santénet2 interventions with respect to the performance of the public health system.

The map below presents KM salama communes coverage by district.

Figure 1. KM salama coverage rate by regional office, district, and malaria zone



The Project provides technical assistance, in conjunction with its implementing partners to 800 KM salama communes in 70 health districts. Hence the Project works in 800/1,143 communes in these 70 districts. There are 1,270 primary health care clinics (CSBs) in the 800 KM salama communes; 4% or 53 CSBs are closed due to lack of staff or poor infrastructure conditions. KM salama communes in Antsinana and Analanjirofo regions are the most affected—1 out of 5 CSBs is closed. In 70 health districts, the total number of CSBs is 1,889 (there are 2,573 CSBs in Madagascar). The Project has trained community health volunteers (CHVs) in *fokontany* that are located 5 km or 1 hour’s walking distance or more from the nearest health facility. The rationale is to provide accessible quality basic health services to mothers and children, the two most vulnerable groups. The CHVs were selected or elected by

the community. Santénet2 provided training in either the mother health area or the child health area. It was planned to train one Mother Health and one Child Health CHV in each *fokontany*. The information, education, and communication/behavior change communication (IEC/BCC) activities are conducted by CHVs, CCDS members, religious leaders, and local radio stations, all trained and receiving support from the Project. The social mobilization (IEC/BCC) and social accountability activities cover the entirety of the communes and are not limited to remote *fokontany*.

Community empowerment, social accountability, sustainable institutional capacity

The Santénet2 Project designed a community-based health system that dovetails with the formal health system. Connecting community health systems to the public health system was possible, despite prevailing political and economic crisis and restrictions banning work with GOM, through design of compatible health system functions and introduction of social accountability in grassroots communities. The implementation phase was conducted at scale through meticulous planning and quality control.

Engaging people

Santénet2 social accountability and quality activities were designed to build skills within community members that will enable them to participate in health needs assessments and solutions. The engagement of community actors in the delivery of health services and promotion of change in health behavior is expected to influence health outcomes in their communities positively.

People assessing their health—a participative health needs assessment process conducted by and for local people—shifts the paradigm beyond individual illness problems. It can bring into consideration the effectiveness of policies, programs, and strategies in improving local health conditions. Grassroots assessments can help identify challenges and provide immediate and adequate remedies—responding to people’s needs while strengthening trust in service delivery points and increasing use of preventive and available treatments.

Social quality process—grassroots participatory assessment, decision making, and actions

As part of social quality and social accountability process, the group facilitator, a member of the community (but s/he is neither the mayor or CSB provider) trained by Santénet2, informs the community about the purpose of the meeting. Community assessment is conducted in each *fokontany*. People gather to discuss and assess their health needs. Prior to the collective discussion, the group facilitator informs participants of their rights with respect to health services:

- Right to access to health information,
- Right to use safe health care
- Right to be treated with dignity while receiving health services
- Right to information on services available at different levels of the health system, from the community level through tertiary level (reference hospital).

Once the needs are assessed, people discuss the availability of different health services to fill these needs, and the group proceeds with an evaluation of their satisfaction with available health services. This participatory and iterative process helps the group to agree upon on a list of priority health needs for action. The group also discusses possible solutions and collectively agrees on solutions to meet priority needs. The results of each *fokontany*-level meeting are discussed in the CCDS meeting at the commune level. Action plans are implemented. Results of CCDS meeting are reported back to communities in each *fokontany*.

Social quality—community-identified priority needs and proposed actions

Based on reports sent by 800 KM salama communes, 3,487 *fokontany* have conducted participatory community assessment exercises. Almost 350,000 individuals participated in these meetings, an average of 100,350 participants per meeting, among which more than 50% were women. The top three needs/priorities agreed upon in all communities are as follows (both at CHV and CSB levels):

- Health service availability
- Drug availability
- Quality of health services

The above results indicate the communities' desire to access quality health services and drugs at community and facility levels.

Communities decide and follow up on actions that can be implemented at the *fokontany* level and communicate/expect action from the CCDS, for actions requiring commune-level decision-making authority.

At the *fokontany* level, communities have initiated actions to build health huts, providing work place/space for CHVs, hence improving continuity in service availability. In addition, in some *fokontany*, communities required CHVs to display schedules of working days and hours outside the health hut (addressing accessibility of services). To date, communities in KM salama communes that have engaged in the social quality process have built 3,001 health huts for CHVs. With respect to drug availability, communities have also organized to help CHVs resupply health products from the commune center. Help included providing seed funds for large quantities of drug procurement, collecting drugs from the commune center on behalf of the CHVs, and monitoring the drug stock available at the CHV level. With respect to service quality, communities have suggested to their communes that CSB providers should regularly supervise CHVs.

Sustainable institutional capacity

Training implementing partners' field workers (support technicians) who support community actors' work—support technicians are also the bridge between the Project team and the communities. They convey bi-directional information (bottom up and top down). In 2009, Santénet2 trained 48 support technicians to implement the KM salama approach, and in 2010, an additional 147 support technicians were trained. A total of 156 support technicians and 48 support technician supervisors are covering the 800 KM salama communes. Support technicians received 6 training sessions, on average one each semester since the inception of the Santénet2 grants-under-contract program. Training covered (1) social mobilization, (2) social accountability/social quality, (3) community-led total sanitation (CLTS), (4)

supervision guidelines and standards, (5) reporting procedures and processes, and (6) KM salama program standards and guidelines compliance.

Training and supervision of CHVs—Santénet2 and its partners work with communities in a mutually respectful process to identify, recruit, and train CHVs. Community involvement in recruiting and continuous supervision and support to CHVs contributes to the functionality and sustainability of community-based services. Santénet2 chooses to train and support two CHVs per *fokontany* that are 5 km or more from the nearest formal health facility. Santénet2 also helps replace eventual drop-outs. Actual attrition has been very low (less than 5%) over the past four years.

The Project provides support to 12,058 CHVs. Since its inception, the Project has trained a total of 12,816 CHVs. The Santénet2 KM salama model centers around a strong training and supervision program complying with national and international standards. Consequently, a low attrition rate, effective quality service provision, and regular reporting are expected outcomes.

Regular CHV supervision sessions are conducted in a comprehensive manner to improve performance and ensure quality of services. The comprehensive supervision addresses the following aspects of CHV routine activities:

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

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

Preliminary results of a CHV survey conducted by the project in August 2012 indicate that on average, each CHV is supervised every 2.9 months.

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

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

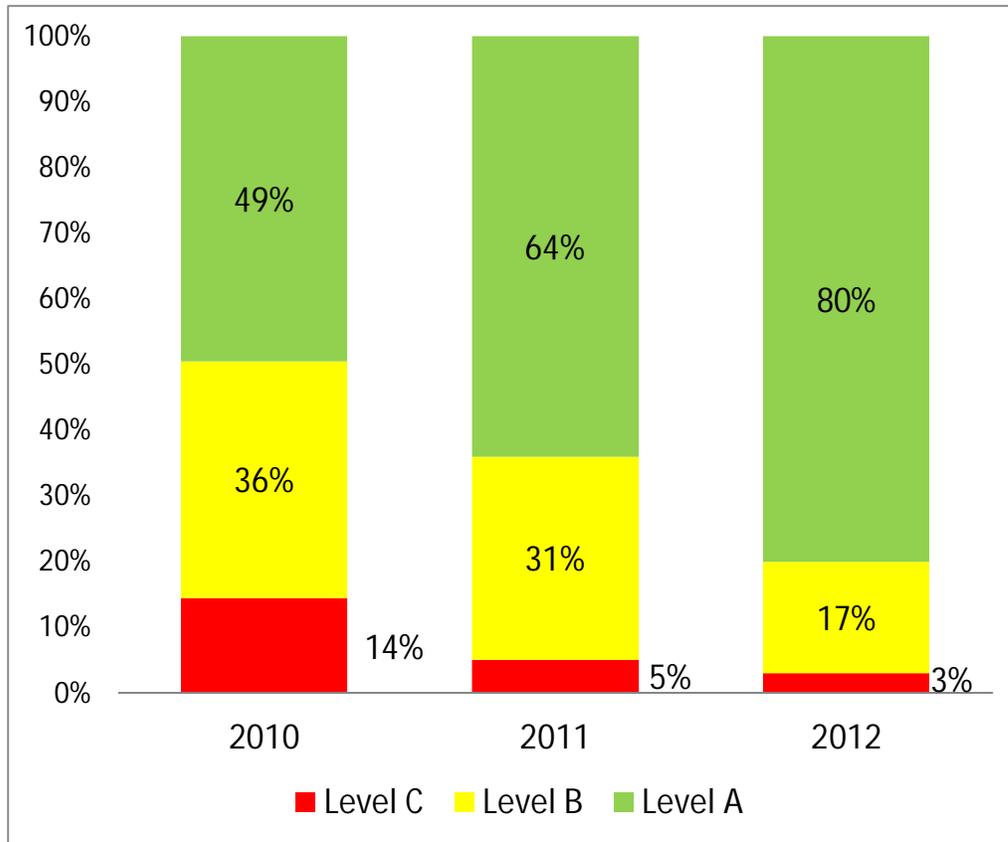
- Level A—CHV can provide services in full compliance with standards.
- Level B—CHV shows difficulties in completing management tools accurately and completely.

- Level C—CHV has either difficulties assimilating all procedures or provides incomplete information on beneficiary.

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

Figure 2 below illustrates the improvements over the last successive three semesters (FY 2011 and FY 2012).

Figure 2. Distribution of CHV performance levels based on supervision results



Data Source: Santénet2 supervision reports.

Community health system strengthening

Health management information system

Santénet2 developed a Community Health Management Information System (c-HMIS) to collect (in a timely manner), transmit, analyze, and disseminate Project-related data for program management purposes. During the reporting period, the c-HMIS manager worked with the implementing partners (their support technicians and their monitoring and evaluation [M&E] managers) to improve reporting in terms of completeness, timeliness, and reliability of data. It should be noted that Santénet2 equipped implementing partners with information technology (IT) materials, Internet connection, and mobile phones and trained the support technicians and the M&E officers on the c-HMIS as part of the effort to ensure appropriate reporting. The completion rate is currently at 71% for the monthly activity reports (MARs) filled out by CHVs. This rate is above that of the MOH. The data collected allow program management and measuring access and use of community health services by the target groups. In addition, information is obtained from the Extranet database (developed by the Project) for financial management by implementing partners and monitoring of tools dispatched to the KM salama communes. Data generated by the Project c-HMIS are used to conduct program achievements analysis.

Over the past four years, performance of C-HMIS has steadily improved. As of September 2012, c-HMIS rates have reached 76% completeness, 84% reliability, and 83% timeliness.

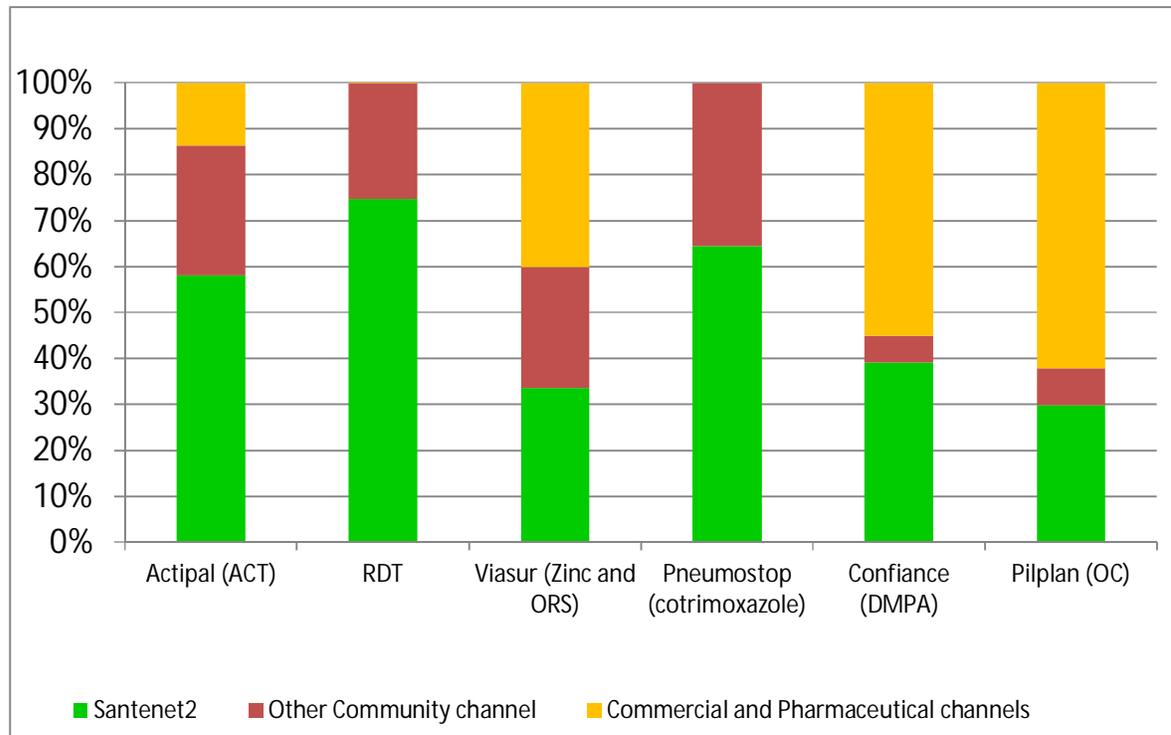
Community supply chain of health products

The community supply chain system, designed in collaboration with the social marketing program, experienced repeating stock-outs of anti-malaria products. The pipeline was re-initiated with artemisinin-based combination therapy (ACT, an anti-malarial drug) and rapid diagnostic tests (RDTs) in November 2011. This effort helped overcome widespread stock-outs. However, malaria outbreaks that occurred in January and February 2012 in eastern and southeastern regions of Madagascar led to stock-outs of anti-malarial products (ACT and RDTs) in KM salama communes in these regions. Santénet2 is working closely with the social marketing program to anticipate future stock-outs and ensure timely re-supply of community supply points with social marketing products. To date, Santénet2-trained and supervised CHVs are managing 18 health products being supplied from both social marketing and community pharmacies within the CSBs. Each CHV has a supply register (logistic data) where s/he records the following on a daily basis (and reports the information on a monthly basis): beginning stock levels, quantity of product dispensed, and end of month stock. The information is recorded in three copies: one copy is collected by the KM salama support technician, the second copy is sent to the CSB, and the third is kept by the CHV.

Preliminary results of the CHV survey indicate that 59% of Child Health CHVs re-supply ACT only from the community supply point, 26% from CSBs, and 15% from both channels. The same survey indicates that the DMPA re-supply source mix is 27% community supply point, 61% CSB, and 12% both channels, respectively. 45% of Child Health CHVs experienced stock-outs of ACT—over the reporting period, the length of the average stock-out was two months. 33% of Mother Health CHVs experienced stock-outs of DMPA lasting, on average, 1.5 months.

Santénet2-supported KM salama communes constitute an important market share for social marketing products as presented in the graph below.

Figure 3. Social marketing product sales by distribution channel



Source: PSI sales data, 2012.

Community-based services—are we meeting health needs?

Five program elements are covered under the strategic results component. These are maternal and child health (MCH), reproductive health/family planning (RH/FP), malaria control, sexually transmitted infection (STI)/HIV/AIDS control, and WASH.

The Child and Mother Health CHVs promote prevention and ensure case management of illness. Textbox 1 describes services provided by the Child Health and Mother Health CHVs by level. Both Child Health and Mother Health CHVs provide services to pregnant women and newborns. The services include screening women for pregnancy at an early stage (3 or 4 months), raising awareness on attending antenatal care (ANC) consultations, and checking that

Textbox 1 Mother Health CHVs

Level 1: Promotion of integrated RH/FP

- Information on FP methods and distribution of oral contraceptives, barrier methods, and SDM
- Messages on the prevention of STI/HIV/AIDS
- Safe Motherhood (ANC, intermittent preventive treatment [IPT], nutrition)
- Postpartum FP

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

Child Health CHVs

Level 1: Promotion of child health services

- Essential Nutrition Actions
- Growth monitoring and promotion (GMP)
- Expanded Program on Immunization (EPI) promotion
- Malaria, diarrhea, and acute respiratory infection (ARI) prevention

Level 2: All the services provided under Level 1 plus community case management of malaria,

the 10 elements of the pregnant women prevention and care package are available (see textbox 2). The CHVs are also trained to identify danger signs in pregnant women and newborns and to provide counseling and referral to patients as needed.

Santénet2 also targeted its effort to control STIs and HIV in most-at-risk populations (MARPs) such as commercial sex workers (CSWs) or men who have sex with men (MSM).

For WASH, this reporting period the Project continued to promote the CLTS approach, water and hygiene system management, and training and qualifying CHVs as WASH-friendly.

Malaria

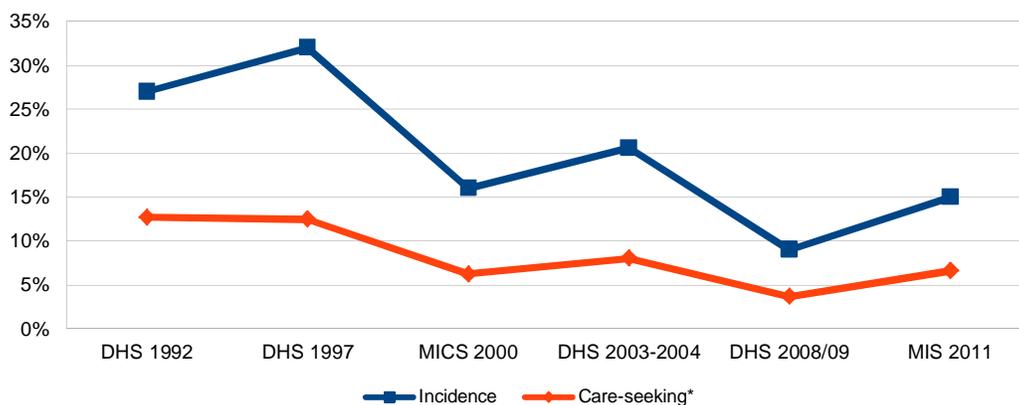
In Madagascar fever, diarrhea, and ARI constitute a major part of the burden of disease, predominantly affecting children under the age of five. Half of the reported symptoms of illness, according to statements by mothers, were fever; approximately 1 out of 5 was diarrhea; and 1 out of 10 was ARI. The incidence levels of these three illnesses are on a decreasing trend over the past two decades (sources: Demographic and Health Surveys [DHS], Household surveys...). During the same period, the percentage of persons seeking treatment followed the same trend. The main reason cited for not seeking treatment (50% of respondents) was that parents did not consider the illness to be serious. The second most-common reason cited by mothers interviewed (*Enquête prioritaire auprès des ménages* [EPM, Madagascar household survey] 2010) was geographical access to service (facilities were too far away). Figure 4 presents the progression of malaria incidence and percentage of those who sought health care over two decades.

Textbox 2
Antenatal Care (ANC) Package

To be monitored, checked, and completed by CHVs

1. Use of long-lasting insecticide-treated bed nets (LLITNs)
2. IFA supplementation
3. Malaria In Pregnancy
4. Immunization (Tetanos Toxine)
5. STI and HIV screening
6. Pregnant women's nutrition
7. Breastfeeding
8. Delivery plan
9. Danger signs
10. Postpartum FP

Figure 4. Fever incidence and care seeking behavior



Data Sources: DHS, Multiple Indicators Clusters Survey (MICS), Malaria Indicators Survey (MIS).

A recent Madagascar Malaria Indicators Survey (EIPM 2011) reports a high rate of fever incidence (15%) among children under five over the 15 days prior to the survey. This rate is

about the same as the 16% found in the MICS 2000 but is much higher than the 9% reported in the DHS IV.

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

Santénet2 started training Level 2 Child Health CHVs in October 2009. As of this writing (October 31, 2012), 5,647 Level 2 Child Health CHVs provide malaria diagnostics using RDTs and treat confirmed simple malaria cases by administering ACT to children under the age of 5 living in *fokontany* that are one hour or more distant from the nearest health facility.

Madagascar is divided into five operation zones for malaria control. Table 1 presents the distribution of KM salama communes as a comparison to all communes by Malaria Control Program (MCP) operational zones.

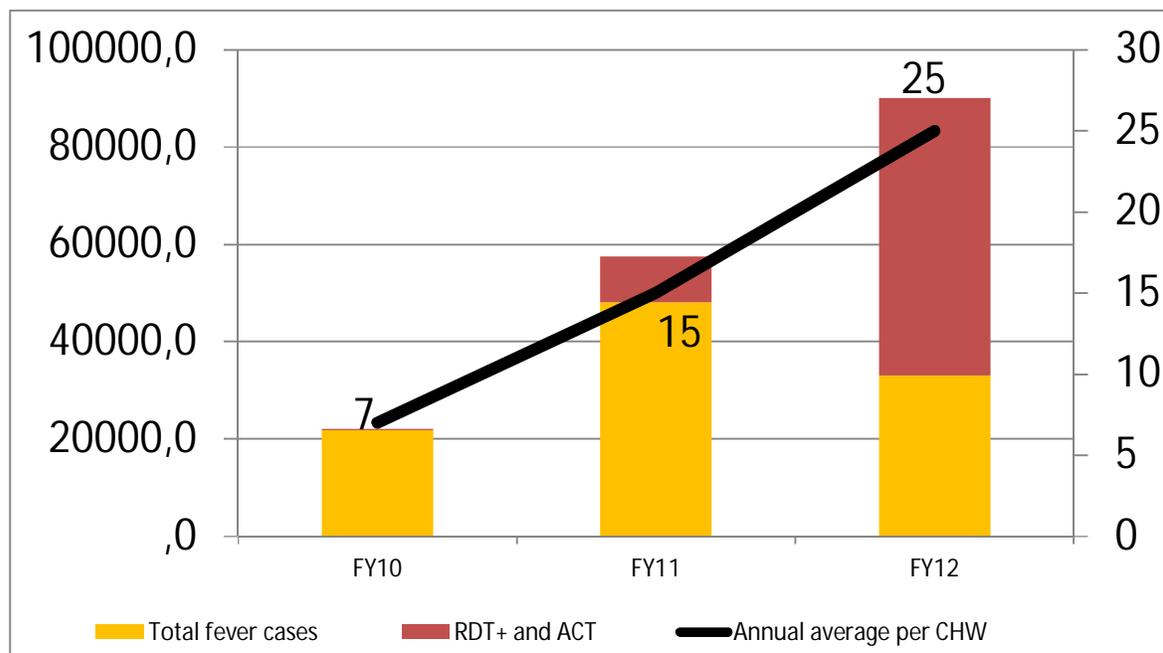
Table 1. KM salama commune distribution by MCP operational zones

MCP operational profile	800 KM salama communes	All communes in Madagascar
East	316	491
Central Highlands	201	345
Margins	120	195
West	84	431
South	79	104
Total	800	1566

The MOH MCP introduced systematic use of RDTs for diagnosis and treatment with ACT in health facilities in 2008. The MOH routine Health Management Information System has been reporting confirmed malaria cases diagnosed in CSBs since 2009. Similarly, the Santénet2 c-HMIS has been reporting confirmed malaria cases (RDT positive) since 2011.

CHVs were trained to use RDTs and ACT to manage simple malaria cases starting in 2010. The updated c-HMIS was effective in 2011 to track RDT positivity for cases managed by CHVs. There were large RDT and ACT stock-outs from June to October 2011, so the number of cases managed by CHVs is lower than it would have been if the CHVs had had enough RDT in stock. Stock-outs of RDT and ACT were also observed in eastern regions in January and February 2012.

Figure 5. Community case management of malaria in KM salama communes



Data Source: Santénet2 c-HMIS data.

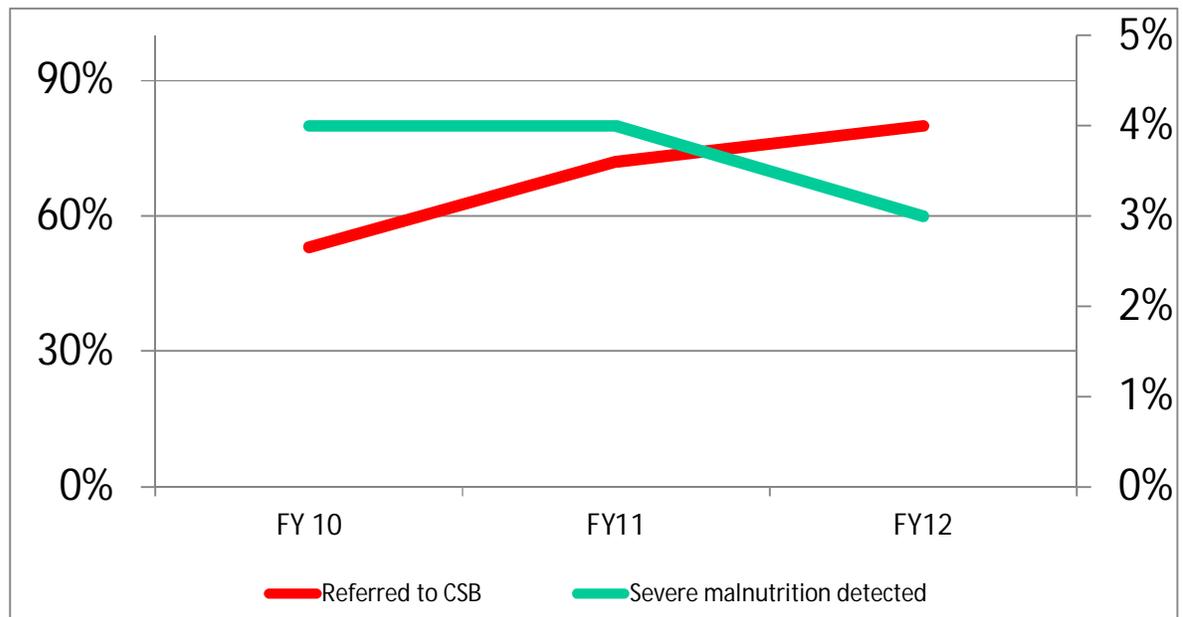
Note: Starting in FY 2011, RDT+ cases are reported. Previous periods are cases treated by ACT, without reporting on RDT results.

MCH and Nutrition

Community-based MCH and nutrition services target 900,000 children under the age of five and 240,000 pregnant women. During the reporting period, more than 192,000 children under five were treated by CHVs for diarrhea, ARI, or malaria. CHVs ensure systematic growth monitoring of 1,333,016 children either through use of baby scales or mid-upper arm circumference (MUAC) measurement. During the reporting period, almost 34,700 children under the age of five were detected with malnutrition problems.

Figure 6 presents the progression of malnutrition detected by CHVs and increase in care seeking behavior at CSBs over the same period. 4,839 pregnant women received IFA supplementation from CHVs, and CHVs referred 6,861 pregnant women to CSBs for ANC. In addition, the community emergency evacuation system put in place in 94 KM salama communes permitted evacuation of 57 pregnant women to the health facility.

Figure 6. Decrease in acute malnutrition and increase in care seeking at CSBs

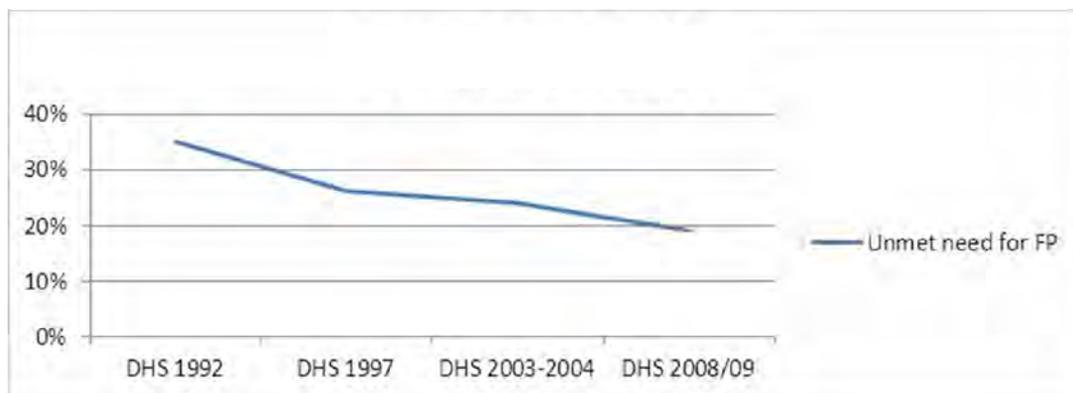


Data sources: Santénet2 c-HMIS data, 2012.

RH/FP

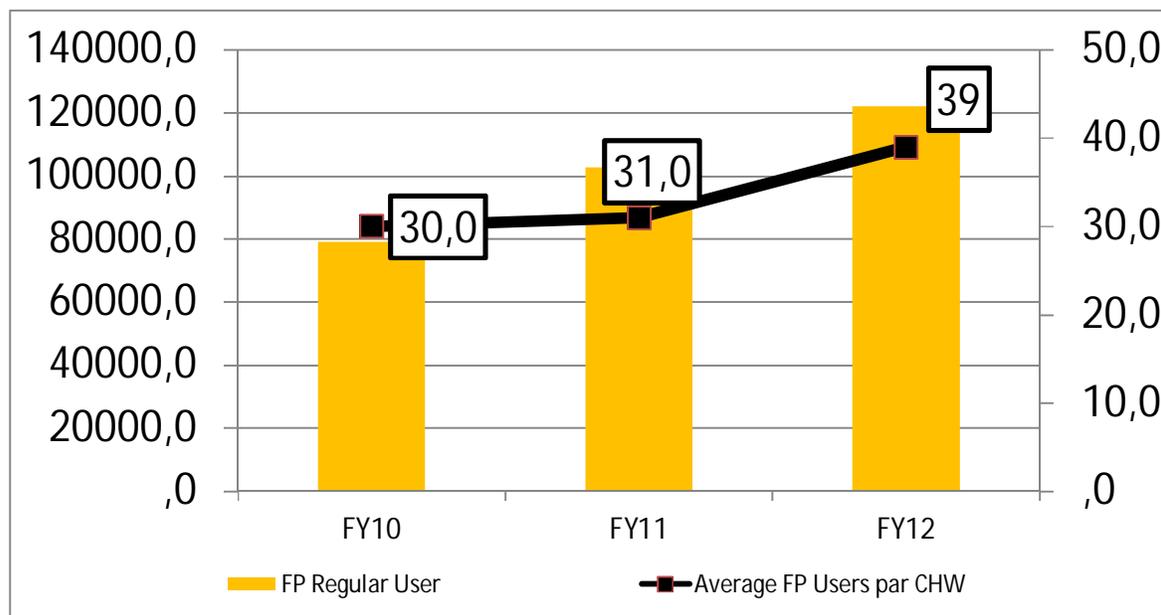
Madagascar has one of the highest fertility rates in the world. Over the past decade, FP services have become more widely available, and an increasing number of women choose contraception to space or limit births. The trend of unmet need for FP is decreasing, although, the 2008/09 DHS indicates that almost 1 out of 5 women has an unmet need (Figure 7). Santénet2 Mother Health CHVs offer FP counseling to women of reproductive age and provide a range of FP methods. Over the past three years, Project-trained and supervised CHVs have steadily served an increasing number of women with FP services. Both the total number of FP users served at the community level and the average number of women using FP served by one CHV have increased, as indicated in Figure 8.

Figure 7. Unmet need for FP—Madagascar



Data Sources: DHS 1992, 1997, 2003/04 and 2008/09.

Figure 8. Community-based FP services in KM salama communes



Data sources: Santénet2 c-HMIS data.

WASH

Santénet2 continued implementation of the CLTS approach in 480 KM salama communes. 6,224 community actors were certified WASH-friendly (use of latrine, hand washing with soap, and access to a source of potable water). 18,477 latrines were constructed by the population (almost 50,000 households), and 755 villages reached open-defecation free (ODF) status.

In 164 KM salama communes, 1,409 water infrastructures were built (new construction) or were improved (existing infrastructures) by the communities' own resources through Project technical assistance.

STI/HIV/AIDS

Santénet2 continued support to MARP associations. A total of 15 associations received Project assistance. During this reporting period, Project-trained peer educator from MARP associations reached almost 22,710 CSWs and MSM through HIV/AIDS awareness-raising and prevention activities, as well as promotion of services. During this fiscal year, a total of 1,879 CSWs and MSM chose to use HIV counseling and testing (HCT) and STI screening as a result of these Project-supported activities

This fourth annual report describes Project activities carried out by RTI International and its partners between October 1, 2011 and September 30, 2012. The report describes achievements in the following areas:

- Community programs
- Strengthening community health systems
- Achieving strategic results

- Program coordination
- Administration and finance
- A gap analysis of activities by component (*Annex 1*)
- Monitoring and evaluation (M&E) (*Annex 2*)
- Environmental Mitigation and Monitoring Report (EMMR) (*Annex 3*)
- Additional information on communication strategy, success stories, tools, radio spots, the gender-based approach and maps provided in the annexes.

TECHNICAL COMPONENTS

Component 1: Community Programs

Introduction

During Fiscal Year 2012, the activities under this component were aimed at (1) making the tools needed to implement activities available to community actors, (2) strengthening the mass behavior change communication (BCC) strategy through the airing of health message spots and reports on KM salama activities on local radio stations, (3) supporting the implementation of the mutual health insurance schemes to improve the population's access to health services, and (4) implementing the WASH strategy in the communes implementing the KM salama approach through several interventions.

Santénet2 updated eleven (11) tools and designed six (6) new ones to meet the needs of activity implementation in the 800 communes implementing the KM salama approach. The needs for tools were quantified, and the tools distributed met the needs for reporting and activity monitoring throughout FY 2012.

For mass BCC, health message spots and reports on KM salama activities were aired on the 28 partner local radio stations. The objectives for this year were exceeded, with 137% for health message spots and by 163% for reports, covering 97% of the population living in the communes implementing the KM salama approach, i.e. about 9 million people.

Reports per program area	Number of airings
MCH (nutrition, diarrhea, ARI, ONE)	34
Malaria (malaria, prevention during pregnancy)	50
RH/FP (ARH-RH/FP)	14
WASH	24
Community commitment (mutual health insurance schemes, KM salama, CHVCHVs)	61
TOTAL	183

Topics for radio spots	
1	ACT
2	EBF
3	ANC
4	IFA
5	Gender and Planning
6	ARI
7	KM salama approach
8	Latrines
9	Nutrition
10	ARH
11	Immunization
12	Health Insurance
13	Social quality
14	CHV promotion
15	Diarrhea/latrines
16	ANC package

Mutual health insurance schemes have been set up according to a new strategy developed by Santénet2 in four selected districts: Vatoman-dry, Ambositra, Ambohimahaso-a, and Ambalavao. Coverage payments to members began in September 2012 for Vatoman-dry and in October 2012 for the three other districts. In Vatoman-dry, 28 members received payments for health care, including three admissions at the district-level hospital, in the first month of

operation. The total number of members was 23,141 in the four districts at the end of September 2012. (See [Strategic Focus 3 for updated information on mutuelle enrollment.](#)) However, in Vatomandry and Ambalavao, membership increased in September 2012 when the population learned the date at which the scheme would start making coverage payments.

Specific Achievements

Strategic Focus 1. Making tools available to community actors

a. Approaches

Community actors and the partner NGOs must have adequate and appropriate tools and materials to implement project activities. During FY 2012, Santénet2 updated some tools and designed new ones to meet these needs. Needs are estimated on a quarterly basis to ensure that the demand is met. Santénet2 sends the tools to the implementing NGOs who in turn distribute them to community actors based on their activity plans.

Santénet2 established a tracking system to ensure that the tools and materials sent from its inventories reach the intended users. It also monitors the availability of tools at the community actors' level by asking NGOs and community actors to send back acknowledgements of receipt.

b. Results

Updating and design of tools

During this fiscal year, 11 tools were updated (compared to the 8 planned). As part of handing over monitoring activities to promote sustainability, WASH activity monitoring forms were updated to facilitate the community actors' work and data collection. The updated tools give community actors a view of implementation's progress—they describe the

List of tools updated or designed

11 tools updated

- § Child register addendum
- § Mother register
- § Early pregnancy screening form
- § Maternal and newborn health job aid
- § Support technicians' monitoring tools
- § CLTS guide
- § CLTS monitoring form for CCDS
- § CLTS triggering monitoring form
- § WASH-friendly CHV monitoring form
- § Activity monitoring form for structures in charge
- § Calendar

6 new tools designed

- § Job aid for Level 2 Child Health CHVs
- § Mutual health insurance schemes poster
- § Mutual health insurance schemes invitation card
- § Quarterly review form
- § Order invoice
- § Commodity distribution job aid

baseline situation and the situation as of the date of the monitoring. Because the calendars used by Mother Health CHVs to monitor the administration of injectable contraceptives become outdated this year, an update was made so that these can be used until 2014.

Six tools were designed (compared to the three planned). Three are described below:

- The job aid for Level 2 Child Health CHVs was designed to help CHVs decide when to use RDTs and to help them use RDTs correctly. Clear improvements have been noted between FY 2011 and FY 2012 as observed in supervision sessions: the percentage of CHVs who are able to classify malaria and provide proper treatment increased from 73% to 85%.
- A new tool, entitled “Quarterly review manual,” was designed and produced for a special review organized by Santénet2 to improve and strengthen the actors' commitment and services.

- The “Order invoice” tool was developed as part of promoting sound management of the mutual health insurance schemes that have been set up.

Distribution of tools

Santénet2 produced 365,473 items during FY 2012 to meet the needs of the community actors in the 800 communes implementing the KM salama approach (see List and number of tools produced in *Annex 8*).

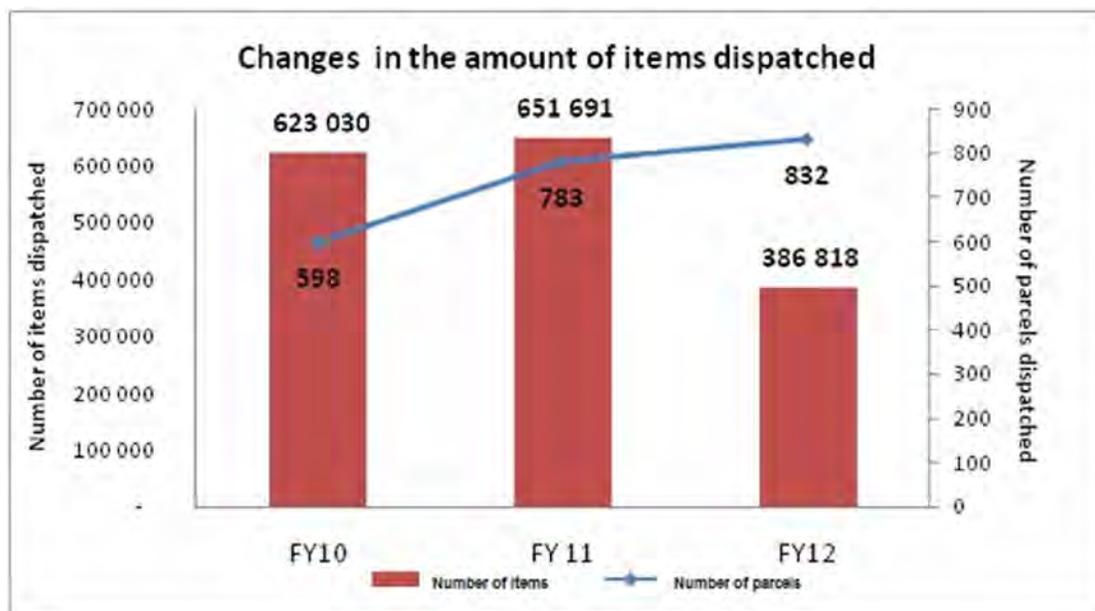
A total of 832 parcels comprising 386,818 items were dispatched to meet the demand expressed by implementing partners (see Tools distributed in *Annex 7*). These parcels served the following purposes:

- Resupply CHVs with management tools
- Strengthen the skills of community actors
- Ensure supervision of CHVs
- Enable community actors to provide quality services.

The number of parcels dispatched increased compared to last year, which is due to more frequent dispatching and supervision. Santénet2 endeavored to be as responsive as possible to the community actors’ needs.

Conversely, the number of items dispatched decreased by almost half compared with the two previous years when training activities were at their peak. Training requires a significant number of tools, whereas as the tools sent this year were mainly intended for supervision and service provision by community actors.

Figure 9. Changes in the amounts of items dispatched



Source: Santénet2’s Extranet and tools tracking table (2010 to 2012).

One of the challenges encountered by the Community Programs component in FY 2012 was to ensure that the tools reached the intended users to enable them to perform up to standards. Two types of receipt acknowledgements were required from partner NGOs:

- Acknowledgment of receipt from the NGOs, documenting receipt by the NGOs
- Acknowledgement of receipt by the CHVs/CCDS, documenting receipt by the final users (CHVs and/or CCDS).

A survey on the validity and reliability of data on community-based services at the communes implementing the KM salama approach in August 2012 found that 90% of the CHVs had the tools required for implementing activities, which means that tools successfully reached their final users.

The production and distribution of tools intended for actors constitute a noteworthy experience in terms of project management. Therefore, Santénet2 documented the system, showing how to distribute tools on a large scale and how to resupply actors with management tools necessary for monitoring activities.

Strategic Focus 2. Implementing a mass BCC strategy

a. Approaches

Since FY 2010, Santénet2 has been collaborating with local radio stations to air health messages in the project's intervention communes as a way to promote behavioral change among the target population. Sixteen (16) health message spots have been aired through partner radio stations after they were translated into local dialects.

The spots addressed Santénet2's five program areas:

1. Maternal and child health: ARI, immunization, diarrhea and latrines, exclusive breastfeeding, iron/folic acid, pregnant women
2. Malaria: ACT, malaria prevention during pregnancy
3. Family planning: ARH, CHVs promotion
4. WASH: latrines
5. Community commitment: the KM salama approach, gender and planning, mutual health insurance schemes

In addition to the spots, targeted reports on the community actors' activities were produced and aired by the partner local radio stations after an orientation was provided to their staff. At the beginning, the radio managers were free to choose which topics to address, but beginning in Semester 2 of FY 2012, the topics were geared toward the program's and/or the respective region's needs. Referring to a job aid to guide them with the reports, the radio staff members go out in the field to interview the range of community workers, including CHVs, CCDS members, local authorities, heads of CSBs, and the target population. After the reports are validated by Santénet2, the radio managers inform the project of their airing plans. An airing report is prepared and submitted to Santénet2 along with audio versions of the reports.

b. Results

Covering 772 communes, i.e. 97% of the communes implementing the KM salama approach through 28 partner radio stations, Santénet2 aired health message spots 18,457 times and

reports on the communes implementing the KM salama approach 183 times. This communication strategy backs the awareness-raising activities conducted by CHVs and CCDS as well as other actors (young leaders, PLeROC, etc.) at the community level.

The achievements are summarized as follows:

- 772 communes, i.e. 97% of the communes implementing the KM salama approach, were reached with spots aired by partner radio stations. This is the same coverage as in FY 2011: the remaining 28 communes are not covered either because there are no radio stations that reach them or the existing radio stations can reach only one or two communes, which does not warrant investing in working with them.
- 28 contracts were signed with partner radios for the airing of spots.
- 52 mystery listeners (compared to the 56 planned) monitored the broadcasts in the various localities (at the rate of two listeners per radio station). Four (4) radio stations have been airing in full compliance with their purchase orders over the two years of collaboration with Santénet2 and therefore are monitored by only one listener. The four stations are Radio Don Bosco (Analamanga), Radio Pangalanes (Mananjary), Radio Rakama (Vohipeno), and Radio Lazan'ny Ladoany (Mananara).
- 18,457 spots were aired, which exceeds the annual objective of 13,440 airings by a large amount. Thus, the achievement rate is 137% and has almost doubled compared to FY 2011 (see Radio spots airing per radio and per topic in *Annex 9*).

Figure 10. Coverage of the KM salama communes by local radio stations

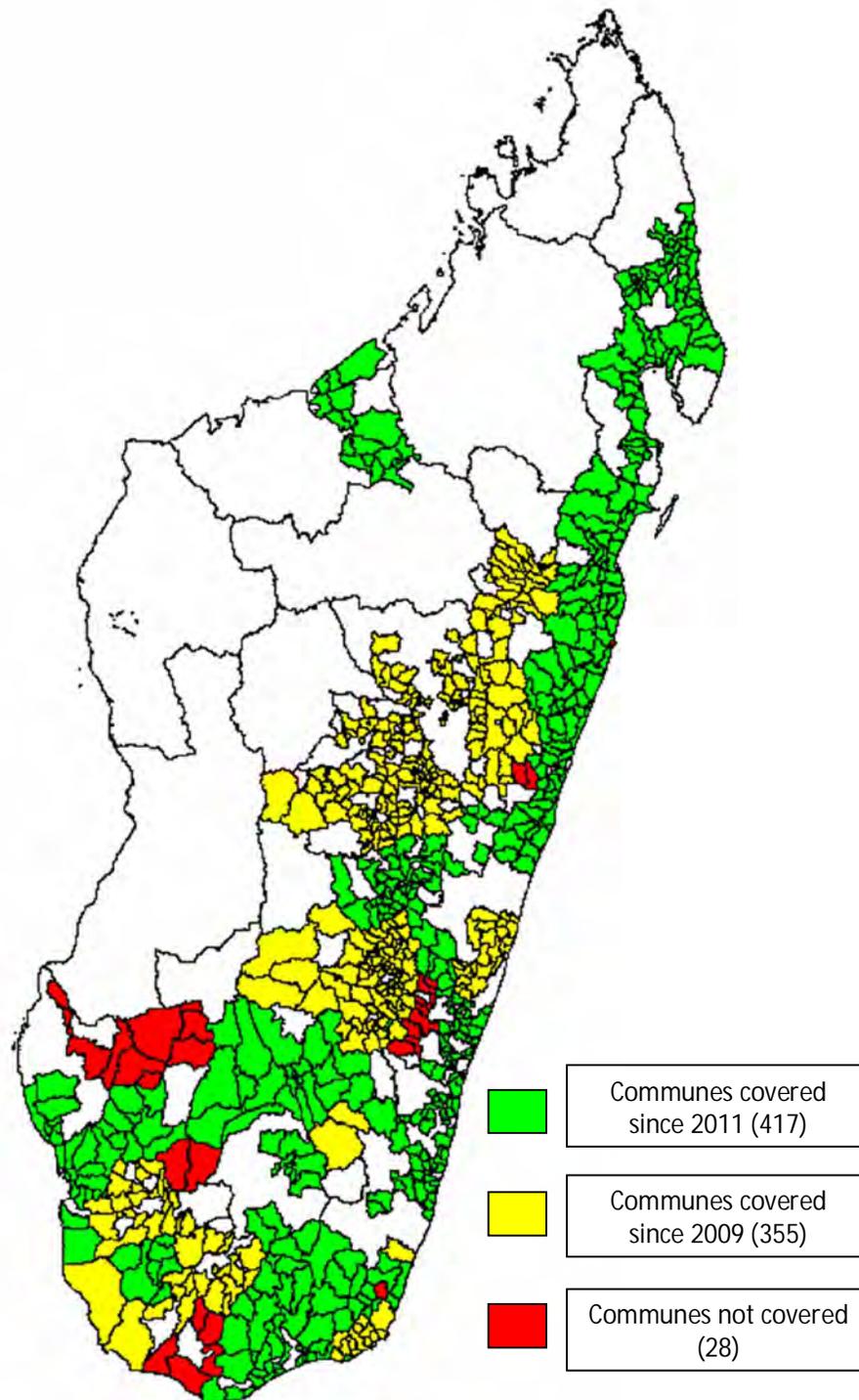
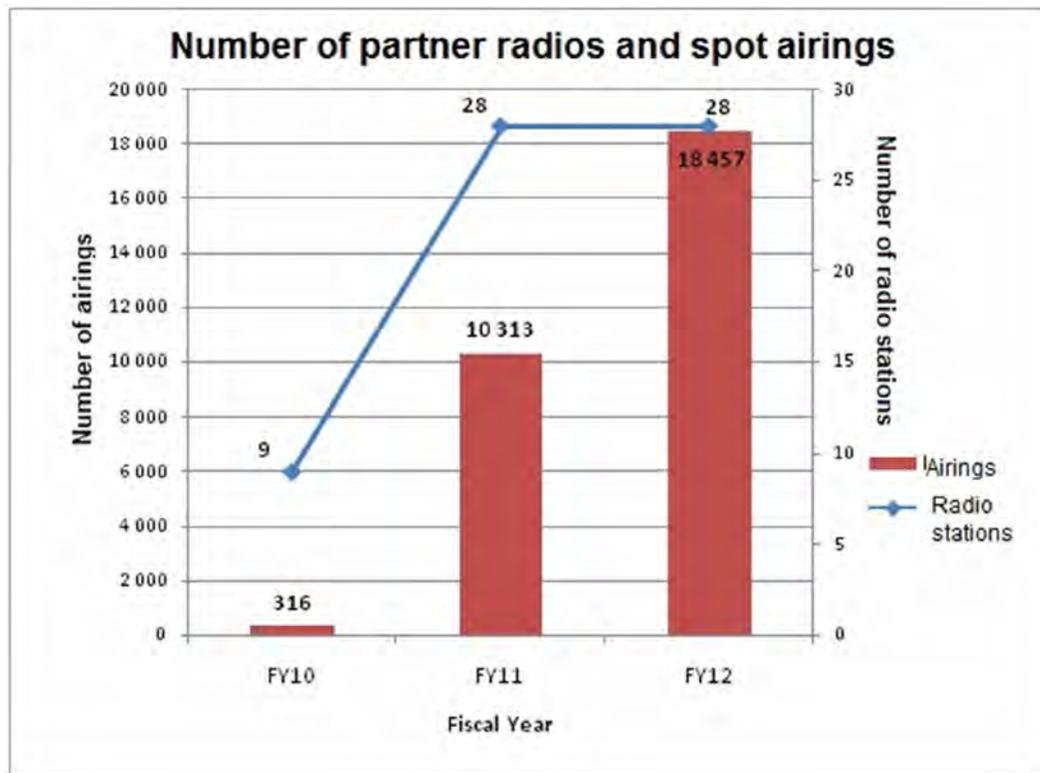


Figure 11. Number of partner radio stations and spot airings



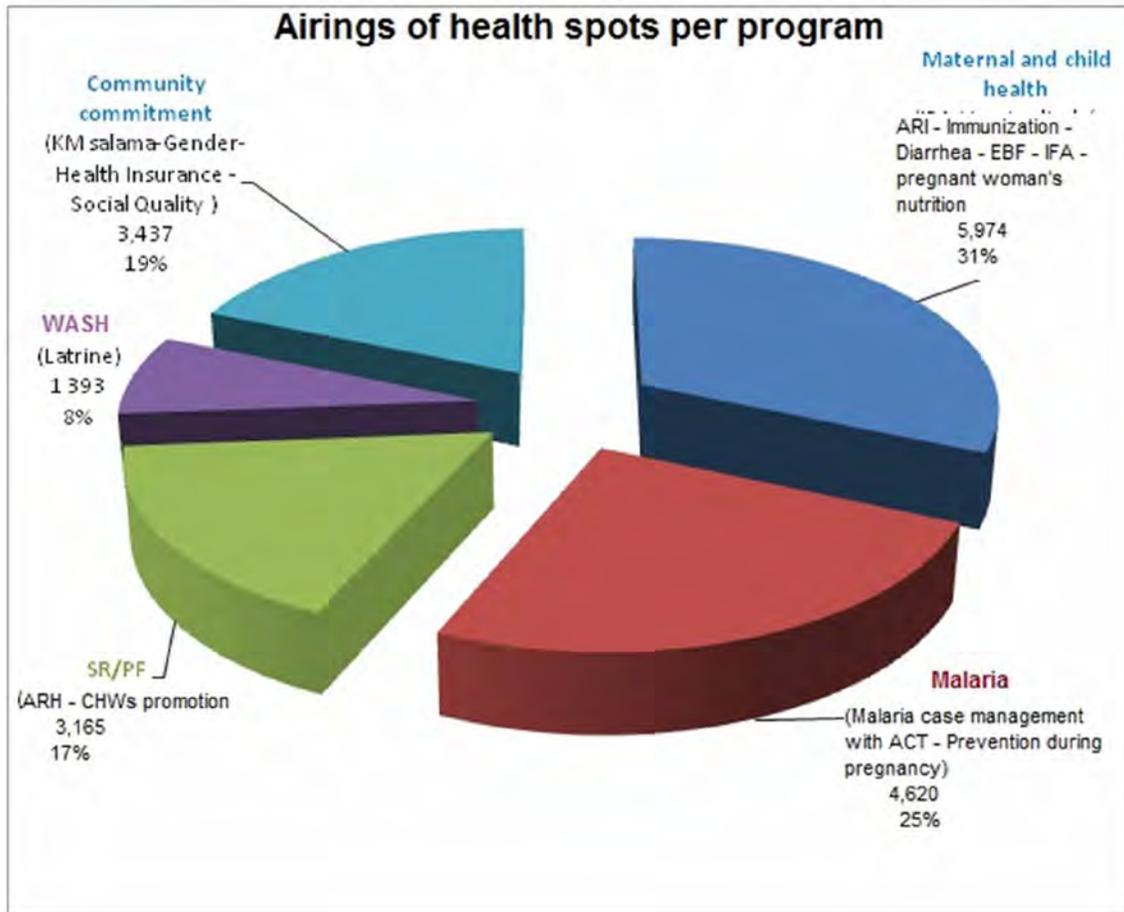
Source: Santénet2, Radio Airing reports (2010, 2011, 2012).

One reason for the excess number of broadcasts is the use of Santénet2’s spots by broadcast managers to illustrate the partner radio stations’ own health broadcasts. In Ambohimahaso, the airings raised the population’s awareness of the mutual health insurance schemes. According to one report, a man stated, “I learned about the health insurance through the spots and I have subscribed since then. People around me have become interested as well and are planning to join soon.” Ambohimahaso has the highest membership rates among the four districts where the insurance scheme is implemented and accounts for 57.5% of all health insurance members in the four districts.¹ Awareness-raising on the use of latrines has also been strengthened to contribute to diarrheal diseases control. The airings of the spot on latrines accounted for 7% of all airings during this fiscal year. It has been noted that the construction of latrines has increased this past year; in 2011 3,677 new latrines were built, but in 2012, 14,221 new ones were identified during monitoring visits.²

¹ Source: Santénet2’s data on mutual health insurance schemes.

² Source: Santénet2’s data on CLTS.

Figure 12. Airings of health spots per program area



Source: Santénet2, Radio Airing Reports (2012).

- 16 radio presenters were oriented on the KM salama approach (compared to the 14 planned for FY 2012). Two presenters who were already oriented last year took part again in this year's session because the radio station they work for covers two districts where the mutual health insurance scheme is implemented according to the new strategy.
- 22 partner radio stations work with Santénet2 to produce reports, covering 502 communes implementing the KM salama approach (see List of radios that produced a report in *Annex 9*).
- Reports were aired 183 times (compared to the 112 planned for the year), which gives an achievement rate of 163%. Similar to the radio spots, some stations use the reports for their own health broadcasts.

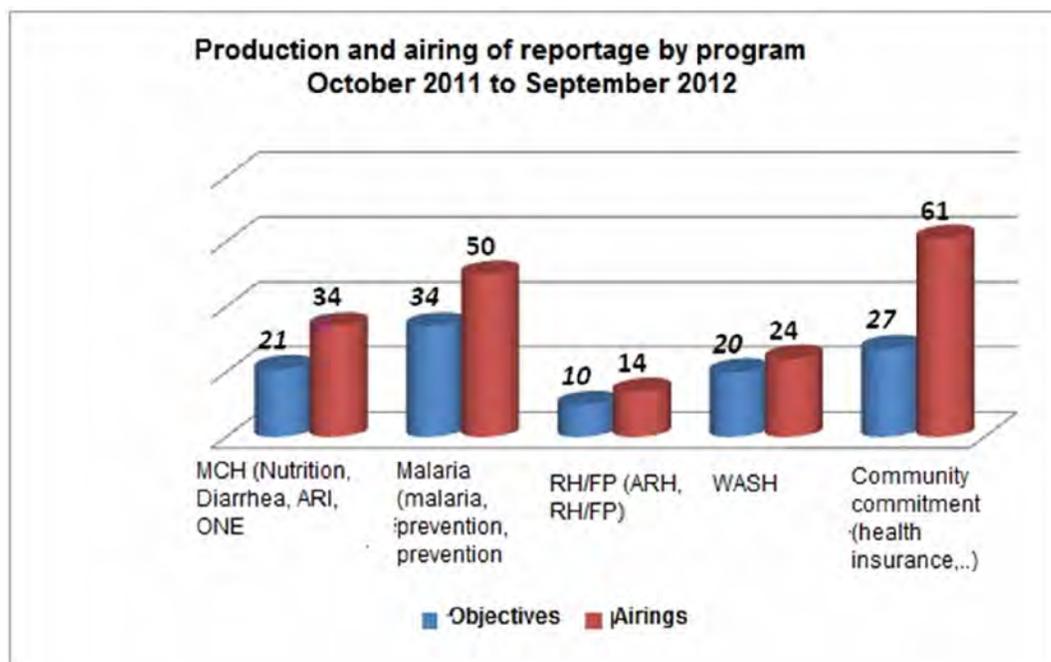
Table 2. Topics of reports aired on radio stations

	Topics	Contents
1	Malaria	Definition, prevention, and treatment
2	Mutual health insurance schemes	Definition, new strategy, membership, awareness-raising
3	Diarrhea	Causes, prevention, construction, and use of latrines
4	CHV	Roles of CHVs in charge of maternal or child health
5	ARH	The bad consequences of STIs
6	ARI	Signs and management
7	ANC	Sensitizing pregnant women to attend ANC
8	RH/FP	The benefits of FP
9	KM salama	KM salama approach
10	Nutrition	The benefits of improved nutrition for children
11	CLTS	Construction and use of latrines
12	c-ONE	The benefits of delivering in a monitored setting

The reports significantly contributed to achieving the project’s objectives. Nine reports on family planning were aired in 288 communes (36% of all intervention communes). For obstetric and neonatal emergencies (ONE), clear improvements were also noted in the community-based evacuation systems: in 2011 there were only 26 systems set up in all the communes implementing the KM salama approach, whereas this year they number 94.³

Similarly to radio spots, the reports were grouped per program area as shown in the following figure.

Figure 13. Production and airing of reports by program area (Oct 2011–Sep 2012)



Source: Santénet2, local radio reports (2012).

³ Source : Santénet2’s Extranet.

c. Challenges and corrective actions

To improve the monitoring of local radio stations' activities, Santénet2 undertook the following activities:

- Strengthened collaboration with the mystery listeners;
- Selected topics for spots and reports to be aired in order to improving targeting based on the needs of each program/region and in reference to local health realities.

Santénet2 is aware of this communication strategy's importance and will document it.

Strategic Focus 3. Implementing the new strategy for mutual health insurance schemes

a. Approaches

The main objective of the mutual health insurance schemes is to address the financial obstacles to the population's access to quality health care. Four districts were selected for implementing the new strategy, which is to scale up the mutual health insurance schemes at the district level: Vatomandry, Ambohimahaso, Ambalavao, and Ambositra.

The initiation phase involves four activities: setting up the structures, training, awareness-raising, and member enrollment along with payment of contributions. The District-level Initiative Committees (DICs) and the Commune-level Initiative Committees (CICs) work together with Santénet2 to carry out this phase.

Management structures are then set up with the goal of having more effective structures. Thus, the initiative committees are replaced by the various management bodies:

- At the *fokontany* level: the *fokontany* representative (*Solontena Isam-Pokontany* [SIP])
- At the commune level: The Commune Executive Committee (CEC)
- At the district level: the Board and the District Executive Committee (DEC).

Except for the DEC, which is an independent organization, all members of the management entities are elected by and among members.

Several trainings are provided by resource people (from partner organizations) and by independent trainers. These trainings are for the initiative committees, healthcare providers, and members of the CECs and DEC to improve their performance.

Awareness-raising activities are designed to encourage the population to join the scheme and thus increase membership. Two types of awareness-raising activities are conducted:

- Those conducted directly by Santénet2: distribution of posters and invitation cards, and airings of spots
- Those supported by the initiative committees: meetings, direct contact with the communities, radio broadcasts

The CICs are in charge of enrollment and collection of contributions, using tools they were given for this purpose: contribution booklets, enrollment forms, and receipts for contributions paid.

During this preparatory phase, the modalities for payments for care are set by the DIC members with Santénet2's support: the amount of contribution, the enrollment modalities, the

period covered, and the service package, as well as the procedures for working with health facilities.

b. Results

The four mutual health insurance schemes have been set up and are operational in the four districts. Until their management bodies are operational, they will be managed at the district level by the DIC, composed of a chair, a vice-chair, a secretary, and a treasurer. At the commune level, the committee is composed of a chair, a secretary, and a treasurer.

For Vatomandry, during September 2012, for the first month activity, 30 external counseling were conducted at the CSB level, 5 ill members were referred and hospitalized at the district health center level 2. The rate for total coverage was Ariary 220,000, of which Ariary 178,000 was paid by TIAVA II.

The coverage modalities were set as follows:

- Contributions and coverage rates

Table 3. Service packages and coverage rates per district

Service package	Case management rate			
	Vatomandry TIAVA II	Ambohimahasoa TIAA	Ambalavao MiAi	Ambositra AMS
CSB (outpatient consultation and admission)	50%	100%	100%	100%
District health center (outpatient consultation)	0%	50%	100%	0%
District health center (admission)	90%	75%	75%	Ceilings: - Medical ward: MGA 50,000 - Surgery ward: MGA 80,000 - Ophthalmology: MGA 4,000
Transportation CSB – district health center	100%	0%	0%	Ceiling: MGA 20,000
Transportation district health center – Regional Reference Hospital Center (RRHC) (lump sum)		MGA 100,000	MGA100,000	
Annual individual contribution	18 years and older: MGA 4,500 Under 18 years: MGA 2,700	MGA 2,500	MGA 2,500	MGA 3,200

Source: DIC meeting reports, August 2011.

- Enrollment modalities: per household or per group
- Service package: the types of conditions and services covered at the CSB and hospital levels are detailed in *Annex 10*.
- Procedures for working with health facilities: specifications for CSBs and hospitals have been developed, stating the obligations of the parties (health facilities and mutual health insurance schemes).

The periods for care coverage were also set. In Vatomandry, coverage started in September 2012. The following table shows the dates when coverage begins for the four mutual health insurance schemes. The coverage runs all year long (12 months).

Table 4. Effective coverage dates

Vatomandry	Ambohimahaso	Ambalavao	Ambositra
Sept.1, 2012	Oct. 1, 2012	Oct. 15, 2012	Oct.1, 2012

Source: Santénet2, meeting minutes, (August- September 2012).

Enrollment

Enrollment reached 22,565 members in the four districts for the first year of operation.

Table 5. Membership status as of September 31, 2012

District	Membership	Average membership per commune	Total contributions
Vatomandry	2 252	119	9 965 400
Ambohimahaso	13 189	733	32 972 500
Ambalavao	5 879	346	14 697 500
Ambositra	1 821	79	5 827 200
Total	23 141	301	63 462 600

Source: Santénet2, mutual health insurance scheme dashboards (2012).

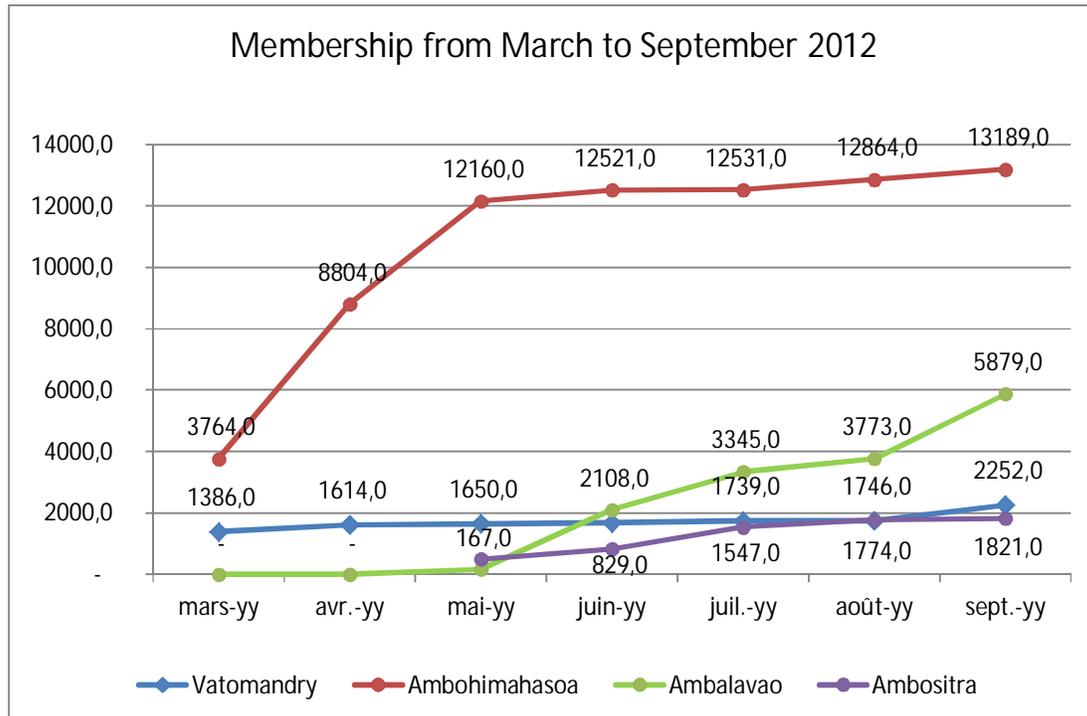
Although the results are well below the targets set by Santénet2 (an achievement rate of 8%), they are nevertheless promising when compared to past experiences with mutual health insurance schemes. In Ambohimahaso for instance, the number of members is higher than the membership numbers achieved by the former mutual health insurance at the commune level (10,000) or by another group called AFAFI (990 members by the end of the first year of operation).

A review of the membership data shows that enrollment sharply increased from project onset in two districts, namely Ambohimahaso and Vatomandry. However, in Vatomandry, enrollment stopped at the time of the two cyclones that affected the region in January and February 2012, diminishing the local population's resources and thus preventing them from enrolling and paying contributions. In addition, a strike among healthcare professionals and the closing of health facilities for almost four months (from June to September 2012) hampered enrollment in Ambohimahaso and Ambositra.

On the other hand, the actions conducted by partners have favored good results. For instance, the four communes implementing the KM salama approach supported by the NGO SALFA in Ambohimahaso succeeded in enrolling more than 1,300 members through the coordination of the CIC members' actions to promote local authorities' and community leaders' involvement, close monitoring, and active participation in awareness-raising. The average number of members is 162 per commune in non KM salama communes and 310 in communes implementing the KM salama approach.

The following graph shows the changes in the number of members in the four districts.

Figure 14. Changes in number of members (Mar–Sep 2012)



Source: Santénet2, mutual health insurance schemes' dashboards (2012).

From August to January of each year, most of Madagascar enters a lean period where the population has not enough resources to meet all their needs, especially their food needs. However, in Vatomandry during September 2012, an increase in membership by 29% (in only one month) was noted, compared to the numbers at the end of August, after it was announced that payments would start. Similarly, in Ambalavao, the announcement that membership cards would be distributed to members raised interest among the population who felt that the project was serious, despite the healthcare staff's strike. The mutual health insurance scheme in Ambalavao saw its membership increase by 56% in September alone, although it was the lean period.

These examples show that the population can develop genuine interest in the mutual health insurance schemes, but they wait to be sure that the schemes are effective before joining.

Although the membership rate is not yet enough to pay for operating costs, the local communities decided to take the initiative and start operations.

- The DICs organized four start-up meetings in the four districts.
- 21,007 membership cards were produced and distributed to members with the support of Santénet2 and partners.
- 113 contracts were signed by the four insurance schemes with health facilities, including 109 CSBs and four hospitals.
- The service packages are available in all healthcare facilities.

Setting up structures

In addition to the four DICs, 77 CICs were set up and are operational, with 899 members (compared to the 680 planned). The number of members per CIC was increased from 10 to 15 or even more to ensure representativeness, especially at the *fokontany* level.

Five communes in the district of Ambohimahasoa succeeded in enrolling more than 1,300 members, namely the four communes supported by the NGO SALFA (Ambalakinresy, Morafeno, Ankafina, and Manandroy) and one commune supported by CRS (Ampitàna). In each of the 46 *fokontany* in these communes, members selected three representatives, for a total number of 138 representatives. The election of *fokontany* representatives (SIPs) is granted when the *fokontany* has reached a certain number of members, which is a way to encourage communes to increase enrollment. In several localities, the population is waiting for the schemes to begin operations before making a decision.

In June 2012, five CIOs were set up by the elected SIPs in the five communes. This is 7% of the planned objective, given that the SIPs elect the three CIC members. No district management structure (Board and DEC) has been established yet because the number of CIOs is still too small and the number of members is not yet large enough to pay the operating cost of a DIC. These structures will be set up gradually based on the increase in membership.

Training

In November 2011, a pool of 46 resource people from the NGOs was set up. Santénet2 organized two training sessions to update them and build their skills and knowledge. Figures relating to trainings carried out are provided in the following table:

Table 6. Number of training sessions on the mutual health insurance schemes

Beneficiaries	Resource people	CIC	Healthcare staff	CEC	DEC and Board
Number of training sessions	2	62	4	1	0
Number of people trained	46	899	147	14	0
Completion rate	88%	132%	134%	7%	0%

Source: Santénet2 training reports (2011–2012).

The objectives for training resource people, CIC members, and healthcare staff were achieved. Local supervisors and their deputies (if they have one) were trained. The deputies will oversee payments to *mutuelle* members in relation to the service packages offered by the mutual health insurance. The training of board members and DECs will occur when these structures are set up, which should take place by January 2013.

Awareness-raising

The four districts benefited from ongoing support in their awareness-raising activities. On average, each commune saw two awareness-raising meetings for the CIC/CCDS/CHVs, for a total of 154 meetings. At each review, NGOs conduct the awareness-raising sessions for the CHVs/CCDS. Local supervisors also went to the field and conducted 19 awareness-raising

sessions in Vatomandry. In the three other districts, local supervisors are planning to go into the field in October. In addition, the CIC/DIC/CCDS and CHVs conducted various activities such as meetings, local activities, and home visits on their own initiative. In all, 2,500 posters and 50,000 invitation cards were produced and distributed in the *fokontany*, and one spot on mutual health insurance schemes was aired on local radio stations.

Monitoring and supervision

To monitor indicators, dashboards were developed for the mutual health insurance schemes and were updated. Similarly, a streamlined technical and financial management system was set up to allow for effective monitoring of the mutual health insurance schemes' activities. In addition, several indicators pertaining to the services offered by health facilities were defined. They include outpatient consultations, health care, and admission per condition and per level of health facility. Santénet2 also tracks management indicators. The indicators to be monitored on a monthly basis as part of ensuring the schemes' viability are listed in the following table.

Table 7. List of indicators for mutual health insurance schemes

List of indicators tracked	
CSB	District-level hospital
<ol style="list-style-type: none"> 1. Outpatient consultation 2. Hospital admission of more than 24 hours 3. Delivery 4. Health evacuation to district hospital 	<ol style="list-style-type: none"> 1. Outpatient consultation 2. Admission in the medicine and pediatrics ward 3. Obstetrics and Gynecology 4. Ophthalmology 5. Lab, X-rays, ultrasound 6. Health evacuation to regional hospital
List of management indicators	
<ol style="list-style-type: none"> 1. Number of members 2. Number of members covered 3. Number of members covered for services at CSB level 4. Number of members covered for services at the hospital level 5. Number of members covered for evacuation 6. Utilization rate of health facilities by the members 7. Ratio of mutual health insurance members/ users of health facilities 	<ol style="list-style-type: none"> 1- Coverage rate of fees 2- Average Cost of care at hospitals and CSB 3- Coverage of services 4- Financing rate : Total Cost of charges / Contributions) 5- Contribution of mutual health insurance to the revenues of health facilities: amount paid by mutual health insurance/total amount of revenues

Table 8. Example of data from Ambositra district

Services	Number of covered patients	
	2011	2012
CSB		
External counseling	85 034	51 509
Referred	789	455
Hospital		
External counseling	1 923	1 104
Hospitalization		
Treatment	1 314	928
Surgery	764	545
maternity	702	481
Referred	402	244

Source: SSD Reports Ambositra, October 2012.

c. Challenges and corrective actions

National experiences such as that of AFAFI and international experiences such as that of Rwanda show that a mutual health insurance scheme reaches its full operational phase only four years after inception and requires the support of a partner throughout this period.

The first year of operation for the four schemes set up by Santénet2 focused on awareness-raising. About 300,000 people were expected to join. Despite the challenges listed above—the population’s mistrust, difficulties in adaptation, and a “wait and see” attitude on the part of people who wanted to see the first payments as proof that the mutual insurance was indeed working—the four schemes will operate and develop their activities.

Although it will be difficult to achieve the target membership of 300,000 people, the membership rate should increase to about 20% of the population in the four districts within the second year. Enrollment will remain open until adequate membership is reached.

Awareness-raising and other actions aimed at promoting interest and trust in the mutual health insurance schemes will be reinforced and diversified:

- Interventions with influential people in the *fokontany*: heads of *fokontany* and religious and social opinion leaders will play an important role in encouraging people to join the schemes;
- Partnership with umbrella organizations to promote group enrollment;
- Awareness-raising by those who already benefit from mutual health insurance services;
- Communication on the positive impacts of the insurance schemes;
- Communication to members on the financial situation of the insurance schemes.

One of the strengths of the mutual health insurance schemes’ implementing strategy is that it is managed by local authorities and local community from the project’s onset, which should facilitate competency transfer and continuation of activities after Santénet2’s withdrawal from the process. Santénet2’s support will need to be oriented on expediting and coaching the establishment of structures so that each mutual health insurance scheme has a board by

January 2013. The remaining months will be used to promote competency transfer through the following activities:

- Training *fokontany* representatives;
- Training new CECs and refresher training for those already set up;
- Training board members.

In addition to receiving training, these structures will have to be equipped with tools to operate for at least two additional years.

In terms of operation, because the schemes are managed by members (through their representatives) and operate based on contributions, it will be necessary to continue the study on setting up a savings/credit component to pay for rare and costly conditions, in order to prevent any risk of bankruptcy.

It should be noted that the coverage payments will be one way to obtain data on the number of outpatient consultations and admissions per condition. Once processed, they will feed into the indicators on access to health care, and thus will allow for assessing the effect of the mutual health insurance schemes on health indicators after a period of six months. It will be important to develop a tracking table for each condition.

As regards services offered, the implementation of the social quality approach in the four hospitals will allow for identifying obstacles and improving members' access.

Finally, the close monitoring missions with community members are of special importance to review and assess the actual implementation of membership coverage as well as the management of insurance scheme funds; these assessments will allow timely decision making, the goal being to improve field operations and increase membership.

As an update to information provided above, the table below provides information on *mutuelle* enrollment and finance through part of the month of November 2012. There has been a slight improvement since the end of the reporting period (September 30, 2012).

District	Number of enrolled members			Average number of members per commune		Total fees	
	30-Sep-12	23-Nov-12	Improvement (%)	30-Sep-12	23-Nov-12	30-Sep-12	23-Nov-12
Vatomandry	2,252	2,396	6.4%	119	126	9,965,400	10,441,980
Ambohimahaso	13,189	13,335	1.1%	733	741	32,972,500	33,337,500
Ambalavao	5,879	5,973	1.6%	346	351	14,697,500	16,230,000
Ambositra	1,821	2,126	16.7%	79	92	5,827,200	6,742,400
Total	23,141	23,830	3.0%	301	309	63,462,600	66,751,880

Despite the fact that the entire country of Madagascar is currently in a lean period, enrollment in health *mutuelles* has seen an increase of 3% (November 23, 2012) compared to the situation in late September 2012—an increase of 689 members. This increase is the result of actions conducted in terms of awareness raising and also the effectiveness of the assistance covered by health *mutuelles*.

Mutuelles have also started to operate and provide health care coverage to their members. Preliminary data from Vatomandry and Ambohimahaso indicate that in two months, 404 patients sought care at CSBs and 17 at hospitals.

District	Sept-12				Oct-12				Total			
	No. of cases managed at CSBs	No. of cases managed at hospitals	No. of assisted evacuations	Cost of assistance (MGA)	No. of cases managed at CSBs	No. of cases managed at hospitals	No. of assisted evacuations	Cost of assistance (MGA)	No. of cases managed at CSBs	No. of cases managed at hospitals	No. of assisted evacuations	Cost of assistance (MGA)
Vatomandry	25	5	5	177,363	29	10	6	706,525	54	15	11	883,888
Ambohimahaso					350	2		428,651	350	2	0	428,651
Total	25	5	5	177,363	379	12	6	1,135,176	404	17	11	1,312,539

To increase enrollment in health *mutuelles* through the end of the project, the action plan proposed in the Annual Report 2012 and the Annual Work Plan 2013 emphasized the following points:

- Ensure assistance for sick members to demonstrate the effectiveness of health *mutuelle* functionality.
- Continue to promote communities' interest and confidence in health *mutuelles* through strong sensitization.
- Strongly engage authorities and local communities in the process.
- Strengthen community trust in health *mutuelle* structures by transferring management to their representatives.
- Ensure a monthly supervision of health *mutuelles* to promote good management and to improve the enrollment rate.
- Initiate a system of collective motivation for the various health *mutuelle* managers according to their performance based on the number of members.
- Analyze the possibility of setting up an additional savings/credit for treatment of rare and expensive diseases (not supported by *mutuelles*) for members.

Component 2: Strengthening Community Health Systems

INTRODUCTION

The Santénet2 Project works to strengthen the community health system and puts service quality at the heart of its KM salama approach. Quality of service is measured through compliance with standards required from CHVs and the linkages between CHVs and their supervisors, as well as the communities' satisfaction with the health services offered.

As part of strengthening the community health system, the Project reviews data generated on an ongoing basis, improves the permanent availability of health commodities, and promotes participatory governance of health services, including organization by the community of referrals for patients/women about to deliver.

However, quality of services cannot be achieved without the communities' commitment. In the communes implementing the KM salama approach, this commitment is materialized in the CCDS' activities. The members of these committees identify their communities' health needs, identify local responses to address these needs, and support local actors in implementing responses.

In compliance with the National Community Health Policy and to ensure availability of health services at the local level, Santénet2 has established qualified CHVs who can provide quality healthcare in the 800 communes implementing the KM salama approach. To date, there are 12,058 CHVs operating in these communes.

Ongoing training is a key factor to ongoing improvement of the program. During this fiscal year, the training was aimed at (1) replacing CHVs who dropped out (estimated at 5% of the total number of CHVs over the life of the project); (2) upgrading CHVs from Level 1 to Level 2 where they provide more advanced services, namely injections; and (3) providing additional training to expand the services of CHVs, building on lessons learned and good practices such as community-based IFA supplementation and malaria prevention for pregnant women, identification of danger signs during pregnancy and delivery, early identification of pregnancies, and newborn care. In all, 476 training sessions were delivered, benefiting a total of 6,152 CHVs—2,344 new CHVs to ensure full coverage with community-based services and 3,808 CHVs upgraded to the expanded service package.

To ensure that those who are trained provide quality services, the Project makes it a priority to support continuous coaching/supervision for CHVs. In addition to the technical supervision ensured by the health workers at the CHVs' referral and supervising CSBs, CHVs also benefit at the *fokontany* level from the support of the CCDS. Their coaching activities are recorded in the CHVs' "Tantsoroka" booklet. During this year, 12,058 CHVs in the 800 communes implementing the KM salama approach benefited from supervision.⁴

Community information management and use of data for decision-making are also key to all program areas; they provide relevant information to program managers at all levels. The

⁴ Extranet database as of October 1st, 2012.

report completion rate this year was 76%, which is a significant increase compared to the 63% recorded in 2011. Frequent exchanges with NGOs have encouraged them to optimize their use of the Extranet and SMS systems.

The information generated from monitoring the supply points performance allows for identifying possible problems in regard to the management of the community-based supply system and for making appropriate decisions to ensure ongoing availability of services and commodities at the CHVs' level.

Specific Achievements

Strategic Focus 1. Engaging the community in improving the quality of health services

Building on the project's overall strategy to make quality healthcare services available at the community level, an enabling environment for demand and supply of such services was designed, tapping into the existing tools for quality improvement. This framework was integrated into the KM salama approach and consists of supporting the community to express their needs and implement activities to improve quality. In this regard, social quality can be defined as creating linkages between service beneficiaries, healthcare providers, and local decision-makers (CCDS). The approach was fine-tuned with inputs from the World Bank's work on social accountability in Madagascar (through the use of Community Score Cards).

Social quality is a community-led and endogenous process that promotes the community voice and encourages them to establish their own definition of quality as applicable to health services. It gradually increases community awareness and builds communities' power by providing them with mechanisms that grant them the opportunity to choose and make decisions.

When coupled with technical quality (i.e., compliance with service standards), social quality boosts the services' performance in terms of access, availability, and use. The level of community commitment in the communes implementing the KM salama approach is measured through a review of reports from community assessment meetings and CCDS self-evaluation reports.

a. Approaches

- To expand the social quality approach to all the KM salama communes, support technicians were trained on the topic so that they could in turn train local pools of facilitators in each KM salama commune who will facilitate two types of activities: CCDS self-assessment and community assessment meetings in the KM salama communes. The training focused on the use of two tools: one for self-assessment and one for the community assessment meetings. The implementation of the social quality approach results in the preparation of a community-based action plan.
- The Quality Index Tool serves to measure quality at the community level based on five determinants and is used every semester.

b. Results

The social quality approach progressively leads the community to address its own health needs.

- In all, 3,487 community assessment meetings were held in the *fokontany*, with almost 350,000 people taking part, including 159,000 women. Female participation in these meetings is high, ranging from 44% to 66%. At the commune level, the *fokontany* coverage rate for the assessment meetings ranges from 28% to 82% and is dependent mainly on geographic access. Compared to the similar Community Score Card initiative, community participation in the social quality approach is five times higher. However, results in terms of the community expressing its perception of service quality are about the same.

Results from these assessments show that communities perceive health services in reference to three main points: access to services; ongoing availability of health products with transparent prices; and appropriateness of the environment in which the services are provided, including infrastructures and equipment.

- The self-assessment results show that CCDS have satisfactory performance in terms of support to community action plans, monitoring of CHV coaching, promotion of sanitation, and a gender approach. However, they need to improve the flow of information to the community and the organization of evacuation from the *fokontany* to health facilities for sick people and women about to deliver.

Based on the needs identified, the communities implemented action plans covering the following types of activities:

- Improvement of access to health services: ongoing coaching of CHVs by local supervisors, organization of and schedules for service availability, information displays (posters), community organization for evacuating sick people and women about to deliver;
 - Improvement of ongoing availability of health services: fund raising, monitoring systems, posting of prices;
 - Improvement of the work environment: new infrastructures and maintenance of health facilities, construction/rehabilitation of health huts, equipment for CHVs, and recognition for CHVs.
- 3,487 reports on the assessment of the services provided by CHVs and health facilities are available. To strengthen the communities' power, 9,552 CCDS members conducted an assessment of their satisfaction with the communities' involvement in addressing their own health needs. The community expresses its needs and based on these, activities are conducted to improve the quality of health services. One concrete illustration of this process is the construction of health huts. In 2011, 351 health huts were built. Currently, 3,001 health huts have been or are being built.
 - When the community contributes to organizing health services according to its own perception, it is more likely to be satisfied with and use the services.

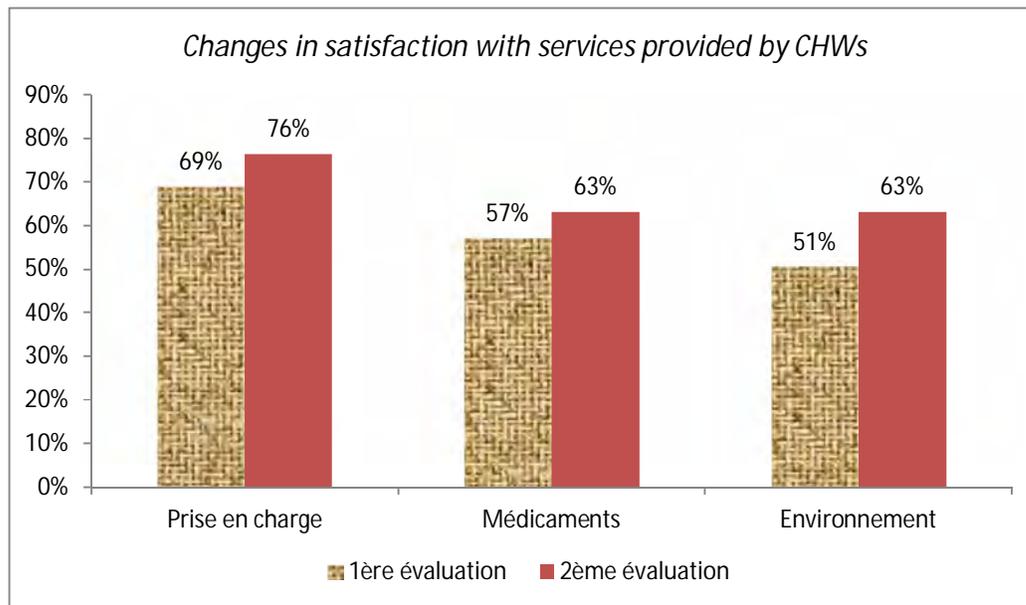
The CCDS members assessed satisfaction in terms of support to and monitoring of CHVs. It was observed that it increased from 77% to 90%. Similarly, the community's satisfaction in terms of case management by CHVs, availability of drugs, and the working environment has improved (see Figure 1.1), and this in turn has led to improved access to/use of health services.

- The number of regular FP users increased by 20%.
- The number of ARI and malaria cases in children under 5 seen by health workers has increased by 50%.⁵

However, the CCDS' satisfaction in terms of the evacuation of sick people and women about to deliver improved by only three percentage points. Referrals for deliveries increased from 13% to 30%.

The figure below shows changes in the communities' satisfaction with the services provided by CHVs.

Figure 15. Changes in satisfaction with services provided by CHVs (case management – drugs – working environment)

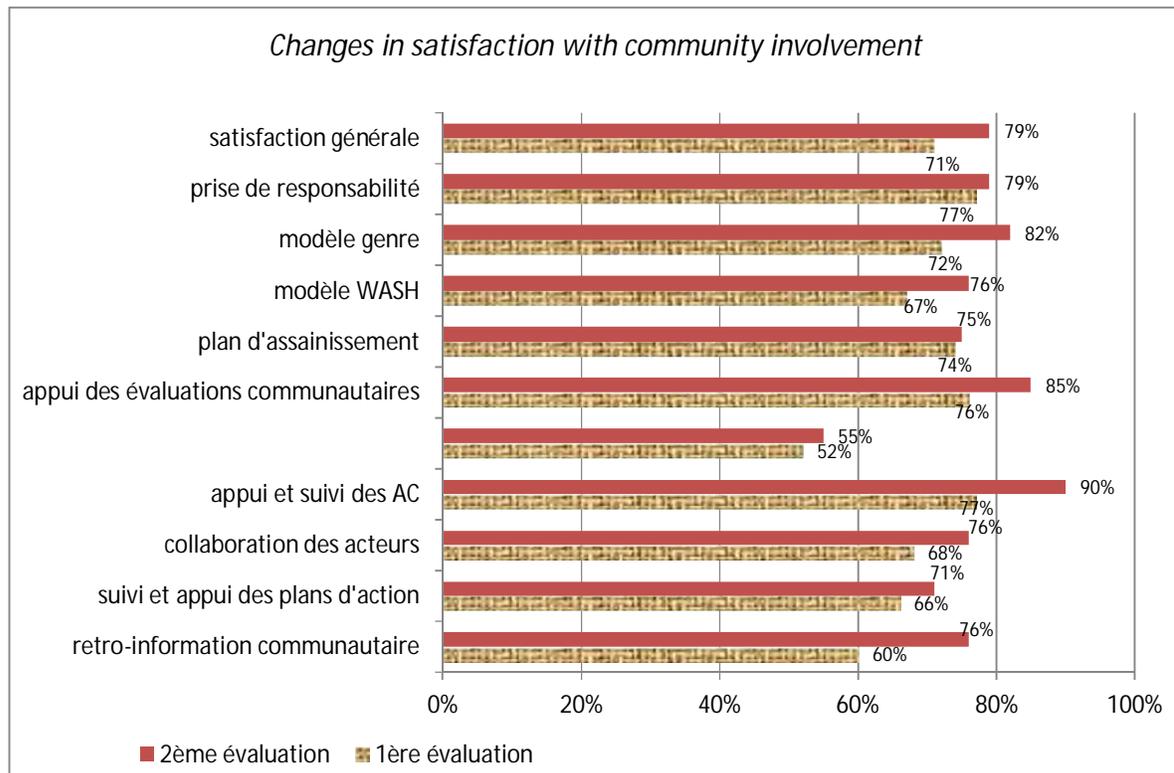


Source: Santénet2, community assessment meetings reports (October 2011 to September 2012).

The CCDS' satisfaction with involvement in actions to improve health is shown in the following graph.

⁵ Santénet2's Extranet as of October 1, 2012.

Figure 16. Changes in satisfaction with community involvement



Source: CCDS' self-assessment reports (October 2011 to Sept 2012).

The following section details the activities implemented to achieve these results:

1. Expanding the social quality approach to all communes implementing the KM salama approach

The social quality approach has been expanded to 796 communes. The four remaining communes will start implementing the approach in October 2012. In addition to the 1,586 quality facilitators, 9,552 CCDS members were trained on leading community assessment meetings and CCDS self-assessments. The CCDS were provided with implementation guides and report templates.

Community assessment meetings are held in *fokontany* and are led by local facilitators. During these meetings, the community is first informed of their rights as clients of health services and then the community's satisfaction with the health services and the gender dimension is measured. Facilitators work to set up an environment of mutual trust where the community can freely express its needs and identify solutions.

- 630 communes implementing the KM salama approach organized community assessments in a total of 3,487 *fokontany*.
- 170 communes implementing the KM salama approach are currently preparing or conducting their assessment meetings.

The self-assessments are organized during the CCDS' review and serve to measure their satisfaction with and their commitment to their roles and duties. The assessments' findings also allow for identifying areas for improvement.

- CCDS conducted self-assessments in 796 communes.

Based on the assessments' findings, the community actions plans are updated, using local resources and competencies.

- 630 action plans were implemented.

The success of actions plans designed to meet the communities' needs is reflected in improvement of the performance of community-based health services. The Quality Index tool is one way to measure such performance.

2. Monitoring the quality of the community-based services through the use of the Quality Index

The Quality Index tool was used twice in all 800 communes implementing the KM salama approach during FY 2012.

Achievements are monitored by intervention communes not only to identify results but also to support quality in implementation. A table showing achievements is shared with partner NGOs on a monthly basis. The assessment of health services' performance is sent every six months for effective decision-making in support of the community.

Strategic focus 2: Ongoing coaching and supervision of CHVs

a. Approaches

- CHVs receive ongoing coaching through training and technical supervision.
- The performance of 156 support technicians was reviewed.
- These 156 support technicians were trained after the performance review.

b. Results

The strategy of providing ongoing coaching to CHVs is effective.

1. Training

During this year, the project conducted 172 training sessions for 126 Level 1 Child Health CHVs, 201 Level 1 Mother Health CHVs, 504 Level 2 Child Health CHVs, and 1,513 Level 2 Mother Health CHVs in 686 communes implementing the KM salama approach to replace those who dropped out for various reasons. The attrition rate is estimated at 5%. The distribution of training session per category of CHVs and per number of CHVs trained is summarized in the following table.

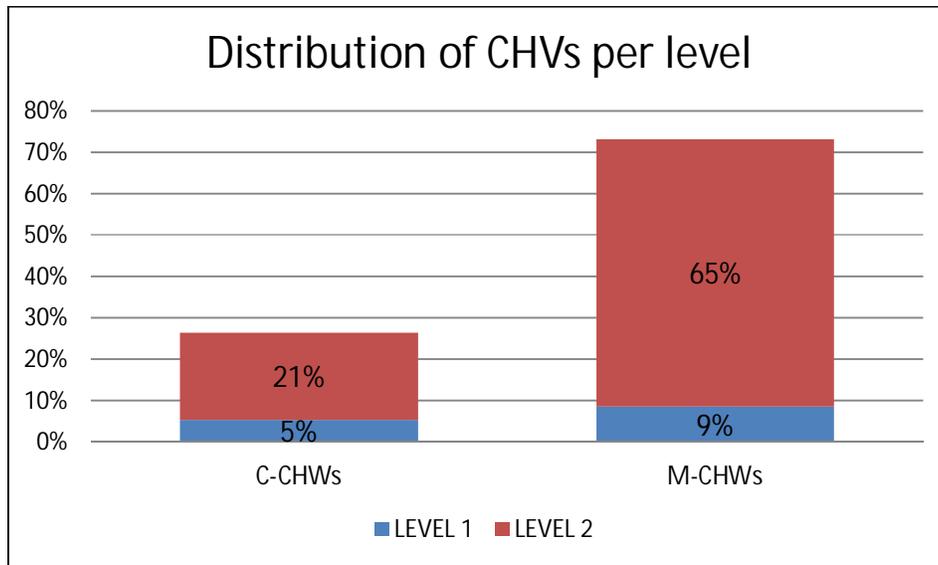
Table 9. Training for CHVs, by level and category

Training topic	Number of sessions	Number of CHVs trained	Average number of participants per training
Level 1 CHVs – Child Health	11	126	11
Level 1 CHVs – Mother Health	20	201	10
Level 2 CHVs – Child Health	39	504	12
Level 2 CHVs – Mother Health	102	1,513	15
Total	172	2,344	

Source: CHV training reports (October 2011 to September 2012), Santénet2.

In all, 95% of CHVs trained during the project are still working, the majority of them (57%) being women. Most of them are now Level 2 CHVs.

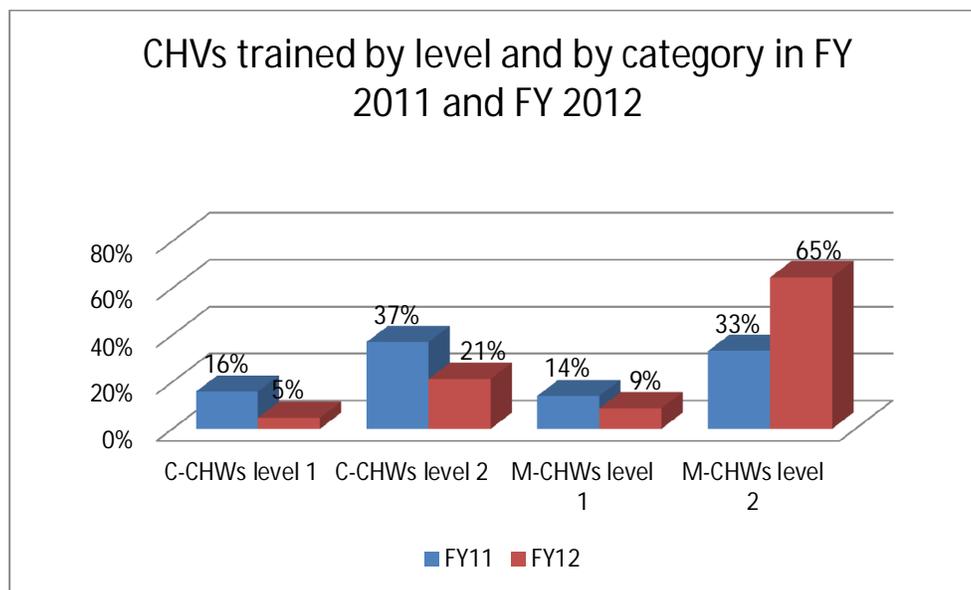
Figure 17. Distribution of CHVs per level



Source: CHVs training reports (October 2011 to September 2012) Santénet2

The figure below provides a comparison between the number of CHVs trained in FY 2011 and in FY 2012.

Figure 18. CHVs trained per level and per category, 2011 and 2012



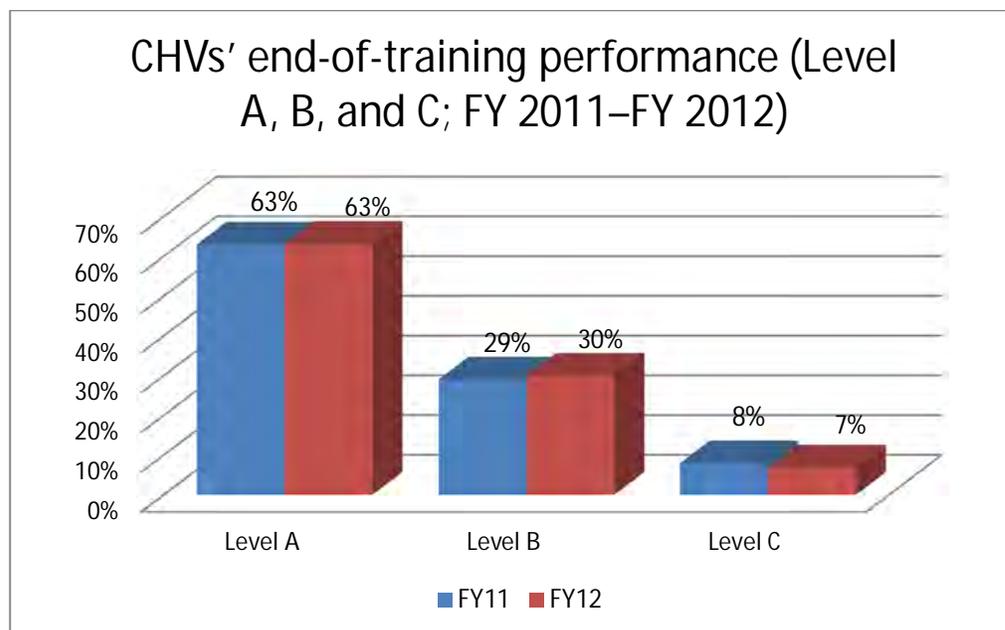
Source: CHV training reports (October 2011 to September 2012), Santénet2.

The proportion of Level 2 CHVs trained was higher in FY 2012 (85%) than in FY 2011 (70%).

It is also noted that the CHVs' end-of-training performance was better in 2012 than in 2011 (see Figure 19 below).

Among CHVs trained, 92%–93% are immediately operational after training, which is due to the quality of the training and the performance of trainers.

Figure 19. CHVs' performance level after training



Source: CHVs training reports (October 2011 to September 2012) Santénet2

2. Supervision

All the 12,058 operational CHVs have benefited from supervision.

In all, 3,187 supervision visits were completed against the 3,200 planned. During the second semester, supervision visits in some communes in the regions of Anosy and Androy were postponed to October 2012 due to safety issues.

Table 10. CHV supervision

	FY11	FY12
Number of supervision visits completed	2,554	3,187
Proportion of CHVs supervised	91%	100%
Number of KMS communes reached	800	800

Source: CHV supervision reports (October 2011 to September 2012), Santénet2.

There were more supervision visits in FY 2012 as compared to FY 2011, and accordingly the proportion of CHVs supervised was higher. This improvement is due to the efforts made by the NGOs' support technicians to support the CCDS in organizing routine monitoring of CHVs. They were in part encouraged to do so through the feedback from Santénet2's regional offices.

Two major activities conducted by the project during FY 2012 account for these results:

- Strengthening the quality of CHV monitoring and supervision

The monitoring and supervision of CHVs has been effective as a result of the following:

- An ongoing coaching and regular supervision system that is implemented by a cadre of competent supervisors;
- Effective supervision tools that have been adapted and support the supervisors in building the CHVs' competency.

Various actors are involved in providing ongoing coaching to CHVs: technical leadership is ensured by the technical staff, organizational capacity building comes from implementing NGOs, and coaching for operational activities at the community level is provided by Santénet2.

To facilitate the technical monitoring of each CHV, the communes implementing the KM salama approach were equipped with supervision checklists (one per CHV), and these checklists are collected at each supervision visit. All the data are then entered by the support technician in charge into the Extranet for processing and review.

- Building CHVs' capacity to provide quality services

All the trainings provided to CHVs are tailored to their needs and capacities while complying fully with national standards. All the operational Level 1 CHVs have been upgraded to Level 2, which means those in charge of child health were trained on c-

IMCI (in addition to nutrition) and those in charge of maternal health were trained in provision of Depo Provera injection (in addition to other FP methods).

In addition, the CCDS members and the NGOs' support technicians must routinely monitor the following:

- CHVs coverage of each *fokontany*
- The trainings received by each CHV
- CHVs' functionality (validation of practicum, supply of health products, submission of MAR reports).

Level 2 CHVs who have not completed their practicum must complete the number of cases required for validation in the nearest health facility: 5 cases of each disease for c-IMCI and 6 injections properly administered for community-based Depo Provera.

Support technicians share the supervision approach with the CCDS and support them in the fulfillment of their supervisory roles. They monitor CHVs and plan with the CCDS the activities to be conducted. They then fill the various reports under the KM salama approach.

A review of the support technicians' performance showed that 61% have a good performance, 31% a fair performance, and 2% a low performance.

Strategic focus 3: Building the analytical and decision-making capacities of the KM salama stakeholders

a. Approaches

A review of the completeness and timeliness of the CHVs' MARs in the Extranet and by SMS is conducted on a monthly basis. Feedback on the performance is prepared by project managers and sent to each NGO to enable them to make decisions at every level.

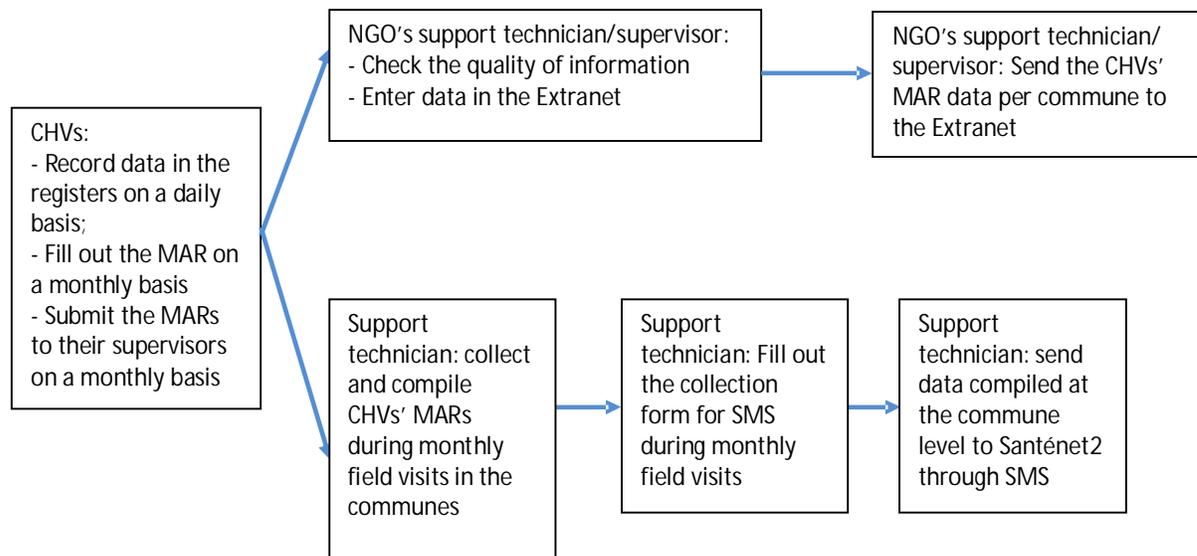
b. Results

The community health management information system (c-HMIS) is operational and generates data for decision-making at all levels, including at the community level.

Santénet2 also has data on the training and supervision received by each CHV in addition to data on service provision, such as the treatment of various diseases, including diarrhea, ARI, and fever/suspected malaria or malaria. The data on the project's vertical programs are also included in the c-HMIS database, including data on WASH and CLTS, ARH, social quality, supply, MARPs/STI, and mutual health insurance schemes.

The information in the c-HMIS comes from the 12,058 CHVs' MARs. The data are forwarded to the Project's office by the implementing partners' 156 support technicians and 48 supervisors (from the 21 grantees). To ensure timely submission of data, the project uses two channels for forwarding MAR data to the central level: the Extranet, covering all program data and project health indicators (31 indicators) from each CHV's MAR, and compilations according to demands (per commune and district and at the national level for the 800 KM salama communes) and SMS are used for 12 indicators compiled from the MARs per commune.

Figure 20. Flow of information for the c-HMIS



Management tools are produced at the central level and distributed to CHVs through the distribution system at the regional level.

The overall performance of the c-HMIS is 79%, with the performance being 76% for completeness, 83% for timeliness, and 84% for reliability.

Santénet2 monitors NGOs on a monthly basis. Monthly statements showing the completeness of the CHV MARs per NGO and per intervention zones are established regularly. The reliability of MAR data was one of the indicators for which data was collected during a survey on the functionality and performance of CHVs in August 2012. The survey measured reliability by comparing the data in the CHVs' service provision registers with the monthly reports that reached the project through the Extranet. These data pertain to the number of cases of diarrhea, ARI, and fever treated, the number of children seen in growth monitoring and promotion sessions, and regular FP users.

Strategic focus 4: Ongoing availability of health products for CHVs

a. Approaches

To meet the needs of vulnerable population groups for health commodities in the 800 KM salama communes, the project adopted an ongoing resupply system based on supply points at the community level.

b. Results

The community-level supply pipeline that has been established is effective and ensures ongoing availability of health commodities at the CHV level. The pipeline was conceived to ensure ongoing product availability for both supply points and CHVs.

- The product utilization data in the CHV reports, the data from the survey among CHVs in 2012, and the data from monitoring CHVs' consumption of health commodities indicate an increase in the use of products distributed through the community channel:

1. Such increase in use is possible only when availability through the distribution system and at the intermediate distribution points has improved.
 2. The average resupply frequency for each CHV is six times per year according to the functionality survey conducted in 2012.
 3. More than half of the social marketing products in the community pipeline are distributed in the communes implementing the KM salama approach.
 4. The resupply of supply points complies with the distribution plan designed.
 5. All the communes are served by at least one supply point.
- The amounts of products purchased by the supply points have increased due to the demand from CHVs.

In all, 805 supply points are operational and regularly supplied. Among them, 800 benefited from fund raising by the CCDS while the other 5 (located at the district level) get their supplies from their own funds.

In addition, 714 supply points are directly supplied by PSI while 86 hard-to-access supply points are supplied by relay supply points.

- Finally, two job aids on the product VIASUR and other social marketing products were designed and distributed in collaboration with PSI. They contain instructions and methods for use and present the products' benefits. The job aid on VIASUR was distributed to Level 2 Child Health CHVs, and the other job aid was distributed to all CHVs, either during training or during the CHVs' resupply visit at the supply points.



CHVs have started using job aids on VIASUR starting this year.

As products became more readily available to them, CHVs were able to manage more and more cases, thus contributing to improving the health of the population living more than 5 km from a CSB (and who are typically more vulnerable than those who live close to health facilities).

Products distribution frequency

Stock-outs were minimized as a result of monitoring of the supply system through invoices/purchase orders from the supply points, monitoring of products in inventories at all levels, and compliance with set intervals for product distribution and ordering.

Results of evaluations of product consumption at all levels led to regular monitoring of monthly consumption levels for both supply points and CHVs. Feedback is shared with all concerned so that they know what their stock status is and can take actions accordingly.



A box and a picture for several social marketing products for CHVs

A frequency interval for resupplying was set during the training of the supply points, ranging from one to four months depending on each commune's remoteness from PSI's warehouse.

Supply points are resupplied based on orders they send. As seen in the table below, the resupply frequency for almost half of the supply points was five times during the reporting period. The survey on the CHVs' functionality showed that the average stock available at the supply points ranged from 1 to 4 months of consumption, depending on the products.

The table below shows the frequency of product distribution from October 2011 to August 2012.

Table 11. Product distribution frequency from October 2011 to August 2012

	Number of resupply occurrences from October 2011 to August 2012										
	1	2	3	4	5	6	7	8	9	10	11
Number of supply points with resupply frequency	0	0	119	104	408	55	13	14	18	25	49

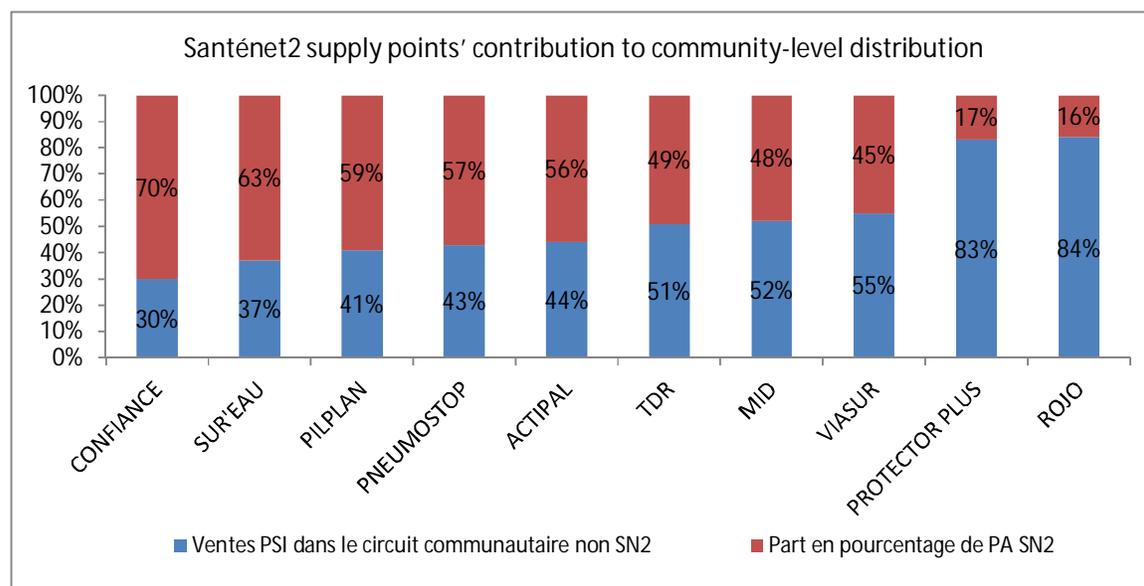
Source: Sales figures, PSI (August 2012).

Supply points' contribution to PSI's overall distribution at the community level

The proportion of products distributed through KM salama supply points compared with the overall amount of products distributed at the community level varies according to products. For those products that are used for managing illnesses among children under five, the proportion is more than 50%.

The graph below shows Santénet2's contribution to community distribution from October 2011 to August 2012, based on PSI's sales figures.

Figure 21. Santénet2 supply points' contribution to community-level distribution



Source: Sales figures, PSI (August 2012).

Challenges and Corrective Actions

When community commitment and participation fueled by internal factors are established, demand for health services (including prevention and case management) can become long-lasting, especially when there is community support for provision of community-based health services.

The performance of the community-based health system is also dependent on its integration with the formal health system, particularly for the information pipeline, product supply chain, and coaching and supervision channels.

- To strengthen the communities' commitment to respond to their own health needs, the project will continue to assess community participation and their satisfaction with health services.
- The CHVs' formative supervision will be strengthened to improve their competency and will be better targeted to meet the CHVs' actual needs.
- Similarly, the support technicians' capacities will be strengthened to enable them to better coach and supervise CHVs.
- The project will also continue supporting implementing partners in analyzing and using data for decision-making.
- The project will continue monitoring the performance of supply points as part of ensuring ongoing availability of products at the community level. Data analysis will identify challenges and provide appropriate solutions.

Component 3: Strategic Results

Introduction

The Strategic Results component focuses on the implementation of five priority programs: MCH and nutrition, RH, malaria control, STI/HIV/AIDS control, and WASH. These programs are implemented in *fokontany* located at more than 5 km from a health facility through Mother Health or Child Health CHVs who promote disease prevention and treatment and use of FP at the community level. By providing a package of integrated services, these community workers contribute to achieving the Millennium Development Goals for Madagascar, namely those relating to the reduction of maternal and child mortality.

During the project's fourth year of implementation, the range of services provided by CHVs in the 800 communes implementing the KM salama approach was expanded. RH services were expanded to include all FP-4 methods and community-based Depo Provera, management of pregnant women and newborns, and STI/HIV/AIDS prevention. Child health promotion includes growth monitoring and promotion (GMP), as well as prevention and treatment of ARI, malaria, and diarrhea.

Figure 22: Integrated services provision

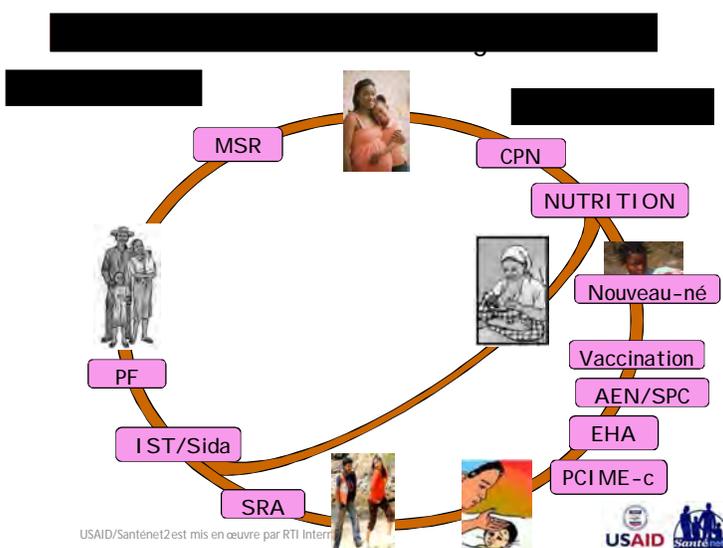


Figure 23: Services offered by Child Health and Mother Health CHVs

Mother Health CHV

- Level 1 – Promotion of integrated RH/FP
 - Information on FP methods; distribution of oral contraceptives, barrier methods, and cycle beads
 - Prevention messages on STI/HIV/AIDS
 - Safe motherhood (ANC, intermittent preventive treatment, nutrition)
 - Post-partum FP
- Level 2 – All services offered in Level 1 with administration of injectable contraceptive Depo Provera

Child Health CHV

- Level 1 – Promotion of child health services
 - Essential actions in nutrition
 - GMP
 - Promotion of vaccination program
 - Malaria, diarrhea, and ARI prevention
- Level 2 – All services offered in Level 1 plus case management of malaria, diarrhea, and ARI at the community level

During fiscal year 2012, 12,058 CHVs were active in the communes implementing the KM salama approach, providing health services at the community-level.

Table 12. Distribution of CHVs per category and level

	Level 1	Level 2	Total
Child Health CHVs (CHV-C)	819	5,647	6,466
Mother Health CHVs (CHV-M)	231	5,361	5,592
Total			12,058

Source: Santénet2, Extranet, Training reports, (2010, 2011, and 2012).

Major achievements by the community actors in FY 2012 are summarized in the following sections.

- **Demand stimulation for access to healthcare services:** 3,293,221 women and 1,947,599 men were reached with awareness-raising activities in the 800 KM salama communes through interpersonal communication (home visits, group discussions), lectures in churches, and local radio station broadcasts of spots with key health messages relating to the project’s five program areas and with messages on community mobilization. Indicators relating to the use of services show that the percentage of the population who has adopted care-seeking behaviors has increased.
- **MCH:** 5,592 Child Health CHVs in the 800 KM salama communes provided MCH services at the community level—pregnancy screening, screening for obstetrical and neonatal complications, referrals to health facilities—to 270,000 pregnant women

who live more than one hour's walking distance from the nearest health facility. The Child Health CHVs managed 49,009 cases of diarrhea among children under five and 53,104 children showing signs of ARI.

- **Nutrition:** Child Health CHVs offered GMP services to more than 1 million children under five, using scales and arm bands. They identified 3% (severe malnutrition) of children with red strip results (severe malnutrition) and 16% of children with yellow strip results (moderate malnutrition).
- **RH/FP:** Mother Health CHVs provided community-based FP services to 122,131 regular users, including 99,432 new users (81% of regular users).
- **Malaria case management:** Child Health CHVs identified 90,156 cases of fever among children under five. Out of these, 57,101 tested positive for malaria (using rapid diagnostic tests [RDTs]) and were treated with ACT.
- **HIV/AIDS:** The project trained 380 peer educators from most-at-risk population (MARPs) associations who in turn reached 22,710 sex workers and men who have sex with men (MSM) with awareness-raising activities and with HIV/AIDS prevention activities. In all, 1,879 sex workers and MSM chose to go through counseling and voluntary screening for STIs as a result of the project's activities.
- **WASH:** WASH activities have been an undeniable success through community ownership of the implementation and monitoring processes. Through the CLTS approach, 12,015 new latrines have been constructed by the communities, and 621 out of 1,671 villages that triggered the CLTS approach have eliminated open-air defecation, becoming "open defecation free" (ODF). In addition, using the same criteria as the WASH-friendly CHV system of certification, community leaders are becoming models for their communities and have completed the three certification criteria. The goal for WASH-friendly CHVs was far exceeded (128% achieved), and 1,082 CCSD members have also met the conditions.

In terms of infrastructure management by the 164 Santénet2-supported communes, 1,153 existing water points have been maintained or improved, and 256 wells or other water infrastructures were installed. These results highlight the success of the WASH component and the communities' ownership of this approach.

Specific Achievements

Strategic focus 1: Providing quality integrated services to improve MCH

Community-based services for MCH and nutrition are available and effective for the 6 million people living in 5,5758 *fokontany* located more than 5 km from a health facility, including 1.1 million children under five, 270,000 pregnant women, and 1.5 million women of reproductive age. These services are provided by actors based in these *fokontany* and are implemented within the framework of the National Community Health Policy. They contribute to reducing under-five and maternal mortality and include GMP for children under five, c-IMCI, management of pregnant women to reduce motherhood risks, and pregnant and lactating women's nutrition.

The work of these community actors also contributes to reducing disparities between rural and urban areas by improving access to health care, providing counseling and information on

health and nutrition practices, and sensitizing the population to improve their living environment. This allows communities to remove existing obstacles to their development, fostering equity so that these vulnerable populations shed their lack of self-confidence and improve their living conditions.

c. Approaches

- Regular meetings are held with MCH and nutrition partners on achievements, challenges, and lessons learned from activities implemented in the KM salama communes and allow for sharing best practices for implementation.
- To allow for expanding the range and improving the quality of services they provide, CHVs benefit from capacity building on topics relating to maternal and child health.
- Monitoring and supervision are essential to ensuring the functionality of Child Health and Mother Health CHVs and the quality of their services.

The project has developed partnerships with entities such as UNICEF to improve practices relating to infant and young child feeding (IYCF), complementary feeding, women's nutrition, micronutrients supplementation, and hygiene. The cooperation between Santénet2 and UNICEF pertains to four areas: (1) IFA supplementation for pregnant women in 88 KM salama communes in the regions of Anosy and Androy, (2) training CHVs on young child and women's nutrition in the communes, (3) refresher training for CHVs on growth monitoring using an arm band in the four KM salama communes affected by cyclone Giovanna, and (4) coordination and experience sharing on maternal and child nutrition and health. The partnership agreement covers these four intervention areas and determines the responsibilities of the two organizations. Santénet2 operates at the community level to collect data whereas UNICEF works at the CSBs and with the districts' health teams. The challenge for UNICEF is to collect information on the IFA tablets distributed and the number of pregnant women served in health facilities.

UNICEF has suggested that Santénet2 collect this information from CSBs; however, this is not possible due to USG restrictions on collaboration with public services. In addition, UNICEF has stated that the current partnership agreement does not comply with its standards and procedures. To address the issue of data collection and compliance, UNICEF has suggested establishing a Program Cooperation Agreement based on a contract. Discussions are underway on the feasibility of the contract because it entails making a clear distinction between USAID resources and UNICEF resources in implementation. Meanwhile, UNICEF has agreed to continue distributing IFA tablets through the Ministry of Health.

d. Results

Service provision by CHVs in their communities has yielded the following results:

- 1,333,016 weighing sessions for children under the age of five were conducted by CHVs as part of GMP. Out the children weighed, 82% were in the green strip, and 3% suffered from severe malnutrition—a decrease by almost half from the figures seen in FY 2011. Children under five are highly vulnerable to diseases especially if they are malnourished, hence the need to regularly monitor their nutritional and health status. GMP services provided in the community offer children a chance to avoid diseases and thus grow and develop normally.

Project activities aim to continuously improve availability and quality of community-based services, including growth monitoring and promotion. The increase in the total number of children subject to community-based growth monitoring is caused by population growth and increased recruitment of CHVs. Baby scales are used to monitor children's weight/age ratio at the community level. In cases of malnutrition, CHVs use the mid-upper arm circumference (MUAC) measurements for confirmation and for referral justification if needed.

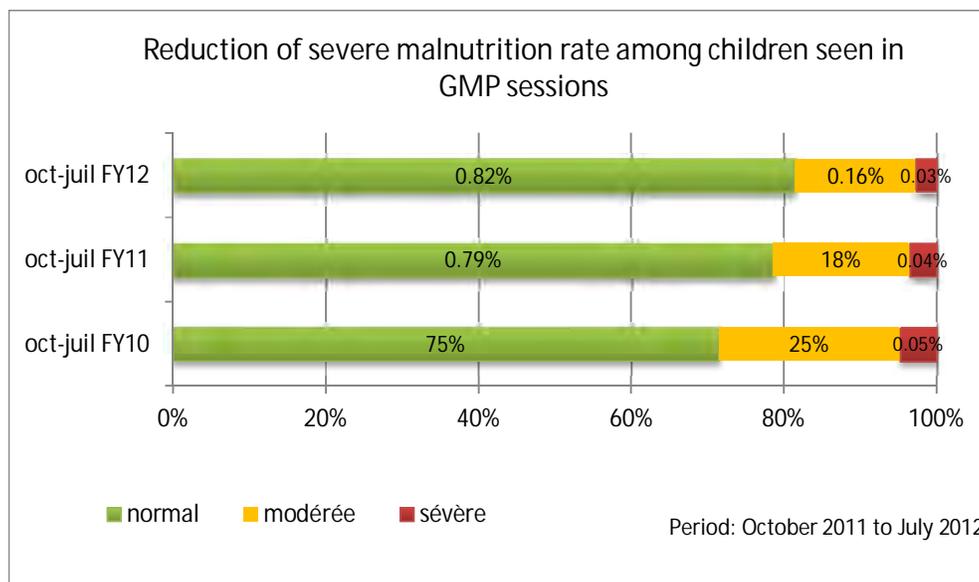
All 800 KM salama communes had baby scales prior to the arrival of an additional 3,000 scales, funded by USAID. The additional scales created a better work environment for CHVs, avoiding the borrowing of baby scales among CHVs or community nutrition volunteers. The procurement of an additional 3,000 baby scales allowed each CHV to conduct growth monitoring activities in their *fokontany* with their own equipment.

CHVs contribute to identifying cases of malnutrition in support of the CSBs. Referrals of severely malnourished children to CSBs have increased from 63% in 2011 to 80% in 2012, although the numbers of cases screened was 45,830 in 2011 and 34,712 in 2012.

Overall, there is an improvement in children's nutritional status. The percentage of severely malnourished children seen by the CHVs during the lean season has also decreased from 5% in 2010 to 3% in 2012, although the number of children screened has tripled. Mild malnutrition is also down—18% in 2011 and 15.9% in 2012. The figure below illustrates these various improvements and reflects the scope of the GMP services delivered by CHVs in the 800 KM salama. Strengthening the CHVs' monitoring and supervision seems to have translated into strengthened monitoring and management of children, including caretakers' improved feeding practices and knowledge.

When compared with the CSBs' data, the results of the CHVs' interventions clearly show that they are meeting the needs of mothers and children in a significant manner.

Figure 24. Reduction of severe malnutrition rates among children

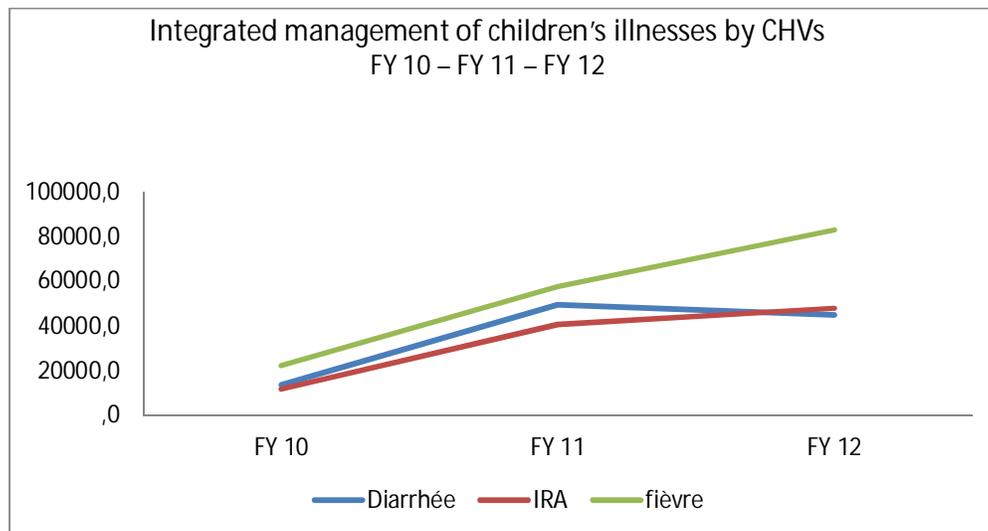


Source: Santénet2, Extranet, CHV MARs (Oct 2011- July 2012).

A survey on CHVs' functionality in August 2012 showed that each of them perform 29 weighing sessions per month on average.

- 192,269 cases of common illnesses in children were managed by CHVs, including 49,009 cases of diarrhea, 53,104 cases of ARI, and 90,156 cases of fever. In 2011, this figure was 147,758. More ARI and fever cases are managed, while the number of diarrhea cases is down due to the communities' efforts to promote hygiene, in particular through the construction of latrines. Indeed, more than 1 million people were sensitized by CHVs on sanitation and hygiene, and especially the use of latrines. In all, 14,800 new latrines were built by the communities themselves. The sanitation program was boosted by the outstanding involvement and support of CCDS. Here again, supervision of the CHVs is one of the key factors that increased their capacity to contribute to child health.

Figure 25. IMCI conducted by CHVs



Source: Santénet2, Extranet, CHV MARs (fiscal years 2010 and 2012).

The data from the CHVs' functionality survey show that each CHV manages on average 1 case of ARI, 2 cases of diarrhea, and 2 cases of fever per month.

Since the inception of KM salama implementation, Child Health CHVs resupply products for diarrhea and ARI management from the CSBs. The equivalent products in the social marketing chain were only introduced recently (second semester 2011 for Viasur and January 2012 for Pneumostop). Preliminary results from a survey conducted by Santénet2 on data reliability and completeness of community-based services in the KM salama communes showed that CHVs experienced stock-outs of diarrhea and ARI management products. 45% of CHVs experienced stock-outs for ARI management products (Cotrim/Pneumostop) and 43% for diarrhea management products (oral rehydration solution [ORS] zinc/Viasur).

Furthermore, the principal cause of stock-outs among Child Health CHVs in case management products for the period of January to June 2012 is linked to stock-outs or absence of supply point managers at the CSBs or at the social marketing level (25% for Cotrim/Pneumostop and 31% for ORS zinc/Viasur). These issues were due to nationwide strikes leading to the health centers closing from February to August 2012, and as of this writing, these products are still not completely available at the supply point level.

The supply of ARI/diarrhea products has decreased because of health center closings and stock-out issues (Viasur from January to March 2012) at the CSB level, as well as the insufficiency of the available stocks and a delay in product resupply at the CHV level because the supply points constitute a source or substitution of these products for the CHVs.

Madagascar's public health system performance indicators tumbled during 2012. The probable causes are a widespread CSB strike and persistent structural problems in terms of human resources deployment, motivation, lack of investment budget, and suspension of donor assistance.

- Only 17,820 out of 26,000 children under five were referred for immunization to improve prevention activities among underage children. Achievement is estimated at 68.5%, caused by the following factors:
 - CHVs refer children to CSBs for immunization; however, parents, families, or caregivers can accept or not accept this referral. If they refuse to go to the CSB, CHVs do not report this referral in their monthly activity report form. During our field visits, we observed that often parents tend to wait for local mother and child health weeks (organized twice a year) to take their children to vaccination sessions.
 - CHVs might omit to copy information in their monthly activity report about the cases recorded in the register after referral.
 - A CSB strike from February through August 2012 significantly restricted access to primary healthcare services, including immunization. This consequence of the political crisis is felt in health service availability and use. Ministry of Health administrative statistics indicate a decrease in the immunization coverage rate in 2012 compared to previous years.

To address this challenge, Santenet2 will conduct the following actions:

- Formative supervision sessions constitute an opportunity to reiterate to CHVs key messages to communicate to parents on the imperatives of immunization as a life-saving behavior.
 - In November 2012, field technicians were instructed to strengthen CHV coaching in terms of referral activities, especially for immunization, as well as for severely malnourished children, danger signs, ANC, and obstetric and neonatal emergencies.
 - Santénet2 will continue to resupply CHVs with referral forms and provide refresher training to CHVs on the use of this form.
 - CHVs and CCDS, as part of the social quality effort, will be reminded of the systematic use of health booklets during case management, awareness-raising activities, and any contact with the mothers and children to strengthen message delivery.
- 38,125 pregnant women were managed by CHVs, of which 23,923 were referred for the recommended four antenatal visits. Among pregnant women, 14,202 benefited from IFA supplementation, including 9,107 cases with supplements provided through CHVs and 5,095 through CSBs. Referrals for antenatal visits are 100% of the objectives set. Danger signs were identified in 753 cases that were then referred for management at a CSB. For malaria prevention, 12,423 pregnant women received IPT. These results show how effective community-based services for pregnant women have been.

Early detection of pregnancies (at three months) is necessary to allow pregnant women to complete the four antenatal visits as recommended, and thus benefit from the full package of care at the CSB. CHVs follow up with the pregnant women in the community, raising awareness, monitoring IFA intake until the full six months are

completed, and referring them for the next antenatal visits and for delivery with qualified assistance.

Coordination and communication on MCH and nutrition activities at the community level with development partners

By taking part in the coordination meetings, Santénet2 was able to share on practices, experiences, and lessons learned from the implementation of the KM salama approach. These meetings also allowed for harmonizing and coordinating activities in the field, especially in terms of MCH.

The project staff attended six meetings on MCH promotion.

- Santénet2 shared information on its GMP activities, information on the management of malnourished children was exchanged, and the Strengthening and Accessing Livelihoods Opportunities for Household Impact (SALOHI) program adopted tools for monitoring CHVs. The meetings also explored the issues of complementarities and harmonization of the CHVs' activities. For instance, the management of malnourished children in zones where there is collaboration with SALOHI was improved with the positive deviance strategy developed by this program in addition to awareness-raising on food production, balanced diet, and nutritional education.
- The project discussed the harmonization of care for pregnant women with the Maternal and Child Health Integrated Program (MCHIP), especially the identification of danger signs and post-natal management. As part of this collaboration, CHVs in the districts of Ambatondrazaka, Fenerive Est, and Taolagnaro benefited from additional training on referral to CSBs for cases with danger signs. The project shared with MCHIP the single-use health card and the CHVs' supervision booklet, and MCHIP revised the messages contained in the health card to include newborn care and signs of eclampsia in pregnant women for referral to CSBs.
- The project also met regularly with the Infant and Young Child Feeding (IYCF)/ Women's Nutrition (WN) task force to share experiences and see how to strengthen the promotion of early initiation of breastfeeding and exclusive breastfeeding in order to tackle the gradual decrease in exclusive breastfeeding rates. Improving CHVs' interpersonal communication skills was also discussed with the intent of using them to further promote optimal feeding for infants, young children, and mothers.
- Santénet2 shared information on its activities on IFA supplementation for pregnant women at the community level with nutrition partners. After a feasibility study initiated by Santénet2 was completed, activities were implemented with UNICEF in the intervention zones in the south. Sharing experiences from this implementation highlighted lessons that can be used for improved coordination among all partners.
- The coordination meetings covering the national monitoring and evaluation plan for the National Nutrition Action Plan II have resulted in the validation of the plan and the definition of a set of indicators for monitoring the nutrition sector at the national level. The National Nutrition Office (ONN) is in charge of coordinating all nutrition activities in the country and initiated the movement "Scaling Up Nutrition," which is supported by technical and financial partners. Nutrition partners will specify the

targets (children aged 0 to 2 years) and introduce a home-based food fortification program led by CHVs.

- Santénet2 shared practices and lessons learned in community-based service provision with the Ministry of Public Health (MOPH) during coordination meetings. The linkages among CHVs, CCDS, and CSBs have been significantly strengthened: community actors are involved in community assessments, in support and coaching by local supervisors, and they take part in exchanges during formative monitoring and supervision visits. The continued supervision of and support to CHVs will be the main challenge to address if we are to maintain the provision of quality services by these community-based actors.

Prevention activities in the communes implementing the KM salama approach

- Counseling by the CHVs is at the heart of the promotion of improved practices in maternal health and nutrition and improved behaviors in terms of the main childhood illnesses.

Conducting 572,163 awareness-raising activities, CHVs reached more than 2 million people with messages or services relating to MCH and nutrition, improving mothers' and other caretakers' knowledge on health and nutrition. As such, CHVs are the main channel for communicating health education messages, and their action is supported by broadcasts of health message spots on local radio stations.

Eight spots and seven radio reports address MCH and nutrition topics—exclusive breastfeeding, safe motherhood with special emphasis on the importance of antenatal visits and birth preparedness, obstetrical and neonatal emergencies, and GMP and its benefits for children under two.

- CHVs sensitized the communities on the need to set up health evacuation systems as part of getting prepared for obstetrical and neonatal emergencies. As a support action to these systems, solidarity funds or family funds are to be set up, depending on the communities' needs.
- Out of the 211 communes where a health evacuation system has been set up, 94 did so through the communities' initiative. In some communes, all the *fokontany* have a system while in other communes, only a few *fokontany* do. The communities are also encouraged to set up solidarity funds or family funds, if they feel the need to do so. The awareness-raising conducted by the CHVs, backed by the CCDS, have led the communities into setting up systems that rely on their own capacities and means (such as locally made stretchers, carts, canoes, etc.). The systems are established at the commune level in principle but can also be extended to *fokontany* if a need is expressed or if the geographical distance requires it.

The procedures for managing the systems have not yet been formalized. Some communities set up emergency organizations (locally called “*vonjy taitra*”). In most cases, they ask the head of the *fokontany* or CCDS members (or the head of the CSB and in some cases, the CHV) to manage the system.

Setting up a health evacuation system is the result of demand stimulation/awareness-raising and actions to promote community ownership and engagement. Communities are making the decision to implement health evacuation systems based on their needs assessments and

perceived risk. Encouraging results from the pilot phase led to the scale-up of the approach to all 800 KM salama communes. All Communal Health Development Commission (CCDS) members in the communes received information and training on the lessons learned and success factors derived from the pilot phase. In addition, all CHVs (Mother Health and Child Health) received complementary training to identify danger signs in pregnant women. Communities were encouraged to consider establishing health evacuation systems in the framework of social quality activities. The process is by essence incremental, building self-efficacy of communities and their social capital. Santénet2 regularly collects information on the implementation of community action plans. Project implementing partners' support technicians (STs) were trained and received tools to collect and transmit data on social quality actions, including health evacuation systems. As of March 2012 during the submission of our semi-annual report, we had reports coming from 175 KM salama communes that had set up an evacuation system. As of the end of the reporting period (September 30, 2012), our records indicate that 211 KM salama communes had established an evacuation system (out of 374 communes that reported on the subject). We also have information on the number of pregnant women and newborn evacuated during the reporting period, respectively 146 pregnant women and 33 newborns.

Often, a stretcher is the simplest means of transportation put in place. Carts are also commonly used in areas where raising cattle is widespread. For those communities that access CSBs through a waterway, canoes are used. Men who are in charge of the evacuation take turns and receive no compensation except when they have to spend several days at the CSBs. In some communities, food is paid for them in that case. In the communes of Andranofasika and Manerinerina, all the *fokontany* have a health evacuation system, including by car. In general, their *fokontany* are not far from national roads and have private associations or projects operating in their localities, which may account for the choice of transportation for health evacuation.

Solidarity funds have been set up in some communes while others have not yet managed to do so. The funds are managed by the head of the *fokontany*, the head of the CSB, or a representative elected by the community. People aged 18 and older, regardless of their gender, are invited to contribute to the fund. However, most of the funds have stopped operating due to the lack of sound and sustainable management, a real challenge for the communities.

During our semi-annual ST training (held in November 2012), we strengthened ST reporting capabilities for social quality activities. During CHV supervision sessions, STs stress the importance of and offer refresher information about CHVs' recognition of danger signs in pregnant women and newborns. The next *Ezaka Mendrika* bulletin issue will highlight KM salama communes that have successfully implemented health evacuation systems.

Expanding integrated community-based services in MCH and nutrition through ongoing coaching and supervision

- 3,808 CHVs were trained on pregnant women and newborn management, and obstetrical and neonatal emergencies in FY 2012. The training addressed the benefits of IFA intake for pregnant women, malaria prevention, pregnant women's nutrition, breastfeeding, the identification of danger signs, tetanus immunization, and

deworming, and provided CHVs with instructions for raising awareness on setting up health evacuation systems and solidarity funds.

- 1,559 CHVs benefited from capacity-building in nutritional monitoring in the three districts devastated by cyclone Giovanna (Moramanga, Vatomandry, and Mahanoro). Twelve trainers contributed to the CHV training and are currently monitoring the activity whose results should be known by late November 2012. It was especially important to build the CHVs' capacity because, given the circumstances, they had to be very effective in managing and preventing acute malnutrition among children under five.

Based on the surveillance results, the MOH will plan for the setting up of nutritional rehabilitation centers (CRENA and CRENAM) at the commune or district level to manage malnourished children.

- 2,413 CHVs were trained on the life cycle, interpersonal communication, IYCF, and WN in 4 regions, 6 districts, and 105 communes in the south.

With the training in interpersonal communication, IYCF, WN, and life cycle, Child Health and Mother Health CHVs have become more capable of managing and preventing malnutrition in children under five and in pregnant women in the zones where Santénet2 collaborates with UNICEF. The project worked with the nutrition partners grouped in the IYCF/WM platform to conduct targeted interventions at the various life cycle stages in order to break the malnutrition cycle. Concurrently, the training strengthened the CHVs' interpersonal communication skills to enable them to generate societal and behavioral changes. The package of messages on optimal practices and services is delivered through home visits and during group discussions, and CHVs negotiate behavioral changes at every contact with mothers or child caretakers. The zones in the south were prioritized due to high malnutrition rates.

- CHVs working in vulnerable areas that are regularly affected by natural disasters benefited from capacity-building in nutritional surveillance coupled with GMP and measurement of the upper arm circumference (MUAC). MUAC allows for confirming acute malnutrition in a child, a situation that may lead to death if the child gets sick in addition to being malnourished. The nutrition cluster, involving various entities with whom the project already cooperates to promote nutrition (Santénet2, SALOHI, ONN, UNICEF with the MOH), designed this routine prevention activity. In correlation with this CHV-led activity, the MOH is planning to gradually extend nutritional rehabilitation centers at health facilities.

Strategic focus 2: Consolidating quality integrated RH/FP service provision

Unmet FP needs stand at 19% in rural areas compared to 18% in urban areas. Potential demand for FP is higher in urban areas (72%) than in rural areas (56%), but demand is better met in urban areas at 76% compared with rural areas (66%) according to the Demographic and Health Survey (DHS) IV. The services provided by Mother Health CHVs at the community level and full coverage of all KM salama communes with such services are Santénet2's way to respond to the unmet needs in rural areas and to reduce the maternal and child mortality rate.

The project's activities are aimed at stimulating demand for FP services, supporting community-based FP service provision in the 800 KM salama communes. The CHVs, trained, equipped, and coached by the project, provide FP services to more than 1 million women of reproductive age in *fokontany* located more than 5 km from a health facility. The Mother Health CHVs have reached 453,532 people with sensitization on FP during the reporting period and serve 122,131 regular FP users. To maintain the quality of these services, the monitoring and coaching of the Mother Health CHVs by various community actors was strengthened, along with the linkages between CHVs, support technicians, and CSBs.

Currently, all communes implementing the KM salama approach are fully covered with community-based services with 231 Level 1 and 5,361 Level 2 Mother Health CHVs operating in these communes.

a. Approaches

The RH/FP partners' committee organizes an annual coordination meeting to harmonize approaches and share experience. In addition, the RH commodity security committee organizes two annual meetings to estimate RH/FP input needs. During these meetings, the project shares information, including data on contraceptive consumption at the community level.

In the field of adolescent reproductive health (ARH), two youth leaders per commune have been established in 599 KM salama communes to conduct group discussions with peers. To identify best practices and challenges in implementing ARH activities as well as to foster exchanges, intra-regional meetings were organized. The youth leaders are monitored by independent trainers on a quarterly basis, and the form used for the monitoring collects data such as the activities conducted, the number of young people reached, and the number of young people referred to a health facility. Reports are collected by the support technicians, sent to Santénét2's regional offices, and then forwarded to the central office in Antananarivo. During youth leader forums, the participants recommended that youth leaders attend the KM salama review.

Mother Health CHV coaching and supervision are done during the grouped reviews and through support by other actors such as the CCDS and support technicians.

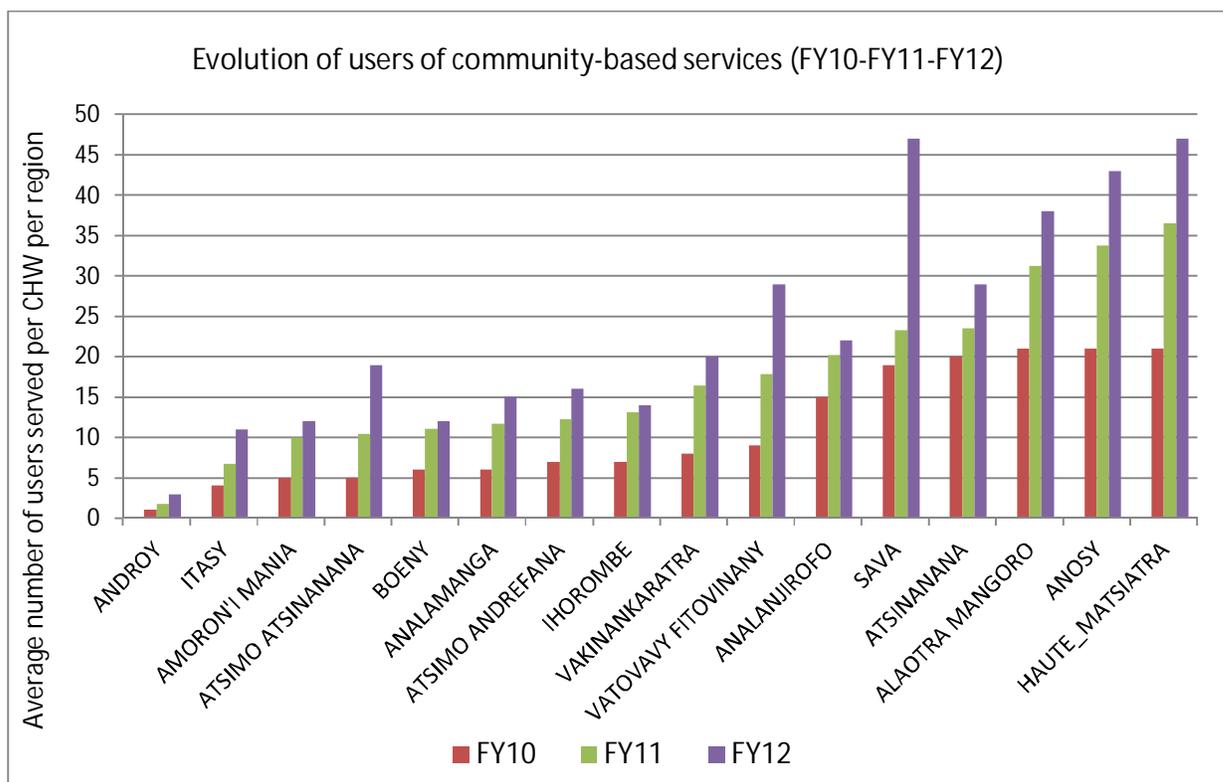
b. Results

1. Community-based FP services

- The 5,592 Mother Health CHVs provided services to 122,131 regular users (RUs), including 99,432 new users. On average, each CHV serves 39 regular users.
- Among regular users, 64% use injectable contraceptives and 30% pills. Injectable contraceptives are the preferred method of users at the community level.
- The average number of regular users per CHV has been increasing since 2009. From 2010 to 2012, it has almost doubled from 15 to 39.

The figures below show changes in the total and average numbers of FP users served by CHVs.

Figure 26-a. Change in the average number of FP users served by one CHV from FY10 to FY12, per region

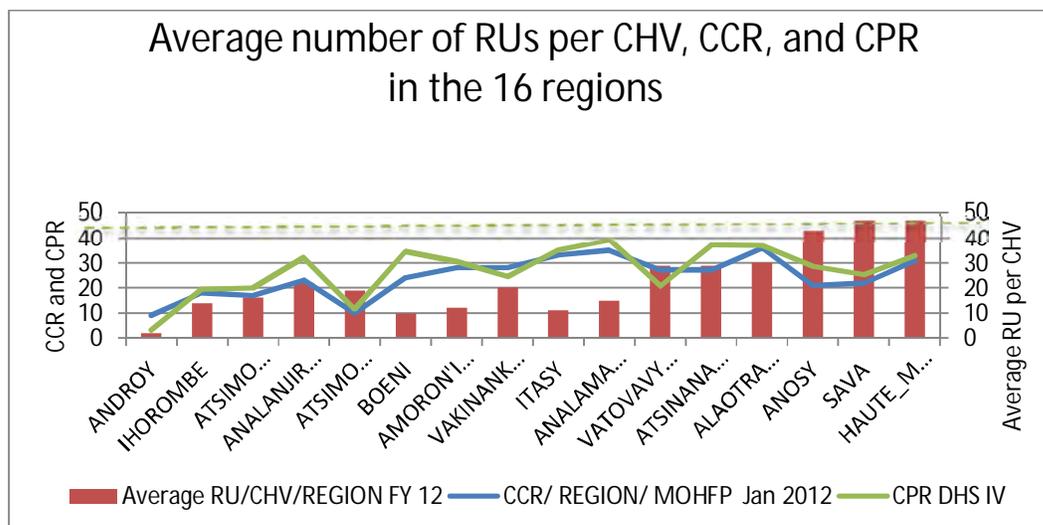


Sources: Santénet2, Extranet, CHV MARs (fiscal years 2010 -2012).

As seen in the figure above, the average number of FP users served per CHV has increased in every region, reflecting the effectiveness of awareness-raising activities conducted by a range of community actors (CHVs, youth leaders, religious leaders, and local radio stations), ongoing coaching of CHVs by supervisors, and the commitment of CCDS members to support the quality of CHVs' services.

Historically in Madagascar, public-sector facilities and private-sector providers constitute the major source of FP services—community-based contraceptive distribution was only 2.2% in DHS IV (2008/09). The KM salama model permits widespread availability of community-based FP services, targeting women of reproductive age (WRA) living in remote areas. A continuous increase in the uptake of community-based FP services indicates encouraging performance in KM salama communes. However, there are variances among communities in use of FP services. We analyzed uptake of FP services in KM salama communes by comparing the average number of FP users served by CHV (RUs), regional-level contraceptive coverage rate (CCR—number of regular FP users served at CSBs divided by WRA), and regional contraceptive prevalence rate (CPR). (See graph below.)

Figure 26-b. Average number of RUs per CHV, CCR, and CPR



Source: Santénet2, MOHFP database 2012 and DHS IV.

In 2008, the average CPR in rural areas was 26%. However, there were major regional variances in rural CPR, ranging from 2% to 47%. Following is our explanation of the graph data.

1. Vatovavy Fitovinany, Atsinanana, Alaotra Mangoro, Anosy, SAVA, and Haute Matsiatra regions—RU, CCR, and CPR are aligned, and the FP uptake is relatively high. Uptake can be increased by targeting unmet need for FP.
2. Amoron' i Mania, Vakinankaratra, Itasy, and Analamanga regions—Community-based FP services (RU) is relatively lower than CCR and CPR. The causes might be related to service delivery. These highland regions are relatively better off in terms of a formal FP service delivery point network, and the rural population's access to service delivery points is easier and occurs more regularly (better road conditions and relatively low transport cost constitute incentives for villagers to travel regularly to the nearest town market to sell agricultural products. These visits are also opportunities to seek health and FP services from CSBs).
3. Androy, Ihorombe, Atsimo Andrefana, Analanjirofo, and Atsimo Atsinanana regions—Demand for FP services is very low due to sociocultural factors—high level of desired fertility.

Santénet2 addresses the challenges listed above through the following actions:

1. Stimulate demand for FP services and continuous improvement of CHV FP service quality:
 - § Strengthen awareness-raising activities by broadcasting FP messages through local radio stations and through youth leaders.
 - § Improve CHV counseling skills during supervision visits. The supervision sessions are an opportunity to remind to each CHV to respect the client's free and informed FP choice and to offer clients comprehensive information on advantages and side effects of the selected methods.

- § Refresher training for CHVs on contraceptive stock management to avoid episodes of stock-out.
 - § Refresher training for CHVs on submitting complete, accurate, and timely monthly activity reports.
2. Continue connecting FP service range continuity:
- § Train the remaining Level 1 Mother Health CHVs in DPMA.
 - § Coordinate activities with MSI/Madagascar to ensure effectiveness of referral for permanent and long-lasting methods by CHVs.

The findings of the survey on CHVs' functionality indicate that Mother Health CHVs contribute to 18.28% of all injectable contraceptives distributed at the community level and 28.8% of pills. The average stock available at their level is 1.9 months for injectable contraceptives and 3.6 months for pills.

The activities carried out to achieve these results are described in the following sections.

a) Taking part in the different coordination meetings and workshops

a.1. National coordination meetings of RH/FP partners

Santénet2 took part in the technical coordination meeting organized by RH/FP partners with the goal of harmonizing interventions among FP actors. During the meeting, the project shared the results and distributed a document on the use of community-based services in FY 2011. Similarly, the other participants shared their achievements, good practices, challenges, and outlooks, which made this meeting a very enriching and productive event.

a.2. Technical coordination meeting of USAID's RH/FP partners

Santénet2 took part in the quarterly coordination meetings organized by USAID and convening partners such as MAHEFA, Marie Stopes Madagascar, and PSI. The meetings serve to map out the partners' intervention zones with the package of services provided and to share on activity progress, achievements, and challenges. Partners especially appreciated the fact that Santénet2's information on its intervention zones was complete.

a.3. Workshop to quantify health inputs needs

Santénet2 took part in a workshop to quantify health inputs needs. The workshop's objective is to ensure that adequate orders are made at the national level. During the meeting, the project shared data on the average monthly consumption of commodities (including contraceptives) per CHV.

It should be noted that the data on Santénet2's CHVs' average monthly consumption are used to estimate the needs of other partners, such as the USAID-funded MAHEFA program.

b) Improving and maintaining quality integrated RH/FP service provision

In order to improve and maintain the RH/FP services provided by Mother Health CHVs, the project continuously builds their skills.

b.1. Ongoing monitoring and coaching of CHVs

Multiple actors are involved in monitoring and coaching Mother Health CHVs to enable them to provide quality integrated services. In FY 2012, 231 Level 1 and 5,361 Level 2 Mother Health CHVs were supervised.

The monitoring and supervision tools used for CHVS allow for (1) identifying technical deficiencies or areas for improvement in individual CHVs, (2) improving the management of their activities (data/information), and (3) tracking their supply of health commodities, which helps to strengthen CHVs' technical and organizational skills from the outset. All CHVs have a supervision booklet that their supervisors fill out at each meeting or contact.

b.2. Compliance in FP

Santénet2 complies with regulations requiring freedom of choice and informed choice for users in implementing its FP program; this important issue is addressed in the training, supervision, and coaching of CHVs.

A review of supervision data over the last three months shows that 88% of the Level 2 Mother Health CHVs are capable of providing clients with complete information on injectable contraceptives and 87% of Level 1 Mother Health CHVs have the skills required to ensure compliance with FP regulations during counseling.

While these results are satisfactory, the supervision tool will have to be revised to be more sensitive to the issue of compliance.

Here again, supervision and ongoing coaching are key to improving the CHVs' capacity to provide FP services in compliance with quality standards and USAID's regulations.

2. Adolescent reproductive health (ARH)

- 459 group discussions involved awareness-raising with 4,598 young people and 552 mass awareness-raising events reached 18,743 young people.
- Six intra-regional forums were organized for youth leaders to strengthen ARH promotion activities in the KM salama communes. The objectives of these meetings were to (1) share the youth leaders' experiences and good practices in terms of leadership and management of group discussions and (2) find solutions to challenges encountered in implementation.

The exchanges during the forums pertained to three topics: (1) leadership; (2) organization of activities; and (3) ARH issues such as early pregnancy, STI/HIV/AIDS, abortion, sexual violence, drug addiction, reluctance to discuss sexual matters in rural areas, and use of health facilities.

The first-hand accounts, discussions, and resolutions made during the forums highlight three key points:

1. Youth leaders are effective relays and channels to convey ARH messages in the KM salama communes.

2. Youth leaders form an integral part of the cadre of community workers and should liaise with all existing structures in charge of community health to be more effective.
3. Youth leaders' actions are tangible and contribute to improving young people's reproductive health.

Being a youth leader results in behavioral change—in the youth leaders first . . . They develop self-confidence and self-esteem. They demonstrate more conviction when they speak. They dare to talk about taboo subjects and were able to lead their peers in discussions about sex.

First-hand accounts and facts noted during the forums are presented here to illustrate good practices and the results of the youth leaders' activities.

Good practices inventoried during forums

- Gobelle, a youth leader in the commune of Savana in the district of Farafangana, works in close collaboration with the *Ampanjaka* (traditional leaders— influential people and nobles in the community). With the support of the *Ampanjaka*, he promotes prevention



© Santénet2 : Animated discussion between youth during the forum in Toamasina

of unwanted pregnancies among young people. Rules have been established: adolescent boys will have to pay a fine (“*Dina*”) of MGA 60,000 (USD 30) if they get an adolescent girl pregnant.

- Youth leaders in Toamasina are consulted and invited to lead discussions or raise awareness at every opportunity: gatherings of young people on the beach, socio-cultural events, sports events, gatherings in locations frequented by young people.

- Youth leaders in Farafangana, in Anjeva Gare, Antananarivo, work in close cooperation with opinion leaders and the heads of their supervising CSB in planning and conducting group discussions in their *fokontany*.



© Santénet2/Working session between young people in Fianarantsoa

- Youth associations use existing infrastructures and/or organizations/gatherings, or set

up new ones for their group discussions in Antananarivo, Fianarantsoa, Anosy, and Toamasina. In Fianarantsoa, they also tap into the regular youth meetings at churches, and in some cases, social events such as exhumation festivals, cattle markets or even “*tse nan’ Ampela*” (“girls market”—a place to meet people of the opposite sex) can be an opportunity for them to carry out sensitization.

- 232 youth leaders take part in the monthly reviews of the CCDS, demonstrating their responsibility, ownership, and commitment to assess their needs and address these in the communes’ plan as part of the social quality approach.
- Youth leaders cooperate with community leaders to facilitate visits to their *fokontany*. These youth leaders divide the *fokontany* into sectors and identify, in collaboration with the CCDS, youth leaders to serve in those *fokontany* that do not yet have one (e.g., the communes of Bezaha, Andranofasika, Ambatolampy, Tsimahafotsy, and Toamasina).
- Youth leaders visit other *fokontany* and communes to share experiences (e.g., Toliara).
- The CCDS pay for the transportation of youth leaders who attend reviews; the youth leaders pay for their own food (Antananarivo).
- Health facilities also cooperate closely with youth leaders and support their ARH promotion activities in the KM salama communes. In addition, health facility managers take an active role in solving technical problems related to discussion themes, as well as caring for young people referred for suspected STIs. Health facilities, in collaboration with youth leaders, organize ARH awareness-raising sessions in the community and supply the youth leaders with condoms to be distributed to young people who ask for them. In turn, youth leaders also contribute to certain health facility activities, such as delivering vaccine boxes during outreach activities and guiding health workers in the villages during field visits (Toliara).
- Places where young drug addicts used to gather have been transformed into leisure grounds in Toamasina and Toliara under the motto “United and responsible young people in good health and free from drugs.”

Youth leaders also contributed to the following activities:

- Closing an abortion house kept by a village woman (Léonie, youth leader in the commune of Anjoman’ Ankona);
- Treatment of STIs in young people at health facilities. In the commune of Andranofasika, treatment (if not free) is paid for through the youth association’s fund;
- Producing a report on the local radio station Mampita in Haute Matsiatra. They also produced a CD in Fianarantsoa.



© Santénet2: Interview of a yougn leader by a local journalist in Fianarantsoa

The forums benefited from media coverage by the following radio or TV stations and newspapers: La Grande Ile, Ao Raha, Hebdo, Don Bosco, TVM, Nouvelle, Vérité, Matin.

The good practices shared during the forums will be documented and disseminated to all leaders during the monitoring of youth leaders in the KM salama communes. Additional communication activities will be implemented in support of the youth leaders' work under the FY 2013 work plan, including reports, airing of messages on the youth leaders' activities and on ARH through local radio stations, and meetings in the KM salama communes, as a way to vitalize and ensure the continuation of their services.

Strategic focus 3: Controlling malaria at the community level

Community-based services are effective in the 800 KM salama communes. For malaria, the services provided by CHVs include (1) sensitization, (2) early and proper management of confirmed malaria cases among children under five, (3) early detection of pregnancies for referral to health facilities for ANC, and (4) referral of severe cases to health facilities.

CHVs use interpersonal communication and group discussions with women to promote malaria prevention during pregnancy and to refer pregnant women to health facilities for ANC.

Management of malaria in children under five falls within the framework of c-IMCI and is therefore provided by Level 2 Child Health CHVs.

a. Approaches

- Malaria prevention and case management are provided through Level 2 Child Health CHVs trained on c-IMCI and on the use of RDTs with children under five in the 800 KM salama communes.
- Santénet2 took part in meetings of the RBM partnership and of PMI as well as in coordination meetings with partners involved in the implementation of c-IMCI activities.
- Support technicians benefited from skills building on monitoring CHVs' compliance in filling out their MARs.
- Supervisors, including local supervisors and support technicians, benefited from skills building in monitoring the CHVs' performance in using RDTs and in filling out their MARs.
- The CHV MAR form was updated to include data on RDTs.
- Data from fever surveillance sentinel sites were monitored as part of a partnership with the Institut Pasteur of Madagascar (IPM).

b. Results

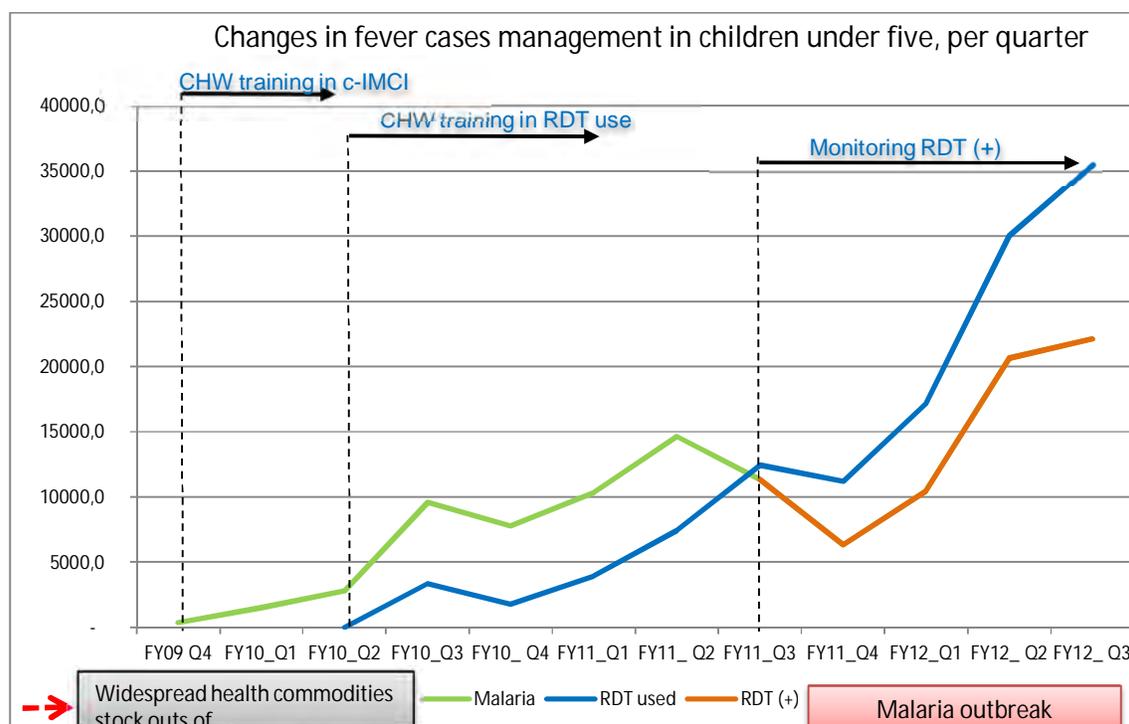
- 23,923 pregnant women were referred to health facilities by CHVs to benefit from the package of antenatal care that includes sulfadoxine pyrimethamine (SP) for intermittent preventive treatment of malaria.
- 192,269 cases of illness in children under five, including 90,156 cases of fever, were managed by 5,647 Level 2 Child Health CHVs under the c-IMCI program. Awareness-raising on malaria reached 1,109,398 people.

- 57,101 confirmed malaria cases were identified early and were treated at the community level, thanks to the supply system that guarantees drugs availability. 8,125 children under five were referred for fever with danger signs.
- Overall, the acceptability and use of community-based services have improved over the last three years.

These increases are associated with the following factors:

- The number of Level 2 Child Health CHVs trained on c-IMCI;
- The training of Level 2 Child Health CHVs, after the authorization to use RDT at the community level in 2011;
- The incorporation of data on RDT+ in the c-HMIS, after the CHV management tools and the c-HMIS were updated;
- 57,101 confirmed malaria cases were diagnosed and treated properly with ACT;
- On average, CHVs managed a total number of 7,500 cases per month—individual CHVs managed 18 cases on average.

Figure 27. Coverage with malaria services by CHVs



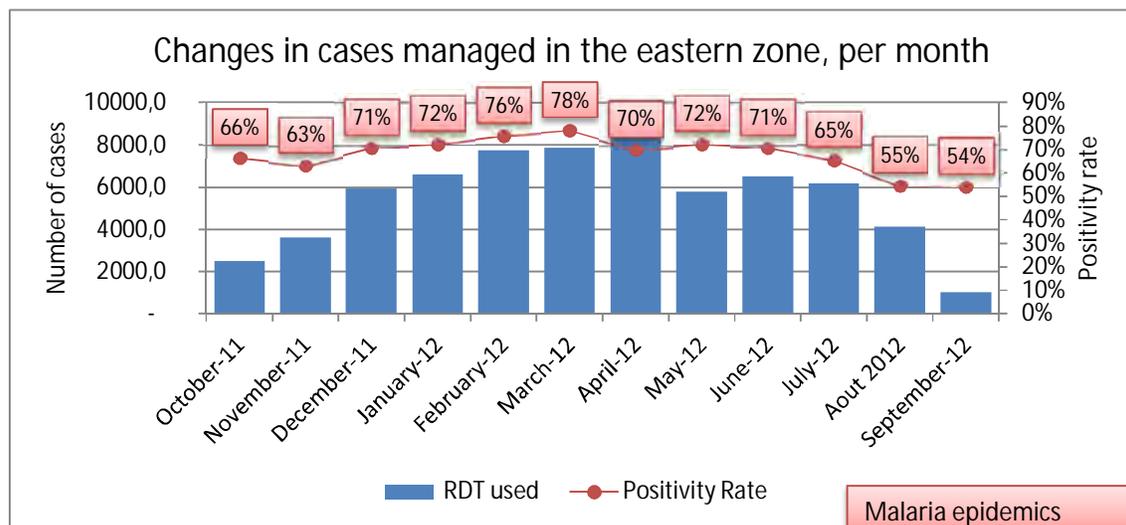
Source: Santénet2, Extranet, CHVs' MAR, (2010, 2011, 2012)

The number of malaria cases varies according to the operational facies and the period of the year. For the purpose of this report, we took into account the results under the eastern and southern facies where seven KM salama districts were affected by malaria outbreaks.

Operational facies in the east:

- **61,233** RDTs were used from October 2011 to July 2012. On average, 63% of the tests resulted in a positive reading. The peak period fell in April 2012, which corresponds to the period when a cyclone affected Madagascar.

Figure 28. Changes in cases managed in the eastern zone, per month

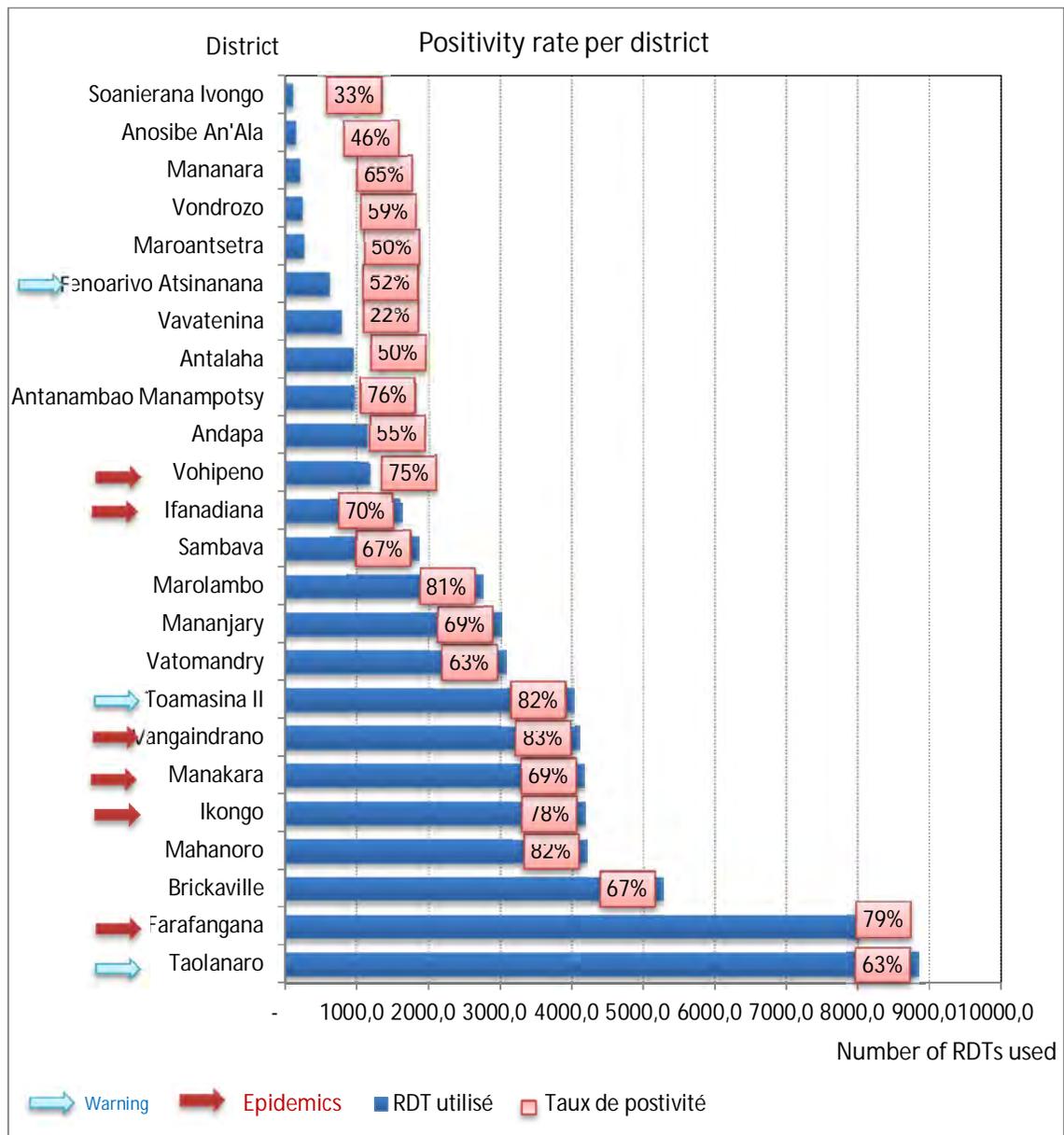


Source: Santénet2, Extranet, CHV MARs (October 2011 to September 2012).

During the second quarter of the year, there were malaria outbreaks in the region of Vatovavy-Fitovinany in the south-east because rainfall significantly increased with the two cyclones, Giovanna and Irina. CHVs' data in the most affected districts show a positivity rate of more than 75% in March and April 2012. To respond to this situation, all operational CHVs in the communes with epidemics were mobilized, and ACT was distributed for free in these areas.

The figure below shows the use of RDTs at the community level and the positivity rate per district.

Figure 29. Positivity rate per district in the east



Source: Santénet2, Extranet, CHV MARs (Oct 2011-Sept 2012).

Operational facies in the south:

The districts of Ambovombe and Bekily were faced with a malaria outbreak from April to June 2012.

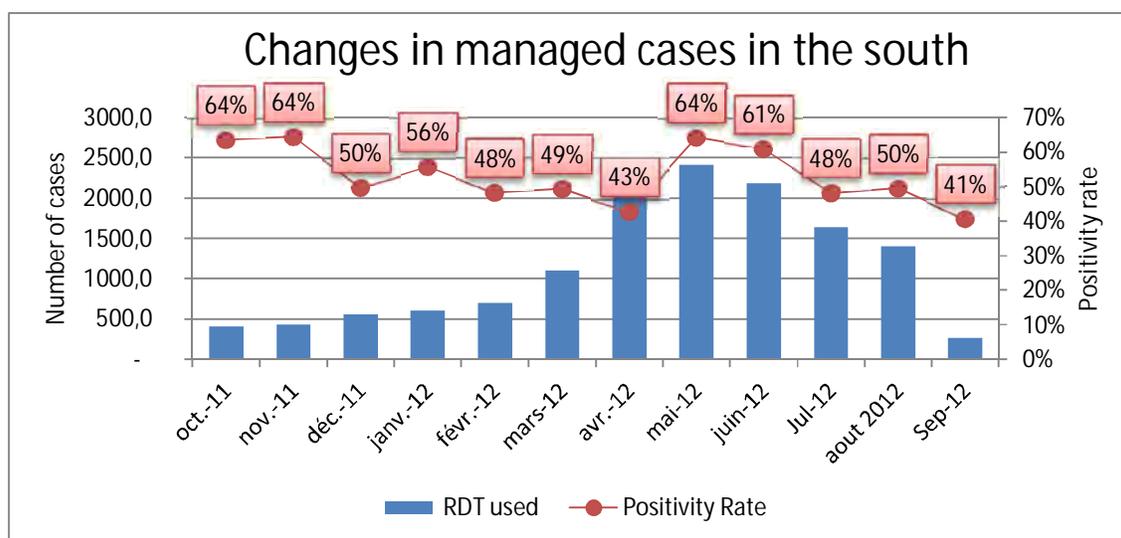
The project supported the response to this situation by mobilizing community actors and conducting the following actions:

- Coordination meeting of all actors (partners, CSBs, CCDS, CHVs, etc.)
- Airing of radio messages and specific spots through local radio stations (radio Cactus in Ambovombe and Tanamasoandro in Bekily)

- Mobilization of CHVs for awareness-raising and active screening of cases in the most affected communes (Bekitro, Beteza and Beraketa)
- Rapid resupplying of the all supply points in the district of Bekily.

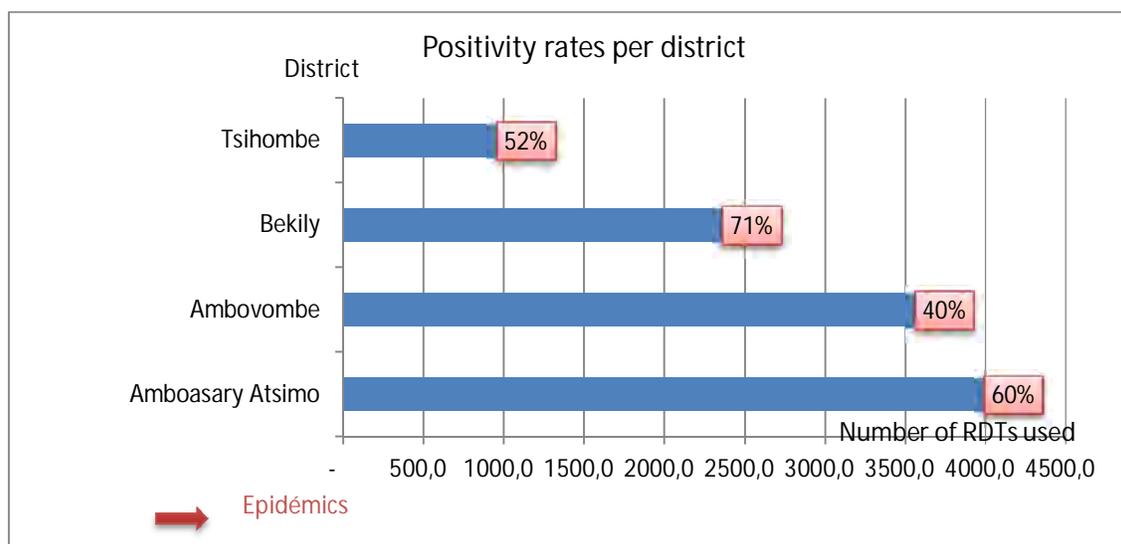
The report by the supervisor of the ASOS SUD zone (a grantee under RFA#3) provides more details on the participation of Level 2 Child Health CHVs in response actions (see *Annex 12*: Trip report).

Figure 30. Changes in cases managed in the south



Source: Santénet2, Extranet, CHVs' MAR, (October 2011 to September 2012)

Figure 31. Positivity rates per district in the south



Source: Extranet, CHV MARs, Santénet2 (October 2011 to September 2012).

The activities carried out to achieve these results are described in the following section.

Coordination of community-based services with malaria control partners

To foster synergy in interventions at the community-level, Santénet2 took part in the various coordination meetings with technical partners. The meetings offered opportunities to share practices, experiences, and lessons learned from the implementation of the KM salama approach.

There are three major coordination committees: the USAID/PMI partners, the RBM committee, and the c-IMCI coordination committee.

Coordination and partnership under the RBM committee

The RBM partnership offers a platform where communications and decisions can be made to strengthen malaria control strategies.

In order to respond to the need to better manage inputs at the national level, the Management, Supply and Stock (*Gestion, Approvisionnement et Stock* [GAS]) committee was set up.

Under the National Strategic Plan 2013–2017, two supply channels were adopted at the community level: CSBs and the supply points developed by Santénet2 in collaboration with PSI. The supply points are being introduced in the intervention zones of the project MAHEFA.

Pursuant to advocacy with the RBM committee and partners, 35% of the Level 2 Child Health CHVs trained in the KM salama approach are now taking part in the training funded by the National Strategy Applications (NSA), and the management tools used by CHVs for c-IMCI have been harmonized. The following are results of these actions:

- The 5,647 Level 2 Child Health CHVs are being provided with the new case management form in partnership with SALAMA.
- Letters from the MOH have been issued allowing CHVs to get their supplies from CSBs.
- The CHVs' MARs have been harmonized.

Coordination with USAID/PMI's partners

The GAS/PMI committee regroups the implementing partners funded by USAID/PMI—PSI, MAHEFA, DELIVER, IPM, and PMI.

To facilitate the estimation of the CHVs' needs for products and other inputs in the 800 KM salama communes, their monthly average consumption was calculated taking into account epidemiological factors, climate factors, and geographical remoteness of the supply points.

From July 2011 to October 2012, a widespread RDT and ACT stock-out was noted in all the supply points in the 800 KM salama communes. Strategies to replenish the pipeline were implemented to revitalize the supply system in support of community-based services. This included distributing six ACT per CHV and storing four at each supply point.

In addition, 400,000 doses of ACT funded by PMI will be distributed throughout Madagascar starting in November 2012.

Coordination and partnership with the c-IMCI committee

Santénet2 advocated for the application of the National Community Health Strategy in all coordination meetings of the c-IMCI subcommittee. Santénet2 reiterated to the training subcommittee the importance of using qualified course directors. In line with this, the pools of trainers established by Santénet2 in the regions were mobilized to improve the quality of trainings conducted with funding from NSA.

In addition, the project suggested using an integrated MAR on child health for CHVs that includes GMP, management of three diseases, an FP component, referral for ANC, and awareness-raising activities. However, the NMCP has not yet agreed to its use.

Malaria prevention in communes implementing the KM salama approach

To date, 5,647 Level 2 Child Health CHVs are operational, but some CHVs have dropped out (up to 5%) over the project's life. Therefore, the project trained 388 new Level 2 Child Health CHVs on c-IMICI and use of RDTs during catch-up trainings as a way to ensure full coverage with CHVs qualified in c-IMCI.

In terms of awareness-raising, 1,109,398 people were reached by the CHVs with messages on malaria prevention through 74,984 awareness-raising sessions—6,249 sessions per month, including interpersonal communication and/or home visits.

The CHVs' awareness-raising activities are reinforced by the airing of health message spots on 28 local radio stations, translated into local dialects to be better understood by target populations. The dissemination of key messages about care is emphasized during malaria's high transmission period to support community-based services. In addition to the spots, 48 reports on malaria were also aired.

Sample conversations in a report

Early management of a malaria case

"I am thankful to the CHV in our *fokontany* for his warm welcome. My child tested positive (RDT+) and then he was healed within three days. And the cost of medicine is very affordable. I encourage all mothers to go to the CHVs in their *fokontany* whenever their child is sick."

Case referred by a CHV

"I am very thankful to the CHV in our *fokontany* for what he did. Without him being there, my child could have died. As he told us, my child had malaria, which was confirmed by a test, but he also presented danger signs. He immediately sent me to the CSB for more appropriate care and insisted that my child's life was endangered. I went without delay to the CSB where they received us well and gave my child good care. Before we went back home, the head of the CSB gave us a counter-referral letter for the CHV. With this letter, the CHV followed up and monitored my child's health. I am very happy with this good monitoring and the good cooperation between the CHV and the CSB."

Ongoing coaching of CHVs

Ongoing coaching for each of the CHVs contributes to improving their skills and their responsiveness to the communities' needs. During this reporting period, 3,187 supervisory visits were conducted, targeting all Level 2 Child Health CHVs.

Strategic focus 4: Increasing most-at-risk populations' (MARPs') capacity to control STI/HIV/AIDS

The main objective under this strategic focus is to provide local structures in nine zones with technical and organizational capacities to conduct STI/HIV/AIDS prevention activities and promote MARPs' access to health services.

Santénet2 maintained its technical and financial support to sex workers' associations and MSM associations with whom it partnered in 2011, in towns with high concentration of these groups—Antananarivo, Ihosy, Manakara, Antsirabe, Mahajanga, Toamasina, Taolagnaro, Toliara, and Fianarantsoa. Where the Global Fund Round 8 was already present (Antananarivo, Mahajanga, Toamasina, and Taolagnaro), the project's support focused mainly on strengthening the associations' technical capacities.

a. Approaches

- Awarding small grants to sex workers' associations and MSM associations in localities where there no funding is available to them;
- Strengthening the programmatic, organizational, and institutional capacities of the associations' peer educators and leaders through 27 training sessions on resource mobilization, project proposal development, STI/HIV/AIDS prevention, and negotiation of condom use;
- Integrating the topic of human rights into STI/HIV/AIDS control;
- Enhancing the effectiveness of the peer-to-peer approach.

b. Results

Fifteen associations (including 9 sex workers' associations and 6 MSM associations) in six towns benefited from grants, and their organizational, programmatic, and institutional capacities were strengthened. They were trained on STI/HIV/AIDS prevention, techniques for negotiating condom use, human rights and fighting stigma, gender and sexuality, resource mobilization, project proposal development, and financial management. Santénet2 produced awareness-raising tools suited to their operating contexts.

Since FY 2011, the peer educators trained by the project have reached 41,600 sex workers and MSM with messages on HIV/AIDS and the use of health services. 554,672 condoms were distributed during awareness-raising activities, and 7,117 sex workers and MSM used HIV counseling and STI screening services.

In FY 2012, 22,710 sex workers and MSMs were sensitized on human rights, STI/AIDS prevention, and use of health services. 60,971 condoms were distributed, and 1,879 sex workers and MSM used health services (STI screening and treatment).

The following activities were conducted to achieve these results:

- Technical and/or financial support to 19 MARP associations: 8 associations benefited from both small grants and technical support, and 11 benefited only from capacity-building because they were already funded by the Global Fund Round 8 (see tables below).

Table 13. MARP associations benefiting from grants and technical support

Town	Association
Antsirabe	PLAJEHVAK (MSM)
	FIVEMIA (SW)
Taolagnaro	Fanantenana (SW)
	Tanora Manan-Jo (MSM)
Fianarantsoa	Mifanasoa (SW)
	Tanora Te Hivoatra (MSM)
	Vonona Mifanasoa II
	Tanjona Miray

Table 14. MARP associations benefiting from capacity-building

Town	Association
Toamasina	Todika (SW)
	Iray Vatsy Iray Aina (MSM)
Antananarivo	Ezaka (MSM)
	AFSA (SW)
Toliara	Fanamby (SW)
	Fihamy (SW)
	Manavotena (MSM)
Manakara	Avotra (SW)
Ihosy	FIVEMAD (SW)
Mahajanga	FBM (SW)
	Ezaka Boeny (MSM)

- Training MARPs' peer educators to enable them to work with their target groups:
 - 21 trainings were conducted on resource mobilization, STI/HIV/AIDS prevention, negotiation of condom use, and project proposal development.
 - 380 peer educators were trained and are operational.



Training of MSMs in Toamasina, © Santénet2/Patric B.

Strategic focus 5: Involving religious leaders and faith-based organizations in stimulating demand for health services by the population in the communes implementing the KM salama approach

The objective is to mobilize religious leaders and faith-based organizations to contribute to improving the communities' health.

a. Approaches

- Santénet2 supports entity members of the religious leaders and faith-based organizations (*Plateforme des Leaders Religieux et des Organisations*)

Confessionnelles [PLeROC]) in disseminating health message in the KM salama communes, during their worship activities.

- To promote sustainability, Santénet2 directly supports local religious leaders by providing them with working tools—a facilitation booklet and office supplies.
- Local religious leaders are linked with the CCDS to which they submit their activity reports indicating the topics addressed and the number of people reached.
- During their monthly field visits, support technicians collect the religious leaders' reports and as needed check the reliability of data contained therein before entering them in the Extranet.

b. Results

Over the reporting period, 361,281 people were reached with awareness-raising and 20 facilitation booklets were distributed to the PLeROC member entities.

Strategic Focus 6. Setting up a WASH strategy in the communes implementing the KM salama approach

a. Approaches

WASH is one of Santénet2's intervention areas in the KM salama communes. The WASH strategy is aimed at strengthening activities in other areas, especially diarrheal disease control, but also the development of the population's ownership of health improvement activities, in terms of WASH in particular. To this end, Santénet2 built the capacities of the CCDS members to enable them to fulfill their roles.

Several activities were carried out to fulfill these goals:

- Implementing the community-led total sanitation (CLTS) approach to encourage communities to use latrines and put an end to open-air defecation;
- Building the communes' capacity to manage works contracts so that they can manage WASH issues on their own;
- Implementing the WASH-friendly CHVs/CCDS approach to raise the awareness of CHVs/CCDSs so that they model key WASH behaviors (use of latrines, having and using a device for hand washing with soap, and using and storing clean water).

In 2012, the CCDS generally led the monitoring of these activities' implementation, thus ensuring the continuation and ownership of the activities by the communities. They forward regular reports to Santénet2 through the partner NGOs' support technicians.

b. Results

Coordination with WASH partners

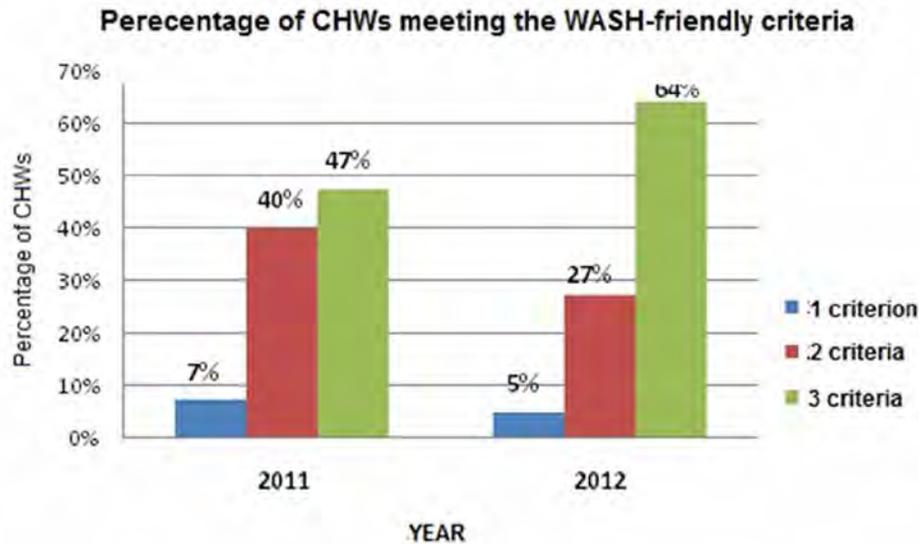
Effective coordination with USAID's WASH partners has enabled Santénet2 to carry out various activities.

Celebrations were held for the World Days for Water, Hand Washing with Soap, and Latrines under Santénet2's partnership with other USAID-funded WASH programs. Various workshops to share experiences were also held with partners and have resulted in improvements in Santénet2's strategy for implementing CLTS.

WASH-friendly CHVs/CCDS

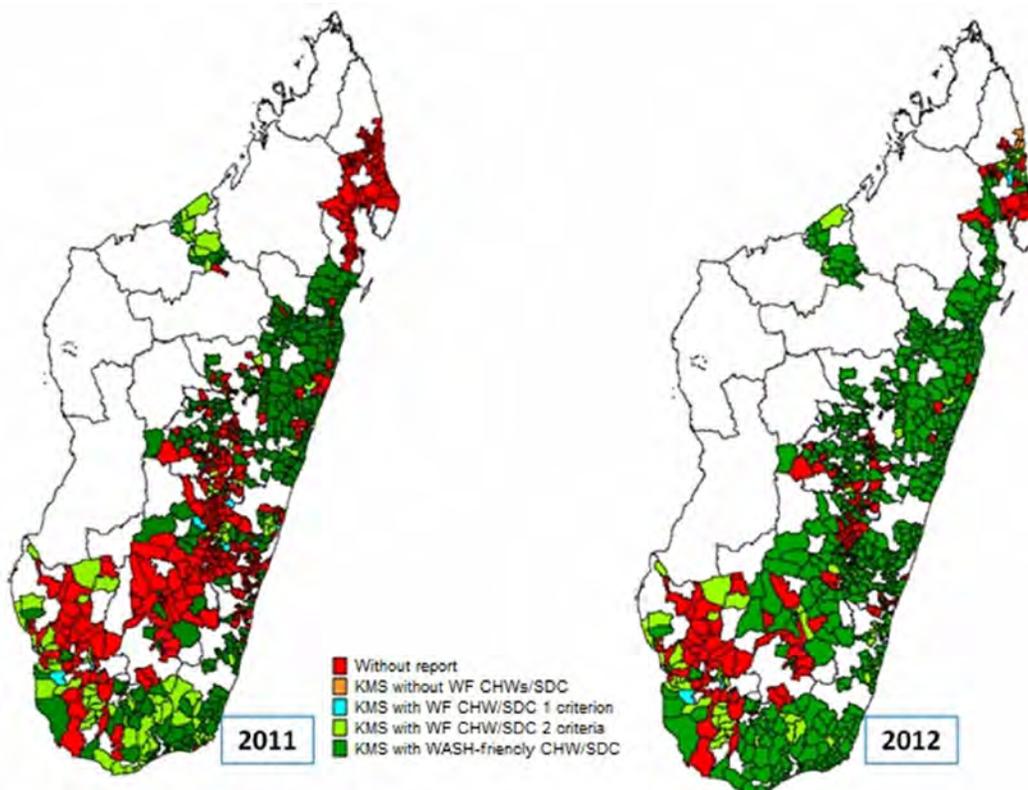
This activity was conducted to encourage CHVs and CCDS to model WASH behaviors. To become WASH-friendly, these community actors have to meet three criteria: using latrines, having and using a device for hand washing with soap, and using and storing clean water. The activity is fully led by the CCDS members in Santénet2's intervention communes.

Figure 32. Percentage of CHVs meeting the WASH-friendly criteria



Source: Santénet2, WASH-friendly CHV database (2011–2012).

Figure 33. Communes with WASH-friendly CHVs/CCDS in 2011 and 2012



As part of implementing this activity, Santénet2 updated the WASH training guide for CCDSs and trained 115 support technicians, who in turn trained 1,715 CCDS members on their role in implementing and monitoring WASH activities.

In 2012, 3,243 CHVs and 1,143 CCDS members were certified WASH-friendly, which is far above the objectives set. In addition, 2,578 CHVs/CCDS met two out of three criteria and 520 CHVs met one.

This activity has been successful thanks to the communes, CCDS members, CHVs, and support technicians taking responsibility for the activity, and this has had ripple effects on other aspects of WASH, namely the CLTS approach and the number of people reached with WASH messages.

CLTS

This approach aims to develop communities' responsibility in eradicating open-air defecation, which entails building and using latrines, without external support. To this end, a “trigger” session is held in the communities to raise awareness on how bad open-air defecation is and thus to lead them to build and use latrines.

In 2012, Santénet2 started encouraging CCDS members to take responsibility for implementing, following up, and monitoring CLTS activities.

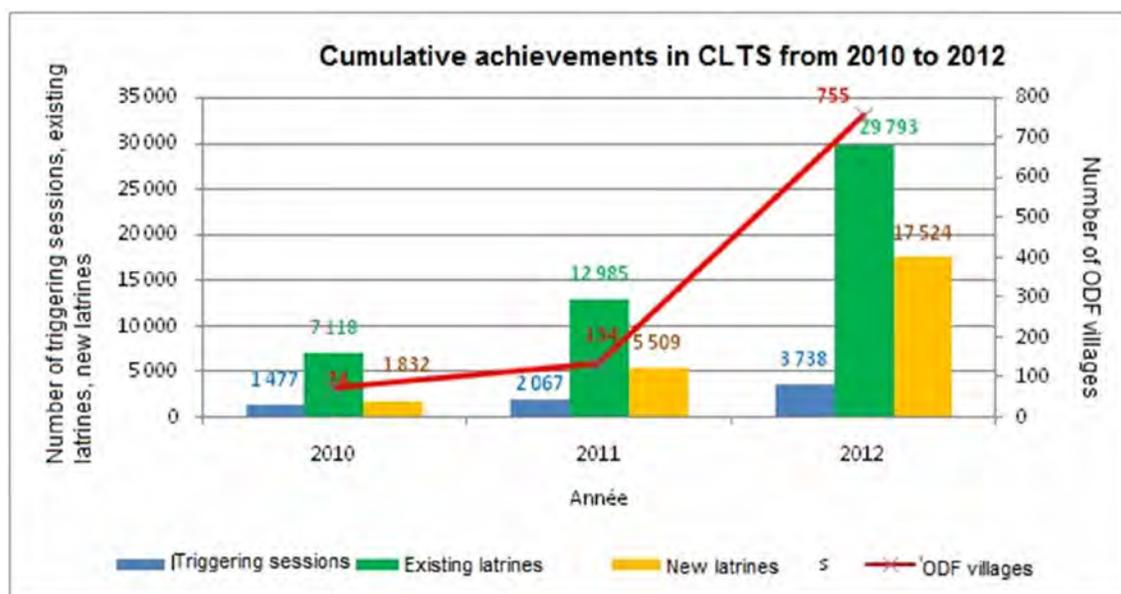
CLTS triggering sessions were held in 2,048 new villages, in excess of the objective of 1,500 villages because Santénet2 strengthened CLTS activity. Strong commitment from the CCDS was noted in implementing the approach as reflected in the number of monitoring visits they performed: 1,814 (compared to the 1,500 planned).

The objectives set for CLTS were largely exceeded: 14,800 new latrines were built with 170 252 regular users, and 755 new villages are now open-air defecation free (ODF). The CLTS approach's success among community members results from the capacity-building provided to support technicians and CCDS members, the intensive awareness-raising on WASH among CHVs and CCDS, the strengthening of WASH-friendly CHV/CCDS activities, and responsibility-taking and ownership by community leaders.



Open-air defecation free certification in the village of Ambohimananarina, in the commune of Fihaonana

Figure 34. Cumulative achievements in CLTS from 2010 to 2012



Source: Santénet2 CLTS database (2010, 2011, 2012).

In all, 1,217,549 people were reached with WASH message, which is far above the objective set and is due to the intensification of sanitation activities (CLTS) as well as the WASH-friendly CHV/CCDS activities. After they are certified WASH-friendly, CHVs/CCDS members are more motivated to sensitize their communities with WASH messages.

Building the communes’ capacity to manage WASH works contracts

Working through subcontractors, Santénet2 built the capacities of 164 communes implementing the KM salama approach to manage WASH works contracts, mainly through the members of their

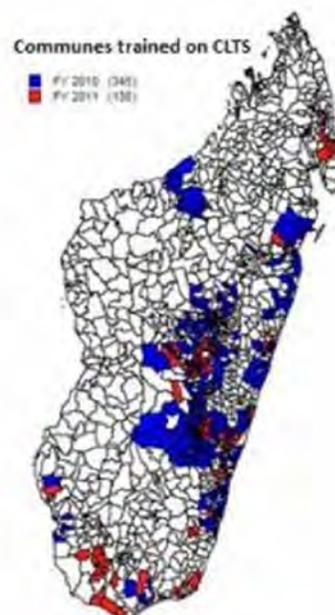
structures in charge of WASH. The support included three major components: assessing water resources, training the members of structures in charge of WASH in the commune, and monitoring. To ensure continuation at the community level, the CCDS members follow up with the work initiated by the commune with the support of subcontractors.

As seen in the 470 monitoring reports prepared by CCDS members in 256 fokontany in the 164 communes supported by Santénet2, improvements to existing infrastructure or new constructions were made by the community, including the following:

- Each commune has a structure in charge of water management.
- Each commune has developed a water development plan.
- 1,153 water points have been improved or are maintained.

capacities of 164 communes

Figure 35. Communes trained on CLTS



- 256 wells or other water infrastructures were built.
- 232 public latrines are operational.

c. *Lessons Learned*

Santénet2 has learned lessons from the implementation of WASH activities as part of the KM salama approach. These lessons learned will contribute to improving results, community ownership, and sustainability of the activities initiated, and include the following:

- Build the CCDSs' capacity to follow up on and monitor WASH activities.
- Institutionalize the WASH-friendly CHVs and CCDSs systems to serve as models to the entire communities.
- Promote CLTS activities for increased impact on diseases, especially diarrhea.
- Support communes to manage water and sanitation works—one of the key strategies for WASH in Madagascar. This enables the communes to fulfill their roles and reap the benefits of water and sanitation management at the local level.

To conclude, the implementation of WASH activities as part of the KM salama approach has enabled the transfer of responsibilities in implementation and monitoring. Communities have clearly demonstrated ownership of these activities, and the approach is now likely to be sustainable.

Challenges and Corrective Actions

The challenges community-based services are faced with include coordination of activities at all levels, ensuring the effectiveness and continuity of community-level services, and keeping CSBs involved in monitoring and supervising CHVs.

To address these challenges, the following actions are suggested:

1. Continue supporting regular coordination meetings with various exchange platforms, task forces, and partners' committees working in the fields of MCH and nutrition, RH/FP, malaria, and STI/HIV/AIDS:
 - Santénet2 will share achievements and experiences in terms of community-based services under the KM salama approach in coordination meetings to enable other entities to strengthen their own implementation of similar services.
 - It was noted that many decisions made at the central level do not trickle down to the peripheral levels and are not implemented at the community-level, which calls for the following coordination action at these two coordination levels:

Central level:

- Build on achievements in the implementation of community-based services by other partners (c-IMCI, FP, community-based Depo Provera, IFA distribution, etc.).
- Optimize funding available for the implementation of the National Community Health Strategy: monitoring and supervision of CHVs and incentives for them.
- Use an integrated MAR to avoid overburdening CHVs with reporting tasks (vertical integration of programs).

Peripheral level:

- Tap into skills existing in the *fokontany*, communes, etc., for instance by integrating all CHVs offering c-IMCI.
- Integrate and use data from all CHVs at the CSB level.
- Strengthen supply of inputs at the CSB level.

2. Ensure the effectiveness and continuity of quality integrated community-based services:
 - Conduct refresher trainings for CHVs on the topics of GMP, nutritional surveillance, c-IMCI, and community-based Depo Provera.
 - Ensure ongoing supervision and coaching of CHVs, with supervisors being primarily responsible for this.
 - Adopt a supervision tool compliant with FP requirements.
 - Monitor the effectiveness of CHVs' supervision, with particular attention to FP counseling and GMP practices.
 - Share results and suggest corrective actions with implementing NGOs and CCDS to enable them to make appropriate decisions.
 - Build community commitment to set up health evacuation systems for obstetrical and neonatal emergencies (ONE) and monitor the setting up of these systems.
3. Support MARPs of five towns in developing income-generating activities other than sex work.

COORDINATION

Introduction

The KM salama approach consists primarily in setting up community-based promotional, prevention, and case management services as part of making the population responsible for improving maternal and child health (MCH). It is implemented in 800 communes.

Sixteen (16) NGOs provide logistic and administrative support for setting up community-based services. The services are delivered by 12,058 CHVs⁶ operating in 5,758 fokontany located at more than 5 km from the nearest health facility, and include RH/FP, malaria control, nutrition, STI/HIV-AIDS control and prevention, MCH, and WASH. Drugs and other health commodities are supplied to the CHVs through 805 community-level supply points. Other actors are involved in the ongoing coaching of CHVs to build their skills, including 204 field workers (out of which 156 are NGOs' support technicians), members of the 800 CCDS, and Santénet2 through its regional offices and Coordination Unit.

Given the large number and the diversity of actors with different but complementary roles, strong coordination is required at all levels for better organized interventions and more efficiency in the implementation of the KM salama approach. Implementing NGOs must also perform well to achieve results, which accounts for the special attention paid by the Coordination Unit to their support and coaching.

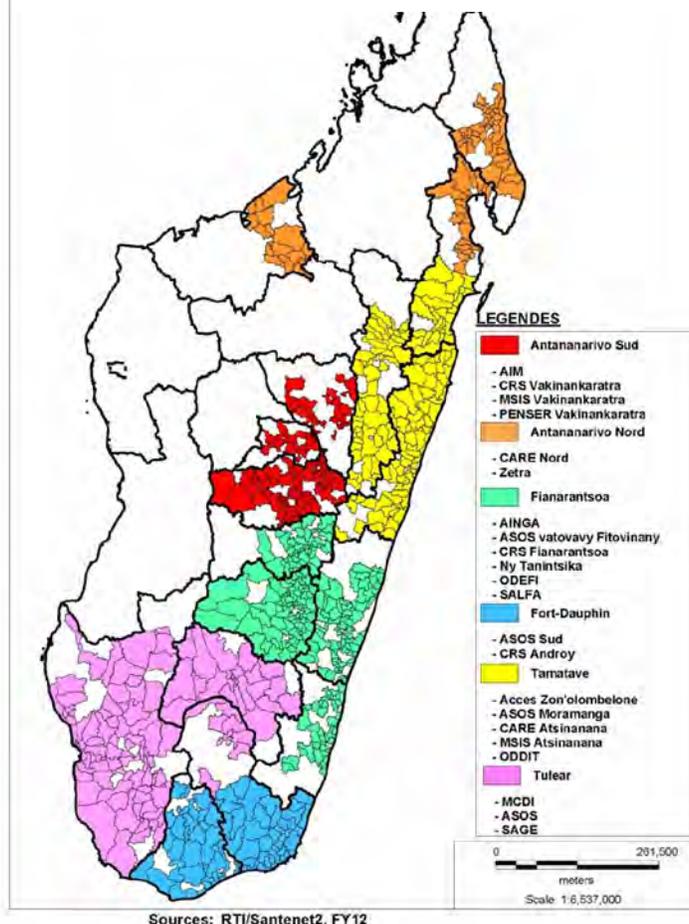
Their coaching involves support for planning their activities, regular monitoring of their achievements and activities, training for their staff, assessment of their performance, monthly coordination meetings, and a national coordination meeting.

Results

Performance of the KM salama implementing NGOs

During FY 2012, Santénet2 continued to build the organizational and institutional capacities of the implementing NGOs to support them in

Figure 36. This map shows the link between different implementing NGO and the 6 Santénet2 regional offices.



⁶ Source: Santénet2's database as of October 1, 2012.

successfully carrying out the KM salama approach. It was observed that their performance has been improving over the years.

An assessment of the implementing partners' performance in terms of quality of services provided to the communities is conducted on a quarterly basis and the findings allow Santénet2 to better target its coaching and allow the NGOs to identify their successes and areas for improvement as part of further enhancing the quality of their services.

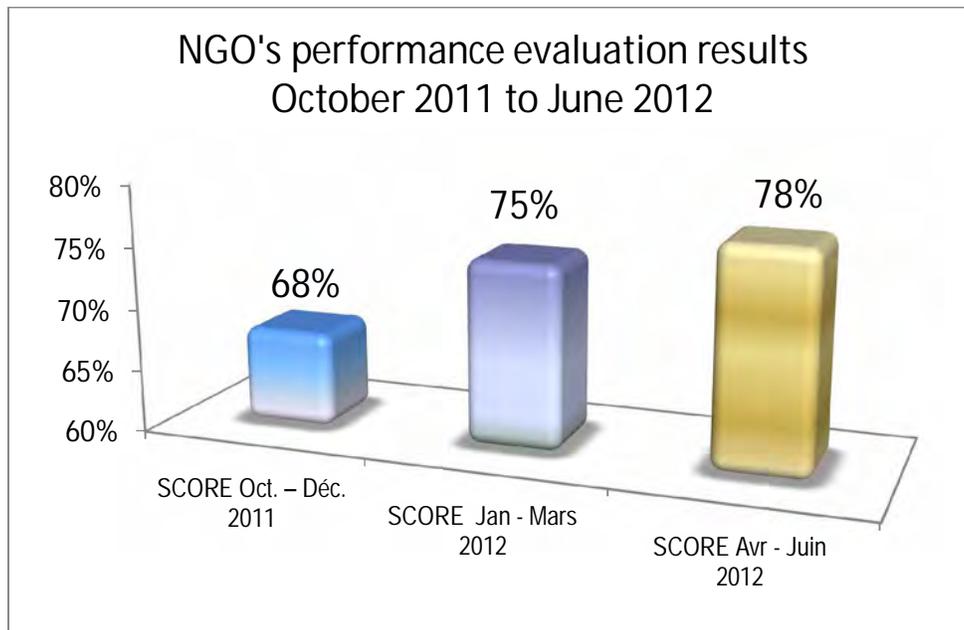
Five criteria are taken into account in the assessment:

- Resources management and supply system (distribution and receipt of tools by NGOs, CCDS, and CHVs)
- Organizational performance (completion of activities planned, CHVs' and CCDS' participation in meetings, completion of supervision)
- Reporting and communication (completeness and timeliness of SMS and Extranet reports, holding of coordination meetings, NGOs' staff participation in coordination meetings, relevancy of topics addressed during meetings, minutes of the meetings)
- Community commitment (involvement of CCDS and communities in the identification and implementation of activities aimed at improving availability of and access to health services)
- Quality of CHVs' services (based on the supervision results that assess, among others, the referral of children seen in weighing sessions whose weight falls in the red strip [severe malnourishment], the use of rapid diagnostic tests, the reliability and validity of family planning data)

Pursuant to the assessment, the NGOs draft action plans to improve those areas where weaknesses were noted, and these action plans' implementation is monitored by the Coordination Unit.

The graphs below show the results of assessments in 2012's first three quarters as well as changes in performance in 2011 and 2012. It is noted that the performance of all the NGOs has improved over time.

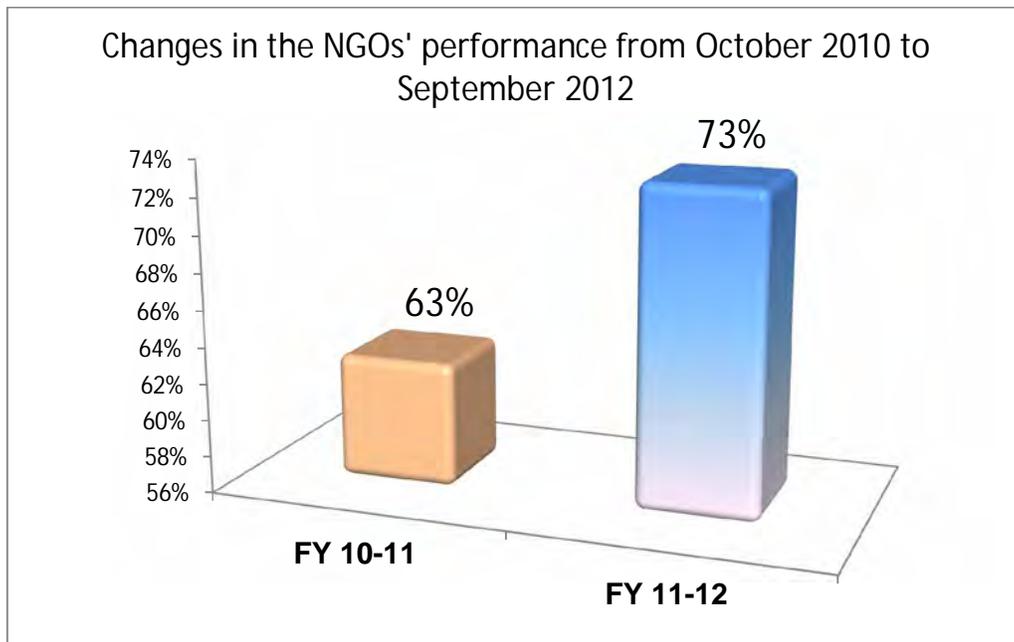
Figure 37. NGOs' performance evaluation results (Oct 2011–Jun 2012)



Source: Santénet2, NGO's evaluation reports (Oct 2011-June 2012)

The main areas for improvement include the timeliness in providing feedback; issues in this area are due to the project's complex scope and the completion rate of CHVs' monthly activity reports.

Figure 38. Changes in the NGOs' performance from October 2010 to September 2012



Source: Santénet2, NGO's evaluation reports (Oct 2010-Sept 2012).

Achievements

The activities in support of the implementing partners are detailed in this section.

Capacity building for implementing partners

Two training sessions were held for the NGOs' support technicians and pertained to the following topics:

- October–November 2011: Training on the principles, methods, and tools of Social Quality and Community Commitment, an approach that is promoted under the KM salama approach
- April 2012: Training on organizing monthly visits to coach CHVs and procedures for the information pipeline, monitoring, and reporting modalities

In all, 204 technicians from the NGOs, comprising 48 supervisors and 156 support technicians working in the 800 KM salama communes, took part in the training, based on the results of their monitoring activities.

The main role of the NGOs' supervisors is to coach and supervise the support technicians in their tasks that consist primarily in supporting community-level actors and conveying information between the community and the project.

Skilled support technicians are among the key factors to achieving better results, which accounts for the project's focus on building the capacities of the NGOs' technical teams, i.e., the support technicians and their supervisors.

In addition, monthly coordination meetings are held with the NGOs to ensure coordination of activities based on the previous month's achievements and the activity plan for the next month.

Santénet2 also takes part in coordination meetings organized by local health authorities, sharing information on the progress of the KM salama approach and contributing to the coordination of future actions.



Training to build the capacities of support technicians through a videoconference (© Santénet2)

Monitoring of achievements through information management

The monitoring of achievements through annual and quarterly work plans has allowed for observing clear progress in activity completion for all NGOs.

Support to planning consists of sharing with NGOs all the information they need, namely on the project's priorities in terms of technical programs. Proposed activities are also assessed to determine if the level of effort is reasonable and if they are consistent with the budget.

Monitoring of partners' achievements

The Coordination Unit team supports partners in the planning process. The partner NGOs submit their annual and quarterly work plans according to a set schedule for review and validation by the project.

- In a first stage, the team monitors the partners' achievements on a weekly basis through a review of their weekly activity reports and an updating of their respective dashboards. Next, it prepares a monthly review of results against the work plan prepared. Similarly, expenditures for activity implementation are monitored on a monthly basis. In all, 1,044 weekly reports were received and reviewed.
- In a second stage, the highlights of the quarter, the activities' progress compared with the annual work plan, and the financial burnout rate are reviewed through the NGOs' quarterly reports. In all, 21 annual work plans and 84 quarterly work plans were submitted by the NGOs and were reviewed and validated.
- Monthly feedback is given to the NGOs to help them initiate or strengthen actions to improve their achievements.

Discrepancies or gaps against plans are reviewed to identify corrective actions with NGOs that are aimed at completing the activities planned within the budget planned.

Summary form for each commune implementing the KM salama approach

A summary form was developed for each of the 800 communes implementing the KM salama approach to serve as a monitoring tool that enables NGOs to strengthen implementation, namely through the supervision of CCDS and CHVs.

The form provides a snapshot of each commune and allows for comparison over time and against progress in other communes implementing the KM salama approach. The information thus garnered feeds into the monitoring and actions carried out by the communities to strengthen and expand the approach in their respective communes.



Community commitment materializes into collective initiatives. In these photos, men are working to build a community hut for their fokontany's CHVs. (© Santénet2)

Coordination

National coordination workshop

A national meeting gathering all the implementing NGOs was organized in April to take stock of the project's achievements and activities and define priorities for 2013. The priorities that came out of the meeting include the following:

- All the communes implementing the KM salama approach should have the opportunity to decide whether they will embark in the social quality process.
- All CHVs should be upgraded to Level 2 and achieve satisfactory performance.
- Stocks will be closely monitored, and early warning will be given in case of stock-out threats.
- The completion rate will be improved for reports, and CHVs' coaching will be reinforced to obtain complete and error-free reports.

The exchanges during the workshop enabled each NGO to identify good practices for implementing the priorities set during the meeting.

Success stories were also shared during the workshop, with pride from partner NGOs.

Monthly coordination meetings with implementing partners

Monthly meetings are held with NGOs to ensure coordination of activities based on the previous month's achievements and the next month's activity plan.

The coordination meetings serve to achieve the following objectives:

- Share useful information on activity implementation.
- Monitor activity completion.
- Identify together corrective actions to be made in activity implementation.

Challenges and corrective actions

- Special emphasis is put on monitoring the NGOs' achievements as part of continuous improvement of the community-based services offered.
- Support is to be provided to the implementing partners in the planning process, information is to be shared, and interventions harmonized with the implementing NGOs in order to have work plans that are agreed upon and lead to orderly implementation.
- The support technicians will receive additional training on checking that the CHVs' tools are filled out correctly and completely, as part of improving data reliability.
- Results and lessons learned on technical coaching of implementing NGOs will be documented to capitalize on this aspect of the Project's work.

ADMINISTRATION AND FINANCE

Personnel

The following changes took place in personnel/staffing during FY 2012:

Recruitment

NAME	TITLE	START DATE
Rakotomalalala Norotiana	MCH & Nutrition Manager	Dec 1, 2011
Hanitriniaina Jocelyne Sylvia	Data Entry Operator HMIS	Jan 3, 2012
Raveloarison Jean Jacques	Warehouseman (IEC Tools)	Jan 9, 2012
Benarivo Richard	IT Specialist	Feb 9, 2012
Clarence Razakamihaja	Program Monitoring Manager	Feb 15, 2012
Dimitri Charles Mitsakis	Grants Assistant Support Clerk	June 1, 2012
Delord Ramiaramanana	Technical Specialist North & South	Sep 1, 2012

Departures

NAME	TITLE	DEPARTURE
Lauriat Rembia	Janitor (Regional Office in Toliara)	Oct 14, 2011
Voahirana Ravelojaona	MCH & Nutrition Manager	Oct 17, 2011
Nicole Razanamparany	Finance, Grants, Subcontracts Senior Director	Nov 1, 2011
Herilala Aurélien	IT Specialist	Dec 1, 2011

Financial status

Cumulative costs invoiced and accrued through September 30, 2012 are approximately \$31.1 million. As in prior years, the “burn-rate” is largely equal to planned expenditures budgeted at the beginning of FY 2012. There is a slight under-expenditure as compared to the total obligated funds available through September 30, 2012, and this amount has been included in the forecasted costs for FY 2013.

Procurement

Other than replacement of a server and 2 laptops, there was no significant equipment procurement in FY 2012. We did carry out normal and routine IEC and material procurement (including 3,000 baby scales).

Grant management

The “burn-rate” for the 18 multi-year cost reimbursement-type grants to 14 local organizations continued in a manner consistent with the planned budget for FY 2012 (approximately MGA 2,100 million [US\$1 million] for 12 months).

Eight (8) fixed obligation-type small grants program awards were made to most at-risk population (MARF) organizations. Grant awards are for the period January 2012 through March 2013 in the amount of MGA 6,250,000 per award.

Financial and administration technical assistance and capacity building of grantees

Grantees have received ongoing feedback and recommendations via the monthly review of their financial reports and quarterly review of budgets related to updated work plans. Also, please see previous annual reports regarding technical assistance provided via implementation of accounting software and Ernst & Young audits.

During FY 2012, a more intensive technical assistance approach was launched. Grantees were invited to participate in a complete review and re-writing of their standard policies and procedures. As a result, nearly all grantees elected to participate in a 12- to 18-month intensive review and development of newly updated detailed policies and procedures for an organization-specific manual for their organizations. The overall goal is to increase capacity for better management of their organizations. The approach/design of the technical assistance is as follows:

- 1) To make the volume of work manageable, the full set of standard policies and procedures topics are broken into 3 separate groups or sets.
- 2) For each set, RTI organized a 2-day workshop that includes review of best practices and examination of example policies, procedures, and forms. The trainers encouraged discussion regarding challenges, obstacles, and customization aspects for each organization.
- 3) Included for consideration are the specific auditor recommendations from their last Ernst & Young external audit. Each organization reviews and considers the specific recommendations that are applicable to the policy/procedure under discussion/review.
- 4) The participants review an RTI checklist of minimum standards/content for each specific topic/section of the manual. The checklist provides guidance describing what should be included/covered for each topic if the manual is to be considered comprehensive and of high quality.
- 5) During the 3–4 months following the workshop, the grantee and an assigned Santénet2 “Coach” (a finance/grants RTI staff member located in Antananarivo or at one of the Regional Offices) prepare drafts and final versions for each chapter/section.
- 6) The cycle repeats, and the next two workshops are held with the same steps as discussed above.
- 7) The final Policies and Procedures Manuals will be completed and printed in early 2013.

The first workshop was held in October 2011, and the following sections were reviewed and discussed:

- Table of contents/topics that would be included in the overall manual
- Description of the organization, including the role/members of the Board of Directors and GOM legally required reporting.
- Personnel/Human Resources

The above sections have been developed and reviewed. For example, RTI’s local Personnel Director reviewed each Personnel section in detail for each grantee and provided constructive feedback.

The second workshop was held in April 2012, and the following sections were reviewed and discussed:

- Procurement
- Travel procedures, including per diem rates, advances and accounting for program/training activities, and vehicle management/logbooks

- Management of bank accounts
- Petty cash
- Accounting software and a standard chart of accounts
- Miscellaneous accounting entries
- Monthly closeout and generation of monthly financial reports
- Bank reconciliations
- Cost and budget analysis
- Management of stock such as office supplies and IEC materials
- Fixed assets/property management
- Internal controls checklist

Many of the above sections are complete as of mid-October, and others are underway/soon to be completed.

Subcontracts

Subcontractors' rates of spending (burn rates) are nearly all consistent with budgeted costs through September 30, 2012. The largest subcontracts are with US-based contractors—CARE, CRS, and IntraHealth. US-based MCDI is also managing a subcontract focusing on implementation in the southern districts. PSI, also US-based, provides support in distribution of social marketing products.

Local subcontractor DRV continued to provide services related to gender awareness and radio message monitoring.

The Pasteur Institute's malaria surveillance subcontract was completed and closed as of March 31, 2012 (total expense of total subcontract was approximately equivalent to US\$570,000).

Three water/sanitation subcontracts ended in FY 2012 (Sandandrano, Fikrifama, APMM), with the total expense of total subcontracts approximately equivalent to US\$370,000.

Annex 1: Gap Analysis by Component

Component 1: Community Programs

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives 2013
Strategic Focus 1: Making tools available to community-based actors				
Intervention 1: Produce KM salama tools				
Activity 1.1.1.1 Design and update tools necessary to implement the KM salama approach	Update 8 tools	11 tools updated	11 tools (compared to the 8 planned in the Annual Work Plan) were updated for the program's needs, including <i>Early pregnancy screening form, maternal and newborn health job aid, mothers' register, child register addendum, CLTS guide, integrated supervision checklist, and support technicians' monitoring tools.</i> In addition, to promote sustainability, the monitoring of WASH activities was handed over to CCDS. Therefore, 4 monitoring forms were updated to facilitate the work of these community-based actors.	Activity completed
	Design 3 tools according to new requirements for activity implementation	6 tools designed	In addition to the three tools planned for design in FY 2012's Annual Work Plan, three other tools were developed for implementation needs: <ul style="list-style-type: none"> - To help CHVs using RDTs, a job aid for Level 2 Child Health CHVs was developed. - To improve and strengthen the commitment and the services of community actors, Santénet2 conducted a special review which required the design of a quarterly review manual intended for community actors. - To promote good management of mutual health insurance schemes, one tool was developed: the "Order invoice" 	Activity completed

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives 2013
Activity 1.1.1.2 Produce KM Salama tools	Estimate needs for tools	4 estimates of quarterly needs developed	Objective achieved	Identify community actors' needs for tools for Semester 1 and for the transition period by end of October 2012.
	Produce tools based on needs estimates	100% of estimated needs met through production	Objective achieved (see details on items produced in Annex 8)	Produce tools according to the community-based actors' needs, by the end of November 2012.
Activity 1.1.1.3 Ensure availability of tools for community-based actors	Collect and analyze the needs of community-based actors	832 requests from the NGOs collected	Objective achieved	By the end of November, collect community-based actors' needs.
	Assess needs expressed from implementing partners	832 requests for tools reviewed and 100% of needs met	Objective achieved	By the end of November 2012, review needs expressed by community-based actors
	Dispatch tools to the offices of partner community-based actors	386,818 tools dispatched to implementing partners, meeting resupply requests	Objective achieved Based on 832 requests for supplies of tools, Santénet2 dispatched 832 parcels containing 386,818 items.	By December 31, 2012, dispatch tools to the partner community-based actors' offices.
	Monitor the dispatching of KM salama tools to community-based actors by implementing partners	Acknowledgement of receipt by the NGOs were issued for 88% of the parcels dispatched.	Objective achieved NGOs prepare and send their acknowledgement of receipt as soon as they receive the tools. A statement of acknowledgment of receipt received by the project is forwarded to them to allow them to make any regularization required.	By the end of March 2013, monitor the dispatching of tools to implementing NGOs and community actors.

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives 2013
	Document the system to distribute tools through networks of community-based actors	A document summarizing procedures and outcomes of the distribution system was developed.	A draft documentation of the tools distribution system was developed.	By end of March 2013, document the review of the tools distribution system to the network of community-based actors.

Strategic Focus 2: Implementing a mass behavioral change communication strategy

Intervention1: Strengthen collaboration with local radios stations

Activity 1.2.1.1 Monitor and analyze the airing of radio spots	Work with 56 mystery listeners for daily monitoring of the spots' airing	52 contracts drawn up with mystery listeners (compared to the 56 planned—93%)	The objective was set, considering that there would be 2 mystery listeners per radio station (i.e., 56 mystery listeners for the 28 partner radio stations). Results in the previous years showed that four radio stations had been consistently complying with their contracts. Therefore, only one mystery listener was assigned to each of them in FY 2012, bringing the total to 52 (4 for the 4 stations and 48 for the remaining 24).	By the end of March 2013, collaborate with 52 mystery listeners to monitor the daily airings of radio spots.
	Analyze data on the spots' airing over 12 months	10 monthly airing review reports (compared to 12 planned—83%)	In October 2011, contracts with the radio stations were renewed and airing plans developed. No airing was done in that month. The airing reports were late. September 2012 was used to collect information from the radio stations.	From November 2012 to March 2013, review data on spots airings.
Activity 1.2.1.2 Air spots on health topics through local radios stations	Cooperate with 28 partner radios for airing spots	28 cooperation contracts drawn up with partner radios—100%	Objective achieved	From November 2012 to March 2013, collaborate with 28 local radio stations.
	Prepare 4 quarterly spots airing plans	4 quarterly spots airing plans prepared	Objective achieved	By March 2013, prepare 2 airing plans.

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives 2013
	Air spots 13,440 times through local radio stations	18,457 airings (compared to the 13,440 planned).	The objectives were exceeded because some radio stations use Santénet2's spots to illustrate their own health broadcasts. Other radio stations broadcast extra airings as a way to express their satisfaction with their cooperation with Santénet2.	From November 2012 to March 2013, air spots 6,720 times through local radio stations.
Activity 1.2.1.3 Produce reports and radio/video programs to support the proximity communication activities conducted by CHVs	Orient 114 local radio station managers on the KM salama approach	16 local radio station managers oriented on the KM salama approach	2 managers from the radio station AINGA located in the Haute-Matsiatra region were trained in addition to the planned number.	
	Produce programs on the KM salama approach through 112 reports	112 programs produced and aired—100%	Objective achieved	By the end of March 2013, air the 24 reports produced through the partner local radio stations.
	Air 112 programs produced on the KM salama approach	Reports aired 183 times in all by radio stations—an achievement rate of 163%	Similar to spots, reports are also used to illustrate the local radio stations' own health broadcasts.	By March 2013, air the 24 reports produced through partner local radio stations.

Strategic Focus 3: Implementing the new strategy for the mutual health insurance scheme

Intervention 1: Establish mutual health insurance schemes in four districts

Activity 1.3.1.1 Establish the mutual health insurance management structures	Establish 68 initiative committees at the commune level (CIC) in the four districts	77 CICs established—113%	In addition to the 68 communes implementing the KM salama approach, 9 other non-KM salama communes in the four districts have adopted the mutual health insurance schemes. Therefore, they set up their initiative committees.	
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Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives 2013
	Support the establishment of 68 Commune Executive Offices (CEO)	5 commune-level executive committees established—7%	Five communes only in the district of Ambohimahasoa have more than 1,000 members and have proceeded with electing the CEO: Ampitana, Ambalakinresy, Morafeno, Ankafinam, and Manandroy. CEO members are elected among <i>fokontany</i> representatives. This decision was made in agreement with the DEC.	All communes will have elected their <i>fokontany</i> representatives and will have completed the setting up of the CEOs.
	Support the establishment of 4 District executive offices at the district level (DEO).	No DEO has been established yet.	In the four districts, the number of members is not enough to pay for a DEO's operating costs, DEOs being independent entities funded by the mutual health insurance schemes. They will be set up gradually as membership increases.	All four districts will have held their General Assemblies, elected their board members, and established DEOs.
Activity 1.3.1.2 Build the capacities of actors in mutual health insurance	Conduct a training of trainers	1 pool of resource people established	A pool of 46 resource people from the partner NGOs and from independent trainers was set up and trained in November 2011.	
	Train 680 members of the CIC	899 CIC members trained—132%	All CIC members, including those in the 9 non-KM salama communes, were trained. While it was planned to have 10 people in each CIC, this number was increased to 15 in some cases to allow for better representativeness. This accounts for the number of people trained being 899.	
	Train the members of 68 Commune-level Executive Offices (CEO)	Members of 5 CEOs trained—7%	Members of the 5 CEOs set up were trained in June 2012. Each CEC has three members: a chair, a secretary, and treasurer. All CIC members, including those of the 9 non-KMs communes were trained. If the number of CIC members is supposed to be 10 persons, to allow representativity at the fokontany level, the number varies from 10 to 15 persons per CIC. That is why number of trained people reached 899.	All CEO members in the 68 communes implementing the KM salama approach will be trained. In addition to the CECs, all <i>fokontany</i> representatives will also benefit from training—a total of 2,034 members.

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives 2013
	Train 24 members from the mutual health insurance schemes' board in the four district	No board set up yet	All the CEOs in a district make up the general assembly of the mutual health insurance scheme. They will elect the board from their members. Since no district has established all the CEOs required, no general assembly to elect boards was organized. The training of board members will be provided as these structures are set up.	All 24 board members in the four districts are trained.
	Train the members of 4 district-level executive committees (DEC)	No DEO set up yet	DEOs will be trained as they are set up.	The members of DEOs set up will be trained.
	Train local supervisors in the four districts on cooperation procedures	4 training sessions held for local supervisors in the four districts	The training for local supervisors was held in May for Ambohimahaso, in July for Vatoman-dry, and in August for Ambositra and Ambalalavao. In addition to the local supervisor, their deputies were also trained. They will be in charge of making the coverage payments to members.	
Activity 1.3.1.3 Monitor the implementation of mutual health insurance schemes in the four selected districts	Conduct 16 supervision visits of the mutual health insurance schemes	16 supervisions conducted—100%	The supervision of mutual health insurance schemes allows for assessing whether field actors implement activities in accordance with action plans. The related activities include meetings with committees, interviews with resource people, and visits to communes.	24 supervisions of mutual health insurance schemes will be carried out, i.e., one supervision visit per district per month during six months.
	Update the monitoring chart regularly	1 monitoring chart designed and updated—100%	The chart allows for monitoring membership in the mutual health insurance schemes, the coverage payments made, and the financial status of the mutual health insurance schemes.	The dashboard will be developed and updated not only to monitor membership but also to track coverage payments made per type of condition.

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives 2013
Activity 1.3.1.4 Raise awareness among communities to join the mutual health insurance schemes	Support 4 districts in conducting awareness-raising among the communities	4 districts supported in conducting awareness-raising among the communities	<p>The 4 districts received ongoing support for awareness-raising, namely through the following:</p> <ul style="list-style-type: none"> - the airing of radio spots and reports and direct interventions by CIC members on local radio stations - awareness-raising sessions at the communes and the <i>fokontany</i> by the CIC members and local supervisors 	All the four districts will receive ongoing support for awareness-raising at the <i>fokontany</i> level as well as for seeking partnerships.
	Design and produce 2 communication tools	2 tools designed and used for sensitizing community members	The two tools are the mutual health insurance schemes poster and invitation card.	
	Increase membership in the mutual health insurance schemes to 300,000—50% of the population	23,141 members—8%	<p>Membership is very low in the four districts. The schemes are only in their first year of operation; activities focus on awareness-raising and on setting up structures. The districts do not follow the same process for setting up their schemes. Vatomandry and Ambohimahasoia are more advanced. The population still doubts the effectiveness of the project due to problems (poor management, fraud, etc.) with past mutual health insurance schemes. In addition, they find it difficult to accept the new approach, because a management structure at the district level is considered to be more prone to embezzlement.</p> <p>In general, people are waiting to see the first coverage payments to decide whether they will join.</p> <p>In Vatomandry, the cyclones in January and February cut the population's resources at the very time the mutual health insurance schemes were recruiting members and collecting contributions.</p> <p>Finally, the public health workers' strike with</p>	At least 15% of the population in the four districts (i.e., 150,000) enrolls in the mutual health insurance schemes.

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual annual results)	Objectives 2013
			the closing of health facilities for almost four months slowed down or even stopped enrollment in all the districts.	

Component 2: Strengthening Community Health Systems

Strategic focus / Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY 2013
Strategic focus 1: Engaging the community in improving the quality of healthcare services				
Intervention 1: Strengthen the community's commitment to address health needs				
2.1.1.1 Expand quality of healthcare services in 800 communes	1,000 CCDS members trained in Social Quality	1,586 facilitators trained on the social quality approach (among CCDS members)	The difference comes from the integration of social quality in each review at the commune level. 796 communes conducted self-assessments and 630 conducted community assessments at the <i>fokontany</i> level, involving almost 350 000 participants (out of which more than 50% were women). Communities define how assessment meetings are to be organized. 170 communes are currently preparing or conducting their assessment meetings. Reports are not yet available at the project's central office.	Monitor the implementation of social quality once it has been initiated.

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY 2013
<i>Activity 2.1.1.2 Monitor the quality of community-based services through the Quality Index in the 800 communes implementing the KM salama approach</i>	Use the Quality Index two times in the 800 KM salama communes	The Quality index was used two times. The 800 communes implementing the KM salama approach have developed their community action plans.	The assessment of community-based services in the 800 communes implementing the KM salama approach was completed. Each commune implementing the KM salama approach has an action plan that specifies improvement actions to be conducted.	Monitor the performance of community-based health services in the 800 communes implementing the KM salama approach.
<i>Activity 2.1.1.3 : Document quality improvement activities and trends in quality of community-based healthcare services in the 800 KM salama communes</i>	Disseminate results to technical and financial partners	4 performance assessments completed for each NGO 2 assessments of health services completed per commune implementing the KM salama approach	Feedback enabled NGOs to adjust their quarterly work plans. Results were discussed during reviews in the communes implementing the KM salama approach.	Document social quality and the use of the Quality Index.

Strategic focus 2: Ongoing coaching of CHVs

Intervention 1: Maintain the quality of services provided by CHVs

<i>Activity 2.2.1.1 Strengthen the quality of monitoring and supervision of community workers</i>	Conduct 3,200 supervision visits at the rate of one supervision group per every three months in the 800 KM salama communes	3,187 supervision visits completed	. During the second semester, supervision visits in some communes in the regions of Anosy and Androy were postponed to October 2012 due to insecurity issues. The supervision findings enabled supervisors to identify actions to improve the quality of the CHVs' services.	Maintain the quality of services provided by CHVs.
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Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY 2013
	Review the findings of supervision visits per CHV, per commune and per NGO in order to identify trends in CHVs' performance	2 reports on the review of the CHVs' performance available	Objective achieved.	Review the CHVs supervision findings per communes implementing the KM salama approach to assess trends in their performance.
<i>Activity 2.2.1.1 Train community-based workers to provide quality services</i>	Conduct 685 training sessions on quality	476 training sessions conducted	Initially, the project planned to have 485 training sessions on care for pregnant women and 200 training sessions for Level 1 and 2 Child Health CHVs. Since care for pregnant women was integrated in all trainings regardless of the level, the number of sessions to be held was reduced. In all, 304 sessions on care for new born and pregnant women and 172 sessions for Level 1 and 2 CHVs were organized this year. 6,013 CHVs were trained.	Catch up with the training of replacements for CHVs who are no longer working.

Strategic focus 3: Building the analysis and decision-making capacities of KM salama stakeholders

Intervention 1: Ensure regular collection of data to feed into the c-HMIS and to enable routine use of data for monitoring the project

<i>Activity 2.3.1.1 Maintain the c-HMIS overall performance at 70% or more</i>	Share information on the status of reporting through the Extranet and SMS as well as data from the CHVs' MARs with the management of NGOs during the monthly coordination meetings	12 Monthly reviews of reports' completeness and timeliness and data's reliability completed	A monthly review of the reports' completeness, timeliness, and reliability is done for each NGO. Findings are shared every month with implementing partners to enable them to monitor the status of their reporting and take the required actions to ensure completeness of the CHVs' reports. Information from the MARs is used by	Maintain the c-HMIS overall performance at 70% or more.
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Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY 2013
			the NGOs and the project for decision making.	
	Hold meetings with support technicians to improve the quality, reliability and use of data in RTI/Santénet2's regional offices	6 meetings with NGOs held at the regional offices	5 meetings with NGOs held at the regional offices. The regional office of Fort-Dauphin and the NGOs (CRS and ASOS sud) who are also in Fort-Dauphin were not visited by the HMIS manager this year.	Monitor the completeness and timeliness of reports in the c-HMIS on a monthly basis.

Strategic focus 4: Ongoing availability of health products for CHVs

Intervention 1: Monitor the functionality of supply points at the commune level

<i>Activity 2.4.1.1 : Distribute job aids to CHVs</i>	Design job aids	Job aids distributed to all supply points	2 job aids for the CHVs were designed in cooperation with PSI (one on VIASUR and the other on all social marketing products). They were distributed either during the training on Pneumostop or when CHVs came to get their supplies from the supply points.	Activity completed
		Distribute job aids to CHVs		
<i>Activity 2.4.2.1 : Measure the ongoing availability of health products for CHVs</i>	Enter and review the invoices/ delivery slips collected from supply points.	Green forms entered and reviewed	<p>The availability of health commodities at the supply points is measured by verifying compliance with the distribution periods at these supply points:</p> <ul style="list-style-type: none"> - 100% of the supply points made orders. 714 are directly supplied by PSI while 86 are supplied through relay supply points. - A review of current data showed the significance of the KM salama approach in the sales of health commodities at the community level and the effectiveness of community- 	Monitor and review trends in health commodities availability in the 800 communes implementing the KM salama approach.

Strategic focus/ Intervention / Activity	Annual objectives	Annual achievements	Gap analysis (expected vs. actual semester results)	Objectives for FY 2013
			<p>based services.</p> <ul style="list-style-type: none"> - Monitoring results are shared with all stakeholders on a monthly basis to enable them to make decisions. - 84% of the CHVs get their supplies from supply points and 25% use both supply channels. 	

Component 3: Strategic Results

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
Strategic focus 1: Provide quality integrated services to improve maternal and child health				
Intervention 1: Coordinate and communicate on community-based MCH activities with development partners				
3.1.1.1 Take part in coordination meetings	4 meetings held	6 coordination meetings were held with the objective of establishing action synergy among partners and harmonizing approaches and tools used in the field. Santénet2 took part in 6 coordination meetings for the promotion of MCH. The meetings were held with MCHIP, SALOHI, ONN, UNICEF, DSEMR, members of the Nutrition task force, and the MOPH. Achievements in terms of community-based services under the KM salama approach were presented during these meetings.	The project participated in two additional meetings: - one on the National Nutrition Action Plan II, for the monitoring and evaluation plan for the nutrition sector (ONN); - one with the MOH to share practices and outlooks for integration of community-based services in the public system.	Organize a coordination meeting at the central level
Intervention 2: Expand integrated quality community-based services in MCH-Nutrition through ongoing coaching and supervision				
3.1.2.1 Promote early screening of pregnancies and management of pregnant women and newborn in the KM salama communes	Training curriculum updated and used for training CHVs	Training curriculum updated and used for training CHVs	To enable CHVs to manage maternal and child health according to standards, c-ONE, IFA, IPT, and use of early pregnancy identification were strengthened in the training curriculum.	Monitor community-ONE. Document results.

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
	4,000 trained CHVs equipped with early pregnancy screening and pregnant women management forms	3,808 Child Health and Mother Health CHVs were trained and equipped with (1) the form for early pregnancy identification and pregnant women management and (2) the job aid for maternal and neonatal health.	Objectives achieved at 95. (5% of the CHVs were absent during the trainings—they will be trained by local supervisors.) The training will strengthen the CHVs' capacity on early detection of pregnant women and referral to the CSBs for the complete package of prenatal care, including sulfadoxine pyriméthamine/IPT, community-based IFA supplementation, identification of danger signs, and community mobilization for setting up an evacuation system.	
3.1.2.2 Train Child Health and Mother Health CHVs in Interpersonal communication, IYCF, women's nutrition, and life cycle	230 trainings conducted	76 trainings conducted	The trainings were conducted in collaboration with UNICEF and ONN. - Training sessions were grouped by communes for better management, more efficiency, and more exchanges because there are more participants. However, standards on the ratio facilitator/trainees (1 facilitator for 8 participants) were always complied with. - Priority was given to CHV training in the districts of Atsimo Andrefana, which meant that training for the CHVs in the KM salama communes of Boeny and Atsinanana will be planned in the next period.	Refresher training for Child Health CHVs on GMP and community-based management in 76 communes implementing the KM salama approach in the 7 districts affected by cyclone Giovanna: the refresher training will be conducted in partnership with UNICEF and SALOHI.

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
	3,500 Child Health and Mother Health CHVs trained in interpersonal communication, IYCF, WN, and life cycle.	2, 413 Child Health and Mother Health CHVs trained in interpersonal communication, IYCF, WN, and life cycle in collaboration with UNICEF and ONN in 4 four regions, 6 districts, and 105 communes in the south of the country	- Given the partners' priorities, the trainings in Atsinanana and Boeny were postponed. - To strengthen the CHVs in IPC, IYCF, and WN, joint formative monitoring of the trainings provided in the south of the country is planned in the second semester of 2013.	
3.1.2.3 Monitor and supervise Child Health and Mother Health CHVs	Supervision grid updated	Monitoring and supervision tools updated include the support technicians' field visit tool and the CCDS' self-assessment tool.	The support technicians' field visit tool enables them to supervise the preparation of MARs, activity reporting, and supply flow as part of ensuring availability of products and social quality. The CCDS' self-assessment tool serves to promote quality of the healthcare services provided by CHVs.	
	CHVs in the 800 KM salama communes supervised	3,187 supervisory visits were conducted, benefiting 6,466 Child Health CHVs that are operational.	CHVs' performance has improved compared with FY 2011.	Child Health CHVs in the 800 KM salama communes supervised
Strategic focus 2: Consolidating community-based reproductive health/family planning services				
Intervention 1: Coordinate and communicate on community-based RH/FP activities with development partners				
3.2.1.1 Take part in the national coordination meeting organized by the RH/FP partner committee	Participation in a national coordination meeting	Santénet2 participated in the national coordination meeting organized by the RH/FP partners' committee. In addition to this national coordination meeting, quarterly technical coordination meetings were held among USAID partners (MAHEFA, MSM, and PSI).	The meetings organized by the RH/FP partners' committee allowed for better harmonization, synergy, and complementarities among the various actors' interventions. Achievements, good practices, challenges, and outlooks were shared during the meetings The USAID partners' coordination meetings allowed for mapping the various partners'	Participate in the national coordination meeting organized by the RH/FP partners' committee at the central level in December 2012. Organize a coordination meeting

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
			intervention zones with their respective service packages.	with MSI in November 2012. Participate in a technical coordination meeting with USAID's FP partners in 2012's second semester.
	Document on RH/FP achievements in the communes implementing the KM salama approach shared with the partners	Share achievements in the communes implementing the KM salama approach through presentations, KM salama brochures, and documents illustrating Santénet2's achievements.		
3.2.1.2 Take part in the workshop to quantify RH/FP products needs	Participation in a workshop to quantify health products needs	Santénet2 participated in a meeting to validate the manual for health input needs quantification organized by the RH/FP partners' committee in October 2011 in Moramanga, as well as a workshop to quantify health input needs in December 2011 in Ampefy.	The meeting with implementing partners allowed for sharing data on contraceptive consumption at the community level, which in turn allowed for estimating needs at the community level.	
Intervention 2: Improve the supply of RH/FP services at the community level through ongoing coaching and supervision of Mother Health CHVs in the KM salama communes				
3.2.2.1 Build the capacities of Mother Health CHVs on integrated RH/FP topics (counseling on FP, referral for LTPMs, provision of COC, LAM, and filling of c-MIS tools)	Design the integrated RH/FP form	An integrated RH/FP tool was designed and distributed to Mother Health CHVs to support ongoing improvement of their performance.	CHVs benefited from capacity building on integrated RH/FP topics during their ongoing coaching.	

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
	Reproduce integrated RH/FP forms			
	Equip Mother Health CHVs with integrated RH/FP form as part of their ongoing supervision and coaching.			
3.2.2.2 Ensure ongoing coaching and supervision of Mother Health CHVs in the 800 KM salama communes	Supervision grid updated	Monitoring and supervision tools updated include the support technicians' field visit tool and the CCDS' self-assessment tools.	The support technicians' field visit tools enable them to supervise the preparation of MARs, activity reporting, and supply flow as part of ensuring availability of products and social quality. The CCDS' self-assessment tools serves to promote quality of the healthcare services provided by CHVs.	Mother Health CHVs in the 800 communes implementing the KM salama approach supervised.
	CHVs in the 800 communes implementing the KM salama approach supervised	3,187 supervisory visits were conducted to the benefit of 5,592 Mother Health CHVs who are operational.	CHVs' performance improved compared with FY 2011.	
Intervention 3: Consolidating adolescent reproductive health (ARH) in the KM salama communes				
3.2.3.1 Organize intra-regional meetings for youth leaders to share best practices and to discuss about challenges in implementing activities	7 meetings organized	6 meetings/forums for youth leaders held	The forums of youth leaders in Antananarivo and Antsirabe were combined to foster sharing of more experiences and good practices of leadership in the field of ARH. This did not affect the process of the forums. The first-hand accounts and the discussions tended to show that young people can be effective relays and channels for promoting ARH,	Document youth leaders' best practices and distribute the ARH document in March 2013. Organize communication activities:

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
			including prevention of STI/HIV/AIDS, early pregnancy, abortions, and drug addiction.	<ul style="list-style-type: none"> • Reports on ARH activities by local radio stations • Youth meetings in the KM salama communes
3.2.3.2 Ensure linkages among support technicians, CCDS and youth leaders	Reporting form available to youth leaders	Youth leaders provided with reporting forms	The reporting pipeline is as follows: from youth leaders to CBSs to support technicians to Santénet2. This improved the completeness of reports.	Review data and information on the youth leaders' activities.
	Youth leaders' reports entered by support technicians into the Extranet	535 reports by youth leaders received and entered in the Extranet	The data in the reports show that 1,101 awareness-raising activities were completed and 23,341 young people were reached with awareness-raising on ARH.	
	Youth leaders' participation in reviews organized by local supervisors	232 youth leaders from 130 communes took part in the meetings and reviews organized by local supervisors, showing that they have developed a strong sense of responsibility, ownership, and commitment to assess their needs and integrate these into the communes' framework plan for social quality.		

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
Strategic focus 3: Controlling malaria at the community level				
Intervention 1: Coordinate and communicate on community-based malaria activities with development partners				
3.3.1.1 Take part in technical coordination meetings for malaria control	10 meetings under the RBM partnership	12 meetings were held and resulted in the adoption by the other partners of 2 supply channels at the community level (through CSB and the supply points). MAHEFA is currently introducing this initiative in its intervention zones.	Additional meetings had to be organized to provide for effective and rapid responses where significant stock-outs occurred.	Take part in 6 monthly meetings of RBM partners.
	4 meetings with PMI	4 meetings held	During the meetings, Santénet2 shared data on the average monthly consumption in the KM salama communes to allow for estimating needs for inputs. The coordination meetings also resulted in the decision to equip Level 2 Child Health with a new case management form through SALAMA, to have the MoH prepare a letter allowing CHVs to get supplies from CSBs, and to harmonize CHVs' MARs.	Take part in two quarterly meetings of PMI.
	6 coordination meetings held with NMCP and NSA partners	6 quarterly meetings held	At the end of the meetings, the pools of trainers established by Santénet2 were mobilized for training CHVs with funding from NSA. Advocacy for the use of the harmonized MAR by all partners for c-IMCI continues with NMCP.	Take part in 2 c-IMCI coordination meetings
	Documents on project achievements distributed	During the coordination meetings, practices, experiences, and lessons learned in implementing KM salama activities were shared.		

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
Intervention 2: Strengthen the capacity of Mother Health and Child Health CHVs to raise awareness and monitor the use of LLITNs and intake of IPT by pregnant women				
3.3.2.1 Train Mother Health and Child Health CHVs to raise awareness and monitor the use of LLITNs and intake of IPT by pregnant women	Training curriculum updated	Training curriculum updated in regard to its contents on IPT and use of the screening form	Objective achieved	
	4,000 CHVs trained and equipped with tools for early pregnancy screening and pregnant women management	3,808 Mother Health and Child Health CHVs were equipped (1) with the early pregnancy identification form and (2) job aids on maternal and newborn health.	Objectives achieved at 95. 5% of the CHVs were absent during the trainings. They will be trained by local supervisors. The training will strengthen the CHVs' capacity on early detection of pregnant women and referral to the CSBs for the complete package of prenatal care, including sulfadoxine pyrimethamine/IPT, community-based IFA supplementation, identification of danger signs, and community mobilization for setting up an evacuation system.	
Intervention 3: Improve c-IMCI service supply through ongoing coaching and supervision of Level 2 Child Health CHVs				
3.3.3.1 Monitor and supervise Level 2 Child Health CHVs in the 800 KM salama communes to offer quality c-IMCI services	Supervision tools updated and distributed to supervisors	Monitoring and supervision tools updated include the support technicians' field visit tool and the CCDS' self-assessment tool.	The support technicians' field visit tool enables them to supervise the preparation of MARS, activity reporting, and supply flow as part of ensuring availability of products and social quality. The CCDS' self-assessment tool serves to promote quality of the healthcare services provided by CHVs.	Train Level 2 Child Health CHVs on c-IMCI to catch up.

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
	160 technical forms for monitoring the use of RDTs distributed to support technicians	165 support technicians received the technical forms.	The technical forms were provided to support technicians to enable them to better coach CHVs on the use of RDT and compliance with standards in service provision.	
	CHVs in the 800 KM salama communes supervised	3,187 supervisory visits were conducted to the benefit of 5,647 Level 2 Child Health CHVs who are operational.	CHVs' performance improved compared with FY 2011.	
Intervention 4: Monitor the implementation of epidemiological surveillance activities by IPM				
3.3.4.1 Check IPM's deliverables' conformity with specifications in agreements	Monthly <i>Epiveille</i> bulletins available	12 <i>Epiveille</i> bulletins available	Santénet2 collaborates with the IPM in the operation of 15 epidemiological surveillance sentinel sites. IPM is supposed to send an <i>Epiveille</i> bulletin every month, providing information on diseases addressed by IMCI, thus allowing the project to see trends in regard to these diseases.	Activity completed
Intervention 5: Conduct a survey on the functionality and performance of CHVs				
3.3.5.1 Conduct an assessment of the effectiveness, sustainability, and quality of services provided by CHVs in the KM salama communes	Assessment conducted in the sites	The assessment was conducted in August 2012.	The draft report is available. The final report will be shared with partners in late November 2012.	Disseminate recommendations and apply them to improve approaches.

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
Strategic focus: Increasing most-at-risk populations' (MARPs') capacity to control STI/HIV/AIDS				
Intervention 1: Promote STI/HIV/AIDS prevention activities among MARPs				
3.4.1.1 Strengthen MARP associations' capacity to implement STI/HIV/AIDS prevention activities	19 MARP associations benefiting from technical support	19 MARP associations benefited from technical support, including 11 who are in the Global Fund intervention areas.	The technical support consists mainly in trainings that build the programmatic and institutional capacities of peer educators and association leaders. The trainings are conducted following curricula developed by the project.	
	8 associations provided with grants (Antsirabe 2, Fianarantsoa 4, Fort-Dauphin 2)	8 MARP associations received small grants.	The associations awarded grants are those operating in localities where the Global Fund is not present. The grants followed the project's grants management procedures.	
	380 leaders trained, including leaders in associations in Ihosy, Manakara, and Mahajanga	380 peer educators are trained and are operational.	MARP educators' capacity was strengthened to enable them to conduct awareness-raising with their peers.	
	27 trainings completed	21 trainings on resources mobilization, STI/HIV/AIDS prevention, negotiation of condom use, and project proposal development were conducted	No training was held in some localities because the Global Fund had already provided training there, namely on STI/HIV/AIDS and negotiating the use of condoms.	
	9,500 IEC tools distributed	652 IEC tools distributed	The associations still had stocks of tools. Therefore, no new production was done, but the tools in stock were distributed.	
	21,000 people reached with awareness-raising	22,710 people reached with awareness-raising by MARP educators	Peer educators collaborate with the leaders of sex workers and MSM in their neighborhoods and work places. Thus, they were able to reach even those who operate clandestinely.	

Activity	Objective 2012	Achievements (October 2011 to September 2012)	Gap analysis	Objective 2013
Strategic focus 5: Involving religious leaders and faith-based organizations in stimulating demand for health services by the population in the communes implementing the KM salama approach				
Intervention 1: Mobilize PLeROC members to contribute to improving community health				
3.5.1.1 Support religious leaders in sensitizing the population in 580 communes implementing the KM salama approach on health topics using their worship places as venues	290,000 people sensitized	361 281 people reached with awareness-raising by PLeROC members	Disseminating health message in worship places has become a common practice for some religious entities. The topics addressed include mainly family planning, prenatal care, tetanus immunization, pregnant and lactating women's nutrition, malaria prevention, IFA intake, child nutrition, STI/HIV/AIDS prevention, safe drinking water, diarrhea, and ARIs.	Activity completed
3.5.1.2 Monitor PLeROC's activities	Monthly reports by religious leaders in 580 communes implementing the KM salama approach available	Reports available and reviewed		
	Results of the review available and shared internally on a quarterly basis	The review results are used by the project for program management.		

Strategic Focus 4: Establishing the WASH strategy in the communes implementing the KM salama approach

Intervention 1: Promote collective behavioral change in the field of sanitation and use of latrines

Activity 1.4.1.1 Expand the initiation of CLTS in the trained communes	Update 115 support technicians from the concerned NGOs on CLTS	115 support technicians updated on the CLTS approach	Objective achieved	
	Update 2,837 CCDS members that were trained in the past	1,715 CCDS members updated on the CLTS process—60%	Reports from support technicians are late. The reporting rate is 54%.	
	Update, as needed, and produce the CLTS guide	CLTS Guide updated	Objective achieved	
	Conduct CLTS triggering sessions in 1,500 villages	Triggering sessions held in 2,048 villages—111%	Santénet2 intensified CLTS activities, especially triggering sessions and monitoring, which is all the more appropriate because the CCDS have taken on the responsibility to implement the approach.	
Activity 1.4.1.2 Monitor and analyze CLTS activity results	Monitor 1,500 villages where CLTS triggering sessions were held	1,814 villages monitored—118%	The monitoring of CLTS activities was entrusted to CCDS members. They report on activities regularly (every month, two weeks, or quarter) depending on their availability. This system is aimed at transferring competency to the CCDS and thus promoting ownership and sustainability of the approach.	Collect and review CLTS monitoring reports from the CCDS.
	Encourage the construction of 3,000 latrines through the communities' own resources	14,800 latrines built by communities using their own resources.	The intensification of CLTS activities, responsibility-taking by community leaders to promote sustainability, and the strengthening of WASH-friendly CHVs/CCDS as well as intensive awareness-raising activities by CHVs have all encouraged households to build their own latrines.	

	Encourage the use of latrines among at least 15,000 people	170,252 new users of latrines	The objective was largely exceeded due to the following factors: <ul style="list-style-type: none"> - intensification of CLTS activities - significant involvement of community leaders (CCDS) in triggering sessions and monitoring of activities - integration of CLTS activities in the awareness-raising package - strengthening of WASH-friendly CHVs/CCDS activities 	
	Document CLTS activities	A document on CLTS activities produced	Objective achieved	
Intervention 2: Promote the population's access to safe water				
Activity 1.4.2.1 Monitor the achievements of communes trained in water management	Analyze the data on the monitoring conducted by subcontractors	Monitoring of results by the 3 subcontractors reviewed	The review of monitoring activities showed that communes that benefited from support on managing WASH facilities contract achieve the following: <ul style="list-style-type: none"> - convey WASH messages - have their own drinking water supply system - adopt a system to protect WASH infrastructures - have set up a fee system for all municipal water points - have established a system for upkeep, maintenance, and construction of WASH facilities - have included a safe water supply project in their Community Assessment - strengthen their mechanism for the management of water resources and water fees. <p>These findings show that it is beneficial to provide such support, especially as they result in the community being in charge of local governance in terms of WASH facilities and in their ownership of WASH actions.</p>	

	Strengthen WASH monitoring by CCDS	164 CCDS in the communes benefiting from support in works contract management monitored WASH activities—100%	<p>The 470 reports on the monitoring conducted by CCDS members in 256 <i>fokontany</i> in 164 communes implementing the KM salama approach supported by Santénet2 show several improvements made to existing facilities or new construction made by the communities:</p> <ul style="list-style-type: none"> - Each commune has a structure in charge of managing water. - Each commune has prepared a development plan for the water sector. - 1,153 existing water points are maintained or improved. - 256 wells and other water facilities were built. - 232 public latrines are operational. <p>The monitoring of activities has been entrusted to CCDS members after capacity-building. This will ensure that the activities can be maintained by the communities themselves.</p>	
Intervention 3: Promote behavioral change at the individual and household levels				
Activity 1.4.3.1 Expand the WASH-friendly CHVs activity	Certify 2,400 CHVs meeting WASH-friendly CHV criteria	3,243 new CHVs certified WASH-friendly—128%	<p>Because CHVs should be models for their communities, Santénet2 adopted a certification system under which CHVs meeting the following criteria are certified as WASH-friendly:</p> <ul style="list-style-type: none"> - use latrines; - have a hand-washing device; - have a clean water storage device. <p>The monitoring was entrusted to the CCDS members, who in turn are expected to model these behaviors to promote their sustainability. 1,143 CCDS members were certified in FY 2012.</p>	Collect and review monitoring reports from CCDS on WASH-friendly CHV activities.

Activity 1.4.3.2 Sensitize communities with WASH messages.	Reach 400,000 people with sensitization on WASH	1,217,549 people reached with WASH messages—261%	The objective was exceeded as a result of the following: - Intensification of sanitation activities - WASH-friendly CHV/CCDS initiative that encouraged these actors to raise awareness on WASH - Implementation of the CLTS approach that strengthened sensitization on WASH	
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Intervention 4: Coordinate and communicate WASH activities with development partners

Activity 1.4.4.1 Celebrate WASH-related World Days	Take part in three WASH-related World Days	Participation in three WASH-related World Days	Objective achieved	
Activity 1.4.4.2 Take part in coordination meetings with the WASH platforms	Take part in two annual meetings of the Diorano-WASH platform	Participation in 2 meetings of the Diorano-WASH platform	Objective achieved	
	Take part in the meetings of the CLTS network.	Participation in 4 meetings of the CLTS network	Objective achieved	

Coordination

Activity		Completion Indicator	Objective 2012	Completed in FY 2012	% of completion in FY 2012	Gap analysis
Strategic focus 1: Coordination of interventions in the communes implementing the KM salama approach						
Intervention 1: Coordinating implementing partners' activities						
4.1.1.1	Support implementing partners in the planning process	21 annual work plans (AWPs) validated	21	21	100%	Objective achieved
		84 quarterly work plans validated	84	84	100%	Objective achieved
4.1.1.2	Hold monthly coordination meetings with implementing partners	176 coordination meetings held	176	231	131%	Meetings are held on a monthly basis with NGOs to ensure coordination of activities, based on achievements in the previous month and the activities planned for the next month. The NGOs also held coordination meetings at their zone level, though this was not initially planned.
		176 coordination meeting minutes available	176	231	131%	
4.1.1.3	Take part in coordination meetings organized by local actors	32 meeting minutes	32	3	9%	Our plans were based on 2 meetings organized by local actors in each of the 16 regions. Santénét2 attended all the meetings organized by partners at the regional level. However, the partners in the regions of Atsinanana, Ihorombe, and Atsimo Andrefana were the only ones to

Activity		Completion Indicator	Objective 2012	Completed in FY 2012	% of completion in FY 2012	Gap analysis
						hold a coordination meeting.
4.1.1.4	Organize a national coordination meeting with implementing partners	National coordination meeting held	1	1	100%	Objective achieved
		Report of the meeting available and shared with partners	1	1	100%	Objective achieved
4.1.1.5	Take part in the celebrations of World Days	Number of World Days attended	4	4	100%	Objective achieved.
		Trip reports available		4		
Intervention 2: Monitoring activities planned						
4.1.2.1	Collect and review information regularly	Weekly activity reports of the NGOs received and reviewed for promptness, completeness, and reliability	1,092	1,044	96%	To allow for monitoring the progress of activities against the AWP, NGOs are required to send reports on their achievements and planned activities every week and every quarter. The 21 NGOs sent these reports. Discrepancies and gaps against weekly plans are due to staff leaves or late feedback. The review of the reports is aimed at ensuring that the NGOs perform the activities in a timely way according to standards.

Activity		Completion Indicator	Objective 2012	Completed in FY 2012	% of completion in FY 2012	Gap analysis
		Quarterly reports received from the 21 NGOs and reviewed	84	84	100%	Objective achieved
4.1.2.2	Update the dashboard to track progress of the NGOs' activities	21 dashboards updated on a weekly basis	21	21	100%	Objective achieved
Intervention 3: Implementing the KM salama approach in 3 communes						
4.1.3.1	Monitor activities in the 3 communes on a monthly basis (Ambanitsena, Anjeva, Ambohitrony)	Monthly reports available	12	12	100%	Objective achieved
		Data available each month on the Extranet and the SMS database	12	12	100%	Objective achieved
4.1.3.2	Organize semester reviews	2 semester reviews held in the three communes.	2	2	100%	Objective achieved

Annex 2: Monitoring and Evaluation

Monitoring and evaluation through the collection and the use of information on the program's progress and impacts on the population are an essential part of Santénét2's management. Through the analysis of monitoring and evaluation indicators, the project's management gains an understanding of how well implementation is performing and determines whether the activities comply with initial plans and whether the objectives set are met. Without a rigorous monitoring and evaluation framework, it would not be possible to grasp where the efforts made have led.

Santénét2 developed the Performance Monitoring Plan (PMP) for the following objectives:

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

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

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

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

In conducting its activities, Santénét2 refers to 22 indicators: 18 indicators regarding five key health areas—Reproductive Health/Family Planning (RH/FP), Maternal and Child Health (MCH) and Nutrition, Malaria Control, Water-Sanitation-Hygiene (WASH), and STI/HIV-AIDS prevention (including 9 USAID PPR indicators)—and 4 cross-cutting indicators. The results obtained under each of the indicators are reported to USAID/Madagascar every semester.

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

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

The first category groups indicators for which targets have been achieved. There are 17 indicators in this category:

- Community-based FP services: (1) couple-year protection and (2) regular users
- The referral of pregnant women to health centers for antenatal care (ANC)

- Community-based growth monitoring and promotion
- Strengthening community actors in regard to maternal and newborn health
- Training for community health workers (CHVs) on rapid diagnostic test (RDT) use
- Awareness-raising activities concerning (1) nutrition, (2) water and sanitation, and (3) STI/HIV/AIDS prevention
- Fever case management among children under 5 years old
- Latrine use
- Most-at-risk population (MARP) peer educators training
- The peer educators' MARP awareness-raising activities for sex workers and men having sex with men (MSM)
- The functionality of CHVs
- Community Health Management Information System (c-HMIS) performance
- The number of communes having a Communal Health Development Commission (CCDS) that has identified, planned, and implemented actions to improve quality
- The number of health providers implementing quality improvement approaches.

The solid conceptual foundation of Santénet2 and the rigorous and standardized implementation of the Annual Work Plan (AWP) 2012 enable the project to strengthen institutional lessons learned, namely sustainability. The good performance of these indicators can be explained by the active participation of the communities in the KM salama approach, the competence of actors (CHVs, supervisors, trainers), the effectiveness of community-based health services to meet the real needs of the poorest population, the continuous improvement of quality through external supervision and the follow-up by the community, and the strong partnership established with 16 implementing organizations.

The second category includes indicators that are about to be achieved compared to targets. There are five (5) indicators related to the number of CHVs reporting stock-outs of products during the period, the number of vaccination referrals by CHVs at the health center, the case management of acute respiratory infection (ARI) by CHVs, the case management of diarrhea, and community funding.

The factors accounting for being off target include the following:

- *For CHVs reporting stock-outs of products:*

Stock-outs of products were noticed at supply points (at the commune level and at the CSB level) because of the following:

- Stock-outs at the national level,
- Non re-supply of supply points,
- Resupply of supply points in insufficient quantity.

This has a negative impact on the availability of products at the CHV level.

The table below shows the distribution of CHV places of supply in health products:

CHV resupply points	ACT	DPMA
Supply point	59%	27%
CSB	26%	61%
CSB, supply point, and pharmacy at the same time	15%	12%

Source: Santénet2, report of survey on reliability and compliance data on community-based health services in the KM salama communes, August 2012.

- *For vaccination referrals to CSBs by CHVs:*

CHVs referred mothers and children to the CSBs but could not routinely report on the number of child referred because the CSBs would not issue counter-referral forms or the mother or child caretakers did not bring back the forms. CHVs seize every opportunity to sensitize mothers or child caregivers to bring their children to CSBs for vaccination. They might not always have a referral form or registers to record data with them at the moment when these interactions take place. This leads to a misreporting of the data.

To meet these challenges, the project will reinforce the messages that these referrals need to be reported to support technicians during coordination meetings.

Also, CHVs work in communities located very far from CSBs. CSBs use advanced strategies for vaccination (mobile teams) in general two times a year, during the mother and child health weeks, which are in April and October each year. Mothers always seize these opportunities to get their children vaccinated.

- *For ARI and diarrhea case management:*

More recent surveys indicate a steady decrease in incidents reported of children presenting with pneumonia during the two-week period prior to the survey (3% per the 2008/09 DHS, and 1% per the most recent EPM 2010). Data indicate that the reduction in community-case management follows the decrease of cases. As a conclusion, we can say that community case management continues to respond to the population's needs according to the treatment trend at the CSB level.

- *For population enrollment in the health mutuelles:*

A simple analysis of membership enrollment data shows that the enrollment numbers have greatly increased from the launching of this program in 2 districts: Ambohimahasoia and Vatomandry. For Vatomandry, it was delayed by the cyclones in January and February. This natural disaster brought poverty to almost the majority of the population at the same time that the health *mutuelle* was in the enrollment and fee collection phase. In parallel, there was a personnel strike leading to the closing of health centers that lasted four months (from June to September 2012); this caused a slow-down and the end of the enrollment process for Ambohimahasoia and Ambositra.

N°	Indicators	Target FY 2012	Achievement FY 12 (October 2011 - September 2012)	% of Achievements	Gap analysis/Observations
INDICATORS FOR WHICH TARGETS HAVE BEEN ACHIEVED					
1	Couple years of protection (CYP)	118,936	108,961	92%	The target was achieved The number of regular FP users reported through the fast track SMS system indicates 122,131 regular FP users served by CHVs in KM salama communes.
2	Number of regular users (RU) of modern contraceptive methods (RU of CHVs)	104,900	122,131	116%	This result indicates that the services offered by CHVs create behaviors conducive to better health outcomes. 64% of RU use injectables for contraceptive methods and 30% use pills. Compared to fiscal year 2011, the number of clients using pills has increased. 81% of clients are new users, 39% of them use injectables and 35% use pills. It also shows the effectiveness of the communication strategy for behavior change implemented by Santénet2, involving CHVs, FBO members, and local radio stations. During this reporting period, CHVs reached 453,532 persons in RH/FP (with an average of 37,700 persons per month).
6	Number of pregnant women referred by CHVs to the health center for ANC	18,500	23,923	129%	Both Child Health and Mother Health CHVs provide services to pregnant women and newborns. The services include screening women for pregnancy at an early stage (3 or 4 months), raising awareness on attending antenatal care (ANC) consultations, and checking that the 10 elements of the pregnant women prevention and care package are available. The CHVs are also trained to identify danger signs in pregnant women and newborns and to provide counseling and referral to patients as needed. Since FY 2010, 11,034 CHVs have been trained to conduct this activity (92% of functional CHVs). The Project conducted refresher training for NGO support technicians and reminded them during all monthly coordination meetings about the reporting of referrals.

N°	Indicators	Target FY 2012	Achievement FY 12 (October 2011 - September 2012)	% of Achievements	Gap analysis/Observations
8	Number of children monitored or referred by CHVs for malnutrition	1,245,657	1,333,016	107%	The target was achieved During this period, CHVs have weighed 1,333,016 children under five (with an average of 111,000 children per month). Among them, 34,712 children are malnourished (which is 3%). 80% of these children are malnourished and referred to a CSB.
10	Number of people trained in maternal and newborn health	4,000	3,808	95%	The target was achieved
11	Number of mothers or child caretakers exposed to IEC/BCC nutrition messages	1,020,000	936,926	92%	During this period, CHVs reached 936,926 persons with awareness-raising on nutrition, with an average of more than 78, 000 persons per month.
12	Number of children under 5 years of age with fever who received treatment with ACT within 24 hours from onset of fever	71,000	90,156	127%	During the period, CHVs managed 90,156 cases of fever (an average of 7,500 cases per month). 63% of cases had a positive result. These results indicate that the services offered by the CHVs create behaviors conducive to better health outcomes. It also shows the effectiveness of the communication strategy for behavior change implemented by Santénet2, involving CHVs, FBO members, and local radio stations. After the 2 cyclones (Giovanna and Irina), an increase of fever cases was observed in 15 project intervention districts. An outbreak was declared in the regions of Vatovavy Fitovinany, South East and Androy.
13	Number of Level 2 Child Health CHVs trained in RDT use	414	388	94%	The target was achieved These CHVs were trained to be operational as 5,647 Level 2 Child Health CHVs.
14	Number of people exposed to IEC/BCC water and sanitation messages	400,000	1,217,549	304%	These results show the effectiveness of the communication strategy for behavior change implemented by Santénet2, involving CHVs, FBO members, and local radio stations. Moreover, the implementation of WASH-friendly activity (CHV and CCDS) and the CLTS approach motivated different actors to

N°	Indicators	Target FY 2012	Achievement FY 12 (October 2011 - September 2012)	% of Achievements	Gap analysis/Observations
					strengthen awareness-raising on water and sanitation. During FY 2012, more than one million people were reached with health promotion messages by CHVs, a monthly average of 100,000 persons reached.
15	Number of people in the Santénet2 intervention zones using latrines	79,500	170,252	214%	The explanation for this indicator's overachievement stems from at least 3 causes. First, the revived engagement of community leaders in widespread promotion and community-based monitoring of community-led total sanitation (CLTS) activities in target KM salama communes has led to an increase in numbers for this indicator. Second, with experience gained from previous project activities, CHVs are more effective in promoting behaviors conducive to better health outcomes. During FY 2012, more than one million people were reached with health promotion messages by CHVs, a monthly average of 23 persons reached by each CHV. Third, WASH-friendly CHVs have become role models within their communities. There are 5,081 WASH-friendly CHVs certified in KM salama communes, as well as 1,143 WASH-friendly community leaders. To become certified as WASH-friendly, CHVs and CCDSs must fulfill three conditions: latrine use, possession of facilities for washing hands with soap, and possession of a place to store clean water.
16	Number of people exposed to IEC/BCC HIV-AIDS messages	682,953	637,865	93%	The target was achieved STI/HIV/Aids awareness-raising activities are conducted by CHVs, FBO members, and young leaders. During this period, CHVs reached 239,415 persons, FBO members reached 361,281 fellows and young leaders reached 37,169 young people.
17	Number of peer educators trained by MARPs' associations	380	380	100%	The target was achieved

N°	Indicators	Target FY 2012	Achievement FY 12 (October 2011 - September 2012)	% of Achievements	Gap analysis/Observations
18	Number of MARPs reached with individual and/or small group-level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	21,000	22,710	108%	The target was achieved 380 MARP educators sensitized 22,170 MSM and sex workers with an average of 1,893 persons reached per month and an average of 60 persons per peer educator.
19	Number of functional (trained, equipped, & supervised) community health workers	12,058	12,058	100%	The target was achieved 3, 187 supervision sessions were organized this year. We should note that the number of supervision sessions organized during the second semester has slightly decreased because supervisions in some communes in the regions of Androy and Anosy could not be conducted because of a rise in insecurity.
20	Performance of the community Health Management Information System (c-HMIS)	>70%	79%		The target was achieved 80,923 CHV MARs are recorded in Extranet and 78,774 MARs received via SMS. The CHV MAR completeness rate is 76%, the accuracy 83%, and data reliability is 84%. The performance of community HMIS was improved compared to last year, which was 55%.
21	Number of communes in the Project's intervention zone having an SDC that has identified, planned, and implemented actions to improve quality in a participatory way	800	796	99,5%	The target was achieved 796 communes developed and implemented actions to improve service quality after evaluations. There are 4 remaining communes to implement in October 2012 according to population's demand.

N°	Indicators	Target FY 2012	Achievement FY 12 (October 2011 - September 2012)	% of Achievements	Gap analysis/Observations
22	Number of service providers implementing quality improvement approaches	11,000	11,060	101%	The target was achieved As part of the project strategy to implement quality health services at the community level, the project created a framework responding to demand and need after an inventory of the existing tools to improve quality. This framework was integrated into the KM salama process. It consists in supporting the community to express its needs. Activities on quality improvement for health services are conducted according to the expressed needs.
INDICATORS TO BE ACHIEVED COMPARED TO TARGETS					
3	Percentage of service providers reporting stock-outs of Depo Provera	5%	Depo Provera: 33% ACT: 45%		Objective not achieved Stock outs of products were noticed at supply points (at the commune level and at the CSB level) because of: <ul style="list-style-type: none"> • Stock-outs at the national level, • Non re-supply of supply points • Resupply of supply points in insufficient quantity The average duration of an episode is 1.5 months for DPMA and 2 months for ACT.
4	Number of children under 12 months of age referred by CHVs to the health center for vaccinations	26,000	17,820	69%	During the period, CHVs reported 17,820 children referred for vaccination. There is a problem in reporting referrals by CHVs (registration in the records, use of reference cards): <ul style="list-style-type: none"> - CHVs referred mothers and children to the CSBs but could not routinely report on the number of children referred because the CSBs would not issue counter-referral forms or the mother or child caretakers did not bring back the forms. - CHVs seize all opportunities to sensitize mothers or child caregivers to bring children to CSBs for vaccination. They might not always have the referral form or registers to record data with them at

N°	Indicators	Target FY 2012	Achievement FY 12 (October 2011 - September 2012)	% of Achievements	Gap analysis/Observations
					<p>the time of these contacts. This leads to a misreporting of the data.</p> <p>- To meet these challenges, the project will reinforce the messages that these referrals need to be reported to support technicians during coordination meetings.</p>
5	Number of diarrhea cases among children under 5 treated by CHVs	112,275	49,009	44%	<p>The explanation for this indicator's gap stems from at least two causes. The FY 2012 and FY 2013 target numbers for diarrhea were set based on a 9% incidence rate (taken from the DHS 2004). More recent surveys indicate a steady decrease in incidents reported of children presenting with diarrhea during the two-week period prior to the survey (8% per the 2008/09 DHS, and 3% per the most recent EPM 2010). Using the 2008/09 DHS data, the Santénet2 target morbidity would be 60,000 for diarrhea, considering children in catchment area of CHVs. During the period, CHVs managed 49,009 cases of diarrhea (an average of 4,000 cases per month). A second part of the explanation stems from the fact that Santénet2 is a multifaceted health program. Achievement in other areas of our program, such as promoting behavior changes in the population that are conducive to better health outcomes as well as providing timely access to community health services for sick children, are very likely to impact negatively on our achievement for this indicator (but in a positive way), in the sense that there are fewer sick children, therefore our CHVs are not achieving their targets in terms of cases managed. Both the recent surveys mentioned above and our holistic approach to community health indicate that although CHVs are reaching the sick children in their communities, there are fewer sick children to be reached than previously estimated.</p> <p><i>In addition, CHVs experienced stock-outs of diarrhea management products (ORS zinc/Viasur), caused principally by CSB or social marketing-level stock-outs or an absence of supply point managers at these levels. These issues were due to nationwide strikes leading to health center closings from February to August 2012.</i></p>

N°	Indicators	Target FY 2012	Achievement FY 12 (October 2011 - September 2012)	% of Achievements	Gap analysis/Observations
7	Number of pneumonia cases among children under 5 treated with antibiotics by CHVs	90,735	53,104	59%	<p>The explanation for this indicator's gap stems from at least two causes. The FY 2012 and FY 2013 target numbers for pneumonia were set based on a 9% incidence rate (taken from the DHS 2004). More recent surveys indicate a steady decrease in incidents reported of children presenting with pneumonia during the two-week period prior to the survey (3% per the 2008/09 DHS, and 1% per the most recent EPM 2010). Using the 2008/09 DHS data, the Santénet2 target morbidity would be 60,000 for pneumonia, in KM salama communes. During the period, CHVs managed 53,104 cases of pneumonia (an average of 4,400 cases per month). A second part of the explanation stems from the fact that Santénet2 is a multifaceted health program. Achievement in other areas of our program, such as promoting behavior changes in the population that are conducive to better health outcomes as well as providing timely access to community health services for sick children, are very likely to impact negatively on our achievement for this indicator (but in a positive way), in the sense that there are fewer sick children, therefore our CHVs are not achieving their targets in terms of cases managed. Both the recent surveys mentioned above and our holistic approach to community health indicate that although CHVs are reaching the sick children in their communities, there are fewer sick children to be reached than previously estimated.</p> <p>In addition, CHVs experienced stock-outs of ARI management products (Cotrim/Pneumostop), caused principally by CSB or social marketing-level stock-outs or an absence of supply point managers at these levels. These issues were due to nationwide strikes leading to health center closings from February to August 2012.</p>
9	Number of people covered by health financing arrangements	300,000	23,141	8%	<p>Objective not achieved.</p> <p>For reporting on health mutuelle enrollment, we calculated a break-even point of 300,000 enrollments for financial sustainability.</p> <p>The explanation for this indicator's gap stems from many causes:</p> <ul style="list-style-type: none"> - First, the health <i>mutuelles</i> are in their first year of implementation.

N°	Indicators	Target FY 2012	Achievement FY 12 (October 2011 - September 2012)	% of Achievements	Gap analysis/Observations
					<p>Activities mainly concern awareness-raising and the setting up of structures. The plan for setting up in each district is not the same. 2 out of the 7 targeted districts are more advanced.</p> <ul style="list-style-type: none"> - Secondly, the population is still unsure about the success (or not) of the program because of previous problems (poor management, fraud ...) during previous health <i>mutuelles</i>. Moreover, it is difficult for them to cope with a new approach—changing the management structure to the district level is considered to be conducive to embezzlement. - Thirdly, most of the people are waiting for the beginning of care coverage to decide about their enrollment. <p>The cyclones and the closing of some health centers during the health personnel strike made the enrollment difficult and slowed down the enrollment process and the collection of fees.</p> <p>Despite these problems, health <i>mutuelles</i> are functional and the number of enrolled people is increasing. For Ambalavao and Vatomandry, an increase of 56% and of 29% was noticed from the beginning of activities. To improve the results, different measures were taken to promote interest among the population and to gain their trust in health <i>mutuelles</i>.</p>

Annex 3: Environmental Mitigation and Monitoring Report – FY 2012

Activity	Mitigation measures	Monitoring indicators	Monitoring and reporting frequency	Responsible	Achievements FY 2012 (Oct 2011–Sept 2012)
<p><i>Management and disposal of hazardous medical waste resulting from the administration of DMPA and the use of RDTs for malaria prevention activities (syringes, contaminated objects, gloves, drug vials, gauze, plastic pockets)</i></p>	<p>Medical waste will be managed in accordance with the National Medical Waste Management Policy of Madagascar and WHO's Environmental Guidelines for small-scale activities in Africa (Chapters 8 and 15).</p> <p>CHVs will be trained and equipped to ensure proper management of waste and safety of injections. The training will cover risk evaluation, safety of injections, and medical waste management and will raise awareness among CHVs. Each Level 2 CHV will receive safety boxes at the end of the training (2 safety boxes for Mother Health CHVs and 1 safety box for Child Health CHVs) as well as clear instructions on the disposal and resupply of safety boxes.</p>	<p>During these three years, RTI/USAID/Santénet2 has trained 5,269 Level 2 Child Health CHVs in c-IMCI and 4,774 Level 2 Mother Health CHVs in community-based DMPA.</p> <p>In fiscal year 2012, supervision visits will be conducted for 5,269 Level 2 Child Health CHVs and 5,233 Level 2 Mother Health CHVs.</p> <p>3,200 supervision visits involving 75% of CHVs trained will be conducted in the communes to assess CHVs' compliance with environmental standards in the disposal of equipment and materials related to community-based provision of DMPA (syringes, needles, gloves, drug vials, bottles, gauze, plastic pockets).</p>	<p>The monthly review and supervision reports will provide the information for assessing the effectiveness of mitigation measures.</p> <p>The project's semester and annual reports will address the issue of mitigation measures set up.</p>	<p>Santénet2 and its implementing partners</p>	<p>5,647 Level 2 Child Health CHVs and 5,361 Level 2 Mother Health CHVs were supervised during the 3,187 visits conducted.</p> <p>Supervision reports indicate that 98% of Level 2 CHVs have at least 1 safety box, use it and are compliant with safe injection standards.</p> <p>328 CSBs out of 1,217 in KM salama communes have a waste disposal system (i.e., an oven to incinerate medical waste). Remaining CSBs are using, as recommended by the national medical waste management policy, a barrel or pit to burn medical waste.</p>

Activity	Mitigation measures	Monitoring indicators	Monitoring and reporting frequency	Responsible	Achievements FY 2012 (Oct 2011–Sept 2012)
	<p>CHVs are instructed to bring their boxes to the CSB when it is two-thirds full and to seek an empty safety box from either the CSB or the supply point.</p> <p>CHVs will follow the procedures included in the "Reference Manual for Immunization Program Managers on Injection Safety Issues and Waste Disposal," especially as regards the use of safety boxes.</p>	<p>In addition, CHV compliance with procedures for the disposal of waste, especially safety boxes, will be checked.</p>			

Annex 4: Success Stories

Success Story: Nutrition / Weighing sessions for children cause a “rush” in Andina



© Santénet2/Ny Tanintsika: The two CHVCHVs in Ampasina using the scale during a weighing session

Community organization is outstanding in Ampasina, a *fokontany* located in the commune of Andina, well-known for its orange production. This commune stands on the Betsileo high plateau in the region of Amoron'i Mania. The *fokontany* is served by community health volunteers (CHVs) established by Santénet2 as well as CHVs trained by another USAID-funded nutrition program, Strengthening and Accessing Livelihood Opportunities for Household Impact (SALOHI), implemented by the Adventist Development and Relief Agency (ADRA). Good coordination exists between these community actors.

After they received a baby scale from Santénet2, the two Santénet2-trained CHVs started organizing weighing sessions for children in their *fokontany*. They currently hold one session on the first Monday of each month, using a villager's courtyard to accommodate all the people who come. This month, the CHV in charge of maternal health, Marie Razafimamonjy, coordinates the session.

The monthly sessions are attend by all mothers in the village of Ampasina with children under the age of five, but the sessions also draw mothers from the neighboring *fokontany* of Ankadilalana and Anjamaivo that do not have CHVs. The sessions are preceded by awareness-raising in the village, which never fails to attract crowds.

At the end of weighing sessions, children whose results show a red strip (severe malnutrition) are taken care of by SALOHI/ADRA's CHVs—they are placed in a nutritional learning and rehabilitation home where their mothers will benefit from counseling on health, nutrition, and food security.

Within the twelve months it has been operational, this arrangement has benefited 805 children under the age of five. All of Ampasina's 475 children have been weighed. The other 330 children come from neighboring *fokontany*. Of the children screened, 15 were severely malnourished and were referred to a nutritional rehabilitation home managed by SALOHI.

Marie Louis Ravaoarimanana, the 25-year-old mother of Saholiarisoa Florence, is happy about this service. “The weighing session is really useful for me because I am raising my child alone. It helps me to have these weighing sessions in the *fokontany* rather than the health facility, which is six kilometers away.”

The head of the basic health center in the commune of Andina, Dr. Harison Randriantsialonina, acknowledges the good job done by the CHVs in Ampasina. “They are real models for the commune of Andina. We are proud to have them. The weighing sessions in the *fokontany* of Ampasina serve as a model for all CHVs. We certainly have less people at the weighing sessions in our health facility since they initiated their own sessions, but we still have all the information needed because they report to us regularly.”



© Santénet2/Ny Tanintsika: The weighing session in Ampasina draws crowds

Success Story: c-IMICI and Community Commitment

A community is willing to compensate a community health worker for her services.

The community of Enakasa, in the rural commune of Ranomfana, has come to appreciate the services offered by their community health worker, Kazy Zafisoa, who specializes in child health.

Kazy is highly motivated in her work: she is always available to see children under five years old in her *fokontany*, spending most of the day's hours in service to her community. In addition to providing counseling, she also treats sick children and is effective and trusted by the community in this role.

In April and June 2012, she managed 92 cases of malaria, 9 cases of diarrhea, and 18 cases of pneumonia in children under five. She also assessed children's nutritional status and identified 78 cases of malnutrition.

The people in her *fokontany* are happy with her work and decided that she should be compensated for the time she devotes to serving them. She is now paid 35,000 ariary per month (a little less than 20 USD) and operates from a health hut that the community built.

Kazy is quite an exception: the 12,058 community health workers trained by Santénet2 are all volunteers who have been elected by their communities. The decision to offer Kazy compensation was made during a community meeting convened by the head of the Enakasa *fokontany*—presented and endorsed during the August 2012 assessment of social quality. (These community assessment meetings are used by communities to express their health needs.)

Mosa Manara, the head of the *fokontany*, takes pride in having Kazy in his village. “We are convinced of Kazy Zafisoa's worth for her promotion of child health in our village,” he explains. “Our next objective is to also compensate the community health worker specializing in mother health.”

Each household contributes 200 ariary (about 0.10 USD) per month, collected by the head of *fokontany*. Once this amount is paid, they no longer have to pay for their consultations with the community health worker.

Kazy Zafisoa is happy with this community recognition. With this monthly income, not only is she able to meet her family's needs, but she can also build up her medicine stocks to treat sick children. “I feel encouraged with what the community is doing for me,” she explains. “This does not mean I will stop if they are no longer able to pay me: I just love what I am doing.”



© Santénet2/ ASOS Sud: Kazy Zafisoa used to receiving ill children at the community hut “Toby Mahavotsy” built by community in Enakasa village

With this initiative, the villagers in Enakasa are able to rely heavily on the services of the community health workers. Previously, they had to travel over an hour to find the nearest basic health center.

Enakasa is one of the 11 *fokontany* in the rural commune of Ranomafana, which is located 90 km from Taolagnaro. It has 13,967 inhabitants in 2,972 households. The commune of Ranomafana has six community health workers in charge of child health and five community health workers in charge of maternal health.

Success Story: Family Planning

Julienne Razanamasy: a woman in service to other women in her *fokontany*

The commune of Vohitsaoka with its 11,839 inhabitants, including 3,090 women of reproductive age, is becoming a model in family planning. The use of family planning has significantly increased in this commune as a result of related services that have become more available with the introduction of the Kaominina Mendrika (KM) salama approach by the Santénet2 project (implemented by RTI International). However, improved availability alone cannot account for this change: the community health worker's commitment is a key factor.

Her name is Julienne Razanamasy. This gray-haired woman is very determined to give the women in her *fokontany*, Soasieranana—and also in other *fokontany*—access to family planning methods of their choice. Despite her age, Julienne walks kilometers to reach women who want information on available contraceptive methods. “It is very important that women have a free and informed choice,” she states. This is the reason she uses all her strength to reach everyone who is interested.



© Santénet2/ODEFI Julienne Razanamasy is always happy to serve her clients.

Within months after her training as a community health worker, Julienne is known to all the women over 25 in her *fokontany*. At some point in time, they have all come to see her. The number of clients she sees increases almost every month. In January 2012, she had 355 clients, and by July 2012, the number had risen to 419. And all of Julienne's clients come back every month for their monthly follow up.

“It's a real relief for me to have Julienne here,” notes Dr. Volatiana Isabelle Raharimalala, head of the basic health center in the commune of Vohitsaoka and supervisor of community health workers. “She manages all monthly appointments and new clients who show up for family planning visits. And she does not spare herself the pain of walking four hours to submit her monthly activity report to the health center! It really takes courage and love for someone to serve 400 women like she does!”

In the 800 rural communes where the Santénet2 project is implemented, community health workers are providing services as volunteers. Like Julienne, some of them demonstrate extraordinary commitment and willingness to serve their communities. It takes people like them to generate significant impact in terms of use of family planning among women of reproductive age in rural areas.

Success Story: Coaching and Supervision of Community Workers

A portrait of a senior community health volunteer

Edwige Razanantsoa is one of the 5,100 community health volunteers (CHVs) trained by the Santénet2 project under the Kaominina Mendrika (KM) salama approach, to provide family planning counseling and methods to women living more than 5 km from a health facility. She lives in the *fokontany* of Ambalamanarina (in the rural commune of Mahaditra, district of Vohibato), a village that is four hours' walking distance from the nearest health facility. There are 18 CHVs like her operating in the commune.

Since she received training provided by Santénet2 on offering contraceptive methods at the community level in 2009, Edwige has been working with women in her village and is currently providing injectable and oral contraceptives to about 80 women. This is a fairly large number when compared with the average 27 clients that each CHV serves per month.



© Santénet2/ODEFI : Edwige Razanantsoa (framed) with CHV from Ankaromalaza, a commune without a CSB near Mahaditra commune

Given her outstanding performance, Edwige has become a model for the other CHVs in her commune, and even in the neighboring commune of Ankaromalaza, where nine other CHVs work. She has been appointed team leader and coach of 27 CHVs working in both maternal and child health.

Edwige shares her experience and work methods with her fellow CHVs, who respect her and take to heart the advice she gives. The head of the commune's health facility (CSB, *centre de santé de base*) also values her experience; Edwige works at the CSB as a volunteer from time to time.

Dieu Donné Randrimiharisoa, the support technician from the nongovernmental organization ODEFI, one of Santénet2's partners in the region of Haute Matisatra, admires Edwige's dedication to her work. "She handles all the monthly activity reports from the 29 community health workers in the communes of Mahaditra and Ankaromalaza. She reviews them and makes corrections, as needed, before they come to me. I really appreciate her organization because she corrects errors and is always trying to help others," emphasizes Dieu Donné.

For Santénet2, supervision and coaching of CHVs is crucial to ensuring and maintaining the quality of community-based health services. People like Edwige Razanantsoa are special assets for the project in working to sustain the activities initiated.

Success Story: Maternal Health

The rural commune of Vohilengo—better prepared for health evacuations

Vohilengo, a rural commune in the district of Fenerive Est, is surviving despite its isolation. All of the commune's *fokontany* are inaccessible by car due to the lack of passable roads. As a result, access to health care remains a big issue for its 30,768 inhabitants. However, supported by health promotion activities conducted by the Santénet2 project, the community leaders (communal social development committee) and the community health workers are taking action to address this problem, in particular in cases of health emergencies.

The community has made a commitment to facilitate transportation of sick people to basic



© Santénet2/ODDIT. Conception of local evacuation chair in Vohilengo commune

health centers, using a traditional palanquin made of bamboo called a “*filanjàna*.” Each *fokontany* organizes its evacuation system and

builds its palanquin—this initiative takes the mobilization of the entire population, who are now aware of the importance of health care. Symphorose Botou, the support technician from ODDIT,⁷ remembers when she saw men in the *fokontany* of Fandalazina weaving mats to make a *filanjàna* to transport a sick man to the basic health center, almost two hours’ walking distance away. “It took them only fifteen minutes to build the palanquin. It was incredible. The sick person reached the health facility on time, transported by four men,” she states.

The establishment of health evacuation systems is a direct result of the training provided by Santénet2 on obstetric and neonatal emergencies, under which community health workers and villagers were also trained to identify danger signs in pregnant women and newborns.

Ninety-four (94) of the communes where Santénet2 is working have set up health evacuation systems. Decisions relating to these systems are made during community meetings where *fokontany* inhabitants participate. In most cases, the communities use local means such as palanquins, carts, and canoes. Some communes with better



© Santénet2/ODDIT. Transfer of patients from village to CSB

access to road networks use cars. In support of the evacuation systems, solidarity funds have been established in some cases to pay for the people who provide the transportation or for medical costs. Almost 75% of the Malagasy population lives in remote rural areas and are poor. The health evacuation systems are one way to provide them with better access to health services.

⁷ ODDIT is a nongovernmental organization that implements the Santénet2 project in the Analanjirifo region.

Success Story: Supply

Exceptional community-based services in the rural commune of Ivandrika

Arison stands out among community health workers. Based in the rural commune of Ivandrika in the district of Farafangana, he provides women with family planning services as a community health worker but also manages the supply point for drugs in the commune as well as at the health facility.

Arison was trained as community health worker specializing in maternal health at the start of the Santénet2 project and has been providing family planning services in his community since then. He provides follow-up care for about one hundred contraceptive method users.

Women feel encouraged to use a contraceptive method because they know that with Arison in charge, products will always be available.

His strong planning skills, his ability to manage time, and his professionalism have earned Arison the trust of the community (4,519 inhabitants) and of community leaders, who chose him for the job of managing the commune's drug supply point from which community health workers get their supplies. At the same time, he works as the drug dispenser at the basic health facility, a job that he performs in the most professional way according to Onesiphore, the head of the health facility. Onesiphore fully trusts him and describes him as his "right-hand man." Since Arison has been in charge of managing the drug supply, the commune has not had any stock outs; drugs for treating children under five and commodities necessary for women's health have been continuously available, both at the community supply point and at the health center.

USAID/Madagascar's Director Rudolph Thomas was much impressed by Arison's work when he visited Ivandrika in March 2012. Community-based services need highly committed people such as Arison to become sustainable.



© Santénet2/Herilaza. USAID Mission director, Rudolph Thomas (right) welcomes Arison (Child CHV and SP manager) during his visit in Ivandrika in March 2011

Success Story: Water, Hygiene, and Sanitation Ampasy Nahampoana: a pioneer commune in hygiene improvement

The life of the population in the rural commune of Ampasy Nahampoana (2,253 inhabitants, 470 households, and 3 *fokontany*) located 10 km from the town of Taolagnaro has changed quite a bit since November 2011.

In the past, people did not pay much attention to hygiene, as evidenced by the lack of a public shower house or latrines in the commune. The only latrines to be found were at the health center and the public primary school.

The Santénet2 project introduced the community-led

total sanitation (CLTS) approach in the commune to help the population put an end to open-air defecation and improve their hygiene. The change has been “total.”

As part of implementing the approach, commune leaders and members of the commune social development committee were trained on the preparation of project proposals to be submitted to donors supporting development. Ampasy Nahampoana is located in the intervention zone of the mining company Qit Minerals Madagascar (QMM) who supports regional development initiatives.

Since October 2011, with the support of this company, the commune was able to build 90 collective showers and latrines, and 16 standpipes for water, at a rate of one latrine/shower for every 4 or 5 households and one standpipe for every 30 households.

The community contributed to the effort by ensuring transportation of building materials such as bricks, cement, sand, and roofing sheets. QMM funded all the infrastructures, which are managed by the social development committee.

The new facilities have had positive impacts on the community. As practices improved, the population’s health also improved, as evidenced by the lower number of diarrhea cases.



© Santénet2/ASOS :The population at work



© Santénet2/ASOS :Model of a working standpipe for water



©Santénet2/ASOS :A model shower room newly built



© Santénet2/ASOS:A model latrine newly built

Success Story: Gender Approach

The KM salama approach enhances women's status in the rural commune of Savana

Local traditions have been preserved for a long time among the 6,000 inhabitants in the rural commune of Savana in the district of Vohipeno on the eastern coast of Madagascar. Under the Antemoro customs, there is a little if no room for women in community life; their role is limited to taking care of their homes and their husbands and raising children. Even during celebrations, they are limited to the role of child caretakers

while men drink, dance, and have a good time. However, things have been changing since the Kaominina mendrika (KM) salama approach was introduced in this commune, especially its gender component. As a very remote commune, Savana was included in the 800 communes where the Santénet2 project works to set up community-based services. Community health workers were established in the commune and conduct awareness-raising, prevention, and treatment activities to benefit maternal and child health.



© DRV/Community in Savana rural commune where women's power rises more and more

Dinika sy Rindra ho an'ny Vehivavy (DRV), a nongovernmental organization (NGO) partner in the Santénet2 project, has been working in the field to sensitize community leaders in the four *fokontany* on the need to ensure that men and women have equal opportunities in terms of health—to contribute to the development of health-related activities as well as to benefit from NGO support. These messages are further promoted through a local radio station called Akama that is one of Santénet2's partners; every day, it airs messages encouraging men and women equally to take part in health promotion. The radio programs seem to have significant influence on the population's attitude, especially men.

The changes came to light during the last mass circumcision festival in December 2011. Women were able to participate in the celebrations while men took their turn caring for children. For Berson Gobelle, DRV's officer in the district of Vohipeno, this is only a reflection of a bigger change that has taken place, which is men changing their perception of women's roles but also of their own roles—women are increasingly making their voices heard in community meetings in Savana while men, on their end, are getting more involved in family health and have started bringing their wives or children to health facilities. “This is totally new!” marvels Berson Gobelle.

Today, people in the commune of Savana are serious about taking care of their own health. One good illustration is that women deliver at health facilities now with the help of community health workers. Through good practices in raising awareness on the gender aspects related to health, the commune has raised its awareness on gender as it relates to life as a whole.

Annex 5: Communication Strategy

For fiscal year (FY) 2012, the Project communication was focused on strengthening the Project's visibility through the use of various means of technology to reach more targeted populations, including social network and media contacts.

This includes Santénet2 participation in big events and the production of diverse brochures and bulletins on Project programmatic activities.

Achievements of the Project communication strategy are two-fold:

- **Internal communication:**
 - ***Standardization of Project presentation tools:*** The Project team now has a standard tool for all PowerPoint presentations. All employees received continuous training in PowerPoint presentations and training in using these visual tools.
 - ***Meetings:*** Apart from the usual meetings organized with all Project staff at the central level, the Project organizes frequent video conferences to communicate with the regional offices and NGO technicians to ensure a very strict follow-up of all activities conducted under KM salama approach.
- **External communication:**
 - ***The Project's social network page:*** The big innovation of this fiscal year was the launching of Santénet2's Facebook page. This is another communication tool enabling the Project to be known at the international level by reaching a diverse set of Internet users. The Project Facebook page has now 76 likes, composed of national and international members. This page is linked with the US Embassy, USAID Madagascar, UNICEF Madagascar, and RTI International Facebook pages. The link of the Facebook page is below:
 <http://www.facebook.com/santénet2>
 - ***Video documentaries:*** Another major achievement is the production of two video documentaries. The first one concerns community-based health services and the KM salama approach. It was widely broadcast on the national TV. The second documentary deals with the social quality approach in KM salama communes. It was produced with a local consultant and is available in DVD. It was distributed to implementing partners' field technicians to better serve as a capacity-building tool for them to support communities in achieving ownership of community-based health services. This documentary was also distributed to all development partners to share Project best practices and lessons learned in social quality implementation.

– ***Ezaka Mendrika Bulletin:***

Through a new distribution strategy, the quarterly-produced *Ezaka Mendrika* bulletin has reached more targets. During FY 2012, four issues of the *Ezaka Mendrika* bulletin were produced. The November 2012 edition was on water hygiene and sanitation. One special issue was produced on Women’s Day on March 8, 2012. The 8th edition was produced in June 2012 on integrated services for children



© Santénet2: Bulletin *Ezaka Mendrika*, published at the community hut in Ampisokina village

under 5 years old in KM salama communes. The 9th edition will come out in October about community engagement in community huts construction. These bulletins were produced in Malagasy and English. They document all the best practices and lessons learned in community-based health services and share the advancement status of all activities per component with community actors (CHVs and CCDS), USAID, and all development partners.

– ***Collection of success stories:*** Six (6) best practices from strategic program areas, including MCH, RH/FP, malaria prevention, STI/HIV/AIDS prevention and control, and water and sanitation programs were documented and inserted in the 2012 semi-annual report submitted to USAID. Other success stories were published on the new USAID website. A dozen success stories were shared during the Project’s last national coordination workshop in April 2012.

– ***Periodic communication with USAID:***

- Periodic meetings: RTI/Santénet2 participated in periodic meetings with USAID. These meetings are a chance for the Project team to discuss specific topics with USAID that relate to activities implementation in the field. Nine meeting minutes were shared and filed in an internal project archive folder.
- Monthly bulletins: Twelve (12) monthly bulletins were shared with USAID during FY 2012. These bulletins give a general overview on a monthly basis of all activities planned for the coming month by diverse components and programs. These documents are submitted to USAID by the third week of each month.
- Contractual documents: The Semi-Annual Report covering October 2011–March 2012 and the Annual Work Plan for October 2012–July 2013 were submitted to USAID.

- **Media coverage and field trips:** Seven big events, organized and led by Santénet2 during FY 2012, benefited from very comprehensive media coverage. These events were organized to show Project activities, achievements, and impacts. World Day celebrations included Hand Washing Day in November 2011, Toilet Day in March 2012, and World AIDS Day in December 2011. There were also specific events such as the grantees’ manual workshop in November 2011. The USAID Mission Director’s visit in Mahajanga in January 2012 was widely covered by the media.



© Santénet2/USAID Mission Director giving the new baby scale to a CHV in Anjeva Gare

Another ceremony was the official distribution of baby scales to CHVs. It was organized on May 24 in Anjeva Gare, 12 km from Antananarivo, the capital city of Madagascar. Rudolph Thomas, the USAID Mission Director, attended the official ceremony and was very satisfied with that event.



Barbara Kennedy, Global Health Group/RTI International former vice-president, visited the rural commune of Moramanga. This visit was covered by local media as well.

© Santénet2/Barbara Kennedy holding a discussion with a CHV in the Andasibe rural commune

Annex 6: Gender Approach in KM Salama

1. CONTEXTE

The life experience of the average Malagasy woman contributes significantly to gender disparities in health. Reducing these disparities is imperative to any plan to improve health standards in the Madagascar.

Undernourishment among women is an important contributor to low birth weight and infant mortality in Madagascar. Cultural practices that favor men in household decisions about food consumption contribute to women's poor nutritional status. Santénet2 always strived to adequately address these gender-driven deficits. Our capacity building activities as well as behavior change and communication activities include a good understanding of the impact of gender on women's health to tailor services to improve women's access to health care services and information. Birth spacing and reductions in fertility and unwanted pregnancies are perhaps the most significant long-term contributors to women's health and child survival. Moreover, we have also conducted activities to involve men in FP and RH decisions and care.

Over the past fiscal year, Santénet2 continue to invest in community and local actors to create an environment conducive to invest in women beyond providing health services. Women and girls were empowered to have equal say in community decision making. As part of the social quality interventions efforts were strengthened to increase to give women real choices about their reproductive and economic lives. We integrated gender into all aspects of project planning, implementation, and evaluation.

Other key strategies we will employ are:

- **Collecting and analyzing gender based data.** We have integrated gender dimension in our C-HMIS since the inception of the project. Data related to CHV training and supervision; CHV services, community leaders were collected by gender to diagnose and recommend enhancements to improve responsiveness to gender issues.
- **Integrating women's voices into community dialogue fora.** Social quality initiative have permitted effective women participation in community assessment of health needs. The initiative ensured women have an active say in assessing needs and proposing solutions and for holding community actors accountable for implementing them. The initiative aimed also activities in ways that promote improved gender equity.

2. ACHIEVEMENTS IN TERMS OF GENDER INTEGRATION IN SANTÉNET2 PROJECT

Gender integration successes in Santénet2 project are :

- ü A better access of women in decision making positions
- ü An opportunity for women to participate in community meetings
- ü A better access to health services

Table 14: Profile of actors with USAID/Santénet2 project, 2009 - 2012

Actors	Men	Women
Direct assistance level		
Field technicians and zone supervisors	69%	31%
Independent trainers	56%	44%
At KM salama level		
CCDS	82%	18%
Gender facilitators	19%	81%
Supply point managers	59%	41%
Young leaders	51%	49%
CHVs	43%	57%
Mysterious listeners ⁸	13%	87%

Sources: Santénet2, List of NGO's field technicians and independent trainers, attendance forms, Extranet, list of mysterious listeners.

§ An opportunity for women to participate in community meetings

In 3,417 *fokontany*, more than 300,000 participants are engaged in community evaluation meetings on health services and on men and women's responsibilities for their health: which is an average of 395 persons per commune. In total, more than 150,000 women could express their needs. Participation rate of women varies from 44% à 66%, which is an average rate of 53%.

During Community Score Card⁹ (CSC) application, the average number of participants during community evaluation meetings is of 78 persons per commune. The participation rate of men is 65% and 35% for women.

Hence, the women ratio participation is completely reversed with the application of social quality in the KMs. Then, there are now five times more participants during these meetings compared to CSC application period.

⁸ Mysterious Listeners = Persons in charge of following radio spot broadcasts secretly in KM salama communes.

⁹ CSC = World Bank pilot project in Anosy region in October- December 2008.

Annex 7: List of Tools Distributed

Code	Tools	Quantity
CDS/03	CCDS guide	12674
CDS/04	JOB AID CDS/UON	12674
CLTS/01	FTTF Brochure	120
CLTS/02	Support technician's FTTF monitoring	350
CLTS/03	FTTF monitoring	1500
CLTS/05	Result of the CLTS initiation	1500
DPC/01	DEPOCOM trainers' booklet (mother)	9
DPC/03	CHVs' document	900
DPC/04	Drugs to be injected for FP	906
DPC/06	FP individual form	2545
DPC/07	MANOME	1570
DPC/08	DEPOCOM Check list	1268
DPC/09	Data collection form for CHVs	1184
DPC/11	Calendar	7058
DPC/12	Training assessment format	1826
DPC/13	Practical training validation form	1319
DPC/14	DEPOCOM JOB AID	1280
DPC/15	Pre/post test form	2433
HYG/01	Malagasy version of Poster: Health activities on Watsan, latrine use	2000
HYG/02	Malagasy version of Poster: Health activities on Watsan, washing hands with soap, healthy child	2000
HYG/03	Malagasy version of Poster: Health activities on Watsan, washing hands with soap, healthy child	1000
HYG/04	Counseling card SODIS	2000
HYG/06	Counseling card; Waste management	2000
HYG/07	Counseling card; Washing hands with soap	1000
HYG/08	Invitation card; Drinking potable water	5757
HYG/09	Invitation card: Using washable latrine	4848
HYG/10	Invitation card: Washing hands with soap	3576
HYG/11	Evaluation of Watsan ny asa vita momba ny rano ataon'ny "Structure en charge"	1900
HYG/12	WASH-friendly CHV Follow-up form	2691
HYG/13	WASH-friendly CHV certificate	5351
DPC/EQ/01	Simple syringe	1316
DPC/EQ/02	Alcohol	1245
DPC/EQ/03	Cotton swabs	1248
DPC/EQ/04	Towel (big size)	1158
DPC/EQ/05	Nail Brush	1822
SR/NUT/EQ/01	Backpack	523
SR/NUT/EQ/02	Blouse	15
SR/NUT/EQ/03	Rain coat	115
SR/PF/EQ/01	Winnowing basket with FP methods	14
PCM/EQ/01	Navy blue cap	587

Code	Tools	Quantity
PCM/EQ/02	Honeycomb weave towel	545
PCM/EQ/03	Soap	1850
PCM/EQ/04	Basin	598
PCM/EQ/05	Beaker 250ml	1133
PCM/EQ/06	Beaker 1l	509
PCM/EQ/07	Teaspoon	564
PCM/EQ/08	Spoon	671
PCM/EQ/09	Pail 12 l	255
PCM/EQ/10	Timer	751
NUT/EQ/01	Brachial perimeter	326
PCM/EQ/11	Baby scale	2920
DPC/EQ/06	Safety box	767
MRP/01	SW brochure	508
MRP/02	MSM pamphlet	144
MUT/01	Premium collection register	974
MUT/02	Premium payment receipt form	974
MUT/03	Membership form	1859
MUT/04	Health Mutuelle poster	2477
MUT/05	Health Mutuelle invitation card	50605
MUT/09	Cash journal	90
MUT/10	Forecasting revenue/expenditure per month	180
MUT/11	Membership card	22500
MUT/12	Ordinance facture	1402
MUT/13	Health center monthly invoice	228
NUT/01	CHV's document	256
NUT/02	Booklet of Child Health CHVs	1
NUT/03	Table of danger signes	256
NUT/04	Pre/post test form	827
SIG/01	Awareness raising register	5530
SIG/02	Referral form	1729
SIG/03	Supply register	6760
SIG/04	Monthly activity report	12407
SIG/05	CHV individual form	540
SIG/06	Mother register	2783
SIG/07	Child register	2207
SIG/11	Supervisor self-evaluation tool	313
SIG/12	Level 1 CHV supervision grid	708
SIG/13	Supervision grid C-CHV1	346
SIG/14	Supervision grid M-CHV1	448
SIG/15	Supervision grid M-CHV2	541
SIG/16	Supervision report C-CHV1	572
SIG/17	Supervision report C-CHV2	328
SIG/18	Supervision report C-CHV2	845
SIG/19	Invoice/ delivery slips	149
SIG/20	Purchase order (supply point)	152

Code	Tools	Quantity
SIG/21	Supply point stock card	242
SIG/22	Additional child register	5608
SIG/23	Field technician supervision tool	4738
SIG/24	Field technician compilation of supervision tool	4738
PCM/01	Participant's guide	715
PCM/03	C-IMCI training of trainers' program	3
PCM/04	Pre-report form	796
PCM/05	Pneumonia management technical form	782
PCM/07	Trainee CHV's individual monitoring form	309
PCM/08	Case management form	32420
PCM/12	Guide for grouped monitoring of CHVs	316
PCM/13	RDT use curriculum	696
PCM/14	RDT job aid	597
PCM/15	C-CHV job aid	2016
PLR/01	FBO Brochure	24
SR/PF/01	Guide on general health for CHVs in charge of sexual health	173
SR/PF/03	Pregnancy Checklist	376
SR/PF/04	Sticker	190
SR/PF/05	Pre/post test form	532
SR/PF/06	Monthly pre-report form for FP	306
SR/PF/07	Individual FP form	942
SR/PF/08	Blue Poster	260
SR/PF/09	Green poster	510
SR/PF/10	Red tickler for CHVs	656
SR/PF/11	Blue tickler for CHVs	320
SR/PF/12	FP JOB AIDS	354
SRA/01	Young leader's guide	1394
SRA/02	Young leader's activity report	256
SRA/03	ARH follow-up tools	110
TRS/01	Health booklet	32415
TRS/02	CHV certificate	2500
TRS/03	Integrated fact sheet	545
TRS/04	Pregnant woman and new born form	5295
TRS/05	Pregnancy checklist	5342
TRS/07	Supervision booklet	619
TRS/08	Guide SL/Fl	1294
TRS/09	Guide for support technician	155
TRS/10	Manual for CHV	12441
TRS/11	Manual for CDS	13625
TRS/12	Community evacuation form/Community investigation report	15850
TRS/13	Compilation of community review form/	1628
TRS/14	CCDS self-evaluation form/CCDS evaluation form	1628
TRS/15	Community action plan	1628
UON.COM/04	Plan for session F9	352
UON.COM/06	Pre-post test F9	7312

Annex 8: List of Tools Produced

Code	Tools	Quantity
CDS/03	JOB AID CCDS	14200
CDS/04	C-ONE CCDS/JOB AID	14200
CLTS/05	Results of the initiation of CLTS	3220
DPC/03	CHVs' document	1050
DPC/06	FP individual form	1500
DPC/08	Depocom Check list	1100
DPC/09	Data collection form for CHVs	200
DPC/11	Calendar	5300
DPC/12	Training evaluation form	350
DPC/14	DEPOCOM JOB AID	1100
DPC/EQ/01	Syringe simple	1200
DPC/EQ/02	Alcohol	1470
DPC/EQ/03	Cotton swabs	1300
DPC/EQ/04	Towel (big size)	1430
DPC/EQ/05	Nail brush	1830
WATSAN/11	Malagasy version of Watsan activity follow-up by structure in charge	1850
WATSAN /12	WASH-friendly CHV Follow-up form	2630
IMCI/01	Participant's guide	500
IMCI/04	Pre-report form	170
IMCI/05	Pneumonia management technical form	10
IMCI /13	RDT use curriculum	450
IMCI /14	RDT job aid	170
IMCI /15	CHV Level 2 job aid	3850
IMCI /EQ/01	Navy blue cap	470
IMCI /EQ/02	Honeycomb weave towel	460
IMCI /EQ/03	Soap	2110
IMCI /EQ/04	Basin	460
IMCI EQ/05	Beaker 250ml	460
IMCI /EQ/06	Beaker 1l	480
IMCI /EQ/07	Teaspoon	520
IMCI /EQ/08	Spoon	550
IMCI /EQ/09	Pail 12 l	160
IMCI /EQ/11	Baby scale	3000
HMIS/01	Sensitization register	6500

Code	Tools	Quantity
HMIS /02	Referral form	1500
HMIS /03	Supply register	7000
HMIS /04	Monthly report form	10000
HMIS /06	Mothers' register	1800
HMIS /07	Children's register	5850
HMIS /11	Supervision grid C-CHV1	500
HMIS /12	Supervision grid C-CHV1	650
HMIS /13	Supervision grid M-CHV1	500
HMIS /14	Supervision grid M-CHV2	100
HMIS /15	Supervision report C-CHV1	650
HMIS /16	Supervision report C-CHV2	1000
HMIS /17	Supervision report M-CHV1	750
HMIS /18	Supervision report M-CHV2	1000
HMIS /22	Additional child register	5700
HMIS /23	Field technician's supervision tool	4800
HMIS /24	Compilation of Field technician's supervision tools	4800
RH/FP/03	Pregnancy checklist	100
RH/FP /09	Green poster	2600
RH/FP /10	Red tickler	420
RH/FP /11	Blue tickler	235
RH/FP /12	FP job aid	200
RH/FP /EQ/01	Winnowing basket with FP methods	100
TRS/01	Health booklet	80000
TRS/02	CHV certificate	2400
TRS/03	Integrated fact sheet	300
TRS/04	Maternal and child health fact sheet	5500
TRS/05	Sensitization form for pregnant women	8000
TRS/06	Strengthening the link between CHV and CSB Guide	1200
TRS/08	Local supervisor's guide/FI	1285
TRS/09	Field technician's guide	158
TRS/10	CHV manual	12158
TRS/11	CCDS manual	12856
TRS/12	Community evacuation form	16200
TRS/13	Compilation form of community reviews	1600
TRS/14	CCDS self evaluation form	1600
TRS/15	Community action plan	1600
C-ONE/04	Session guide F9	361
C-ONE/06	Pre-post test F9	6600

Code	Tools	Quantity
MUT/03	Membership form	2000
MUT/11	Membership card	25000
MUT/01	Fee booklet	1000
MUT/02	Fee receipt	1000
MUT/10	Receipt of revenue/expenditure	800
MUT/04	Health <i>mutuelle</i> poster	2500
MUT/05	Health <i>mutuelle</i> invitation card	50000
MUT/09	Cashier journal	800
MUT/12	Ordinance facture	1000
MUT/13	Monthly invoice	250
WATSAN/13	Wash-friendly CHV certificate	4800

Annex 9: Spot Broadcasts per Theme and per Radio Station

CODE	THEME
1	ACT
2	Exclusive maternal breastfeeding
3	Antenatal care
4	Folic Iron Acid
5	Gender and Planning
6	Acute Respiratory Infection
7	KM salama approach
8	Latrine
9	Nutrition
10	Adolescent Reproductive Health
11	Immunization
12	Health <i>mutuelle</i>
13	Social Quality
14	CHV promotion
15	Diarrhea prevention/Latrine use
16	ANC package

Radio	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	TOTAL
RNA	24	12	12	12	12	12	13	24	24	36	12	0	19	46	56	72	386
Radio Lazan'ny Ladoany	102	70	23	20	61	24	24	94	27	51	20	0	19	48	75	135	793
Radio 2000	48	48	24	14	17	12	12	12	12	12	12	0	12	12	60	24	331
RDB	36	36	12	12	12	12	12	36	12	60	24	0	24	0	48	66	402
JRDB	46	14	4	16	16	26	20	19	20	20	19	0	35	33	35	73	396
RNM VTM	74	40	12	12	0	24	24	72	12	36	0	295	12	40	118	36	807
Radio Maromaniry	60	36	18	12	12	12	12	48	12	36	24	0	24	49	75	73	503
Radio Akon'Analanjorofo	195	36	12	12	12	22	12	171	12	112	12	0	333	352	309	429	2031
Radio Akon'ny Nosivolo	52	36	8	12	12	12	12	36	12	36	16	0	12	38	56	74	424
Radio Feon'ny Mangoro	56	36	12	12	12	12	12	37	12	37	24	0	24	48	60	77	471
Radio Feon'ny Toamasina	59	36	12	12	12	13	16	37	12	49	20	6	24	48	64	103	523
LAFA	122	72	24	24	24	33	24	24	24	74	24	0	72	98	55	48	742
CACTUS	93	12	12	12	29	24	24	24	24	53	24	0	24	53	99	60	567
JOSVAH	103	12	12	12	17	24	24	44	25	67	26	0	67	94	88	69	684
KALETA	60	36	12	12	24	12	12	12	12	36	24	0	48	48	72	60	480
MANDROSO	84	12	12	0	12	0	0	12	12	36	24	0	28	50	98	62	442
Radio Pangalane	64	42	8	12	24	12	12	48	12	48	24	20	24	47	98	67	562
Radio Feon'ny Mania	54	36	12	56	44	31	80	94	69	56	12	198	70	92	80	98	1082
Radio AINGA	0	0	0	0	0	0	0	48	0	48	0	490	0	0	143	48	777
Radio Akon'ny Tsienimparihy	56	16	13	113	19	12	12	105	72	66	69	238	81	71	240	190	1373
RAKAMA	109	85	25	24	24	30	74	73	79	81	24	0	46	25	66	236	1001
Mampita	78	90	11	24	16	12	10	94	23	127	66	5	36	67	172	92	923
Radio Sakatovo	60	24	12	12	24	12	12	36	12	48	24	0	24	76	90	48	514
Radio Tea Longo	48	24	12	12	25	14	14	38	12	53	24	0	24	72	72	48	492
Radio Soatalily	36	153	9	28	15	0	1	77	12	61	24	0	50	59	102	41	668
Feon'ny Linta	38	27	28	0	16	14	24	23	14	49	53	0	1	57	19	18	381
Radio AVEC	24	9	0	0	0	5	5	15	5	10	5	0	4	20	5	5	112
Radio Sakaraha	52	24	24	12	24	12	0	40	12	50	24	0	36	74	98	60	542
TOTAL	1833	1074	375	499	515	428	497	1393	586	1448	654	1252	1173	1717	2553	2412	18409

Annex 10: Service Packages Offered by Health *Mutuelles*

	CSB	District level hospital
Vatomandry	<ol style="list-style-type: none"> 1- Les consultations externes 2- Hospitalisation de plus de 24 heures 3- Les soins et accidents involontaires 4- Small surgeries 5- Sanitary evacuation, only with medical reference from CSB 	<ol style="list-style-type: none"> 1- Hospitalisation au service médecine et pédiatrie: Paludisme grave, Diarrhée et déshydratation, Toxi infection alimentaire collective (TIA) et ICAM, sauf suicidaire et éthylique, Maladie chronique et Cardiopathie (pour le premier traitement d'un nouveau cas seulement), Affection digestive, IRA, RAA 2- Gynéco-obstétrical : OC, GEU, Affection génito urinaire, Grossesse et maladie 3- OPHTA-STOMATO : Accident, Opération cataracte 4- CHIRURGIE : Traumatisme , Hernie, Spléno , Appendicite, Goitre, Prostate, Lithiase biliaire, Abscès chirurgical 5- LABO – RADIO –ECHO
Ambohimahaso	<ol style="list-style-type: none"> 1- Tout traitement <ul style="list-style-type: none"> - Les consultations externes généralistes - La fourniture de médicaments 2- Hospitalisation locale au sein du CSB 3- Les soins <ul style="list-style-type: none"> - Les soins infirmiers préventifs et curatifs (soins de routine) - Routine accidents 4- Delivery : Eutocique, Dystocique, évacuation 	<ol style="list-style-type: none"> 1- Hospitalisation pour tout type de maladie : 2- Urgence : médicale et chirurgicale, pour les premiers soins uniquement 3- HTA/AVC 4- Accouchement dystocique 5- Traumatisme 6- ANC
Ambalavao	<ol style="list-style-type: none"> 1- Les consultations externes généralistes Les médicaments sont limités aux médicaments génériques existants Les maladies chroniques sont prises en charge pour les MEG existants seulement 2- L'accouchement <ul style="list-style-type: none"> o Eutocique (MEG) o Dystocique 3- Tous les soins (MEG et consommables existants) 4- Mise en observation (MEG et consommables existants) 	<ol style="list-style-type: none"> 1- Consultation Externe de référence 2- Hospitalisation pour les maladies suivantes : Poly traumatisme, Hémorragie digestive, Gastro entérite, Brancho pneumopathie, Intoxication, HTA / AVC, Paludisme grave, Convulsion, autres pathologies 3- Accouchement : eutocique, dystocique, avortement spontané uniquement 4- Urgence : médicale et chirurgicale : pour les premiers soins, actes et médicaments 5- Santé bucco-dentaire 6- Evacuation sanitaire vers CHU : frais de transport , soins pré transferts
Ambositra	<ol style="list-style-type: none"> 1- Les consultations externes : Y compris premiers traitement des maladies chroniques pour le premier cas (Traitement d'une durée de 5 jours au maximum) 2- Mise en observation moins de 72h 3- Les soins et accidents involontaires 4- Accouchement 5- Consultation Pré natale (CPN) 6- Evacuation sanitaire au CHRR, uniquement sous référence médicale du CSB 	<ol style="list-style-type: none"> 1- HOSPITALISATION AU SERVICE MEDECINE pour toutes maladies Pour les maladies chroniques : prise en charge d'un cas par an Pour les nouveaux cas : prise en charge par hospitalisation 2- CHIRURGIE pour toutes maladies 3- OPHTALMOLOGIE : toute maladie sauf lunetterie

Annex 11: Health Mutuelle – Examples of Follow-up Indicators – Vatomandry District

(CSB) Diseases	Number of new cases							Total	Referred
	0 - 28j	29j - 11m	1 - 4 years	5 - 14 years	15 - 24 years	>25 years			
Diarrhea (Di) sans déshydratation	1	505	620	188	180	231	1 725	4	
Dysentérie (Dy) sans déshydratation		60	138	179	256	404	1 037		
(Di) et (Dy) avec déshydratation		22	19	7	3	13	64	2	
Cough or cold	53	1 236	1 850	1 206	839	1 498	6 682	6	
Pneumonia	3	144	185	73	45	86	536		
Acute Pneumonia	2	22	28	1	1	10	64	8	
Other ARI	7	237	518	425	388	817	2 392	3	
Simple malaria		230	1 799	2 688	840	868	6 425	80	
Suspicious cough of tuberculosis				2	17	98	117	59	
Coqueluche							0		
Eruptions morbilliformes (vaccinés en VAR)				4			4		
Eruptions morbilliformes (non vaccinés ou inconnus)	1				1		2		
Tétanos							0		
Ecoulement génital				16	401	401	818		
Ulcération génitale				7	146	208	361	1	
Suspicion of HIV infection					1		1		
Méningite							0		
Parasitoses intestinales		153	849	547	300	374	2 223	1	
Suspicion de cysticerose							0		
Suspicion de rage humaine							0		
Affections cardio-vasculaires			2	11	25	76	114	11	
Affections cutanées	28	212	434	265	202	384	1 525	7	
Affections bucco-dentaires	2	41	66	123	169	218	619		
Affections de l'oeil et de ses annexes	25	75	82	74	78	176	510	11	
Affections digestives	5	79	231	353	537	1 085	2 290	28	
Affections ostéo-articulaires		2	3	55	238	821	1 119	15	
Affections mentales et troubles psychiques			4	5	14	22	45	2	
Affections neurologiques		2	14	14	25	49	104	14	
Asthme		8	60	76	61	159	364	1	
Hypertension artérielle					28	527	555	5	
Ears Affections de l'oreille		10	29	60	48	76	223	1	
Malnutrition	1	19	69	14	5	5	113	13	
Spasmophilie			3		6	9	18		
Suspicion de diabète					1		1		
Suspicion de drépanocytose							0		
Traumatismes	1	13	70	190	271	394	939	27	
Other pathologies pathologies	17	187	553	687	1 092	2 071	4 607	145	
TOTAL	146	3 257	7 626	7 270	6 218	11 080	35 597	444	

(CHD) Illnesses	Number of new cases								referred
	0 - 28 j	29 j - 11 m	1 - 4 ans	5 - 14 ans	15 - 24 ans	25 ans et plus	Total	%	
Diarrhée avec déshydratation sévère d'origine bactérienne		6	7		5	13	31	2,3	
Dysentérie avec déshydratation sévère		1	3				4	0,3	
Fièvre typhoïde								0,0	
Pneumonie grave			1	1			2	0,2	
Paludisme simple		1	1	7			9	0,7	
Paludisme grave et compliqué		3	44	71	35	43	196	14,8	2
Rougeole compliquée								0,0	
Tétanos								0,0	
Coqueluche								0,0	
Malnutrition grave		2	6	2			10	0,8	
Tuberculose						1	1	0,1	
Accidents								0,0	
Traumatismes				1		1	2	0,2	1
Intoxications			5	5	5	7	22	1,7	
Diabète								0,0	
Spasmophilie								0,0	
Autres maladies métaboliques et endocriniennes					1	4	5	0,4	
Maladies neuro-psychiques		4	3	4	5	2	18	1,4	3
Affections ORL-O		1			4	11	16	1,2	
Maladies de la peau		6	2	2	2	6	18	1,4	
Appareil locomoteur non traumatique			1	1	1	10	13	1,0	
Affections rénales et génito-urinaires			3			5	10	1,4	
Asthme et allergies respiratoires					4	6	10	0,8	
Autres affections de l'appareil respiratoire	1	18	33	31	31	99	213	16,1	18
Hypertension artérielle					1	45	46	3,5	1
Accident vasculaire cérébral								0,0	
Autres affections cardio-vasculaires					1	4	5	0,4	
Ulcère gastro-duodéal					8	26	34	2,6	
Autres affections digestives	2	11	32	22	8	76	151	11,4	2
Ecoulement génital								0,0	
Ulcération génitale								0,0	
Suspicion de l'infection à VIH								0,0	
Méningite								0,0	
Suspicion de cysticercose								0,0	
Suspicion de rage humaine				1			1	0,1	
Drépanocytose								0,0	
Autres pathologies médicales	5	18	41	71	92	275	502	37,8	12
TOTAL	8	71	182	219	208	639	1 327	100,0	39

Annex 12. Activity Reports during Malaria Outbreaks in the Districts of Bekily and Ambovombe

Reporter: Dr Haja Andriantsoa (Zone supervisor in Bekily district)

I- Background :

A threat of abnormal malaria outbreak occurred in Bekily district at the end of April 2012. This happened after incidencies of tremendous fever tested positive with RDT in Antsely commune. Lots of fever cases tested positive were noticed afterwards at the fokontany level during fiels visits organized by the CSB chief in the Bekitro, Beteza and Beraketa communes. For Ambovombe district, incidencies of malaria outbreaks are detected in some fokontany of Antanimora sud, Andalatanosy and Ampamata communes.

II-Intervention KMSalama and Palu GF7 teams

Due to this emergency situation, the KMSalama program manager in the Bekily district went for a field trip in Bekily zone in May 8th 2012 with the assistance of the PALU GF7 program. This trip was organized to coordinate the response strategy with the existing health system at the distrist level. A coordination meeting was organized thereafter in May 9th 2012 with the participation of all health partners working in the district including regional health service of Androy, team from district health center of Bekily, Unicef representative, Médecin Sans Frontière team, Santénet2 team and palu GF7 team in the district. It was agreed that a Santénet2/Palu GF7 team composed of one doctor zone supervisor, 3 field technicians from ASOS Sud, Santénet2 implementing partner (Clotilde, Nenette , Nehemia) will take part in the response strategy according to the team organization based on the zone affected with the malaria outbreak. The role of was to ensure the information flow at the health district office of Bekily on the epidemiologic situation, to mobilize community health workers to strengthen health centers in conducting a mass detection of fever at the fokontany level and to assist the mobile teams that are conducting in parallel a mass screening of malaria cases in other fokontany and in the health center level.

The intervention was organized as follows:

Date	Locations	Responsible	Activities conducted
May 9, 2012	Bekily	All partners in the health sector	Coordination meeting to define the response strategy and the management of health products as well as human resources
May 10–20, 2012	Beraketa	Field technician Clotilde with CSB, MSF, UNICEF	-Epidemiologic surveillance and communication -Mass screening of fever cases and case management of malaria cases at the CSB level -Community health volunteers' mobilization to assist mobile teams in conducting a mass screening of fever cases at the <i>fokontany</i> level
	Bekitro	Dr Haja KM Salama with CSB, MSF, UNICEF	
	Beteza, Antsakoamaro	FT Nenette, Nehemia with CSB, MSF, UNICEF	

IV- Interesting notes :

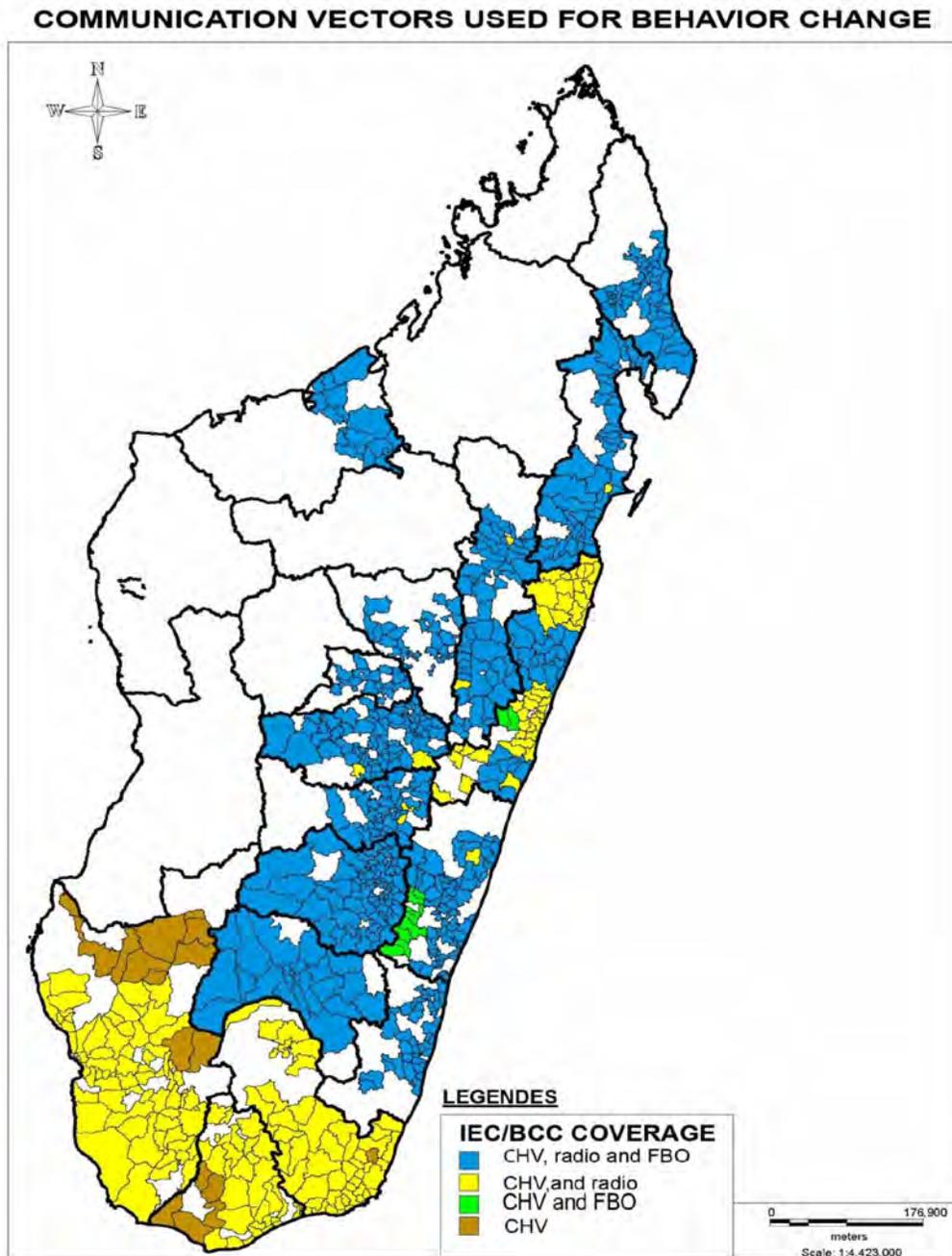
Community health workers in the zones affected by malaria outbreaks actively participated in the mass screening of fever cases activities among children under five. They helped also the mobile health team in managing the positive cases of big children and adults by prescribing medicines for these age groups. According to the SSD Bekily team, the assistance of community health workers was very important and worth to manage the whole situation. Their performance and skills during the intervention mostly in RDT use were worth noticing during these malaria outbreaks period.



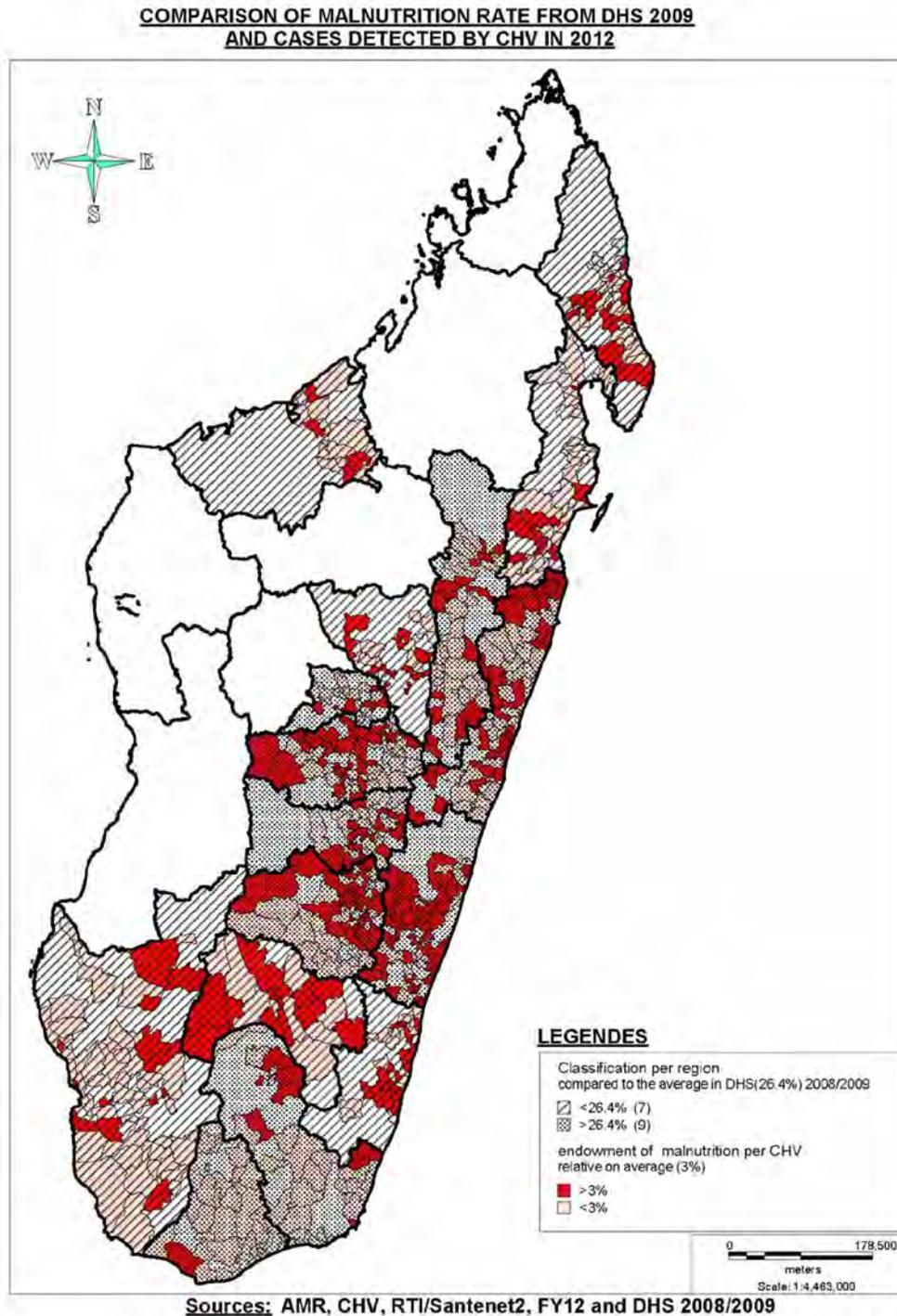
Child Health CHV, *fokontany*: Ankilimiary and Betakapaky, rural community of Bekitro.
Screening of malaria cases in Betakapaky.
Photo: Haja ASOS, May 2012

Annex 13: Maps showing project achievements

Map 1: IEC/BCC coverage in the 800 KM salama communes

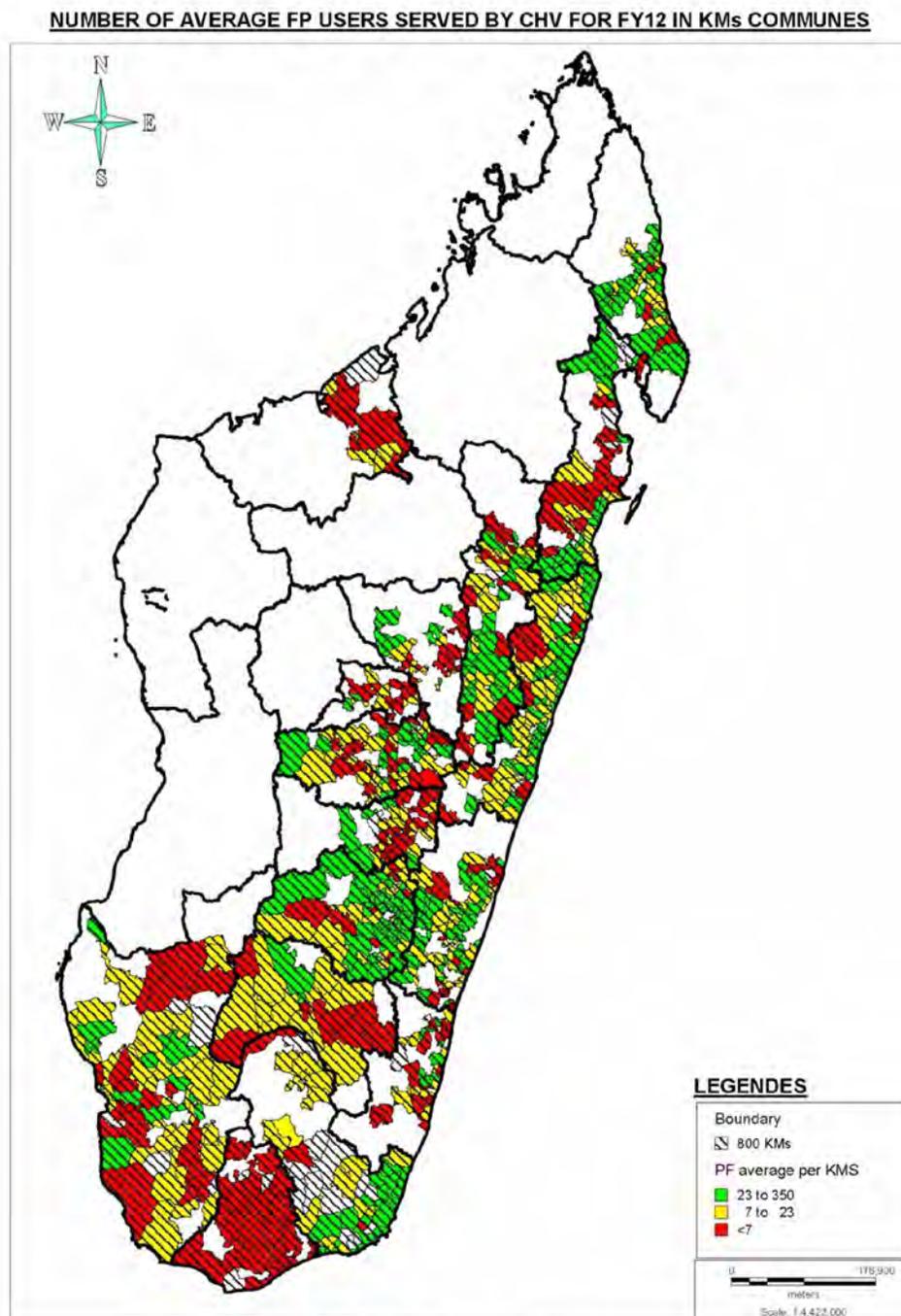


Map 2: Comparison of malnutrition rate from DHS 2009 compared to CHV detected cases in 2012



Map 3: Family Planning

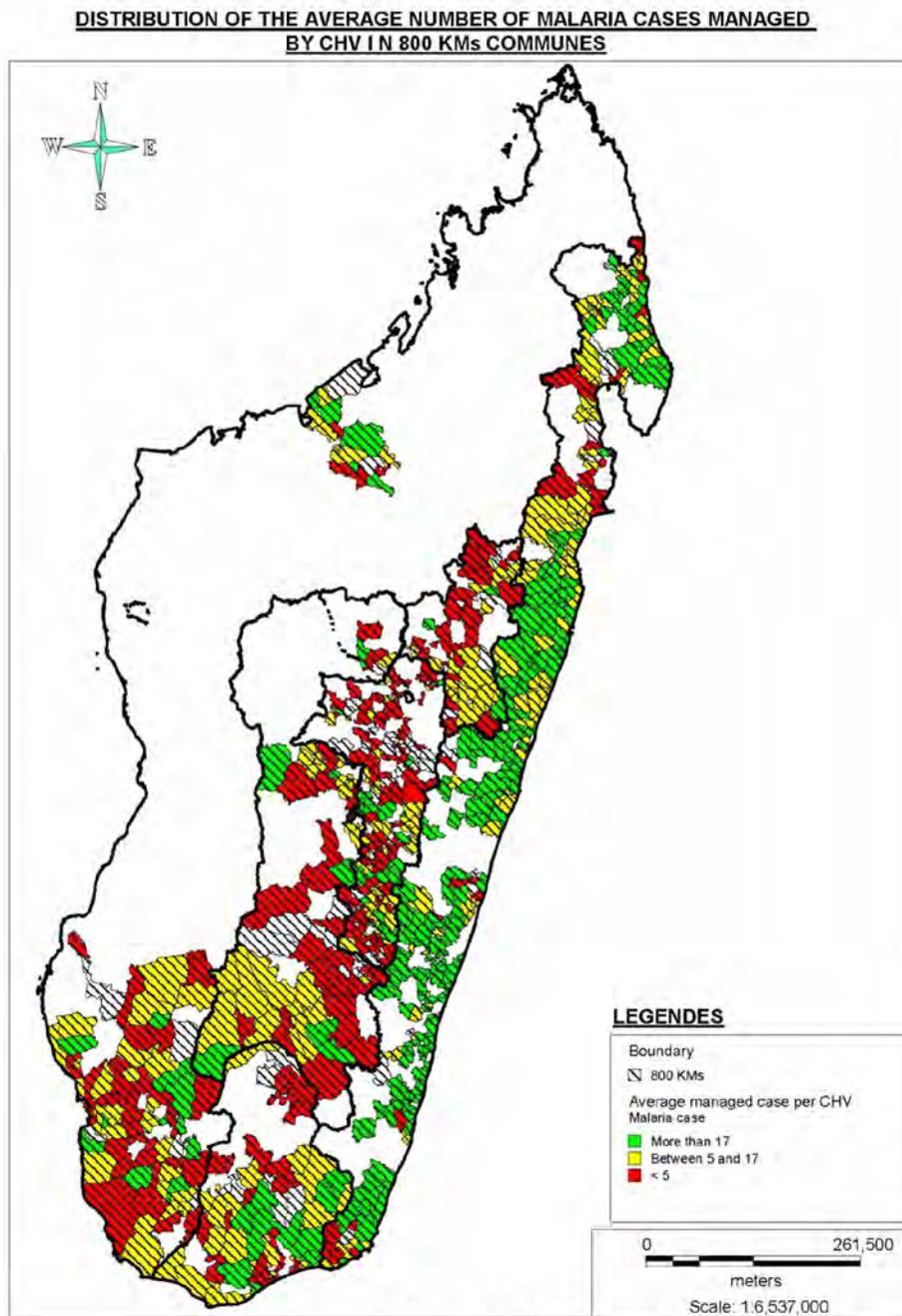
This map shows the distribution of FP regular users (number served by CHV) in the 800 KM salama communes. CHV Regular users vary from 1 to 350



Sources: AMR, CHV, RTI/Santenet2, FY12

Map 4: Fever case management in KMs commune

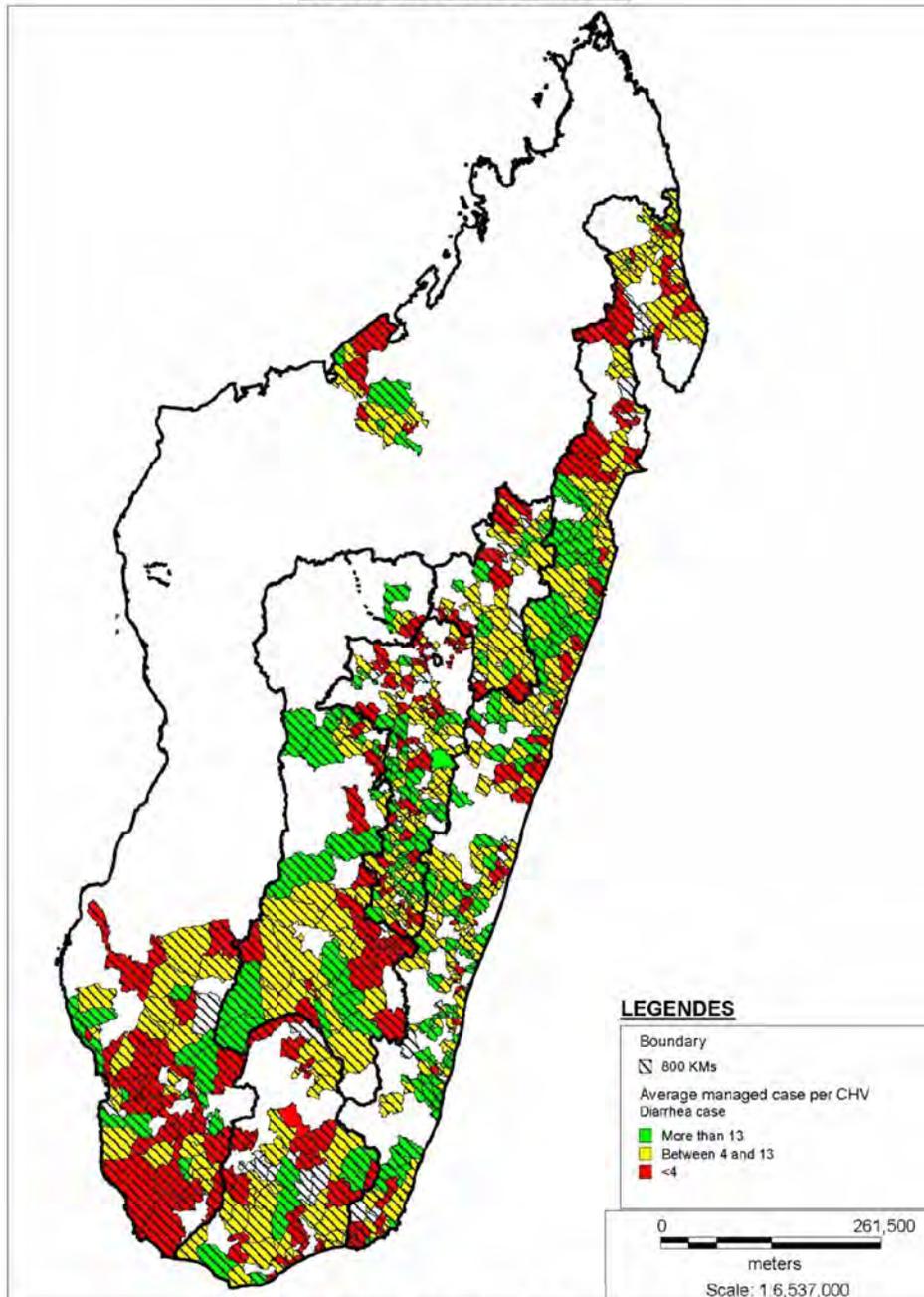
This map shows the distribution of fever cases (average number of cases managed by CHVs) in the 800 KM salama communes. In the eastern zone, fever cases are the primary cause of consultations with CHVs. The annual number of cases seen per CHV ranges from 17 to 421.



Sources: AMR, CHV, RTI/Santenet2, FY12

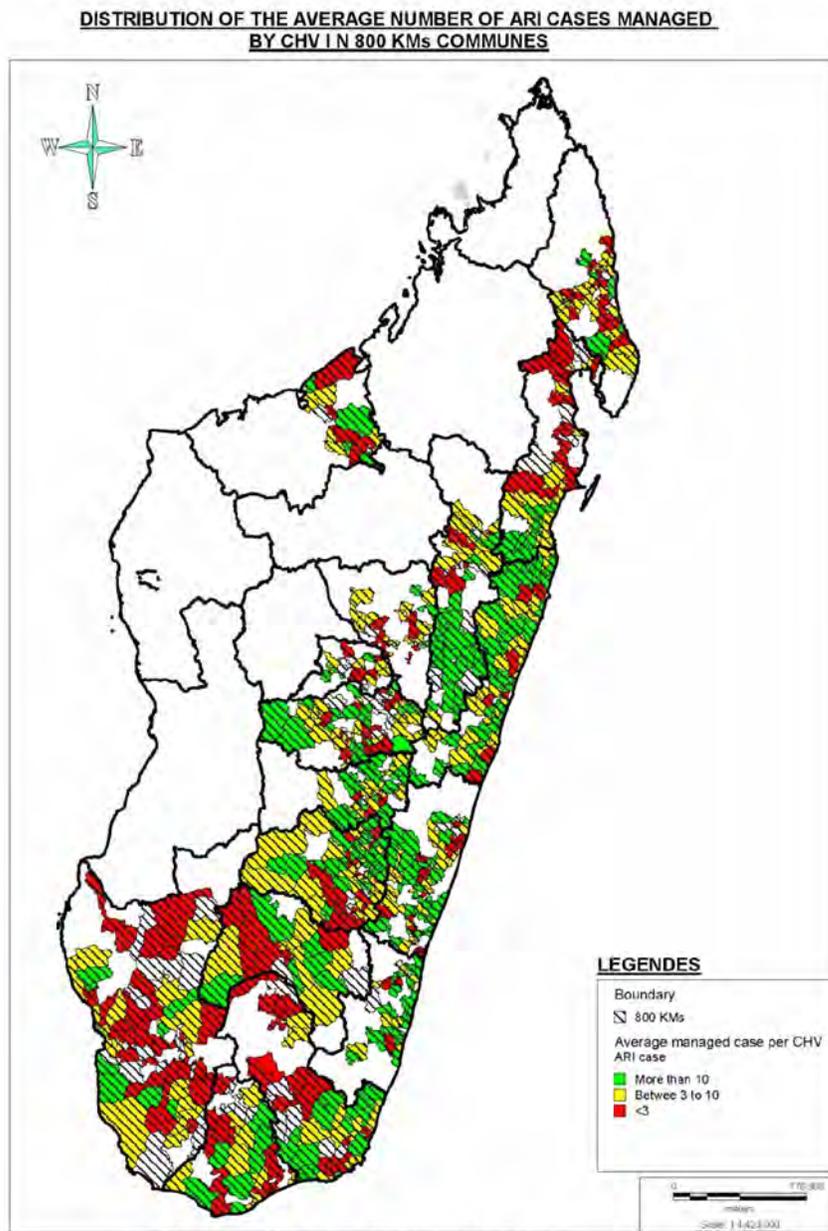
Map 5: Diarrhea case management in KMs communes
This map shows the distribution of diarrhea cases (average number of diarrhea cases managed by CHVs) during FY 12.

**DISTRIBUTION OF THE AVERAGE NUMBER OF DIARRHEA CASES MANAGED
BY CHV IN 800 KMs COMMUNES**



Sources: AMR, CHV, RTI/Santenet2, FY12

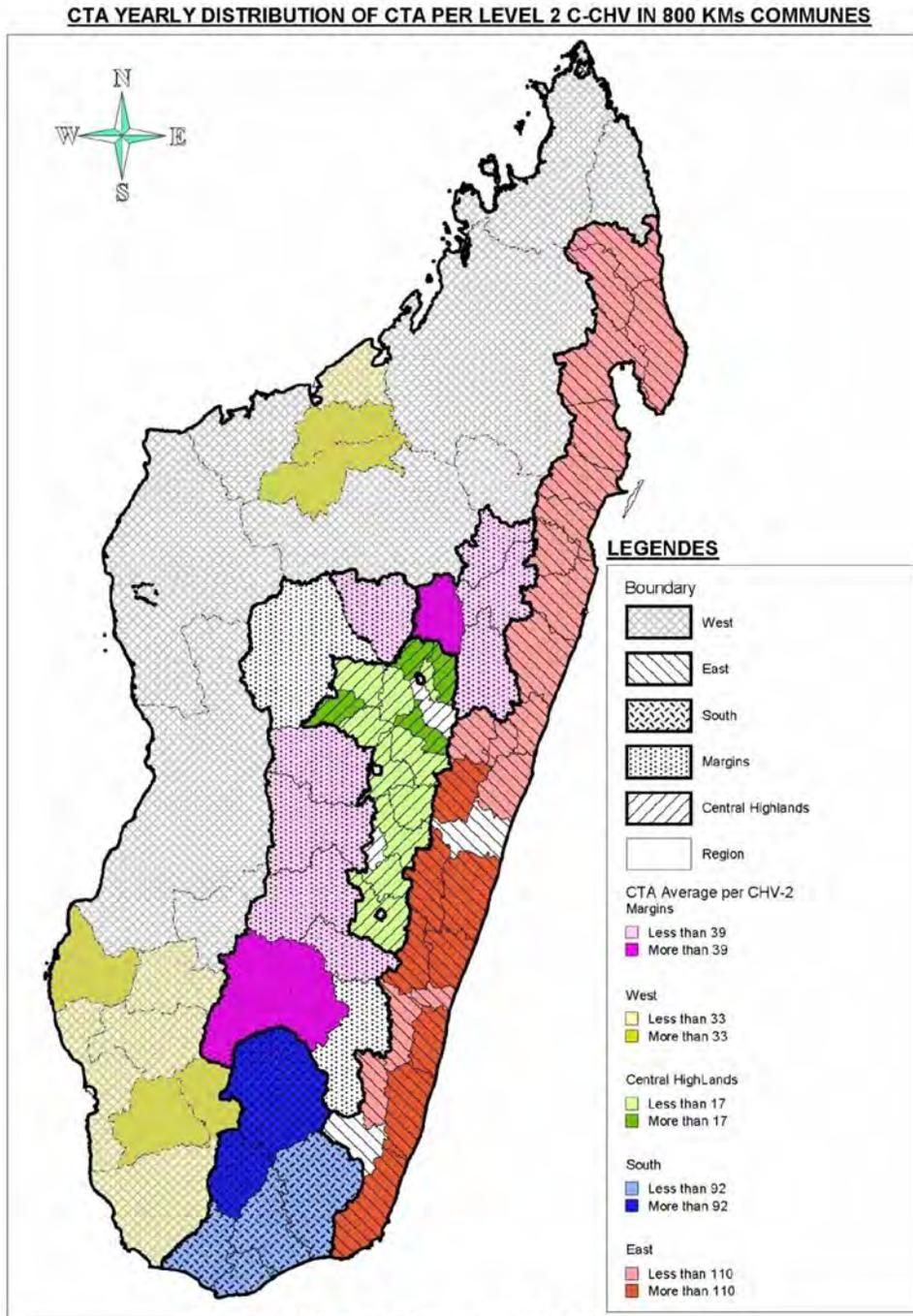
Map 6: ARI case management in KMs communes
This map shows the distribution of the average number of ARI cases managed by CHVs in the 800 KM salama communes



Sources: AMR, CHV, RTI/Santenet2, FY12

Map 7: CHV Supply

Supply points ensure that all CHVs are resupplied with ACT for IMCI activities in every commune. The average amount of ACT resupplied per CHV varies in the different operational zones - the quantity of ACT distributed in a zone follows a similar trend as the malaria mortality rate in that same zone.



Sources: AMR, CHV, RTI/Santenet2, PSI FY12